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# Coming Through it Together:
# Narratives on the Relational Aspects of Maternal Postpartum Depression and Parenting Practices

by

Alyssa Jane O'Brien

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

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GRADUATE DIVISION

of the

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By
Alyssa J. Abraham O'Brien

This work is dedicated to my husband, Shaun Patrick O'Brien
and to my son, George Thomas.

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**Abstract**

Coming Through it Together:

Narratives on the Relational Aspects of Maternal Postpartum Depression and Parenting Practices

Alyssa J. Abraham O'Brien

Depression that occurs in new mothers during the postpartum period is the most common complication of childbirth with an etiology and course similar to depression that occurs in women during other life events. However, postpartum depression (PPD) deserves dedicated research and clinical focus because of the critical role this period plays in the development of a family. The partner relationship is a well-known support for women during this time, yet little is understood about the associations between PPD and this relationship. The aim of this interpretive phenomenological study, conducted using the narrative and thematic interviewing style and analysis methods of Benner (1994), was to examine the experiences of couples as they made the transition to parenthood within the context of a maternal PPD diagnosis. Ten couples were interviewed within three years of the mother's PPD diagnosis. Findings indicate that couples experienced a range of responses to maternal PPD, including the processes of dismissal, acknowledgment and accommodation. These processes influenced their experience of their transition to parenthood, and their interpersonal relationship, and the functioning of their household. Multiple patterns of interaction and coping that varied by relationship style, were also identified and impacted daily habits and practices in the home. Three relationship styles were identified: 1) an equally supportive relationship style; 2) a relationship style that consisted of differing perspectives, but was still supportive; and 3) a discordant relationship style that created significant dysfunction in all aspects of the relationship. Relationship and parenting experiences were impacted differently depending on the couple's style of interaction and the quality of the

support they reported. Finally, results highlighted ways that parenting practices were influenced by a mother's PPD and how couples worked together, even through disagreements in the attempt to shelter their children from a mother's depression and their relationship conflicts. These findings suggest a need for perinatal nurses and health professionals to develop family centered postpartum assessments and interventions when the mother is diagnosed with PPD.

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## Introduction

Depression is a significant health problem that affects many people throughout their lifetime, often during periods of transition (Boland & Keller, 2009; van Praag, de Kloet, & van Os, 2004). Researchers have found that the rate of depression in adult women is twice that of adult men (Simonds, 2001; Sprock & Yoder, 1997; Weissman & Olfson, 1995). The prevalence of major depression is highest in samples of women in their childbearing years (Kessler, 2003). Depression that occurs in new mothers during the postpartum period is the most common complication of childbirth and is similar in etiology and course to depression that occurs in women during other life transitions (Beck, 2002a). This diagnosis significantly impacts the mood and experiences of 12-20% of new mothers (Beck, 2002a; O'Hara & Swain, 1996). The symptoms of postpartum depression have been shown to complicate the important bond between mother and infant, as well as the experience of the partner (Moehler, Brunner, Wiebel, Reck, & Resch, 2006; Goodman, 2004b). Despite the similarities between major depressive disorder and postpartum depression, postpartum depression deserves dedicated research and clinical focus because of the critical role this period plays in the development of a family.

The literature also shows that the partner relationship is a source of support and conflict for couples as they make the transition to parenthood ((Hammen, 2003; Papp, 2010; Williams, 2003), yet little is understood about the associations between maternal postpartum depression and this relationship. Although postpartum depression is a diagnosis that is given to an individual, its effects have been shown to influence partner behavior and the development of children (Goodman, 2004b; Ramchandani, Stein, Evans, O'Connor, & ALSPAC study team, 2005; Ramchandani et al., 2008). An understanding of the relational aspects of maternal

postpartum depression is a necessary prerequisite to the development of interventions that assist families during this important period.

Based on these needs, 3 research questions were addressed in this study:

(1) What are the patterns of emotional response, in mothers and their partners, to maternal postpartum depression?

(2) How are anticipated parenting and partner roles disrupted or changed by maternal postpartum depression?

(3) How are the couple's practices and processes of child monitoring and care impacted by maternal postpartum depression?

The first chapter of this dissertation contains a review of the gaps in the current postpartum depression literature. The literature review draws from the science of depression as well as that of interpersonal relationships to construct a broad knowledge base of how depression impacts the lives of women. This is then used to inform the research on postpartum depression and the transition to parenthood and the partner relationship. The literature is criticized for being overly dependent upon the use of measurements instruments to identify risk, instead of using samples of women that have been diagnosed with postpartum depression. In addition it is noted that although partners are experiencing the same transition to parenthood, there is very little research dedicated to the partner's experience and to understanding how couples experience this unique transition together while coping with maternal postpartum depression.

With the understanding of the gaps in the literature, the second chapter of this dissertation contains an examination of commonly referenced theories of depression and family coping are examined. First, there is a review of the diathesis-stress theory of

depression, which has been elaborated beyond the understanding of biological diathesis and is referred to as the Elaborated Cognitive Vulnerability-Transactional Stress Theory (Hankin & Abramson, 2001). This model informed the understanding of how the complex interplay of vulnerabilities, negative affect and life events increases depression in the individual (Hankin & Abramson, 2001). Patterson's (2002) model of Family Adjustment and Adaptation (FAAR) is also reviewed. The model informed the understanding of the processes that families actively engage in to arrive at a balance between the demands placed upon the family and the capabilities of the family unit to achieve adjustment or adaptation to stress. It is noted that although concepts from each model are applicable to the phenomenon of the impact of postpartum depression to the partner relationship and parenting, it is necessary to develop a framework, drawing from both theories, to guide this area of research. This model is proposed and discussed beginning on page 72.

Following the theoretical discussion, chapter three presents an overview of the interpretive phenomenological methodology, as well as the data collection and analysis methods, and an overview of the participant sample of this research study. The study used the methodology previously outlined in the work of Benner (1994). The research explicated the meaning of and the concerns within the partner relationship during the transition to parenthood within the context of maternal postpartum depression.

Chapters four, five and six present the findings of this research study. The study provides a glimpse into the lives of couples that have made the transition to parenthood while simultaneously coping with the unexpected diagnosis of a mother's postpartum depression and highlights the co-created relational aspects of this experience. These findings are explained in more depth in chapters four, five and six. Within the narratives that the couples revealed, it is

possible to more clearly understand their concern, confusion, resiliency and love for each other and their children. They express moments of shared triumph and sadness and together the couples explain their search for the answers that explain the mother's feelings and symptoms. Together couples struggle through a period of trial and error, as they search for ways to address the needs of the mother while still providing support and care for their children and completing the necessary tasks of their household. Couples also reveal the sacrifices they make to attempt to shield their newborn children from the symptoms of the mother's depression.

Finally, in chapter seven, an overall review of the findings is presented, with implications for theory, policy and practice discussed. In addition, a commentary, informed by the finding of this research, regarding the updates to the postpartum depression specified in the fifth edition of the *American Psychological Association's Diagnostic and Statistical Manual* (DSM-V, 2013) is shared. The model developed as a framework for this study that is originally discussed in chapter two, is revisited in this chapter, including proposed updates based upon the findings of this research study. Lastly, limitations of the study are shared, including how the inclusion criteria requiring participants to be living together may have excluded mothers who experienced more severe symptoms and couples who had more struggles and strife in their relationship.

In addition to allowing access to a deeper understanding of this experience, these findings will help to create a practical framework of couples' engagement during this complex transition. These findings can be used by practitioners to guide the care of women and families coping with postpartum depression during the transition to parenthood.

## Chapter One: Depression and the Partner Relationship in the Context of Life Transitions

Sociological and behavioral researchers report that life's many transitions such as the transition to parenthood are usually expected and are often called "normal" (Gottlieb, 1988; Skolnick & Skolnick, 2007). These life changes, however, can give rise to many stressors and possible crises for an individual and her or his partner relationship (Patterson, 2002; Skolnick & Skolnick, 2007). Women who experience stressors such as marital discord or financial instability during the transition to parenthood are often at risk of postpartum depression, a diagnosis that affects 12% to 20% of women in the first year postpartum (Beck, 2008a; O'Hara & Swain, 1996). Although postpartum depression is a mood disorder that is diagnosed on an individual basis, its effects have been shown to influence partner behavior and developmental outcomes in children (Goodman, 2004b; Ramchandani, Stein, Evans, O'Connor, & ALSPAC study team, 2005; Ramchandani et al., 2008).

Health care practitioners often expect life partners to support mothers in the early postpartum period (Association of Women's Health, Obstetric and Neonatal Nursing, 2001; Evans, Heron, Francomb, Oke, & Golding, 2001; McQueen, Montgomery, Lappan-Gracon, Evans, & Hunter, 2008). Research, however, shows that the quality of a woman's partner relationship has been associated with an increased risk of depression and, in relationships of poor quality, the support garnered may be insufficient to meet the woman's needs (Hammen, 2003; Papp, 2010; Weissman & Olfson, 1995). Partner relationships can be an additional stressor or a protective factor for women as they transition through parenthood (Hammen, 2003; Papp, 2010; Williams, 2003). The purpose of this paper is to present a foundation for understanding the complexities of major depression as it relates to interpersonal relationships and to determine how

research in this field may inform the association between postpartum depression and the couple relationship.

The effects of depression and feelings of uncertainty that often accompany it can be devastating to families and the partner relationship during the early postpartum period when couples face rapid skill attainment and multiple role adjustments and when child development is so readily influenced by parental interaction (Mercer & Ferketich, 1994; Walker, Crain, & Thompson, 1986). Maternal postpartum depression is the most prevalent complication of childbirth and has been shown to greatly influence the quality of mother-infant interactions (Beck, 2009). Researchers have also shown that maternal depression during the postpartum period can also influence the development of depressive symptoms in new fathers (Deater-Deckard, Pickering, Dunn, & Golding, 1998; Ramchandani et al., 2008). Yet, how maternal depression in the postpartum period influences fathers and the partner relationship (Goodman, 2004b) is poorly understood.

Researchers must develop a foundational understanding of the effects of postpartum depression on the partner relationship and what role interpersonal relationships may play in perpetuating or alleviating the symptoms of depression in new mothers during this time (Beck, 1996a; Mercer & Ferketich, 1994). The following review will examine the literature on major depression and the couple relationship and critically review research studies on postpartum depression and its effects on this interpersonal relationship.

This paper will focus on several issues that involve depression, postpartum depression, and the partner relationship. Research and development of the diathesis-stress model of depression have shown that depression in women over a lifetime is a multifactoral phenomenon that is influenced by life experiences, interpersonal relationships, biological and genetic factors,

and cognitive-behavioral characteristics (Hankin & Abela, 2005; Simonds, 2001). Consequently, this review will also examine the role of the intimate partner relationship throughout normative and nonnormative life transitions. The role of the partner relationship, as mediator and moderator between life events and the risk of depression, will be explored. Finally, appraising the importance of the partner relationship during these transitions – a key focus of current literature - will be highlighted (Hankin, Fraley, & Abela, 2005).

## Depression

As one of the most prevalent psychiatric disorders, depression has been shown to influence self-perception and interpersonal relationships (Garber, 2005; Gotlib & Hammen, 2009). The etiology of depressive psychopathology is often complex and may be influenced by events that have occurred throughout a lifetime (Boland & Keller, 2009; van Praag, de Kloet, & van Os, 2004). A significant body of literature has explored the relationship between depression and life events such as childhood abuse and traumatic events including marital aggression and violence. Researchers have also studied normative life events such as marriage and the transition to parenthood and the development of depression and depressive symptoms during that time. This review of the literature on depression will focus on (a) the etiology and course of depression, (b) the development of depression during normative and nonnormative life transitions, and (c) the mediating or moderating influence of the partner relationship during those transitions.

### Definition and Symptoms

Despite the development of theoretical and ongoing research on the risk factors and prognosis of depression, researchers and health care practitioners continue to debate the clear causes, defining characteristics, and best treatments for depression (Beck & Alford, 2009;

Goldstein & Rosselli, 2003; Hankin, Fraley, & Abela, 2005). Although these differing points of view persist despite advances in the neurobehavioral sciences, a significant body of literature indicates that psychogenic factors such as psychological stress, personal conflict, and environmental and organic factors such as disturbances in the hypothalamic-pituitary-adrenocortical axis probably play a role in the development of depression during one's lifetime (Beck & Alford, 2009; Gotlib & Hammen, 2009; Hankin & Abela, 2005).

The reported symptoms and posited causes of depression vary widely, particularly as they pertain to age, gender differences, and effect of the illness on interpersonal relationships (Hankin, Fraley, & Abela, 2005; Spotts et al., 2004; Zlotnick, Kohn, Keitner, & Della Grotta, 2000). The American Psychological Association (APA) has used conceptual definitions of depression that have been consistently reported in the medical literature to create a foundation for diagnostic criteria of the subtypes of depression (Beck & Alford, 2009). Based on current research and anecdotal evidence from clinical practice, Beck and Alford (2009) state that depression exhibits the following attributes: (a) a change in mood (e.g., sadness, loneliness, or apathy), (b) reports of a negative self-concept, (c) expressed feelings of withdrawal or self-punishment (e.g., wanting to hide, disappear, or die), and (d) changes in diet, energy, or desires (e.g., anorexia, libido changes, and sleep disturbances).

In current clinical practice, the diagnosis of depression is most often based on the Diagnostic and Statistical Manual of Mental Disorders, (DSM-V), published in 2013, that separates mood disorders into unipolar and bipolar disorders (APA, 2013). Within the category of unipolar depression, the DSM-V makes a further distinction between major depressive disorder, which is most often categorized as *depression* in the literature, and dysthymic disorder (APA, 2013). The diagnosis of major depressive disorder must be accompanied by reports of one

or more depressive episodes that comprise at least 2 weeks of depressed mood and as at least 4 weeks of the previously mentioned symptoms: insomnia, loneliness, self-harm, and the like (APA, 2013; Nuyen et al., 2005). It is the variability of the symptoms, the timing of the occurrences of the depressed mood, and the varied length of illness that complicate the diagnosis, treatment, and eventual outcomes of depression (APA, 2013; Furler et al., 2010; Nuyen et al., 2005).

**Incidence and Lifetime Prevalence**

As one of the most prevalent psychiatric disorders, depression has been shown to be one of the most costly to society in terms of total disability-adjusted life years (Garber, 2005; Gotlib & Hammen, 2009). Yet, understanding the prevalence rate of depression is muddied by many factors, including biases in the data used to make prevalence estimates, the age of the sample being studied, and historical factors that may influence findings within entire birth cohorts. Because of the complexity in determining the rate of depression and because estimates from medical or psychiatric clinical data may be biased, researchers have concluded that the ideal sources for estimating prevalence are community-based sample studies (Hankin, Fraley, Lahey, & Waldman, 2005). Further, prospective, longitudinal studies are the preferred research design to determine lifetime prevalence over cross-sectional data because of the possible age cohort effects and misleading data that can arise from identifying lifetime prevalence rates from multiple studies (Hankin & Abela, 2005; Kessler, Avenevoli, & Ries Merikangas, 2001). Longitudinal studies are also ideal because many researchers view depression as a diagnosis that varies throughout one's lifetime, indicating that signs of depression during childhood will often place a person at risk of depression in later adult life (Hankin et al., 1998; Hankin, Fraley, Lahey et al., 2005; Lewinsohn, Solomon, Seeley, & Zeiss, 2000). In their prospective follow-up of a birth-

cohort study ($N$ = 1,037), Kim-Cohen and colleagues (2003) found further evidence to corroborate this view; 75% of the study's adults who had major depressive disorder by age 26 also had depressive issues during childhood and adolescence.

Although cross-sectional studies are not the ideal research design to determine prevalence, much of the data on the symptoms and prevalence of depression is drawn from such studies (Gotlib & Hammen, 2009). Researchers will often combine the findings of cross-sectional studies in an attempt to represent the prevalence of depression in community samples across the lifespan because few, large, longitudinal cohort studies have been conducted. Thus, using community surveys and self-report symptom-screening scales, researchers have found that as many as 20% of adults and 50% of children and adolescents report depressive symptoms in the recall period of 1 week to 6 months (Kessler et al., 2001). These percentages are significantly higher than the point prevalence of major depression found using structured clinical interviews for diagnosis, which have shown rates of 2% to 4% in samples of adults (Ustun, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004) and 6% in samples of adolescents (Kessler et al., 2001). Furthermore, research has found a 2:1 sex ratio in samples of adults: twice as many women showed rates of depression compared with men (Simonds, 2001; Sprock & Yoder, 1997; Weissman & Olfson, 1995). The prevalence of major depression is highest in samples of women in their childbearing years (Kessler, 2003).

The current research that seeks to estimate the incidence and prevalence of depression is limited by the small number of large prospective longitudinal studies and by the instruments they use to measure depression (Doebbeling et al., 2000). Further, measurement instruments are limited because clear defining characteristics and the etiology of depression are lacking. In addition, researchers and clinicians frequently use many instruments to measure and screen for

depression and depressive symptoms. Each of these instruments has been developed and tested in different clinical and community settings (Doebbeling et al., 2000). Thus, creating a clear estimate of the types of symptoms and the prevalence of depression in different populations and settings is difficult. Because the diagnosis of depression and its etiology are not clearly defined, the methods of screening for and measuring depression differ, and specific samples (shared diagnosis or clinical setting) are frequently used, great debate continues on the true prevalence of depression across the lifespan, and the results of some studies may not be generalizable to other samples or settings (Doebbeling et al., 2000; Kessler & Wang, 2009).

**Risk Factors and Outcomes of Depression**

It is well documented that depression and depressive symptoms affect generations of families, and that a family can affect the development of depression directly or indirectly (Kane & Garber, 2004; Ramchandani et al., 2008; Sullivan, Neale, & Kendler, 2000). Current models of depression risk highlight, not just the causes of depression, but also the interrelationship of potential causes and the degree to which people may be vulnerable to them (Garber, 2005; Garcia-Toro & Aguirre, 2007). Garber (2005) points out that risk is not a question of genes or environment, but is the complex and combined effect of cognitive, environmental, and genetic factors that dispose one to the development of depression. In addition to the influence of family, researchers have identified several other significant risk factors for depression: (a) the diagnosis of a medical illness (Pruchno, Wilson-Genderson, & Cartwright, 2009), (b) being of younger age (Hankin et al., 1998), (c) having been divorced or separated (Amato, 2000), (d) having a previous history of depression or a family history of depression (APA, 2000), (e) being of a lower-socioeconomic status (Riley et al., 2009) and (e) being female (Doebbeling et al., 2000; Hankin et al., 1998).

A large, nationally derived survey study of the prevalence and risk factor profiles for "pure" and comorbid major depression found that the factor profiles for risk of depression differed depending on the diagnosis of the comorbid conditions (Blazer, Kessler, McGonagle, & Swartz, 1994). When the model was constructed for depression without other coexisting psychiatric conditions, the factors that were determined to have statistically significant odds ratios (OR) were being female (OR 1.56), being in nonmarried cohabitation (OR 1.83), and being a homemaker ( OR 2. 83) (Blazer et al., 1994). The model that consisted of depression with other psychiatric disorders was significantly different and varied by age, cultural ethnicity, and educational attainment (Blazer et al., 1994). The statistically significant factors in this model were (a) being female (OR 1.56), (b) nonmarried cohabitation (OR 2.16), (c) reporting a Hispanic ethnicity (OR 2.31), (d) education of 12 years (OR 2.31), (e) employment as homemaker (OR 2.61), (f) age 35-44 (OR 2.8), (g) age 15-24 (OR 3.0), (h) education 13-15 years (OR 3.79), and (i) educational attainment of 0-11 years (OR 6.82). The variability and complexities within these models further highlight the difficulty of determining a concise definition of major depression and identifying a comprehensive model of etiology. Of interest, the models reveal that educational attainment, marital status, and working for pay may protect one from the development of depression, but additional risks may be associated with age, gender, ethnicity, and poverty that need further evaluation.

Although more prospective-longitudinal studies are needed to examine the prevalence of depression, longitudinal reporting of case studies has documented the short- and long-term course of the illness in depressed individuals for quite some time (Beck & Alford, 2009). Initial studies, as far back as 1913, examined the life histories of depressed people, many of whom were hospitalized, to determine how depression varies across one's life course, but the data from these

studies were highly variable and almost always taken from acutely ill hospitalized patients (Beck & Alford, 2009). Today, studies examining samples of depressed and nondepressed individuals in different settings have established an understanding of depression across the life course (Hankin et al., 1998; Hankin & Abramson, 2001; Hankin, Fraley, Lahey et al., 2005).

Based on extensive documentation, depression can be classified as a chronic or recurring disorder. As many as 50% of adults who are diagnosed with depression have a reoccurrence within the first 2 years (Boland & Keller, 2009; Solomon, Haaga, & Arnow, 2001). The risk of recurring episodes increases with each new episode. The APA reports that at least 60 % of individuals who have had a major depressive episode will have a second episode (APA, 2000). Although the length of each new episode of depression is not significantly longer, it has been shown that the time between episodes is shorter throughout the course of depression (Boland & Keller, 2009). Research has established, therefore, that depression is a complex diagnosis that can recur across one's lifespan and is complicated by risk factors such as age, gender, educational attainment, and relationship status. Depression and depressive symptoms may also be buffered by factors such as employment status, positive marital interactions, and social support.

**Gender and Ethnic Differences**

When discussing the diagnosis of major depression across the lifespan in community samples, one must recognize that prevalence differences by gender have been consistently reported; adult women show rates of depression twice that of adult men (Simonds, 2001). Although longitudinal studies of depression by gender show that more boys than girls are found to be depressed in early childhood, the studies have found that this ratio changes after age 12 or 13, when more girls than boys experience depression from early adolescence through adulthood

to older age (Hankin et al., 1998; Weissman & Olfson, 1995; Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997). Petersen et al. (1993) established that roughly 25% to 40% of adolescent girls show high levels of depressed mood, compared with 20% to 35% of adolescent boys. Although many reasons for the significantly higher rate of depression in women than men have been presented, the gender differences are most likely the result of a complex interplay of biological, psychological, societal, and interpersonal factors.

From the biological point of view, researchers have posited that there are strong genetic factors that increase one's risk for depression (Monroe & Simons, 1991; Simonds, 2001). However, they do not believe that genetics alone are the reason why more women than men are at an increased risk of depression (Donald & Dower, 2002; Simonds, 2001). Anecdotal statements and societal beliefs have argued through the years that women experience behavioral and psychological changes because of their hormones and the hormonal cycles that they experience during their childbearing years. Although higher rates of depression *do* begin during adolescence when a young woman's reproductive hormones are fluctuating and some psychological diagnoses such as premenstrual syndrome seem to be closely linked to fluctuations in reproductive hormones such as progesterone, the biological evidence is inconclusive and can not account for such a significant disparity in rates of depression by gender (Simonds, 2001; Sprock & Yoder, 1997). Researchers have posited that the hormone fluctuations that women experience throughout their reproductive years may create additional vulnerabilities or even that these fluctuations act as physiological stressors that can increase the risk of depression or depressive symptoms in women and not that the hormonal changes are the direct cause of depression (Condon, 2010; Sprock & Yoder, 1997). Essentially, it has been proposed that the synthesis and metabolism of hormones that are known to be associated with depression such as

dopamine, norephinephrine, and serotonin are influenced by the female reproductive hormones *estradiol* and *progesterone* (Sprock & Yoder, 1997; Weissman & Olfson, 1995). Consequently, the times in a woman's life when those hormones are in highest concentrations or are undergoing rapid rates of change such as adolescence, pregnancy and the postpartum period, perimenopause and menopause, and times when women are taking infertility and birth control medications create increased risk of the development of depression and increased difficulty in diagnosing and treating the illness (Simonds, 2001; Sprock & Yoder, 1997; Weissman & Olfson, 1995).

However, this overtly biological position for the increased rates of depression in women does not account for the many sociological differences between the genders. Multiple sociological and environmental factors such as intimate partner violence (IPV) and single parenthood are disproportionately experienced by women (Dutton et al., 2006; Simonds, 2001). These factors are likely to play a role in the discrepant rates of depression in men and women across the lifespan.

In addition to the possible biological differences that have been associated with an increased risk of depression in women, researchers have examined the different life experiences that may increase stressors for women when compared with their male peers (Condon, 2010; Gotlib & Whiffen, 1989; Simonds, 2001). The vulnerability and stress theory of depression suggests that the experience of stressful life events can increase depression (Gotlib & Whiffen, 1989; Hankin & Abramson, 2001; Monroe & Simons, 1991). Researchers have posited that this places women at greater risk than their male counterparts because women have higher rates of exposure to certain stressful life events (Gotlib & Whiffen, 1989; Hammen, 1991; Hammen, 2003). For example, more women live in poverty and have lower status jobs than men, women are more likely to report role-strain and more often report being affected by the stress

experienced by other people, women are more often the primary caretakers of children and older adults, and more women are exposed to interpersonal violence (Dutton et al., 2006; Hammen, 2003; Hammen, 1997; Kendler, Neale, Kessler, Heath, & Eaves, 1993; Sprock & Yoder, 1997).

These findings suggest that there is a complex web of stressors that place women at an increased risk of developing depression from adolescence through their senior years; the highest risk occurs during the childbearing years when physiological and psychological stressors appear to be at their peak (Hammen, 2003; C. Hammen, 2005; Kendler et al., 1993). Nonetheless, researchers must continue to investigate the complex interplay of biological and sociological factors that may affect the increased rates of depression in women.

## Depression and the Partner Relationship

Studies of interpersonal conceptualizations of depression have shown that women with depression were significantly more likely to engage in stressful interpersonal events that may influence the course of their illness (Hammen, 2003; Hammen, 1999). A review of the literature on depression and marital discord found that the interactions of dyads with a depressed partner were found to have a higher frequency of negative communication behaviors such as blame or withdrawal and a lower frequency of positive communication behaviors such as problem-solving or smiling (Rehman, Gollan, & Mortimer, 2008). This suggests that the partner relationship may also play a role in the development and course of depression in women. These research findings underscore the importance of understanding the issues that may be related to depression in adults within the context of normative and nonnormative life transitions and of further delineating the mediating and moderating influence of the partner relationship during those transitions and events.

Before exploring how the partner relationship may influence the relationship between life events and depression, one must understand how family and life events are understood in the literature. In describing the importance of family in Western society, Goode (1982) explains that the family is a unique social construction that regulates a wide variety of social behaviors and activities. Within this social institution, there come societal and familial expectations of normative and nonnormative roles and transitions (Goode, 1982; White & Klein, 2008). When considering depression as an illness that can occur or recur at different times in one's lifetime and that life events can influence an individual's course of depression, one must be mindful that some of these life events may be transitions that families and couples undergo together (Billings & Moos, 1985; Mazure, 1998).

These transitions are often defined as *normative* or *nonnormative* in family and behavioral research and theorizing (Skolnick & Skolnick, 2007; White & Klein, 2008). Norms are a set of social rules and expectations that are often taken for granted and govern family, group, and individual behavior (White & Klein, 2008). Examples of normative transitions in family life that are accompanied by socially constructed expectations are marriage, parenthood, and caring for an elderly parent (Brody, 1985; Cherlin, 1992; Deave, Johnson, & Ingram, 2008). Nonnormative transitions can occur at any time in the life span, for example, teenage pregnancy in Western society or not meeting expectations for the individual or for society (e.g., loss of a partner in young adulthood, experiencing a loved one's acute or chronic illness, or the experience of IPV or divorce; (Aseltine & Kessler, 1993; Blanchard, Blanchard, & Becker, 1976; Cascardi & O'Leary, 1992; White & Klein, 2008). These normative and nonnormative transitions trigger stressors in the individual, the partner relationship, and the family (Skolnick & Skolnick, 2007; White & Klein, 2008). Thus, when discussing depression in the context of the partner

relationship, identifying the type of transition and stressors a couple or individual is experiencing is vitally important.

**Normative Transitions**

**Marriage.** In Western societies, marriage is a normative transition in adulthood. A significant body of literature has shown that marriage provides physiological and psychological protective factors to married individuals (Skolnick & Skolnick, 2007; Williams, 2003; Williams & Dunne-Bryant, 2006). However, research has also established that the transition carries with it many stressors that place an individual at risk of developing depression and depressive symptoms (Hammen, 1991; Mead, 2002; Umberson, Williams, Powers, Liu, & Needham, 2006). When controlling for multiple factors such as education, race, and income, researchers have shown that married people have lower rates of depression and are emotionally and physically healthier than never-married or previously married singles (Coyne & Benazon, 2001; Waite & Gallagher, 2000). Conversely, a significant amount of research has also shown that these protective factors essentially disappear and an individual can be placed at risk of depression when there is marital discord or dissatisfaction in the relationship or when individual expectations of the marriage partnership are not met (Aseltine & Kessler, 1993; Mead, 2002).

These findings appear to be contradictory. How can marriage be a protective factor against and a risk factor for depression? The key finding is this: appraising the quality of the partner relationship is a critical factor in this association. Essentially, relationships seen to be harmonious or satisfactory may result in decreased exposure to interpersonal stressors, thus lowering the risk for depression during life transitions (Kouros, Papp, & Cummings, 2008; Williams, 2003).

A 2008 study that explored the association between marital satisfaction and depressive symptoms in a community sample of couples ($N = 296$) in established relationships ($M = 13.25$ years) found that changes in marital satisfaction predicted depressive symptoms (Kouros et al., 2008). As measured at three intervals, levels of depressive symptoms increased in men and women as marital satisfaction decreased (Kouros et al., 2008). This same longitudinal study also highlighted the bidirectional nature of the association between depressive symptoms and relationship satisfaction; changes in depressive symptoms were negatively associated with marital satisfaction; increased symptoms of depression throughout the 3-year period predicted lower levels of relationship satisfaction (Kouros et al., 2008).

Although these findings illustrate the difficulty researchers have experienced in trying to untangle the complexity of associations between depression and marital relationships, the measures in the study focused on depressive symptoms and should not be accepted as a clinical diagnosis of depression (Rehman et al., 2008). Also, without observational data or daily diary ratings to show prospective data on conflict and relationship satisfaction, retrospective data from questionnaires may not provide a complete understanding of the subtle marital processes inherent in daily interactions (Herr, Hammen, & Brennan, 2007; Kouros et al., 2008).

Further support for the association between interpersonal relationship satisfaction and quality and depression was reported in an analysis of findings from the National Comorbidity Survey, 1990-1992 ($N = 8,098$; Zlotnick et al., 2000). This analysis, which made the important distinction between the clinical diagnosis of depression and other psychiatric disorders and the reporting of symptoms, used a diagnostic interview to determine not symptoms of psychological disorders but diagnosis. It was determined that major depressive disorder was significantly related to fewer positive interactions and more negative interactions in all of the relationship

domains studied (marital/live-in partner, friend, and relative) when compared with a group without psychiatric disorders ($p < .001$). When assessing the relationships between the groups (major depressive disorder, dysthymia, nonaffective disorders, and no disorders) and relationship interactions, researchers found that the interpersonal effects of major depression were most pronounced in the marital/ live-in partner relationship, thus supporting the findings of previous research (Fredman, Weissman, Leaf, & Bruce, 1988; Zlotnick et al., 2000). However, this study's cross-sectional design did not allow for the determination of causality between depression and negative interpersonal interactions and only allowed for the determination of correlation, which does not aid in answering the question of what came first, the major depressive disorder or the negative interpersonal interactions.

Additionally, findings in the literature are at odds regarding the association between the quality of the partner relationship and reporting of depression and depressive symptoms by gender. Zoltnick et al. (2000) reported that women with a diagnosis of major depressive disorder were not significantly more likely than their male peers to report poorer quality of positive and negative interactions with their spouse or live-in partner. This lack of support for a gender difference between marital satisfaction and depression was mirrored in the findings of Davila et al.(2003), who could not find a model that supported strong gender differences. However, findings have also shown that negative intimate partner interactions affect women and men differently and that a difference exists in the association between relationship satisfaction and depression by gender (Whitton et al., 2007). The association between poor relationship interactions and depression is more significant for women than men (Herr et al., 2007; Whitton et al., 2007).

In contrast, Fincham et al. (1997) used structural equation modeling to examine marital satisfaction and depressive symptoms measured during an 18-month study of 116 couples who responded at each of the two waves of the study. The researchers found that the relationship between marital satisfaction and depression differed by gender; men showed a causal pathway that began with depression and led to marital dissatisfaction and women reported relationship dissatisfaction that led to risk of depression. However, other researchers have been quick to point out that those results have proved controversial because they have not been replicated in similar sample groups (Davila, Karney, Hall, & Bradbury, 2003; Kurdek, 1999). Possible causes of the discrepant findings may be the studies' many methodological differences, which include the use of diagnostic interviewing for depression instead of self-report of depressive symptoms or questionnaires to measure relationship interactions and observational data (Davila et al., 2003; Rehman et al., 2008). Despite the reasons for the differences, further exploration of this complex relationship is warranted (Davila et al., 2003; Williams, 2003).

The literature exploring the association between the life transition of marriage and depression is based on the understanding that the partner relationship influences the development of depressive symptoms during this time. Some researchers have found differences in this association by gender, although others have not found this association to be as robust (Fincham, Beach, Harold, & Osborne, 1997; Herr et al., 2007; Whitton et al., 2007; Zlotnick et al., 2000). Additionally, researchers have found that the marital relationship can be a buffer against and a risk factor for depression and that martial quality plays a key role in how this relationship is to be understood (Aseltine & Kessler, 1993; Mead, 2002; Umberson et al., 2006; Williams, 2003). Despite these findings, the literature is limited because the use of empirical measurement instruments presents a myopic view of the context of marriage, depression, and marital quality.

Measurement instruments do not individualize the life event and do not allow for the expressed meaning, importance, and emotional effect on individuals or couples. Additional research using interviews will allow for a more expansive understanding of this life transition, depression, and the appraisal of the partner relationship (van Praag et al., 2004).

**Parenting.** Researchers have found that the normative transition to parenthood is often accompanied by changes within the family that increase the risk that partners will experience increased dissatisfaction and strain in the partner relationship (Cowan, Cowan, Pruett, & Pruett, 2007; Levy-Shiff, Einat, Mogilner, Lerman, & Krikler, 1994). Research has often identified several themes of stressors that accompany the role of parenthood: childcare; financial strain; and partner conflict, support, and parenting style (Cowan et al., 1985; Morrill, Hines, Mahmood, & Córdova, 2010; Ventura, 1987) This review will focus on the stressors related to partner conflict and support to highlight the associations between partner relationships, life transitions, and depression.

A study of 54 mothers and 58 fathers during early parenthood showed that 14% of the mothers and 11% of the fathers reported feeling stressed with their spouse (Ventura, 1987). When the theme of partner stress was further explored, it was shown that it related to three categories: marital conflicts, lack of spousal support, and sexual relations. After using the Ways of Coping Checklist (Lazarus & Folkman, 1984) to measure reported stressors and coping strategies in mothers and fathers, the researcher concluded that early parenthood remains a stressful time for couples. Adding the stress of childcare can make parents feel fatigued and "tied down"; these feelings leave less time for the partner relationship and increase reports of relationship conflict (Ventura, 1987). Although this study used a mixed methods approach to further clarify statements on the subjects' questionnaires, understanding the complex actions and

negotiations that couples engage in during everyday parenting activities was hindered by the lack of observational or narrative data.

The association between relationship satisfaction and parental satisfaction was further supported by examining data from a nationally representative sample of 1,200 parents (Rogers & White, 1998). The investigators tested the idea that the relationship between marital satisfaction and parental satisfaction could be bidirectional; previous research had often used conceptual models that implied such a pathway (Erel & Burman, 1995; Rogers & White, 1998). Over the 4-year, two-wave study, the researchers found, through cross-sectional analysis, that parenting satisfaction was significantly higher for married couples, for those who were parenting their own biological children, and for women. Although parenting satisfaction seemed to remain stable, a positive relationship between parenting satisfaction and marital quality was observed. Structural equation modeling also showed that the path from marital happiness to parenting satisfaction was positive and significant, indicating that increases in marital happiness were significantly associated with increases in parenting satisfaction.

Additionally, the path from parenting satisfaction to marital happiness was also positive and significant, indicating that increases in parenting satisfaction were associated with increases in marital happiness (Rogers & White, 1998). This intriguing finding calls for further analysis of the complex association between parenting stress and satisfaction and martial satisfaction. Additionally, the findings could be further explicated through analysis of parents' perceptions of how marital satisfaction and parental satisfaction are associated within their own relationships, instead of the continued use of questionnaires that measure the constructs of stress and satisfaction but do not allow for the analysis of the constructs' meaning in everyday family interaction. It is also important to recognize that the use of terms such as "stress" may be loaded

with other meanings for research participants because of the way these terms are used in our society.

A study of 200 dual-income couples with children found that higher levels of occupational and parental stress were equally correlated to depressive symptoms in both women and men (Windle & Dumenci, 1997). The investigators' intent was to differentiate the relationship between types of stress and depression within the context of gender, noting that previous research and theorizing had focused on the idea that employment was associated with increased levels of self-esteem and perceived worth in women (Barnett & Marshall, 1991; Windle & Dumenci, 1997). Consistent with other research, the investigators found that higher levels of parental and occupational stress, more years of marriage, and lower levels of marital satisfaction and family cohesion predicted higher levels of depression in married couples (Barnett, Marshall, Raudenbush, & Brennan, 1993; Rogers & White, 1998). Based on the model, the predictors explained 35% and 40% of variation in levels of depressive symptoms in men and women, respectively (Windle & Dumenci, 1997). This study, like many others in this field of research, is limited by the use of questionnaires to measure depressive symptoms and the lack of clinical interviews to diagnose depression. The net effect is a model that only indicates increased depressive symptoms, not one that shows an actual increase in the rates of diagnosed depression.

Many studies ask couples to discuss retrospectively what the transition to parenthood was like and how stress may have influenced that time in their lives (Beck, 1996b; Edhborg, Friberg, Lundh, & Widstrom, 2005; Milgrom, Westley, & McCloud, 1995). Recognizing that this retrospective approach might alter parents' perceptions of this time, Deave and colleagues (2008) began with antenatal interviews followed by interviews at 3 to 4 months postpartum. Several themes were distilled from the couples' reports of the transition period, including a lack of

knowledge about the reality of their transition to parenthood (e.g., lack of breastfeeding and practical baby-care skills) and feeling uninformed about relationship changes during this time (Deave et al., 2008).

These findings support the idea that, within the context of early parenthood, many women feel incapable of mastering infant-care skills, and their partners feel frustrated by their infant's needs and their inability to express what they need when they are fussy (Edhborg et al., 2005; Edhborg, Seimyr, Lundh, & Widström, 2000; Mauthner, 1999; Milgrom et al., 1995; Tammentie, Paavilainen, Astedt-Kurki, & Tarkka, 2004). The researchers reported that parenting education tends to focus solely on pregnancy and the labor process and less on becoming new parents (Deave et al., 2008; Parr, 1998). Parents were able to express the need for more information before their transition to parenthood, not only about infant-care skills and the delivery process but also about the transforming change having a child would have on their partner relationship and about their partner's perspective of becoming a parent (Deave et al., 2008). Although the study was conducted at two health care centers in Southwest England and access to parenting classes was therefore similar for all couples, limiting the range of experiences discussed, this study highlights the need to expand perinatal education for parents to prepare them for the changes and stressors attendant to the transition to parenthood. Additionally, these findings establish that couples associate transition to parenthood with a change in their partner relationship, thus increasing the need to better examine the relationship between the transition to parenthood within the context of depression and the role of the partner relationship during this time.

Despite the value of the above studies, questions remain about parenting stress, gender and relationship satisfaction, and apparent contradictory findings (Rogers & White, 1998;

Ventura, 1987; Windle & Dumenci, 1997). In one study (Windle & Dumenci, 1997), for example, the findings show a relationship between more years of marriage, parenting stress, and increased risk for depression, while a second study (Rogers & White, 1998) found no changes in the level of parental satisfaction and marital quality over time. Further analysis of the associations between marital quality, parental experiences, and depression over time is needed to untangle this complex relationship.

The literature that focuses on the relationship between the transition to parenthood and depression shows that potential risk factors may increase the risk of depression in new parents during early parenthood such as financial strain, partner conflict, and a lack of parenting education and support (Cowan et al., 2007; Cowan & Cowan, 2002; Deave et al., 2008; Morrill, Hines, Mahmood, & Córdova, 2010; Ventura, 1987). Additionally, factors such as partner satisfaction and support during early parenthood can be protective against the development of depression during this life transition (Rogers & White, 1998). Despite these findings, the literature is limited; few studies have used the clinical diagnosis of depression, choosing instead to focus on the association between parenting stress, the partner relationship, and depressive symptoms. Future researchers should examine this multifactoral association from a less structured standpoint, allowing parents to recount this complex transition within the context of diagnosed depression. Unlike the use of measurement instruments, such a method would allow for a nonatomistic view of couples' experience as it is being lived and expand our understanding of the stressors that affect the partner relationship during this transition.

**Nonnormative Transitions**

**Divorce.** Research has shown that a clear relationship exists between stressors and the diagnosis of an affective disorder such as depression. However, it has also been shown that the

type of stressor can affect the type of diagnosis and relapse of illness (Tennant, 2002). The most extensive body of research on the relationship between nonnormative life events and stressors and depression has focused on interpersonal loss, such as separation and bereavement (Hammen, 2005). Divorce or separation from an intimate partner is a life event that has been shown to significantly increase exposure to stressors that lead to depression (Amato, 2000; Aseltine & Kessler, 1993; Christian-Herman, O'Leary, & Avery-Leaf, 2001; Varner & Mandara, 2009; Williams & Dunne-Bryant, 2006). However, like the difficulty in untangling the associations between other stressors such as parenting, marital satisfaction, and depression, determining the associations between relationship dissolution and depression has proved difficult for researchers (Aseltine & Kessler, 1993; Williams & Dunne-Bryant, 2006).

Aseltine and Kessler (1993) used a representative community sample of 1,755 men and women in the Detroit metropolitan area in 1985 to understand the effects of marital disruption on depression. This longitudinal study allowed the researchers to distinguish depressive symptoms that were present before and after the marital disruption and to examine the effect of marital quality over time. They found that the bivariate association between marital disruption and depression was significant ($p = .249$) for the 61 respondents who separated or divorced during the study. This finding is similar to that of previous research and could be interpreted as evidence that interpersonal loss could be associated with depression that could not be explained through other models (Aseltine & Kessler, 1993; McLeod & Kessler, 1990). There also appeared to be a difference by gender in the strength of the relationship between marital disruption and depression over time, showing a stronger correlation for women ($b = 0.383$; $t = 2.3$; $p < .05$) than men ($b = 0.007$; $t = 0.0$; *ns*; Aseltine & Kessler, 1993). This finding seems at odds with previous research that discounted the effect of gender on depression in marital disruption (Booth & Amato, 1991;

Doherty & Burge, 1989; Kitson, Babri, & Roach, 1985). However, the small subsample who experienced marital disruption during the study ($n = 61$) may account for these findings, warranting further evaluation. Also of interest, the study found a negative relationship between poor marital quality and depression among men ($b = -0.868$; $p < .05$) and women ($b = -0.800$; $p < .05$) following separation or divorce, showing that marital disruption may actually provide a protective factor for those in a relationship that is deemed highly stressful. As a whole, this study's findings were limited because the sample consisted of White couples only and did not use clinical interviews to diagnose depression.

Williams and Dunne-Bryant (2006) also found a relationship between divorce and psychological well being and sought to explain some of the factors that moderate this association. An analysis of data from the National Survey of Families and Households ($N = 4,811$) revealed that the effects of marital dissolution on adult depressive symptoms was greater for those who had young children at home at the time of separation, suggesting support for a stress model of depression. Further, the investigators' finding that the relationship between depression and martial dissolution was stronger for women then men ($b = 4.210$; $p \leq .01$) supports findings of previous research (Aseltine & Kessler, 1993; Marks & Lambert, 1998; Simon, Chisholm, Treglia, Bushnell, & LIDO Group, 2002; Williams & Dunne-Bryant, 2006).

Williams and Dunne-Bryant (2006) also determined that the added stress of having a school-age child in the home at the time of the marital dissolution increased depressive symptoms substantially for men and women ($b = 4.550$; $p \leq .05$), showing that there was a mediating effect on depression. The researchers hypothesize that marital disruption affects women's global happiness and depressive symptoms more so than men because divorced women face the added stress of financial strain, a finding supported in other research (Amato, 2000;

Williams & Dunne-Bryant, 2006). This study has its limitations; because the time between each of the two-waves in the analysis was fairly short (3 years), the study's findings may only partly explain the estimated effects of marital dissolution over time. Thus, research studies that span a longer period of time are warranted.

Drawing data from the National Longitudinal Survey of Youth, a study of 443 African American mothers who were continuously married or experienced marital transitions (Varner & Mandara, 2009) supports findings that show an association between financial difficulties, depression, and marital transitions. The researchers found that African American mothers who quit marriage during the study had a significant increase in depressive symptoms ($b = 0.86$; $p < 0.05$) when compared with the continuously ($b = 0.45$; $p < .05$) and newly married ($b = 0.52$; $p < .05$), a finding that has been supported by research using different samples (Aseltine & Kessler, 1993; Williams & Dunne-Bryant, 2006).

Researchers also found that financial resources moderated the effect of marital transition on changes in depressive symptoms and that those women who left marriage with fewer financial resources experienced a significant increase in depressive symptoms, a finding consistent with a stress and resiliency model (Varner & Mandara, 2009; Wang & Amato, 2000). As with other studies, the findings of this research are limited by the use of questionnaires on depressive symptom that allow for the assessment of symptoms only, thus indicating risk of depression and not an increase in the diagnosis of the sample. Because of the strength of the findings, however, further research of varied populations is needed using clinical diagnostic interviews.

**Intimate partner violence and lifetime trauma.** Research has shown that lifetime exposure to traumatic events such as IPV and childhood maltreatment is associated with increased levels of adverse physiological and psychological outcomes such as depression and

posttraumatic stress disorder (PTSD; Cascardi, Langhinrichsen, & Vivian, 1992; Fletcher, 2010; Humphreys, Cooper, & Miaskowski, 2010; Teicher, Samson, Polcari, & Andersen, 2009). This presents an increased risk to women in their childbearing years. Clinic-based studies have shown that as many as 26% of women seeking prenatal care have been victims of violence before pregnancy and as many as 7% experience violence during pregnancy (Campbell & Soeken, 1999; Martin et al., 2006; McFarlane, Parker, & Soeken, 1996). Because of the complex interplay of factors that place women at a disproportionate risk of depression, it is important to review how their exposure to trauma such as IPV throughout their lifetime may influence their psychological status and place them at increased risk.

When considering the connection between aggression and IPV and depression, health care personnel must realize that IPV disproportionately affects women; as many as 22% of American women report IPV in their adult lives, compared with 7% for men (Tjaden & Thoennes, 2000). Researchers who have studied the objective characteristics of IPV such as frequency and severity have shown that increased victimization over time can increase the experience of adverse mental health outcomes such as depression and anxiety (Cascardi, Langhinrichsen, & Vivian, 1992; Vogel & Marshall, 2001). This suggests that frequent and long-term exposure to IPV can increase the exposure to chronic psychological and physiological stress, affecting physical and mental health in women, especially in their childbearing years.

Marital aggression and IPV have been associated with depression and depressive symptoms in men and women (Cascardi, Langhinrichsen, & Vivian, 1992; Vaeth, Ramisetty-Mikler, & Caetano, 2010). However, many studies have reported that additional stressors on the relationship such as alcohol use can increase the risk of depression and injury significantly and decrease reports of quality of life (Cascardi, Langhinrichsen, & Vivian, 1992; Temple, Weston,

& Marshall, 2005; Vaeth et al., 2010). Research has also shown that aggression and violence in an intimate partner relationship can affect the perpetrator and victim alike and can increase risks for health problems in both partners (Cascardi, Langhinrichsen, & Vivian, 1992; Temple et al., 2005; Vaeth et al., 2010). This section will examine the association between relationship aggression, IPV, and depression, to further expand upon the effects of nonnormative life events and transitions on depression.

The understanding that women and men may experience risk of depression as a perpetrator or victim of IPV and aggression is supported by Vaeth, Ramisetty-Mikler, and Caetano (2010). This multiwave study examined the relationship between IPV and depression, while controlling for alcohol-related factors and childhood exposure to violence, in 1,136 couples. Using bivariate analysis, the investigators found that couples reporting IPV had higher scores of depressive symptoms than "intact" couples who did not report violence in the relationship. Further, sexual aggression resulted in the highest depressive risk scores for men and women, suggesting that type of aggressive experience can influence the risk of depression (Cascardi, Langhinrichsen, & Vivian, 1992; Vaeth et al., 2010). Reports of binge drinking and its relationship to depressive symptoms differed by gender, as did exposure to childhood violence and its effect on depression in later life, suggesting that some life events may affect risk of depression in men and women differently (Hammen, 2005; Temple et al., 2005; Vaeth et al., 2010). In using a cross-sectional design, the study was limited to the reporting of correlations and could not determine whether depression was an antecedent or a consequence of IPV.

This study, like much of the literature in this area, is significantly limited because of its retrospective, cross-sectional design, which does not account for the multiple sociological and biological factors that place women at increased risk. These findings should trigger the

development of longitudinal studies, which take into consideration the subjective appraisal of lifetime events and their relationship to partner aggression and depression.

Adding to the importance of this body of literature is the understanding that long-term psychological abuse can result in significant rates of depression and anxiety in the same way that physical or sexual abuse can (Pico-Alfonso et al., 2006). Although physical and sexual abuse may be easier for practitioners to recognize because of the potential physiological results of such trauma, clinicians and researchers alike should include psychological abuse in their clinical assessment of women and in research studies because exposure to any form of IPV has been shown to increase rates of depression, anxiety, PTSD, and suicidal ideations in women (Dutton et al., 2006; Martinez-Torteya, Bogat, von Eye, Levendosky, & Davidson, 2009; Pico-Alfonso et al., 2006).

In keeping with the understanding that appraisal of life events is a key concept in the development of depression, researchers have found that a woman's subjective appraisal of her experiences of IPV can influence her reports of stress and depression (Martinez-Torteya et al., 2009). Women who report higher levels of IPV are found to report increased levels of depressive symptoms above and beyond the strictly objective severity or frequency of IPV (Martinez-Torteya et al., 2009). Thus, several key factors may play a role in the relationship between IPV and depression in women. First, because appraisal is a key factor, health care personnel must understand how previous life experiences such as childhood maltreatment might influence a woman's cognitive appraisal process. Future researchers should focus not only on the objective measures of violence in intimate partner relationships but also on the context of such aggression and violence; a pregnant woman who uses aggression to counteract the threat of violence from

her partner presents a very different contextual situation than the man who reports his wife's verbal abuse.

Further, exposure to certain forms of trauma such as childhood maltreatment may influence the development of depression in adult life (Fletcher, 2010; Teicher et al., 2009). Childhood maltreatment is a traumatic life experience that includes sexual abuse, physical and psychological abuse, and neglect (Fletcher, 2010). Consequently, researchers have noted a significant relationship between childhood maltreatment and depression in adults, a relationship that is particularly robust in community and clinical samples of adult and adolescent women (Donald & Dower, 2002; Fergusson, Swain-Campbell, & Horwood, 2002; Kendler et al., 2000; Teicher et al., 2009; Wise, Zierler, Krieger, & Harlow, 2001). Childhood maltreatment may not always lead directly to adult onset depression. Instead, exposure to this type of trauma during childhood may sensitize a person, increasing her or his risk of depression in adolescence and adulthood (Andersen & Teicher, 2008; Teicher et al., 2009). Thus, the pathway from childhood maltreatment to adult depression could be influenced by an individual's further exposure to stressors such as trauma or loss (Teicher et al., 2009).

These findings might explain why early childhood rates of maltreatment are similar across gender, yet women are more likely to be depressed throughout adolescence and adulthood. This is caused perhaps by the compounding effects of additional sociological, biological, and psychological stressors experienced by women in their childbearing years (Fletcher, 2010). Overall, the literature on childhood maltreatment is limited in much the same way that the IPV literature is: No prospective longitudinal studies have investigated the effect of childhood trauma throughout the lifetime, and research has focused on the objective measures of childhood maltreatment and less on the victim's appraisal of such events.

Recently, researchers have begun to examine the relationship between IPV and mental health diagnoses in perinatal women (Cerulli, Talbot, Tang, & Chaudron, 2011; Malta, McDonald, Hegadoren, Weller, & Tough, 2012). A cross-sectional study of 188 mothers who were asked to self-report IPV and demographic information, as well as undergo a semi-structured psychiatric diagnostic interview at their well-baby clinic appointments found mental health diagnoses were significantly higher in women who had experienced IPV (Cerulli, Talbot, Tang, & Chaudron, 2011). The researchers asked participants to identify IPV experiences and 21% of the women reported have one or more occurrences in the year prior to their appointment. The women who experienced IPV were more likely to be diagnosed with a mood and/or anxiety diagnoses ( $p < 0.05$, Fisher's exact test). The strongest associations were between the experience of IPV and current depressive symptoms ($p < 0.01$) and panic disorders ($p < 0.05$). It was also found that among all the women in the study, the strongest contributing factor towards a diagnosis of perinatal depression is a previous experience of major or minor depression (OR 3.18; $p < 0.0001$). This study was unique, in that it did not focus upon the use of self-reporting measures to identify risk for mental health diagnoses or symptoms, instead it used semi-structured interviews by trained providers to determine mental health diagnoses. As a result, the study was able to address a gap that is often found and reported in the literature, allowing for the examination of the complexity of mental health diagnoses in the perinatal period.

Another study examining the relationships between interpersonal violence and maternal mood and parenting in the perinatal period, included a large ($N$ =1319) prospective community based sample of women (Malta, McDonald, Hegadoren, Weller, & Tough, 2012). Participants were asked to complete self-report measures in early pregnancy (before 25 weeks), during their third trimester, and again at 4 months postpartum. Thirty-percent of the women in the study

reported at least one experience of interpersonal violence during their lifetime. Mental health concerns at 4 months postpartum were reported at rates significantly higher in this group when compared to the women that had not reported a history of violence: anxiety (24% vs. 12%), depression (22% vs. 10%), higher perceived feeling of stress (24% vs. 14%), and low parenting morale (29% vs. 16%). Child maltreatment was found to be an independent risk factor for postpartum depression symptoms, while IPV was found to be significantly associated with low parenting morale. These findings highlight the importance of including a women's history of violence and stressful events and experiences across the life time when examining depression in the perinatal period.

Thus, researchers should conduct prospective longitudinal studies of the relationship between IPV and childhood maltreatment, focusing on the complex interplay of genetic vulnerabilities, lifetime exposure to environmental stressors, social support, and previous exposure to trauma that place women of childbearing age at an increased risk for IPV and adverse psychological and physiological outcomes. In summary, IPV and childhood maltreatment play a significant role in the lifetime exposure of women to stress; this exposure to trauma increases the risk for adverse psychological and physiological outcomes such as depression and chronic pain in women of childbearing age (Fletcher, 2010; Humphreys et al., 2010; Pico-Alfonso et al., 2006). And, a woman's appraisal of her traumatic experiences plays a significant role in the development of her depression, suggesting that certain personality characteristics such as resiliency or self-esteem may play key protective roles against the illness (Martinez-Torteya et al., 2009; Teicher et al., 2009).

After reviewing these normative and nonnormative life events and transitions, it is apparent that there are associations between the experience of stressors within the couple

relationship and increased risk for depression in men and women (Hammen, 1991; Mead, 2002; Umberson et al., 2006; Vaeth et al., 2010; Williams & Dunne-Bryant, 2006). However, it is equally apparent that differences exist in the strength of the relationship between life events and depression by gender, type of event, and at times length of exposure (Booth & Amato, 1991; Cascardi, Langhinrichsen, & Vivian, 1992; Doherty & Burge, 1989; Hammen, 2003; Kitson et al., 1985; Vaeth et al., 2010). Further research is needed to clarify these complex interactions between types of events, gender, and depression, specifically longitudinal studies to determine if stressful life events lead to increased risk of depression, or if depression is the pathway to stressful life events, or if this is a bidirectional or circular relationship.

**Summary**

Research has shown that depression is a complex and multifactoral diagnosis that can occur and recur throughout one's lifetime and often follows life events, losses, and transitions (Boland & Keller, 2009; Hankin & Abramson, 2001). A significant factor in the relationship between depression and normative and nonnormative life events is the appraisal and quality of interpersonal relationships, notably the partner relationship (Hammen, 1991; Mead, 2002; Umberson et al., 2006). This partner relationship, when identified as supportive and concordant, may act as a buffer against depressive symptoms during life events such as making the transition to marriage or parenthood (Cowan et al., 1985; Cowan et al., 2007; Cowan & Cowan, 2002; Hammen, 1991; Mead, 2002; Umberson et al., 2006). However, a discordant, aggressive, or even abusive relationship has been found to increase the risk of depression throughout one's lifespan and, in turn, the dissolution of that relationship could actually decrease the risk of depression in women (Dutton et al., 2006; Martinez-Torteya et al., 2009; Pico-Alfonso et al., 2006).

Because this literature has often been retrospective and has used instruments to measure depressive symptoms, further research is needed to investigate the association between diagnosed depression and life transitions, as they are being experienced. This research should take a less rigid approach in identifying the role of the partner relationship in the association between depression and life transitions and should not only use measurement instruments that lack the ability to identify the complex experiences of couples, but also include the use of interview-based research methods that allow for a wider range of responses and possibilities.

## Postpartum Depression

Because the transition to parenthood has been deemed a normative life event that imposes many stressors on new mothers and the partner relationship, postpartum mood disorders are considered to be the most frequent complication that women experience during this time (Beck, 2008a; Beck, 2008b; Simonds, 2001). Roughly half of all women experience a disturbance in mood and behavior related to the birth of a child (APA, 2000; Beck, 2002a; Beck, 2008a; Beck, 2008b). About 12% to 20% of these women experience severe cases of depression in the early postpartum period (Beck, 2002a; Beck, 2008a; Beck, 2008b; O'Hara & Swain, 1996). Typically, postpartum depression begins 4 weeks postpartum and lasts up to 1 year after the birth of a child (Beck, 2002a). The symptoms of depression have been shown to cause a reported sense of unequal parenting burden and difficulty bonding with a new infant (Beck, 2002a; Beck, 2008a; Beck, 2008b; Edhborg, Matthiesen, Lundh, & Widstrom, 2005; Edhborg et al., 2000). Women who are experiencing depressive symptoms during early parenthood often express a lack of partner support and subsequent changes in the marriage relationship; the larger the discrepancy between partner support expectations and reality, the greater the risk of maternal depression and marriage dissatisfaction (Cowan et al., 1985; Cowan et al., 2007; Cowan & Cowan, 2002). Thus,

the experiences that place women at risk of postpartum depression are similar to the interpersonal risks that place all women of childbearing age at an increased risk of depression (Areias, Kumar, Barros, & Figueiredo, 1996; Leigh & Milgrom, 2008; Robertson, Grace, Wallington, & Stewart, 2004; Simonds, 2001).

Maternal postpartum depression has been shown to influence the behavior and mood of male partners and children in the family unit (Ramchandani et al., 2005; Ramchandani et al., 2008). Researchers have shown that men are at a greater risk of depressive symptoms during the postpartum period if their partner is also depressed (Deater-Deckard et al., 1998; Pinheiro et al., 2006; Ramchandani et al., 2008). Depression during the postpartum period has been associated with increased levels of externalization of blame, relationship conflict, and substance abuse for both mothers and fathers (de Tychey et al., 2005; Pinheiro et al., 2006). In addition, longitudinal research in the United Kingdom has shown that children raised in families with parents diagnosed with depression during early parenthood are at an increased risk of behavioral health problems, exhibit aggressive episodes, and have fewer peer-relationships (Ramchandani et al., 2005; Ramchandani et al., 2008). These behavioral and emotional health issues in children remain even when maternal depression is controlled for, suggesting that a relationship exists between paternal depression in the postpartum period and risks to children (Ramchandani et al., 2008).

Secondary data analysis of the National Longitudinal Survey of Youth in the United States suggests that the effects of maternal depression on child development and behavioral problems are inversely related to a father's positive involvement (Chang, Halpern, & Kaufman, 2007). Because of the relationship that has been shown between maternal postpartum depression and paternal behavior and mood and the understanding that a father's behavior may decrease the

negative effects of maternal depression on the family, researchers must understand better the complex association between postpartum depression and the partner relationship.

Although maternal depression is generally understood to affect partner mood and behavior during early parenthood, little is understood about a father's experience of this complex life transition and the role of the partner relationship during this difficult transition (Goodman, 2004a). Yet, emerging literature suggests that the experience of maternal postpartum depression places a father at greater risk of depression during early parenthood, suggesting that there is an association between depression in parents and the partner relationship (Areias et al., 1996; Ramchandani et al., 2008). Also, little is known of the prevalence of postpartum depression in the total population of fathers (Goodman, 2004a). However, because of ongoing debates in the literature about the similarities between postpartum depression and major depressive disorder in women, it is plausible to draw from the literature on depression in the context of the partner relationship to support the small body of literature that addresses maternal postpartum depression and its influence on the partner relationship (Manber, Blasey, & Allen, 2008).

**Clinical Definition and Incidence**

Researchers define postpartum depression as an affective disorder that starts within 4 weeks following childbirth (Wisner, Moses-Kolko, & Sit, 2010). "Postpartum onset" is described as a "specifier" for mood disorders such as major depression, bipolar disorder I, or bipolar disorder II, and is said to be frequently associated with severe anxiety or panic attacks (Austin, 2010). However, ongoing discussion in the field of psychology and women's health has expressed the need for a more comprehensive definition of postpartum depression (Austin, 2004; Austin, 2010; Condon, 2010; Wisner et al., 2010). Some researchers suggest that the term *postpartum* or *postnatal depression* should be expanded to include the entire perinatal period

from pregnancy through the first year after birth. They base this recommendation on the understanding that depression during pregnancy is just as prevalent and potentially harmful as depression after pregnancy (Austin, 2010; Condon, 2010; Gaynes et al., 2005).

Supporting this expansion of the timeframe for depressive onset to 1 year postpartum, research has shown that the risk of hospital admission or outpatient treatment for women from delivery through 3 months is significantly higher when compared with women who had delivered 11 to 12 months before (Kendall, Hollon, Beck, & Hammen, 1987; Munk-Olsen, Laursen, Pedersen, Mors, & Mortensen, 2006). However, because the risk of depressive disorder remains elevated throughout the first year postpartum, it has been recommended that postpartum depression be defined as depressive onset reported up to 3 months after delivery and that it may continue through 12 months postpartum (Munk-Olsen et al., 2006; Wisner et al., 2010). In addition, ongoing debate and evidence suggest that postpartum depression in 9% to 30% of women is likely to persist into the second postpartum year and beyond (Campbell & Cohn, 1997; Horowitz & Goodman, 2004).

Reporting the prevalence of postpartum depression in women and men within the first year postpartum is complicated by several methodological factors (Goodman, 2004). First, researchers have used different instruments to screen for depression during the postnatal period and have used varying cut-off points, including scores for either the high or low range of depression or including all levels of depression in the same study (Evans et al., 2001; Hiscock & Wake, 2001; Matthey, Barnett, Ungerer, & Waters, 2000; McIntosh, 1993). Second, estimating rates of postpartum depression is complicated by other biopsychosocial factors that a mother may experience. As a result, it has been noted that rates of depression in adolescent mothers is higher then in adult women and that low income status and first-time experience of motherhood

also place women at higher risk (Hobfoll, Ritter, Lavin, Hulsizer, & Cameron, 1995; O'Hara & Swain, 1996; Troutman & Cutrona, 1990). Researchers have also found that the period prevalence, or number of women who experience postpartum depression symptoms at any time throughout the first year postpartum, may be as high as 27.3% or as low as 24 % (Kumar & Robson, 1984; Matthey, Kavanagh, Howie, Barnett, & Charles, 2004). It is commonly understood, however, that 13% to 20% of women experience postpartum depression during the first postpartum year, many being diagnosed within the first few weeks after delivery and experiencing symptoms throughout the first year and beyond (Goodman, 2004b; Horowitz & Goodman, 2004; Munk-Olsen et al., 2006; O'Hara & Swain, 1996).

**Risk Factors and Symptoms**

Several meta-analyses of the postpartum depression research have shown common risk factors for the development of depression in the postpartum period: prenatal anxiety, a poor partner relationship, a previous history of depression or mood disorder, difficult or fussy infant temperament, postpartum ”blues” (increased depressive symptoms following childbirth that dissipate quickly without intervention), single status, low socioeconomic status, and unwanted or unplanned pregnancy (Beck, 1996a; Beck, 1996b; Beck, 2001; Beck, 2008a; Beck, 2008b). Several studies have also reported low social and partner support as risk factors for depression in women; the former has been shown to be correlated to increased risk for depression in adolescent mothers (Logsdon, Birkimer, & Usui, 2000), white primiparas (Logsdon, McBride, & Birkimer, 1994), African-American mothers of low income (Logsdon & Usui, 2001), and women from varying cultural backgrounds (Dennis & Ross, 2006; Leung, Arthur, & Martinson, 2005).

In addition to the risk factors above, research has also shown that women who report low levels of self-esteem or ability, negative cognitive attributional style, and the experience of

stressful life events during pregnancy or after delivery have an increased risk for postpartum depression (Areias et al., 1996; Beck, 2001; Leigh & Milgrom, 2008; Robertson et al., 2004). Exposure to traumatic life events before pregnancy such as childhood sexual abuse may increase the risk of postpartum depression as well, creating a risk profile of postpartum depression that is quite similar to the commonly reported risk factors for depression in all women of childbearing age whether they are in the postpartum period or not (Areias et al., 1996; Leigh & Milgrom, 2008; Robertson et al., 2004).

The symptoms of women who have experienced antepartum and postpartum depression have been reported to be similar to those in women of the same age experiencing major depression who are not pregnant and have not recently given birth (Beck, 2001; Beck, 2002a; Manber et al., 2008). However, women and health care practitioners often report difficulty in determining if the expressed symptoms or emotional and physiological changes that women experience during the first year postpartum are ”normal” sequelae of the postdelivery time period or if they are related to depression (APA, 2000; Erlick Robinson & Stewart, 2001; Robertson et al., 2004). The reported symptoms of postpartum depression include tearfulness, feelings of guilt and loss, changes in diet and sleep, feelings of inadequacy and inability to cope with the infant, changes in memory and concentration, and increased irritability and despondency (APA, 2000; Erlick Robinson & Stewart, 2001; Remick, 2002; Simonds, 2001).

Several researchers have reported on the risk of depression and behavioral health problems for the partner during the same postpartum period, especially when the mother is depressed and how the health of one partner may influence the health of the other partner and the health of a child (Areias et al., 1996; Edhborg, Matthiesen et al., 2005; Matthey et al., 2000; Paulson, Dauber, & Leiferman, 2006; Pinheiro et al., 2006; Ramchandani et al., 2008). Because

social support and relationship quality and stability play a role in the risk of developing postpartum depression in new mothers and because depression in new mothers has been associated with increased risk of depression in new fathers during the same postpartum period, further research is needed to understand the complex interpersonal associations between depression and the partner relationship in early parenthood (Areias et al., 1996; Dennis & Ross, 2006; Leung et al., 2005; Logsdon et al., 1994; Logsdon et al., 2000; Pinheiro et al., 2006; Ramchandani et al., 2008).

**Postpartum Depression and the Partner Relationship**

Understanding that women in their childbearing years show the highest rate of prevalence for major depression and that social support and the quality of partner relationships are risk factors for depression, the association between postpartum depression and the partner relationship and family outcomes is a most important consideration (Dennis & Ross, 2006; Logsdon et al., 1994; Logsdon et al., 2000). Depressed mothers report that they feel less involved with and show less affection toward their children and that they feel less competent in their ability to parent than non-depressed mothers (Areias et al., 1996; Beck, 1992; Beck, 1996b; Leigh & Milgrom, 2008; Robertson et al., 2004; Webster-Stratton & Hammond, 1988). Researchers have shown that depressed parents have more dysfunctional relationships with their children than non-depressed parents and that they report more conflict within their families (Hammen, 1997). However, research has shown that the partner can be a means of social support for new mothers and a possible buffer against the effects of maternal postpartum depression on the child and family (Beck, 2008a; Beck, 2008b; Chang et al., 2007; Ramchandani et al., 2008). This section of the paper will examine the literature on the association between maternal postpartum depression, the partner relationship, and partner health.

In a longitudinal descriptive study of first-time parents (54 women and 42 partners) in Portugal, Areias and colleagues (1996) reported that the 12-month prevalence rate for depression was 53.7% for the women and 28.6% for the men. Logistic regression also showed that the strongest risk profile for depression in women postpartum (0-12 months) consisted of reporting reduced social support ($p < .001$) and depressive disorder before pregnancy in themselves and in their partner and the experience of more life events (6.5, *SD* 3.6, $p < .05$) than in a non-depressed female sample (4.3, *SD* 2.0, $p < .05$), echoing findings in the literature on depression and women outside of the perinatal period (Areias et al., 1996; Simonds, 2001; Whitton et al., 2007). The strongest risk profile for postnatal depression in fathers during the early postpartum period (0-3 months) was the presence of depression in their partner during pregnancy (OR: 42.3, 95% CI: 3.2 - 554.5, $p < .005$) and a personal history of depression (OR: 20.95, 95% CI: 1.9 - 230.7, $p < .02$), supporting the literature on the partner relationship and depression outside of the postpartum period (Areias et al., 1996; Zlotnick et al., 2000).

This study was limited by its relatively small sample size and possible cultural factors that went unmeasured, which could have resulted in a much larger prevalence of depression in the sample than is typically reported in postpartum depression studies (Areias et al., 1996). However, the findings suggest a significant interrelationship between depression in one partner and reports of depression and depressive symptoms in the other, suggesting a bidirectional association that was reported in other research outside of the perinatal period. Such findings emphasize the need for further work to better understand this association (Fredman et al., 1988; Zlotnick et al., 2000).

The above findings were further supported by Matthey, Barnet, Ungerer and Waters (2000) in their study of 157 couples that were expecting their first child and eventually delivered

a healthy baby. The prevalence rates of depression were similar to findings in other studies (Meighan, Davis, Thomas, & Droppleman, 1999; Munk-Olsen et al., 2006): 10.1% of men and 27.3% of women experienced depression in the first postpartum year (Matthey et al., 2000). Significant correlations were found between the mothers' and fathers' scores on the Beck Depression Inventory and the Edinburgh Postnatal Depression Scale. These findings were most significant at the 6-week and 12-month screenings, suggesting that early parenthood presents stressors for men and women and that other factors may be affecting both partners when depressive symptoms persist through the whole first year (Matthey et al., 2000). Echoing the findings of other researchers, Matthey et al. noted that depression during pregnancy in women (42.1%) and men (66.6%) was correlated to postpartum depression sometime during the first year (Areias et al., 1996; Matthey et al., 2000).

Although these findings support the relationship between depression and depressive symptoms in the mother and their influence on her partner, the use of measurement instruments precluded a broader understanding of what aspect of the partner relationship may lead to this increased risk in the father. Is the partner placed at increased risk because of additional stressors related to parenting and everyday care of the household? Is there increased emotional stress? Is there a reported decline in the quality of the partner relationship during this time? Further analysis, including observation of partner interactions and measures of quality of the partner relationship and stressors, is needed to better understand these findings.

Using grounded theory analysis of interviews with nine families, Tammentie et al. (2004) further examined the factors related to family and partner dynamics when the mother has postpartum depression. As has been reported in other qualitative studies, there is often a discrepancy between expectations of parenting and family life and reality for new mothers and

fathers (Berggen-Clive, 1998; Mauthner, 1999; Tammentie et al., 2004). Within this category, three themes emerged: the need to strive for perfection, a feeling of being tied down to the infant, and expectations of family life together (Tammentie et al., 2004). New parents reported feelings of increased discord in their relationship, estrangement from their spouse, loss of time for self and each other, withdrawal from outside social contacts, and a need for concrete partner support and urgent support from family and friends. All of these themes have been reported in other studies of families during this time period (Beck, 1996a; Berggen-Clive, 1998; McIntosh, 1993; Tammentie et al., 2004).

The study expanded the understanding of the partner relationship and family dynamics during the early postpartum period, however the inclusion criteria for depressed mothers was a score of 13 or higher on the Edinburgh Postnatal Depression Scale, which indicates increased risk for depression and not a clinical diagnosis of depression. Additional studies should be conducted using clinical diagnostic interviews or previous diagnoses of postpartum depression as inclusion criteria because risk of depression does not always mean clinical diagnosis (Cox, Holden, & Sagovsky, 1987).

Qualitative studies have shown that women and their male partner report a sense of loss when they experience postpartum depression, a finding that shows a strong connection to research that has examined depression outside the postpartum period (Beck, 1996a; Beck, 1996b; Berggen-Clive, 1998; Hammen, 2005; Mauthner, 1999; Meighan et al., 1999; Morgan, Matthey, Barnett, & Richardson, 1997). The theme of loss can be as fleeting as the loss of time because of the need for infant caretaking (McIntosh, 1993) or as potentially damaging as loss of control and identity (Berggen-Clive, 1998; Mauthner, 1999). Although these studies vary in methodology (phenomenological methodology was the most frequently used method) and sample

characteristics, their findings were strikingly similar (Beck, 1992; Beck, 1996b; Berggen-Clive, 1998; Mauthner, 1999; Meighan et al., 1999; Morgan et al., 1997). Women and men felt strain in their personal relationship. They reported feeling unsupported by their partner and others. They felt uncertain about their abilities and the future. Women felt anxious and overwhelmed, while men felt as though they needed to "fix things" for their partner and their family (Beck, 1996a; Mauthner, 1999; Meighan et al., 1999; Tammentie et al., 2004).

Although these findings bring heightened attention to the feelings and experiences of new parents in the context of maternal postpartum depression, the lack of observational and narrative data on partner interactions and the use of different screening instrument cut-off scores (without the clinical diagnosis of depression), muddies the reported findings with more ambiguity. Future research should include both observation and the clinical diagnosis of postpartum depression (Beck, 1996b; Mauthner, 1999; Tammentie et al., 2004).

In addition to reported feelings of loss, many research studies have examined the possibility of stressors outside of the partner relationship and their influence on the experience and risk of depression in new mothers and fathers (Deater-Deckard, Pinkerton, & Scarr, 1996; Deater-Deckard et al., 1998; M. Edhborg et al., 2005; M. Edhborg et al., 2000; Milgrom et al., 1995). Edhborg and colleagues (2005) recruited 106 couples that had recently delivered to investigate the association between blues symptoms, bonding, perceptions of the child's temperament, and depressive symptoms in the mothers and fathers. The researchers discovered these important findings; the parents reported different perceptions of their infant, fathers significantly reported ($p < .0001$) that their child was more unpredictable then did the mothers, and the fathers reported more difficulty bonding with their child and felt rejected and angry at 1 week and 2 months postpartum ($p < .0479$; $p < .0001$; Edhborg, Matthiesen et al., 2005). These

findings show that an infant, however much desired, can be a stressor to either parent and potentially to the partner relationship during early parenthood (Beck, 1996b; Edhborg, Matthiesen et al., 2005; Edhborg et al., 2000). The subjects in this study had a high drop out rate; of the 465 mothers and 429 fathers who agreed to participate, only 106 couples completed the entire study, illustrating the amount of stress on new parents; parents who dropped out of the study often reported stress as a reason for leaving (Edhborg & Matthiesen et al., 2005).

In an earlier study of parenting stress and postpartum depression in women and their spouse, 38 women and their partner were compared with a control group of 46 nondepressed women and their partner at 3, 6 and 12 months postpartum (Milgrom & McCloud, 1996). The investigators found that couples in which the mother had postpartum depression reported higher levels of tension, confusion, depressed mood, anger, fatigue and less vigor than in nondepressed controls ($p < .01$), a finding that is similar to research in couples outside of the postpartum period (Milgrom & McCloud, 1996; Zlotnick et al., 2000).

Parents in the maternal postpartum depression group reported significantly higher levels of stress related to parenting, including child adaptability, acceptability, "demandingness," and mood ($p < .01$) (Milgrom & McCloud, 1996). This indicates that the diagnosis of depression in one partner does affect the reported mood and coping of the other partner and that stressors that influence one partner during the transition to parenthood can affect her or his partner and pose greater risk to the partner relationship and the family (Edhborg, Matthiesen et al., 2005; Edhborg et al., 2000; Milgrom & McCloud, 1996).

More recently, researchers have begun to pull apart the complex relationship between depressive mood in the early postpartum period and satisfaction with the partner relationship in new mothers and fathers. A study published in 2011 predicted that there would be a

bidirectional, lagged-effect between relationship adjustment and symptoms of depression and anxiety in the perinatal period (Whisman, Davila & Goodman, 2011). A convenience sample of 113 pregnant, married or cohabitating women, completed a series of self-report measures throughout their pregnancies and up to 6 months postpartum. The researchers selected criteria that would allow for a sample of women who were at significant risk for postpartum depression, because they had previously experienced a major depressive episode. Using multilevel modeling, the researchers found, that in a lagged effect model, greater depressive symptoms predicted decreased relationship adjustment ($p < 0.05$). This is associated with the stress generation theory of depression, which concludes that depressed individuals impact the occurrence of additional stress in their lives, including additional stress in their intimate relationships. It was also reported that lower relationship adjustment at one measurement, was associated with higher anxiety at the next measurement.

Limitations of this research include the use of a sample that had previously experienced major depressive disorder in their lifetime (Whisman, Davila & Goodman, 2011.) As such, the researchers may have limited the types and directions of the relationships that they noted in their models. The kindling theory of depression, for example, would posit that the effect of stressful events, such as poor relationship adjustment and the transition to motherhood, would be different in both direction and strength for women without a history of major depressive episodes when compared to a sample of women that do have a history of depression. Moving forward, it will be important to review these results with a larger sample of women and include those that do not have a history of depression. Also, the study only includes self-report measures from the women in the partner relationship. As studies have shown that maternal depression may impact depression in her partner during the postpartum period, researchers should begin to look at

relationship adjustment and satisfaction from the perspective of both the mother and her partner (Falceto, Fernandes & Kerber, 2012).

The association between depressive mood during the perinatal period with mood and the partner relationship was also examined in a longitudinal study of 419 first time mothers (Lilja, Edhborg & Nissen, 2012). The researchers found that 22% of the women enrolled in the study scored high on the EPDS 10 days postpartum. It was also shown that low mood remained prevalent over the first year postpartum and that women with depressive symptoms showed less closeness, warmth and confidence in both infant and partner relationship scales. The limitations with the study include, the use of different scales to measure mood at different data collection points in the study. The researchers used the EPDS at 3 days and 10 days postpartum and then used a non-validated short scale to measure mood at 6 and 12 months, which may create problems with the construct of depression. In addition, the use of cut off scores on the EPDS to identify depressive symptoms and not an actual diagnosis of depression in the sample may mean that the association between the reporting of distant, cold and difficult partner relationships and the diagnosis of postpartum depression may be different than what was reported in this study.

Recently, researchers have shown that there was a close relationship between the levels of relationship discord reported by women and men in the postpartum period and that there was a moderate correlation between relationship discord and EPDS scores taken at 3-months postpartum (Kerstis, Engstrom, Sundquist, Widarsson & Rosenblad, 2012). Beginning one week after the birth of their child, 305 couples were asked to report perceived levels of relationship discord and adjustment using the Dyadic Consensus Subscale (DCS) and the Dyadic Adjustment Scale (DAS). Mothers and fathers were also asked to complete the EPDS at 3-months postpartum. The overall correlation between DCS scores in mothers and fathers was found to be

0.595 ($P < 0.001$). The researchers also found that mothers and fathers with depressive symptoms, as defined by a cut-off score on the EPDS of $> 9$, reported higher levels of discord than couples that were not at risk for depressive symptoms. The model developed showed that the correlation between the total DCS scores and the EPDS scores were -0.253 ($P <0.001$) for mothers and -0.313 ($P <0.001$) for fathers. Further research is needed to understand the differences that mothers and fathers noted within the DCS items. For example, although overall scores were similar between mothers and fathers, they differed in their perceptions of discord in different areas of their relationship, such as household tasks, time together and leisure activities. A better understanding of this issue in the first year postpartum can be developed by allowing couples to share narratives of their relationship, highlighting not only discordant moments, but also where they continue to find satisfaction and harmony in their relationship.

Researchers also find a strong association between perceived partner support and lower levels of emotional distress in women postpartum (Tanner-Stapleton et al., 2012). Tanner-Stapleton and colleagues, used structural equation modeling to identify the direct and indirect impact of interpersonal security, partner support and relationship satisfaction upon maternal and infant distress postpartum (Tanner-Stapleton et al., 2012). It was found that high quality partner support mediated the effects of mothers' interpersonal security and relationship satisfaction upon both maternal and infant outcomes, wherein women who reported strong social support from their partners at mid-pregnancy had lower emotional distress postpartum. This highlights the key roles the partner and interpersonal relationships play in the emotional needs of women throughout the perinatal period.

Based on the results of these research studies, several conclusions about the transition to parenthood and the effects of postpartum depression on the partner relationship can be made.

First, during the transition to parenthood, mothers and fathers are exposed to additional stressors and, although these stressors may affect them differently, they pose risks of depression for both partners (Areias et al., 1996; Beck, 1996a; Beck, 2002a; Edhborg et al., 2005; Edhborg et al., 2000; Matthey et al., 2000). With new mothers, relationship satisfaction and adjustment is associated with depressive mood and anxiety in the early postpartum period (Whisman, Davila & Goodman, 2011; Lilja, Edhborg & Nissen, 2012). Also, maternal postpartum depression poses an increased risk of depressive symptoms in the father and strains the partner relationship (Areias et al., 1996; Matthey et al., 2000; Ramchandani et al., 2008). Emerging research also highlights that there is a relationship between marital discord and risk for postpartum depression in both men and women, although significantly more research is needed in this area to fully understand this complex association (Kerstis, Engstrom, Sundquist, Widarsson & Rosenblad, 2012).

Because of the lack of prospective longitudinal studies, further research is needed to clarify how the association between maternal postpartum depression, the increased risk of paternal depressive symptoms, and the quality of the partner relationship interact over time and the meaning of the partner relationship for parents during this transition. Further, research is needed that includes observational data and the use of participant narratives from mothers and their partner. Such studies would allow researchers and health care practitioners to better understand the shared meanings within the partner relationship, including attitudes, concerns, and coping strategies related to the transition to parenthood in the context of maternal postpartum depression.

## Conclusion

Depression is a significant health problem that affects many women throughout their lifetime and during different life transitions (APA, 2000; Hammen, 2003; Hankin et al., 1998;

Hankin & Abramson, 2001). The research that has been reviewed in this paper has shown that the diagnosis and course of depression is a multifactoral and complex phenomenon and is influenced by life events, even when they are expected and normalized (Hankin & Abramson, 2001; Mazure, 1998; Monroe & Simons, 1991). Research has also shown that the partner relationship can be both a risk factor for and buffer against depression during different life transitions and that appraisal of the relationship is a key factor in how the partner relationship is associated with depression and life events (Cowan et al., 1985; Cowan et al., 2007; Mead, 2002; Umberson et al., 2006).

Depression that occurs in new mothers during the postpartum period has been shown to be similar in etiology and course as depression that occurs in women during other life transitions. However, it deserves dedicated research and clinical focus because the postpartum period is so important to the development of a family (Beck, 2002a; Edhborg et al., 2005; O'Hara & Swain, 1996). The stressors associated with the transition to parenthood during the postpartum period are often expected, but they can still pose a risk of depression for those women who are vulnerable to psychopathological disorders (Beck, 2001; Horowitz & Goodman, 2004). The partner relationship can provide support to women who are vulnerable to depression, but it can also create additional stressors for women during an already stressful time and create a vulnerability to depression (Cramer, 2004; Papp, 2010). The association between postpartum depression and the role of the partner relationship needs further evaluation to allow for an understanding of the unique stressors that may arise as a result of the transition to parenthood and the quality of the partner relationship.

The research reviewed in this paper often used retrospective methods and measurements instruments to understand the multifactoral associations between life events and depressive

symptoms and the mediating or moderating role of the partner relationship in the context of those life events. These methods, however, do not allow for an examination of the transition to parenthood as it is being experienced and thus may present threats to internal validity and rigor due to history or maturation as memories of experiences can change over time. Using participants who are at risk of depression or are experiencing depressive symptoms is an important research technique, however research that focuses on clinically depressed women during the postpartum period may provide added understanding of this complex transition in the subgroup of new mothers and their partner. Finally, research must forgo the strict use of measurement instruments to develop a more holistic view of how different factors influence the role of the partner relationship in the context of maternal postpartum depression and the transition to parenthood and, in turn, how the partner relationship may influence the development of depression during this transition. Particular attention should be paid to the role of partner support and the coping strategies and practices within the partner relationship during this complex and stressful time for new parents.

## Chapter Two: The Individual and Couple Context of Postpartum Depression: A Theoretical Examination of Two Models

Depression is a multifaceted diagnosis that does not follow a simple pathway and has varying etiologies (Beck & Alford, 2009; Goldstein & Rosselli, 2003; Hankin, Fraley, & Abela, 2005; Hankin & Abela, 2005). There are also multiple familial factors that may play a role in depressive psychopathology (Garber, 2005). This same understanding is true of postpartum depression. Within the context of postpartum depression, the behaviors and emotions of one family member will often have an effect on others within the family unit, thus impacting interpersonal relationships such as the partner relationship (Ramchandani, Stein, Evans, O'Connor, & ALSPAC study team, 2005; Ramchandani et al., 2008). However, many of the models and theories developed to better understand the psychopathology of depression do not focus on the complex interplay of familial and individual vulnerabilities, stressors and coping mechanisms.

The diagnosis of postpartum depression affects approximately 20% of women after the birth of their child (Beck, 2008a; CBeck, 2008b). Researchers have also shown that postpartum depression in the mother places both her partner and their infant at risk for emotional and behavioral diagnoses (Beck, 2008a; Beck, 2008b; Pinheiro et al., 2006). Pinheiro and colleagues concluded that depression in women during the prenatal and postpartum periods placed their male partners at an increased risk for developing postpartum depression and that as the severity of depression in the women increased, so too did the risk posed to the partner (2006). This suggests that there is need for further exploration of family and relationship factors throughout the transition to parenthood within the context of maternal postpartum depression.

In addition to these correlational findings, a team of researchers in the United Kingdom has been gathering longitudinal data in families for over a decade. Their research has shown that in addition to the increased risk for shared diagnosis in couples, depression in parents during the postpartum period places children at an increased risk for behavioral and psychological issues (Ramchandani et al., 2005; Ramchandani et al., 2008). Parental postpartum depression has a long lasting affect on developmental outcomes in children and affects their relationships with peers during their school-age years (Garber, 2005; Ramchandani et al., 2005). Although children are at risk when only one parent is depressed, the effects of having two depressed parents places children at greater risk of poor bonding with both the mother and father and creates a potential for more severe outcomes. These outcomes show a strong link between depression in one family member and poor psychological outcomes in other family members (Garber, 2005).

It is therefore plausible that there are inherent family processes involved during the transition to parenthood. These processes may place families at an increased risk for poor adjustment to life changes and an impaired quality of family interactions when one parent is depressed. In turn, these same inherent family processes have the potential to be a source of stress or, in the case of long-term exposure, an underlying vulnerability placing the mother at risk for postpartum depression. This is not a simple linear relationship. Rather, there is a complex and ongoing interrelationship between different familial and individual vulnerabilities, stressors and coping strategies. This paper will seek to explore and evaluate two theories, a diathesis-stress theory of depression and a family stress and resiliency theory, to tease apart the complex interrelationships between maternal postpartum depression and the partner relationship. Some of the techniques used for theory analysis proposed by Walker and Avant (2005) will be used during evaluation of the utility of the two models. The techniques used will be meaning and

usefulness. The technique of logical adequacy will also be addressed through the presentation of a new conceptual model integrating the two theoretical approaches and a description of the interrelationship of concepts within that model.

Diathesis-stress theories of the etiology of depression focus on the ways that long-term vulnerabilities and proximal stressors converge with life events and cognitive schema to increase mood disorders in the individual. These theories are useful for examining the ways that environmental, genetic and cognitive vulnerabilities interact with stressful life events, such as the transition to parenthood, to place women at risk for postpartum depression. However, because the theories focus on the individual, they are not useful when examining the ways that maternal postpartum depression may influence the family and partner relationship. When focusing only on diathesis-stress theories of depression, it is difficult to see how the vulnerabilities and stressful events also influence the partner. To bridge the gap between the conceptual understandings of the diathesis-stress theory of depression in the individual and stress and resiliency in the partner relationship, it is necessary to also include family stress and resiliency theories.

Family stress and resiliency theories focus on the understanding of family resilience during times of increased stress (Patterson, 2002). Consequently, the theory relates closely to how families and individuals within the family respond to and cope with the stress of parenthood and the additional stressors of depression and depressive symptomatology. The model allows for useful and testable theorizing relating to the partner relationship during the transition to parenthood within the context of maternal postpartum depression.

## Theories Regarding the Etiology of Depression

Due to the many manifestations of depressive disorders (i.e. unipolar, bipolar) and the complexities of diagnosis and treatment, there are multiple theories regarding the etiology of depression. Throughout the research on depression there is repeated mention of several theoretical models for how the individual may become vulnerable to the diagnosis. Scientists and practitioners alike continue to disagree about the exact etiology, and the theories discussed here are constantly being tested and evaluated (Hankin & Abela, 2005). These models of vulnerability include: the psychodynamic model; the attachment model; the biological model; the cognitive-behavioral model; and the diathesis-stress model. The model that this paper will focus upon, the diathesis-stress model, was selected because it can be applied to the development of depression and depressive symptoms following stressful life transitions, such as the transition to parenthood. Additionally, the model also examines how multiple vulnerabilities experienced throughout the life-course, including environmental, biological and genetic vulnerabilities, can affect the development of depressive psychopathology, an understanding that is particularly salient to the development of depression in women.

### The Diathesis-Stress Model of Depression

Although originally developed as a theory for the development of schizophrenia, the diathesis-stress model has also been adapted to theorize about other forms of psychopathology, including depression (Monroe & Simons, 1991). Diathesis-stress theory originally focused on biological diatheses and how those diatheses created an increased vulnerability for depression in people when also exposed to stressful life experiences. Although this interaction between biological diathesis and stressful life experiences does provide for testable hypothesis, it does not account for the complexity of the development of depression across the lifespan or the

interaction of environmental factors and cognitive vulnerabilities (Hankin & Abela, 2005; Monroe & Simons, 1991).

The current diathesis-stress theory of depression has been elaborated beyond the understanding of biological diathesis and is referred to as the Elaborated Cognitive Vulnerability-Transactional Stress Theory (Hankin & Abramson, 2001). This model will be utilized to examine how the complex interplay of vulnerabilities, negative affect and life events increases depression in the individual (Hankin & Abramson, 2001). This presentation will expand upon the understanding that preexisting vulnerabilities, including genetic, environmental adversity and personality, increase the risk for the experience of negative life events and cognitive vulnerabilities. The occurrence of a negative event contributes to increases in initial levels of negative affect. Over time, increased levels of negative/depressive affect can lead to increases in depression. These cognitive vulnerability factors moderate the likelihood that a person will experience increases in depression. They do this by interacting with initial negative affect to amplify the affect and lead to the increased probability that the person will eventually experience depression. Increases in depression result in the experience of additional negative dependent events, or negative events that are partly influenced by the individual.

**Concepts in the Elaborated Cognitive Vulnerability-Transactional Stress Theory.** Using the techniques outlined by Walker and Avant (2005) the meaning within the Elaborated Cognitive Vulnerability-Transactional Stress Theory (Hankin & Abramson, 2001) will be evaluated through an identification of the main concepts within the model. Following the identification and definition of the concepts, the interrelationships among the concepts will be outlined through a description of the causal chain of maternal postpartum depression.

***Preexisting vulnerabilities.*** The construct of vulnerability is different from the experience of stress or stressors, in that vulnerabilities are viewed as factors that reflect more enduring traits, characteristics or adverse exposures. Within the model presented by Hankin and Abramson there are several preexisting vulnerabilities that place a person at an increased risk for the experience of negative life events (Hankin & Abramson, 2001; Hankin & Abela, 2005); these preexisting constructs include genetic, personality and environmental vulnerabilities. Although preexisting vulnerabilities are presented as discrete concepts within the model, the three factors are likely interconnected (Hankin & Abramson, 2001).

Within the model, genetic risk for depression is seen as a vulnerability that increases the likelihood that some people will experience more negative events (Hankin & Abramson, 2001). With the use of twin studies and advanced genetic technologies, scientists are beginning to expand upon the understanding of genetics and biology in the development of psychopathology. Twin studies show that there is a moderate heritability of depression (Gotlib & Hammen, 2009; Kendler, Neale, Kessler, Heath, & Eaves, 1993). It is, however, not fully understood if this is a direct parent-to-offspring genetic transmission, a result of children growing up in close proximity to a parent that is depressed, or a combined interaction of this genes-plus-environment situation (Garber, 2005; Gotlib & Hammen, 2009; Hankin & Abela, 2005; Kendler et al., 1993). This complex interaction seems most significant in women and influences interpersonal, negative events (Kendler et al., 1993). However, genetic researchers have not been able to determine exactly how this genetic vulnerability for negative events operates.

One possible hypothesis is that genetic vulnerabilities may result in changes in neurotransmitter response, which in turn influences personality characteristics. Within the Hankin and Abramson model, personality traits are viewed as genetically linked. Personality

vulnerabilities are posited to influence the experience of negative life events and therefore result in increases in depression. One personality characteristic that appears to directly increase negative life events is neuroticism, or the disposition to experience negative affective states (Roberts & Kendler, 1999). These affective states include anger, anxiety and depression. The mechanism by which these personality characteristics influences life events and depression is still unclear. However, prospective research has shown that neurotic individuals do encounter more negative events across the lifespan (Hankin et al., 1998).

In addition, researchers have repeatedly identified that long-term exposure to adverse environmental vulnerabilities, such as neglect and trauma during early childhood and adolescence, can be associated with an increased risk for mood disorders later in the adult years (Kendler et al., 1993). Although it is likely that environmental factors interact with other vulnerabilities to increase the risk for depression, researchers have also shown through twin studies that some environmental vulnerabilities are not influenced genetically (Kendler et al., 2000; van Praag, de Kloet, & van Os, 2004). These environmental vulnerabilities include maternal protectiveness, conflicts in the parent-child relationships, significant financial difficulties and marital conflict and divorce (Kendler et al., 2000).

***Negative life events.*** Another link in the causal chain within the Hankin and Abramson model is the understanding that increases in depression can contribute to the creation of more negative life events (2001; Hankin & Abela, 2005). This proposed relationship is based upon interpersonal theories of depression (Hammen, 2005). Hankin and Abramson distinguish between dependent and independent negative events. Dependent events are experiences that individuals partly contribute to through behavior and personality, including experiences like divorce or arguing with a loved one. Independent events are best described as being outside of

one's control, such as the death of a child or spouse. These negative life events are usually measured through self-report, interviews or observations (Monroe & Simmons, 1991). In the causal chain presented in the model, both types of events, dependent and independent, can lead to increases in initial negative affect and depression (Hankin & Abramson, 2001). Increases in depression can then increase the experience of more negative dependent life events.

***Initial negative affect.*** Within the elaborated causal chain proposed in the model, increased depression begins with the experience of a negative event. This negative event contributes to elevations in initial levels of negative affect (Hankin & Abramson, 2001). Negative affect is later posited to increase depression over time. The construct of negative affect includes different negative emotions, including anxiety, depressive mood and anger and can be assessed using self-report, interviews and observations.

***Cognitive vulnerabilities.*** The cognitive-behavioral model of depression is frequently used in theorizing, researching and treating depression. Yet, when considered as a component within the concept of diathesis in the Hankin and Abramson model, a much richer understanding of the development of depression is evident. Within the model, cognitive vulnerability factors moderate the likelihood that an individual will experience increases in depression (Hankin & Abramson, 2001). The cognitive vulnerability link in the causal chain explains that a person with a cognitive vulnerability is more likely to become depressed when confronted with a negative life event than a person who is not vulnerable. Thus, cognitive vulnerabilities, including having a negative inferential style and dysfunctional attitudes, have been associated with increased risk for depression (Beck & Alford, 2009; Milgrom, Westley, & McCloud, 1995).

Postpartum women with immature defenses, higher rates of "self-downing" and increased needs for approval and perfection have higher rates of postpartum depression (Milgrom et al.,

1995; Milgrom & McCloud, 1996). Further longitudinal research has also shown support for the cognitive-diathesis concept in postpartum depression by showing that general and maternal dysfunctional attitudes in the mother, as well as her reported need for approval, was higher in women with postpartum depression (Grazioli & Terry, 2000). It is plausible that this increased need for perfection and approval places additional strain upon the partner relationship.

***Increases in depression.*** Hankin and Abramson (2001) explain that depressive mood and depressive disorder likely exist on a continuum. On one end of the continuum is depressive mood, in which the individual has a depressed affect, including feelings of sadness, for any given time period. At the other end of the continuum is depressive disorder, in which depressive symptoms (appetite, concentration and sleep issues) appear and last for at least two weeks, resulting in functional impairment (American Psychiatric Association; APA, 2000). Although depressive mood has been linked to increased risk for depressive disorder, many with depressive mood will never develop the disorder (Hankin & Abela, 2005). Because the severity of symptoms increases in those diagnosed with depressive disorder, it is important to differentiate between people with depressive mood and people with depressive disorder when implementing clinical interventions and developing research studies.

**The causal chain of maternal postpartum depression.** Using Hankin and Abramson's model for increased depression, it can be posited that for some women the transition to parenthood is a stressful or negative life event. Preexisting genetic, environmental and personality vulnerabilities, including neurotransmitter changes, neuroticism and childhood trauma, influence this experience. The transition to parenthood creates an increase in negative affect, including increased levels of anxiety and negative emotions. The mother's initial negative affect, when combined with cognitive vulnerabilities, can increase depression in the postpartum

period. Thus, the mother's increased depression can influence her experience of ongoing negative events and influence interpersonal relationships.

## Theories Regarding Family Stress and Resiliency

Although there are multiple theoretical models that focus upon the etiology of depression in the individual, the focus of this paper is to provide a foundation for research that will highlight the experience of couples making the transition to parenthood within the context of maternal postpartum depression. Because of this focus it is necessary to move past the perspective of the individual experience and consider the impact of life stressors and events upon the partner relationship. The demands of the transition to parenthood can be considered as a proximal stressor experienced by the partner dyad. The dyad is the smallest unit of analysis in the extant family research. Family research concerning the impact of stress upon the partner relationship is often guided by family stress and resiliency theory. This theoretical approach is rooted in the work of Hill (1958) and posits that family meaning of an event influences adaptation to a crisis, the resources available to the family and the type of stressor event (Boss, 2001).

Researchers understand that normative and non-normative transitions and events can place stress upon the partner relationship (Lavee, 2005). At times this exposure to stress can place the partner relationship at risk. However, certain stressful events and situations can result in a more connected and stronger partner relationship (Lavee & Mey-Dan, 2003). A model for stress and coping used in partner research should consider that the meaning of an event and the couple's perspective of world-view may play a role in coping with stressful events, such as parenting or the diagnosis of depression in a loved one. Additionally a model should focus upon the capabilities inherent in the partnership. Research studies often identify the dysfunction that exists in partner relationships, but it is equally important to also focus upon what the partners do

right in the face of stress. A model that represents these concepts and can be readily applied to the partner relationship during the transition to parenthood within the context of maternal postpartum depression is the Family Adjustment and Adaptation Response model (FAAR; Patterson, 2002)

**The FAAR Model of Family Stress and Resiliency**

Patterson (2002) proposes that family relationships are capable of adjusting and adapting to the needs of vulnerable members. This model of family stress and resiliency has not been explicitly used in research regarding postpartum depression and the partner relationship during the transition to parenthood. However, it has been used in the study of how parents cope with illnesses in their children, a life event that is also considered stressful for parents (Patterson, 2002). As the model focuses on the response to family crises and the capabilities of the family to help vulnerable members in those situations, it appears wholly applicable to the experiences of couples coping with maternal postpartum depression (Patterson, McCubbin, & Warwick, 1990).

Within the framework of the FAAR model Patterson uses the perspective of family resilience from previously published work in the field of family stress and coping theory. The model is intended to show the processes that families actively engage in to arrive at a balance between the demands placed upon the family and the capabilities of the family unit to achieve adjustment or adaptation to stress (Patterson, 2002). When faced with a stressful situation or change, such as the transition to parenthood, couples move through processes of adaptation and, if needed, adjustment. During the adjustment phase couples negotiate the demands made upon them by stressors, strains and daily hassles.

Through their world-view, identity and situatedness, couples give meaning to these demands and to their own capabilities for adjustment. In order to positively adjust to change and

stress, a couple must be able to use their resources and the coping behaviors that are available to them. This is a relatively stable period of time within the partner relationship and interaction remains predictable. If a couple is unable to adjust or if the demands placed upon them exceed their resources, they face maladjustment and enter a state of disequilibrium or crisis. When the couple moves into the crisis phase, a period of adaptation always begins. This phase is marked by the couple's attempt to restore equilibrium through obtaining new resources and coping behaviors, reducing other demands or changing their identity as a couple and/or changing their worldview. If the couple is still unable to adapt to demands they enter maladaptation and continue through a cyclical process of adaptation until they are able to cope with demands.

**Major concepts in the FAAR model of family stress and resiliency.** As was previously done with the Elaborated Cognitive Vulnerability-Transactional Stress Theory, the meaning within the FAAR model will be evaluated through an identification of the main concepts within the model (Walker & Avant, 2005). Following the identification and definition of the concepts the interrelationships among the concepts will be outlined through a description of the couple's response to maternal postpartum depression.

***Family demands.*** Patterson defines family demands as stressors, strains and daily hassles and posits that these demands are similar to the concept of risk factors (2002). She further explains that stressors can be identified as normative or non-normative and can be considered discrete events of change in the family. Using this definition, the transition to parenthood can be viewed as a discrete event that is a normative stressor for couples. Family strains are ongoing and viewed as unresolved, menacing tensions. Given this description, partner conflict related to parenting roles can be viewed as ongoing, unresolved strain placed upon the couple. Daily hassles are minor, ongoing, day-to-day disruptions. These are equivalent to unexpected changes

in daily routines, like getting a flat tire on the way to a pediatrician appointment. Family demands can arise from one family member, the family as a unit, or community sources.

***Family capabilities.*** Family capabilities consist of what the family has and what the family does. This includes psychosocial and tangible resources and coping behaviors. For couples making the transition to parenthood, capabilities could include social support systems, such as family and friends who are willing to provide emotional and tangible support, financial resources, and coping processes such as shared infant caregiving. In Patterson's model, family capabilities are similar to protective factors. Similar to family demands, family capabilities can come from sources inside and outside of the family.

***Family Meanings.*** Patterson's model differentiates between three different types of family meanings: situational; family identity; and world-view. Situational meanings are the family's appraisal of the demands that they must face and the appraisal of their capability to cope with those demands. Family identity is how the family views themselves from the inside. For a couple making the transition to parenthood, how they view themselves as a couple (i.e. competent parents, stable providers) can impact their experiences. The family world-view is the way that the family sees their relationship to the world outside their family unit.

***Family Adjustment.*** The phase of family adjustment is a stable, day-to-day pattern of interaction within the family. Demands are placed upon the family unit, and they use their existing capabilities to meet those strains, stressors and hassles (Patterson, 2002). At times, family demands can exceed the existing capabilities of the family and place the family in crisis. For a couple that has recently had a baby, the new routines and concerns associated with infant care will require adjustment and the use of existing capabilities within the relationship. However,

the additional diagnosis of maternal postpartum depression can exceed the couple's coping capabilities and place them in crisis.

***Crisis.*** The phase of family crisis is marked by significant disorganization, disequilibrium and disruptiveness (Patterson, 2002). It is the result of a prolonged imbalance between family demands and family capabilities. Family crisis can result in major changes within the family structure or patterns of functioning. A couple that is coping with maternal postpartum depression may need to adjust partner roles and tasks within the family to adapt to their situation.

***Family Adaptation Phase.*** The adaptation phase consists of either positive changes in family functioning that result in bonadaptation, or increased vulnerability, known as maladaptation (Patterson, 2002). A couple that is trying to cope with the transition to parenthood and maternal postpartum depression may seek outside help through individual and couples counseling. This process may help reduce demands and increase the future capabilities of the couple. Subsequently, this same couple may forgo counseling and begin experiencing increases in conflict interactions. This would place them in continued disequilibrium and result in maladaptation.

**The couple's response to maternal postpartum depression.** Following the model presented by Patterson, it could be understood that the transition to parenthood is a stressful adjustment for new parents (2002). The couple must use the resources within their partnership, such as caring practices, financial resources and prior familial knowledge of parenting to help them make the adjustment from a dyad to a family of three. The additional strain upon the partner relationship presented by maternal postpartum depression could have the potential to overwhelm the resources of the partner relationship and thus present a risk for crisis to the couple.

## The Utility of the Two Selected Models

The usefulness of the two models, as they are applied to the phenomenon of maternal postpartum depression within the partner relationship will now be discussed (Walker & Avant, 2005). Through the examination of the concepts within Elaborated Cognitive Vulnerability-Transactional Stress Theory of depression it can be posited that depression is a multifaceted diagnosis with multiple factors playing a role in diagnosis (Hankin & Abramson, 2001). The model supports the complexities found within the literature and although none of the concepts show direct causal relationships, there are strong interrelationships found among the different vulnerabilities for depression. These interrelationships are also found in the development of postpartum depression in women. The ways that vulnerabilities interact with depression in the individual have been reviewed. However, further understanding of how the vulnerabilities may interact with partner relationship processes is needed.

Although the diathesis-stress theory of depression is complex, with multiple vulnerabilities and potential stressors coming together to place a person at risk for depression, the model presented by Hankin and Abramson is parsimonious and shows relationships among the concepts that offer opportunities for testing through research (Hankin & Abela, 2005). The model, as it has been reviewed, accounts for several of the important understandings of depression currently found in the research, including the changes in depression that are inherent across the lifetime, the prevalence and complexity of the disorder, the gender differences in depression and the recurrence of depression throughout childhood and the adult years (Hankin & Abela, 2005; Hammen, 2003). Each of the relational statements that can be constructed from the model allows for the development of testable hypotheses that can potentially support the model. However, the apparent interrelationships among vulnerabilities and stressors may require

complex, longitudinal research designs to determine which vulnerabilities and which stressors pose risks for women prone to postpartum depression (Beck & Alford, 2009; Hammen, 2003; Hankin & Abela, 2005).

Additionally, when attempting to support some to the relational statements, such as the relationship between antenatal life-events and postpartum depression, it would be vital to have prospective research data. This is often difficult, though, because depression is not diagnosed until weeks or even months after delivery (Robertson, Grace, Wallington, & Stewart, 2004). A significant critique of the Hankin and Abramson model is the lack of clarity about how negative affect and cognitive schema can interact with life events from some women and result in postpartum depression, and yet not have the same result for other women. Because of this issue, it is important to consider the use of models that allow for the inclusion of the unique meanings assigned to those life events. The FAAR model allows for further theorizing related to the ways that maternal negative affect and cognitive schema interact with the shared and individual meanings within the partner relationship to assess the experience and impact of life events, such as the transition to parenthood.

If women who are depressed report greater frequency of negative life events, especially with regards to interpersonal relationships, then it could be posited that these events may also pose a risk for partners as well (Hammen, 1991; Hammen, 2003; Patterson, 2002). The transition to parenthood places expected and unexpected stressors upon couples and increases the demands made upon the family (Deave, Johnson, & Ingram, 2008; Leigh & Milgrom, 2008). The demands of caring for a new infant increase the experience of strains and daily hassles, as posed by Patterson (2002), and this taxes the couple's capabilities, resources and coping behaviors. Researchers have shown that during this time couples report feeling supported by

family, friends and healthcare professionals. However, they often report unexpected changes in their partner relationship (Deave, Johnson & Ingram, 2008). Knowing that this is the experience for many parents, adding the additional stressors that may occur when the mother has postpartum depression creates further opportunity for straining the resources that the couple shares.

Beyond the example of changes in the partner relationship, partners of women with postpartum depression report feeling the additional strain to "fix things" within their family when their partner has postpartum depression; this can create further demands upon the father during an already demanding time in the life-course (Tammentie, Paavilainen, Astedt-Kurki, & Tarkka, 2004). Because the needs and meanings of one person can influence the needs and meanings of the partner relationship (Patterson, 2002), difficulties within the partner relationship related to maternal postpartum depression should not always be attributed exclusively to the mother.

Furthermore, because of this understanding and the knowledge that the postpartum period is an important time for infant and family development, it is vital that researchers begin to further investigate how maternal postpartum depression impacts the partner relationship (Goodman, 2004). Practitioners often look to a partner as the person that is able to support the mother and buffer the family against the effects of maternal postpartum depression. Researchers must better understand how partners and the couple relationship are impacted by the demands of postpartum depression, so that couples can be better supported through resources that increase the family's capabilities during this transition (Areias, Kumar, Barros, & Figueiredo, 1996; Edhborg, Matthiesen, Lundh, & Widstrom, 2005; Matthey, Barnett, Ungerer, & Waters, 2000).

The concepts and causal chain of the Elaborated Cognitive Vulnerability-Transactional Stress Theory of depression are pertinent as a foundation for research involving maternal

postpartum depression. However the model does not allow for the consideration of how depressive disorder and depressed mood in the mother can impact the day-to-day interactions of the couple during the transition to parenthood. This gap can be bridged using the concepts of couple capabilities, demands and meanings from the FAAR model of family resiliency. The proposal of a unique integrated model using the concepts of the Elaborated Cognitive Vulnerability-Transactional Stress Theory of depression and the partner level concepts of couple capabilities, demands and meanings will be outlined as it pertains to maternal postpartum depression, the partner relationship and the transition to parenthood.

## Proposal of an Integrated Conceptual Model

The examination of the two models within this paper indicates that there are distinct similarities and interrelationships between the Elaborated Cognitive Vulnerability-Transactional Stress Theory for depression in the individual and the FAAR model of family stress and resiliency. However, moving back and forth between the concepts of the Elaborated Cognitive Vulnerability-Transactional Stress Theory of Depression and the concepts within the FAAR model becomes awkward and inefficient. It is therefore plausible to create a conceptual model that shows the similarities in the two levels of theorizing. The model, presented in Figure 2, shows that the transition to parenthood is not the only factor that results in women being at risk for depressive symptoms and the diagnosis of postpartum depression. Factors such as childhood abuse and trauma, negative affect and increases in depression that influence dependent life events all play a role in the development of depression during the postpartum period.

However, the complex interrelationship of factors that result in postpartum depression in women share similar conceptual attributes with the factors that place the partner relationship at risk during the transition to parenthood. Daily demands and hassles experienced by the mother,

such as caring for a sick or fussy infant, also have the potential to influence her partner. The use of diathesis-stress theory does not allow for explanatory power about the ways that these interrelationships influence the partner relationship. Instead it is useful to consider the conceptual factors of the FAAR model.

It is possible that shared household tasks and child-care may shift to the non-depressed partner. It is also plausible that a mother struggling with postpartum depression may not be able to return to work, as the couple had planned. This unexpected change may overwhelm the family's financial capabilities. The concepts within the FAAR model have the potential to bridge the gap between our understanding of postpartum depression in the individual woman and the impact of that phenomenon upon her partner relationship.

The conceptual model that has been developed is intended to further guide this understanding of the interplay between the concepts related to the individual and the concepts related to the relationship. It is useful to show how the concepts within each model could be considered to influence both the mother's experience of postpartum depression and the transition to parenthood as well as the couple's adaptation and response to the transition.

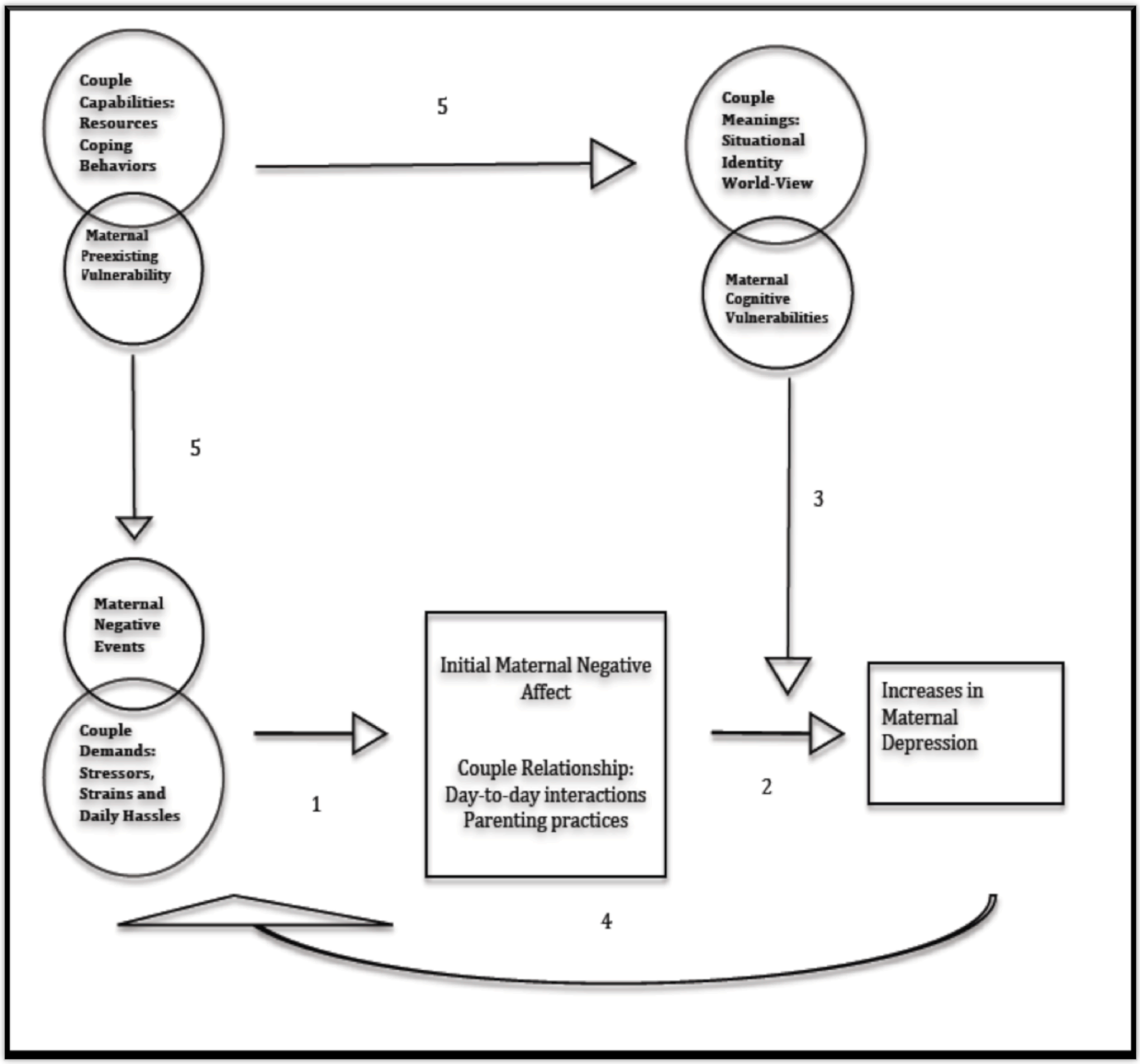


**Figure 1**. A Proposed Conceptual Model: A proposed conceptual model to integrate the concepts of the Elaborated Diathesis Stress Model of depression and The FAAR Model of family resiliency that will guide this project.

The experience of a negative live event in the Elaborated Cognitive Vulnerability-Transactional Stress model is proposed to contribute to increases in initial negative/depressive affect. As such, the transition to parenthood could be identified as both a proximal negative event for the mother and an event that carries additional strains, stressors and daily hassles to the

couple in the FAAR model. These demands made upon the couple become overwhelming with the addition of maternal postpartum depression. The couple slips into crisis and begins to make changes to adapt to this situation.

The vulnerabilities that are experienced by the mother, such as living in poverty or having a self-blaming personality style, which may contribute to her experience of postpartum depression, could also be viewed as impacting the capabilities of the partner relationship. Additionally, the potential for depressive affect and cognitive vulnerabilities in a mother with postpartum depression can also have an influence on interpersonal relationships and therefore impact the world-view and identity of the couple.

**Examination of the Relationships Between Concepts within the Integrated Model**

The assumption that the mother is engaged in day-to-day interactions with her partner stands behind the description of the causal chain of the integrated model. Within the integrated model the overlapping circles reflect interactions among the concepts from the two separate models, the Elaborated Cognitive Vulnerability-Transactional Stress theory and the FAAR model. The directional arrows propose a direct effect in the causal chain of increasing maternal postpartum depression and couple stress and resiliency. For ease of discussion, the causal chain within the integrated model shown on page 70 has been numbered. The proposal of relational statements will follow the order shown in the model.

**Link one.** The first link in the causal chain of the integrated model is the relationship between the interaction of maternal negative events with couple demands and initial maternal negative affect with the day-to-day interactions within the couple relationship. It is proposed that negative events experienced by the mother have the potential to impact the demands made upon the partner relationship. As an example, the mother may see her transition to parenthood as a

negative event. The demands made upon her during this time, such as infant care, are also experienced by her partner. Therefore, emotions associated with increased negative affect in the mother, including anxiety, depressive mood and anger, can have a direct impact on her day-to-day interactions with her partner.

**Link two.** The second link in the causal chain of the new model is the relationship between the interaction of initial maternal negative affect with the day-to-day interactions of the couple relationship and increases in maternal depression. The day-to-day interactions of the couple can either increase maternal feeling associated with negative affect, or buffer against those feelings. When the partner relationship reinforces maternal emotions such as anxiety, the mother's initial feelings of negative affect increase. An example of this can be found in cases where the partner is verbally or physically abusive. A supportive and loving partner relationship can result in day-to-day interactions that decrease maternal anxiety and as a result buffer against increases in depression.

**Link three.** The third link in the causal chain of the integrated model is the relationship between the interaction of maternal cognitive vulnerabilities and couple meanings with increases in maternal depression. The combination of maternal cognitive vulnerabilities, such as having an external locus of control, interact with couple meanings, such as situational identity, to moderate the likelihood that the mother will experience increases in depression. An example of this interaction occurs when mothers attribute negative events in their lives to stable, external causes become hopeless. This increase in maternal hopelessness can impact the way that the couple views themselves in relation to the world and the situation they are facing.

**Link four.** The fourth link in the causal chain is the transactional relationship between increases in maternal depression and increases in the experience of maternal dependent negative

life events, thus increasing demands made upon the couple. Within the Hankin & Abramson model increasing depression over time results in the experience of more dependent negative life events. As was previously explained, the mother's experience of negative life events will increase the demands made upon the couple. An example of this is that as depressive mood increases, the mother's behavior will become impacted by the symptoms that accompany depression. These symptoms include lethargy, hopelessness, anxiety and liable mood, and can change her interactions with her partner, potentially increasing discord within the relationship. Increased relationship discord could be viewed as a negative event to the mother and result in increases in initial maternal negative affect, subsequently leading to further increases in depression over time.

**Link five.** The fifth link in the causal chain of the integrated model has two components. The first proposes that preexisting maternal vulnerabilities interact with the capabilities of the couple, thus impacting both maternal cognitive vulnerabilities and couple meanings. Maternal vulnerabilities, including genetic risk, personality and environmental adversity interact with the capabilities of the couple. An example of this interaction is that mothers who have personality vulnerabilities, such as neuroticism, may create a strain on the shared coping behaviors of the couple. The increased strain on the couple capabilities will impact their understanding their identity during their transition to parenthood. The second component posits that the interaction between maternal preexisting vulnerabilities and couple capabilities also impacts the experience of maternal negative events and couple demands. The same neurotic tendencies in the mother will also increase the demands made upon the couple, adding to the daily hassles, stressors and strains related to parenting practices that the couple must face.

Finally, it should be noted that this model is posed as a dynamic interaction. As such, maternal and couple interventions at any link within the causal chain can decrease depressive mood in the mother and increase couple capabilities. This will allow the couple to adapt to their new situation as parents and help the mother to decrease her experiences of negative events. The concepts and relationships within this integrated model create a more useful foundation to inform research on maternal postpartum depression in the context of the couple relationship during the transition to parenthood.

## Conclusion

Postpartum depression in new mothers is a complex, multifactorial phenomenon. The Elaborated Cognitive Vulnerability-Transactional Stress model presented by Hankin and Abramson (2001) allows for a clear and parsimonious understanding of this complex diagnosis in the individual. However, it does not adequately elaborate on the interaction of the vulnerabilities, stressors and life events in the individual with the capabilities, meanings and demands made upon the partner relationship during the transition to parenthood. The use of Patterson's FAAR (2002) model does allow for a deeper understanding of how couples navigate through life transitions and unexpected experiences. By bringing together the concepts found within each of these models, it is possible to develop a framework to guide research designed to better understand the partner relationship during the transition to parenthood within the context of maternal postpartum depression.

## Chapter Three: The Choice of Method: Interpretive Phenomenology and The Study Design

Depression following the experience of life events and transitions, specifically postpartum depression following the transition to parenthood, is a complex illness complicated by a multifactorial etiology, difficult diagnosis and uncertain progression (Beck, 2008a; Beck, 2008b; Hankin & Abramson, 2001). Depression is frequently associated with the occurrence of life events and the transition to parenthood is a life event that can create stress for new parents (Cowan et al., 1985; Cowan, Cowan, Pruett, & Pruett, 2007). This transition to parenthood, combined with risks associated with previous life events, the stress of becoming a new parent and the quality of the partner relationship can come together to place women at increased risk for postpartum depression (Beck, 2001; Edhborg, Matthiesen, Lundh, & Widstrom, 2005; Leigh & Milgrom, 2008). In addition, previous research shows that there is a relationship between maternal depression and paternal mood and behavior during the postpartum period, but little is understood about the dynamics of that relationship (Deater-Deckard, Pickering, Dunn, & Golding, 1998; Pinheiro et al., 2006; Ramchandani, Stein, Evans, O'Connor, & ALSPAC study team, 2005).

Through a review of the current depression, postpartum depression and partner relationship research, as well as a theoretical exploration of the diathesis-stress model of depression, it is apparent that the partner relationship plays a significant role during the transition to parenthood. And although there is a significant body of research that explores the experiences of women who are diagnosed with postpartum depression and another body of literature that explores the partner relationship during the transition to parenthood, it is not well understood how couples experience this transtion together within the context of postpartum depression.

There is a lack of understanding related to what the main concerns of couples are in relation to postpartum depression and the partner relationship during the transition to parenthood. Furthermore, it is important to better understand how couples utilize available resources to cope with changes during this experience.

This chapter will examine the use of interpretive phenomenology, including narrative analysis of semi-structured interviews, as the most appropriate methodology for examining maternal postpartum depression in couples. The philosophical underpinnings of interpretive phenomenology as it is used in nursing research and how the interpretive assumptions of what it means to be-in-the-world influence this method of research study will also be reviewed. Following this, the design, sample, and methodological steps of this research study will be explicated.

## Choice of Method

The review of the literature pointed to a continued lack of understanding about the experience that couples face when making the transition to parenthood within the context of maternal postpartum depression. Therefore, the aim of this research is to better understand the experiences of couples who are making the transition from their dyad-relationship to being a family of three, while simultaneously experiencing that transition within the context of maternal postpartum depression. Underlying this aim is the secondary goal of understanding how the partner relationship may be affected by this transition, because this is a key concept that had not yet been explored in the existing research. The first step in the process to complete the goals of this research is to determine if the study should be quantitatively or qualitatively focused.

A review of research that includes the concepts of depression, the partner relationship and life events and stressors, found that this body of research often focuses on correlational empirical

studies using personal, couple and developmental risk characteristics. Some researchers speculate that this limited view of research design, focused on determining risk, creates a field of science that has muddied our understanding of the ways that stress and life experiences impact depression in the individual (Monroe & Simons, 1991; van Praag, de Kloet, & van Os, 2004). When researchers focus on correlational analysis of vulnerability and risk factors it is difficult to assess the participants' appraisal of life events in the course of depression.

These issues may arise from a research framework that assumes that there is a universal and objective understanding of the human experience (Laverty, 2003). Grounding research in this rationalist view of the world creates an examination of reality that is founded upon a structure of rules and principles that guide everyday life. These classically empirical methods, such as correlational analysis of risk, vulnerability and stressors during early parenthood, assume that the world consists of measurable context-free factors that can be separated from human concerns (P. Benner & Chan, 2010). Therefore science based in empiricist methods focuses on that which is observable and readily accessible or measureable (Laverty, 2003).

Theory and extant research suggests that the genesis of depression varies widely on a case-by-case basis and that there is no single definitive pathway for depressive psychopathology (Hankin & Abramson, 2001). Meaning and appraisal are important constructs in individual and family vulnerability and stress models. However, because so much of the everyday experience is taken for granted and because concepts like meaning and stress vary in their clinical definitions, these constructs can be difficult to isolate empirically (Hammen, 2005; van Praag et al., 2004).

Quantitative research does allow for the clinically important measurement of some physiological and psychological phenomena related to depression. However, the inherent assumption that there is an objective reality of the human experience does not allow for the

understanding that there are situated subjectivities. Appraisal, meaning and context are important factors in family-related studies and because it is difficult to measure these concepts, strictly empirical research designs may lead to a less holistic view of the phenomenon. Specialists in the field of stress and depression acknowledge that life events may have enormously different meanings and therefore suggest research designs that tap personal meaning of events and depression (Hammen, 2005). Because of the importance of the concept of individual and family appraisal in depression and postpartum depression research, there is a need for the use of a method that allows for a deeper understanding of the individual experiences and the situated realities of the participant couples.

Moreover, when determining the method to be used for researching the experience of postnatally depressed women and their partners making the transition to parenthood, it is important that the method allow for a holistic understanding of the phenomenon. The method must highlight the context, the intents of the couple, the meaning of the situation, who the couple is in the world and in the situation, as well as the complexity of the relationship between events, people and context (Benner & Chan, 2010). There are multiple qualitative methodologies, each with its own epistemological and ontological underpinnings and theoretical frameworks. Three different methodologies will be reviewed, grounded theory, ethnography and interpretive phenomenology. Each of these methods, as it applies to the topic of maternal postpartum depression and the partner relationship will be discussed here. Although there are some similarities among the different qualitative methodologies, each is unique in its processes and intended outcomes. It is important that the method fit the specific aims of the proposed study (Holloway & Todres, 2003).

**Grounded Theory**

Grounded theory is anchored by the philosophical tradition of American pragmatism and the sociological understanding of symbolic interactionism. This method focuses on the perspective that people act upon things based on the meaning that those things have for them. These meanings are constructed through social interaction and active interpretation (Blumer, 1969). Blumer believed that human beings act toward each other in social situations by interpreting the actions of others and constructing their own actions; human interaction is not just a reaction to others (Blumer, 1969). Blumer was reacting to behaviorist theories of human interaction that denied the importance of interpretation and instead focused almost entirely on a stimulus-response model of human behavior.

Using the assumptions laid out by Blumer, Glaser and Strauss developed the method of grounded theory. Their work was a response to the critique that qualitative research lacked rigor, was not verifiable and could not be validated (Strauss, Strauss, & Corbin, 1997). The goal of grounded theory is to develop new theories grounded in collected data through an inductive process that allows the data to drive the development of a hypothesis. This method uses a rigorous process of developing codes from the text that are then grouped into concepts, then categories and finally these categories are used to develop a theory or hypothesis related to the phenomenon and focuses on action.

The assumptions related to symbolic interactionism and the methods associated with grounded theory appear to allow for understanding the process of how maternal postpartum depression influences the partner relationship. These assumptions also appear to allow for the exploration of how parents, as individuals, interpret their interactions. However, the focus on the development of theory is not in alignment with the purpose of this research. Therefore, the

grounded theory methodology was not an appropriate fit to the specific goals of this research. This study aimed to better understand the experience of couples who were making the transition to parenthood within the context of maternal postpartum depression. This study also aimed to better understand how the partner relationship was influenced by this transition. Theory construction is not the intended outcome of this research.

Instead, this study sought to better understand the patterns in couples making the transition to parenthood within the context of maternal postpartum depression. In addition, the goal was to understand how couples co-create meaning during this transition, including patterns of emotional response to the mother's postpartum depression, patterns of child monitoring and care and how anticipated gender roles are disrupted by maternal depression. Many of these patterns and disruptions are not entirely related to social level processes. Research designed to focus on these aims must include the meaning of this experience from multiple levels of analysis including the mother's perspective, her partner's perspective and the co-constructed perspective of the couple.

**Ethnography**

Ethnographic methodologies have a long-standing history in the field of human sciences and cultural studies (Hammersley & Atkinson, 2007). Originally intended as a method that allowed for the study of cultures that were foreign to the researcher, ethnography focuses on understanding the ways of living within a particular culture (Bailey, 1997). Researchers using this method today often include the use of observation and spoken interaction with informants to highlight the voice of those living within the culture instead of focusing mainly on comparing the studied culture to the researcher's own cultural practices and understanding. As a result, the primary goal of most ethnographic research is to understand the rituals, customs and structure of

a culture or society through the use of detailed fieldwork methods using participant observation and informant interviews (Hammersley & Atkinson, 2007).

Researchers have shown, through the review of multiple studies across different cultures, that certain cultural practices and kinship relations may influence the way that postpartum depression is expressed by a new mother and accepted by her family (Posmontier & Horowitz, 2004). These findings warrant further research that focuses on cultural practices and societal beliefs related to the transition to parenthood within the context of the maternal postpartum depression. However, that was not the intended goal of this research study. Although new parents live within their culture and society and as a result may practice customs or traditional parent and partner roles associated with their cultural believes, the primary goal of this proposed study was not to focus on this experience from the societal level.

**Interpretive Phenomenology**

The aim of interpretive phenomenology (IP) is to explain particular patterns of meaning in life events, relationships and practices for people within similar contextual experiences (Chesla, 1995). The method is systematic, using reflective and narrative questioning to ask participants to convey a particular situation or experience. The use of narrative questioning and analysis allows for the examination of couple and family patterns of response to life transitions and illness. Researchers have used IP to study the relational patterns of couples living with chronic pelvic pain (Strzempko, Butt & Chesla, 2007), to understand the cultural and familial challenges faced by immigrant Chinese Americans who are managing their type 2 diabetes (Chesla et al., 2009) and to understand the habits and practices of healing in couples and families following the death of a child (Gudmundsdottir & Chesla, 2006).

In this study, the focus was upon the couple's experience of the transition to parenthood within the context of maternal postpartum depression. When studying issues and concerns within the couple relationship, the level of analysis and understanding must move past the individual level to highlight the shared meanings and processes within the relationship (Chesla, 1995). Because IP draws on Heidegger's philosophy of being-in-the world, which examines shared meanings, engaged activity and concerns, it was an appropriate method to study the processes between partners during different life transitions and experiences of illness.

## Philosophical Roots of Interpretive Phenomenology

As a method of qualitative research it is important to note that IP has a rich foundation in philosophical discourse. Phenomenology is also a philosophy that has both epistemological and ontological roots (Mackey, 2005). As a philosophical perspective, phenomenology gained popularity during the first half of the 20th century and was a direct response to the debate that focused on the questions that sought an answer to 'what is knowledge' (Blackburn, 2005). Phenomenologists were interested in the study of conscious experience as experienced from the subjective or first person point of view. It was not their concern to determine what knowledge was, but instead early phenomenologists were interested in the state of human being. This new philosophical stance also called for a change to the previously established notion of human existence, Cartesian dualism.

The epistemological foundation of phenomenology is rooted in Husserl's emphasis on using reflection as a method to reveal the essence of phenomena that exist independently of conscious experience. Researchers using the foundational concepts of Husserlian phenomenology focus upon questions related to the descriptive understanding of the world and the objects within it, rather than the nature of being-in-the-world (Mackey, 2005). In the same

way that Blumer disagreed with the purely behavioristic approach to human interaction, Husserl understood that humans are necessarily more complex than animals and that we do not follow the same strict stimulus-response behavior as Pavlov's dog (Laverty, 2003; Mackey, 2005).

Heidegger, a student of Husserl's, believed that philosophical thought had been focused on the wrong questions for a significant period of history. He suggested that instead of focusing on what can be known and understood about the world, the focus should be on what it means to be a person and to live within the world. By placing the focus on being in the world, the emphasis upon the split between the subject and the external world was removed. It was previously posited by Descartes that the person was a subject who thought about the external world through representations of objects in the mind. Heidegger posited that the person already exists within the world and that the self was not a being that existed only in the reflective consciousness (Leonard, 1989). As a result he moves away from the ideas related to a mind-body dualism that had been the foundation of many of the empirical, rationalist approaches to science (Benner & Chan, 2010). Heidegger presents a philosophical stance in which the person is engaged in the activity of being in the world.

**Being-in-the-World**

Heidegger turned to the ontological perspective of understanding based on his disagreement with the widely held belief that science should focus upon epistemological questions rooted in a Cartesian perspective (Mackey, 2005). He believed that this important shift was the only way philosophy would ever be able to understand, with clarity, anything about the human world (Leonard, 1989). Phenomenologists explicate that the epistemological constraints of traditional science inhibit our understanding of people's actions, concerns and relationships (Leonard, 1989). The current IP stance acknowledges the importance of traditional science and

the findings that have helped people living with illness. However, questions related to the relationship between the person and their world cannot be answered through the methods of traditional science (Leonard, 1989). These questions require an ontological focus.

Heidegger's ontological stance regarding what it means to be a person has been used in the framework of many nursing research studies and in the development of theoretical perspectives of coping and health. These studies have focused upon the experiences of couples coping with the diagnosis of an illness in one partner and parents experiencing a loss (Chesla, Chun, & Kwan, 2009; Gudmundsdottir & Chesla, 2006; Strzempko Butt & Chesla, 2007). The tenets within Heidegger's philosophy of being are based in his understanding of human situatedness, caring, time, and modes of engagement (Leonard, 1989). These views were discussed in his text "Being and Time" which was first published in his native German in 1927 and differed from prevalent phenomenological thought primarily in the notion of "Dasein" (Mackey, 2005). Dasein was Heidegger's conceptualization of what it means to be a person and to exist within the world. Throughout this paper this notion of Dasein will be expressed as human being, or being. Heidegger's tenets of being, as a foundation for the IP understanding of what it means to be a person, will now be discussed in further detail.

**Situated Beings**

Heidegger assumes human beings are already situated within meaningful activities and relationships. This is understood as "thrownness", indicating that humans are thrown and socialized into a pre-existing situation and world that consists of everyday activities and involvements (Laverty, 2003). The pre-existing world into which the being is thrown, cannot be fully represented or described. Ultimately, human beings take their world and the everyday activities and relationships within that world for granted (Leonard, 1989). Because of this it may

not always be possible for them to directly reflect upon their experiences or to express the meanings of the activities they may engage in within their families. This taken for granted understanding makes the world, other humans and relationships sensible and interpretable.

Unlike the Cartesian understanding of the relationships between the person and the objects that exist separate from the person, the phenomenological perspective of being-in-the-world is grounded within the understanding that persons are both constructed of and by the world in which they live (Leonard, 1989). By shifting his stance from Cartesianism, Heidegger pushed for an understanding of self that is inextricably linked to the world. Persons can not be understood outside the context of the world that they are a part of, can not be separated from the cultural, familial and societal practices and activities in which they remain and are always, already engaged (Leonard, 1989).

**Caring Beings**

Heidegger's second tenet is that humans are the types of beings for whom things matter. People live in the world according to their concerns, or what matters to them (Leonard, 1989). Heidegger explained "Dasien's Being reveals itself as *care*" (Heidegger, 1962, p. 241). If people exist within the world by engaging in activities, their very existence and engagement is a reflection of what they care for and what they take care of in their lives (Dreyfus, 1991). How we are involved in our world is made possible and constrained by what concerns us or by what matters to us (Mackey, 2005). These concerns shape our life-worlds, influencing what is seen and what is spoken and the actions that we make (Dreyfus, 1991).

**Beings in Time**

Leonard (1994) explains that Heidegger has a different perception of time than previous philosophical thought had outlined. The empirical perspective of time focuses on the

understanding that time is linear and is always moving forward, allowing the person to have an awareness of the present and the future as two separate entities. Heidegger believed that time was not linear and instead presented an understanding of time in which the past, present and the future were constantly interrelated. In his description of temporality, the person always 'is' in time. As a self-interpreting being, the person has a constant awareness of his or her past, which affects his or her experience of the present and their perceptions of what is expected to occur in the future. Because Heidegger describes the person as being-in-time, the person and the understanding of being cannot be separated from where he or she is in time and from the events that have occurred.

**Modes of Engagement**

As human beings who are always already in the world, we are involved and engaged in meaningful relationships and practical activities (Plager, 1994). Heidegger explained that practical activity consisted of three levels of engagement with the objects human beings use in daily life. These modes are ready-to-hand, unready-to-hand, and present-to-hand. He further explained that most of the practical activities of daily living are in the ready-to-hand mode. In this mode of engagement activities are smooth, spontaneous and transparent (Plager, 1994). An example of this mode of engagement is a young g couple preparing their favorite meal together. There is a smooth flow of movement around the kitchen. Each person knows what to do next, often without any verbal communication. In this mode of engagement, equipment goes unnoticed and is a seamless extension of the body (Benner & Wrubel, 1989).

When there is a breakdown of this smooth flow the activities become less transparent. The person becomes aware of the equipment and relationships involved in the activity. This mode is recognized as the ready-to-hand mode of engagement. Breakdown of smooth flow

occurs because the equipment may not be working properly or because the person takes notice of it as the result of a change or self-consciousness (Benner & Wurbel, 1989). Using the previous example of a young couple preparing dinner, a baby that wakes and needs comforting will disrupt the typical smooth flow of the couple's engagement with preparing the meal.

The third mode of engagement, present-at-hand, is a mode when day-to-day practical activity stops and the person stands outside the situation and reflects. The equipment used in the activity is no longer an extension of the body, but is instead an object separate from the self (Benner & Wurbel, 1989). This is a disengaged and reflective mode where activities such as theoretical reflection, observation and experimentation happen (Plager, 1994). It is here that the interrelationship between aspects of the situation, equipment and time is lost (Benner & Wurbel, 1989). Because of this objective stance, the present-at-hand mode of engagement is often the focus of inquiry based in Cartesian tradition. In this context it is not possible to understand the lived experience because the focus is on an outside looking in perspective, instead of a description as it is being lived.

**Being-in-the World and the Partner Relationship**

Heidegger's understanding that humans live their lives in engaged practical activity and that they live in a world for which things have meaning, is an important idea when discussing family and partner relationships. If the couple's way of being in the world is through engaged practical activity, then to understand their experiences of life transitions, or living with a diagnosis such as postpartum depression, it is necessary to use methods that allow for an explanation of that engagement (Chesla, 1995). Because couples are constituted by their family cultural meanings and practices, the meaning of engaged activities and interpersonal relationships cannot always be readily expressed. Instead, these meanings can be uncovered

through the thoughtful examination of the ready-to-hand mode of involvement. This thoughtful examination should be rooted in hermeneutic accounts of the couple's ways of coping with particular situations. To access these accounts of coping and engaged activities researchers can use both observations of the couple engaged in daily activities or narratives of action regarding a particular situation.

## Study Design

### Pilot Study

Following the review of the literature and the completion of a pilot study, it was apparent that there were further questions left unanswered when seeking an understanding of the meaning of the partner relationship during the transition to parenthood within the context of maternal postpartum depression. The pilot study highlighted the concerns of fathers during early parenthood when their partners had postpartum depression. The themes identified needed further exploration with a larger group of participant couples, allowing for a multifocal understanding of the experience and the ways that partners provide support. The themes expressed by the fathers showed they had concerns about their partner relationship. They sensed that their relationship interactions had changed and that their role in the family had also changed:

> Mike: But when I realized that the postpartum depression was going to change things, you know I even went to the counselor and she basically said that I need to take a much more active role. I am going to have to be more vigilant in what is going on and not just be the sideline person. And I think that is what guys are a lot of the times. We stand on the sidelines and we really only help when things are needed. The mom is definitely the quarterback of everything. But you know, she says, now you have to be more active and you have to keep an eye out.

The fathers also expressed concerns about experiencing emotional changes and that these changes were often connected to how postpartum depression symptoms were affecting their partners:

> Angelo: Do I think that it has changed me a little bit? Yeah. I mean, you know what they say about those men that like experience labor or whatever, along with their wives. You know umm, sympathy pains or whatever. Yeah, so I think maybe men can feel the same way when their wives have depression, like we can feel a little depressed too. Maybe not sympathy depression, yeah, no, that could be it, sympathy depression. When she is having an off day, sometimes I have one too.

These concerns and experiences needed to be further investigated from the context of the couple relationship to create a deeper understanding and a richer description of the meaning and the appraisal of this transition for new parents.

IP methodology and the use of narrative analysis and hermeneutic techniques allowed for grounding this understanding in the societal and cultural context of parenting and depression. As with many mental health issues, postpartum depression has been stigmatized through media influences and stories discussing infanticide. Familial and cultural understandings of parenting, parental roles and mental health issues were also be part of the fore-structure of how couples come to understand their current experiences. Further analysis of this situation was designed to help bring forth some of those stigmatizing experiences and concerns, in addition to the everyday concerns of couples and can be used by healthcare professionals that work with women and families during the early post-natal period.

**Research Goals and Specific Aims**

Beginning with the Heideggerian view of the person allows nurse researchers to focus on the experience of the individual and the couple as partners and to explore what it means to be within their world. Rather then suspending presuppositions about what it means to be a parent with depression, the researcher must explore those preconceptions while examining the reality that is lived by the parents. In this sense, the nurse becomes part of the research, thus being both a researcher and a part of the study.

Based upon the phenomenological assumptions of what it means to be-in-the-world and the theoretical framework of vulnerability, stress and coping in individuals and families, the specific aim of this interpretive phenomenological study was to explore the lived experiences of couples who made the transition to parenthood within the context of maternal postpartum depression. The goal of the study was to explicate the meaning of and the concerns within the partner relationship during the transition to parenthood within the context of maternal postpartum depression. Additional clarifying aims included examining the patterns of care and coping in couples, the patterns of emotional response in partners of depressed mothers and how anticipated roles may be disrupted by maternal postpartum depression. The specific aims that guided the study were:

(1) What are the patterns of emotional response, in mothers and their partners, to maternal postpartum depression?

(2) How are anticipated parenting and partner roles disrupted or changed by maternal postpartum depression?

(3) How are the couple's practices and processes of child monitoring and care impacted by maternal postpartum depression?

Any study that seeks to understand relationship practices and experiences in the midst of a family crisis or illness must focus on the couple's difficulties, conflicts and deficits, as well as their coping abilities and the ways that they succeed and thrive. This study was designed to allow for the exploration of linked-lives and shared meanings of partner and family caregiving. This method allowed for the investigation and articulation of care practices in the everyday and in extraordinary situations. By attending to the everyday, this study created a greater understanding of that which was taken for granted in the couples' experiences and relationships.

## Sample

**Inclusion and exclusion criteria.** Mothers and their partners were considered eligible if (1) mothers must have been diagnosed with postpartum depression within the first year after giving birth, and (2) must have been diagnosed with postpartum depression after the birth of the mother's first child (3) must have given birth within the last three years. The mother and her partner each had to be (4) English speaking, (5) married or living together through the transition to parenthood and at the time of enrollment in the study and (6) had to be 18 years or older and (7) both the mother and her partner had to agree to be in the study. In addition, in order to decrease the risk for additional stress placed upon the mother, her partner and the family, (8) the mother's depression had to be well controlled and she had to report that she was in a healthy state of wellbeing. This was initially assessed using the telephone screening script found in Appendix C.

Couples were not considered eligible if the mothers reported current depressive episodes and/or a history of harm to herself or her infant, as involvement in a research study was thought to pose an additional stressor for the family. All potential participants were screened for current intimate partner violence and in the case of a history of violence, couples will be excluded for their own safety and referral to resources will be provided (Appendix G).

**Recruitment.** Recruitment for this study was lengthy and difficult. There are several possible reasons for this. First, it is possible that as busy new parents, couples did not feel that they had the time to commit to the interview process. It is also possible that the stigma related to mental health, especially postpartum depression which seems to go against the grain of societal discourse about motherhood, kept couples from wanting to openly share their experiences (Lazzare, 1997). The study was advertised in online and print advertisements on Craigslist and

with many parenting groups and practitioner associations in the Bay Area. In addition, local practitioners that were well known in the community for working with women with postpartum depression were also approached as asked to hand out information to their clients. Contacts were made through the professional relationships of the researcher and there became a snowball effect of people learning about the study through word of mouth and then giving the study information to their clients. In the end, the 10 couples were recruited in various ways, with five answering advertisements and five hearing of the study through friends or their practitioners such as midwives or therapists.

It is also a possibility that the inclusion criteria narrowed the possibilities for recruitment. Several interested mothers called after seeing the advertisement, however two were further than three years away from their diagnosis and one was no longer living with her partner. It is also interesting to note that several of the couples that did enroll reported having difficult finding resources specific to postpartum depression in the metropolitan area where they were living. This lack of resources may have also played a role in the difficulty of recruiting couples because there were few dedicated support groups or online resources that targeted the sample needed.

**Sample characteristics.** The sample in this study consisted of 10 couples. Within each couple, both the mother and her partner agreed to participate. Of the couples in this study nine were married and one was in a long-term committed relationship. Each couple lived together in the same home at the time of the mother's diagnosis and at the time of the interviews. Each mother was diagnosed with postpartum depression after the birth of her first child. Two of the couples were expecting their second child at the time of the interviews and two of the couples had more than one child. (Further description of the couples can be found in Appendix A.)

The majority of the participants in this study identified as being Caucasian, with 16 participants stating that they were of Western European decent, two participants stating they were of American born Chinese decent and two stating that they were ethnically Jewish. Sixteen of the participants completed at least a bachelor's degree, one completed an associates degree, three reported that they completed some college classes without completing a degree, and ten reported graduate education. The mean number of years of education was 16.1. Respondents ranged in age from 26-45 with a mean age of 35.1. The monthly household income in this study was high, with a mean of $9,430, a reflection of the mean annual income within the geographical location where this study took place. However, there was a wide range of monthly income, from $4,300 up to $17,000. The couples that participated in this study were mostly of American born, European decent, highly educated, high-income earners and were in long-term committed, relationships.

Table 1

*Participant Demographic Information*

| Demographics | Average | SD± |
|---|---|---|
| Participant Age (Years) | 35.1 | 5.47 |
| Years of Education | 16.1 | 1.57 |
| Length of Relationship (Years) | 8.9 | 3.87 |
| Monthly Household Income | 9,430 | 5,215 |
| Number of Weeks Postpartum at Time of Maternal Depression Diagnosis | 8.3 | 2.11 |
| Months Postpartum at Time of Enrollment in Study | 17.1 | 6.59 |

Table 1

Each of the couples in this study had at least one child in the home, with one family having two children and a second family having three children (one set of twins and another child). One of the couples had an older child, from the father's previous marriage living with them part of the time. None of the couple's children were enrolled in school, spending the majority of the time in the home under the care of a parent or a trusted care provider. At the time of the interviews two of the mother's were expecting their second child. Although several of the families had extended family living with them during the first few weeks after the birth of the child, none of the couples had other family members, who were not their children, living with them at the time of the study.

Each of the mothers enrolled in the study had a diagnosis of postpartum depression with the birth of their first child and had been diagnosed within three years of enrollment. At the time of their first interview the average number of months postpartum was 17.1 with a range of 30 months to 8-months. The average number of weeks postpartum at the time of diagnosis was 8.3 weeks with a range of 12 weeks to 6-weeks. At the time of the interviews the average length of time since diagnosis was 13.9 months with a range of 27 months to 8.75 months. Six of the 10 mothers were still regularly seeing a therapist or psychiatrist for their depression and seven of the 10 were still tapering off their medications. Three of the partners had received support and counseling of some sort, with two experiencing diagnosed depressive episodes.

**Data Collection**

The data for this study were mainly collected by interviewing couples both together and separately. Both the mother and partner were asked to fill out a demographics sheet, at the first meeting, as well as the Life Stressor Checklist-Revised (LSC-R; Wolfe & Kimerling, 1997) and finally the Edinburgh Postnatal Depression Screening scale (EPDS; Cox, Holden, & Sagovsky,

1987) was completed at each meeting. These items were collected as a way to better describe the sample. In addition to the interview screening data, field notes were written and research observations were audio recorded following each interview and used to inform the data analysis.

With the exception of one couple, Christine and Connor who only completed the couple interview, all participant couples were interviewed three times. First, they were interviewed as a couple and then they were each interviewed separately. These interviews took place over multiple visits and were completed within 3 months of enrollment into the study. All interviews were completed, at the couple's convenience, in the home, with the exception of two that took place in restaurants, per the request of the participant. Each of the interviews was audio recorded and lasted from 90-120 minutes, although at times the interviews were slightly longer and only at the convenience of the participant. These audio recordings were transcribed verbatim and reviewed for accuracy. The transcriptions became the data for analysis.

Following a phone interview for ensuring that potential participants met the inclusion criteria (see Appendix C), an initial interview was scheduled, at a location and time that was convenient to the couple. At this first meeting, prior to beginning the interview, the couple was asked to review and sign the consent form (see Appendix B) and complete the demographics sheet (see Appendix D), and they were also asked to individually fill out a depression screening instrument. The depression screening and the demographic sheets were then reviewed and discussed to ensure that the information was understood and to ensure that neither participant was currently at risk of harming themselves or another family member. This information was also used to better understand the sample characteristics. The first interview then began with the couple together and followed the non-standardized interview guide found in Appendix E. This first interview focused on the co-constructed narratives of the couple regarding their experiences

before, during and after the mother's postpartum depression diagnosis, as well as their shared experiences of parenting and their partner relationship during this time.

At the end of the initial couple interview the follow-up interview dates were arranged with the mother and the partner. In addition each participant was left with a copy of the LSC-R (Wolfe & Kimerling, 1997) and instructed on how to fill it out. It was asked that they take some time to answer the questions prior to their second interview. The information from the LSC-R was reviewed with the participant at the second meeting and discussed during the interview and was also used to inform the sample characteristics. The follow-up interviews with individual participants were used to clarify information shared in the first interview and to understand the experiences of postpartum depression and the transition from the individual's perspective.

Throughout the interview process, several types of questions were used. Semi-structured, reflective questions were used to examine the participant couples' beliefs about maternal postpartum depression and the transition to parenthood as well as the aspects of postpartum depression that created challenges for the couple during an already challenging life transition. For example, the use of direct questioning allowed participants to reflect upon their beliefs about gendered parenting roles and familial support systems. Narrative questioning was also used to examine the cultural, familial and transitional processes of becoming parents and coping with maternal postpartum depression (Strzempko Butt & Chesla, 2007). Narrative accounts of recent experiences related to parenting and maternal depression highlighted the totality and complexity of the situation. IP methods call for the use of narrative questions to understand the couple's engagement in the activities of parenting and semi-structured reflective questions to learn more about the couple's ideas about their situation (Benner, 1994). The interview guide was used to loosely structure the interview process and to encourage participants to share full narrative

accounts of what happened. In addition, many follow-up probing questions were used to encourage participants to share their experiences and to engage the participants to share the context of the narrative. These narratives gave a closer understanding of the actual everyday habits, practices and events that happened within the couple relationship during the postpartum time. The probing questions were used to complete the narrative by adding information about the specific situation, what happened before and after, how the situation evolved in the moment and what the concerns of those involved were at the time (Benner, Tanner, & Chesla, 1996). Narrative interviewing allowed for the examination of the processes of care and the couple's response to parenting and maternal postpartum depression and created a non-atomistic perspective of the situation.

**Data Analysis**

Data analysis was based upon the methodological process of Benner (1994) and included narrative and thematic analysis of the interview data. Interview data, interpretive notes, observations and journaling were organized using the ATLAS.ti version 6. Data analysis began at the first meeting with the first couple and continued through the final review of the data after the last interview of the research study. Following the first interview with a couple the data was transcribed and the transcription and the observation notes made during this initial interview were reviewed before the next interview was conducted. This process continued with each interview and allowed for the clarification of information given in the couple interview during individual interviews. Information learned during an individual interview was carefully protected and not shared with the other partner during their interview.

The interview text was also read multiple times in its entirety during the interpretive process and notes were taken and journaling was used to outline initial impressions of the

concerns and meanings of the couple (Benner, 1994). The method of interpretation included a holistic perspective of the test while simultaneously moving through a more detailed reading of the text. This holistic view was also informed by case summaries that were written for each couple using demographic data, findings from the collected depression screening scales, and the LSC-R, and the observation notes that were written during and immediately following each interview. This movement from the whole read, to the detailed parts and back to the whole, also known as the hermeneutic process, is the foundation of the interpretive phenomenological method and allowed for the identification of specific patterns of lived experience.

The hermeneutic process is also representative of the idea that there is circularity in the understanding of life experiences and science. This allowed for the interpretation to be situated within the pre-understanding of the researcher. Journaling included what was known from the researcher's practical experience, from theory and from the awareness of the issue being studied. This pre-understanding was not a rigid point from which to judge and interpret data, but rather it was a foundation for the movement back and forth between a projected understanding and a corrected understanding that developed from working with participants and the text (Benner, 1994). Having this projected understanding allowed for initial meanings and concerns to emerge from the early review of the text because the researcher already had questions. However, care was taken to avoid allowing presumptive understanding to cloud or hide alternative meanings from the text.

The interpretation proceeded via the interpretation of a whole case. In this study the "case" was a couple and the way that they were experiencing the transition to parenthood within the context of maternal postpartum depression. The interpretation began with the analysis of each case and all forms of data within that case. Following the analysis of one case, it was compared

with other whole cases to identify concepts of similarity and difference. As a result of this process, the project was wholly comparative: a case was used to make sense of other cases. Throughout the interpretive process summaries from each couple case were created. The case summaries included all the narratives that had been analyzed within that case, all observational notes, and thematic analysis related to parenting and postpartum depression. As the process of data analysis moved forward, whole integrative summaries of what the case revealed about the concerns, beliefs and actions of the couple were also written. Memos written on the basis of these case summaries guided the cross-case analysis and this process ensured that data interpretations occurred simultaneously with data analysis and subsequent interviewing.

Following these initial reviews of the text, and the development of case summaries, and initial questions were asked of the data, the text was reread and narratives were isolated that highlighted the specific habits, practices, meanings and concerns of each couple. The text was then reread in its entirety with new questions to develop a deeper understanding of the couple's experience of postpartum depression and the transition to parenthood. From this point, additional cases were reviewed in the same manner to bring to light the similarities and differences within each couple's reported experiences (Chesla, 1994). Following Benner's (1994) methodological practices, three overarching approaches were used during the interpretation of the text: paradigm cases, exemplars, and thematic analysis.

**Paradigm cases.** A paradigm case is a compelling pattern of concern and meaning that brings to light the habits and practices of a couple and creates a deeper understanding of how they are situated within their world. The realization of this pattern then allowed for the comparison of the paradigm case to other cases and informed the recognition of other similar or contradictory patterns within the text from other couples' interviews. A paradigm case is

revelatory in that it allows what was hidden from the researcher to now be seen and creates a starting point for comparison and further understanding (Benner, Tanner, & Chesla, 1994; Leonard, 1994). This pattern was not used as rigid set of instructions to make predictions from the text, but instead created an opportunity to understand something that was not previously noted in previous readings.

**Exemplars.** Stories that reveal particular aspects of the couple's experiences, including their concerns and meanings, their habits and practices are seen as exemplars (Leonard, 1994). The analysis of exemplars in the text was a way to highlight the engaged practical activity and the concerns of the participants (Benner, 1994). This level of analysis was grounded in the contextual background of the situation, the participant's emotional tone, the action as the experience unfolded and the retrospective reflection of the participant as the story was shared. Exemplars allowed the researcher to gather new meanings and a deeper understanding of situations that are revealed in the text. Unlike paradigms, exemplars focus on a particular situation and not upon a whole case (Benner, 1994). They allowed for the exploration of the demands that the situation has placed upon the couple, the concerns expressed by the narrator and explained through the actions of the couple and what actions were taken up or rejected as the couple attempts to resolve their issues.

**Thematic analysis.** In addition to the analysis of narrative within the text, the analysis of the data also included a thematic approach that focused on the beliefs and practices of the couples regarding parenting roles and maternal postpartum depression. This study employed three different levels of thematic analysis: holistic, selective and detailed. With the holistic thematic analysis the entire interview was reviewed and described to obtain the fundamental meaning of the text. Central themes were identified and annotated for ongoing analysis. At the

selective level of analysis themes were identified that were directly related to the specific aims of this project. Lastly, the detailed, line-by-line level of analysis examined the text in its entirety so that discrete aspects of the couples' experiences were highlighted. Throughout all the levels of analysis interpretive notes were written and re-written to examine the interrelationship of themes and how the text related to the specific aims and research questions of the study.

**Addressing Validity and Rigor**

If this study had been developed as a quantitative inquiry, measures of depression, relationship satisfaction, conflict and lifetime stressor assessment and appraisal would be used. If that were the case, the issue of validity would be handled through research design, statistical and psychometric analysis of the data and instruments used (Shadish, Cook, & Campbell, 2002). However, with qualitative research, different methods for validity and rigor have been established. These measures of rigor have been widely debated because there has been concern that the use of such hallmarks for rigorous methodology may inhibit the creativity and emancipatory stance inherent in all qualitative research methods. However, Whittemore and colleagues have proposed guidelines for validity in qualitative research that allow for both methodological adherence and creative expression (Whittemore, Chase & Mandle, 2001). These guidelines were used to ensure the rigorous interpretation of the data in this study.

The discussion of validity in qualitative social research must address issues of rigor, ethics, subjectivity and reflexivity (Davies & Dodd, 2002). Whittemore et al. (2001) used these considerations and the discourse surrounding rigor and creativity to establish a series of primary and secondary criteria to be used to assess validity and establish rigor in qualitative research. These criteria establish rigor without sacrificing the creativity and subjectivity necessary in qualitative work. Primary and secondary levels of criteria are meant to address the flexibility

and inherent differences within the different qualitative methods, while still establishing sound criteria that can be applied to all methods. Primary criteria are necessary for any qualitative research endeavor and include credibility, authenticity, criticality and integrity. Primary criteria alone are not seen as a sufficient means to establish validity. Therefore the secondary criteria must all be considered as benchmarks in further evaluating qualitative papers.

The primary criteria of credibility and authenticity are established to decrease the threats of interpretive distortion, researcher bias and a shallow representation of the experiences of participants. Credibility refers to the researchers' attempts to portray an accurate interpretation of meaning and establishes fit between the descriptions of experiences made by the participants and the explanations made by the researcher. Authenticity is closely related to credibility and refers to the representation of the meaning of the lived experiences of the participants. In examining authenticity the research took into consideration that there was a range of variation within the couples' experiences and their appraisal of meanings. Rigor required that the researcher remain open to the different voices, as well as the silences in the research data.

Criticality and integrity are closely linked to the importance of reflexivity in the qualitative research process. The establishment of criticality calls for the exploration of not just expected findings in the interpretive process, but also the investigation of the ambiguous, the alternative and the unexpected. Integrity refers to the careful movement from data to interpretation, the reflexive process of self-criticism. Criticality and integrity are meant to help the investigator to avoid bias and to include negative or variant cases.

The secondary criteria are additional benchmarks by which to judge the quality of the research by focusing more on the flexibility and the creativity inherent in qualitative methods (Whittemore et al., 2001). Because of the variations in qualitative epistemologies, there has been

some debate as to whether it is possible or necessary to establish one singular set of criteria (Rolfe, 2006). However, the secondary criteria explicated by Whittemore et al, allows for the flexibility that is found in the various methodologies, but still provides for the evaluation of rigor. The secondary criteria are explicitness, vividness, creativity, thoroughness, congruence and sensitivity.

Explicitness is synonymous with the concept of auditability. It refers to the consistent and thoughtful recording of investigator created data and interpretations. This can be established through the reporting of study design and data interpretation procedures. Vividness refers to the relaying of participants' experiences by sharing particularly salient quotes that represent the theme being discussed. Although methodological rigor is necessary to establish validity, the criterion of creativity allows for the use of new approaches to data collection to answer specific research aims. An example of this criterion would be the use of different types of interviews, such as individual, couple or focus groups, within the same study. Thoroughness does not require large sample sizes and is not linked with the amount of data gathered, but instead links the themes and ideas to the data and explores the full range of variation in the phenomenon being studied. Congruence could also be seen as the correctness of fit between the study aims and questions, the data collection and analysis methods, and the findings. Finally, sensitivity is established through the researcher's acknowledgement of and focus upon ethical considerations through out the research process.

In this research study several key elements were integrated into the interpretive process to ensure a more rigorous review of the text. First, initial review of the text and observation notes took place immediately following the couple interview and the beginning interpretation was brought back to the participants at their individual interviews. In addition, the interpretive

process was not completed solely by the researcher. Initial understandings were shared with other members of the researcher's professional circle. This allowed for the challenging of the researcher's ideas and helped to open the researcher up to alternative or unseen readings of the meaning within the text.

Research that successfully addresses these multiple criteria, as established by Whittemore and colleagues (2001), is judged to be more rigorous, and yet there is no absolute guarantee of quality or rigor. Instead judgment is continually refined throughout the research process from data collection through the presentation of data. Multiple techniques are used to demonstrate rigor throughout this process and include sharing sampling decisions and the consideration of a self-conscious research design, demonstrating prolonged engagement in the data generation process and the use of member checking and the exploration of rival explanations in data analysis (Whittemore, at al., 2001).

**Issues Related to Sensitive Topics**

**Power relations.** When discussing the partner relationship or maternal depression and the transition to parenthood, participants shared experiences that were quite personal and sensitive. The use of unstructured and semi-structured interviews to gather narrative data allowed the participants a significant amount of control regarding the disclosure of sensitive topics (Corbin & Morse, 2003). When discussing sensitive topics such as issues within the partner relationship, the transition to parenthood and life experiences that the participants felt could have played a role in their development of postpartum depression, there was always the potential concern that participants could have become emotionally distressed when sharing their experiences. However, this potential for distress was mitigated by the control over personal disclosure held by participants in these qualitative interviews. In addition each of the participants

reported that the process of being involved in the research study was found to be cathartic. In addition, previous researchers have also reported that the potential for benefit can outweigh the possibility of distress when participating in a research study (Corbin & Morse, 2003).

**Maintaining confidentiality.** Another issue that can arise when interviewing couples and individuals concurrently, was the need to not disclose information shared in individual interviews with the other partner. Each person's right to confidentiality was maintained through out the entire research process. This was be achieved by using the individual interviews as a forum that allowed the participants to opportunity to examine their own experiences and not to fact check information provided by the other partner. Acknowledging that informants elect to disclose differently in different contexts (1:1 versus couple interviews), the researcher diligently guarded against revealing any information to the partner that was shared in 1:1 interviews.

**Blurring the boundaries.** Although participants found the process of disclosure of experiences cathartic, the researcher worked to maintain the boundary between her roles as researcher and as a healthcare professional. Research interactions did not slip into the realm of therapeutic sessions. Maintaining the focus of data collection on understanding the shared narratives of action and reflective explanations of participant's experiences assisted in this effort. Entering the interview with the goal of understanding, not assisting with problem solving or changing the situation, positioned the researcher well for the investigation. As both a nurse with clinical experiences caring for women and families impacted by postpartum depression and as a scientist, the researcher also worked to maintain her own boundaries. This was done through thoughtful memoing and reflexive journaling.

**Harm to self or infant.** Because of the symptoms of postpartum depression, other concerns related to the disclosure of information in this study included reports of self-harm or

suicidal ideation and the potential for infant harm or neglect. Although there was no report of these issues by the participants, as a nurse, the researcher had to adhere to professional standards of practice and legal responsibility as a mandatory reporter when interacting with participants. All informants were notified of this fact as part of the informed consent process. It was necessary for the researcher to use clinical judgment, based upon knowledge and experience working with women with postpartum depression, to evaluate how the participants were coping with the research process. The researcher had an ethical responsibility to ensure that the research process did not cause undue stress or additional harm to the participants. These issues did not arise during this research study, but the safety of participants was always the top priority.

## Conclusion

This study used an interpretive phenomenological method to conduct the collection and analysis of the data. This lens allowed for a deeper understanding of the phenomenon of postpartum depression within the situated context of the partner relationship and early parenthood. Researching the topic of postpartum depression and the couples' experiences created unique concerns for the researcher. These concerns are related to both the sensitive nature of studying maternal mental health issues in a society that celebrates the mother-child dyad as beautiful and central to the woman's role and also related to studying couples and their partner relationship. The design of this study and the use of unstructured interviewing allowed for the protection of the participants by placing control over what was revealed within the hands of the participant. Finally, although the researcher followed the interpretive process and took steps to ensure rigor within the work, no analysis can be wholly complete for all time and no study can be entirely rigorous.

# Chapter Four: The Processes and Practices of Couples Experiencing the Diagnosis of Maternal Postpartum Depression

This chapter will discuss the processes that participant couples moved through as they navigated the mother's postpartum depression diagnosis. It is essential to understand how the participants experienced this time because parenting practices and relationship issues during early parenthood are closely connected with postpartum depression. Thus, these practices and beliefs must be placed within the context of the lives of participant couples. This chapter will bring into focus the ways that participant couples navigated the unexpected experience of the postpartum depression diagnosis and how they co-constructed their narratives during this period of time. Although they created new practices to cope, each of the couples felt that they were still living with the impact of maternal postpartum depression more than a year after the birth of their child. Narratives shared by couples, as well as reflective responses will be used in this chapter to provide exemplars that create a foundation for a deeper understanding of the couples' journey through the postpartum depression experience.

## Patterns of Response to Postpartum Depression

Participant couples were asked to share the timeline of their depression diagnosis, beginning where they felt was most appropriate. This open-ended style of questioning led them to share a range of practices and processes in response to the diagnosis of maternal postpartum depression. These practices and processes were identified through interpretive analysis as 3 patterns of response from the couples and are defined as: 1) dismissal, 2) acknowledgement, and 3) accommodation.

For most of the couples these responses occurred in this sequenced order. However, it was also common for certain symptoms or emotions of a mother's postpartum depression to be

acknowledged while others were still being dismissed. One example was that while one couple quickly realized that the mother's sleeping issues were outside of the normal range for her, they continued to dismiss her ambivalence about her new lifestyle as a mother. This was more shameful to them and therefore they continued to dismiss it as an issue for several weeks.

Dismissal characterized the earliest response to the symptoms of postpartum depression. Dismissal can be defined as a process that was seen as both an attempt at normalizing the early symptoms of postpartum depression and as a way to shield the mother from judgment. During this time in the process, mothers and their partners did not openly discuss their emotional struggles or their concerns with each other. This part of the process was varied in length. Some couples were quicker to initiate conversations when concerns continued for several days. Other couples continued to dismiss symptoms for weeks and months before disclosing their concerns to each other.

Acknowledgment often occurred in the first few months postpartum and followed the experience of unexpected events or emotional responses. Acknowledgment can be defined as the acceptance that the couple was experiencing something outside of the norm of what was expected; these unexpected behaviors, emotions or symptoms were brought to light and shared by mothers and their partners. Acknowledgement was also associated with participant couples no longer being able to normalize or hide the maternal adaptation to the transition to parenthood. At times it took place after treatment for postpartum depression had already started and was a process where mothers or their partners admitted the concerns that they had previously been keeping secret from others. A key point that emerged from discussions with participant couples was that some things were easier for couples to discuss or more readily acknowledged by the

couples, while other emotions or concerns were not as easily shared. This variability in ease of disclosure will be further explored in this chapter.

Accommodation was closely related to acknowledgment and most often began soon after the couple acknowledged concerns for the mother's health and sought treatment; either medications from a primary care provider or the specialized help of the therapist or psychiatrist. Accommodation can be defined as the practices and processes associated with adapting and adjusting to the mother's diagnosis and treatment. The process of treatment frequently resulted in a period of making adjustments and planning ways to accommodate new processes to focus on the care needs of the mother and still complete the normal tasks within the household and to ensure the care of the newborn. This was a period of fluctuation, of trial and error, where couples tried different approaches until they found a new pattern that worked best for them. It was not always an easy process for the couples with some partners reporting frustration and mothers reporting feelings of guilt and disappointment.

This chapter will proceed through a more in-depth explanation of each of these processes and will provide examples from the interview data to better explicate the responses that couples had to maternal postpartum depression.

**Dismissal**

Dismissal was the earliest response that couples had to the symptoms of postpartum depression experienced by the new mothers. Partners reported that they began dismissing symptoms as early as the day of their newborns' birth and mothers reported that in hindsight they were likely dismissing some symptoms, such as uncertainty about the pregnancy, even before their child was born.

**Alice and Albert.** Alice was a first time mother who had been diagnosed with postpartum depression 8 weeks following the birth of her daughter. Prior to her being diagnosed, she had felt a sense of losing herself. She had left her job and family behind to make an international move to be with Albert. Alice and Albert married after her move and she expressed great feelings of love in her relationship with Albert. Although Alice had a family history of depression and some depressive episodes in high school, she did not think of herself as at risk and described her pregnancy as a happy one with feelings of uncertainty she expected all mothers must feel. She admitted that she was nervous about becoming a new parent, but she did not expect to have such a difficult time with postpartum depression. Yet, when she came home from the hospital, her self-described spiral into depression was a quick and deep experience. She felt isolated despite assistance from family and from Albert. She explained that she went so deep into her depression that for weeks she did little else but sleep and breastfeed and only breastfed when someone brought the baby to her. Despite this, she was slow to admit that she was depressed, even to herself. She and Albert had attended birthing classes and she had read many popular trade books about pregnancy and birth. Alice revealed that she knew what postpartum depression was and that she felt she was having a hard time from her first day in the hospital after giving birth, but that she was not quick to recognize her postpartum depression.

> Alice: So she would wake up in the morning and I would feed her a bottle and then I would swaddle her and I would then put her down straight away, right back into the crib. I would not interact with her. I just wanted her to sleep so that I could sleep some more…There were a couple of occasions where she wouldn't go back to sleep and she was crying and I just left her. I just left her. We had a futon in her room and I would sleep on it next to her when she had her nap and I just let her cry. And I thought 'Why can't you just be quiet? Why can you just shut up and let me sleep?' And so you know, looking back, that was the depression obviously, interfering with my ability to nurture and care for her at that point. But I didn't realize that then. I just felt terrible and I thought you know, 'Why can't I just pick her up and cuddle her? What's stopping me?' And you know I don't really think that I had a good answer for that.

In another discussion Alice revealed that in addition to her emotional struggles, she was having physical symptoms that she was also keeping to herself.

> Alice:…he thought I was resting while he looked after the baby. But I really wasn't getting any rest. There was one evening where Albert was watching the baby in the living room. I could hear them interacting and I could hear him laughing. I remember at one point I was just lying in bed with the covers over my head and I was just trying to get sleep and I had this huge sort of panic attack and I got up and, we have these huge old sash windows in our bedroom, and I threw open the sash window and I stuck my head outside because I felt like I couldn't breathe. And that was all going on behind closed doors in the bedroom. Because you know, I used to close the doors so that I wouldn't be able to hear the baby and he was sitting out there with her and he thought that I was asleep. I still don't know if he knows all that, really.

Alice, like many of the other participant mothers, was clearly showing signs of postpartum depression. She felt an emotional disconnect from her daughter. She was having difficulty sleeping and had a heightened sense of sadness and anxiety. She had been taught in her classes and by her health care professionals, that these were symptoms of postpartum depression. Alice had seen her own father and brother experience what she described as 'breakdowns' related to their own depression. Her husband Albert had also been previously diagnosed with major depressive disorder, but still, she did not easily recognize that she herself was depressed. Alice reported that she felt as though initially she as just 'barely holding on' and that she was most focused upon using all her spare physical energy and emotions to keep herself from spiraling further. She felt that many of her symptoms were related to her difficulty sleeping and because she was struggling with breastfeeding. Once she began to admit to herself that something else might be going on, she continued to disregard her concerns about herself because of the embarrassment she felt admitting that she sometimes wished that her daughter had not been born. She was also concerned with the wellbeing of her mother and Albert and did not want to share her concerns for herself for fear that she would add additional stress to the family.

At other points in the interview, Alice revealed that she felt that everyone around knew that she was struggling and that they did their best to try and help her. But she also admitted that the ways they tried to help her often made her feel more frustrated and left her feeling worse about her struggles. Her mother, who stayed with her for a few weeks to help her, would often try to encourage her to do more with the baby or try to explain how easy it was to care for the baby. She would tell Alice that the baby only needed motherly love. This made things even more difficult for Alice because she knew at the time it was the main thing that she was incapable of providing.

Alice's husband, Albert, explained that if he was honest with himself, he recognized that Alice was having a difficult time within a few minutes after the birth of their daughter. At the time he would dismiss his concerns by telling himself that Alice was experiencing many things that all new parents must go through. He would tell himself that she was just overly tired. That she would be better if she could get some sleep or if she just had dinner.

> Albert: …And you know I was in tears, Alice's mom was in tears, I was just so happy and she was just so lovely. She was so beautiful. And then we went to the recovery room where Alice was coming to and she was feeling pretty beat up. And she seemed pretty focused on that, on feeling tired, on being uncomfortable. Which I get, I get that, but there was none of that apparent happiness, that euphoria that sort of takes you through the hard parts, through the difficult things. She didn't have that and I could see that almost immediately. We sort of took that baby and gave her to Alice and I was expecting this glow, this happiness and she just, I don't think that she would even notice this, but she seemed to me to be going through the motions. I was thinking I should take the baby back from her and I thought, 'Oh well, she doesn't do well when she doesn't have much sleep, she will just reach a point where she will just deal with things, take it all in and she just reaches a point where she is just too tired to do anything.' And then, she was just like that. So I thought 'Well, ok, she just needs to recover from the surgery and she will be just fine.' In the ward afterwards, after we moved from the recovery over, she was just not involved and would have much rather have had someone else take the baby away, take her to the nursery and give her a bottle. Alice was fine with that and that was hard to see. I had to bite my tongue a lot, just because you just can't say… I felt like I couldn't tell Alice that she isn't doing well.

In this narrative Albert shared both his own emotional pain that Alice was not sharing in his joyful experience, but also his admission that he didn't feel he could share his concern for Alice openly. Albert revealed through other narratives that he did not feel he had a right to say anything to Alice that might seem judgmental. He felt that it would have added to her struggles and that as a man, he did not want to tell her how to take care of her own body postpartum. It was important to Albert that Alice enjoy the time with their daughter and that she feel supported. In order to try to encourage these feelings in Alice he would take on more responsibility around their home and spend as much time with their newborn baby as he could. This was the way that Albert felt he could help Alice and ensure that their family was coping with all the changes that they were experiencing.

**Donna and David.** David was a 34 year old father who considered himself lucky because he was able to take a good deal of time off from work to help care for his newborn son. His wife Donna had to return to her business rather soon after having the baby and David stepped up to challenge of staying home. But he was surprised that Donna removed herself so easily from the care of their son and how she avoided taking care of him even when she was home from work, but he did not think that this meant that she was depressed. He explained in his personal interview that he saw some of her behavior as just part of her personality.

> David: I don't think that I thought it was normal, but I also didn't think that it was abnormal in a bad way. I was doing more than most dads and I was definitely doing more than Donna was, but our situation allowed me to do way more than the normal first-time dad would do. Initially three weeks off of work or something, I was home for 3 months. I sort of thought that I was doing a better job than most people would. At the same time, I remember, in thinking about Donna, I don't think that I thought that there was anything wrong with her. I didn't necessarily think that. I just thought that this was normal for Donna. Then, I also, we were both so sleep deprived, so I figured that a lot of it was probably the sleep, a brand new baby and being completely tired.

During this discussion, and others, David revealed that he thought he was doing well, that he was able to support Donna adequately by taking an extended leave from work. While there were many moments were he noticed that Donna was struggling, he continued, for weeks, to attribute this to her personality and her lack of sleep. During this time Donna became more and more depressed and continued to hide her feeling from David. Donna felt isolated without her family and friends living close by and with her heavy work schedule she felt overwhelmed by the idea of caring for a baby. She actually welcomed David's enthusiasm for taking care of their newborn baby, but in hindsight also felt that by letting David take over and stepping aside for weeks, she pushed herself deeper into her depression.

Donna and David created an environment where David took over anything that needed to be done. By avoiding being involved in most of the infant care and necessary household tasks, Donna was able to escape responsibilities that may have forced her to take a closer look at how she was coping emotionally. This also created space between Donna and David where David could also dismiss how Donna was adjusting. He stayed home and Donna went to work. Because of this he found it easy to attribute her behavior to her stress about work, her personality and the lack of sleep that they were both getting. Had David not been present, or as involved, and Donna had been forced to take on more responsibilities in the home, they may have considered that her inability to complete these tasks could have been related to something more than just being overtired.

**Gabby and George.** Not all of the mothers felt that they were dismissing their symptoms to protect their partner or themselves. At times symptoms were dismissed because they were judged to be normal expected maternal emotions following the birth of a child. This was the situation explained by Gabby during our first couple interview. Gabby and George were a

married couple in their early 30's. Their daughter was 2 years old at the time of our interview and Gabby was diagnosed with postpartum depression 8 weeks after the birth of their daughter. Gabby explained that she did not feel she was depressed because her depression was not the typical postpartum depression that you hear or read about.

> Gabby: I just want to explain before I really get started, that my postpartum (depression) wasn't normal. I didn't have any thoughts about hurting myself or the baby, not ever. So from the beginning I didn't think I was depressed because my symptoms didn't match up. I wasn't sad, I was totally in love. It was all consuming and I never thought about anything else. I couldn't focus on anything other than how much I loved her. When I didn't see her, I was thinking about her. It would keep me awake at night or I would want to just stand there and constantly watch her, even when she was sleeping. I stopped taking care of anything else.

Gabby didn't see her postpartum depression when she was starting to struggle because she didn't recognize that her all-consuming love for her daughter was a form of anxiety. She knew that mothers were supposed to feel an immediate bond with their newborns and she did feel that connection, but she wasn't able to see that her connection was impacting all the other aspects of her life. It wasn't until her lack of sleep and lack of focus left her feeling emotionally drained and incapable of coping, that she admitted that she what she was experiencing was outside the norm. Previously, Gabby was able to focus on and appreciate many activities and relationships in her life. She enjoyed her church community, she was successful in her career and she had a loving connection with her husband. When her daughter was born, all of those things that she had previously enjoyed took a backseat. Yet, because she didn't have the symptoms that are most often discussed as being signs of depression, sadness and thoughts of self-harm, she dismissed her experience as part of the process of her transition to motherhood. It was weeks later, when she revealed these symptoms to a friend from church, that the topic of postpartum depression was first mentioned. Only after that discussion, did she reveal how she was feeling to George.

Dismissal was not a process that was used to intentionally hurt a spouse. Partners did not dismiss symptoms because they just did not care and mothers were not hiding their symptoms to intentionally manipulate anyone. Instead, couples engaged in this process of dismissal because there was a legitimate concern that admitting symptoms and concerns aloud would make matters worse by seeming judgmental or burdensome. Couples were also confused by the possibility of a range of normal versus abnormal patterns of response to the transition to motherhood. They recognized some symptoms as potentially normal, such as feelings of exhaustion that all new parents must feel. And labeled other feelings, which the mothers were not experiencing, such as the urge to hurt their newborns, as the type of response that would need immediate attention. As a result, the process of dismissal could carry on for a significant amount of time, 8 weeks or longer, allowing mothers to sink deeper into their depression.

**Acknowledgement**

Acknowledgement was the process of revealing symptoms and admitting that things could not continue to be normalized. There was a significant range in the ease that couples felt in revealing their concerns and emotions. Certain emotions or thoughts were viewed as more upsetting than others and therefore remained unspoken longer.

**Christine and Connor.** Often, something would occur that the mother, her partner, or a close friend or family member could not dismiss as a typical "new parent" response or behavior. Once the participant couples experienced the process of acknowledging that there was a concern, they often began to navigate the health care system in an attempt to determine what the mother was experiencing. This acknowledgment of concern happened at different times in the postpartum period, but most often occurred within the first 12 weeks after delivery. It was a process that often brought up mixed emotions, both a sense of relief that the struggle was out in

the open, and uncertainty related to admitting the mother's symptoms while not knowing what the recovery process would be.

Christine was diagnosed with postpartum depression in her third month postpartum. She described feeling that she had many stressors late in her pregnancy and postpartum. She felt that these stressors manifested themselves in obsessive feelings about the safety and security of her family. Her husband, Connor, was traveling for work and Christine was staying with her parents when she finally acknowledged her concerns, her "hidden self" to her mother.

> Christine: Anything I was feeling before the 6-week period was sadness because of moving away from my friends and because Connor was away for five days a week. So, to me it wasn't depression at that point. When I got to my parent's house, I think the one thing that happened that really made me think that something was wrong was I started to have all these fears. We were staying at my parent's house and the extra bedrooms were downstairs in the basement. The room that we were staying in is on the slant, so the window is right at the ground and then when you get to the back window where I was staying, it was a normal window. But I had these incredible fears that someone was coming through the window or that someone was in the room. At one point, I had a golf club in the closet of my bedroom and I was standing outside of the door. It actually happened a couple of different times. I think I called Connor once or twice. I can't remember if I called him at the time, or told him about it the next day. But I don't think I made it sound serious at all. Just tried to be light about it. I was afraid to tell my Mom because I just felt crazy, like I was losing my mind. But I did slowly start talking to her about it a little bit because I knew that my Sister was having problems and that my Mom had had problems. This was kind of…I do not think I told her until the middle of March, or even later. I kept it all to myself for quite a while. I told to her and we decided that I would see someone when we got out to the West Coast with Connor. Because at the time we did not have insurance, we had some sort of bridging insurance to cover some things, but it wouldn't cover anything complicated. We decided to do that. It took me 2 months once I was out here to actually find somebody."

Christine was surprised by her own behavior. She admitted that in hindsight she was probably experiencing some depressive symptoms late in her pregnancy because she was on bed rest, but she did not immediately connect her postpartum fears with depression. Christine explained that she was slow to admit that she was having difficulty expressing her concerns for herself because of several factors. First, she felt she was "crazy" which embarrassed her. She

could see that her behavior was outside the norm, but she kept it to herself because it seemed so irrational that she feared people's judgment. In subsequent discussions during our interview, Christine also admitted that there was so much flux in their household at the time and she saw how much pressure Connor was under at his new job, she did not want to add anything to the stress of the family. So, for weeks she kept her feelings to herself. But the process of acknowledging her concerns immediately helped her to feel more at ease. Understanding that another person knew her fears, was comforting. Christine's moment of acknowledgment happened before her diagnosis, but set her on a path to seeking help.

**Betty and Bob.** Betty, a 37 year old mother, diagnosed with postpartum depression 4 weeks following the birth of her daughter turned to her husband first when she realized that she needed help.

> Betty: I was just physically exhausted. I was in a lot of pain in my breasts. I started to have weepy times. I had *What to Expect When You're Expecting* and I sat down and looked up the couple of paragraphs about postpartum depression, and it described it as normal to feel overwhelmed and weepy for the first couple of weeks after the birth of a child. I shared the information with Bob and we decided to wait a couple of weeks. The book said that if you are feeling anger or any violence toward the baby, then that is the real sign. I really didn't have that. I wasn't wanting to strangle this kid or feeling any regret that we had the baby, so I didn't have that part of postpartum depression. I was crying all the time. Then it started to be the third week, and I am crying a lot and just feeling depressed. And I had a panic attack, I had a few actually. I sat on the couch and I'd shake all over. It lasted 10 minutes or more and I was just really, really, really shaking. Bob was giving Bekah a bath and I called my mom. I said, 'Mom, can you just chat with me for a bit, I am not feeling great right now.' I felt bad because I knew that would upset her.
>
> I had them in the past. I haven't been diagnosed with depression before, but I have fought anxiety attacks or panic attacks throughout various times in my life, which had really gotten better, particularly since I married Bob. …So it wasn't something that I had dealt with within the last three years, but I had them a lot before.
>
> They're awful. It's the worst feeling. It felt like I'm turned inside out. Those are the times when you kind of wonder if you are better off dead. It's really difficult to suffer through a panic attack. I didn't have any thoughts of hurting myself or anything, but it was no fun and it was difficult. When the weeping and the crying periods continued well into the third week and I started with the panic attacks, I approached Bob and I said 'This

> is not okay and I need help.'… He was receptive when I said I needed some help and that this wasn't okay.

Recalling her first panic attack and admission that she wasn't doing "okay" was difficult for Betty even a year later. Telling the story, she became tearful. She knew that she was struggling before the panic attacks began, but she and Bob turned to a trusted source and felt it was better to wait because her weepiness seemed like a normal phase in the postpartum period. In subsequent narratives both Betty and Bob expressed their frustration that the books they read and the sources they sought online poorly explained postpartum depression. Betty did not feel like hurting herself or her baby, she was just overwhelmed; In the first 4 weeks postpartum, they believed online sources suggested these feelings were normal.

The decision to wait to seek help for Betty upsets them both now. However, when Betty's panic attacks and anxiety returned, she knew it was outside of the norm and she turned to the person that she felt had the most significant impact on ending her previous panic attacks, Bob. The admission of these symptoms helped both partners realize they could approach the problem as a team. They struggled to identify and then engage the needed resources; however, Betty's initial acknowledgment of her panic began the family's healing process.

**Alice and Albert.** Not every mother experienced this moment of acknowledgement before her diagnosis. Alice explained that her true moment of acknowledging her depression came after she had begun to see her therapist. She had admitted that she was having issues and needed someone else to speak to about it 3 weeks earlier, but she still did not acknowledge the depth and extent of her emotions right away. She worried that people would think she was a "monster". Alice described the moment that she did acknowledge her feelings as "powerful" and even a year after her own acknowledgment to her therapist, recounting the moment brought Alice to tears.

> Alice: Oh, yes I remember that because it was such a weight on me. I can't remember if I had written it in my diary. Because sometimes I would write things down before I could bring myself to say them or things I wanted to say to the therapist. I would have flashes of what was inside of me, or problems that I wanted to talk to her about. And I remember wanting to say it out loud the whole session, it was there in my head the whole 55 minutes. And I wanted to say it the whole time and I felt more and more anxious than I did for a while. I remember thinking, 'I know that this is confidential, and she is not likely to judge me, but I didn't know that.' I knew it was confidential, but I was so fearful of the judgment because it was such a terrible thing to admit to, to having the feelings and the thoughts that I was having. I still felt that she would judge me, because how could she not? I had been having these sort of waking daydreams about, I would stand at the top of the hill near the park and I would stand there and think about letting go of the handles. And having those thoughts scared me. I thought, 'I need to tell her this. I need to.' But the whole session I couldn't do it. I was having so much inner turmoil about it. But I knew that I needed to, this is scary stuff. But I didn't want there to be consequences to admitting that. So I left it. I left it until right at the end of our session and I had my coat on and I was handing her the check and I said, I didn't look at her because she had her back to me, she was writing a record for our next appointment down. And I said, 'Sometimes I wish that she had never been born' And I could see it sink in and she kind of turned to me and said 'Well OK Alice, that makes sense.' Just the way that she looked at me and I was completely ready for her to look completely repulsed and horrified and to just have her say 'That makes sense'. You know that was so powerful for me. She said "Life was easier before she was here. Of course you want the time when she wasn't here back. You could just do stuff, you didn't have her to think about.' And then she looked at me and I was overcome. She said 'And you have been worried about that feeling, haven't you? And you were worried about what I would say. What did you think I would say?' I told her that I thought that she would say 'You Monster! That is not normal! Let me call CPS, you shouldn't have a child!' And telling her and her reaction just made me feel better. The weight was lifted somewhat.

Throughout this narrative, Alice describes her reluctance to reveal the emotions that she was struggling with the most. Despite having sought help and having received her diagnosis, some things still seemed off-limits to openly discuss. Alice felt well supported by her husband, Albert. She trusted her therapist, but was still fearful of her judgment. She had convinced herself that the darkest emotions she was experiencing were hers alone. She had felt reassured that other women experienced postpartum depression and she was well read on the symptoms and experiences of other women. But before she expressed her feelings to her therapist, she was truly distraught by her thoughts, thinking of herself as such a terrible mother that she was a

monster. In acknowledging her thoughts to her therapist and not being judged, the weight was lifted, and Alice felt this was the first major step in beginning her recovery process.

Alice's husband, Albert remembers the moment when he finally acknowledged that Alice wasn't just going to get better on her own. He describes one evening where he felt he made a significant change in his plans because Alice needed him and spending time with her allowed him to recognize how much she was struggling. It was a different moment from what Alice described and occurred earlier in the timeline from the Alice's visit with her therapist.

> Albert: So, before our office Christmas party the idea of me going out was weighing heavily on Alice's mind… It was probably 3 or 4 weeks after Adele was born and I was getting my stuff to get changed. I had come home from work and I was getting my stuff ready to get changed. I was getting dressed up and Alice sort of, she as sitting on the bed and then sort of started wandering around the bedroom while I was getting ready. Have you ever seen *12 Monkeys?* And she was doing it and it was getting more and more as I was getting ready. She would pace and snap her fingers and wring her hands. It was such a distraction, all the physical movements. She said 'I don't know what is happening to me.' She was scared. I just turned to her at one point, because I had really been looking forward to this break for even just one night, because you know I was always on-shift, so to speak. But I looked at her and I realized that I just couldn't go out and I asked her 'Do you want me to stay?' and she said 'Yes, could you please stay here, can you stay home. And it was just, I think it was actually the first time we had been awake and up in the same place the whole of that month. I mean it was only 10 or 15 minutes that we were together in the bedroom, but that whole month, leading up to that, other than eating or sleeping, we hadn't been spending any time together in the same place. And so it was the first time that I had seen that level of distress in her. I wasn't sure if it was because this was the moment that it got really bad, of if it was because it was a period of time when we were sharing a space and we weren't doing something else. I think it was then, that whole thing, that really crystalized it for me, that it wasn't just going to get better.

When Albert was in a situation where he could see Alice's struggles first hand, he quickly realized that she wasn't just tired and recovering from her cesarean section. He could see that Alice was powerless to her emotional state of being and it manifested in repetitive behaviors that he had never seen in his wife before. The film he references in his attempt to explain how Alice was behaving, features a manic and uncontrollable main character that is living in an asylum. Albert used this comparison to illustrate how far beyond her normal behavior Alice was

at this time. As many participants explained, there was a moment of frustration, but it was quickly replaced by concern. Albert had been doing what he thought Alice needed to get better, allowing her to rest and taking some of the burden off of her around the house. But it was the brief 15-minute encounter with his wife when he was able to see how significant Alice's anxiety had become and it worried him greatly.

**Hanna and Hank.** Other partners also expressed a moment that seemed to surprise them and after these experiences they could no longer dismiss the symptoms that their wives were having. Hank was a 45-year-old first time father. He and his wife Hanna were having difficulty coping with the recent loss of his mother, as well as experiencing breastfeeding issues. When asked when he thought Hanna's depression became obvious to him, he recalls one night when he woke up to find her gone from bed.

> Hank: The stress really started to happen and it was really tough. What do I do…what can I handle? I was doing everything else. I did just cleaning and putting things away. When Hanna went into her dark cycle of…she gets hot flashes all the time. That's something that I have always known. When she'd get up in the middle of the night, and she has always done that. But one night I remember the baby wasn't crying and she wasn't there. The baby wasn't crying and I walked down and she was standing on the balcony, right there, in the dark. I could see her through the windows. She had opened all the shades. I asked her what was going on. She said she couldn't be in the house anymore. She said, 'I can't handle the house'. I asked her what she meant and she told me she felt trapped. I didn't understand how it scaled up and how it scaled down and how bad it could all be, what postpartum (depression) could be. I didn't understand conceptually what she meant about not being able to be inside. I said, 'You have wanted to take a break from work for months and now you finally have the time off and you can't relax, you need to be outside. This is nuts. Come inside, please.' And she couldn't do it and when she did come in, she wouldn't let me close the shades and the windows. Everything had to be open. I just was really struggling with her because I was like, 'What the hell is going on? She has to be outside, she had to go out in the middle of the night.' I was struggling to be a good son, a good worker, being a good husband and this all didn't correlate. I knew that night that it wasn't a normal hot flash and that everything was leading up to this. It was worse than I had realized and we needed to get help.

Initially, Hank knew that they were both struggling, that they were sharing these difficult experiences and that he was doing what he could to take the strain off of Hanna. But there was a

limit to what he could ‘fix’. He began to feel overwhelmed by all the responsibilities before him and in juggling all his roles. When he began to acknowledge his own difficulties he was also able to more clearly see how poorly Hanna was coping. Hank always respected his wife for being such a strong and caring woman and he could see that she loved their daughter, but he knew that she was at a point beyond her normal ‘hot flashes’ and waking up at night. In a sense, seeing her alone on the balcony at night both frightened Hank and allowed him to see how vulnerable Hanna was at that time. It was with this realization that he knew they needed more help than just what he could do for them both.

The process of acknowledgment was both a relief and great source of anxiety and concern for couples. There was a sense of relief that things that were hidden were being revealed, but there was also a sense of fear and concern about how to handle what had come to light. Acknowledgement was also an ongoing process, not everything was revealed at once. Those feelings and symptoms that were seen as more shameful or further outside of the normal range of what a new mother should experience were often kept secret even longer, being revealed under circumstances where mothers felt safe and not judged. Mothers were most concerned that they would be viewed as horrible mothers or “monsters” that did not love their children or were unhappy with their family. This created a situation where they held onto their concerns longer, only revealing their true selves when they felt safe accepted.

Acknowledgement of a mother’s symptoms by her partner most often occurred after the mother began to reveal certain aspects of her struggle or when the partner encountered something that they could no longer dismiss as within the normal range of maternal experience. This was because the partner’s primary concern was protecting the mother and the newborn baby. It was safe to reveal their concerns after the mother began to express her own, as this created a non-

judgmental tone to the conversation. This process in the patterns of response to postpartum depression was the most varied. However, it was essential to the process, because only after concerns, emotions and symptoms were revealed could couples begin to make adjustments to accommodate the needs of the mother.

**Accommodation**

When couples sought assistance from their care providers for the mother's postpartum depression, there was a period of adjustment where couples had to go through a process of accepting this unplanned and unexpected diagnosis. This was a period of time that was characterized by the mother's need for support. Initially there was a lot of uncertainty in the home, with couples repeatedly trying new approaches to everyday household tasks, infant care and scheduling until they found a rhythm that worked for them. At times they looked for support outside their own relationship, seeking out friends and family. Some of the partners took on specific tasks that they felt they would be most successful at, but left other care and assistance tasks for friends or family.

The transition aroused many complex emotions. Mothers expressed guilt, and sorrow for the disruption that their postpartum depression had caused to the household. Mothers and their partners suggested that everyone was doing the best that they could. At times partners reported feeling frustrated with the mothers or the situation in general, but that these moments passed quickly and they we more focused on ensuring a supportive environment to the best of their abilities. Once the families made the necessary accommodations and found a daily rhythm that worked and once the symptoms of postpartum depression started to improve, the couples expressed a feeling that something positive had come from their experiences. They felt that, as a family, they made improvements to how they communicated and accomplished day-to-day tasks.

**Betty and Bob.** Betty and Bob felt that they had a very egalitarian household and that they had a close relationship before their baby was born. After the birth of their daughter, Bekah, they still went through the process of figuring out a way to share many of the new infant care tasks. Betty felt she needed the most help around breastfeeding and she was grateful to Bob that he took care of her while she took care of Bekah. When both partners realized that Betty was having symptoms of depression, Betty asked Bob to be responsible for finding a care provider for her. She just couldn't do it all.

> Betty: Trying to figure out how to get help was not necessarily easy, especially when you feel like you don't have the time or the energy. I called the OB/GYN practice and spoke to the on call doctor. She was the one that I liked the least in the practice, unfortunately. She listened to what I had to say and then just prescribed Zoloft and some vitamins and said I should see a therapist. She recommended a psychiatrist and I called their office. The psychiatrist explained that she had gone into private practice and didn't take our insurance. It was way too expensive. So then I had to find a psychiatrist that would be on our insurance…and this is when I turned to Bob. I was like 'Bob, I can't…I don't have the time to sit in front of a computer and look this up. You have to do this for me, and you have to do it now.' I remember there was, he was awesome. He's busy trying to cook and help with everything and I put this other thing on his plate and it was more difficult than we realized it would be. I was getting impatient with him because it was taking a while, and I expected him to drop everything else and do this one thing. But he couldn't just drop everything else, I was focused on taking care of Bekah and Bob was taking care of everything else.

In the past, Betty had taken care of her own healthcare needs and had shared most of the household tasks with Bob. But after the birth of Bekah, Betty was overwhelmed by breastfeeding and a lack of sleep. She had always considered herself to be a woman who was capable of taking care of herself. Prior to her postpartum depression, Bob played a big part in helping her feel grounded and capable through his support and encouragement. But she still felt that she had her life in order and could take care of herself. She had a successful professional career and had finally begun to recover from her previous anxiety issues. She was proud of her recovery. After Bekah was born, she had to admit that she needed more than just support from Bob, she needed

him to take over the search for a psychiatrist. In a later discussion Bob explained that Betty's request for help, signaled that she had significant concerns for herself. It was hard to find the resources that she needed, but he kept looking until he developed a list. He worked hard because this request was so outside of what Betty would have normally asked him to do; he felt that accommodating this need was very important to her.

**Gabby and George.** Many of the mothers in the study believed that their partners were key to helping to turn around their postpartum depression. Gabby definitely attributed part of her recovery to her husband George. He was a steady presence in her life and she explained that it could not have been easy on him because she expected so much of him during that time. He had been laid off from work two weeks before their daughter Gina was born and so he was able to be present every day in the first few months. Gabby admitted that she misdirected some of her emotional turmoil at George, but that he was always there to get done what needed to be done.

> Gabby: Moving to a new apartment after we had the baby wasn't easy. We invited friends to come over and have a packing party with us, but it was more of a party without the packing. We ended up paying someone to do the kitchen because I was going to flip out. Remember I really freaked out? Then we just paid someone to finish it off for us and really that was something that we would not usually have spent money on before, but George was trying to keep everything together and I was focused on Gina and myself. Anyway, we moved to the new place and I was like, 'George, I can't explain why, I can't deal with moving in right now. I can't unpack. I know it doesn't make sense and I know it's not logical. I am sorry. I can't handle it right now. I just want things to be where it used to be, unpacked, no boxes. I need you to take care of it. I can't handle it right now.' And there were just boxes all over the house. And George was probably upset, but he just did it. He went from room to room and unpacked. I could not have done that without him. In the past we would have done it totally together. But I couldn't handle that and he knew it. So although he had a lot going on and packing and moving is just the worst, he did it. There were a lot of moments like that. Everything from making dinner to the laundry to watching Gina so I could sleep. George stepped in and did it.

Even in the moment Gabby felt she was asking for something irrational, beyond what she should expect of George. But she felt that it was out of her control and she just needed him to get it done. Gabby had already started her outpatient treatment at this point and George was aware of

how much she was struggling. As he did many other times during Gabby's depression, George quietly stepped in and did what Gabby needed of him. This was, in a sense, reassuring for George because he felt that if he had a task to complete; he was helping Gabby. For Gabby, George's willingness to accommodate her needs during her recovery was a 'blessing'. In a subsequent discussion Gabby explains that the whole process of diagnosis and recovery from postpartum depression helped her to realize how amazing her husband was and how much he must love her. For a time, while she was recovering, George and Gabby's new rhythm at home followed a cycle of Gabby asking George for help and George taking on and accomplishing these new tasks. It was a process that worked well for them.

**Felicia and Frank.** Frank and Felicia struggled with finding their rhythm after Felicia's diagnosis of postpartum depression. Frank indicated that it was something that they were still working on 20 months after the birth of their son. He was surprised by this, but was happy that the process of making adjustments was something that they were both still committed to working on. He described how in the time before they had their son, each partner took on very specific relationship roles and each had unique household duties. He reported that he had taken on much more than Felicia since Finn was born. He continued to feel frustrated, but was hopeful that they would find a healthy process for the whole family if they keep working on making adjustments and being honest with each other when things were not working well.

> Frank: I was picking up the slack, yes.
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> Alyssa: Can you explain that more? What sort of things were you doing?
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> Frank: Everything. I had always cooked and I've always enjoyed cooking. In some ways cooking dinner is special time for me. I get a bottle of wine and mosey around the kitchen. I built that kitchen. I've always really enjoyed that part of it. At least that part, those moments were not as bad. We've always argued back and forth on who does more work and who does more housework and stuff like that. I guess that is neither here nor there. I don't mind doing a lot of that stuff; I just kind of do it. Yes, there was all that

> stuff that needed to be done. I just looked at it like, nobody else was going to do it anyway. A lot of the stuff that…I don't think it's a lot of stuff that I necessarily started to do just then, like the laundry or the dishes, or taking out the trash or all that; cleaning the bathrooms, sweeping, mopping. I've just always done those things anyways. She's got the things that she has always done, and we definitely had more of a balance before the baby came, on what she did and what I did. Once the baby came, then it was kind of clear that those were mine now too, my responsibilities for sure. So I got things done, and I still do. I come home from work and usually do some laundry and make dinner. She might take a shower or go to yoga. It is a lot with the added responsibilities, but we are still working it all out. We argue from time to time, but try to make changes.

It was important to Frank that his efforts were acknowledged, but he also felt that it was just expected of him at that point in their transition. Frank's biggest concern was not that he had to take on so much more around the house, but rather that he was being taken for granted. There was no discussion or planning, it just became Frank's job to get it done. At other points in the interview he expressed his appreciation for all that Felicia did for their son, but he was also frustrated at his continued burden around the home. He knew that Felicia needed these accommodations during her struggles with postpartum depression. But when she stopped seeking treatment for her depression, he hoped that the household responsibilities would become more egalitarian, as they had been in the past.

Frank and Felicia had sought the help of many professional health care providers and holistic practitioners throughout her pregnancy and while dealing with her postpartum depression. Frank felt that Felicia was focused upon following their advice verbatim, instead of making accommodations for what would work within their household and in their relationship. Many other participant fathers also felt this same struggle; wanting to make an effort to help their partners but also to find a way to meet their own needs as well. Frank felt that the system that was in place to care for Felicia did little to acknowledge the efforts he was making or to understand that he needed support as well.

**Isabella and Ira.** This feeling of being unacknowledged was also expressed by Ira, a 26 year-old father with a 13-month-old son, Ian. His partner, Isabella, had been diagnosed with postpartum depression at 10 weeks postpartum. Ira and Isabella had struggled with following the sleep schedule that was recommended for Isabella by her therapist.

> Ira: So Isabella comes home from her second or third therapy session and she mentions that the therapist was concerned about her sleep schedule. At the time I thought, um, 'no kidding, no one sleeps well with a newborn'. But apparently since sleep issues were a problem that they focused on in their sessions, the therapist wanted her to be on a more regular sleep pattern. We were breastfeeding so that seemed nearly impossible to me. But Isabella decided that she would breastfeed and pump and she would store enough milk so that we could also bottle feed. So, she would feed Ian and then head to bed, probably around 9 or 10pm. I would wake for all the feedings until Ian woke between 5 and 6, and Isabella would take over. I would aim for that block of sleep, which was usually about a 4-hour block straight. At first our sleeping arrangements were the same and I kept the baby monitor on my side, so when Ian woke up I would get up and feed him, settle him and then head back to bed. I was waking up at least a few times a night. At the time, Isabella was still on maternity leave and I was back at work and school. It was really making things hard for me during the day. But Isabella was waking up when I was getting up, or she would still hear the baby monitor and I started sleeping in the guest room. I just remember being so tired a few times that I thought I was losing it. Looking back from now, I wonder who the therapist thought would be getting up with the baby at night.

Like each of the participants, Ira made accommodations for Isabella because he was concerned for her health and he was trying to work within the recommendations of her care provider. He felt that making this all work for Isabella and ensuring that Ian was being taken care of was a major priority for their family, but he got to the point where he wondered how long he could take this change. Ira and Isabella continued to sleep separately until Ian began sleeping for longer stretches of time at night. He struggled regularly during this time with his sense of responsibility to take care of his wife and son and with balancing his own needs as well. He let the stress build during this time without turning his back on Isabella and Ian, but it was a great cost to his own emotional and physical health.

When Isabella spoke of this time during our interview, she expressed gratitude for the sacrifices Ira made for her and she acknowledged the difficulty that he must have had with being back at work and school on such a small amount of sleep. However, she did not see any alternative to this arrangement. Couples acknowledged multiple times that they made many of their accommodations because they did not see an alternative. As with Ira, many couples made decisions because they were in crisis and they knew something needed to be done, even if the accommodations being made were less than ideal.

Couples frequently reported that they were still in the process of adjusting their routines, even months or years after a mother's diagnosis of postpartum depression. The process of accommodation was one of trial and error that couples revisited often in order to find what worked for their family. Hidden within their adjustments to their habits and practices was the love that they had for each other and for their child. Partners made great sacrifices to their own needs during this time, foregoing sleep or giving up their favorite hobbies in order to devote their time to caring for their newborn or taking on more tasks around the household. These adjustments were made so that mothers could have the space, time and support that they needed to heal from their diagnosis of depression.

## Conclusion

The narratives and themes presented here highlight the processes that couples experienced during the transition to parenthood and the diagnosis of maternal postpartum depression. These adjustments were navigated carefully and with significant uncertainty. The couples expected to have some ups and downs as they transitioned to becoming new parents, but they did not expect the mother's postpartum depression diagnosis. Despite taking steps to become more transparent with each other and finding ways to accommodate the needs of the

mother during her treatment and recovery, couples continue to express feelings of guilt and frustration many months later. Couples were proud of themselves for finding the courage to be more open regarding their fears and requests for support, but they continue to strive for a household where the needs of all were protected. Their efforts were directed to allowing mothers and their partners a space to be supported and have their personal needs met.

Although the mothers that participated in this research study were the ones diagnosed with postpartum depression, the diagnosis impacted both the mothers and their partners directly. For different reasons, participants dismissed early signs and symptoms of maternal postpartum depression. Both mothers and their partners were at once relieved and overwhelmed by the eventual acknowledgement that something was happening outside their expectations for early parenthood. Partners were key players in acknowledging of the depression and making accommodations to aid mothers in the process of recovering from their postpartum depression.

Throughout their transition, couples admitted that they struggled with coping with the symptoms and finding ways to accommodate the needs of the mother while still providing a space for the fathers to feel support. As they were able to reflect back upon their experiences, couples expressed that the processes of acknowledging their concerns and the trial and error of seeking accommodations that would help support the mother created new opportunities for them to better understand themselves and their relationship. In many cases they admitted that they were still working on smoothing out the process of coping, but participants felt they came through the other side better prepared for future difficulties that may arise in their personal health and in their relationships. Most couples felt they were more capable of communicating openly with each other regarding their needs and concerns.

## Chapter Five: Making the Transition Together: Narratives on the Partner Relationship and Factors that Influence the Trajectory of Maternal Postpartum Depression

In the body of literature on postpartum depression, the diagnosis is seen as multifactorial. Women who are diagnosed often have many risk factors, life experiences and previous health diagnoses that are believed to play a role in the development and in the trajectory of a postpartum mood disorder. Although this literature is well supported and has advanced the current care and treatment practices, it fails to highlight the relational aspect of the shared experiences of couples during the transition to parenthood. The couples in this study shared that some of their main concerns during this time were experiences that both the mother and her partner felt impacted them and their family. These concerns included experiences of family, loss, support, and styles of communication which all impacted the couple's perceived trajectory of the mother's postpartum depression. Mothers and their partners do not experience these concerns as individuals, but rather as life partners experiencing a shared life transition.

The current literature on postpartum depression and the practices of healthcare professionals often overlook the way that these shared concerns can affect the partner and the relationship of the couple. Because the diagnosis of postpartum depression is situated within an individual lens, many of the current therapeutic practices focus upon the mother alone and her partner is included as a part of the process only occasionally. Most often, that is when there is a perception that the partner has either played a role in the factors that resulted in the diagnosis or when the partner is seen as a support person that can help to provide maternal support.

Yet, the couples in this study shared experiences that influenced both the mother and her partner. At times the couples relied on their relationship as a means of support, but also reported that their experiences left them both feeling more anxious and stressed. Through shared

narratives of coping with maternal postpartum depression, the couples revealed that their relationship was a strong influencing factor in their perceptions. During the interpretive process it was noted that this was a circular relationship. The factors that influenced the trajectory of postpartum depression also had the potential to impact the partner relationship and that the partner relationship had the potential to impact the factors that were a part of the maternal diagnosis.

The emphasis in this chapter will be upon narratives that examined the ways that perceived influences were incorporated into the everyday habits and practices of the couples as they were coping with the maternal postpartum depression diagnosis and the interplay between those factors and the partner relationship. The chapter will begin by focusing upon the shared experience of support that a mother and her partner described during the interview process. Within these narratives, it was revealed that their supportive relationship helped to buffer the impact of their concerns and helped the mother and her partner cope with postpartum depression. Then the chapter will examine one couple that came together despite differing perspectives. Despite approaching situations from very different worldviews, they continued to make efforts to make things work. However, these different worldviews created some uncertainty in their relationship. This uncertainty negatively contributed to their ability to cope with the factors that were seen as influential to their transition to parenthood and their experience of maternal postpartum depression. Finally, the chapter will focus on the ways that a mother and her partner felt that their difficult relationship did not meet their personal needs and how this created dissonance in their relationship, which complicated their abilities to cope.

These narratives will focus on the common experiences of support and couple communication. However, it will highlight the ways in which couples take up these shared

experiences and how they differ by relationship style. These stories of shared experiences and of the differences in each relationship will come from three couples that shared stories highlighting the experiences of shared support, uncertainty and dissonance. These couples were identified as paradigm couples during the interpretive process. As paradigm cases, these couples showed strong examples of behaviors, beliefs, concerns and ways of being in the world that illuminated previously unrecognized patterns. Once understood and identified, these patterns then made it easier to compare and contrast the shared experiences of other couples within the study.

## A Supportive Relationship

### "In This Together": Alice and Albert's Experience

**Shared support practices.** Alice and Albert both had a relationship that they both felt was supportive and deeply rooted in trust. When Alice was diagnosed with postpartum depression, Albert admits that he "saw it coming" and could tell that Alice was struggling even when she never verbally admitted her concerns about herself to him. He felt this was because he just "knows her well enough" to see when she is not acting like "her normal self". Both Alice and Albert found ways of supporting each other and through our discussions it could be determined that their previous life experiences prepared them to know how to care for each other in times of difficulty. Albert had previously been diagnosed with depression and he could recognize some of his own symptoms in Alice. Alice had seen her family seriously affected by depression as a child, and she knew that Albert would also need support, just as her own mother had in the past. Alice explains that their past experiences better prepared them to handle her own depression as a couple better than any outsider could have done.

> Alice: Well, Albert has had a history with depression. He wasn't being actively treated for it at the time. I mean he was on meds, he is always on meds, but he wasn't seeing his therapist. He goes in and makes appointments when he needs to, but when we had the baby he was in a really good place. So that is what I meant. I think that someone who has

> been depressed themselves may have a better understanding of how someone who is depressed feels. He knows that the stigma doesn't make sense. That you can't just snap out of it. He gets the feelings of inadequacy. I felt like my mom was judging me, all those things coming at you from your own Mother. I mean wow. But Albert, he just got it… And also, because we have this all in our family history. Because we have both had struggles with depression. Knowledge is our power.

Initially when Alice was diagnosed, they came together and focused all their energy on Alice. This was mainly because Alice needed this and because Albert understood what it felt like to be depressed. Eventually this started to feel overwhelming for Albert, as he was back at work fulltime and having to care for Adele in the evenings, at night and on the weekends. This eventually led to Albert having a relapse of his own depression and the couple quickly realized that they needed to make some adjustments so that they could both be supported. One of the main things they did was work hard to carve out time for each of them to have "alone time" and this made difference in how they relate to each other when they are together.

> Alice: So when he gets home, he does take over. He gives her a bath and I get her room ready and sort of tidy up. Then I put her to bed and then we have time together. Or, sometimes, he can go off and play his guitar or something. But we had to actually sit down and really talk about that, find a system, something that would really work for us. Because I think you get into it and realize that you have no time to yourself and that is sort of a hard thing to cope with.
>
> On weekends we both get time where we specifically make time for the other person to have alone time. So then we sort of get into a pattern, and I think we are there right now, where we get alone time, but no time together, just us. So, that doesn't work for a relationship. So we recently renegotiated our time. We used to be in a pattern where he would get the Saturday and I would get the Sunday. You know he would go off for several hours during the day. Maybe meet up with friends, or whatever. I would go to a coffee shop or something and just sit alone and read. It is really great to just not need to be actually doing something all the time. But then we never see each other. So now, it is more like we spend time together in the morning and then we get the afternoon to do whatever and be by ourselves. But this is definitely a conscious decision.

Alice and Albert made a conscious effort to find a system that worked for them both and they now find ways to support that protected time for each other. Alice feels that protecting their time to be together as a family and also making time for each other to be alone creates a better

space for both Albert and she to get everything they need from their relationship. This was a process of trial and error and they must still make the time to ensure that the system is working for them both. This takes a good amount of effort, but both Alice and Albert feel that this is important.

> Alice: This was not something that we just eased into. Albert sort of blew up one day and said 'I can't breath! I feel like I don't have anytime. I work all week and I come home and I am always on. Our weekends are taken up by doing stuff with the kids. There is no time for me.' And I remember this now, I do. I did this terrible thing. Instead of hearing what he was saying, I just yelled back 'Well me too! I am always home with her, I am always on too, she is always needing something from me. Our weekends are spent together as a family. I can't even take a shower some mornings because she needs me! I don't get that either.' So we had some discussions around that and this is how we got into the original pattern of taking a weekend day each, we decided that would work for us. But then we didn't have time together. And when I say together, it is typically as a family. We still don't get a lot of time, just the two of us.

For both Alice and Albert, arguing and spending a good deal of time being frustrated or upset also takes a good deal of effort and energy on their part. But they took the opportunity to refocus their attention on finding ways to make things work better. They have had to make adjustments, but right now, it is working and they have found that this is something that they are very happy about. Albert gets the time he needs to write music or read the newspaper at a coffee shop around the corner. Alice takes her time to take a walk with friends or to take an occasional yoga class. But most importantly they have found it possible to also spend time together as a family. Currently, they are working on a way to spend time together as a couple. Alice feels this is very important for their romantic relationship and she hopes that this will make it easier to reestablish the level of intimacy they had before their daughter was born. This has become more of a sticking point because of the need for childcare and because they are not entirely sure how to make it work with their current agreement.

In addition to supporting each other by working hard to meet each other's needs, Alice and Albert have also realized that they need to be vigilant with noticing when the other person needs support. They have realized that this needs to happen even when the other partner does not explicitly ask for support or seem to appreciate the efforts being made. Alice explained an example of this while discussion Albert's relapse with depression.

> Alice: You will have to ask Albert more about this time for him. But what I remember is that I was starting to feel better. My mum had gone home and I was feeling settled with my meds. I just remember that all those steps we had taken to find something that worked for us both as far as taking care of the baby and the house and our alone time and whatnot was sort of out of the question because he was in bed wallowing in it all. Like physically ill. I did feel like I was in a better place, and I sort of needed to be because he was unavailable. A lot was put onto my shoulders for those 2 days or so. It was a time; it was the same thing that Albert said about my depression. I think I was sort of annoyed. I mean I felt like sure he is depressed, but I wanted to say 'Get up out of bed and doing something about it.' It was a time when I wanted to say 'Alice, just tell him to get up and pull himself together.' But, sure, that would be really helpful. And I know that I knew better. But it is that helpless feeling that you want to do something. You want to solve the problem, so you do what you think is helpful, even though maybe it is not.
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> Alyssa: So, can you think of an example of something like that?
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> Alice: So, umm, I would say things like 'Do you want to eat some lunch now? Get up and take a shower.' And I would sort of take those decisions away from him. I would push him towards doing something. I would say 'Do you want to go out for a walk?' I would sort of try to goad him into action.
>
> Alyssa: And why do you think you tried that technique?
>
> Alice: Well it certainly wasn't because it worked for me (laughing)! I mean I can remember Albert and my mother trying the same things with me and it would annoy me and sometimes I would do as they asked and sometimes I wouldn't, but it was pissing me off when they would do it. I think I just felt like I had to try something to get him moving. Even at the time I thought, 'This would really annoy you.' But it did work for me eventually, didn't it. It took a while, but it did. The push to go out to the coffee shop, the push to get me to eat something, they did eventually work. It annoyed me, but it worked. And so I just tried the same thing. I was really between a rock and a hard place. Because I knew what he was going through, I could either just let him wallow in it or I could annoy him until he got up. So, even though I knew it would annoy him, I did it anyways because I thought it would help.

Alice is able to take the support she received from Albert and her mother and use it to help Albert when he becomes depressed. At first she felt frustration because they had worked so hard to find a system that works for them and suddenly they are back at the beginning. Alice felt like it is on her shoulders and she was still coping with her own depression. But when Alice realized that she had the tools to help Albert and that she was in a "better place" than he was, she was able to step outside her own situation and support Albert. Being in a position to support Albert left Alice with a feeling that she was doing better with her own depression because she could see that she had the energy and the ability to take care of and support Albert in his time of need. For Alice, she saw this as a marker that she was finally turning away from her postpartum depression and was recovering.

This reciprocal support has been a cornerstone of their relationship. They know that they need to work from time to time to create the space where they both find the support that they need within their relationship, but it is something they have decided, together, is worth the effort and the sacrifice. Both Alice and Albert felt that their relationship was an added security to help them cope with their depression more effectively in a safe and supportive space. Because of this, they felt that their depression was easier to cope with during the postpartum period and beyond.

**Safe Communication.** Alice and Albert both share that they are in a "good place" now when it comes to sharing their feelings and expressing their needs. But they also explain that this was a bumpy path after the birth of their daughter and it took them some time to find a way to talk with one another openly and without the added worry of judgment or hurting one another. Alice explains that for her, this all came down to trust and not wanting to burden Albert more. For Albert it was a matter of accepting that Alice was not as fragile as he imagined her to be in her depressive state and that he did not need to be so protective of Alice. They both needed to

trust that being open with their communication would be the easiest was for them to come together to find ways to develop solutions to the issues that were arising everyday. Alice explains that this was not a huge change for them, that they had always been very good at communicating with each other, but that when she was initially diagnosed, it became difficult to be as open with each other as they were previously because they both had concerns. This made it difficult to cope with their day-to-day needs. But, once they started opening up with each other and communicating without fear, they were able to approach their concerns and needs as a couple.

> Albert: Looking back I can honestly say that I knew she was struggling before I said anything to her. I felt that as a man, it wasn't my place to tell her things about mothering and postpartum. I mean who the hell am I to go on about that? We were struggling with a lot of decisions at once. How to best treat Alice's depression, what to do about breastfeeding, having Alice's mum as a houseguest. She was there to help, but she was still a guest. And I just bit my tongue a lot because I could see that Alice wasn't doing well. In the past, I would have just said something, given an opinion, explained what I needed. Like, when I would get home from work, after being there all-day and worrying about the new job and also how things were going at home. I would get home and Alice would ask me to take over for her mum, to give her a break. And normally I would have said, I need a break too. But I didn't want to argue and I didn't want to upset Alice and I was so grateful to her mum for being there, she was brilliant. But I was getting more and more pissed about it all. When did I get a break? But I didn't ask for it. I couldn't ask for it. Alice needed me to take over and so I did. But it got to be too much and I eventually blew up at her. It was just before the annual holiday party at work and I was really looking forward to going. I was getting ready, had just come out of the shower and Alice was in the bedroom pacing. She had this strained look on her face and I asked her what was wrong. She asked me not to go to the party. I was so angry. It all sort of bubbled up and I sort of flew off. Her mum was there to help, why did it have to be me. But she said it did need to be me. She needed me there. And I could see how bad she was. And I did what I could to refocus and I stayed home. But even now I am feeling annoyed just telling you about it. There were a lot of these sorts of things at that time. And once Alice was able to share how she was feeling with me more regularly, I think it had a lot to do with what she was working on in therapy, I was able to start being more open with her about how I was feeling.

Albert was focused on protecting Alice and keeping things in order at home. He saw how Alice was having difficulty and he began to see his wife, whom he had always considered a remarkable and strong woman, as fragile and needing protection. As a result, the way that he

communicated with her began to change. Instead of being open and honest and readily offering his opinions, he did as Alice asked and "bit his tongue". Albert was uncertain if this was the best approach, but he decided upon this course of action because he did not want to hurt Alice more than he already saw her hurting. But eventually, in his attempts to protect Alice, he began to neglect his own needs and this caused him to become resentful. He was resentful of the situation and he eventually directed his frustrations and resentment at Alice. At a later point in the interview, Albert explained that he knew his resentment of Alice was misdirected, but all the responsibility on his shoulders, without the support he was used to receiving from Alice caused him to become angry with her. He knows that this was unfair, but couldn't help himself. They continued with this pattern until Alice reached a point in her own treatments for postpartum depression that she began to trust Albert with her honest and direct feelings.

> Alice: Having postpartum depression and being diagnosed is a long process of having to looking inward at yourself. When you are first depressed you feel like you can't even ask for what you needed, like just barely saying 'I need you to do this for me' takes energy that you don't even have. So I just figured that my mum and Albert would take over for me. The only thing I was doing was breastfeeding and sleeping. I was living inside my head a lot and when that happens the thoughts that you have start to feel so terrible that you think you can't tell people what they are. Looking back Albert and I had always been very honest with each other. We were both in serious relationships before we got married and we knew what didn't work in a relationship, so we tried to do the opposite in our own marriage. But when I was first diagnosed, it was nearly impossible for me to ask for things for Albert and to tell him what I was feeling. I didn't have the energy and the things I was feeling about being a mom and about Adele were scary to me. And I knew that they would scare Albert and I also feared his judgment. He had never judged me for anything before, but I couldn't tell Albert that I wished we hadn't had Adele.

Alice was stuck within her own depression and she felt her thoughts were so unspeakable that she could not bring herself to share them with the one person she had become accustomed to sharing everything. Her postpartum depression had created a situation where she made adjustments to the way that she communicated with Albert. She was shutting down their typical lines of communication. She was holding back her true feelings because she was scared of

hurting Albert, but she was also scared about saying her true feelings about being a mother and about their daughter out loud, as if giving them voice made them more real and made her a more "horrible" mother. Alice goes on to explain that Albert never gave her a reason to feel this way and that these feelings were completely of her own creation.

However, Albert's instinct was also to protect Alice from his concerns and any thing that may have seemed like he was judging her. He did not speak up when Alice seemed to be struggling because he did not want Alice to feel that he was making assumptions about her abilities as a mother and even now says that Alice is a much better parent than he is.

> Albert: Like I said last time, I think I noticed that something was off with Alice right away. She just seemed disconnected. And when we got home she struggled with breastfeeding and with the lack of sleep. She had her mom and I there to help and we had loads of support from friends. But Alice still seemed out of sorts. At first I kept my thoughts to myself because, honestly, Alice doesn't handle a lack of sleep well and I actually thought that was what might have been going on with her. But then it became obvious with her symptoms and her anxiety that it was something more than that. But then, I did what I could to support her when she asked or I did what I could around the house, but I felt like I couldn't just say what needed to be said. (Long pause) If I look back, I think that I kept my thoughts to myself because Alice wasn't ready to tell me anything either. I didn't want to put other thoughts in her head. I had never thought of her as anything less than totally put together before, so this was a totally new feeling for me. To this day I think she is the best mom, the strongest person that I know. But seeing her in that different light, I couldn't say whatever came to my mind.

Albert was concerned for Alice, but he had a strong fear that by voicing his concern to her, he would only bring her struggle out into the open more. He did not want to exacerbate her anxiety and her symptoms, which included a good deal of physical ticks and behavioral repetitions, by pointing out what he was seeing and giving her more to process and think about. Instead, Albert focused on keeping quiet and supporting Alice in other ways. He took over household chores that Alice had typically done in the past and he would watch the baby as soon as he came home from work each day and on the weekends. Albert was also protecting his long-standing image of his wife as a strong and organized woman. Any vocal admission that Alice

was not coping would also change the way that Albert saw his wife interacting with their family and with the world. However, both Alice's decision to keep things from Albert and Albert's decision to not share his concerns with Alice left them at a communication stand-still that was not helping either of them to cope with Alice's emotions and behaviors and with all of the other life changes that come with caring for a newborn.

After a certain point in her therapy sessions, Alice's therapist encouraged her to begin writing things down in a journal at home. This was an important step for Alice because she felt that she could organize her thoughts and share them with her therapist. When Alice's therapist did not pass any judgment onto her because of what she expressed regarding her thoughts and feelings, Alice felt that she could share her thoughts with Albert also and not be judged. This was a major step in opening their lines of communication again and actually lead to them being able to more readily cope with Alice's and Albert's depression as a couple.

> Alice: I came home from my appointment and Albert was in the kitchen. I looked at him and I just said all the things that I hadn't said out loud, that I thought were truly awful. I told him that sometimes I wished that Adele had never been born, that things were easier before. And he looked at me and just said, "Ya, I totally get that. It would be easier without her." And for him to just hear that and not totally go crazy and get all worried and nervous and say that sometimes he basically feels the same way, that was a game changer. I felt this weight immediately lift from me and it made things so much easier from there on out because I felt like I could just share my thoughts with Albert, no matter what.

Alice was able to reveal her feelings to Albert when she finally felt that she was able to share without fear of judgment, when she felt safe. When Albert did not make Alice feel terrible and he agreed with Alice, it opened up a whole line of communication where they both felt safe enough to share what hadn't been said since Alice's diagnosis. Alice's understanding that Albert shared some of her feelings that she thought were too dark to express, also helped her to realize that Albert was also struggling from time to time with their transition to parenthood, that they

were having a shared response to a shared transition. In addition to fostering open and safe communication with each other, this revelation also brought Albert and Alice closer together as a couple and as parents.

Alice and Albert have a relationship where they have created a shared space that is safe for both of them. They are able to adapt and make changes to ensure that both partners' needs are being met. They make these adaptations to support each other and although it is not always easy to make changes and to provide support, they do so for each other because creating a safe place in their relationship is something that they both value. Their previous experiences with Albert's depression and Alice's family history of depression had given them some of the tools that they needed to help each other through their transition to parenthood and for coping with Alice's depression. Their previous life experiences and their personal beliefs about support and safe communication created a space where they were able to help each other through the more difficult experiences of their depressive episodes. As they both look back upon the first 3 months after Adele was born, they feel that they are better off now for having worked together to get through the "hard spots" and that they now have even more experience to fall back on if things become difficult at another point in their relationship.

## A Relationship from Differing Perspectives

### "We Go Back and Forth": Elizabeth and Edward's Experience

**Differing ideas of support.** When Elizabeth and Edward were married they both admitted to being on the same page about most of the "major decisions" newly married couples face. Neither Elizabeth, nor Edward wanted to have children. They shared a passion for working hard and advancing their careers and they enjoyed the time they spent together traveling, eating out and experiencing the local art scene. It was a lifestyle that they were able to experience

together because they did not have children. However, a few years into their relationship Elizabeth experienced a major health scare and decided that something was missing in her life. She came to the conclusion that she "desperately" wanted to be a mother. When she shared this with Edward he admitted that it was "like a punch to the gut." He never wanted to have children and despite her admitting that she did, he still did not want to become a father. But he loved Elizabeth and had to make a decision between losing Elizabeth and letting her follow her dream. He decided to stay with Elizabeth and go through this transition with her, but their relationship immediately took on a degree of uncertainty. He explained throughout the interview process that he loved his daughter deeply, but he still struggled with the idea of seeing himself as a father. Elizabeth felt that in the past, Edward was never emotionally supportive of her and she sought that support from friends. But after having their daughter, she felt she needed to feel that support from Edward. Elizabeth felt that Edward was not engaged and Edward did not know how to relate to being a father and a supportive husband.

> Edward: You know I do what I have always done. I run to the grocery store when we need stuff for dinner or I run out late night to the drugstore when asks me to. She will probably tell you that I am not there for her on some emotional level that she needs me to be. That just isn't who I am and I have never been that person. But now it seems like she needs me to be and I am not. My whole life I have never been an emotional person and I have never needed that. I can count on one hand the number of times I remember my parents telling me they love me, but that isn't what my family is about. Elizabeth seemed to be fine with this before, but now it is obvious that she needs more and I try and pick up the slack in other places, cleaning, helping with chores, but I can't be emotionally supportive. That is what she has her friends for. Sometimes she has a rough day or a rough patch and I know she wants to sit down with me and talk about it and I just am not that person. Like last week, the baby was teething and it was pretty rough around here. No one was sleeping well and feedings were frustrating us all. Elizabeth was obviously hitting a rough patch. She kept reaching out to me to start conversations about how she was feeling and whenever that happens it is usually a pretty one-sided conversation and she seems to get pretty pissed with me (laughter). Eventually she had some friends come over and they went for a walk and she seemed to do better after that.

Edward easily admits that he is not emotionally supportive of his wife. He never has been and he is unable or unwilling to take on that role despite their transition to parenthood and Elizabeth's diagnosis of depression. However, he does not feel it is necessary for him to be emotionally supportive and feels he supports Elizabeth and their family in other ways. Edward's worldview has been colored by his experiences growing up with his family. His parents were never affectionate towards each other or their children. He is not upset about this. To Edward, he just grew up in a home with different priorities. He has difficulty being affectionate and emotionally supportive with his own spouse and daughter because he has never been put in this situation before. In addition, Edward believes that he is providing his own type of support to Elizabeth and their daughter. Elizabeth stepped away from her career to take care of Elise and Edward is now the primary breadwinner. For Edward, providing for his family, coupled with all the tangible tasks that he takes care of around the house, cleaning, shopping, maintaining the cars, and working from home occasionally to help care for Elise, is being supportive. Edward believes he is doing a great job. He feels that that he is supporting Elizabeth in the best way that he is able. He does not see his role as emotionally supportive because despite their new roles as parents, he has never been an emotionally supportive spouse. Elizabeth understands that this is not who he was or is now, but she is hopeful for something more. Initially, when she was diagnosed with depression, Edward's lack of engagement scared Elizabeth.

> Elizabeth: Yes, then it was going back and forth between all of these emotions and also just feeling unjustifiably so, but still emotionally abandoned by Edward because he was just … I just wanted him to be there for me emotionally. He just couldn't and so I was terrified for the night when everybody else would go away and it would just be him and I. It was worse than being alone.

When she was first diagnosed with postpartum depression and their routine at home was still new with the baby, Elizabeth needed Edward the most. During the day she had friends and

family to help her with Elise, but in the evenings she felt isolated and alone despite Edward's presence. But as she later explained "he never signed up for this" and she eventually had to realize that she needed to stop asking him to be someone he would never be and focus her attention inward. This allowed her to stop feeling "abandoned" by Edward and instead allowed her to focus on what was working in their relationship. She was able to turn back to their old way of being in their relationship and she was able to stop feeling disappointed.

They both admit that they still have moments where Elizabeth wants more from Edward and Edward feels closed off, but they are able to see the way that the other views the world and defines their relationship. They have turned back to their old roles, no longer expecting more from each other than the other is ready to give and this has brought back a sense of normalcy to their relationship.

> Elizabeth: Sometimes I feel like we could benefit from Edward coming to my therapy sessions. Like maybe we need to talk this out more. But I understand who he is and he is doing what he can. Do I wish we had a more affectionate relationship from time-to-time? Yes, but we also have a really good relationship in so many other ways. For a while having the baby made me think we would become different people, but we didn't. We are who we are, we just have a baby. When I was able to see that, we started doing better.
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> Edward: We do go back and forth and there have definitely been some issues that have come up, like we still argue about stuff. But every married couple argues about stuff. But we have come to a point where she has found a way to find the support and I can feel comfortable. For now, this is working. Whatever this is (laughter). Kidding. We try to make it work.

Despite their differing views of support, the couple still has times when they feel things are working out. During their couple interview they smiled easily with each other and there was laughter in their interviews. They admitted to having found a "groove" where their relationship and their household was running smoothly most of the time, as it was before they had Elise. After Elizabeth stopped pushing Edward to change and went back to seeking out her friends for help, they settled into a routine. But just because they have found a routine that works right now,

does not mean that they are both equally happy with the way things have gone. Elizabeth still wants to point out that the future is uncertain. At the time of our interviews she was expecting her second child and was still seeing her therapist for her postpartum depression.

> Elizabeth: I think at the very end of the day I can't necessarily blame him for this. There's also the part of him too going, 'my, god, this isn't' what I signed up for'. We're supposed to be happy home the first day home from the hospital and for the next 20 years. Its like you look at each other and think, 'I got you and you got me'. I'm not bitter toward him. I get that he had his own things that he needs to work on. I think it was foolish of either of us to rely on each other entirely, but I think because there's still a degree of social judgment around postpartum depression, that's happened at times. If we turned inward and some people do well that way but we really try to guess what each other needs when there are problems. We don't just ask for things or we don't ask each other what the other person needs. We gave up on that. That's just the pathology in our relationship. I recognized it a lot better now so I'm much better able to step away and take a break like leaving early when I notice I was getting mad at him. I just leave. Being able to take break like that, recognizing that issue is good for our relationship. The problem with this is I don't know if we can keep doing it this way forever. We are still growing as a family and I don't know if this can be sustained. But right now, it works for us.

Elizabeth is uncertain and nervous about their family's future, but it is mainly because she is nervous about her next experience of birth and postpartum. Although she still sees her therapist, she is no longer taking her medications and feels she is in a good place with her postpartum depression. However, now that she is expecting again, she is nervous about having a significant relapse and she is worried that she will not get the support she needs from Edward again. In Elizabeth's eyes there is a social stigmatism about postpartum depression and this makes it difficult to share everything she needs to open up about with her friends and extended family. The uncertainty in the support she receives from Edward is something she thinks of often as she prepares her self, her family and her home for her next child. She does still hold out hope that Edward will be able to make some type of adjustment in the future. She feels that he cannot keep walking away from her needs and his refusal to provide her with the support that she is asking for creates a significant concern for her when she thinks of the uncertainty that exists in

their future as a couple. But at the same time that she feels this uncertainty, she also explains that they have each other and that right now, it is working out.

It is also important to highlight that despite their differing expectations regarding being parents and their different worldviews of the ways that a family shows support, Edward and Elizabeth both deeply care for their daughter and despite being nervous and uncertain, made the decision together to have a second child.

> Edward: …I even surprised myself. I will still say upfront that (I) had never seen myself as a father and I am still not going to write the book on the joys of fatherhood, but I have developed a really soft spot for her. You know how they say that fathers just melt over their daughters and mothers are in trouble if they have sons. I can't imagine not having her here. But I do still miss our lives from before, things were easier and we got along better. Elise is a wonderful part of my life now, but she did make things more complicated. If people tell you kids are easy, they are lying. And as far as number 2 on the way, I think we were in a hurry because of our age, but it will be good for Elise to have someone to play with. We both had siblings growing up and now that we have one, I can't imagine her not having someone else.

Becoming a family of three was a difficult step for Edward and Elizabeth. They have both struggled with the transition and also with their relationship as a result of all the changes. However, this change has also introduced new love and possibilities into their lives. They both cherish the love they have for Elise and despite their fears and concerns, they are expanding their family again so that Elise may feel the love and support of a sibling, a connection that both Edward and Elizabeth feel is an important relationship to have in life.

It might be easy to assume that this is not going to work out for Elizabeth and Edward over time. As a couple, they still struggle significantly from day to day with not meeting each other's needs and expectations. Elizabeth and Edward's relationship differs from Alice and Albert's in that Alice and Albert see their differences and, with practice, they have reached a point where they can negotiate and adapt to make changes that create a space that meets the needs of both partners. In Elizabeth and Edward's relationship, it seems to them that someone is

always settling for something that does not quite work for them. But for right now, this settling is admittedly working for them. In the long term, Elizabeth and Edward are hopeful for a resolution, yet they have not yet found a way to make that happen when supporting each other emotionally. As a result, Elizabeth seeks out her emotional support elsewhere and Edward does what he can to provide tangible support, such as running errands for the family to fill a need in their household. But in the end, they are both reassured that they both have each other in some context and this gives them both hope for how things will work out for their family.

**Communicating from different perspectives.** Elizabeth and Edward also shared that they often struggle with how they communicate with each other. This is not constant and there are days when everything just moves along smoothly without argument or a need to pause for discussion. But they often have disagreements over different aspect of the household, such as finances, how to take care of Elise and how to make time for themselves. Elizabeth admitted that this is an ongoing struggle in their relationship and that it complicated her experience of post partum depression. She explains that she understands that she is partly to blame for their difficulty communicating.

> Elizabeth: I hate to admit this, because it is so stereotypical, it is something that you see play out in bad romantic comedies, but I have this expectation that Edward will just know what I want or need without me having to ask for it. Rationally I know that this is ridiculous and I should just ask for things or explain how I would like things to be done, but I don't.
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> Alyssa: I am not sure I understand.
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> Elizabeth: OK, let me think of an example. Edward travels for work from time to time. I don't think he understands how isolating it feels for me to be home with Elise and to not be working. It was my decision to stay home after she was born, but it is still isolating. I know that the people he works with would allow me to go also and bring Elise. I think this would be a great thing for us. We did it when our work schedules allowed before the baby. But Edward never asks me any more. I want him to ask. Instead I just resent him every time he tells me he is traveling again. I should just ask if we can go along, but I

> want him to know me well enough to know that this is something that I would want to do. It is frustrating.
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> Alyssa: Can you help me to understand what made it so frustrating?
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> Elizabeth: I don't really know. The reality of it is that I know traveling with an infant isn't easy. If I had to guess why he doesn't ask us to join him I would say I think that he is used to doing things his way when he travels for work and so it would just be one thing after another and we would both probably be tired. It wouldn't be anything like it was before, but I want him to ask. I think maybe I want him to also express that he misses us when he is gone and that he would want us to come with him because of that. Instead I feel like he can't wait for the time away. And that may not be how he feels, but I don't know how he feels because he never talks about it.
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> Alyssa: Why don't you ask?
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> Elizabeth: Hmm, like I said before, I want him to make the effort without me always asking. I start to feel like I am nagging him or like I seem overly needy. Having to always ask makes me feel like I can't do things on my own. I know he probably wouldn't mind if we came along, and he probably would agree if I asked him to, but I want to be invited and I want to do things together without me having to spearhead it all the time and without it being this massive discussion.

Having to ask Edward for help, instead of him taking the initiative to help her when she is struggling, has created a situation where Elizabeth feels incompetent at times. When she feels this way, she feels weak and this leaves her second-guessing her abilities. During her most depressed state, it increased her sense of helplessness. She feels Edward would complete the things that she needs help with, but that having to ask makes her look even more helpless than she already feels. In Elizabeth's world her husband should know her well enough to see that she needs his assistance and she should not have to ask. If Edward were to initiate the conversation or provide that help and support, it would be a sign of his love and caring for her and Elise. Instead, Elizabeth is left with what she has now, which is a source of increasing frustration. This frustration is a factor in her depression. As she reflects on this need, Elizabeth admits that it is a behavior that is stereotypically seen as a negative female behavior, but she still cannot stop herself from feeling this way. The disconnect between what Elizabeth needs and what Edward

gives her is a signal toward the larger issues that exist in their relationship. Their ongoing communication issues highlight the underlying problems in their marriage. Her hope that Edward will just know what she needs without her having to ask also shows that she desires a deeper connection with Edward and that she wants him to know her better and understand her needs and concerns. Elizabeth also readily admits that they do not do the best job of having constructive conversations. Often times, when they do sit down and talk about each other's needs or concerns the conversation will eventually devolve into an argument.

> Elizabeth: Edward can back me up on this, but I do remember that our first night out without Elise turned into an ongoing argument. We got into a little tiff before we left the house and Edward probably would have let it slide from there, but it was in the back of my mind at dinner. So the dinner conversation, and I think this is funny, we both commented at the restaurant that we were looking forward to having a night when it would just be the two of us doing something on our own, the way we did before the baby, but we ended up talking about Elise the whole time.
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> Edward: (Laughs) We really did.
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> Elizabeth: I also remember that after our food came to the table, I brought up the argument at the house again.
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> Edward: I think it had something to do with doing the laundry.
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> Elizabeth: You are right, it did. I was upset because I felt like I was still doing so much of the work around the house and I needed more help from you. So you decided to work from home as much as possible. I was expecting that when you would work from home that you could be helping me too, but when you were working from home, you were really focused on work. So I was like, 'What is the point? Just go back to work!' The argument was because you stayed home that day and I had asked you if you could do a few loads of laundry that day and you never did it. I felt like I was drowning in laundry.
>
> Edward: The truth is that I had totally forgotten about the laundry and if she had just asked me again, I would have done it. So as we were getting ready to go out, she noticed that the hamper was still full and she got pissed.
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> Elizabeth: So we had the little tiff about the laundry at the house, but I brought it up at dinner again. Instead of bringing it up and having an adult conversation about it, I started ragging on him immediately. This was totally counterproductive because then you didn't want to talk to me about anything after that, never mind sharing household chores! But it

had been bothering me, coupled with other things, for so long that it just came out. I know I do that often and it makes having conversations more difficult.

Edward: Not all of our conversations take a turn for the worst. But it does happen and we seem to allow it to happen more often than most. When I think she is nagging me, I just shut down. That is my default mode and then eventually I get really upset. But Elizabeth wants to talk things out and I want to just silently stew over it.

Elizabeth: Alyssa, I think, when I look back at the early weeks and months after Elise, that because I know many of our conversations fall apart this way, when I was at my most depressed, I kept a good deal of things bottled up because I was worried about the increased stress of adding an argument to the mix and honestly I didn't even have the energy. So instead of having arguments, we didn't really communicate at all.

Although discussions can often become arguments, this conversation shows that Elizabeth and Edward are both taking responsibility for their shortcomings when it comes to communicating in a constructive manner. They both realize that they often make mistakes in the way that they try and talk to each other. However, they have yet to find a way to improve their style of communication. Instead, they often engage in friendly banter and avoid serious conversations, creating a gap in the intimacy of their relationship. Edward and Elizabeth feel that they are often sharing their lives with each other from a distance. Elizabeth explained that she has times where she feels like they are friendly "roommates" and not a married couple. They previously had conversations about art, about technology and local issues. Now they talk about Elise and argue about household expenses and chores. These arguments are exhausting for them both, so instead of communicating as much as they used to, Elizabeth focuses on Elise and Edward shuts down. Now they cope through a lack of communication and by keeping their distance from more serious conversations. Instead they each do what they feel they need to do for the family and they have stopped discussing it first. Edward and Elizabeth have always had differences in how they communicate, but since having Elise it is not working out as it used to work. They are tired and continue to fall back into their old ways of communicating.

Edward feels he needs to focus on many things at once. He feels a great deal of pressure as the sole family breadwinner, where before Elise, this was a shared responsibility. So, he is often focused on work when he is at home, but he sees this as another way that he is helping the family. As far as Edward is concerned, he cannot "read Elizabeth's mind" and that communicating without arguing is something that they have struggled with since they were dating.

> Alyssa: When we met all together Elizabeth described a night when you both went out without Elise for the first time and ended up getting into a pretty heated argument. Can you think of any other sticking points you have had recently or do you have anything you want to share about the night you got into the fight at dinner?
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> Edward: (Laughs) I think I should start off by saying that Elizabeth and I have been pretty good at arguing about things since we met. Most couples probably are, but I think we are both a little stubborn, which probably isn't a good combo. We also push each other's buttons when we get into it. We know each other well enough to know what really gets under the other person's skin and we sort of use that to our advantage. I would say that we are more skilled in communication than Elizabeth let on, but we are skilled at a style of communication that has the sole intent of infuriating the other person. Honestly, I think we do it on purpose and we always have. I don't think it is something that will change anytime soon, or ever.

For Edward, this style of communication in their relationship is nothing new. It has not come about because of the birth of Elise or because of Elizabeth's depression. This is just how it has always been. He has a lot on his plate and Elizabeth has a lot of needs and she "nags" him and he focuses on his other responsibilities. Unlike Elizabeth, Edward does not think that the way they are communicating is an issue because he has been experiencing it since they were dating and it is just as much a part of their relationship as anything else. Their current style of communication and Edward's belief that it does not need to change is creating a situation where Elizabeth feels more isolated and where her anxiety is increasing. She chooses not to share her feelings or needs with Edward out of her concern that there will be another argument. Waiting

for the next argument to occur is just another uncertainty that Elizabeth feels she lacks control over.

Admittedly, their arguments are not constant and they are able to enjoy a lighthearted conversation about Elise or share a memory of life before baby and they both look forward to those conversations. This adds to Elizabeth's feelings of uncertainty because some conversations go really well and others become arguments. Their issues communicating arise when one of them needs something, or when one of them has different priorities than the other person. They are not able to expresses these needs or differing priorities without "pushing each others' buttons", as Edward put it. For Elizabeth, not communicating all her needs is also a way to control her own anxiety by avoiding conflict and confrontation. However, this creates a situation where Edward feels like he needs to make guesses, thus, worsening both the communication and support in their relationship. It is possible that Elizabeth and Edward could use their moments of enjoyable communication to model the way that they communicate when there is a potential for arguing, but this is not something that they can do on their own at this time and would likely need guidance.

Elizabeth and Edward view their relationship, and their roles in that relationship, from two very different perspectives. As a result of this, both Elizabeth and Edward are not supporting each other in the ways that they should be. It is not that their relationship lacks support in general. Instead, their relationship is one where the support that is offered and provided is not always the support that is being sought. In addition, they also admit that neither of them communicates their needs as well as they should. This has created a relationship where they both feel uncertainty from time to time and this uncertainty has created a space where neither of them feels comfortable consistently expressing their needs and neither of them feels fully supported.

These factors have influenced their experience of Elizabeth's postpartum depression because the uncertainty increases Elizabeth's anxiety. In turn, as Elizabeth's anxiety increases, the need for support and clear communication also increases, yet Elizabeth and Edward are still unable to fully meet those needs. However, despite their differing perspectives, they both continue to find ways to try and offer the support that they are capable of giving and to focus on their moments of communication that are not problematic. These practices give them both the hope that things can continue to improve in their future. They both express a desire to find ways to ease the uncertainty in their relationship, to the best of their own abilities. As Edward explains, "it isn't perfect, but it is us and it is working for us for now."

## A Difficult Relationship

### "We Don't Connect Any More": Donna and David's Experience

**Discordant support.** Donna and David have experienced a great deal of change since the birth of their first son, Dean. David had lost his job and decided to transition to becoming a stay at home Dad, a decision he was happy to have made. Donna continued working in her professional field and left all the home responsibilities to David, including nearly all of Dean's care. Donna experienced postpartum depression after Dean, however, she feels that her depression was more significant after the birth of their second son, Derek. After Derek was born, Donna decided that she wanted to stay home with the boys. This created a situation where David was forced to go back to work, even though he had found staying home to be a fulfilling experience. This change in their career paths also put a significant amount of financial strain upon the family. David's commute became a 4 hour round trip and with his 8-10 hour work days he admits that he sees little of the family now.

Also, when Donna became more deeply depressed after Derek was born, she began to distance herself from caring for the boys and from the needs of the household. Although this is much better now, it created a situation where David was feeling the stress of beginning a new career, being sleep deprived and still needing to shoulder most of the household concerns. David saw Donna as someone who was struggling and needed help, however he also resented her and the position he was being put into.

> Donna: He leaves pretty early in the morning, most days before 5am and when he gets home it is like 7 or 8pm. He is tired and he seems pissed off most of the time and tired. His commute is stressful, work is stressful, I get it. I think he is mad at me a lot of the time, but I haven't really figured out why. He was happier when he was at home, but we agreed that I would stay home this time. It just seems like overall, we are never on the same page anymore, like never. We don't have conversations once the boys go to bed, we don't talk quietly or touch each other, or smile very easily. Yesterday he came home from work. The boys were excited as soon as he pulled in the driveway. I was excited because there would be someone else here to help all weekend. I was more excited about you coming over today and wanting to talk than I am about David coming home. That is terrible. But yesterday when he came home, he came in the door, said hi to the boys and smiled and laughed with them for a minute and then looked at me and asked me when we were having dinner and if he had time for a shower first. No smile, not a 'How was your day?' Those are things I really need. I need David to be affectionate to me in order for me to feel affection for him. And when we don't have that level of intimacy, when everything becomes about just getting by, about just taking care of the boys, or just getting in a days work, or just getting dinner made and boxes packed, I don't have the energy or the will to find a way to make anything about David and I. Of course, I didn't ask him how his day was either. We both stopped having those moments at some point. I think in the beginning we were just really tired, everyone has that feeling with a newborn, but somewhere along the way we got past the tired part and the lack of intimacy and the space in our relationship has stayed.

Donna feels a distance from David that she has never felt before. She has a longing for the way they were before the children came into their lives and she misses the ease with which she and David used to interact with each other. To Donna their current interactions and relationship seems forced and lacking in intimacy and trust. They now have a relationship that revolves around the care of their household and their children and, in Donna's opinion, they have stopped supporting each other emotionally and physically. Donna has felt a significant change in

her relationship with David and it has deeply affected her. Donna relates this change to the birth of their children and the way in which their priorities and responsibilities changed. She does not see any reason why David should suddenly resent her or be upset with her. She does not mention her postpartum depression because she does not see it as a factor in the recent changes in her relationship with her husband. At this time, She does not see a path to repairing the problematic aspect of their relationship because she sees this as the place that their relationship has evolved to and they both lack the energy to change anything. She also feels that David, in a sense has abandoned her and is on his own path.

However for David, he feels the changes in their relationship came about because of Donna's response to becoming a stay-at-home mom and the amount of responsibility she still places onto him. He wonders if her inability to handle the care of the household and the boys is related to her postpartum depression or if it is related to an aspect of her personality that he has felt has always been present, even if Donna does not admit it.

> David: Most days it all boils down to a fight or to silence. I come home from work and I am tired as hell and she wants me to do something around the house, like make dinner or clean up something or help with bath time and I want to be like 'Are you fucking kidding me? I have been awake since 4 AM. I had a 4-hour round trip commute and a 10-hour workday. I am not giving the boys a fucking bath.' But I still do it and some nights I say no, grab something to eat and go to bed. Half the time I look at her and I think she looks frazzled, but I want to tell her that what she is doing is the easy part. Take a step back and enjoy it. She is doing better than she realizes she is. The boys are great kids and that is because of both of us. I feel like I should be the one that feels frazzled. I never feel relaxed any more. But I can't let that show. I can't be stressed out in front of Donna because I am not really sure she can handle it. If she isn't capable of doing this, I guess… I guess I resent it. I mean it might not be ok to say this, but I am pissed at her. I want to support her, but I can't get past feeling resentment toward her and the way she is handling it all. I helped a lot more at first, when she was initially diagnosed, but now, she has finished taking her meds, she refused therapy and she says she isn't depressed any more and I have to say, 'So this is just who you are now?'
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> Alyssa: And this is different from before?

> David: How can I say this…Donna has always been demanding, some might even say a bit bitchy, she has really high expectations of people and situations. She struggles with just going with the flow. I have always been more easy going. I just roll with it and I think that it was better when she was working and I was at home because her days were pretty controllable. Our patterns were more predictable. I stayed home and took care of the baby, she worked in town, so she was home by 5:30 every night. We made dinner together and on weekends we gave each other a break so we each spent time watching David and we each had time to ourselves. Now I live with a constant nagging. I want to head out and take the boys for a bike ride on the weekend and instead she has the day planned to the last second and blows right past my idea. I stopped trying. I just shut up and work. If I try, we fight. I am done on so many different levels.

David readily explains that he feels as though Donna is to blame for the issues that are currently impacting their relationship. There have been a number of role changes for them both and David feels that Donna has the easy part and he has taken on more and more. In a sense, Donna has let him down. From David's perspective, Donna's response to her transition to motherhood and her postpartum depression has left him feeling the brunt of the household responsibilities. He feels a complete lack of support from Donna. He cannot be physically present during the week because of his job, but he can strive to excel at his work to ensure that he remains well employed for the sake of the family. He is the sole breadwinner and he finds this a heavy burden to carry. However, despite everything he does do, David feels that Donna only wants more. To David, this has always been a part of Donna's personality, but it has become more complicated and more bothersome to him with the addition of their children to the family and the shift in responsibilities. At the very least David would like Donna to acknowledge all that he does do for her and the boys, but this does not happen. Instead they now share a household where they interact very little except to ensure that the boys are well taken care of each day. By asking the question, "So this is just who you are now?", David alludes to the idea that he does not see an end to Donna's current way of being in the world and that there is little chance of change in their relationship.

When she looks at where they were and where they are now, Donna also sees little hope of a change for the better.

> Alyssa: Can you explain to me how you would like things to be different because I am not getting a clear idea of that? Maybe even an example of something.
>
> Donna: It is hard to think of a concrete thing…So, I am trying to start a business from home related to mothers supporting mothers and helping people to find the resources that they need, but I never have the time to just sit down and work on it. It is important. It is to me. David doesn't care. Well he does, but he cares about it for financial reasons, we need the income. He doesn't care that it is just important for me. I am still in charge of cleaning up after dinner or whatever. He grabs something to eat and checks out. We don't sit and talk. Right now we are packing and I feel like I am literally doing all of it. From going through everything and throwing stuff out to packing the boxes to stacking stuff in the garage. Everything and I don't even want to move. He comes home during the week and nothing. On the weekends it is his time or his time with the boys. I do it all and I can't get to the stuff that I really want to do. I don't know how to explain it better than to say that it is very disappointing. I don't feel fulfilled. And a huge part of me puts that on David and him seeming not to care. And that is all he is to me now, the guy that goes to work and comes home, eats and sleeps. I don't feel like I am in this together with anyone.

There is a disconnect between Donna's priorities and David's availability to support her and this is ongoing. Donna wants to find something rewarding for herself to help her pull herself out of her depression. She feels that starting her own business is a way for her to feel a sense of purpose and will boost her self-esteem. As a woman who previously had a specific career path, Donna is used to completing projects and seeing her work make a significant difference. She does not feel the same connection to her daily work in the home and had hoped that her new ideas for starting a business would leave her feeling a sense of purpose. Instead, she is still left with the majority of the housework and she feels very isolated from the woman that she once was. To Donna, David has contributed to these feelings because he does not work with her to create a space for her needs. David is so preoccupied with his own priorities that Donna feels he completely dismisses hers. She does not feel any sense of a team-work approach to household

needs, a system that would allow her the time to focus on her own personal projects and priorities, and instead is left completing many tasks without any help or support.

Despite their marriage, both Donna and David feel very alone and disappointed in their situation and in each other. Unlike Alice and Albert and their supportive relationship, neither Donna, nor David, feels acknowledged or well supported by the other person. And, unlike Elizabeth and Edward and their uncertain relationship, neither Donna, nor David, knows how to turn the current pattern into a different situation. They do not have the confidence that it will improve. Their transition to parenthood and Donna's experience of postpartum depression created an environment where they both felt a heavy burden of responsibility and experienced a significant amount of change. In both their eyes, their relationship has gone from being one of mutual affection and creating enjoyable moments together, to one of necessity to care for their children and their household. This has been a difficult transition for them both and they have both decided that they cannot depend upon each other for support. Feeling unsupported only makes them both feel more upset and resentful of each other, leading to a need for more support that never comes, thus creating a circular relationship between a lack of support and feelings of resentment. Donna and David do not see an end in sight until something breaks this circle. But they both admit that they do not have the energy or the desire, at the moment, to find a way out of the cycle that they are currently in.

**Limited communication.** Before Donna and David had children and before Donna was diagnosed with postpartum depression they both feel that there was a lot of affection in their relationship. David admits that he enjoyed having long conversations with Donna about issues that came up at work and how they would brainstorm ways to fix them. It made him feel connected to Donna and kept him feeling involved with the creative aspects of his personality.

Even when Donna was still working after Dean was born, David felt that they were able to talk to each other without arguing and that they still had casual conversations in their day-to-day interactions. He still enjoyed going out with Donna for dinner downtown when they could find someone to watch Dean. Not everything was perfect all of the time, but they were able to have an argument, get over it, and keep going about their day and interact with each other with caring and affection.

David now admits that many of their conversations seem like arguments and when they do try and talk, the boys often interrupt or want to talk to and nothing gets done. But he still makes the point to explain that he does what he can to "leave the door open" for Donna, to allow her a way in if she wants one.

> Alyssa: Can you share an example of those communication problems?
>
> David: Umm, no, we've been really bad and just in the last couple of weeks it's been sort of, I think we're both realizing that we're not in the best place with our relationship right now. A lot of it is because of our issues that never get resolved, she says, and I feel, that she's very stressed out about this. It's just touchy. Because we aren't communicating everything is very touchy. I think I sent her an email, one over the last two days, and said, you know, we really need to spend ten minutes a day talking. We need to, we're going to get really more focused on our personal finances, now that we have to make this move, and we're getting a little tighter on income because of it. We're going to spend Mondays for a half an hour just reviewing our finances. Then I also had said, but you know, we need to spend at least ten minutes, five minutes for me to say, yeah, how was your day and five minutes for you do to the same. Maybe that turns into a half an hour, great. But it never gets started in the first place because neither of us ever sets the ball rolling. I can say, 'We should do this.' But it never plays out. I guess I make the suggestion because I know that in the past, it would have helped. But now, honestly, I am not so sure.
>
> Alyssa: And that is something that you are missing?
>
> David: Oh, for sure. Definitely a reason for our problems because I think we're both holding things in because we don't have time to talk about and we are avoiding an argument. Things get, instead of saying things, all of the sudden two weeks have gone by and then it's just; oh, would you just leave me alone about that or something. Then for just five minutes are just at each other's throats or something, like there is a real anger there. It never really gets resolved. We just kind of go our separate ways. That's what we have going on right now. We've digressed a little bit because that's maybe how it

> was, at a certain point then we got better at it somehow, but now it is the worst it has ever been. And even if I try and make an effort, it falls apart. I have to really remind myself, but lately I have been trying, I come home and ask her how her day went because we are not good at those conversations. We can talk about stuff that needs to get done. We can tell each other what to do, but we can't have a small conversation about ourselves. Donna is afraid of situations she can't control and those types of 'Hey how is it going' type of conversations can go in any direction and that is an unknown, especially for us these days.

David sees the faults in their current way of communicating. He even thinks that he may have found some ways to work on the issues. But after David takes the first step by asking for a few minutes each day where they can sit down and just talk about how their days went, they still cannot find the space to make that connection and they cannot find an idea for the second step. It is even becoming difficult for them to communicate about the things that are really important to running the household. They need to schedule time within their day to sit down and have those conversations. They make an actual appointment with each other on their daily schedule. However, those appointments are not kept and the conversations most often devolve into arguments. Not keeping the appointments is a reflection of how far apart they have become and how hectic things are within their home. There is also a lack of any casual conversation between them now. This is something that David saw as a hallmark of their lives before they had children. They truly enjoyed sitting and talking with each other. They no longer have this and David feels that this is directly related to Donna's postpartum depression and her need for control over every aspect of her life.

Motherhood and her depression have created a situation where Donna feels ongoing anxiety and she uses control as a means to cope with her depression. This has complicated many things in Donna and David's relationship, most notably that David feels constantly nagged, creating tension and resentment. As David previously explained, the nagging and the poor communication usually result in them being "at each other's throats" and Donna shared her

perspective on this as well. She explained that she bottles her frustrations up and when they come spilling out of her, it can easily get heated quickly.

> Donna: He doesn't have a response. He kind of walks away and won't talk to me. We actually got into it the other night because he kept telling me, "Settle down, settle down." And I won't settle down. You need to let me express this and you need to be okay with how I'm feeling and let me feel it. If I need to raise my voice to get you to understand, then you need to let me do that because I'm a stuffer. I stuff my stuff and then it explodes out of me. I think that's what happened the other night. He doesn't want to talk to me when I'm not in this calm and peaceful bubble. I can't always talk when I'm calm and peaceful because that's not when it's going to come out.

Further discussion with Donna revealed that she grew up in a household where her father was very strict and did not share his emotions and ruled the home with a totalitarian attitude. Her habit of bottling up her feelings and concerns comes from her experiences at home growing up. When she stops bottling it up and releases her feelings she wants to be able to express all her emotions as they come rushing out because as a young girl they were not allowed to speak unless spoken to first. When David tells her to relax and 'settle down' it increases her anger because she remembers her mother never speaking up for herself when speaking with her father. She does not want to become her mother and she does not want David to try and control her. She recognizes enough of her own patterns of behavior to attempt different ways of dealing with her emotions, but this has led to mixed results.

> Donna: I am a writer so I find if I write it down … I wrote him a letter. I didn't give it to him but I wrote him a letter so at least I can get it a little bit out of my mind, but I still need to talk to him about it. It's just hard too because we'll be having a quiet evening or something and I don't want to ruin that so I don't want to bring it up even though I know that he wants to talk. I don't know, it's hard for me to say, "Okay, well, remember, two Saturdays ago … " because he won't even remember. And two Saturdays ago I was actually really upset with him. We got into an argument about him not watching the boys and giving me time to work even though it was his turn to watch the kids so I could work and take a shower and just as I am about to jump into the shower he goes into the bathroom without letting me know and I am stuck watching the boys for like an hour. I tried to handle it in the moment instead of bringing it up later, but I have been so frustrated that it all came out. I got so upset and he won't even think that there's an issue. He would look at me and say, "Why do you even get bothered by that. I was just going to

> the bathroom?" For me, that little thing for him was a huge thing for me. When that happens there seems to be no way to an agreement. I don't think I should have to tone down how I feel about it and he can't bring himself to see it from my perspective, he just wants me to get over it. I am not going to get over it and then the discussion itself becomes a fight because it seems like we aren't even talking about the disagreement itself, but about how we both look at it.

Donna is not certain she can trust herself enough to not get emotional in her conversations with David and she does not want to lose control over the situation. When she does try to approach him and have a discussion, he regularly plays it down and she becomes increasing frustrated and vocal. Donna resents the idea that she cannot express her emotions with David as she wishes. When he questions her or tries to calm her down, she becomes more enraged. She does not want to calm down. She wants him to really 'hear' her. She also sees David's attempts to calm her down as a way for him to control her. This pattern of not feeling heard and being told to keep her emotions in check have played a role in Donna's postpartum depression. She kept her feelings and concerns bottled up in order to avoid conflict with David and avoid feeling brushed aside. This contributed to her not admitting her depressive symptoms when she began to become concerned for herself and delayed her seeking treatment. As a result of her depressive symptoms, Donna eventually lacked the energy to have any sort of conversation with David about anything. As a result, both Donna and David feel they are out of practice communicating with each other. Now that Donna is feeling better, they still struggle and they both question if they will be able to return to a time when they could converse more easily.

Donna and David have had many difficult changes and transitions in their lives over the last 2 years. They are in a place now where they are not connecting on an emotional level as they once did and this is creating tension in all aspects of their relationship. Neither of them feels appreciated or acknowledge by the other and this has resulted in a significant amount of resentment. Previously their relationship had moments of conflict, as all relationships do, but

they could find their way through them. Their recent experiences with parenthood, career changes, financial concerns and Donna's postpartum depression have created a space where they lack the energy to find new ways to cope and they feel overwhelmed by their role changes. The dissonance in their relationship is almost palpable within their home. They have stopped eating meals together. They divide their time caring for the boys and working, but have not carved out time to be together. The difference between Alice and Albert having difficulty finding time together and Donna and David struggling with this, is that Alice and Albert express a desire to find that time and Donna and David do not.

Donna and David's relationship has become one where energy is saved for completing the necessary household tasks and any attempts that one of them might make to create a more supportive environment at home or to improve their communication style, is often met with increased frustration and arguments. Right now, Donna and David cannot see a resolution to their current relationship issues and the stress of those issues is adding to Donna's concerns regarding her postpartum depression. However, it is still important to mention that Donna and David are still together. Donna's initial diagnosis of depression was after the birth of their first child, over three years ago. She was diagnosed again, after the birth of their second child who, at the time of their interview, was 22 months old. This struggle has been a part of their lives for 3 years and yet, they have not stepped away from their shared lives and they say that they are not currently headed for a separation or divorce. Divorce or separation is a possible outcome of the stress and strain placed upon a couple following the birth of a child and the diagnosis of postpartum depression. Two couples that expressed interest in joining this this study withdraw before they enrolled because they had decided to separate. Yet, right now, Donna and David are still moving forward together. Things are admittedly not easy and there is more distance in their

relationship, but there is also reassurance to be found in being together that may help them pull through this difficult time in their lives.

### Postpartum Depression and the Couple Relationship: A Circular Understanding

The literature on postpartum depression places the focus upon the maternal experience, thus creating a knowledge base that is grounded in the experience of the individual and has pushed the relational aspects of postpartum depression to the periphery. The birth of a child brings about many changes to a couple's household and relationship. They move from their lives as a dyad and into a unit of three, changing interactions within the couple, bringing about new challenges, practices and routines. The mothers and their partners had to adapt to new role responsibilities as parents and their relationships with each other changed as a result of these new roles. The diagnosis of maternal postpartum depression during this transitional time period can further impact the partner relationship.

Within this chapter, the lens has been turned toward the couple and their shared experience of maternal postpartum depression. A reciprocal relationship between postpartum depression and the couple relationship was evident. Each couple studied discussed the ways that their relationship was impacted by postpartum depression and the transition to parenthood, but they also revealed the ways that their relationship effected the mother's postpartum depression.

### Maternal Postpartum Depression and its Impact Upon the Couple Relationship

During the transition to parenthood couples must adapt and adjust as they shift from a coupled partnership into a family of three. Throughout the shared experience of pregnancy they begin to develop expectations of what parenting will be like and how their relationship may change and what roles they may need to take on. The symptoms and diagnosis of postpartum depression creates many unexpected concerns and requires that the couple make adjustments to

their planned parenting practices. It also brings with it feelings of disappointment, inadequacy, fear and sadness.

The couples discussed in this chapter had different experiences of maternal postpartum depression in their transition to parenthood. Each of the couples remained together, but they all responded to the stress of parenting and the mother's symptoms of depression differently. Alice and Albert and Elizabeth and Edward, responded to maternal postpartum depression in the same way that they have responded to other stressors in the past. As couples they took in the diagnosis and experience of maternal postpartum depression and it became a part of who they are in the world. For Alice and Albert, they remained in sync throughout the process, as they have in the past. Prior to having their daughter, Alice and Albert had a relationship that was built upon trust and mutual support and respect. As a result, they were able to lean on those strengths after Alice was diagnosed with depression. They worked together as a united front to help Alice through her darkest days. Following our interviews Alice explained that when she looked back upon those days, her postpartum depression might have been a blessing in disguise.

> Alyssa: In closure, is there anything else that you want to say about your experience? Anything that we haven't discussed yet?
>
> Alice: I want people to know that it can get better. That is why I work with the other moms online. I want them to know that they are having feelings that other people also have. And I think that the change, that change is something I can look back on positively. I have said this to people before, but it was a blessing in disguise. I learned to take time for myself, to stop being a martyr. We learned as a couple to focus on each other. To make sure the other is doing ok and is healthy. We are better together because of this experience. We were doing great before hand, but we are better versions of ourselves now. That is what I want people to know. That trying to get through this will get you to dig deep and get closer as a family.

The experience of Alice's postpartum depression allowed Alice and Albert to fine-tune their partner relationship. The stress of this experience allowed them both to realize how much

they are capable of us a couple. They came through the experience closer and with the realization that they can come together when faced with difficult experiences or stressful situations.

Elizabeth and Edward have a relationship that is very different from Alice and Albert's. They do not have the same cohesive history that was amplified by their experiences. In many aspects of their relationship and in the way that they handled Elizabeth's diagnosis, they are opposites. Elizabeth craves support and an emotional response from Edward. Edward sees his role as a support person as someone that provides for his family and finds ways to give tangible support, such as cooking and running errands. Elizabeth is an emotional person that seeks deeper connections with those around her, but struggles with voicing her concerns and her needs because she wants Edward to know her well enough to know her needs without asking. Edward does not know how to be that person for Elizabeth, but he still tries to support her in the ways that he can. However, these differences in their role expectations and in their needs and styles of communication have been a part of their relationship since before the birth of their daughter and before Elizabeth's diagnosis.

> Edward: When she was diagnosed it all made sense to me. I feel like this is just a part of Elizabeth's personality. Honestly the diagnosis didn't really surprise me. I don't think it has changed us all that much, except maybe that it made things seem more urgent for awhile or maybe it was hard for me to see her struggling. But I don't think it changed anything or I don't think we learned anything from the process other than knowing that this could happen again. We just pushed through as we always have. She has also become more vocal about letting me know what she needs without getting to the point of blowing up, but I still do what I can, just like I always have. I guess we came to realize that we grew up differently and even today we have different needs. That won't change, ever.

As a couple, moving through the process of coping with Elizabeth's depression highlighted the differences that already existed in their relationship. Edward explains that they are who they have always been. This may be hard for them at times because it makes coping

with change or concerns more difficult, but as they always have, they are still able to move through these times.

Finally, Donna and David had a different response to Donna's diagnosis of maternal postpartum depression. Unlike the other couples, Donna and David's relationship did change. Both explained that prior to Donna's diagnosis and having children they were very close as a couple and they saw eye-to-eye on the big decisions of their relationship. However, they now feel more pressure in their relationship and admit that they are not coping well with the changes in their lives since they became parents and Donna was diagnosed with her postpartum depression. Because things have been happening so quickly, they have not had to opportunity to cope with each change as it comes along and this has placed a lot of stress onto their relationship.

> Donna: I think we need to reestablish who we are as a couple because somewhere in all of this we have gotten lost in the day to day. But right now, we can't seem to figure out how to make that happen and I am worried that we are so far removed from who we were that we won't be able to make the changes that we need to get back to where we were. I don't think we will get back. I think we will get back to something different, we are different people.

Immediately following the birth of their first son Donna and David became even closer, leaning on each other for support and figuring out how to parent together. But, within a few weeks, as Donna began to struggle, the combination of the transition to parenthood and the concerns related to Donna's depression and their financial strains became more than they could bear. They responded by apart and finding themselves on two different paths. Perhaps, Donna's depression created a situation where they could no longer adapt to additional changes and their abilities to support each other and cope as a couple began to break down.

Due to the enrollment requirements for this study it was not possible to interview couples that were not living together. Therefore it is possible that there are couples experiencing even greater relationship discord, perhaps leading to separation or divorce. This was reflected by the

two couples that expressed interest in enrolling but separated before they could take part in this study. The research regarding major life events, stressors and depression show that relational discord occurs alongside stressful life events and can increase depressive symptoms (Kouros, Papp, & Cummings, 2008; Poyner-Del Vento & Cobb, 2011; Whitton, Stanley, Markman, & Baucom, 2008). It is therefore plausible that these same discordant relationships can occur during the major life event of the transition to parenthood and the diagnosis of maternal postpartum depression and have similar outcomes regarding increases in divorce and separation rates.

**The Couple Relationship and its Impact on Maternal Postpartum Depression**

This paper also sought to explain the effect that a couple's relationship can have upon their experience of maternal postpartum depression. In the previous section, it was shown that postpartum depression created a relational situation that allowed Alice and Albert to create a united front to overcome their concerns. They took up Alice's maternal postpartum depression and they responded with a relationship pattern of mutual support and unity. Alice explains that they learned a great deal about themselves as a couple during this time. However, it can also be said that Alice and Albert's relational foundation, which they cultivated throughout their relationship before the birth of their daughter, created a space for them to more readily cope with postpartum depression. Their relationship of support, mutual respect and unity allowed them to be aware of each other's needs and to be sensitive to subtle changes in the other person's behavior and respond. This awareness of each other, which they relied on in a time of family crisis, allowed them to look past their occasional annoyance and frustrations with each other and instead focus on the larger picture of making things work for their family and helping Alice overcome her postpartum depression.

Elizabeth's postpartum depression created a situation where Elizabeth and Edward were on uncertain ground. Early on in their relationship, Elizabeth and Edward had not planned on having children. The shift into parenthood may have created a situation where they did not have the coping mechanisms within their relationship present to help them both adjust as they needed, thus increasing Elizabeth's symptoms of depression. Their relationship lacked emotional support, as it always had, but after becoming a new mother, Elizabeth needed that support. Therefore, it is probable that after their initial transition to becoming new parents, Elizabeth and Edward had unmet and divergent expectations, thus creating turmoil in the relational pattern of their marriage and increasing Elizabeth's symptoms. It was only when they were both able to see that they could still relate to each other as they always had, that they were able to begin coping and Elizabeth began to feel that she was improving.

Donna and David felt that their experiences of maternal postpartum depression and the transition to parenthood changed who they were in their relationship and in the world. They experienced many role changes and outside stressors. However, before their transition and the decisions that they made to change careers and restructure the financial norm of their family, Donna and David had never really experienced any significant and stressful events together as a couple. Therefore, they had never faced something as significant as Donna's depression and the ways that their roles would change as they became parents and as a couple they lacked some of the coping skills, such as shared support, that were present in Alice and Albert's relationship.

## Conclusion

Overall, this study highlights the need to understand the couple relationship following the diagnosis of maternal postpartum depression. Couples must adjust and accommodate to the changes that they experience following their transition to becoming new parents. When the

diagnosis of maternal postpartum depression is also part of these changes, they must dig deep into their coping abilities in order to create a relational way of being where both partners can find safety, support and mutual respect.

Postpartum depression affected the couple relationships of the participants in this study by bringing to light the strengths and weaknesses and the similarities and differences already present in their marriages. In turn, the couple relationship also affected the ways that couples responded to postpartum depression and its symptoms. However, much more research must be done in order to fully understand this phenomenon. This study has shown that understanding maternal postpartum depression from the individual lens does not create a complete understanding of the ways that women and their partners experience this time in their lives. This study is only the stepping off point for a body of literature that should begin to turn its focus upon understanding maternal postpartum depression within the context of the partner relationship.

## Chapter Six: Expectations, Routines and Differences of Opinion: The Transition to Parenthood and Maternal Postpartum Depression

Prior to the birth of her child, a mother begins to develop expectations of what her delivery experience will be like, of the parent she will be, how her child will behave and how she will create a new family unit with her partner (Darvill, Skirton & Farrand, 2008). Expectations are complex and varied. They develop from previous life experiences, societal influence and familial factors. In the literature there has been a link examined between a mother's expectations and her experience of postpartum depression. Mothers with unmet expectations of partner support and infant temperament, have a higher risk of postpartum depression (Belsky et al. 1985; Whiffen & Johnson, 1998; Tulman & Fawcett, 2003). In the current body of research regarding postpartum depression, the mother's partner is seen as a factor in whether or not expectations are met. Partners are seen as a source of support and the quality of support has been identified as an influence on the development of depression.

However, it is important to recognize that couples co-create many of their expectations of pregnancy, parenthood and of their newborn child. Their shared transition to parenthood is a significant and expected life event that brings with it the need for many role changes and adjustments to household routines. With this transition the parenting couple makes adjustments and adaptations to their previously established habits, practices and expectations in order to make room in their lives and their home for their child. Some of these changes are purposefully chosen, such as the decision to exclusively breastfeed. Other changes evolve out of need, such as how they will cope with a routine that includes disrupted sleep.

Early on in their pregnancy, the couples in this study began to develop expectations of the habits and practices of parenting together. Some of these expectations were consciously created,

others were a part of the fabric of who they were and were not realized until something interrupted their transition. Couples sought out advice from health care professionals, they read books and searched online resources. They shared the news of their pregnancy with family and friends, who were often quick to share stories of their own experiences of pregnancy, birth and the first few months postpartum. Couples discussed their beliefs in child-care practices, their preferences for birth choices, and their expectations of their infant and their new roles as parents long before their child was born. All of these factors and more come together to influence their ideas of what parenthood will be for them as a couple. Although there was always concern and hope that everyone would make it through the process healthy and happy, couples felt that they were not well prepared for their experiences of postpartum depression.

As they brought home their newborns and began to adapt to their new schedules, they were focused on completing many of the necessary tasks at hand; feeding the baby, finding time to rest, returning back to work and establishing a new normal, everyday routine at home. They felt the ups and downs of bonding with and caring for a newborn baby. During this time of change, previously established expectations where played out. Couples began to recognize that not all of the expectations that they had created were turning out as planned. For some, breastfeeding was much more difficult than anticipated. For others parenting roles became unexpectedly blurred as one parent struggled with a lack of sleep or symptoms of anxiety and the other had to take on more infant care. And for each couple, an unexpected diagnosis of postpartum depression was a catalyst for changing how they were adjusting to their routine as new parents.

As the literature has shown, each of the couples felt that they had unmet expectations and that they encountered unexpected disruptions in their routines. Despite all their initial efforts,

they felt that they were not well prepared for all aspects of parenting, including coping with maternal postpartum depression. However, this did not always result in turmoil. Instead couples used their interpersonal relationship skills to re-examine and shift their expectations, and change their practices to make things work for them. Despite reports in the literature, couples did not believe that maternal postpartum depression created a parenting environment that harmed their child. They believed that together they were able to make adaptations that protected their child from any of the negative effects of postpartum depression that have been identified in the research. This was the central theme throughout the entire process of adjusting their lives to accommodate the needs of the child. The new child was a cherished and deeply loved addition to the family and therefore all of their sacrifices and struggles were worth the time and effort it took to try and make things work because it was all for the sake of their child.

Couples reported that it was especially difficult to adjust and adapt when their opinions on certain aspects of parenting differed. This created a potential for strife in their relationship, which in turn affected their ability to make smooth transitions in parenthood. However, they all felt that their partners were excellent parents and they trusted them with caring for their children. This was evident in the expressions of love that each couple shared in regards to their children.

The focus of this chapter will be upon developing an understanding of the interplay between a couple's expectations, how they made changes in their routines, their parenting practices and postpartum depression. The narratives of how couples created and shifted their expectations regarding parenting roles and practices and how they adjusted their routines and schedules and how they coped when their parenting views differed will be presented and examined. Paradigm couples will be used to highlight different phenomenon that were revealed through the interview and interpretation process.

## Creating and Managing Expectations

Expectations seemed to always linger in the background throughout pregnancy. One mother explained that they began to come on in waves for her when she started to feel her baby moving. She would find herself daydreaming of what her baby would look like, special moments that they would share and how wonderful her husband would be as a father. These "daydreams" began to solidify in her mind as her delivery date approached. Each of the participants in this study explained that they had many different types of expectations regarding parenthood before and after the birth of their child. They did not actively and purposefully create these expectations, but they developed over time from many different sources. Some of their expectations were viewed with a negative lens, such as the expected feeling of being unprepared for many aspects of infant care. Other expectations were feelings, emotions and new practices that parents looked forward to, such as reading favorite books to their babies, starting a small organic garden and making homemade baby food and the ways that caring for their newborn would strengthen their love for each other. The themes discussed in this section were the concerns and influencing factors that parents discussed most frequently.

### Family of Origin

The couples in this study each discussed the interplay of their expectations, their habits and practices and their families of origin. During the interview process, when the topic of discussion moved to their own transition to parenthood, each couple in this study talked about their relationships with their own families, both as children and as adults. As children growing up in their homes, with their parents, and taking hold of the traditions of their own family, they began to develop expectations of what it meant to be a parent and of how children should be raised. Upon marrying or committing to a life together, the couples merged many of their

expectations, borrowing from their familial traditions and parental influences to construct their new life as a couple. When they began to discuss starting a family, or learned they were pregnant, they also began immediately integrating their familial past into their expectations of parenthood and parenting. The ways in which their own parents interacted with them as children and as adults contributed to their expectations of how they would act as parents. For example, couples that reported having complicated relationships with their parents, or having parents that had tumultuous relationships with each other, had many more questions about how to parent their own child, and how to cope with unforeseen events that occurred postpartum. Couples that were close with their own parents and families growing up wanted to maintain those ties as they started their own families. Maintaining those close ties allowed the parents to have a source of constant support and valuable experience that helped them to cope when they needed advice on how to adjust and adapt to the changes that they were experiencing.

**Christine and Connor: close family ties.** Christine and Connor both reported having very close relationships with their parents. While growing up they both felt safe and loved by their parents. They developed rich relationship with their siblings and they both remain close to those siblings as adults. They currently live quite a distance from their families because Connor's career brought them to a new city. When Christine was younger she imagined having a family that would be similar to her own. She grew up in the Mid-West and her extended family was in close proximity to each other. They spent a great deal of time together, Sunday dinners, play-dates, and frequent trips made as a family. She had hoped that her own children would have the same experiences because she felt they were important to her own development. Connor had grown up in a family that moved often because of his father's work. They lived all over the world and although he was not close with all of his extended family, he was very close with his

parents and siblings. His immediate family had always been a source of security because they were a constant in his life growing up in an environment of frequent changes. It was his hope that his children would grow up near their grandparents.

Christine and Connor learned they were pregnant after several years of trying. The pregnancy was something that the entire family celebrated and because of this they immediately felt even closer to their parents. When they had their first child, they were living near Connor's parents and it was something that was important to them both. However, within a few weeks Connor lost his job and they had to move thousands of miles away from both of their extended families. This crushed both their expectations and they felt the loss of being grounded by their families and the close support they received. When discussing Christine's postpartum depression, they both felt that the unexpected distance from their families was a contributing factor.

Christine took this especially hard because she was staying home with their daughter and did not know anyone else in the area. As she explains…

> Christine: I honestly didn't think we would ever end up here. I had never been here before. I thought we would be living near Connor's parents or my family. This was like an 'out of the blue', not in a million years kind of thing. Growing up I was really close with my cousins, my sisters, my grandparents. I wanted that for my own kids. But what can you do? We needed money too and this was it. Connor came out first to get everything set up and I stayed with my parents. That is when my anxiety really started to take hold. Everyday I would call him and I would struggle with the idea of pulling myself out of my parents' house. It was a place I felt safe and supported. We went out to dinner one night and I stepped away from the table to call Connor and I was beside myself. I kept telling him I didn't think I could make the move, that I knew we had to, but I didn't know how I was going to do it. He didn't know what to tell me. I lost myself that night because I was really enjoying that night out. I realized I wasn't going to have those moments with my kids.

Christine sat in her living room as she shared this story. She began to wring her hands and bounce her knee. She looked over Connor's shoulder at a large arrangement of framed

photographs of her children playing. There were multiple photos of the kids with their grandparents, aunts, uncles and cousins. It has remained important to Christine to keep those reminders close by to keep a connection to her family. Her expectation was that her children would be close to their extended family members; instead she has had to focus upon keeping the ties close even when there is a significant distance separating them. She continues to feel the loss of having her family close, only now the loss that she feels is coupled with the loss she feels for her children because they do not have the familial relationships she had hoped for. She loves her children dearly and wants what is best for them. To Christine, this includes ongoing interactions with extended family to bring even more love and support into her children's lives.

Connor explains that when they were first married they had always hoped to travel. They met working overseas, both having sought out the adventure of the unknown when they were younger. However, they had always planned to settle down somewhere close to family. They expected this because family was something that was so important to them. Now they have to maintain close relationships through technology and regular visits. And for Connor and Christine that isn't the same thing. Connor feels this burden very strongly because he blames himself and his career for pulling them so far away.

> Connor: Growing up I was close with my parents. My sister and brother and I fought like hell, we were pretty close in age. You know, at some point, as an adult you start to think about your choices and you sit there and imagine your life spreading out in front of you and I imagined that my kids would grow up the same way. My dad was always really busy with work, he was an engineer, but I never felt a distance from him. I have been working my fingers to the bone since we moved here and I feel this gap between the kids and me. I feel like I live here, but like not in the way I pictured. I feel like I come home and there is this whole world that I am like tangential to it. There are jokes going around that someone needs to explain to me. Today I got home and they had this thing going on with like these silly noises or whatever and instead of getting into it, I was getting annoyed. And looking at that, I get pissed at myself. I could have just decided to think it was funny; instead I wanted them to stop. I can't really explain it. Growing up my dad was gone a lot, working on projects. But when he came home, he was home. You know. I don't know how he did it, but he left it at the door and I always felt like he had all the

> time in the world for me. Now, I come home and I am still working. This tech start-up shit never stops. I work with kids and so I don't get to spend anytime with my own. And maybe it is because the nature of my work is so different. Deadlines are fast and furious and because we are doing so much project planning it needs to be done when it needs to be done, whether I want to play with my kids or not. I would love to have my dad here and just be like "How the hell did you do it?" I mean the phones calls are all about what is really going on, like who can tie their shoes, who has a funny new story to tell.

Connor looked closely at Christine as he shared what he had hoped for. She smiled back at him quietly nodding. It became increasingly obvious that they had both been truly disappointed by the loss of having family close. For Christine this directly contributed to her postpartum anxiety, but for Connor it impacted his entire understanding of fatherhood. He had the expectation that his dad would be there to help him through this process and he feels like the phone calls and the video-chats aren't working out for him. His family of origin was a source of support, safety and strength for Connor. As he continues in his stressful career path, trying to balance family and work, he wants to have his parents close.

Christine and Connor both sincerely enjoyed traveling and working far away from their families as young professionals. However, becoming parents changed their expectations for familial bonds. They looked back on their own childhoods, times that they both remember fondly, and created expectations that their own children would have the same experiences. Their expectations signify that they believe family was an integral part of them developing into the adults that they are now. It also signifies that they believe that family creates a safe and supportive environment, the best kind of atmosphere to raise children. Because of the love that they have for their children, Christine and Connor want what is best for them, as parents often do. Because they cannot have their children in that environment at this time, they are trying hard to create the environment and the connections in other ways.

> Christine: I call my mom every day, really. I have her talk to the kids. I talk to her. I ask for her input a lot. You know like, this is what is happening, what would you do? Right

> now Carrie is being a handful when we are at the playground. She is acting out like crazy and I have no idea why, it is a totally new thing for her. She threw sand at a kid the other day. And I have to tell you, these Moms around here are like striving for perfection about everything, about their kids, about themselves, and sometimes I feel like I have the kid that eats paste. (Laughter) But really, my kid is just a normal kid. And that is what my mom reminds me of often. She keeps me grounded. I sit there and go over and over it in my head. Seeing her throw the sand, seeing the other kid crying, the looks the other mom gave me, no matter how many times I apologized. She made me feel like a terrible mom. But I called my mom and she told me this funny story about a time that I put gum in some kid's hair and it helped me see things from a different angle. My mom makes me laugh, but those talks are so important to me. I really want to sit here have coffee with them everyday, watch the kids play together in the living room. Share stories and advice. Instead I feel like I am constantly competing with the other moms in the neighborhood. I put on makeup to go to the playground up the street. I mean what the hell is that all about? I don't get the support I need from them, but I also don't want the judgment.
>
> Connor: They aren't judging you. You are judging you.
>
> Christine: Maybe, maybe. But I still wish I could sit down with my Mom and Cadi and have the kids be really close. I think we both wanted that.

Christine finds that her mother is a source of comfort for her when she is struggling. She also feels a concrete loss because she cannot live out her imagined fantasy of having her sister and her mother be there with her on a day-to-day basis. Connor reminds Christine that she places a lot of these expectations for "perfect" motherhood upon herself. In a sense, Christine knows this, but she is unable to help making constant comparisons because she is seeking a connection with the other women at the playground. She feels that if her mother and her sister were closer, they would be the connection to other moms that she needs, they would be the buffer against her negative feelings she has about herself. Just as Conner did, Christine expected a stronger support system to help her work through the questions she had regarding parenting and taking care of her children.

Connor and Christine have positive memories of their childhood and still look to their families as their primary support systems. Together they integrated their positive emotional attachments to their families into their expectations for early parenthood. They see their parents

as an ideal, as role models for the type of parents that they hope to be and as a significant aspect of their support system. They expected to remain close and to have their families in their everyday lives. Because this has not played out as planned, they have both struggled with this loss and have found temporary ways to maintain that closeness. The primary placement of family photos, the frequent phone calls and the twice yearly visits are not a substitute that they feel takes the place of their ideal situation, but they are what they have for now and so they have made them dear parts of their family life.

**Felicia and Frank: wanting to be different.** Unlike Christine and Connor, Felicia and Frank looked at their relationships with their parents and realized that they wanted to be different kinds of parents. Looking back upon their childhoods created feelings of missing out on an emotional attachment and a sense of distance from their parents. They both decided early on that they expected to be a more integral part in their son's daily life. They wanted to foster an attachment with him that was strong and provided him with a sense of emotional safety and an environment of stability. They turned to books that focused on "attachment parenting" methods as a technique for raising Finn. For Felicia this grew out of a childhood with a mother that she thought was "flighty" and prone to changing things on a whim; a reality that left her feeling that she could not rely on her mother for consistency and support. For Frank, he grew up in a home where his parents had, what he describes as, an obvious disdain for each other. As a young child, this made Frank feel like he was responsible for bringing his parents happiness, a task he was always failing at and a role he still feels some responsibility for.

As parents they wanted Finn to feel none of this uncertainty and they did not want him to have a sense of responsibility beyond his years. As a result they had the expectation to create a home that was very different from the homes that they grew up in. They wanted Finn to grow up

in a home where he felt loved and safe and where he could be an unworried and easygoing child. Felicia and Frank would joke back and forth about their parents, rolling their eyes and giggling as they shared stories that they thought were ridiculous. In a sense it was something that they had bonded over and they did not dwell on the possibility of sadness or anger and instead found a way to channel that energy into something different. Felicia had turned to holistic healing methods and Frank had developed his musical talents at a young age. This allowed them to create a home very different from their childhood homes and that was filled with laughter, security and what Felicia called "juicy expression".

> Frank: I knew early on in high school that my parents had a difficult relationship. I knew it before then, but it didn't hit me until I started spending time at other people's houses, like sleeping over at a friend's house or whatever. Then I saw how my friends' parents would interact with each other. I really began to understand it all then and I resented a lot of the shit I had gone through. I was a stereotypical angry white kid for a long time. So when we started to talk about having kids, I didn't want to have the kind of home that left that on my kids. When things got tough after Finn was born, I found myself getting frustrated a lot and so I had to turn to other ways of getting over it because I didn't want any of that to be something that Finn picked up on. I wanted it to be easy. I know you are hoping for specific stories, but it is hard for me to think of that time like that. I don't really remember specific things, like specific moments, other than that. Honestly, it was like being in a survival mode and that whole time I was just trying to keep things under control. It all blends into one memory, like I don't remember from day to day. But I remember the feeling. I just kept evaluating the whole thing and saying 'Don't let this go in that direction.' I was trying really hard to not become my parents.
>
> Alyssa: It is ok.
>
> Felicia: We were both in this weird 'Is this normal?' phase. And we were trying really hard to keep things feeling open and supportive. We'd go out for a walk every day. You'd play music for me too. That made me feel better. You played some guitar. He'd play music for me sometimes. Or we would play music … we'd sing and stuff. We'd play music and sing. He did all the cooking, but we had a lot of friends bringing stuff too. I remember feeling supported, but there is something about that time in your life that you feel like you want to turn to your own mother. I knew I couldn't really depend on her and so that was hard for me.

During their transition to becoming parents, both Felicia and Frank, found themselves reflecting back upon their own relationships with their parents. The main thing they took from

those moments of reflection was the need to foster a different experience for them and for Finn. They explain that they still experience feelings of frustration on a day-to-day basis, but they communicate their frustrations and make every effort to shield Finn from those moments. They turn to different mechanisms than their parents did. Frank revealed that his parents tended to shut down and that made the whole house feel like they were walking on eggshells. So he does his best to include Felicia in the discussion when he is struggling. Felicia explained that it was just she and her mom growing up, but that her mom seemed to always be focused on being friends with her. This is not the relationship that Felicia needed with her mom. She needed more stability, more support and guidance, and because she did not get that as a child, she feels she cannot depend on her mom for that as an adult. To fill the void left by her rocky relationship with her mother, Felicia depends upon Frank and the relationships she has built with her female friends that are also mothers.

They incorporated practices and skills that they had developed to cope with their own parental relationships into their relationship as a couple. They added physical activity, they sang and played music together, they opened their home to friends and holistic health practitioners, and they always included Finn. They wanted to expose him to what they felt were healthy coping mechanisms from day one. They researched birth methods and decided upon a home birth. They created a network of like-minded friends and support people to come to their home and help them through that process. This was a practice that they felt would empower them as parents and would bring Finn into a world where home was a central focus. Instead of focusing on the negative aspects of their relationships with their parents, they created a home that was warm, consistent and different from the ones they grew up in.

> Felicia: I do still talk with my mom and of course I told her when we were pregnant and shared a lot about what was happening at every step with her. I don't hate my mom, I just

> don't see her as my best advocate. When I eventually explained the home birth idea, she thought I was insane. I was surprised because she was sort of hippy-dippy growing up, but apparently this was even too far out there for her. I tried to tell her that it was really safe, that I was really healthy and so was the baby, but she still thought I was nuts. It was important for us to do this at home. I was really anxious about giving birth and being at home seemed like a way to feel safe and to have something warm and familiar there at the same time.

As she explained this decision, Felicia was breastfeeding Finn, who had just woken up from a nap. She smiled at him as she talked and twirled her finger in his grasped hand. Frank sat quietly on the couch, relaxed with his shoulders down and his head back against the back of the couch. There was a peacefulness that felt palpable. The living room was open and filled with light and bright colors. There were wooden children's toys tucked into the corners of the room. There were framed pictures of doodles that Finn had made hung up along with large framed art posters and record album covers. For their family, this was the safest place in the world, the central feature of their support structure. Finn's presence in their lives was apparent throughout their home, from the bucket of cloth diapers on the front porch, to the children's toys strewn across the backyard. There was nothing in their home that was off limits to Finn and he was the most celebrated member of their little family.

Felicia's anxiety about giving birth is an emotion shared by many women, many women that also choose to have their deliveries in hospitals and medical centers. For those women, the medical support that they find in those institutions is a great source of comfort. Instead Felecia developed a trust in Frank and an emotional association to the home that they had created together. This was not an emotion she experienced growing up, but she had found it as an adult. She wanted to ground her family in that feeling; she wanted to ensure that Finn felt the same way as a child growing up in their home. To ensure this, she brought Finn into the world in the space that she and Frank had created together that she considered an extension of their familial love

and safety. Frank and Felicia continued to cultivate this space, to fill it with their love. This was something that required their time and effort, and there were times when it was a struggle, especially when coping with Felicia's postpartum depression, but they worked through it together for the sake of Finn.

The couples in this study often spoke of their relationships with their parents and siblings when they shared stories of parenting and their own relationships. Their families of origin played a large role in the relationships that they had fostered as adults and in the creation of their expectations of what it meant to be parents and what it meant to create a safe and supportive home for their children. One aspect of the way that they created their identities as parents and spouses was by either modeling or rejecting the habits, practices and environments that they were exposed to as children and young adults living with their parents. The coping mechanisms that they developed early on, such as turning to creative outlets or discussing troubling concerns with their parents, continued into their homes and their parental practices as adults. It was not always easy to adapt to their new routines with their children, but they used the skills that they previously learned from their families to aid them through this life transition. For the parents in this study, the struggles they faced during their transition were a minor sacrifice to ensure the happiness and safety of their children.

**Societal Influences**

Upon learning that they would be new parents, the couples in this study began to feel pressure to do what was "right" for their children and their families. This desire to do what was best for their children arose from their deep affection and their strong instinct to protect their newborns. Participant couples felt like some of this pressure came from societal influences outside their home. They felt pressure regarding their decisions to breastfeed or vaccinate their

children. They felt pressure to provide a financially secure home. With these pressures, they were often surprised at how engendered their expectations for themselves were. Fathers reported feeling an expectation to ensure the financial security of their growing families, even when their partners were also working. There was also an expectation that mothers would be responsible for more of the everyday care of the newborn, even when couples felt that their relationships were egalitarian in nature. For example, it was expected that mother's would wake for the majority of night feedings because newborn feeding, whether by breast or bottle, seemed to be a task that was associated with maternal care.

**Betty and Bob: The pressure to provide.** Betty and Bob both enjoyed their careers. They had the expectation that, following the birth of Bekah, they would both go back to work. In her professional career, Betty actually made more money than Bob. This was not an issue for them; it was just a matter of fact. They combined their incomes and maintained and provided for their household from one account. They admitted that there was never a feeling that 'this is my money and this is your money'. But when they learned that they were pregnant, Bob explained that he felt a significant amount of pressure to ensure that the family was well provided for and that they were financially secure. This surprised him because it had never really been a concern for him before. Betty also explains that she was surprised by her own expectation that she did not want to have to deal with any of the family's financial concerns she was on maternity leave. Prior to having Bekah, Betty was responsible for managing the household account and paying the bills. However, with the birth of her daughter, her concerns became focused on Bekah and she did not want to deal with anything else. Bob sought out an advancement at work and transitioned into a new role within the first few weeks after Bekah was born with the goal of

helping them be more financially secure. In hindsight he feels this was not the right time for that move, but he was searching for ways to provide security.

> Bob: So ya, at some point during the pregnancy I started really thinking about Betty's maternity leave. She would still be getting part of her salary, but it wouldn't be the full amount and as I thought more and more about that, I started to feel like, 'I need to fix that.' I don't know where it was really coming from; overall we were going to be fine. But I felt like we needed to be more than fine and I needed to make sure that happened. So I took the exam and made the move. Not sure, looking back it was the right time because it changed a lot of my work responsibilities, which changed my schedule here at home. But I was so focused on making sure we had enough money. I was on a mission (laughs). That is out there right. Dad brings home the dough. Our relationship was never like that. But I felt more responsibility to be that Dad. I also think there is this feeling, as the dad, when your wife is pregnant and when you have a new baby, that a lot of stuff is out of your control. This was something that I could get a handle on and so I expected a lot of myself in those months. I even picked up a lot of extra overnight shifts before Bekah was born. I wanted that cushion.

Bob created high expectations for himself as a provider for his family. He and Betty were going to be fine financially, but he felt a pressure to ensure that they were better off after Bekah was born than before. He saw this role as his responsibility, as a father and a husband. The message that the "man must provide" was "out there" in the world around them and this created a feeling of urgency for Bob. His desire to create an environment for Bekah that was more secure was an extension of the love and concern he had for her. He wanted things to be better for her than they were for them as a couple.

There are a lot of unknowns when a person becomes a parent for the first time. Bob and Betty had a lot of the normal concerns that new parents feel at this time. Bob was trying to support Betty emotionally and financially, but he felt overwhelmed by her emotional needs and he focused on the tasks that he could accomplish. Bob did what he could to respond to all of Betty's requests for help, staying up late with Bekah, setting up Betty's "lactation stations" all over the house, but the one thing he felt he had the most control over was taking care of the family financially. From the pregnancy through the postpartum period and their concerns related

to Betty's depression, Bob held fast to the role he had taken on, he would ensure the financial security of the family, despite the turmoil.

> Betty: I would ask him to do really specific things for me to be able to make it through the day. Like put water and snacks at each station and most of the time he would do it. I would actually get really upset when he didn't do it. I remember one night early on, I was up around 2 am with Bekah and I went into the living room to sit on the couch and feed her. I always got really hungry and thirsty when I was breastfeeding. I didn't like to turn the lights on because I didn't want to wake Bekah up like all the way. And I reached for a water and it was the half empty bottle from the night before and there wasn't a snack out. I was so mad. I was obsessed with those lactation stations being just right all the time. But I remember him being in and out of the house a lot at that point. His previous work schedule was like 3 or 4 shifts a week and he worked graveyard then. So he was home a lot during the day. Which was great because before Bekah, he was able to get a lot of things done around the house while I was at work. It was always a joke between us that Bob was the homemaker in the family. My schedule was the standard Monday through Friday kind and I worked long hours and I think I had the expectation that Bob would keep up with the household stuff after Bekah and my focus would be on the baby. But he was working more. We were both exhausted and not sleeping well. I will freely admit that he still does more than I do around the house. But his focus had shifted a bit.

While Betty was discussing this, Bob was in the kitchen preparing a spaghetti dinner, something Betty explained was a go-to quick and easy weekday dinner that he made often. Betty was sitting in front of Bekah, who was in her high chair, and was feeding her dinner. She was multitasking answering interview questions, interacting with Bekah and regularly responding to questions from Bob from the kitchen. To an outsider looking in, this was a seamless operation. But as both Bob and Betty explained in their interviews, there was a lot going on under the surface and it took them nearly a year to get to this point. Betty felt like a lot of things were out of control in the beginning between her depression and her anxiety and she fixated on certain aspects of her daily routine. She needed Bob to help her create the controlled environment that she needed. However, Bob had placed the highest importance on his role to provide for his family, and many things were missed as a result.

During their most stressful periods, Bob took on as many of the responsibilities that they expected to be Betty's, as he was capable of doing. Their original assumption, based on their household division of labor before Bekah, was that there would continue to be an equal division of baby care and household responsibilities. They expected, that for the most part, Bob would continue with taking care of the household and Betty would take care of the baby. However, as they felt the pressure of their roles and they developed concerns related to Betty's depression, more and more of the responsibilities fell on Bob's shoulders.

This was difficult for Bob, but he took a "logical approach" and did "what needed to be done". Bob felt that there wasn't any other option. If he didn't do it, who would? He wanted Betty to have the space and support that she needed to feel better. He wanted their daughter to have what she needed, so he threw himself into being successful at work and into caring for Bekah when he was home. These were the ways he could care for Betty and Bekah and he would do everything he could to ensure that they were well taken care of. This was the role he had expected to take on, protector and provider. Although it did not go exactly as planned, he eventually found the best way to provide those things for his family. This afforded Betty the support and time that she needed to recover from her postpartum depression and it allowed her the flexibility to take a part-time position at work following her maternity leave. This part-time position was something that Betty considered to be central to her ability to follow thorough with her postpartum depression therapy and to bond with Bekah. Bob's sacrifice created the security that they needed at this difficult time in their transition.

**Elizabeth and Edward: breastfeeding.** The pressure that parents felt to breastfeed was significant for the couples in this study. They discussed the pressure to practice exclusive breastfeeding as something they felt from the societal norms surrounding birth and newborn care.

They felt disappointed when breastfeeding was difficult and they received mixed signals from pediatricians, obstetricians and psychiatrists who the couples felt had conflicting views on what was best for the baby and best for the mother. Overall, disappointment in the expectations related to breastfeeding was one of the most discussed topics during the interview process.

Elizabeth had always planned to breastfeed her children, even before she knew if she was going to have any. It was just an expected thing. She knew that breastfeeding was the best thing for children. She had friends who had children and they had all breastfed. She and Edward had nieces and nephews and they were all exclusively breastfed. Elizabeth was a well-educated woman, with well-educated friends and family and in her inner circle it was an expectation that women were informed of the benefits and would choose to breastfeed because it was best for the baby and for bonding. Breastfeeding had been successful for Elizabeth's friends and family. She also believed that it was natural and therefore Elizabeth expected to be successful when she breastfed Elise. Instead it was a struggle from day one.

> Elizabeth: I wanted to do it, I wanted it to work out, but the truth was, it didn't. Elise had trouble latching, I had trouble producing enough milk. We went to see lactation nurses, we had a follow up visit with the pediatrician and she wasn't gaining any weight and I was like, this isn't happening. And actually I kind of hated it. I felt very stuck when I was trying so hard to breastfeed, I felt like she was always attached to me. You never have any time to yourself at that point. I never had the chance to get away from her. I needed a break. I was frustrated at first. I wanted to breastfeed her because I just kept hearing that it was what I needed to do and it was what I had planned. I told my mother that it wasn't working out and I got an earful about how I just needed to stick to it through the hard part. Our pediatrician wanted me to keep with it, recommending additional consultations with the lactation nurses and writing me a prescription for a hospital grade breast pump so the insurance would cover it. But my therapist was saying that I had to do what was best for us as a family. But there was a lot of guilt and feeling of failure at that point when I stopped breastfeeding early on. I think it was a weeknight because I was taking care of Elise overnight by myself. I was having a hard time. I was deliriously tired, like not seeing straight tired. I was trying to feed her and it was taking like an hour and I just thought, 'I can't do this any more'. She was crying and I was crying and the next morning I had Edward go and buy formula. And the most f'ed up part was that I was doing something right for our family and every time I went to buy her the formula I felt

> guilty. I felt like other people were staring at me and thinking I was a bad mom. I got over it eventually, but it was hard.

Sitting in her living room, explaining her struggles with breastfeeding, Elizabeth still looked uncomfortable. She made very little eye contact and she looked down at her hands frequently, becoming tearful at times. Edward reached over and rubbed her shoulder. Breastfeeding was such a weighted topic to Elizabeth and she associated breastfeeding with being a good mother. She loved her daughter very much and wanted to give her the best start at life that she could. All the experts agreed that breastfeeding was what was best for children and her inability to "stick to it" as her mother had told her to, made her feel inadequate and selfish. Because she could not fulfill the expectation to breastfeed, she felt betrayed by her own body, frustrated with the mixed messages and ashamed to feed her baby formula.

> Edward: We both admitted that it was a really hard decision. It wasn't something we did lightly. When you are on the online parenting forums people actually have the balls to call it "poison". So then we turn around and feed Elise formula and you can't help but think it is the wrong decision. My expectation wasn't that Elizabeth keep doing something that was such a 24-hour a day struggle. But I really thought breastfeeding would be easy, it would be the natural thing. No need to go buy anything, it just happens. Mom and baby would figure it out. But when it wasn't, all I wanted was a happy and healthy family. However we got there. But people judge, do they ever. People did look at us. She isn't making that up. This area of the country is filled with breastfeeding Nazis and those women are mean when you finally give it up.

The practice of feeding Elise when she was hungry and ensuring that she was adequately fed was Edward's biggest concern. He had thought it would be through breastfeeding because he knew other women that had breastfed their children and because he knew it was a natural thing. Edward made the assumption that natural would be easy. However, when it did not work out, he was only upset by the way that he perceived they were judged for using formula. He was not upset with Elizabeth or her decision. He wanted to make sure that his wife and his daughter were healthy and if that was going to be achieved with formula feeding then he was happy with that

decision. In this study this sentiment was repeated frequently. The fathers in the study felt that the ultimate decision to breastfeed or not was to be made by the mothers and even if they felt disappointment, they would never think to voice it to their partners. Their greatest expectation was that their partners would get healthy and that their babies would be fed, formula or breast milk, it did not really matter to them in the long run. This sentiment from the fathers was a reflection of the concern and love that they had for their partners and their newborn children.

For the couples in this study, societal pressures played a significant role in creating their expectations for establishing a safe home environment and for how they would care for their children. For Bob, he felt the immediate pressure to be a provider for his family. He had never felt this pressure as a husband, but as a father, it became a driving force in his decisions. He saw the role of father as a supporter and a provider, an image he had seen played out over and over again. For Elizabeth, society labeled breastfeeding as the best thing she could do for her child as a mother. Edward saw it as something that was natural and therefore should be easy. But when they struggled, those societal pressures to do one thing made them feel labeled as wrong or as harming their child because they wanted to ensure that Elise was well fed and therefore did something different from what was considered the ideal.

Couples felt pressure to be the best parents and to always make the right choices. This often surprised them, but they still found themselves comparing their childcare practices and their decisions with what others around them were doing. As a result, there was often distress when they felt they were not meeting the standard that society had set for new parents. This distress was rooted in their feelings that they would never want society to judge them as parents that did not care for their children enough or in the right way. They made sacrifices and struggled both emotionally or physically because they had a profound love for their children and they

wanted to ensure that their children started their lives in the best position possible for happiness and success.

**Prior Loss**

Previous experiences, especially prior loss, weighed heavily on the parents as they made their transition to parenthood and took part in the day to day routine of caring for their newborn. While each couple mentioned some form of loss in their interviews, there was a wide range of loss experiences that played a role in their transition. For some, with the diagnosis of maternal postpartum depression there was a loss of an idealized transition to parenthood that was only felt when they looked back in reflection. Seven of the couples in this study mentioned the loss of loved family members or the loss of a prior pregnancy. They thought of their lost loved ones often and wondered how their loved ones would interact with their new baby. They kept mementos of their loved ones close by and would talk about them with their children, even before the children could truly understand what they were saying. As their family grew larger, it was important to incorporate the memory of lost loved ones into their routines. Previous pregnancy loss was also often looked back upon during their pregnancy and the early postpartum period, with thoughts of "What if?" often sneaking into quiet moments shared with their newborn infants.

**Hanna and Hank: expecting the worst.** Hanna and Hank experienced many losses before the birth of their daughter Holly. Hank's mother passed away while Hanna was pregnant, an unexpected loss that continued to remain in the forefront even when Holly was nearly a year old. Hanna explained that she continued to feel a great loss when she thought of Hank's mother. She described it as almost a feeling of emptiness.

> Hanna: I still get emotional about this. Hank's mom was a wonderful woman and I loved her so dearly. Knowing that she was sick during my pregnancy left me with feelings of

> anxiety and I always thought that the worst was right around the corner. She died before Holly was born. She was so insanely excited that we were pregnant. She would call almost everyday and ask how I was feeling. She was so far away, I think I regret that a lot. I only saw her once while I was pregnant. I really wanted her to meet Holly. I wanted to have that memory of her holding her and smiling and playing with her. I still sit and imagine what she would think of Holly. I hear things that she had said in my head as I care for Holly. I got to see her interact with Hank's brothers' kids and so I have somewhat of an idea. I find myself using her advice. But really I just miss her so much. For a long time it felt like a hole in my center, like someone cut something out of me. I think I felt her loss even harder than Hank. She was my role model for being a mom and I really wanted to have her here. I still feel the loss of her everyday. I mourn for her interaction with Holly, just was much as I actually mourn for her. Does that make sense?

Hanna expected to have the same opportunity to create memories with her mother-in-law and her daughter that her nieces and nephews had. She wanted the emotional connection and the support from Hank's mom that she had always had from her. As she cares for Holly and experiences the excitement of Holly's milestones, she also mourns for the loss of sharing those moments with Hank's mom. To keep her memory present, they have small mementos of her in Holly's room. Because Hank's mom knew they were pregnant before she passed away, she sent small gifts for the baby. They have a beloved teddy bear that sits on a bookshelf in Holly's room. Hanna brought the bear into the living room during her interview and explained that she makes a regular habit out of telling Holly that it is "Grandma's Bear". Even though Holly cannot understand what Hanna is talking about yet, Hanna still does what she can to mention Grandma everyday.

Hank explained that he thought Hanna felt this loss so significantly because they also had a previous miscarriage. They miscarried at 15 weeks, after they had told people they were expecting. He discussed how excited his mother had been and about how supportive she had been when they experienced the loss of their first pregnancy.

> Hank: My mom was the first phone call I made that day. I was away on business and I had to travel back home. So I called my mom and I told her and I asked her to call Hanna and talk to her because I couldn't be there. It was the best I could do. That really

> strengthened their relationship. When my mother passed away and we were pregnant again, it brought a lot back for Hanna emotionally. We were much further along in the pregnancy, but I think she had some sort of flashback happening when my mom died. I think she immediately started to feel more anxious about the baby. Holly was born a few weeks early, but she did really well. Hanna had a hard time accepting for a long time that there was nothing wrong with Holly. She was always expecting something terrible to happen. Like right now, she is still that way. Holly wakes up from a nap and Hanna immediately hears her making noises on the monitor and she runs right in. I am like "Babe, let her be. She is fine. Let her do her thing for a bit." But Hanna always moves off the couch or out of bed with the first sound. She has a hard time not always having eyes on Holly. She has so much anxiety over her and always thinks something is going to go wrong. She needed my mom to bounce thoughts off of. I am not much help. Holly was my first too. I am like fireman Hank, I want to run into the fire and fix everything, but there was a lot I can't fix. I could use my mom for advice too. Like how to help Hanna.

As Hank shared this he shook his head multiple times and frowned slightly from time to time. He still feels their losses as well, but he also feels the loss of his own ability to fix what is wrong. He wants to keep Hanna happy and he wants her to see that Holly is a healthy and very happy baby. If Hank's mom were around to answer questions and give advice to them, things would be easier than they have been. Hank believes that Hanna would not be as focused on the anxiety that she feels because she could get reassurance that Holly is behaving normally. Because Hanna is always expecting the worst to happen, she looks for little details and obsesses over them. Hank has a hard time convincing her that everything is fine because she wants the expertise of someone who has done it all before.

> Hanna: I do think of the miscarriage often. It was an emotionally dark place to be and actually it was also pretty painful. Hank wasn't here and I had to go to the clinic alone. When they said there wasn't a heartbeat it was like everything around me went black. I fell into a hole and having Hank's mom on the phone when they did the procedure made a huge difference. I shouldn't hold it against him, but I am still upset with Hank for not being there. I don't like it when he travels for work. When he says he has a trip coming up I kind of freak out. My anxiety level goes from high to out of control. Each time he leaves I think something is going to happen and I relive what happened before. But when I do that I am also reminded of her and although it is bittersweet and sad, there is something there that feels stronger.

Hank's mother is an anchor that they both expected to have in their lives when they had children. Her memory is an anchor to them now as they raise Holly together. They try to keep her memory alive in their home, but even without the photos of her and the gifts that she gave to Holly, she left a legacy that they both old onto. Her protection in their previous loss and her support in their darkest time are still memories that they hold onto to remind them that it will get better. They think of her fondly and the feelings of love that they felt from her has guided them as they care for their daughter, even after her death.

Hanna and Hank's story became the paradigm case for previous loss, postpartum depression and parenting. Their story was colored by their losses and the experiences and the memories that they thought that they had missed out on because of those losses. They both admitted that they regularly day-dreamed about what it would be like to have two children and what it would be like to have Hank's mom as a central figure in Holly's life. Because of these losses they had days, especially early on after Holly's birth, which were clouded by darkness and bittersweet sadness. It was hard for each of them to look at Holly or to take care of her without thinking of Hank's mom. Over time, it has become easier and they have both been able to shift some of their focus to sharing happy memories and keeping her spirit alive in their home.

The couples in this study each had stories of loss. For some it was the loss of something intangible, like feeling a loss of control or identity. For others there were spaces in their lives that they expected to be filled by loved ones that had either passed away, or had not lived up to the expectations that they had for them. Even while they were enjoying having their newborn in their lives, during moments that they said they cherished, they revisited their previous losses. Sometimes this lead to feelings of sadness and other times it lead to feeling grateful for the

memories. Either way, couples explained that they had not expected these memories to play such a significant role in their emotional wellbeing and in their journey to parenthood.

## Finding a Routine and Shifting Schedules

Each of the couples admitted that they frequently experienced unexpected events, emotional responses and unmet expectations regarding how their newborn would behave and how they would manage their family in the first few months. Some of the changes to their routine and schedules were expected. After all, they were adding a new family member that was dependent upon them for care into their household. However, some aspects of change were unexpected. They knew that their lives would change when they became parents, but there were shifts in expectation and in their routines that they had not previously considered. At times these changes were thought to be necessary because of the mother's postpartum depression, at other times they were seen as a normal adaptation in response to the needs of their family. But this did not always result in a crisis within the household. When unexpected routine changes occurred, more often than not, couples explained that they found a way to make things work out. They shifted responsibilities, they made schedules regarding newborn and household care, and they sought guidance from family, friends, healthcare providers and their faith.

### New Routines

**Jenna and James: sleeping through the night.** James felt that he was always the sort of person that did not need a lot of sleep. He admitted to being both a "night owl" and an early riser before they had Jessica. James enjoyed the time he had to himself in the mornings before they had a baby. When Jenna was diagnosed with postpartum depression, Jessica was not sleeping through the night yet. At that time, she was still waking every 3-4 hours for feedings and sleeping about 12 hours a night. Jenna's therapist recommended that she begin to get more

uninterrupted sleep. As a couple they discussed that James would take over the "night shift", so Jenna could get back on a schedule of sleeping at least 8 hours a night.

> James: So we couldn't just say let's start right off the bat. Because we were still breast-feeding we hadn't really been pumping because Jenna was still home from work. So I remember she came home from her therapy sessions and she explained the therapist said that she needed to start sleeping more at night. At that point we had both been getting up every time Jessica would wake up so we decided that Jenna would start pumping and if we needed to maybe we would use a little formula but thankfully we never really had to do that. So she started pumping during the day while I was at work. She would feed and then pump and then store the milk and then at night I would come home and in the evenings you know and we would have some time together as a family. Not very much time but a little bit, a couple hours and Jenna would go to bed around 9 o'clock and at that point the baby would already be asleep for the night. Jessica would wake up about 3 hours after she had gone down to sleep. So I would just go warm up a bottle, which was hard to do when you're really tired. (Laughs) And then she would usually fall asleep pretty quickly. Then I would go back to bed. I was sleeping in the spare bed in the nursery. Then she would wake up again, after like 3 hours and I would do it again. Jenna would take over somewhere between like around 7 maybe 6 and would take care of her. Around that time I was getting up for work already. So that Jenna would be able to sleep from like sometime around 9 o'clock to sometime between 6 or 7. So that was working pretty well for her. But for me I was kind of surprised at how much of an adjustment that was. I never really considered myself someone that needed a lot of sleep. But I think it's like the type of sleep I was getting. Just a few hours here and a few hours there. But I was able to handle it and Jenna, at the time, couldn't. I took the hit for the family. I was tired a lot but I think all parents complain about that, right. People want to tell you all the time "Oh man, say goodbye to your sleep!" I expected to be tired, but I expected us to be doing it together, or you know getting a break or something every now and again. But no, I probably had that schedule for about 3 months. So like, Jessica was around 5 months old or so and we got her sleeping more at night.

As all new parents do, Jenna and James had to get up at night to feed Jessica. They both admitted that they wanted to try and get her on a sleep schedule. They were surprised when she got into a routine of only sleeping 3 hours at a time. They tried multiple recommendations to get her to sleep more but it took months for that to happen. In the first two months after Jessica's birth, both Jenna and James were waking up at night. James explained that he was on diaper duty and Jenna would breast-feed. James expected that this would be their ongoing routine. However, Jenna was diagnosed with postpartum depression when Jessica was 8 weeks old and shortly after

that her therapist explained that she needed to be getting more sleep. This change in the routine surprised James because he thought that their shared routine at night was working well for them. However, James did not feel angry over his responsibility. He was surprised that he needed to adjust to his new sleep schedule and he was surprised that he was doing it alone. However, he viewed this as something that needed to be done for Jessica and he was ready and willing to got through his days feeling sleepy if it meant that Jessica would get what she needed at night.

James had a very matter of fact description of this time in Jessica's development. Someone had to take over the feedings and Jenna needed the time to get better so he just did it alone because as far as he could tell someone had to feed the baby. Once Jenna was in a better place in her healing process and Jessica was sleeping in longer stretches at night they went back to the expected routine of sharing the responsibility. James did not make any major adjustments to the rest of his life. He still had all the same responsibilities in his day that he normally had and he added the nighttime feeding routine into his schedule. Despite feeling tired and not being his best at work, he was grateful for the time he had to bond with Jessica during those quiet nights together.

> James: When I look back at that time, when I was the only one up at night with Jessica, it made a real difference in how I understood her. There's something different at night, when it's quiet and the lights are dim and it was just her and me and the feeding. Before we changed the sleep schedule around, Jenna was the only one that was doing feedings because she was breast-feeding and I obviously couldn't do that. So when we started using the bottle at night, maybe this sounds corny or whatever, but it felt like I somehow got to know Jessica better. The nighttime was our time. When I fed her I would hold her close sometimes I could feel her little heart beating against my hand because of how I would prop the bottle. I loved sneaking the chance to smell her hair. We would give her a bath before bed and she smelled like the baby shampoo. It wasn't all perfect and believe me when I say I was tired as hell. Eyes blurry kind of tired, like when your chest hurts and you feel groggy all day. Some nights it was hard to get her to sleep after a feeding and I would get stressed about knowing how tired I would be at work. I really got into coffee back then (Laughs). I really started to know her and understand her more. I wouldn't have had the opportunity at that point if we stuck to our old routine.

From their adjusted routine, James found an opportunity to bond with his daughter in a way that he felt would not have been possible if Jenna had not needed to get more sleep at night. For James, night feedings became a quiet haven separate from the busy routine of his days. He was slowing down and spending time with Jessica. Before they shifted into this new sleeping schedule, he was alongside Jenna during the nighttime care, while she took the lead. Now it was he and Jessica and a quiet space where they got to know each other better. This was very important to the development of his relationship with his daughter.

Jenna recalls how important the added sleep was during the most difficult times of her depression.

> Jenna: Everything seemed like it was coming to a head. I couldn't keep up with it all and something had to give, but when you are that depressed, you can't think logically or make the decision yourself… it was this weird period where I felt like a child. I didn't feel like someone's mom. People had to remind me to eat, remind me to sleep. I was so focused on doing everything that had to be done for Jessica that everything else fell away. My therapist said I needed to sleep more and it was something that I hadn't really thought about. But I told James and he just stepped in and took over at night. I am so grateful to him because I can look back and tell you that the added sleep made such a big deal. We would both get her ready for bed. We would have maybe a half hour together alone and then I would start to get myself ready. I was taking medication to help me sleep and I would also pump one more time before bed. Then I would close the door and got to bed. It would take me awhile to fall asleep and sometimes she would wake up and I would hear her and it would make me feel guilty. But I had to sleep and most often I would just stay in bed until the sleeping pill kicked in and then I was out till morning. I am so thankful that James was able to take over then because I needed time to myself and I needed the sleep. He is seriously an amazing husband.

Jenna relates to this time in her life as being a "child" who needed to be cared for. She could not view herself as the strong independent woman that she always thought that she was. She was not able to care for Jessica in the way that she hoped to and expected to as a new mother. Instead, she became dependent on the one person that she trusted the most. At a time when their family was most vulnerable, James was able to take over and provide the much needed care and emotional support to both Jenna and Jessica. Jenna felt a sense of guilt that she

needed to ask James to take this on and that she needed space away from Jessica in those early months, but the time to heal was so important for them all. Because she trusted James and knew that he was a capable partner and a competent father, she was able to turn away from Jessica at night. This time in Jenna's life was difficult, but when she looks back on the sacrifices that James made to ensure that Jessica was well taken care of, she found that she felt an even deeper connection to her husband then she had before they became parents.

Expectations regarding sleep and caring for the newborn at night were frequent topics of discussion during the interviews for this study. Each of the couples mentioned feeling a lack of sleep in the early months after the birth of their children. Couples knew they would be tired because they had heard stories from friends and family regarding lack of sleep and because parents who are exhausted is a common cultural theme. However, when the mothers were diagnosed with postpartum depression and began counseling or seeking the advice of a healthcare provider, such as their primary care physician, it was frequently recommended that they adjust their sleep schedule. With the mother's diagnosis and the treatment of her symptoms, the father was expected to "pick up the slack". Most often, this meant that the fathers needed to take on more infant care than they expected and that much of this care took place at in the evenings and at night.

At the time enrollment, all of the fathers in this study were working full time. As one father described it, for months he was left "burning the candle at both ends". This created a routine that involved fathers feeling exhausted at work and they felt that their work performance was, at times, diminished because of their lack of sleep. However, they still took on additional responsibilities and muddled through their days because they deemed themselves more capable of handling the exhaustion than their partners, who were coping with depression, anxiety and

exhaustion. This was also a role they were willing to take on because they cared deeply for their partners and their children. They wanted their partners to have the space they needed to heal from their depression and they wanted their children to have everything that they needed.

**Gaby and George: a community of faith.** Eight of the couples in this study thought that it was important to feel included and supported by a community of parents and others who understood their current experiences and could listen to their concerns and offer suggestions about raising their children. This needed connection often required couples to change their routines and schedules to fit time in to foster their new relationships. These communities took many different forms, including informal groups of friends, structured support groups and communities of people who shared similar beliefs or hobbies. These were communities that they would not have been so involved in if they had not had children and had not experienced postpartum depression.

Gabby and George were surprised at how central to their lives their faith community became. Their faith in God and the celebrations of their shared beliefs had always been something that was a part of their relationship. However, when they had their daughter, Gina, they found it difficult to be so far away from their families in the Mid-West. They began to become heavily dependent upon their church community. This required that they make a significant adjustment in their weekly family routines and they were grateful that they did. They started to go to church events to be around other parents, they enrolled Gina in a church day-care, and on the weekends they took part in church playgroups, lunches, prayer circles and services. Being a part of this community helped them to find strength in their relationship and allowed Gabby to better understand how to cope with her diagnosis of postpartum depression. It also allowed them to seek advice from other parents about their questions regarding Gina. Their

church began to mean more to them than a place of worship. Church came to be a place of celebration and worship, but also a place of love and support.

> Gabby: Anything involving our church because that is very centered around families because they have potlucks and growth group meetings and Bible study and just general things like that. That has been new for us since having Gina, but it has been such an important new routine in our lives. We have always gone to services, but we weren't overly involved in everything else. But since she started day care there, we have found really great friends, other parents that are having similar experiences. I've probably become more involved in the church just because of having a family. I don't know if I would've been so involved if I hadn't had her just because it's allowed me to meet so many of the people, and I probably wouldn't have tried that hard to meet people if I didn't have a kid I guess. I just felt like it was so important to meet the other kids and the other parents so I worked really hard on that. I wasn't really very social before, so this is something that I have had to make an effort to do…
> …I don't know. We do a lot more kid-based things like Fairyland and the zoo and things that I actually really, really like doing. And we go with the other families we have met from church. I think it is important for the kids, but it feels even more important for me to spend time with other moms and to see George talk with other dads. And we all share stuff, like little tricks that work for nap time, or what to do when you just want to scream…
> …one of the moms that I met also had postpartum issues. She was the one that helped me realize that it wasn't the depression that was so debilitating for me, but the anxiety. I told her that I felt like I couldn't relate as easily with the people in my support group because they were all so severely depressed. I explained to her how I was feeling and said "I don't have typical postpartum (depression). It isn't that I don't love Gina or wish she wasn't here. It is that I love her so much I can't stop thinking about her. I can't focus on anything else." Before I spoke to her about it, I wouldn't have seen that as anxiety. I thought all new moms felt that way. But she sort of helped to me to realize that I was basically obsessing over Gina and that it was a form of anxiety and that it was all rolled into my depression. If I hadn't made the effort to get to know more parents at church, I think it would have taken me a lot longer to reach that point. It was a major "Ah-Ha!" moment for me in all this.

Gabby quickly realized that it was important to her that she and George and Gina become a part of a larger community that was filled with children and others parents. As their family grew, she developed an awareness about herself that she wanted to be around other families and become friends with other couples that also had children. She had not expected to find this community at church because they had never been so involved before. However, since they were already regularly attending services and because Gina went to daycare at church, it was easiest

for them to adjust their routine to add more family church activities. This took less effort at a time when Gabby already felt overwhelmed, than it would have taken to go and seek out a whole different community of families.

Gabby has never considered herself to be a socially outgoing person. Before she met George, she enjoyed spending time with friends, but she mostly stayed close to home. She explains that she was never into the "bar scene" and that she has never been totally relaxed in social situations. But when she became a mother, she stepped outside her comfort zone because she felt that creating a social environment was important to Gina's wellbeing. Gabby sifted her expectations of what her church community could do for her family and it created an environment that has provided friendship, support and even a better understanding of Gabby's postpartum depression. For George the inclusion of these new activities had also helped him, in that it had brought more opportunities for developing friendship into his life. These were relationships he had been missing since they became parents.

> George: Saturday night we had a family bowling night thing with other friends and family members from our church. Sunday, after church, was a play date at the zoo with one of Gina's little friends and another couple that we get along with from Gina's school. That's pretty typical how it goes. We sort of do most things on the weekends together as a family and a lot of our activities are part of the church or with people we have met through church or Gina's school. I have friends that I see occasionally, but not that much. When we became parents that sort of changed. Like the cliché that married couples only have friends that are married and once you have kids you only have friends that have kids. Most of our friends are couple friends and we do things with people who have kids. We just call and hang out. I don't know if it happens to be like that or if we've been fortunate, but Gina's friends typically are people that we get along with really well and we become friends too. A lot of our friends now are from people that she's kind of known or people that are the same age or are some good friends of ours that have had kids around the same time and they all go to the church day care together. So it is nice because we see the other couple's at church services and other events and we get to talk and hang out. It helps us a lot too because Gina is our first and or parents and family live so far away. It is cool to have local people to talk about parenting with, like to get suggestions from and talk about what works and what doesn't work. I don't know if other people are as lucky and I hadn't thought about it ahead of time, but it has really made a difference for us. And I don't think I realized how little socializing we were doing before.

> We were sort of like in our own little cocoon here at home. We went to work, we went to the gym and church and we stayed home most of the other time. It was just Gabby and I a lot of the time. Then when we had Gina, it was just the three of us a lot at first.

George lost the opportunity to be as social as he was before he and Gabby had Gina. This was especially true when Gabby became depressed because George felt it was important to stay close to home to support Gabby and help care for Gina. Because church was already part of their routine, they could easily become more involved. He was surprised when Gabby wanted to become more involved at church, but he was also relieved, because he was able to fulfill his need to be more social and found a source of support all at the same time. George feels that being isolated as a family, without making new connections and friendships, is not healthy for any of them psychologically. Church came to symbolize a safe environment where new relationships could be made with people that had similar interests and with parents that had the same concerns and schedules as they did. This served the dual purpose of easing many of the concerns that George had for Gabby because he found people he trusted that he could talk to about it and provided a new social outlet for the family.

When the couples in this study became parents they felt that they were instantly members of a new group. They felt that there were many truths about becoming a parent that other parents could relate to. It was important to feel a connection to that community of other parents in some way. For Gabby and George, they did not have to seek out a whole new community to find a place to fit in. Instead, they realized that they already had a community that they were members of and they only needed to shift their expectations of what their church congregation could mean to them. This slight shift in thinking allowed them to easily incorporate new church activities and events into their routine because they already felt safe at church and trusted the members of their congregation because of their shared interests and faith.

In addition to the community of faith that Gabby and George discovered, there were many other groups that couples joined. Alice and Albert, Donna and David, Felicia and Frank and Isabella and Ira met parents with children the same age as their own by joining structured play-dates. These play-dates were originally meant to be experiences for their children to socialize, but they also realized, over time, that they became sources of support and friendship for them as well. Nine of the ten mothers in the study joined structured support groups for mothers or for mothers with postpartum depression. These groups were invaluable to them throughout their processes of healing. Fathers in the study expressed gratitude when they saw how beneficial these groups were for their partners and they wished that they could have also been involved in those structured groups. Three of the couples started using online resources for help during this time. These unstructured online forums provided a safe environment where they could remain anonymous, but also find the support they needed.

**New Schedules**

**Isabella and Ira: the family binder.** Time management was a skill that each of the couples reported they had to improve upon. During their transition to parenthood they were establishing new routines and they often struggled with integrating those new routines into their daily lives. When they added the additional changes they were making to help cope with maternal postpartum depression, such as making time for appointments and the mother's difficulty focusing on tasks that needed to be completed at home, scheduling became even more complex. But they found a way to make it work out and still find time for coping with maternal anxiety and depression.

Isabella and Ira had adjusted their lives so that Isabella could stay home with Ian after he was born. This resulted in a tight financial situation, but it was as sacrifice they were happy to

make if it meant Ian could be cared for at home instead of going to daycare. They had expected that with one of them at home, things would actually become much easier for them. Prior to having Ian, they were both working full time and Ira was in graduate school full time. This created a hectic routine around the house with many household chores going unfinished and a lot of take-out meals for dinner. When they made the shift to a single-income family, they were nervous but excited about what it meant for bonding and Ian's development. They felt that they were lucky for the opportunity to allow Isabella to stay home because they could supplement their household income with Ian's student loan money. They felt very unprepared for Isabella's postpartum depression diagnosis, but they did not slip into a crisis and made some adjustments early on that really worked well for them.

> Isabella: …before I got into the "Mommy and Me" group, I thought they all had it figured out and I was a mess. You see them around campus looking pretty put together, they have their babies in carriers and the babies are sleeping quietly. Ian is and was a screamer. He is an intense kid, so I didn't take him out very often and when I did it was to walk him in his stroller until he fell asleep. He is very hands on. I can't lay him down and expect him to play or sleep long enough for me to get anything done around the apartment. We thought I would be home so we could save money because I would be able to make dinner instead of take out. It makes me laugh that that was what I thought, that Ian would sleep and I would get things done. The kid hates sleep. He is a maniac. He would fight it with all his will. I would cry and rock him and rock him and he would scream and scream. When we are home in the apartment, I barely have time to go to the bathroom. I mean I actually take him into the damn bathroom. I took a photo of him as a newborn lying on the bathroom floor because I had to pee and he was screaming. And breastfeeding too. So I thought I was going to get all this stuff done around the house and little projects I had planned. I started to knit stuff for him, none of it is finished. I bought a baby book scrapbook thing that I had wanted to work on, I think I did a half of one page and the rest is sitting in a drawer. I wanted to cook. When I was pregnant I even started bookmarking "make ahead" recipes. I had this intention that I would have this well stocked freezer full of thaw and serve homemade meals. I pictured myself walking to Trader Joe's with the baby and buying all this healthy food. I created a grocery budget. I expected to be in charge of more household stuff on my own, like laundry and what not. Not happening at all. Stuff was getting piled up. One day Ira looked at me and sort of got stressed out because he opened his underwear drawer and he didn't have any clean to wear to work. He had to wear dirty boxers. He was pissed because I had said I would do the laundry for like a week and hadn't done any.

Feeling overwhelmed is a common symptom reported by new mothers and difficulty adjusting to the routine of caring for a newborn has long been considered a hallmark symptom of postpartum depression. This is what Isabella was feeling and as unfinished tasks began to pile up, she felt overcome by it all. Her perception of Ian as being "difficult" is also often reported in the postpartum depression literature. Despite making adjustments that allowed her to devote all of her time to Ian and running the household, Isabella felt that she was losing her battle to keep a handle on things. When recalling this period in there transition Isabella now laughs at herself. She feels she was terribly naïve about how things would be with a baby at home. When she was able to start taking Ian to the informal mother's group on campus, she was able to talk to other women about their transitions. As a result she was able to start reframing her thinking and she found a few role models that helped her problem-solve the issues she was having with her new routine. She no longer looked at Ian as a difficult child and instead saw him as "strong willed", a personality trait that she saw had both positive and negative aspects to it. She began creating household task schedules and, per the advice of another mom in the group, she created what she called a "household binder" to help organize their routine. The binder became a symbol to Isabella. It was a symbol of what she was capable of and it became a touchstone to her that reinforced her sense of strength and allowed her to feel like "herself" again when she was feeling most overwhelmed. Ian's already hectic schedule made it difficult for him to take on all the tasks that Isabella was struggling with. But the binder and the lists helped them both accomplish what needed to be done at home and gave Isabella a sense that she was able to successfully complete the tasks set before her.

> Ira: She created lists here and there at first. I would find a post-it stuck to the kitchen counter. She would have like three or four things written down as goals for the day. They ranged from quick and simple to more complex. At one point she was struggling with breastfeeding and she had started pumping too, so I remember one note was actually just

> a list of times to remind herself when she should try to feed and when she should try to pump. She was actually crossing them off as she was doing it. She liked having it to remind herself, but she also like looking at all the times that she had crossed off and feeling like even though she felt like she hadn't really done anything, that she had actually done it. She got the idea from someone in her group. You have to realize that many of the moms in the group are getting their PhD's or are doing a post-doc in some kind of bench science. I work with these people; these are anal people (laughs). Of course their recommendation would be to make lists. At times I thought that she was bordering on being obsessed with making the lists. I would actually catch her writing down stuff she had already done, just to cross it off. She would also make multiple lists in one day, putting similar things on each one and she would cross the stuff off multiple times. One of the mom's in the group had her make this thing called she called the "Family Binder". Actually I think she ended up with three of them and they were all something different. She had one just about all of Ian's stuff. It had daily journal things in it. Like she filled out when he ate and when he slept and his diapers etc. The she had this "household binder" and in it she made like a chores calendar thing. Like what day of the week was laundry day and what was grocery day.
>
> It was definitely obsessive, but in a way it helped her a lot because she got this major sense of accomplishment from getting things done. She made lists for me too. Which could have been annoying, and at times they were, but it took the guess work out of knowing what she needed and it also helped us get into this rhythm of a new routine because the stuff on each of our lists was basically the same from week to week. It also had a family calendar, which we eventually made digital, but we could both see when we had appointments and stuff.

While describing the binders, Ira went into the kitchen and grabbed one off the counter. He thumbed through it, showing off different aspects that they used most often. There were dog-eared pages and everything was color-coded. He explained that working on the schedules in the binders had become somewhat of a family ritual. On Sundays, after Ian was in bed, he and Isabella would sit down and look at their digital calendars. They would chat about the upcoming week and then create a master family schedule in the binder. From this master schedule they were able to break down the tasks that the family needed to accomplish into daily chunks and from that Isabella would make daily sheets for them both. They were quite detailed and included everything from daily chores to spaces for a shopping list on the day that Isabella would go shopping.

To the outsider looking in, creating the master schedule and the daily lists seemed like a chore in and of itself and the reverence they were given seemed to border on an obsession. However, for this family, it was an important step in managing their home. The lists helped to ensure that Ian made it to all his play dates and that everything from formula and diapers, to family snacks and coffee filters were well stocked. It took several iterations to find a system that worked for their family, but now that they had, things were running much more smoothly and Isabella felt less overwhelmed and Ira felt like he was better able to compartmentalize his responsibilities and time at work, school and at home.

The issues related to managing time and household routines with a newborn and a mother who was diagnosed with postpartum depression were discussed many times by each of the couples in this study. Isabella found a unique way of managing the needs of their family that allowed her to feel less overwhelmed and for Ira to no longer have to guess at what were the best ways to help her from day-to-day. Couples coped with managing their changing routines in different ways, many turning to new digital time management applications in some way, synching calendars and sending text reminders to each other. Whatever method was used to adjust to new schedules, each couple reported that it took some type of trial and error and a conscious effort on their part to find a routine that would work best for them.

In each of the narratives regarding successful shifting and adjustment of expectations the most important shared component was open communication between the partners. The couples needed to have the skill of communicating well to ensure that each person felt comfortable sharing their needs with each other. When parenting and household tasks were becoming overwhelming for one of them and they shared their concerns with their partner, the couple came together to find a solution. Most often the couples found that shifting responsibilities or creating

new routines could avoid a crisis at home. There was always a brief period of acclimation to this new routine. New routines often went through much iteration and a trial and error period before couples found what would work for them. At times this was a temporary solution that was used while mothers attempted to cope with the symptoms of their depression, such as with nighttime feedings. At other times these newly established habits and practices became a part of the normal daily routines of the family, such as with the creation of a written household schedule or joining a new community of parents for social support.

## Differences of Opinion and Searching for Agreement

Each of the couples reported that there were situations or ongoing sticking points when it came to their shared responsibilities as new parents. While it was obvious that all the couples wanted what was best for their children and for their families, at times there were disagreements about the best way to ensure this. When living within these moments, it appeared that there would never be agreement on these issues. The participants felt that their partners lacked flexibility or a willingness to change or see things from their perspective. This complicated the mother's experiences of postpartum depression, because the added discord, no matter how small, played a role in feelings of anxiety and uncertainty. However, it was most often reported that the couples, despite admitted frustration, would eventually realize that there were positive things to be found in having more than one approach. They also reported that they always tried to shelter their children from these disagreements.

### Different Approaches

**Elizabeth and Edward: two paths to the same outcome.** Edward and Elizabeth frequently brought up discussions regarding their differing opinions and expectations of how to take care of their 21 month old daughter, Elise. Edward feels that "kids are kids" and things will

work themselves out. He does not think that everything needs to be so structured all the time or that certain things should be totally "off limits". Elizabeth wants more structure for Elise. She wants there to be a regular schedule at home and planned activities to keep Elise stimulated and involved in learning. Edward offers his explanation for why they do not always see eye to eye on planning activities for Elise.

> Edward: Elizabeth tries to make these perfect plans for Elise. They are pretty elaborate at times. Classes with other kids. Music classes. Tumbling classes. Tumbling. She had her in these activities before Elise could even talk or walk at all. And this whole time I am thinking 'why are we doing this?' First, it adds up money wise and it just took up so much time. I never went, but it seemed like Elizabeth was running them out the door to this or to that. I guess, I guess…I look at myself as a pretty successful person. I own my own home, I did above average in school and I make a pretty decent amount of money. It is enough for Elizabeth to stay home and we do all right. But no one ever dragged me to all these classes. My family was pretty low key about this stuff. When my parents hear about it they crack jokes about 'modern parenting'. I just don't see the benefit. Just let her be a kid. She will figure out the rest.

Edward cares a great deal about Elise's happiness and her development. However, he has a different view about how to get her there and how to encourage her when he compares his style to Elizabeth's. He knows that they both want their daughter to develop into a well-educated and well-rounded child. He wants to foster her creative side and give her opportunities to develop social relationships with other children. But for Edward, these things will just happen if they create free time and let Elise be herself. He sees her as a small child that should be allowed to be a child. Edward places a great value on freedom of childhood. As an adult he has many responsibilities and while she can feel free of the burden of expectations and responsibility, he wants Elise to have fun. Elizabeth does not see structured scheduling in the same way. She wants to foster learning and a sense of creativity and engagement in Elise and she believes that needs to start at an early age through organized opportunities.

> Elizabeth: Since I am staying home with Elise fulltime, we like to get out of the house a lot. I actually plan a lot out for us. There are some groups we attend on a pretty regular

> basis and it is good for us both. I get to talk to other parents and she gets to know the kids pretty well. I purposefully plan structured and unstructured play for Elise. She is taking a few classes right now. Edward thinks I overdo it, but I let her pick what she wanted to do. She is taking ballet, which she is totally obsessed with, and she is in an art class. On Tuesdays we walk to story hour at the library. On Saturdays I try to plan a play date with other parents that we get along with pretty well so we can hang out and the kids can play.

By her own admission, Elizabeth felt a great loss of control regarding her birth experience and during her early postpartum period and she has been searching for ways to get that feeling of control back. To decrease her anxiety, Elizabeth likes to maintain a fairly structured routine. She likes creating structured play and learning opportunities for Elise because she thinks they are important for her daughter's development, but also because with a fixed schedule Elizabeth feels more at ease. Initially she argued with Edward about this quite a bit. He felt she was spending a lot of money on classes and other groups. Additionally, he felt that Elise needed more free time before she started school. Elizabeth explained that this conversation comes up on a rather regular basis, but mainly when Edward felt that there was too much going on at home. He regularly suggests that she cut back on some of the activities, especially the classes, but Elizabeth feels that Elise genuinely enjoys these opportunities and she has no intention of canceling them. Edward does not push the matter because they both admit that Elise is a pretty happy kid and it seems to be working out well. Edward places a lot of value and importance on unstructured playtime where Elise can be creative in her decisions. Elizabeth values structure as a way to ensure that Elise experiences a full range of opportunities and activities that she enjoys.

Elizabeth and Edward are both hoping for the same outcome for Elise. They want her to be happy and to find activities that she likes, that are a positive way to channel her high level of energy, and that allow her to socialize with other children before the birth of their second child and before she starts school. They disagree on the best way for Elise to experience the activities

that will benefit her most, but they find common ground in their love for their daughter and their shared hope that she turns out to be "an alright kid" as Edward explained. Their disagreements about Elise do not turn into heated arguments, as other disagreements sometimes do and since Elizabeth is the one staying home with Elise, she is afforded the most control over Elise's daily schedule. As a result, both Edward and Elizabeth admit that Elizabeth had the final say and that things will likely stay that way.

**Alice and Albert: a stronger connection.** Alice and Albert realized soon after Alice's diagnosis that one of the best things that they could do as a family was establish a family schedule. This has worked out for them very well. They have a routine of spending time together and each having time alone. This has ensured that they each have the opportunity to engage in other activities that they find to be fulfilling. It also means that they are often spending time with Adele one-on-one. Because Alice stays home with Adele, she spends the most time with her. Both Alice and Albert readily admit that Alice understands Adele better and they have a well-established routine together. Albert describes Alice as a "brilliant" mother, but feels left out of the loop when it comes to certain aspects of taking care of Adele and doesn't feel as connected to his daughter as Alice is to her. Alice feels that Albert likes to have too much control over Adele because he becomes anxious over messes and disorder at home. But she doesn't readily see that he feels that he is on the outside of her close relationship with her daughter.

> Alice: She likes to feed herself now. And it is awful, it is messy and it gets everywhere. But if she doesn't try she won't learn how to do it. Like, the other day, Albert had a little pot of yogurt that he was trying to feed her while she was sitting in her high-chair in the kitchen. I was behind the counter trying to get something ready for the rest of us to eat and I was listening to them while he tried to feed it to her. It was so obvious that she didn't want to be fed, she wanted to do it herself. And I think he said something like "Well, either you let me feed you or we are all done." And so I had just left the room and came in at the tail end of this and she was saying "me, me me" and he walked away and put the yogurt down and said "That is it, we are done." And I said to him "Oh, I have taken to letting her feed herself." He looked at me like I was nuts, "It goes everywhere."

> He said. “It is yogurt, it is going to go everywhere.” I said. “I know and I don’t want her to be 21 and not be able to use a spoon!” And he sort of thought about that for a second. I was smiling, he was not. But he said “OK. I will let her feed herself.”
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> He still gets nervous, you know, that it is going to be a mess. But he lets her try it. It is like, if I was going to give her some toast and some peanut butter on her tray. I don’t sit there and watch her every second. I think he still does. I can be in the kitchen when she is in her chair eating her toast and putting it in the peanut butter. I can listen, I can look over at her every now and then. I know she isn’t choking. But, I just do that. I do something else. Because I cannot stand there and watch her do it all the time. It makes me anxious to just hover over her and it gets her pissed off. And if I stand there and hover she starts slamming the spoon down and kicking her feet. Once I would sort of hold the bowl on the table and she was trying to pull it away from me and it just flew off. And if I had just left her to it, it would have been a mess, but it wouldn’t have been such a huge mess. So I was telling him, “Well, what I do is just sort of put things on the tray and I turn around and keep an eye on her. But I don’t hover because it makes me nervous to watch her.” And he was like “Well, ya, ok. I can try that.” I sort of explained, “You know, just don’t put everything on the tray at once. It won’t be such a mess.” But it frustrates me to no end. He says “Ya, ok.” But every time he still tries to take control. Adele is at that phase where she wants to do everything and they are both so stubborn that it always ends in her melting down and he gets frustrated. All that to avoid cleaning up a mess. Just let her make a mess, she is a toddler, that is what they do!

Alice and Albert both experience anxiety when it comes to different aspects of caring for Adele. However, their anxiety manifests itself in different ways. Alice becomes anxious when she hovers over Adele because she knows that at this stage in Adele’s development Adele is very independent and industrious. If Alice hovers, Adele will eventually have a “melt-down” and this will make Alice feel overwhelmed. Albert becomes anxious regarding Adele making a mess. He needs to lead Adele in different situations to keep his anxiety under control and this will often result in Adele exerting her independence. In addition, although Albert enjoys and respects the relationship that Alice and Adele have, being on the outside of it also increases his anxiety because he does not know the best way to handle many situations. He misses out on many things when he is at work, or having time to himself and it can be hard to rejoin the relationship that Alice and Adele have created together.

These are times when Albert and Alice feel that Alice just "knows" Adele better. But despite her repeated suggestions to Albert, recommending ways to make feedings easier, Albert still sticks to his old routine. Albert says he will try new things that Alice suggests, but this back and forth between Albert and Adele happens several times a week. Albert feels that this is related to his absence because of work and because Adele always wants her "Mom" and not him. He thinks that they do not understand each other very well because they do not spend as much time one-on-one. Albert's viewpoint frustrates Alice because she feels that she communicates the routine to Albert, he just chooses to ignore it.

> Albert: Oh, she is a brilliant Mum. Adele always wants her first. If she is upset or tired, she wants her Mummy and she wants to cuddle. Which is fine and I completely understand why. They spend the most time together. During the week I really only see her for a few minutes in the morning and again for an hour or two before she heads to bed. On the weekends we get more time, but I am not always up-to-speed, you know. They figure a lot out when I am not here, they have a way of getting things done together and I just don't know it. And kids go through a phase when they just want their Mums and she could care less about me most of the time. Alice gets frustrated with me when I step in because I am all thumbs about it. I have no idea what is going on half of the time.

Albert sees Alice as an expert in Adele's care and he appreciates the bond that Mother and Daughter share. The time they spend together is important and he appreciates how wonderful of a mother Alice is to Adele. Albert feels that because of the time that Alice and Adele get to spend together, Alice knows the routine and knows Adele's needs better than he does. To Albert, time together is a benefit that allows mother and daughter to establish closeness and a routine and he does not share in that time; their closeness and routines do not involve him. He does not recognize that his own anxieties and preferences play any factor in the different ways that he and Alice care for Adele. It is likely that Albert's anxiety over how to care for Adele would lessen if he could establish a stronger relationship with his daughter; if he could join the inner circle that Alice and Adele have created.

Alice and Albert share the belief that they need to foster an environment for Adele where she is able to learn to take on certain tasks on her own. They explicitly agree that establishing and maintaining a routine is the best way to ensure that this environment is created and sustained. They disagree about why Albert has a hard time entering into the daily routine. Alice sees it as a result of Albert's need for control. Albert feels that it is because he is not there most of the day and that Alice and Adele have established a relationship and a routine that doesn't include him. He is an outsider. What is most likely is that both issues play a contributing factor that prevents Albert from smoothly joining Adele's daily routine and from establishing the same type of bond that Adele has with Alice. He continues to care for Adele one on one when he is home from work, and continues to seek ways to make connections with his daughter. Albert doesn't just want to have a part in the routine, but instead wants to be a part of the bond that he sees between mother and daughter. When discussing this in the interviews, both Alice and Albert explained that they would become annoyed and frustrated at times because of this ongoing struggle, but that it didn't impact their relationship with each other and the frustration was often short lived.

It is easy to understand why parents would want to foster a sense of independence in their children. In a Western culture independence and autonomy are highly valued personal characteristics. Mastering skills and becoming more independent means that children will become less "hands-on" and that multi-tasking will become easier. However, parents do not leave their own personalities and needs behind when they have children, instead they must find a way to incorporate the needs of their children into their lives. Anxiety and the need for control likely become heightened when children become a part of the family. When additional anxiety, as the result of postpartum depression is also present, this can turn regular daily events, such as a

toddler feeding herself, into potential triggers. It is also easy to understand that the caregiver that spends the most time with a child would become more familiar with the routine that works the best. This can create a barrier for the other parent, especially when routines have been created that help one parent cope with their anxiety. These same routines that ease anxiety for one, may create anxiety in the other.

**Searching for Common Ground**

**Donna and David: balancing work and childcare.** Based on their career situations when their first child was born, Donna and David decided that David would stay home with their son. They both found that this was a perfect situation at the time. They did not have to leave Dean in daycare or at home with someone they did not know and probably could not afford. When Donna and David became pregnant with their second, Donna decided that she would like to step away from her career and stay home with the boys. David found a new job. The transition was stressful for him, but he was excited by the opportunity to learn a new trade and to spend time outside the house after being home for more than a year. He is quick to explain that he loved being home with Dean, but that he was ready for a change when the time came. He had expected the same division of labor in their home that he had when Donna was at work. Essentially, "everything baby" was left to David and Donna only had to focus on work and some household tasks. But when he returned to work, this routine did not play out the way that David had imagined. David realized that this was partly because of Donna's postpartum depression, but he still became frustrated with her at times.

> David: I was home with Dean. I really did so much after Donna went back to work. We didn't breastfeed for very long because Dean was sensitive to like everything Donna was eating. It was too hard. So at first she was at least waking up with him for feedings. But even that turned into either an all me or a shared thing when we got him on the special formula. With Derek, he wouldn't take the bottle at all, so she was having to still get up with him at night. Maybe it was because she was so tired, but she struggled with getting

> things done during the day with both of them. I don't want to sound like an asshole, but when you go to work and you are gone for 15 hours of the day, you come home exhausted and you just want to eat and go to bed. I would come home and it felt like chaos a lot of the time. I think this was hard for Donna because she likes everything to be just so. She is the controller and the analyst. I definitely go with the flow more.
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> Anyways, I would come home and she would have one of them in bed and the other one ready for a bath and she just seemed so spent. I would try and talk her through stuff at night, like how to get it under control, but that logical part of her was gone. I ended up taking on a lot more than I had expected because she just physically couldn't do it. She didn't have any energy at all. It was different than it had been with Dean. She was dealing with depression both times, but with both boys and her being home, even when we would send them to daycare for the day, she never got caught up. I loved being home with Dean and I love the days that it is just me and both of them. But it was exhausting at the worst of it. I was working, taking care of the boys while I was home and really my brain was always focused a little bit on Donna because she was so unlike herself. I wasn't worried that she would hurt anyone, but I was worried about how she was coping, when she would get it all together. That worry doesn't turn off for a long time and it is draining.

David had a lot of balls up in the air. He had envisioned their routine in a different way, with more responsibility falling on Donna's shoulders when he returned to work. Because of Donna's depression, this is not how it worked out and he had to juggle many responsibilities at once. He admits later in the interview that he actually became frustrated and angry with Donna during this time. He struggled with seeing the difference in the time when he took care of Dean at home and the time when Donna was home taking care of both boys. He admits that much of this frustration was likely born from his stress about his new job and with the way that Donna was handling her emotional outbursts. As a result of Donna's change in behavior and her anxiety, David had to take on more responsibility at home in addition to working long hours.

This was not the family routine that David had expected when they made the decision to have a second child and when Donna explained that she wanted to stay home with the boys. Because things were not going as planned, David felt a lot of pressure to ensure that the boys were sheltered from the stress that he and Donna were experiencing.

> David: I have made an effort to take the boys out of the house a lot on the days when I am home from work. I worry that they don't get enough boys being boys time. Donna does a lot with them, but I think control is her way of coping. There isn't a lot of running and yelling and craziness that I think they need from time to time. I used to be huge into the outdoors, you know mountain biking and backpacking and rock climbing. I think it is good for the soul to spend time outside like that. So I take the boys outside as often as I can. I mean look at where we live, people travel from all over the world to be here and be outdoors. I want the boys to get that connection with what surrounds them. When they are home during the week I think things are too structured a lot of them time. I don't hold that against Donna, it is what it is. But I want them to feel like not everything has to be just so. So I make time to make that happen. Boys need to get dirty and they need to be loud. We have a lot of stress at home right now, we are getting ready to move, Donna is still struggling from time to time and our relationship could be on better ground, but dammit, I love my kids and I am not going to let any of this get to them at all. When we head out for the day, we leave that all behind and we explore.

David knows that Donna loves the boys. She runs the daily routine in the way that works the best when she is home with both boys and they have developed a special bond over time. David respects that mother-son bond and feels it is strong and gives the boys a sense of security. But David finds Donna's way of being with the boys over-protective. Donna needs this structure to cope with her anxiety, but David wants the boys to experience more spontaneity from time to time, so that they can experience the unknown and develop their imaginations. This time away from home is also his way of protecting them from the stress related to Donna's emotional struggles, their financial concerns and they preparations to move away. In David's experience, being outdoors is a symbol of freedom and a way to achieve personal growth and because he loves his sons, he wants to pass that on to them. The time they spend outdoors is his way to prepare his sons for the unexpected events that they may encounter, an opportunity to pass on important life lessons that they may not have the exposure to in their home.

Donna was grateful for the time to herself, but would sometimes get frustrated in the boy's behavior after their time outdoors with their father.

> Donna: Mommy-time. I love my mommy-time. It is restorative to me. I can spend time working on my special projects and maybe even take a bath that lasts a lot longer than the typical 3-minute shower I regularly get. David takes them hiking or bike riding or skiing

> on the weekends. Sometimes they camp and stay out over night. I do go with them from time to time, but I think it is important for them all to be together, to have boy time. And I think it is important for me to have time to myself. At first all I wanted to do was sleep. But since feeling better, I can focus on other stuff. When I was depressed I didn't want to admit to needing time to myself because it was really important to me that people thought that I was fine. I wanted them to see this big happy family that did everything together. I wanted it to look like I had it all under control. I needed to get over that and creating a space for boy-bonding time and mommy-time when I get to do what I want to do has been really important for me. And it didn't seem like "I want them out of the house!" when I explained it to people. They got it. It didn't seem like I was avoiding them when they would go hiking for the day and I would stay home. People got it and so I didn't have to feel guilty about it.
> But sometimes I get pissed at David when he comes home with the boys and they are like totally wired. I go from feeling relaxed and excited to spend time working on my own projects and then things just explode. The boys are bouncing off the walls, David is off doing his own thing and I have gone from relaxed to totally on. I run around and pick up toys, I feel lost to it. Like everything I was working on is off the table.

Donna had not expected to actually need to spend time away from her boys when they were such a young age. Her ability to stay home with the boys and nurture strong mother-son bond was a opportunity that she had been dreaming of since she had Dean and needed to go back to work. But, as someone who had found contentment and self-expression in her professional career, she needed to find a way to incorporate that sense of purpose into her new routine. Being given the opportunity to spend time alone also allows Donna the space she needs to express herself. The routine of having this protected time helps her to focus on the boys better when she is home with them.

However, just as David explained, Donna gets frustrated with the differences in parenting styles they both have. It is easy to see that they both love their children very much and they want to find ways to keep them happy and healthy. However, at times, they are at odds on how to best accomplish this.

During the individual interviews the participants revealed stories about ways that they and their partner disagreed about their household routines and their childcare practices. These

discussions rarely came up during the couple interview. It is likely that the participants wanted to protect their relationships with their partners and did not feel totally comfortable airing their grievances in front of an outsider. Bringing up issues that were continued points of contention would have had the potential to engage in argumentative conversation during the interview process. However, participants also explained that these small disagreements did not really effect their day to day lives and that they were sticking points, not because of how significant the arguments were, but because the were just always there, in the background. These were issues that the couples realized they would likely not resolve easily. Because they were comfortable in the idea that the most important concern was that they both wanted what was best for the children, these disagreements fell into the background and were only brought up occasionally.

## Concluding Thoughts

Expectations regarding family routines and child-care arise from many different aspects of new parents' lives and experiences. This chapter has focused upon the construction of expectations and the ways that couples coped with expectations that were unmet or conflicting. Couples were surprised by the diagnosis of maternal postpartum depression and felt unprepared for the ways that it would change their transition to parenthood. However, even with the additional stress of coping with maternal postpartum depression and the ways that it impacted how they cared for their children in the early months of parenthood, couples were able to engage in a series of adjustments to eventually arrive at new routines or schedules that worked for them as a family. It was not always easy to make these adjustments and participants felt a real struggle to find ways to make it work. They made sacrifices and struggled because they had a profound love for their children and their families. It is important to highlight that couples developed these new routines together and when they did disagree, they were able to focus on their shared love

for their children as a means for finding common ground. Most significantly, it must be highlighted that each couple in this study felt that their child was protected from any negative effects that maternal postpartum depression may have had on their development. However, it is possible that parents left their fears and concerns regarding this unsaid. The possibility that the mother's depression could have negatively impacted the child in some way, may have been too overwhelming a thought to share.

**The Children are All right**

As this chapter has highlighted, parents experienced a period of turmoil or realized unmet needs when the symptoms of postpartum depression began to impact the expected or established routines and decisions regarding childcare. However, the coping practices of shifting routines, making new decisions, and initiating new habits were seen as ways to ensure that the family could avoid a crisis. Routines were adjusted to allow mothers more time to sleep and recover. New decisions such as switching to formula feeding were complex and difficult, but also viewed as the best decision for the couple and their baby. Adding the habitual practices of creating a more controlled family schedule allowed for better communication among the parents, a better routine for the baby and allowed for a certain amount of control to ease anxiety. And yet, despite these changes and symptoms of depression, parents always reported that they felt there was no negative impact for their children. Despite couple's differences and frustrations, the children were always the primary focus of concern in the home and ensuring their happiness and safety was the top priority in making decisions.

> George: I don't think it had negative effects for her. I think it made our relationship a little strained from time to time. We would fight a little more or argue a little more or something like that, but I don't think it really affected Gina that much because she was still so well taken care of. But even with Gabby, I would go and she had anxiety and she was basically an insomniac without any energy, she would still do the most important aspects. She would still breastfeed and get up when Gina was crying. Maybe she wasn't

> as responsive all the time, but I was there to step in when she needed it… it wasn't like one of those postpartum things where she didn't want anything to do with Gina or anything like that.
>
> She just had this … whatever, sleeping issue and anxiety and stuff. I guess it was like she was depressed because she was taking Zoloft or something. I don't know … I didn't really see that that much, I guess. It wasn't like something where she didn't want to be around us or wasn't enjoying things. She has a really strong bond with Gina.

The sentiment that George revealed was similar to statements made by each of the partners and the mothers involved in this study. With the benefit of hindsight parents could see how their children were developing and they could see that, at least up until the point of the interviews, their children were developing normally. Despite these feelings, research has shown that parental depression has the potential to impact developmental outcomes in children (Ramchandani, Stein, Evans, O'Connor, & ALSPAC study team, 2005; Ramchandani et al., 2008; Mercer & Ferketich, 1994; Walker, Crain, & Thompson, 1986). Observations within the home showed that children were meeting their developmental milestones. However, each of the children observed was age three or younger. It is possible that issues may still arise throughout childhood and into the adult years. Yet, at the time of the interviews, parents felt that they had successfully developed ways to buffer children from the impact of postpartum depression. It is also possible that participants were not revealing their concerns as another way to prevent additional feelings of guilt in the mother. The women that were diagnosed with depression spoke repeatedly of feeling guilty throughout their diagnosis and treatment. Adding the concern that his or her child may have been impacted by depression may feel too much like placing blame on someone that is already vulnerable. Children were the top priority for each couple, but the primary function of family was seen as supportive and protective. The father's reports that their children were not impacted by depression may have been because they were creating a protective environment for the mothers and shielding them from feelings of additional guilt.

**The Family is Stronger**

Couples also looked back and thought that the struggles that they faced taught them a great deal about themselves, their partners and their children. These struggles helped them become stronger as a family.

> Felicia: I just guess, I mean, since you didn't ask…I want you to tell other people that this is really hard, right. It is hard and it is painful and sometimes you will want to walk away from it. But it was also something that I can look back at and say, that was important for us. I have even more trust in Frank now. I think I appreciate my time with Finn more. We learned to communicate with each other better, that took work and I don't think we were terrible at it before, but we do a better job of asking for what we need now. I think going through the worst shit you could imagine and coming out the other side of it and surviving and still loving each other and having a happy baby makes you all the better for it. I know that when I was in the middle of it, I couldn't have said that. But it is true. Frank and I managed to make it all work and Finn is doing great. So I think, maybe in a way, it gave us a stronger family. I need to hold onto the idea that it was for something, and I think that is it.

Theorists who look at family resiliency have long believed that in order to become resilient a person or a family must first experience turmoil or crises and learn how to cope with them (Patterson, 2002). With the benefit of hindsight, the couples in this study echoed the same sentiment. Their struggle to cope with postpartum depression and to find ways to protect their children from the impact of maternal symptoms, have given them new tools that they can rely on as a family when things may get tough again in the future. Being able to find a reason for their struggles is an important step in the recovery and healing process. Couples want to know that it was all leading up to them becoming a family that was better equipped to handle whatever comes their way.

## Conclusion

The couples in this study have shared poignant examples of the many ways maternal postpartum depression impacted their expectations and routines when caring for their children. The diagnosis of maternal postpartum depression creates a more complex family routine, but it is

one that couples were able to cope with together. Together, parents felt that they had developed their own ways to prevent depression from impacting their children and still allow mothers the recovery period that they needed. However, it is possible that parents did not reveal their concerns regarding their children in order to protect the mother from additional feelings of guilt and self-blame that would have the potential to increase depressive symptoms. Even when couples disagreed on parenting techniques, it could always be appreciated that they both wanted what was best for their child and that their shared love for their child would give them a way to move past disagreements and focus upon creating a safe and supportive family environment. Despite the complications and struggles related to incorporating maternal postpartum depression into the family's routines and practices, couples felt that this experience did not harm their children and made them stronger as a family.

# Chapter Seven: The Experience of the Postpartum Couple Coping with Maternal Postpartum Depression: Implications for Theory and Practice

The purpose of this study was to further illuminate an understanding of postpartum couples by examining the habits, practices and lived experiences of women and their partners who have made the transition to parenthood while coping with the diagnosis of maternal postpartum depression. The specific aims addressed:

(1) What are the patterns of emotional response, in mothers and their partners, to maternal postpartum depression?

(2) How are anticipated parenting and partner roles disrupted or changed by maternal postpartum depression?

(3) How are the couple's practices and processes of child monitoring and care impacted by maternal postpartum depression?

This study was developed with the intention to support current research and fill gaps in the knowledge regarding maternal postpartum depression and the partner relationship.

## Practices and Processes of Couples in Response to Maternal Postpartum Depression

The study used an interpretive phenomenological lens to interview couples and interpret the data. Through this analytical process it was found that each of the couples had a wide range of responses related to the mother's postpartum depression and that these experiences influenced their transition to parenthood, their interpersonal relationship and their household. Each of the couples studied responded to maternal postpartum depression with three patterns of processes and practices; 1) dismissal, 2) acknowledgement, and 3) accommodation.

Dismissal was the first response to the symptoms of postpartum depression seen in the mother. This process was characterized as a response where couples attempted to normalize

maternal behavior. For example, Gabby did not feel that she was depressed because her symptoms did not appear to be those of a depressed individual. She was unable to see that the feelings of love she had for her daughter were all consuming and led to anxiety and obsessive compulsive behaviors. Dismissal was also a process that couples used to protect the mother from feelings of judgment. Albert did not want to reveal his concerns to Alice because he felt that they would complicate her own struggles even more. The dismissal of symptoms varied in that some couples disclosed their concerns to each other within days and others waited weeks or months, complicating the process of diagnosis and treatment.

This study also identified that couples move from dismissal into a process of acknowledgement. Acknowledgement was the process of recognizing unexpected events or emotional responses and vocalizing that the mother's symptoms can no longer be normalized. It was important to note that some symptoms were easier for couples to discuss than others and that this was a direct response to the couple's continued attempts to protect each other from burden and judgment and because participants reported that some emotions or behaviors were viewed as more shameful than others. This came to light through Alice's narrative regarding her discussion with her therapist when she was finally able to admit, out-loud, that sometimes she wished that Adele had never been born because things were so hard now. This narrative gave a deeper understanding of these concerns and was identified as an exemplar, which was used during the data analysis to find similar patterns of response within other cases. Each of the couples shared narratives that were examples of this same phenomenon.

Following the processes that lead to their acknowledgment of concerns, couples also went through a process of accommodation. Their primary focus in this process was to ensure that the couple was making adjustments to meet the needs of the mother, to provide newborn care

that was not impacted by the mother's diagnosis, and to make sure that important household tasks were being completed. This process was not always straightforward or easy for couples and presented the most opportunity for feelings of guilt and frustration. Yet, couples revealed that any strife that arose during this process was short-lived. Partners explained that their feelings of care and concern for the mother, whom they now saw as more vulnerable, quickly surpassed their own concerns and needs. During this time, couples tried different approaches to support each other, found ways to ensure that there was no gap in infant care and made changes to get necessary tasks done around the home. They went through many iterations of these routines until they found one that what worked best for them and at the time of the interviews, each couple was still assessing their needs and making small adjustments to their practices to continue to support the mother and cope with changes as their child grew older.

**Implications for Theory and Practice**

**Dismissal.** The finding that couples often do not recognize the symptoms as signs of postpartum depression, supports the research by Beck and Gable (2000) and Cox, Holden and Sagovsky (1987) which have shown that postpartum depression symptoms are often confused with typical complaints of the new parent such as anxious feelings regarding infant care and feeling overly-tired. These authors' body of work led to the creation of postpartum specific depression screening instruments that are now widely used in practice within the perinatal health community (Cox, Holden & Sagovsky, 1987; Beck & Gable, 2000). The findings of this current study would support the analysis of such instruments for use with partners of women diagnosed with postpartum depression as three of the partners in the study experienced depressive episodes as well and all of the partners reported feeling a considerable amount of stress related to the additional responsibilities related to their concerns for the mother and the newborn. Further

research should be conducted to determine the validity of such instruments in the population of partners who are parenting with mothers that are diagnosed with postpartum depression. This would allow for practitioners to successfully identify partners who are struggling and allow for the development of a support system that would aid both the mother and her partner and get them connected to the help that they need.

**Acknowledgment.** The concept of acknowledgement is a jumping off point from which the couples were able to begin making adjustments and adaptations within the relationship and the home to help cope with the mother's concerns and diagnosis. The practices that couples engage in as they cope with maternal postpartum depression are similar to many aspects of Patterson's (1988, 1989, 1993, 2002) work on family resiliency and the development of the Family Adjustment and Adaptation Response (FAAR) model. Her model highlighted the need for the family's appraisal of difficult situations before they could determine if they have the capabilities to cope with the situation. This research study has added to the concepts within that model by showing that prior to this appraisal, if a couple is going to successfully manage the needs of the mother and care for the newborn, they must reveal their concerns to each other. This is a complex process that will need further investigation, but it is complicated by the couple's appraisal of their relationship, feelings of trust, and the couple's previous experiences related to support, as well as by what the diagnosis of postpartum depression means to them and their family.

This new understanding of this process must also be incorporated into the proposed model found in Chapter Two. In the proposed model, acknowledgment would become a key concept related to couple meanings, situational identity and worldview. Couples must acknowledge their concerns for themselves and each other before the can give meaning to and

fully understand their experiences. In addition, a couple's worldview may impact what they are able to comfortably acknowledge. For example, Alice and Albert found it easier to reveal their concerns to each other than Gabby and George did because of they had previous experiences with Albert's depression and Alice's family history of mental health issues. However, Alice still found that it was difficult to admit her desire to have her "old life" back, because admitting that was something that a mother "shouldn't say". This stigma regarding her struggles related to coping with complex postpartum emotions is grounded within the parent's culture and society and influences their process of acknowledgement.

Additionally, understanding that there are many emotions tied into the couple's comfort in revealing their concerns, and that this acknowledgment process was an important step in getting the health care support that they needed, nurses working within this population could take the lead in acknowledging the variety in the range of responses to the transition to parenthood. Nurses can play an important role in helping couples to heighten their own awareness of the range of responses and educate couples on which symptoms may be of concern. Mothers in this study struggled with revealing their emotions regarding motherhood for fear of judgment. Mothers and their partners felt that there was a prevalent discourse in North American society that woman should have feelings of happiness and fulfillment when becoming mothers. In addition they felt that there are specific, gendered expectations of fatherhood, such as the expectation to provide financially. Feeling this pressure made it even more difficult to express feelings of sadness or disappointment, for fear of judgment or increasing the pain experienced by the mothers and the stress felt by partners. Because nurses work so closely with women and their families during the transition to parenthood, they can play an important role in assessing the

family's response, providing non-judgmental care and in ensuring that they receive interventions tailored to the entire family.

**Accommodation.** The process of accommodation is the area where the most research and clinical changes are needed. Couples reported that there was a significant amount of confusion regarding how best to handle the unique concerns related to maternal postpartum depression in their home and that they received conflicting advice from practitioners. The process of trial and error with new routines and practices created an environment that, at times, felt uncertain and placed couples feeling that they were walking a fine line between the mother's needs and the capabilities of the family to meet those needs. This process placed a significant amount of strain on the resources of the family and left partners shouldering a great deal of the household responsibilities. Partners did everything they could to ease the mothers' concerns regarding depression, but this was a significant adjustment and felt burdensome from time to time, leading to frustration.

Surprisingly, despite all the struggling that occurred during this period of adjustment, if couples were able to come together to make improvements and address the needs of the mother, the newborn and the household, they felt a sense of accomplishment. The couples in this study expressed that following the worst of the mother's depression and working together to come through the darkest days, they now had the tools that they needed in their relationship to address other concerns that may come their way. A concept that family life theorists have defined as resiliency (McCubin & McCubin, 1998; Patterson, 2002; Cowan & Cowan, 2006; Walsh, 2012). It was important for couples to label this difficult experience in the life of their young families as something that was very sad and scary, but also had a beneficial outcome for them in the end.

This gave their experiences a deeper meaning and left some of them "thankful" for what they were able to accomplish together. However, this resiliency was hard won.

It is during the process of accommodation where nursing practice has the potential to make a significant impact on the couples' ability to come together and make changes that can benefit both parents. By shifting away from the sole use of patient-centered care and incorporating a family-centered focus into nursing assessments and interventions, a nurse can help the couple to develop interventions together that will work for their family. By focusing on interventions that can be carried out by the couple, but also benefit both the mother and her partner, nurses can help these new parents avoid frequent readjustments and assist them to more readily find systems that work for them. This would help to decrease their stress and potential frustration.

These recommendations could easily be incorporated into a plan of care that included home visits in the early postpartum period. Recently, as local public health departments and hospital systems have felt budget constraints, supportive practices have been cut from the standards of patient care. It is imperative that practitioners and health care systems return to the practice of postpartum home visits to ensure that all families are adequately adjusting to the lifestyle, schedule and household changes that come with the addition of a new child in the home. This is even more important when the mother and/or her partner are diagnosed with depression in the postpartum period. Home visits from registered nurses trained in the assessment and intervention of postpartum depression could provide a care service for families who are most at risk.

Couples shared stories of such concern that they were left feeling scared that the mother might not make it through the darkest days of her depression. There was never a mention that she

would hurt herself, but there was sense that she was disappearing or that she would leave. Couples had the expectation that they would have to make adjustments to their lifestyles when they became parents, however they did not expect and felt poorly prepared for coping with postpartum depression. Therefore, nurses can focus on better preparing both the mother and her partner for this transition in advance and when there is a diagnosis of postpartum depression, nurses can help to facilitate dialog between the mother and her partner where concerns and emotions are more readily shared.

**The Couple Relationship and Maternal Postpartum Depression**

The analysis also established that there were multiple patterns of interaction and coping that couples engaged in during their experiences of the mother's postpartum depression. These patterns of interaction varied by relationship style and in the way that perceived influences upon the couple's experiences were incorporated into their daily habits and practices. When couples shared the same perspective and supported each other, they were able to create a safe place that allowed for more open communication and adaptations and adjustments were made to meet the needs of both partners. When couples had differing perspectives of how to support each other and these differing perspectives also complicated the ease with which they communicated with each other, there was more difficulty meeting the needs of both partners. These complications had the potential to create struggles within the relationship, thus impacting the mother's postpartum depression. However, when the couples viewed situations differently, they still held onto the hope that eventually they would arrive at a process that worked better for them, improving their support, making communication easier and decreasing their anxiety and uncertainty.

Finally, it was revealed that a discordant relationship can further complicate a mother's postpartum depression and the couple's ability to cope by creating a situation where neither partner feels supported or acknowledged and communication becomes strained and limited. With all of the energy going towards addressing the needs of the household, couples with difficult relationships felt too tired to seek ways to improve their current situation and find a way out of the patterns that they are living out. It is important to note that couples in this situation were still together and did express genuine concern for each other and a longing for they way their relationships were before they encountered strife. With the right tools integrated into the relationship, such as safe communication and compromise, these couples may be able to find their way back to where they were before.

Most significant within this analysis of the partner relationship and postpartum depression was the circular association between a couple's experience of the mother's postpartum depression and their relationship. This indicated that the partner relationship played a significant role in the couples' perceptions of maternal postpartum depression and that in-turn the mother's depression significantly impacted the partner relationship. Managing the mother's depression in early parenthood brought forth the strengths and weaknesses already present in their relationship. Couples had to rely on some of the skills that they had already developed within their relationship, such as supportive communication. In addition, skills that they had developed that were not as effective, such as allowing differences in preferences to evolve into repeated arguments, continued during the postpartum time and escalated anxiety and concern, thus increasing depressive symptoms. As postpartum depression symptoms or interventions became more significant, couples began to feel that the situation required them to turn to their

relationship more often. If they were already concerns or strains upon the relationship, these concerns became more pronounced.

Couples had varied experiences during this period of transition. Postpartum depression was an unexpected diagnosis, but out of concern for their families and their partners, couples did what they could to meet the needs of the mother and also the family. At times, this was not a smooth process and couples struggled. But even when there was significant disagreement and discord, couples in this study stayed together and partners made an effort to support the mothers. Although these supportive practices may not have been what the mother preferred, they appeared well intentioned, suggesting an underlying care and concern for the mother's wellbeing.

**Implications for Theory and Practice**

Many of the white papers that have been developed by professional associations over the last 20 years to address the issues related to postpartum depression focus upon the partner as secondary to the mother's needs and concerns. For example, the Association of Women's Health and Neonatal Nurses' (AWHONN) position statement regarding the role of nurses (2008), indicates that the relationship between the father and the mother may be strained by postpartum depression and that both women and their families need to be educated about resources. However, there is no mention of screening the partner for depression, offering support for the partner and focusing on the strengths within the relationship to help mothers and their partners cope with the concerns related to this diagnosis. The piece states that a primary role of the nurse is to engage women to discuss their negative feelings about pregnancy and their transition to motherhood, however there is no acknowledgment of the partner's experience.

As this research study has shown, the fathers revealed that they too were experiencing a great deal of strain and had difficulties adapting and at times felt frustrated with the needs of

their partner. Nurses should take on the role of ensuring that partners are also screened for their psychological response to the transition to parenthood and in addition to acknowledging the range of possibilities in the mother's response, the partner's response should also be addressed. The couples in the study made their transitions together. They rarely spoke about their experiences without discussing their relationship and they often shared their deep concern for their partner. Mothers regularly revealed concerns that their depression was impacting their entire family. Partners shared their concern for the mother. Our theories and our interventions should acknowledge this connection and move from patient-centered care to a family-centered focus during this time that is so important to the development of a family.

**Shared Parenting Practices and Maternal Postpartum Depression**

Finally, this study highlighted the ways that parenting practices were influenced by a mother's postpartum depression and how couples worked together, even through disagreement, to shelter their children, as much as possible, from a mother's depression and their arguments. When asked to share their experiences of early parenthood, couples revealed that they had many expectations, which they co-created, regarding pregnancy, parenthood and their newborn child. These expectations were both consciously created and taken for granted as a part of who the couple was in the world. These expectations of their child and of parenthood were influenced by their own experiences growing up, by society and by their relationship. The mother's postpartum depression impacted these expectations by shifting the focus from adapting to the newborn, to adapting to the newborn but also remaining conscious of the mother's needs. This placed a good deal of unexpected responsibility upon the partners, who did everything they could to ensure that there were no interruptions in the care of their newborn.

Each of the couples in this study was trying to start a family when they learned of their pregnancy, and they were excited for this new milestone for their family. With this expected life transition came the need to make role changes and adaptations to practices and habits that would make their home ready for a new child. The analysis of the couples' narratives revealed that at times these changes and adaptations were purposefully chosen, such as the decision to breastfeed. At other times, the changes evolved out of need, such as how to cope with the mother's increased need for sleep at night. When the couples were asked to share the ways that the mother's postpartum depression impacted their child, each couple was quick to say that they did not feel that the mother's depression had a significant impact upon the development of their child.

Couples developed new routines and practices to support the family during this time period, such as Isabella's family binder and Gaby and George becoming more involved at church. These adjustments benefited the couple, but also provided a way to relieve some of the anxiety of postpartum depression and connect with parents that are having similar experiences. Some of the necessary adaptations placed a disproportionate amount of the responsibility for newborn care upon the partner. This was especially apparent when it came to sleeping practices because medical practitioners and therapists wanted the mothers to be sleeping through the night while she recovered from her depression. This created a situation where partners, who were most often back at work, had to also get up throughout the night with feedings. This was the single most frequent thing that partners discussed regarding their frustrations with the changes that were made to help cope with the mother's depression.

Despite the difficulty that couples experienced making these adjustments and coping with maternal postpartum depression, each of the couples in this study felt that these experiences

made their family stronger and more prepared to react to unexpected events in the future. It was important to them to find a positive meaning in their experience. Alice described it as feeling "grateful", saying "Now that I am through the worst of it, and I don't mean I wished this on us or on anyone, but now that it is over, I am almost grateful. Because it got us into this scheduling, this routine that really works for us. And I am glad I can say that." For Alice, finding a routine that worked for Albert and her, has given a meaning to her depression other than the sorrow of it all. She can say, after they were through the roughest patches, that something positive happened as a result of her depression. This takes away some of the guilt, some of the sadness and allows Alice to reframe her thinking and enjoy her time with her family without regularly feeling upset about her previous experiences.

For the parents in this study, finding ways to cope with the mother's depression, led to new habits within their homes that made some things more manageable for them as a family. Finding these new practices helped to ease the strife and concern and also gave the couples a sense that they had protected their children from any negative impact from the mother's depression. Alice continued our conversation by saying that now that she can see some of the positive, she also worries less about Adele. "I don't think this affected her at all. I mean, she won't remember the hard days. She was never unloved and there was always someone there with her. Even when I didn't want to, or didn't think I could be there for her, someone was there, handing her to me, encouraging me to spend time with her." Bob echoed this same sentiment when he explained that he and Betty's daughter, Bekah, was the happiest kid he had ever met. "She is seriously funny and fun to be around. None of this affected her. It couldn't have. When Betty was sleeping or needed a break, I was there. It wasn't like this image of a baby alone in a crib or something. Betty was sad, but she still loved Bekah." It is possible that these sentiments

were co-created by couples to protect the mother from feelings of guilt that she somehow hurt their child, but the stories were repeated again and again and where expressed with genuine emotion. Because they had come together to work through the mother's depression, they believed that, for now, their children made it through unharmed.

**Implications for Theory and Practice**

Researchers have repeatedly identified that the mother-child relationship can be greatly harmed by the mother's postpartum depression. Her depression negatively impacts her bonding experience with her child and this, in turn, creates behavior and emotional issues for her child in the future (Lyons-Ruth, Connell, & Grunebaum, 1986; Murray, Hipwell, Hooper, Stein, & Cooper, 1996; Moehler, Brunner, Wiebel, Reck, & Resch, 2006). Moehler and colleagues determined that because depressive symptoms in the early months postpartum did have a correlation to poor mother infant bonding, there needed to be a focus upon support and protection of the mother-infant dyad in that vital time period. This study would challenge researchers to take their methodology a step further, to begin to recognize that there is not just a dyad in the home between mother and child. Instead there is series of relationships, mother-child, mother-partner, partner-child, etc. Focus should be upon explicating each of those relationships and recognizing that even when the mother-infant relationship may be impacted by maternal depression, there may be, as there was in this study, another person in the home establishing a strong bond with the newborn. As James described in his narrative about getting up with Jessica for night feedings, the bond between daughter and father was truly strengthened by the experience of taking over when Jenna needed to get sleep at night.

It is possible that all of the focus upon the important mother-infant dyad has blinded postpartum depression researchers to the importance of other attachments in the early months of

childhood. By creating a body of research that repeatedly stresses the importance of a healthy mother-infant dyad, researchers are contributing to the discourse that pressures women into an idealized sense of motherhood. This perception of the ideal mother plays a role in the mother's appraisal of self that may feel lacking, thus contributing to her feeling of inadequacy and increasing her risk for depression. In addition to supporting the mother-infant dyad, researchers and practitioners must also support these other attachment relationships.

## Limitations of This Study

As with any study, there are limitations in the findings of this research. First, as it was mentioned in the description of the sample in Chapter Three, the sample in this study was mainly of Western European decent, highly educated, and had a high mean household income. Although this was a reflection of the geographical location where this study took place, it does mean that in a sample that is categorically different from this sample, there may be even more range in the variation of experiences of postpartum depression and early parenthood for couples. It is possible that the concerns, practices and habits would be similar and that the processes of dismissal, acknowledgment and accommodation would still be experienced, but the ways that couples sort these out, depending on their access to resources and their prior life experiences, could be different. In fact, any adjustments in the sample in regards to cultural, demographic, or lifestyle factors could open up the range of possible experiences, practices and processes even more than what was found in this sample.

It is also worth noting that this study limited the sample to couples that were still living together. As a result the range of possible responses within the partner relationship could have also been limited. For example, several interested mothers did not meet eligibility requirements because they had separated or divorced from their partners. It is likely that a sample that included

couples that had reached a point where they separated or ended their marriages would also have experienced more relationship discord and conflict and may have included a range of processes that included practices not discussed by the couples in this sample.

Finally, it should be stated that at some point following their diagnosis, most of the mothers in this study were treated by a therapist. Although the therapeutic techniques and the length of time in therapy varied greatly, the women, and occasionally their partners, were engaged in therapeutic practices that may have guided them to make certain decisions or engage in new practices or routines in attempts at coping with the mother's symptoms of depression. It is possible that couples would have eventually come to take on these new practices and routines without the guidance of their practitioners or therapists, however the process in which they arrived upon these changes may have been different had they not been engaged in such therapeutic practices.

## Commentary on the DSM-V Classification

In May of 2013 the American Psychological Association (APA) published the highly debated and long anticipated 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-V*). Researchers and advocates for postpartum depression were both pleased and disappointed by the additions to the major depressive disorder specifier for postpartum depression. In the previous edition of the *DSM-IV* (1994), postpartum depression was identified using a specifier format under the diagnosis of major depressive disorder. Postpartum depression was a major depressive episode with onset in the first 4 weeks postpartum. Researchers have long debated the onset timeframe presented in the *DSM-IV* and have called for extending the current diagnostic criteria to include antenatal depression with an onset during pregnancy and

postpartum depression with an onset of 4 weeks to 6 months or longer after delivery (Serge & Davis, 2013).

This current research study would support extending the timeframe of onset of symptoms, as many couples in the study continued to dismiss symptoms of postpartum depression that occurred in the first 2 months postpartum as normal responses to the adjustment of life with a newborn. Initially, they did not recognize the research-supported symptoms of postpartum depression, such as concerns regarding sleeping and anxiety about infant care, as abnormal responses to the transition to parenthood. Therefore, many couples did not seek medical advice or interventions until 6 weeks or longer postpartum.

In addition to including diagnosis outside the current timeframe, this study also found that each of the mothers still expressed concerns about her depression well after the postpartum period. Many of the participants were no longer in therapy or taking medications for their depression, but they revealed that they still have periods of anxiety or sadness and that they do their best to cope and ask for help. However, each of the mothers expressed a fear that because of her prior diagnosis of postpartum depression, she would experience periods of depression in her future. Therefore, it would benefit mothers and families to extend psychiatric insurance benefits outside of the postpartum timeframe of 4 weeks to allow for additional counseling sessions when and if difficulties arose again.

In the *DSM-V*, the APA adjusted the specifier to peripartum onset, which now allows for the identification of depressive episodes that are diagnosed during pregnancy. This change is key to addressing the health needs of women during pregnancy because research has shown that antepartum depression is just as prevalent in the population as postpartum depression (Eberhard-Gran, Tambs, Opjordsmoen, Skrondal, & Eskild, 2004). However, in the *DSM-V* the APA

continues to delineate a time frame of onset that ends at 4 weeks following delivery. As researchers in the field of perinatal depression have repeatedly noted, in current clinical practice, women are typically diagnosed with major depressive disorder with postpartum depression when symptoms occur within the first 12 months postpartum (O'Hara & McCabe, 2013). While addressing this concern, the APA reported that, as of the time of publication of the *DSM-V*, there was not enough large-scale epidemiological research completed for them to justify changing the time frame of diagnosis (Serge & Davis, 2013).

It is also important to note that many in the clinical practice community urged the APA to consider the variety of symptoms that women experienced in the postpartum period and recommended that a peripartum onset specifier be included in the diagnosis of anxiety disorders and obsessive disorders (O'Hara & McCabe, 2013). This was not done in the current edition of the *DSM-V*. However, the findings of this research study would support this specifier change to editions in the future. Many of the mothers in this study also reported feelings of anxiety and exhibited obsessive behaviors. This was most apparent when Gabby explained that she did not see her issues as postpartum depression because she was not feeling sad or overwhelmed. She exclaimed "I don't have typical postpartum (depression). My problem wasn't that I didn't love my daughter enough, but rather that I loved her too much." Gabby was becoming consumed by her obsession and began developing severe anxiety over everything related to the care and development of her daughter. Gabby further explained that she had difficulty "fitting in" to the treatment plan in her outpatient care group because she couldn't relate to the other mothers in her group. It is possible that Gabby would have been better treated with a plan of care that focused on anxiety and obsessive compulsive disorders, however because of the onset period, her care provider diagnosed her with postpartum depression. It is important to include the peripartum

onset specifier to anxiety and obsessive-compulsive disorders to ensure that women receive the most appropriate treatment approaches and medication regimens.

The changes to the specifier of peripartum depression in the DSM-V are a step in the right direction for improving the detection of postpartum depression. It also acknowledges the range in onset of depressive symptoms that women experience during pregnancy and within the first month after giving birth. However, there must be further research to create the foundation needed to extend the diagnosis period to reflect what is seen in practice, up to one year postpartum and to also include the range of disorders such as anxiety and obsessive-compulsive behaviors during the same peripartum period. In addition, there needs to be more research into the experiences of partners during this same timeframe, as in this study four of the partners were diagnosed with depression and others experienced depressive symptoms. When both the mother and her partner are experiencing depression, it can seriously hinder the process of recovery and leave children and families at greater risk. With a stronger body of research, the academic community can urge the APA to address these changes in subsequent revisions to the DSM.

**Commentary on a Relational Model of Postpartum Depression**

The foundational background of this research study is based upon the philosophical tenant that the person and the couple are always situated in the world where they live (Heidegger, 1975). Beginning with this assumption allows the researcher to see the taken-for-granted habits and practices of couples that are coping with maternal postpartum depression and parenthood. As a result it is not possible to fully understand an individuals' experience of postpartum depression without considering the relationships and the world in which they are situated.

The findings of this study would challenge the current prevailing theories of postpartum depression and should encourage theorists, researchers and practitioners to develop and use relational models of postpartum depression that will include both the mother, who was diagnosed, and her partner. This is especially important during early parenthood, when couples revealed that they relied on each other significantly during the difficult first months of caring for a newborn and coping with postpartum depression. This study has identified that all of participants were experiencing the strains and stressors that played a role in the mother's development of postpartum depression. Three of the partners in this study were diagnosed with depression and several others reported symptoms but never sought help for their concerns. We must develop theories and models that include a family-centered focus and are inclusive of both the mother and her partner during this time.

Currently, the five main theories of postpartum depression are the medical model, the feminist perspective, attachment theory, interpersonal theory and self-labeling theory (Beck, 2002b). Despite emerging research, the medical model of postpartum depression remains the dominant model in practice. This model labels postpartum depression as a disease and the mother as a passive being with genetic and physiological factors impacting her (Beck, 2002b). This removes her postpartum depression and her experiences from the context of her lived parental transition and from the relational aspects of this time in her life.

Existing literature and theories that explore postpartum depression focus upon relationship issues where the mother's attachment needs are not being met by her significant other and do not consider the relational aspect of depression in this unique time period (Whiffen & Johnson, 1998). Nor do these theories situate their assumptions in the shared familial space of early parenthood and they are focused upon the individualistic nature of the postpartum

depression diagnosis. For example, within the feminist perspective, treatment is focused upon helping the mother to develop her own coping mechanisms and develop a more attainable concept of motherhood (Lazarre, 1998). Interpersonal theory comes closer to including the partner relationship, but again, the focus is upon the mother and her perspective of her interpersonal relationships (Stuart & O'Hara, 1995). Self-labeling theory situates the mother within society; a society that she feels has different expectations of motherhood when she compares her own feelings to those around her (Beck, 2002b). This takes another step closer to acknowledging a piece of the issue, namely that there is a discrepancy between a mother's expectations of her experience and her emotions when compared to her actual experience. However, again, there is little recognition of the partner and their relationship.

This study has provided a view into the world of couples that have made the transition to parenthood while simultaneously coping with the unexpected diagnosis of postpartum depression. Within their narratives their concern, confusion, resiliency and love is more clearly understood. They have revealed their shared struggles and triumphs. Together couples search for the answers that explain the mother's feelings and symptoms. Together couples struggled through a trial and error period to help ease the mother's symptoms. And together they created a buffer to shield their newborn children from the symptoms of the mother's depression. Clearly, theories that identify the psychopathology of postpartum depression are important to the body of literature on maternal perinatal depression and have played a role in the identification of risk and in improving treatment. However, alongside these theories we also need to create theories that are inclusive of the relational aspects of postpartum depression. By incorporating aspects of Patterson's (2002) FAAR model and including pieces of the five models discussed here, theorists and researchers could begin to develop an inclusive model which focused upon the mother and

her needs, but also included the role of her partner, her family and situates her within the context of her world.

The findings of this study can inform the conceptual model proposed in chapter two. The processes of dismissal, acknowledgement and accommodation are in direct alignment the concept already outlined in the model. Dismissal and acknowledgement are influenced by the couple's worldview and coping behaviors. The couple's ability to find ways to accommodate the mother's needs is related to their capabilities, resources and coping behaviors. This process of accommodation, when it creates significant changes in the typical or expected daily, can increase the strain, demands and stressors experienced by the couple.

The proposed conceptual model and the commonly used theories of postpartum depression can be used to influence best practice techniques for nurses working with patient and families. Because nursing does not ascribe to one philosophical or theoretical stance, perinatal nurses working with and researching patients and their families can assess the mother and the family's response to postpartum depression and their needs and can create a hybrid theoretical perspective and model of treatment, drawing from each of these theories. The nurse can assess the mother and her partner and help them to determine what is best for them. For example, following the medical model and prescribing medications for the mother, but also drawing from interpersonal theory to focus upon how the transition to parenthood has disrupted their relationship. Also incorporating the concepts within the FAAR model (Patterson, 2002) that the couples create meaning together and can make adjustments together to adapt to the new roles and avoid further crisis.

No one theoretical model or approach for treatment will work for all mothers and their partners. Just as postpartum depression is a multifaceted diagnosis, the theoretical perspectives

from which practitioners and researchers base their interventions and investigations upon must also allow for the flexibility of a full range of possible experiences. Without this adjustment to become more inclusive, research and care will be insufficient to meet the needs of couples during their transition to parenthood, thus presenting greater risk to families during this important time. At this time, there is not enough research to explicate what this theoretical model would look like, but there is sufficient information within this study to see that the partner relationship plays a key role and must be included in models moving forward.

## Conclusion

The birth of a new child and the transition to parenthood changes the established practices and habits within the relationships of partnered couples. This transition is often expected and welcomed, however when the mother is also diagnosed with postpartum depression, new concerns must be addressed and new routines are established to provide space for the mother to cope with the symptoms of her diagnosis. Coping with the mother's depression during early parenthood is complex and couples need support that is tailored specifically to their needs.

The partner relationship plays a key role in the processes of diagnosis of postpartum depression, coping with the symptoms and protecting children from the potential effects of the mother's depression during this time. Partners feel a strong commitment, rooted in concern and love for their growing families, to assist mothers in their healing process and to make the process as smooth as possible. However, couples feel ill prepared for the experience of postpartum depression and partners reported frequent feelings of uncertainty and frustration. This study showed the relational aspects of postpartum depression. Revealing that mothers and their

partners co-create their experiences of early parenthood and work together to make adjustments to cope with postpartum depression.

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## Appendix A: Description of the Couples

### Couple One: Albert and Alice

Alice and Albert are from the United Kingdom and have been in a relationship for 7 years and married for 4 years. This is Alice's first marriage and Albert's second. They both have graduate degrees. Alice is in her late thirties and Albert is in his early forties. Albert works 70 hours per week outside the home and the family lives in a three-bedroom apartment in a large city on the West Coast. Albert has an adopted daughter, Abby, that is in high school that lives with them occasionally and together Albert and Alice have an 18-month-old daughter, Adele. Following Adele's birth Albert transitioned into a new position at work that he felt put him under a lot of pressure. They were both grateful that Alice's mother came a stayed in the home with them for three months after Adele's birth to help Alice with household chores and taking care of the baby. Alice was diagnosed with postpartum depression at 8 weeks postpartum after they sought help for her overwhelming anxiety. Alice's treatment consisted of a combined pharmacological and counseling regimen. Albert has been being treated for a major depressive disorder since young adulthood. All interviews were completed in the home and took place approximately 16 months after Alice's diagnosis.

### Couple Two: Bob and Betty

Betty and Bob are both from the West Coast and have been in a relationship for 8 years and married for 6 years. Betty has a professional degree and Bob is a government employee. They both work approximately 40 hours per week outside the home and they are both in their late thirties. They live in a rented home in a large residential neighborhood in a city on the West Coast. They have a 14-month-old daughter Bekah and Betty is currently expecting their second child. Betty was diagnosed with postpartum depression 6 weeks after the birth of Bekah and her

treatment regimen consisted of medications and counseling sessions. She visited several therapists before finding someone she felt a connection with and her medications were changed multiple times before they found a prescription that worked for her. At the time of our interviews Bob and Betty were working opposite schedules to help with day care needs, Bob was on the graveyard shift and Betty was working during the daytime. They also enrolled Bekah in daycare on a part time basis. Bob and Betty reported that their second pregnancy was not planned and that Betty was nervous about having another experience with postpartum depression and anxiety. All interviews took place in their home and began approximately 12 months after Betty's diagnosis of postpartum depression following the birth of Bekah.

**Couple Three: Connor and Christine**

Christine and Connor are a married couple in their forties and late thirties. They have been living together for 7 years and have been married for 5 years. They have a 32-month-old daughter named Carrie and Christine was diagnosed with postpartum depression 10 weeks after having her daughter. They also have 14 month old twins and Christine was diagnosed with depression 8 weeks after having the twins. Christine and Connor moved from the United Kingdom to the West Coast for Connor's job several weeks after the birth of Carrie. Our couple interview took place in their large, modern home, which they own, in a residential neighborhood near a major technology development hub. Connor worked 60 hours a week outside the home, but lost his job several days following our initial interview. Christine did not work outside the home, but had previously worked in the publishing industry prior to moving to the West Coast for Connor's job. The move to the West Coast had been difficult for both Connor and Christine. Conner found it difficult because his family lived in Europe and because he felt financially responsible for the family and found his work environment to be highly stressful. For Christine,

she missed her work relationships and her family who lived in the mid-west. She had a difficult time making close relationships with the women in her neighborhood because she felt that they had little in common. Following Connor's lay off, the couple decided that they could not commit to remaining in the research study because they were moving out of the area. The initial couple interview took place 12 months following Christine's second diagnosis and the beginning of her treatment for postpartum depression.

**Couple Four: David and Donna**

Donna and David are a married couple that live in a rural mountain community in California. They are in their mid-thirties and have been married for 6 years and living together for 7 years. They have two sons, Dean and Derek. Donna was diagnosed with postpartum depression after Dean's birth and had another diagnosis of depression 8 weeks after Derek's birth. Derek is 22 months old. Donna is self-employed doing consulting work from home and David commutes over two hours a day for his new position working in insurance sales. Their family income is less than $4,500 per month and they are currently experiencing a short sale of their home and are preparing to move closer to David's new job. David reports that his new position in sales is high stress and that he must meet certain quotas to maintain his position. This makes it difficult for him to focus on things at home. David does not currently have health insurance through work and the family is using some state and federal assistance programs to help them provide insurance for their sons and to help make ends meet. At the time of our interviews it had been three years since Donna's first experience with postpartum depression and 11 months since her second diagnosis and beginning her current treatment plan. Donna tried psychotherapy twice, but decided it was not an appropriate intervention for her depression and instead decided to follow her practitioner's recommendation for medications and to rely heavily

upon her network of friends for support. Part of Donna's recovery process has been to seek out women who are struggling after becoming new mothers. She seeks to connect with these women in online forums and wants to provide a source of support for them. The upcoming move has left Donna very anxious because she will have to leave her friends behind. All of the interviews took place in the home while the boys were visiting with neighbors next door.

**Couple Five: Edward and Elizabeth**

Elizabeth and Edward are a married couple that have been living together for 14 years and have been married for 13 years. They live in a large home outside of a major metropolitan area on the West Coast. They have a 21-month-old daughter named Elise and Elizabeth is currently pregnant with their second child. Elizabeth was diagnosed with postpartum depression 12 weeks after Elise's birth and she was in the process of tapering off her anti-depressant medications at the time of our interviews. Prior to the birth of her daughter Elizabeth worked in the finance industry, but she decided not to return to work following her maternity leave and she now stays home with Elise. Edwards works approximately 30 hours a week outside the home and 20 hours a week from an office at home. The family income is $16,000 per month. When Edward and Elizabeth first married, they decided that they did not want to have children. But after 10 years of marriage Elizabeth experienced several health issues that although minor, made her reevaluate her life decisions. Elizabeth and Edward describe Elise's birth as a traumatic experience for Elizabeth. The couple interview and my individual interview with Edward took place in their home. My individual interview with Elizabeth took place at a local coffee shop because she was excited to get out of the house. At the time of our interviews it had been 18 months since Elizabeth's initial diagnosis with postpartum depression.

**Couple Six: Frank and Felicia**

Felicia and Frank are a married couple that have been living together for nine years. They have a 21-month-old son named Fin. Felicia was diagnosed with postpartum depression 8 weeks after Fin's birth. Felicia is a schoolteacher, working about 32 hours a week outside the home. She has completed a graduate degree in education. Frank works in a warehouse and works about 40 hours a week outside the home. Their monthly household income is $7,000. They live in a large, well maintained home in a neighborhood that is economically depressed. Felicia had a home birth with a midwife and a doula. She considers herself a very holistic and spiritual person. She has not used traditional counseling and instead has focused upon supplementing her anti-anxiety and anti-depressant medications with the use of complementary medicines and therapies. Fin is in daycare during the school year and Felicia and Frank also rely on family members that live nearby to help with childcare. Our couple interview and the individual interview with Felicia took place within the home while Fin was napping or playing in the living room. The individual interview with Frank took place at a local restaurant after he got out of work one weekday. The interviews took place 13 months after Felicia's initial postpartum depression diagnosis.

**Couple Seven: George and Gabby**

Gabby and George are a married couple in their early thirties. They have been married for 8 years and in their relationship for 10 years. They have a daughter, Gina, who is two and a half years old. They live in a well maintained, rented home in a large residential neighborhood that is a suburb of a major metropolitan area on the West Coast. Both George and Gabby are originally from the mid-west and moved to California because Gabby was admitted to a graduate school program. They stayed after her graduation because of employment opportunities. Gabby and George work outside the home for 40 hours per week and their monthly household income is

$8,000. Gabby was diagnosed with postpartum depression and anxiety 3 months after Gina's birth. She had previously been treated for a depressive episode in high school, but had not been followed for any depressive symptoms for 14 years. Following Gina's birth Gabby and George moved into their current home and Gabby was laid off from work. She felt an overwhelming sense of stress and anxiety from those experiences and decided to enroll in an outpatient treatment program for postpartum depression on the recommendation of her therapist. At the time of our interviews, her treatment consisted of monthly appointments to her therapist and she was tapering off her anti-depressant and anti-anxiety medications. Gina is enrolled in a church sponsored day care program and Gabby and George rely heavily on their faith and the support of their church community. All of the interviews took place in Gabby and George's home around the holiday season. At the time of the interviews, it had been 27 months since Gabby's postpartum depression diagnosis.

**Couple Eight: Hank and Hanna**

Hanna and Hank are a married couple in their mid-forties. They have been in their current relationship for 17 years and have been married and living together for 3 years. They live in a three-bedroom townhouse in a compact, urban neighborhood. They have an 8-month-old daughter named Hailey. Hanna was diagnosed with postpartum depression 8 weeks after Hailey was born. Her treatment plan consisted of individual and group counseling as well as anti-anxiety, anti-depressant and sleeping medications. In the few years leading up to Hailey's birth, Hank and Hanna had experienced a previous miscarriage and some infidelity issues that had them in couple counseling for a while. During Hanna's pregnancy with Hailey, Hank's mother passed away and the couple moved to Northern California to open an office of Hank's family business. All these events lead to Hanna developing anxiety during her pregnancy with Hailey

that became increasingly worse after Hailey's birth. After Hanna sought treatment for her depression and anxiety, Hank realized that he was also struggling emotionally and sought out his own counseling for a depressive episode. At the time of our interviews both Hanna and Hank were working 40 or more hours a week outside the home and they had Hailey in day care. Their monthly income was $15,000. All of our interviews took place in their townhouse while Hailey was napping. At the time of our interviews it had been 6 months since Hanna's initial diagnosis and she was still seeing her therapist once a month and was tapering off all of her medications. Hank was no longer seeing his therapist.

**Couple Nine: Ira and Isabella**

Isabella and Ira are both 26 years old. They have been in their current relationship for five years and living together for 4 years. They are not legally married but they do call each other husband and wife in conversation. They live in a rented 2-bedroom apartment near a large college campus and have a 13 month-old son named Ian. Isabella has a graduate degree in marketing, but she and Ira had decided that she would stay home after Ian's birth because they had Ira's school loans and grants to supplement Ira's work income and it had been Isabella's dream to stay home with the baby for the first few years. Ira was working on a graduate degree in applied sciences, but also working as a researcher in a lab on campus. Their monthly income, with Ira's loans, was approximately $4,000 per month and their housing cost were supplemented by the University because they lived in graduate student housing. Isabella experienced several severe anxiety attacks following Ian's birth and was diagnosed with postpartum depression 6 weeks after giving birth. Her treatment for depression included several therapy sessions and the use of anti-depressant and anti-anxiety medications. She was still taking her medications at the time of our interviews, but had stopped going to her therapy sessions because she was concerned

about the cost and didn't really feel like they were helpful for her. Instead she was attending a weekly, informal mother's group with other mom's on the campus that she felt was a significant source of support for her. All of our interviews took place in the apartment and at the time it had been approximately 11 months since Isabella's postpartum depression diagnosis.

**Couple Ten: James and Jenna**

Jenna and James are a married couple in their late twenties. They have been married for three years and living together for five years. They have a 10-month-old daughter named Jessica and Jenna had been diagnosed with postpartum depression 7 weeks after Jessica's birth. They live in a suburban coastal town south of a major metropolitan area in Northern California. They live in a small, two-bedroom cottage, which they own, near the beach. James commutes about 2 hours a day for work and works about 50 hours a week outside the home for a major internet service provider. Jenna works part-time at a retail store near their home that is owned by a close friend. They live close to their parents and find a great deal of support from their families. Jenna's diagnosis of postpartum depression surprised both James and Jenna because it was Jenna's first experience was a depressive episode. Her treatment plan consisted of medications and temporary counseling. At the time of our interviews, Jenna was still on her medications, but was no longer in counseling. Jenna and James had always discussed having several children, Jenna grew up in a big family, but since Jenna's diagnosis they have been nervous about having more children. All of our interviews took place at Jenna and James' home and at the time of our interviews it had been approximately 8 months since Jenna's diagnosis with postpartum depression.

## Appendix B: Consent Form

## UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

## CONSENT TO PARTICIPATE IN A RESEARCH STUDY

**Study Title:** The Partner Relationship During the Transition to Parenthood and Postpartum Depression

This is a research study about the experiences of couples making the transition to parenthood within the context of maternal postpartum depression. The study researchers, Dr. Janice Humphreys, RN, PhD FAAN and Alyssa J. Abraham, RN, MS from the UCSF Department of Family Health Care Nursing will explain this study to you.

Research studies include only people who choose to take part. Please take your time to make your decision about participating, and discuss your decision with your family or friends if you wish. If you have any questions you may ask the researchers.

You are being asked to take part in this study because you and your partner are parents and have experienced maternal postpartum depression during the transition to becoming parents.

**Why is this study being done?**

The purpose of this study is to better understand the concerns and practices within the partner relationship, during early parenthood, when the mother has postpartum depression. The study seeks to examine the questions: "What are the patterns of emotional response within couples experiencing maternal postpartum depression? What are the processes and practices of child monitoring and care within couples experiencing maternal postpartum depression? How are anticipated parenting and partner roles disrupted by maternal postpartum depression?"

This study is not financially supported from outside resources and will be financially supported through the personal funds of the co-primary investigator.

**How many people will take part in this study?**

About 20 couples, or 40 people will take part in this study.

**What will happen if I take part in this study?**

If you agree, the following procedures will occur:

- You will be asked to fill out a sheet about some personal and family information.
- You will meet with Ms. Abraham at a location that will provide privacy and comfort and take part in a couples interview with your partner. You and your partner will be asked to describe your experiences with postpartum depression, parenting and your partner

relationship during early parenthood. This interview will take no longer than 120 minutes.

- A second couple's interview or individual interviews may be necessary to clarify information from the first interview. The additional interviews will take no longer than 120 minutes.
- Ms. Abraham will make a sound recording of your conversation. After the interview, someone will type into a computer a transcription of what's on the tape and will remove any mention of names. Once the transcription has been reviewed and compared to the audio recording, the recording will be destroyed.
- Study Location**:** All these procedures will be done at a location that is mutually agreed upon between you and the researcher. The location will provide for privacy, comfort and safety for you, your partner and Ms. Abraham.

**How long will I be in the study?**

Participation in the study will take a total of about 4-6 hours over a period of 1-3 interviews. *Follow up interviews will be completed within two months of your initial interview. Therefore your participation in the study will take place over a two month period.*

**Can I stop being in the study?**

Yes. You can decide to stop at any time. Just tell the study researcher or staff person right away that you wish to stop being in the study.

Also, the study researcher may stop you from taking part in this study at any time if she believes it is in your best interest, if you do not follow the study rules, or if the study is stopped.

**What side effects or risks can I expect from being in the study?**

- Some of the interview questions may make you worried or upset as you remember sensitive experiences. You are free to not answer any question. You are free to end the interview at any time.
- If you do not wish to continue an interview, you may request to reschedule at a later time.
- Confidentiality: Participation in research may involve a loss of privacy; however your records will be handled as confidentially as possible. Only Ms. Abraham, Dr. Humphreys and those working on the research study will have access to your records. After the interview information has been transcribed from the audio recording and verified, the recording will be destroyed. Your name or other information that interviews you will not be used in any reports or publications that may result from this study.

**Are there benefits to taking part in the study?**

There will be no direct benefit to you from participating in this study. However information that you provide may help health professionals better understand the experiences of couples making the transition to parenthood when the mother has postpartum depression.

**What other choices do I have if I do not take part in this study?**

You are free to choose not to participate in this study. If you decide not to take part in this study, there will be no penalty to you. You will not loose any of your regular benefits, and you can still get your care from our institution the way you usually do.

**Will information about me be kept private?**

- We will do our best to make sure that the personal information gathered for this study is kept private. However, we do not guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used. If, during participation in this study, you report instances of child abuse or neglect, or intimate partner violence the researchers will report these events to the authorities as well as your contact information that you have provided. In addition if you report thoughts of self-harm, for your safety, the researchers may also take further action. Further explanation of these instances is given below:

    - Suspected child abuse or neglect: If during the interview process you reveal information that suggests that a child has been abused or neglected by you or anyone else, Ms. Abraham and Dr. Humphreys are required to report this to Child Protective Services for further investigation.
    - The law in California requires that if someone tells a health care provider that they are currently being abused, a call must immediately be made to the Domestic Violence Unit of the police department and a form faxed to them within 48 hours. However, we will not be asking you directly to tell us if you are currently being abused.
    - Suspected self-harm or suicidal thoughts: If during the interview process you reveal information that suggests that you have thoughts of hurting yourself or share thoughts of suicide, Ms. Abraham may contact the San Francisco Department of Mental Health Emergency Psychiatric Services.

Organizations that may look at and/or copy your research records for research, quality assurance, and data analysis include:

- UCSF's Committee on Human Research

**What are the costs of taking part in this study?**

You will not be charged for any of the study treatments or procedures.

**Will I be paid for taking part in this study?**

In return for your time, effort and travel expenses you will be paid $25.00 per interview for taking part in this study, the maximum payment will be $75.00. You will be paid in cash, immediately following the completion of each interview.

**What are my rights if I take part in this study?**

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you in any way. You will not lose any of your regular benefits, and you can still get your care from this institution the way that you usually do.

**Who can answer my questions about the study?**

You can talk to the researchers about any questions, concerns, or complaints, you have about this study. Contact the researchers Alyssa J. Abraham at (415) 475-9380 or Dr. Janice Humphreys at (415) 476-4432.

If you wish to ask questions about the study or your rights as a research participant to someone other than the researchers or if you wish to voice any problems or concerns you may have about the study, please call the Office of the Committee on Human Research at 415-476-1814.

**CONSENT**

You have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

If you wish to participate in this study, you should sign below.

_____ _____

Date Participant's Signature for Consent

_____ _____

Date Person Obtaining Consent

## Appendix C: Telephone Screening Guide

Hello and Thank you for your interest in this study. Dr. Janice Humphreys, a Professor in the Department of Family Health Care Nursing at UCSF and I, Alyssa J. Abraham, a nursing PhD candidate at UCSF are conducting a study to better understand the experiences of couples during their transition to parenthood when the mother has experienced postpartum depression. Taking part in the study is voluntary and once you and your partner agree to take part you both may still leave the study at any time. Participants will be asked to take part in 1-3 interviews that will last no longer than 120 minutes each. The first interview will be as a couple. Follow-up interviews may be together as a couple or individual interviews. At the completion of each interview you will receive $25 in cash for taking part in the study, the maximum payment amount will be $75.00 per person.

Before I can determine if you are eligible to take part in the study I need to ask you a few questions:

1. *How old are you?* **If over 18…**

2. *Are you a parent?* **If yes…**

3. *If you are, how old is your child?* **If between the ages of 3 months and 3 years old…**

4. *Have you or your partner been diagnosed with postpartum depression by a health care provider?* **If yes…**

5. *Are you and your partner currently living together*? **If yes….**

6. *Are you or your partner currently experiencing issues related to depression that may present harm to you, your partner or anyone?* **If yes, proceed to Option B***:*

7. *Have you or your partner been treated by a doctor or seen a counselor related to a diagnosis of postpartum depression*? **If yes***, has the practitioner reported that they have any concerns related to your, or your partner's current state of well-being?* **If yes, proceed to Option B:**

Option A:
*Well it appears, based on your answers that you are eligible to take part in The Couple's Experiences of Maternal Postpartum Depression during the Transition to Parenthood study. If you are still interested in being involved in the study, do you have any questions that I can answer for you before we schedule a time to meet?*

Schedule a time to meet

*Thank you for contacting me about the study, I look forward to meeting with you and your partner and hearing more about your experiences.*

Option B:
If participants answers no to any eligibility questions OR if they express concern about their own mood or their partner's current state of health, they will not be eligible for the study:

*I am sorry, but at this time it does not appear that you are eligible for involvement in the study. I thank you for the time you have taken to inquire about the study.*

If caller expresses concerns about themselves, their partner or their family:

*I would like to give you the phone number for Children and Family Services. They can refer you to people who may be able to help you and your partner at this time. The phone number is 800-632-4615.*

Participant Meeting Information:

"Name":
Date and Time of phone call:
Eligibility:
If no, what action was taken and what services were provided?

If yes:
Meeting Date and Time:
Location:
Is it ok to call with a reminder?
If yes, phone number where message can be left:

## Appendix D: Demographic Questionnaire

Mother's Age: _____ Relationship status: Married_____

Partner's Age: _____ Significant Other_____

How long have you been in this relationship?_____

How many children are in your household?_____

What are the ages of the children in your home?:_____

Is there any one else in your home that is a dependent?:_____

Does anyone else live in your home?_____

How long have you and your partner been living in the same home?_____

Have you ever been diagnosed with depression? Yes_____ No_____

If yes, when?_____

How long post-delivery?_____

How long did your treatment last?_____

Has your partner ever been diagnosed with depression? Yes_____ No_____

If yes, when?_____

Work Status of the mother: employed Yes _____ No_____

If you are employed how many hours a week do you work_____

Work Status of your partner: employed Yes_____ No_____

If your partner is employed how many hours a week do they work_____

What is your Monthly Household Income:_____

Last year of school completed: Mother:_____

Partner:_____

Where does your family go for your healthcare?:_____

Does your family have health insurance?:_____

Who helps you or your family if you need support?:_____

Are you receiving any governmental assistance?:_____

## Appendix E: Non-Standardized Interview Guide

Study Aim 1: To begin to examine the **patterns of emotional response, in mothers and their partners,** to maternal postpartum depression.

1. Couple: As we have discussed, I am interested in understanding more about your life as a couple and as parents and about the ways that postpartum depression has impacted your life. I am wondering of we can talk about the story of you and this time in your life.
2. Individual: I would like to begin by trying to get a sense of when you first realized that depression was a part of your lives.
    a. Mother- Can you tell me about the history of your experiences with depression? When did it get worse or better? For example, when did you first realize that you may be experiencing depression and what has taken place since that time?
    b. Partner- Can you tell me about when you first realized that your partner may be experiencing depression and how this has unfolded for you?
3. Couple and Individual: Just so that I don't miss anything, to help me better understand this time for you both, can you tell me if there were any turning points for you as a couple from the time that the postpartum depression was diagnosed until now?

    (These guiding questions will be used following each of the narrative questions related to each study aim.)
    a. In general, tell me what happened during this turning point.
    b. What other events lead up to this turning point?
    c. How did you both respond to this situation?
    d. Did your actions change the situation?
    e. How did this turning point make you feel?
    f. Looking back upon this turning point, the events that lead up to it, and what has happened since, is there anything that you would change about the way that you reacted?
    g. How would you describe your emotional response during this time?
    h. Is there anything else that you would like to share with me about this experience?

Study Aim 2: To examine the **couple's processes and practices** of childcare and interaction.

Now that we have reviewed how the history of your life with depression and how it has unfolded, I would like to shift the focus of our discussion to how depression has impacted your experiences of parenting and childcare.

1. Individual: Mother- Can you tell me about a situation where your depression influenced the way in which you cared for your child, either for the better or the worse? How do you feel this has impacted your partner's experiences?
2. Individual: Partner- Can you tell me about a situation where your partner's depression influenced the way in which you cared for your child, for the better or the worse? How do you think that your actions impacted your partner?
3. Couple- As you both look back over this time since the birth of your child, how have your experiences with depression impacted your experience of parenting? Can you describe a specific time when you feel that depression impacted your experiences of parenting and your couple relationship?

    a. Can you recall this situation for me and tell me how it unfolded?
    b. Where there other events lead up to this situation?
    c. In what ways did you both react to this situation?
    d. Did your actions or change the situation?
    e. How did this experience make you both feel?
    i. Looking back upon this disagreement related to parenting and the events that lead up to it, and what has happened since, is there anything that you would change about the way that you reacted?
    j. Is there anything else that you would like to share with me about this experience?

Study Aim 3: To examine how anticipated **parenting and partner roles** are disrupted by maternal postpartum depression

1. Couple: I am also interested in understanding how postpartum depression has changed your expectations related to parenting. I am hoping that we may now shift the focus of

our discussion to this experience. Looking back over your shared experience of your transition to parenthood can you tell me the ways in which you felt your parenting roles turned out differently because of postpartum depression.

   a. Individual: Mother- Looking back over your experiences of becoming a parent, can you tell me the ways in which you felt your expectations of parenthood turned out differently because of your depression?

   b. Individual: Partner- Looking back over your experiences of becoming a parent, can you tell me the ways in which you felt your expectations of parenthood turned out differently because of your depression?

2. Couple: I am also interested in better understanding how postpartum depression has changed your expectations related to your partner relationship. Looking back over your shared experience of your transition to parenthood can you tell me the ways in which you felt your partner relationship turned out differently because of postpartum depression.

   a. Individual: Mother- Looking back over your transition to becoming a parent and your experiences of depression can you tell me if there has been a situation where your expectations of your partner relationship have differed from what actually occurs in your relationship?

   b. Individual: Partner- Looking back over your transition to becoming a parent and your experiences with your partner's depression can you tell me if there has been a situation where your expectations of your partner relationship have differed from what actually occurs in your relationship?

   c. Reflecting back, why do you think that these experiences stood out for you?

3. Couple and Individual: Is there anything else that I have not asked you or that we have not talked about that you would like to share?

All questions listed as "Couple" questions will be asked during the joint couple interviews. All questions listed as "Mother" or "Partner" will be asked during individual interviews whenever possible.

## Appendix F: Approved Advertisement

Posting Title: Research Study Seeks Couples that Have Experienced Maternal Postpartum Depression

Dr. Janice Humphreys, RN, CS, NP, PhD and Alyssa J. Abraham RN, MS, a PhD candidate at UCSF, are doing a study to try to understand the experiences of couples making the transition to parenthood when the mother has been diagnosed with postpartum depression.

Ms. Abraham is looking for volunteers for her study. Volunteers must be:

- At least 18 years old
- English speaking
- Couples who are living together with a child between the ages of 3 months and 3 years old
- In a relationship where the maternal partner has been diagnosed with postpartum depression.
- Participants who are not currently depressed.

Volunteers will be asked to meet with Ms. Abraham in a location that is mutually agreed upon, and talk about their experiences. Interviews will last no longer then 120 minutes. Volunteers will take part in one or two interviews as a couple and one interview alone with Ms. Abraham. Volunteers will receive $25 in payment per interview, maximum payment is $75 per person, for involvement in the study.

The study is completely voluntary and you have the right to not take part and can also leave the study at any time.

If you are interested in helping Ms. Abraham with her research you may contact her directly to discuss any questions about the study. Ms. Abraham may be reached by phone at (415) 475-9380 or by email at Alyssa.abraham@ucsf.edu.

## Appendix G: Participant Resource Guide

**Depression Resources:**

Suicide Prevention & Crisis Hotline
(415) 499-1100

Postpartum Health Alliance of Northern California
Free and confidential telephone counseling for postpartum depression. Provides support for women experiencing postpartum blues, depression and anxiety.
1-888-678-2669
9 am - 9 pm, seven days a week.

TALK Line
Parental stress, child abuse prevention, emergency respite care, single parent network, parents' group, crisis counseling, substance abuse services and ongoing therapy.
(415) 441-KIDS
TALK Line phone hours: 24 hours a day, seven days a week.
1757 Waller Ave, San Francisco (between Stanyan and Shrader)
Parent drop in hours: Monday – Thursday, 9 am – 2 pm

Public Health Nursing
Free home visits by SF Department of Public Health's Public Health Nurses regardless of income, insurance or health care provider. Services are available in English, Spanish, and Chinese.
1-800-300-9950
8 am – 5 pm, Monday - Friday

Postpartum Depression Support Group
Facilitated by Ceres Rutan, PsyD
Time: Tuesdays 11:30-12:30
Place: 2482 Sutter (Divisadero & Broderick)
Contact: Dr. Rutan: 415-820-1585

CPMC Mental Health Clinic
For people who cannot afford private psychiatry and want an evaluation for medication, CPMC has a mental health clinic that accepts payment on a sliding scale.
(415) 600-3247.

UCSF Pregnancy and Postpartum Mood Assessment Clinic
This clinic is cutting edge in terms of psychiatric medication and research. For those women receiving medical care through this hospital, this is a great starting point. They do not provide treatment, but they do assess for anxiety and depression and then provide referrals and treatment suggestions.
www.ucsfhealth.org/women
(415) 353-2566

**Family and Child Resources:**

Alcohol and Drug Helpline
650-573-3950

Children and Family Services
800-632-4615
A 24-hour line for reports of abuse, abandonment or exploitation.

Child Care Coordinating Council (4Cs)
650-655-6770
Referrals 650-655-6770
2121 S. El Camino Real, Ste. A100, San Mateo, CA 94403
http://www.thecouncil.net
Referrals for licensed child care, infant care, preschools, extended day care, summer camps; parent resource center and library; parent groups.

Child Abuse Prevention Center
650-562-0730
400 Convention Way, Suite 200, Redwood City
Child abuse resource, referral training, education, advocacy.

**Emergency food, shelter, clothing:**

Coastside Opportunity Center (El Granada)
650-726-9071

Daly City Community Service Center
650-991-8007

Fair Oaks Community Center (Redwood City)
650-780-7500

Family Support Center of the Mid-Peninsula (East Palo Alto)
650-322-1821

North Peninsula Neighborhood Services Center (South San Francisco)
650-588-8822

Pacifica Resource Center
650-359-0250

Samaritan House (San Mateo)
650-347-3648

**Temporary Financial Assistance**

TANF, General Assistance, Food Stamps
North region
1487 Huntington Avenue, South S.F. 650-877-5663
271 - 92nd Street, Daly City 650-301-8400
350 - 90th Street, Daly City 650-301-8720
Central region
550 Quarry Road, Belmont 650-596-1025

South region
2500 Middlefield Road, Redwood City 650-599-3811
2415 University Avenue, East Palo Alto 650-363-4175

**Legal services**

Family Law Services
650-366-8401, x 311
609 Price Avenue, Suite 207, Redwood City
Provides family law assistance to men, women and families.

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**Publishing Agreement**

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Date 6/9/2015