

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**“KEEP ON, KEEPING ON”: ONE MAN’S PHENOMENOLOGICAL  
EXPERIENCE OF POSTNATAL DEPRESSION**

A study presented in partial fulfillment of the requirements for the degree

of Master

in Nursing at

Massey University

Submitted by: Elizabeth Frances Moore

Year: 2000.

## ABSTRACT

Postnatal depression has been documented as a disease/illness exclusively linked to mothers. The dominance of biological and psychological perspectives of postnatal depression in women, have upheld the dichotomy which seems to make postnatal depression in men inexaminable. In response to the lack of research into men's experience this study offers a trilogy that firstly examines a father and then a mother's separate perspectives on postnatal depression. The third dimension of this study aims to present an integrated view from this couple of postnatal depression. In order to achieve this, this work describes one man's perspective of the phenomenon of postnatal depression employing Crotty's (1996) mainstream phenomenological approach. Although the biological and psychosocial approaches show that postnatal depression is a very real disorder in some women's lives following childbirth, the phenomenological approach has identified the equally real disequilibrium that occurs in some men's lives when living with postnatal depression. The findings provide a detailed account of the co-researchers distress as he seeks to understand the essence of his experience of postnatal depression and realize the reality of his life-world. Thus potential health risks are identified which warrant further investigation that have implications for men's health.

## PREFACE

### *Understanding Phenomenology*

“I’ll try to give a personal, experiential account of the beginning of my fatherhood. How did “having children” enter my life? I remember several occasions when friends of ours would speak of the deep satisfaction of having children of their own. How it changed their way of looking at life and at the world. I always thought that I understood what they were saying (now I know that I did not). I countered that I felt no lack, no need for a family and argued, eloquently, I believe, how the children I taught at school gave me similar satisfactions without having to “possess” fatherhood, and privately considered my friends to be quite foolish. Talking to young parents is like talking to religious converts, I said to Judith, my wife. As we would return home, we would talk about how we prized ourselves lucky to be able to enjoy each other, our quiet, our books, and our freedom to do what we liked and to go where we pleased. Very occasionally Judith would speak of her doubt about our resolve not to have children at thirty-something and felt young. One day we visited Judith’s cousin, who had just given birth to her third child. I recall the chaos of the home – food smells, crackers, junk, stains, toys, and blankets. Altogether I felt somewhat repulsed at the greasiness of the child scene – such contrast to our home or my classroom. One moment stands out clearly. My wife had taken the newborn baby in her arms and then I felt strangely moved – she and this baby, so lovely – it seemed so right, good. The next time the topic of having children came up (I might have brought it up myself), I still resisted, but weakly. I doubted my ability to be an enthusiastic father: I told Judith a last time that I distrusted the world we live in; it seemed so foolish, so egotistical to put children in this madness. Secretly, I could hardly wait for our first child to be born. Yet at times I felt afraid. What if I could not love this child Judith was bearing? Feeling guilty, I only admitted my uncertainties to myself while talking supportively to my wife” (van Manen, 1984, p. 51-52). Copyright granted by kind permission of Max van Manen, personal communication, 26.9.00).

## ACKNOWLEDGEMENTS

To Paul, I thank you and feel humbled that you wished to share the difficult journey through your life-world of postnatal depression with me. Like Topsy “you just grewed”, into a magnificently strong person, that I have the utmost respect for. To Gill, thank you for your indomitable support and forbearance through thick and thin, and there were many times when I was incredibly “thick”. To Ann Giles, thank you for inspiring me through your wonderful thesis. To “the tribe”, thank you for all your love and support, I could not have this experience without you. I have experienced, first as your mum and second as a nurse, that my immediate instinct is to love and protect you, especially from lack of knowledge. Hopefully, these words will do just that.

## CONTENTS

<b><u>ABSTRACT</u></b>	ii
<b><u>PREFACE</u></b>	iii
<i><u>Understanding Phenomenology</u></i>	iii
<b><u>ACKNOWLEDGEMENTS</u></b>	iv
<b><u>KEY TO TRANSCRIPTIONS</u></b>	ix
<b><u>KEY TO TRANSCRIPTIONS</u></b>	ix
<b><u>CHAPTER ONE</u></b>	10
<i><u>Introduction</u></i>	10
<i><u>Background to the Study</u></i>	11
<i><u>Outline of Postnatal Depression</u></i>	11
<i><u>Definitions of Postnatal depression.</u></i>	12
<i><u>Postnatal Depression – The Biological Perspective</u></i>	14
<i><u>Postnatal Depression – The Psychological Perspective</u></i>	15
<i><u>Postnatal Depression – The Sociological Perspective</u></i>	16
<i><u>Transition to Parenthood</u></i>	16
<i><u>Justification of the proposed research</u></i>	17
<i><u>Researcher and co-researcher</u></i>	18
<i><u>The Topic</u></i>	18
<i><u>Research Question</u></i>	19
<i><u>Definitions</u></i>	19
<i><u>Significance</u></i>	19
<b><u>CHAPTER TWO</u></b>	22
<i><u>Literature Review</u></i>	22
<i><u>The Transition to Fatherhood</u></i>	22
<i><u>Men as Research Participants – Antenatal Period</u></i>	23
<i><u>Labor and Birth</u></i>	28
<i><u>Postpartum</u></i>	30
<i><u>Psychiatric Morbidity</u></i>	30
<i><u>Summary</u></i>	37

<b><u>CHAPTER THREE</u></b>	<b>39</b>
<i><u>Phenomenology</u></i>	39
<i><u>Defining Phenomenology</u></i>	39
<i><u>Historical and Philosophical Background</u></i>	41
<i><u>Objective Experience</u></i>	41
<i><u>Subjective Experience</u></i>	42
<i><u>Embodiment</u></i>	42
<i><u>Mainstream Phenomenology</u></i>	43
<i><u>Intentionality</u></i>	43
<i><u>Intuiting</u></i>	44
<i><u>Essences</u></i>	44
<i><u>Immediate Experience</u></i>	45
<i><u>Epoche, Bracketing or Phenomenological Reduction.</u></i>	45
<i><u>The Foundations of Phenomenology</u></i>	46
<i><u>Crotty's Method</u></i>	46
<i><u>The Five Step Approach</u></i>	47
<i><u>On A Criticism of J.K. Baxter's Poem 'Old Man'</u></i>	48
<i><u>Summary</u></i>	48
<b><u>CHAPTER FOUR</u></b>	<b>50</b>
<i><u>Method</u></i>	50
<i><u>Research Design</u></i>	50
<i><u>Assumptions</u></i>	50
<i><u>Sampling</u></i>	51
<i><u>Procedure</u></i>	51
<i><u>Data Collection</u></i>	52
<i><u>Crotty's (1996) Method</u></i>	53
<i><u>Organising the Data</u></i>	54
<i><u>Trustworthiness</u></i>	55
<i><u>Auditability</u></i>	56
<i><u>Credibility</u></i>	56
<i><u>Dependability</u></i>	57
<i><u>Ethics</u></i>	57
<i><u>Summary</u></i>	58

<b><u>CHAPTER FIVE</u></b>	<b>59</b>
<i><u>Paul</u></i>	59
<i><u>Summary</u></i>	64
<b><u>CHAPTER SIX</u></b>	<b>65</b>
<i><u>Analysis of the Research</u></i>	65
<i><u>“It’s a mental war”</u></i>	65
<i><u>Postnatal depression: “It’s a bit of a mystery”</u></i>	68
<i><u>Interpreting real life: “Keep on, Keeping on”</u></i>	71
<i><u>Discovering real life: “Who am I?”</u></i>	75
<i><u>Summary</u></i>	78
<b><u>CHAPTER SEVEN</u></b>	<b>80</b>
<i><u>Discussion</u></i>	80
<i><u>Biological Factors</u></i>	80
<i><u>Social and Socio-Psychological Factors</u></i>	81
<i><u>Psychological Factors</u></i>	84
<i><u>Spiritual Factors</u></i>	86
<i><u>Phenomenology</u></i>	87
<i><u>Methodology</u></i>	87
<i><u>Method</u></i>	88
<i><u>Trustworthiness</u></i>	90
<i><u>Audit Trail</u></i>	91
<i><u>Credibility</u></i>	92
<i><u>Dependability</u></i>	92
<i><u>Insights I have gained from the research</u></i>	92
<b><u>CHAPTER EIGHT</u></b>	<b>95</b>
<i><u>Conclusion</u></i>	95
<i><u>Education</u></i>	96
<i><u>Nursing research</u></i>	97
<i><u>Clinical Nursing Practice</u></i>	98
<b><u>PAULS REFLECTIONS ON THIS STUDY</u></b>	<b>100</b>
<b><u>REFERENCES</u></b>	<b>101</b>

<b><u>APPENDIX 1</u></b>	<b>110</b>
<i><u>Information Sheet For Participants Taking Part In Research</u></i>	<i>110</i>
<b><u>APPENDIX 2</u></b>	<b>113</b>
<i><u>Consent Form</u></i>	<i>113</i>
<b><u>APPENDIX 3</u></b>	<b>114</b>
<i><u>Participant Worksheets</u></i>	<i>114</i>

## KEY TO TRANSCRIPTIONS

The following symbols are used throughout this report:

p. = page

pp. = pages

(1:) = conversation number

(:1) = transcript number

*Italics* = the actual words of the co-researcher

... = words omitted from within the sentence in the transcript

.... = sentences omitted from within the transcript

## CHAPTER ONE

### *Introduction*

Aeons ago, arguably English literature's greatest bard William Shakespeare (1564-1616) penned these words in his play *Hamlet, Prince of Denmark*,

“And therefore as a stranger give it welcome,  
There are more things in heaven and earth, Horatio,  
Than are dreamt of in your philosophy.”

(In Alexander, 1965, p.1038)

Although Shakespeare's plays were written primarily to entertain, the characterizations show an immense insight into the human psyche. In these poetical words the character Hamlet advises Horatio to have an objective approach on all matters as if experiencing the subject for the first time, and not to prejudge that which falls outside his own beliefs and values. Hamlet's passionate speech encapsulates the aim of this study that is to reveal what it means for nurses to capture the nature of the person's illness experience in their care. No two experiences will ever be the same and this very uniqueness is what sets us apart as humans and yet can provide us with the bond that breaks down barriers and enable us to understand the meaning of the other person's life-world. Nothing is beyond the barriers of exploration, and everything is worthy of examination, to provide meaning to the body of knowledge in the discipline of nursing. It has been discussed in the literature that nursing means different things to different people (Lucas, 1993). Nevertheless, the essence of nursing is clear that it is to provide holistic care that encompasses the physical, psychological and spiritual needs of the recipient.

It is noted that the focus in literary discourses attributes postnatal depression as a mood disorder of some women when they become mothers presenting biological, psychological and sociological perspectives. The transition to parenthood is a very human condition yet since the 1980's the dominant focus in research and the media has been on the mother/infant dyad. This raises the question, can a parallel mood disorder be assigned to some men on becoming fathers? Most research on men, as fathers, is presented in studies on parenthood with often little information on the father's perspective (Morgan, Matthey, Barnett, & Richardson, 1997).

The discussion in this first chapter will explore the researcher's interest in postnatal depression that led to producing this study. Paul as the co-researcher is introduced and his wish to tell the story of his experience of postnatal depression. The Australian lecturer and researcher Michael Crotty provided the underlying philosophy for this study. Crotty's (1996) method fitted the intention of including Paul as the co-researcher as he strives to interpret the essence of his own experience. The chapter concludes with an overview of the structure of the study.

### ***Background to the Study***

This chapter begins with a brief outline of postnatal depression, providing definitions and an account of the prevalence of this disorder. My interest in men's health stemmed from completing a paper at Massey University on women's health. On completion of the paper, I was left wondering about the other fifty percent of the population, namely men. So my search into men's health began. My interest in this topic was additionally fostered by attending national conferences in Australia as a recipient of the Florence Nightingale Award administered by the New Zealand Nurses Organization. A focus into postnatal depression came through postgraduate studies at Massey University. Despite fiercely arguing against undertaking the maternal mental health paper, as I had no wish to renew my personal acquaintance with this debilitating state of health, I was encouraged to present the man's perspective.

### ***Outline of Postnatal Depression***

Postnatal depression is an emotional and physical disorder that occurs for some women during the puerperium. There has been prolific research both overseas and in New Zealand that recognizes postnatal depression as a woman's disorder (Boyce, Staneck, & Gilchrist, 1999; Boath & Cox, 1999; Mills, 1999). Whilst being one of the commonest occurrences in the postpartum period it receives scant attention from health professionals. Postnatal depression can cause severe health risks to all the members of the family. History reveals that research by the French psychiatrists Esquirol (1845) and later Marce (1858), first provided detailed accounts of postnatal depression (Cox, 1986). Research on postnatal depression continues today emphasizing the areas of prevention, diagnosis and treatment (Cox, 1989). The development of screening devices, for example, the Edinburgh Postnatal

Depression Scale (Cox, Holden & Sagovsky, 1987) assisted in diagnosing maternal depression/unhappiness but no similar device was reflected for men.

Treatment options for postnatal depression are a combination of psychotherapy with pharmacology, more commonly carried out in the community setting, with only severely affected women requiring hospitalization. Defining postnatal depression should assist in early detection and prevention of postnatal depression.

***Definitions of Postnatal depression.***

The following definitions of postnatal depression are offered in order to gain a better understanding of the disorder. Patient diagnoses in the field of psychiatry are assisted by the use of the Diagnostic and Statistical Manual (1995) (DSM-IV). Postnatal depression is defined in the DSM IV as:

- “The Specifier With Postpartum Onset can be applied to the current (or most recent) Major Depressive, Manic, or Mixed Episode of Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder or to Brief Psychotic Disorder if onset is within 4 weeks after delivery of a child.”(American Psychiatric Association 1994 p.386).

Another definition of postnatal depression is offered by The World Health Organization (1992) that established the International Classification of Diseases (ICD 10).

- “The ICD10 recognizes depression as part of a scale of psychological disturbances that can be present in the postnatal period.” (Littlewood & McHugh, 1997, p.106).

There are problems with the classification of postpartum disorders within the confines of the DSMIV and the ICD10. The Satra Bruk Workshop on the Classification of Postnatal Mood Disorders (November, 1999) was held to clarify the defining of postnatal depression and has made various recommendations e.g. “that a defined diagnostic category be introduced in mood disorder sections of both classifications, for subsyndromal or minor depression, also permitting the postpartum specifier.” Health professionals have voiced concerns with postnatal depression as a mood disorder that presents in stages versus a continuum of events, based on the degree of severity (Boyce, Staneck & Gilchrist, 1999). An outline of the events of postnatal depression follows to provide greater understanding of the experience. The “baby blues” has its onset two to three days postpartum and is

characterized by brief bouts of weeping, irritability and anxiety that resolve after two weeks. These symptoms are distressing for the mother but may be adequately addressed and resolved by competent health professionals through early detection and treatment to prevent the disorder merging into postnatal depression.

Cox (1989, p.326) defines the term postnatal depression as “a psychiatric disorder that has its maximal onset two months after childbearing and is optimally identified at three months postpartum”. Postnatal depression is a serious threat to the woman’s health, her family’s health, and the baby’s health that occurs in 10-15% of women in the first year after childbirth (Cox, 1989; Wood, Thomas, Droppleman, & Meighan, 1997; Boyce, Staneck & Gilchrist, 1999). Vegetative symptoms, late insomnia, diurnal mood variation and anhedonia are all symptoms of postnatal depression (Boyce et al. 1999).

Hallucinatory and behavioral psychosis develops in 0.2% of the postpartum population (Cox, 1989; Buist, 1996). Onset of postpartum psychosis can be within twenty-four hours of childbirth with assessment of the mother sometimes revealing harmful religious ideation of good and evil involving herself and/or the baby. Medical intervention is required immediately to prevent serious harm occurring to the mother or baby. However all figures quoted are dependent upon the criteria for diagnosing postnatal depression and the methods used to collect research data.

Boyce et al. (1999), in their study of postpartum melancholia, asked the question are all episodes of depression arising out of childbirth the same type? They sought greater classification of depression because the clinical picture of postnatal depression is traditionally thought to be of non-melancholic major depression, with the risk factors being predominantly psychosocial. Yet many women do not present with this typical clinical picture. Boyce et al. (1999) proposes a unitary model where all depression is the same but varies in intensity, and a binary model that has distinct types of depression in categorical group form. One group has a biological basis and the residual group has a non-biological basis. Boyce et al. (1999) believes psychosocial factors play the lesser role in postnatal depression, as these women often have an obsessional premorbid personality, a family history of depression and generally are in a stable and supportive relationship. Whilst these women do respond well to tricyclic antidepressants or ECT they tend to relapse into depression in subsequent pregnancies.

### ***Postnatal Depression – The Biological Perspective***

Quantitative and qualitative types of research that examine postnatal depression in women present theories into the cause of this disorder that suggest biological and psychosocial explanations and include bio-medical, socio-anthropological, psychological and critical social frameworks. It has been suspected that genetic, obstetric and hormonal variables are associated with postnatal depression in women. The organic theory suggests physiological factors such as hereditary genetic links as a contributory reason for the lowering of mood in motherhood where there is a family history of postnatal depression (Stern & Kruckman, 1983). Whalley, Roberts, Wentzel & Wright (1982) propose genetic links through autosomal dominant disorders, for example, as a possible cause of postnatal depression.

Negative responses of women have been associated with a cascade of interventions that includes caesarian sections, forceps deliveries and epidural anesthetics (Inch 1982; Fisher, 1999). An Australian study by Fisher (1999) presents a prospective longitudinal study of 320 multiparous pregnant women who completed telephone interviews and self-report questionnaires in each trimester of pregnancy at two and eight months postpartum. Socio-demographic and personality factors, obstetric history, social and marital support were assessed at the onset of pregnancy and after the birth along with the physical and psychological symptoms. The findings show that multiparous women's psychological state is governed by personality characteristics, quality partner relationships and socio-economic status. The effects of having had an instrumentally assisted vaginal or emergency caesarean section were difficult to assess given that in Australia such invasive interventions are used disproportionately among those of high socio-economic status. Associated increased anxiety in late pregnancy and other negative symptoms in the participants of the study were recorded at eight months postpartum. Fisher (1999) proposes that operative interventions appear to be indicative of posttraumatic distress of late onset and provide evidence that operative procedures are not psychologically benign.

Further physiological studies highlight an imbalance in the endocrine system such as thyroid depletion or unstable oestrogen and progesterone levels (Unterman, Posner & Williams, 1990; Henderson, Gregoire, Kumar & Studd, 1991). Some understanding of women's reproductive cycle is necessary before and after childbirth, to appreciate the link

between unstable hormone levels causing postnatal depression. As a consequence, postnatal depression from the bio-medical perspective is located first as a disease and second, as exclusive to women as mothers (Dalton & Holton, 1996).

***Postnatal Depression – The Psychological Perspective***

Psychological perspectives of postnatal depression suggest attachment/bonding theories and loss of self-identity, self-efficacy and self-esteem by the mother. The attachment/bonding concepts present both negative and positive perspectives. The attachment/bonding theories of the 1950's by Bowlby offered evolutionary ideas on motherhood. Further research into the critical bonding period (Klaus & Kennell, 1976) ultimately raised anxiety in women if the bonding did not occur within six hours of delivery. However, this perspective changed hospital policy radically and increased the contact between mother and baby (Martell, 1995). Littlewood & McHugh (1997) suggest that loss of self identity may be an integral part of the quality of life a woman experiences during her transition to motherhood. How well she copes with the maternal role is dependent upon her psychological and emotional well being as they are intertwined with her self-esteem and self-efficacy state (Cutrona & Troutman, 1986). Internal representations of self by the mother as "a good mother" can also lead to negativity and depression (Bishop, 1999; Fowler, 1999).

Fowler's (1999) study uses a feminist post-structuralist method that inquire into the beliefs on mothering: that it is the fulfillment of the woman's "role" in life, and that the mother will instinctively know how to care for her baby. A potential outcome of these beliefs is the silencing of mothering experiences and the development of unrealistic expectations that cause distress and feelings of failure and incompetence that result in long term implications for the baby, other children and the family. A limited longitudinal study of 9-12 months has been completed by Fowler (1999) that gathered data from 15 women. The data consisted of three extended semi-structured interviews with each woman that explores the experiences of pregnancy, childbirth and the first months of mothering. The researcher provides recommendations that will offer a more productive way of thinking about motherhood and how to acquire these skills. Fowler (1999) proposes that mothering is learnt through everyday practices with infants, children and young adults and as such this research offers much on learning how to become a mother.

### ***Postnatal Depression – The Sociological Perspective***

It has been suggested in the research that inadequate social support networks are a contributing factor in the origin of postnatal depression in women (Hrobsky, 1977; Lealailauloto & Bridgeman, 1997). Morse (1993) has presented a multifactorial model that examines the predisposing sources of parental stress in the postpartum period. In this study are presented economic, physical, psychological, marital, and societal factors. Examples of these indicators are extra financial demands upon the working couple to provide for the baby and the loss of one income when the mother ceases working. Physical signs include sleep deprivation, boring repetitive and often unpredictable tasks, and limited adult contact with isolation leading to social deprivation. The manifestations of no relief or personal space from the responsibilities of childcare for the carer, who may be totally inexperienced in caring for a baby, becomes evident. This may signify the realization that new sociological skills are required to process the multiple demands of parenthood. If these demands are not met it may reveal the mother feeling out of control or being overwhelmed.

Social support groups have emerged that are useful to women at different stages of recovery from depression (Unterman, Posner, & Williams, 1990). These groups provide an avenue for women to ventilate their feelings in a safe environment with other women (Creedy & Shochet, 1996). Research presents the view that the appropriate emotional response that mothers make in postnatal depression is a normative process in the transformation to motherhood (Nicolson, 1990; Barclay & Lloyd, 1996). Therefore, societal norms could change if women are able to express their emotions when suffering postnatal depression, without fear of rejection.

### ***Transition to Parenthood***

The women's movement provided the forum from which women have been supported in making choices in the methods of care during childbirth. Midwife assisted births ("with woman") became more prevalent and as a consequence the emphasis since the 1980's has been on the mother/infant dyad. However, both partners' health should be recognized as vulnerable in the puerperium and carefully monitored and tended to by health professionals. Even so, the measure of mastery of a behaviour or skill such as parenting is often dictated by the prevalent opinion of the populace (Vickers, 1994). Ignoring health deficits associated with postnatal depression has far reaching consequences for the

development of stable relationships between all members of the family network. If postnatal depression is allowed to continue, the effects of dysfunctional families is perpetrated from one generation to the next unabated. Currently, the emphasis still remains upon the woman's needs in childbirth, thus the voices of men are not heard and the silence that surrounds men's health issues continues.

There is a paucity of literature that ascribes postnatal depression as a man's health problem thus reinforcing the notion that it is not a contentious issue. The biological perspective reveals there is little research to examine the role men's hormones play in expectant fathers, except in relation to couvade symptoms that mirror image their pregnant partner's health status (Mason & Elwood, 1995). Psychological frameworks provide only medical markers in which men describe parallel feelings of loss of self-identity in the transition to fatherhood and the significant distress that it causes them. The sociological perspective examines similar support groups designed to assist men in supporting a partner with postnatal depression, in which men have identified that they present with parallel feelings and emotions that report them feeling isolated and lonely (Webster, Markou & Huxley, 1999).

A brief examination of some of the biological, psychological and sociological perspectives that examine organic, cognitive and behavioural aspects surrounding women and postnatal depression has been presented. A paucity of literature on men and postnatal depression has been identified. By investigating some of the research about women and postnatal depression a framework has been established through which the voices of men may be heard. In chapter 2 the little research there is about men and their experience of postnatal depression will be explored.

### ***Justification of the proposed research***

A study by The World Health Organization (WHO, 1996) has identified that by the year 2030 depression will be the single most common ailment in Western communities. A recent study by Ballard, Davis, Cullen, Mohan, & Dean (1994) found in a study of 200 fathers that rates of depression were 9% at six weeks postpartum and 5.4% percent at six months postpartum. Therefore, a phenomenological study of one man's experience of postnatal depression is the research under examination in this report. A phenomenological approach that provides detailed descriptions incorporating the essence of the lived

experience of the person being studied is used. The purpose of the research is to give meaning to a phenomenon. The aims are to provide accurate descriptions of the phenomenon of postnatal depression that emerge as this man as co-researcher tells his story and strives to interpret the essence of his own experience. It is to be hoped that through illustrating one man's experience of postnatal depression, others will benefit. From the earliest studies there has been recognition that postnatal depression does impact unfavorably upon the father, yet no definitive measures have been undertaken to attend to the suffering that men undergo and their understanding of the experience.

### ***Researcher and co-researcher***

My function as researcher in this study is to ground myself in the research. This is accomplished by locating myself in relation to the one participant of this study, in relating his experience of postnatal depression. My specific role is to listen to his story, gather the data and assist in interpreting his story. Crotty (1996) draws the readers attention to the fact that in phenomenological research the method requires that the person providing the data is seen as the co-researcher, simply because it is a one person exercise and the experience cannot belong to any other person except the one relating the story. Thus, a partnership of myself as researcher and Paul as the co-researcher is established. At the initial interview the eloquence and determination of this man to be heard on issues appertaining to men's experience of postnatal depression impressed me. Here was the participant for this report.

### ***The Topic***

The statement of interest in this study is the essence of postnatal depression for one man as he experienced postnatal depression. There are social and personal implications in this particular study for both the co-researcher and the researcher that need to be addressed. First, there is the desire of one man to tell his story in the hope that it will help others suffering the effects of postnatal depression. Secondly, there is the wish to inform nursing and midwifery practice for those nurses and midwives working with families where postnatal depression may be manifested. My choice of a phenomenological method of inquiry arose first from a better understanding of qualitative research obtained through postgraduate studies, and secondly, from the knowledge that a phenomenological perspective valued the humanistic experience and would fit well with the holistic ethic of care found in nursing. The use of a phenomenological method of inquiry will enable a

deeper understanding of the experience of 'living' with postnatal depression from the male perspective. Such insights, imparted to nurses and midwives, will assist their understanding, and impact upon their practice.

### ***Research Question***

Thus the fundamental research question that underpins this study is "What is the essence of postnatal depression for this man?" In order to provide common understandings to guide the research, the search for the reality of one man's experience of postnatal depression will be assisted by definitions of key words:

### ***Definitions***

- Man is defined as the man at the center of the study who is the co-researcher. He will be introduced later.
- Experience is defined in a mainstream phenomenological sense as "the objects of human experience" (Crotty, 1996 p.3) e.g. "what" he experiences is the essence of postnatal depression for this man.
- Postnatal is defined as 'after childbirth'.

Mauthner (1995 p.311) states that "Postnatal depression is viewed as the result of individual deficiencies, whether of biochemical, hormonal, or psychological origins (e.g., Boyce, Parker, Barnett, Cooney & Smith, 1991; Dalton, 1989)". This medical-psychiatric approach has dominated definitions on postnatal depression that precludes sociological perspectives, and all are solely concerned with postnatal depression as a disorder of women. I have been unable to find a definition of postnatal depression as experienced by men. Littlewood & McHugh (1997) state "Written in the understanding that birth, like death, is a process that should not, in ordinary circumstances, be minimized, denied, manipulated or controlled."

### ***Significance***

The significance of this study is that it sets out to search for the reality of one man's phenomenological experience of postnatal depression that overrides subjectivism and reveals the object (essence) in and through his subjective thoughts and emotions (Crotty, 1996). Themes will arise from the data that provide meaning (significance) for this man. The themes may also have significance (meaning) for others suffering this emotional

lowering of mood and provide a platform for further research in the area of postnatal depression. It is hoped that the significance of this study as nursing research, is that it will inform and transform nursing practice in relation to the care of men in their experience of postnatal depression.

It should be acknowledged the important work that is being accomplished world wide in the field of postnatal depression by the Marce Society and Postpartum Support International through furthering research and by practical means. As a member of these societies it has helped me understand a great deal more about postnatal depression. In writing this report it has had a cathartic effect in allowing me to come to terms, after twenty-nine years, of my own personal experience of postnatal depression. I have lived the experience all over again and am here to tell this man's tale.

"Keep on, Keeping on: One man's experience of postnatal depression," is the story of Paul's experience of postnatal depression from a phenomenological perspective that will unfold in the following chapters. Chapter Two investigates some of the literature surrounding the men's perspective of postnatal depression from different disciplines.

Chapter Three defines phenomenology and presents the historical and philosophical background to Husserl's transcendental phenomenology. An Australian lecturer/researcher Crotty (1996, p.29), through critical examination of other phenomenology's, affirmed Husserl's catch cry of getting "Back to the things themselves", and formed the concepts of mainstream phenomenology which underpins this study.

Chapter Four presents the opportunity to test Crotty's (1996) mainstream phenomenological approach where discussion of the research process takes place. The topic is identified as one man's experience of postnatal depression and the method is described based on Crotty's (1996) five step model. The researcher (myself) and Paul, (as co-researcher) are introduced and ethical considerations are addressed.

Chapter Five introduces Paul as the co-researcher for this study and his experience in the transition to parenthood.

Chapter Six provides the reader with the insight into the co-researcher, Paul's life-world as the analysis of the research presents his experience of postnatal depression. His phenomenology is revealed through four separate but interwoven themes as the essence of the phenomenon of postnatal depression comes into view.

In Chapter Seven I discuss aspects of the analysis with reference to the literature review on postnatal depression as exposed by Paul. The phenomenological methodology is examined and the limitations and benefits exposed. Reference is made to the method and the barriers that have presented with its use.

Finally, in Chapter Eight a summary is presented of the research and an evaluation of the method used is made. The research is ongoing and forms part of a trilogy. The trilogy comprises of the phenomenological experience of postnatal depression of the man, his wife and an integrated study of the two reports. The relevance of this study to education, nursing research and clinical nursing practice is explained and the potential new areas of research into postnatal depression in men are referred to.

## CHAPTER TWO

### *Literature Review*

When contemplating the prolific empirical research from overseas and New Zealand on postnatal depression as a woman's disorder, it is important to note that there is little literature that ascribes it as a health problem of men. Due to the paucity of literature concerning men and postnatal depression, in particular that in which the phenomenon can be associated with health problems for men, literature regarding the emotional and psychosocial transition of men to fatherhood will be examined. Transitional psychosocial adjustments for men to pregnancy, labor, birth and the postnatal period may parallel those of women, yet be little understood in the absence of biological markers. In addition, within these phases of childbirth, the *couvade* phenomenon, psychiatric morbidity, and correlations with a mentally ill or depressed partner are also examined. The sociological implications of gendered masculinity as men enter fatherhood may also warrant further exploration (Connell, 1995). Under a medical model of cause, effect, diagnosis and treatment, issues for men may well have been overlooked.

### *The Transition to Fatherhood*

According to White (1998, p.21) transition is defined as a period when "one must abandon one set of assumptions and develop a fresh new set in order to deal with a new and altered life space." One such theory that offers explanations of dealing with change in our lives is that written by Piaget (1984). The developmental and cognitive theory of intellectual organization and adaptation espoused by Piaget (1984) refers to the processes of assimilation and accommodation. The balance between assimilation and accommodation is referred to as a state of equilibrium. An imbalance in assimilation and accommodation is known as disequilibrium. Equilibration is the process of returning to equilibrium. This process of equilibration may be the process that men work through in the transition to fatherhood as a developmental process.

LeMasters (1957) described the transition to fatherhood as a period of crisis. In contrast Hobbs (1965) and Hobbs & Cole (1976) minimised LeMasters findings by suggesting that the transition to parenthood might be difficult for some parents but that it did not warrant being referred to as a crisis. Hrobsky (1977) examined the transition to parenthood according to Rossi's (1969) phases named as the *anticipatory phase*, the

*honeymoon phase*, the *plateau phase*, and the *termination phase*. Hrobsky (1977) posited that whilst society dictates harmonious norms during the transition to parenthood, in reality most families experience some level of disharmony. The anticipatory phase Hrobsky (1977) defines as inclusive of the pre-pregnancy and antenatal period when two adults make a commitment as a couple. A revision of the couple's roles and redefining new parameters of those roles takes place. The honeymoon phase refers to the intensity of cementing the relationship of each adult with the child, and the relationship role between the two adults takes on a lesser importance. The concepts of ambivalence in the parent-child relationship and the availability of support systems are also explored at this time. The plateau and disengagement phases identify that parental roles are fully accepted and the transitional process is complete. Attempting to mesh all the needs of the family requires expertise that most humans do not have in great abundance. Adjustment is necessary as family life moves through the different phases. From a couple relationship, to the advent of the birth of one or more children, incorporating the needs of other members of the household whilst retaining individual needs, requires a great deal of skill to avoid deteriorating mental health. Whilst it is acknowledged that Hrobsky's (1977) study is not recent, it still offers insightful comments that will aid practice particularly in the area of careful in-depth antenatal assessments of all the family members and their specific needs. Nevertheless, it should be noted that, this research appears to be culturally based on the values emanating from white, heterosexual middle-class educated standards and that may be inappropriate for either a solo parent, or a couple from a different culture, or different family groups.

#### ***Men as Research Participants – Antenatal Period***

The literature surrounding the transition of childless men, as they become fathers has been examined through the onset of pregnancy to their involvement in childbirth and their experiences in the post partum period. Discourses are included concerning the *couvade* (Behrmen, 1992; Khanobdee, Sukratanachaiyakul, & Gay 1993; Mason & Elwood, 1995), the fathers' emotional reactions (Gerzi & Berman, 1981) and their psychological status (Buist, 1996). Kendall, Wainwright, Hailey, & Shannon (1976) posit that the postnatal period is not a time of increased psychiatric morbidity in men, based on statistical data obtained from general practitioners. However, their study does not include men attending specialist services or attending a health professional at all. Men do not

commonly avail themselves of their general practitioners services (Margo 1996) so Kendall et al's (1976) data is open to conjecture.

Present day society has yet to assimilate the fact that mental ill health is not gender specific, only the manner in which it is expressed. Many women openly report when they are depressed whilst a number of men partake in risk-taking behaviours for example substance abuse, or they present a stoic exterior and pretend that nothing is wrong. As a consequence women can become labeled and stigmatized as mentally ill, whilst often men's depression goes unreported and untreated.

Preindustrialised societies of men had a greater involvement with childbirth and manifested distinct behavioural changes known as "the couvade" (Mason & Elwood, 1995), which are not evidenced today and could provide explanations of expectant father's depression. The loss of the couvade rituals may be one reason that new fathers report feelings of loss, and exclusion in the childbirth process. *Couvade* is derived from the French word "couver" which means to hatch. The attention to couvade rituals and taboos clearly recognized the important caring functions that the man carried out, which gave him social recognition for his changed role and status on becoming a father. It was the man's job to ensure that there was an adequate supply of firewood and that the fires were lit and the water boiled in preparation for the birth of the baby.

In addition, the couvade syndrome highlights a series of signs and symptoms characteristic of "pregnant" men (Mason & Elwood, 1995). Anthropological studies describe pregnant women's spouses in primitive societies undertaking certain rituals such as sexual restraint, being less socially inclined and having a desire to eat certain foods, thus perhaps mirror imaging their pregnant partners behavior (Paige & Paige, 1981).

Understanding men's experience of pregnancy and childbirth, may elicit enquiry into modern day couvade rituals and the signs and symptoms of the couvade syndrome experienced by some 14% of men (Trethowan & Conlon, in Buist, 1996). Summersgill posits (in Alexander, Levy & Roch, 1995) that the presence of the expectant father in the labor ward, assisting his partner in labor, may fulfill his own need for couvade rituals and thus gain social recognition as a father.

Men are not constantly reminded of the pregnancy, like their partner, through physiological signs such as changing body image, and thus may find it difficult to engage

with the concept of the forthcoming birth of their child (Martell, 1995). Therefore attendance at childbirth education classes with their pregnant partner, is one means for the expectant father to take active participation in the pregnancy and childbirth (Jordan, 1990; Nichols, 1995; White, 1998).

To reveal the parallel experience of the father in pregnancy and early childbirth is the purpose of Jordan's (1990) research. This American nursing researcher used a grounded theory method to gather data from 56 expectant and new fathers. The constant comparative technique was used to analyze the data. The findings revealed the fathers a) grappling with the reality of the pregnancy and child; b) struggling for recognition as a parent from partner, co-workers, friends, family, baby and society; and c) persisting with the role making involved in fatherhood. The author posits that the men were not recognised as parents but as helpmates or breadwinners that interfered with validation of the reality of the pregnancy and child. They felt excluded from the childbearing experience by their partners, health professionals and society. The purpose of Jordan's (1990) study is to promote greater understanding of the men's experience of expectant and new parenthood and may be the start of the development of interventions that support and promote paternal behaviour.

Adjustment to parenthood is a time of stress for new parents and the benefits of attending antenatal classes are the subject of research by Nichols (1995). This American longitudinal descriptive study compared the adjustment to new parenthood in two groups of first time mothers and fathers. Participants included 106 married couples, 58 (55%) who attended prenatal education classes and 48 (45%) who did not. The study variables included prenatal, intrapartal, and new parent experiences. The parents completed questionnaires during the last trimester and one month after delivery of a healthy newborn. Fathers were present at the labor and birth irrespective of prenatal class attendance. The groups differed in maternal age and in parent education levels, but did not differ in measures of prenatal attachment, paternal childbirth involvement and satisfaction, parenting competence and ease of transition to parenthood. The results suggest the need for further study of the influence of prenatal classes on becoming a new parent, and of the effects of the father's presence during childbirth on birth and the new parent experience. The participants, whilst drawn from what is presumed to be an homogenous group in the army, nonetheless bring

with its own specific culture that could be seen as a bias of this study. Other variables such as psychosocial factors of emotional and social support need to be included. The information imparted at the classes should be evaluated on how much of it was valuable and is indicative that health professionals need to be innovative in their methods of teaching at prenatal classes.

White (1998) has produced a study in two parts on childbirth education classes. The first part of this American survey examined the concerns of 98 men attending a six-week, hospital based childbirth education class. Results indicated that the expectant fathers primary concerns centered on the health and safety of the mother and child. In the second part of the study the author examined the men's concerns compared to their pregnant wives and discussed the differences between the two groups. The expectant mothers' concerns centered on the health of the baby and their ability to handle labor and birth. The findings suggested that the role of the expectant father should continue to be reevaluated. It is encouraging to see research that does not emphasize the mother-infant dyad but reveals an approach that highlights the very real fears of both expectant partners. If happy stable family relationships are to survive from one generation to another, then free and open communication between the partners, and between health professionals must be entered into.

Friedwald (1999), in his Australian report, indicates the importance of a male midwife acting as a facilitator at separate men's antenatal classes so that men are able to discuss any issues they have about childbirth. The men cover the following topics:

- Do men want to be present at the birth? labour/birth – both partners needs
- Men's emotions/feelings
- Postnatal depression
- Resumption of sexual relation's
- Transition to fatherhood and support networks.

The Preparation for Parenthood (P4P) antenatal classes focus predominantly on physiological aspects of pregnancy and the labor and birth. Postnatal events may or may not be addressed which is seen as a failure of these classes by parents, on the part of health professionals to adequately prepare the people they are teaching for parenthood.

Some women do experience an eventful pregnancy and birth and their partners may be thrust into the role of fulltime caregiver. One cohort of men who are constantly reminded of the pregnancy are those with partners who are placed on antepartum bedrest either at home or in hospital. Maloni & Ponder (1997), in their American study, used a retrospective descriptive design with a sample of fifty-nine men who had contacted a bedrest support group, Sidelines. In this research it has been suggested that fathers with partner's who experience a high-risk pregnancy, where there is the impending threat of a premature birth, have increased stress, negative psychological responses, and decreased support from family, friends and support services. The participants were asked to complete a questionnaire of open-ended questions that sought to identify paternal concerns, stresses and supports. The findings highlighted by the men were assuming multiple roles, managing emotional responses, and caring for their partner and the fetus. The men used various emotional and tangible coping strategies and although some were able to verbalize their concerns they received little help from health professionals. Whilst this is a small pilot study it revealed information regarding the men maintaining their mental health, financial status, and their physical functioning to enable them to get through the ensuing stages of labor, birth and the postpartum period.

Slater (1999) in her study of childbirth education and prenatal classes which recognized the needs of men, highlighted that most childbirth educators are female and are mothers themselves, which does give them a personal perspective on labor and birth. Childbirth education classes usually concentrate on the mechanics and choices of the labor/birth experience with emphasis on the mother. The father's role is often only seen as the support person but Slater (1999) proposes that men too are going through major life changes at this time and warrants an understanding of their experience. The importance of being seen both as an individual and a partner is stressed as the couple makes the transition to parenthood. The importance of education in the antenatal period for the expectant couple to promote positive outcomes in the labor and birth is also examined (Cox, 1989). Furthermore Cox (1989) proposes that there is no evidence to support that instruction on psychiatric disorders, in the antenatal period, has deleterious effects upon the expectant parents.

### ***Labor and Birth***

It is now common place for the father to be present at the birth (Riley, 1995). In the last twenty years the father is supposed to play a significant role in the labor process (Alexander, Levy, & Roch, 1995). Fathers present at the birth, that have undergone antenatal education, may be seen in the support role similar to that of the doula. Doulas are mature, medically untrained women, who accompany the pregnant woman through labor, that are familiar with the process of childbirth and the procedures that take place within the hospital. Conflicting research reveals that this support role in labor may be culturally inappropriate for expectant fathers in some societies and cause the arousal of adverse emotional responses to childbirth (Niven, 1995; Barclay & Lupton, 1999). The Australian nurse researchers Barclay & Lupton (1999), in their socio-cultural analysis examine the experiences of new fatherhood. A longitudinal qualitative study examined the significant role changes that 15 men undergo in first time fatherhood and their relationship with their partners in the first eight months of parenthood. The interviews were semi structured and took place on four different occasions from a few days after the birth to five or six months after the child was born. The data shows that the men were expected to be provider, guide, household help and nurturer. The demands of these roles, and the tensions that sometimes ensue, challenge the men in their relationships with their partners and the meaning and place of work in their lives and their sense of competence. Almost all the men found that the early weeks of fatherhood were more uncomfortable than rewarding even though their expectations had been high.

Other research literature examines the experiences of the father in childbirth that reveals the father feeling excluded from the birth (Fein 1976). For some considerable time expectant fathers have been the subjects of research to understand their emotions and feelings at the labor and birth of their child. For example, in an early American study, Fein (1976), utilizing an exploratory approach, identified men's feelings following the birth of their child. Thirty-two middle income first-time parents were non-randomly selected from childbirth education classes, obstetrician's offices, and through word of mouth. They were interviewed four weeks before and six weeks after the birth of their first child and the implications of fathering were included as the particular emphasis of this study. The study design presents statements of correlation and attempts to explicate patterns of association.

Three major variables arose in the data; dependence, marital sharing, and anxiety. At the first interview the men were asked about their experiences during pregnancy, their childbirth preparations, their hopes and expectations for labor and delivery and for the postnatal weeks, their previous experiences with children, their preferences for girl or boy babies, the amount of support they expected from their family, friends, and work, and their thoughts about being expectant parents. At the second interview couples were asked about their labor and delivery experiences, their first weeks as parents, the kinds of supports they received (and wished they had received), and the meaning to them of becoming parents. The findings revealed the importance of men and women having choices and support in the weeks after the birth. Some men wanted to share the experiences of childbirth with their wives despite social norms. The need for parenting education is called for, starting at school level, that demonstrates the mechanics of baby care. Support groups are also called for that will allow men and women to explore their particular experiences with other parents. Finally, conditions of employment options are suggested that will assist both parents to mix their work and parental obligations.

Another study by Chandler & Field (1997), using an ethnographic design, reported first time fathers experiences of the birth of their first child. Fourteen fathers were interviewed and prenatal expectations were compared with the father's perceptions after the birth. The findings reported show that whilst the men expected to be treated as part of the laboring couple, they found themselves in a supporting role. Eight themes emerged from the study:

- The men and their partner's ability to cope with labor
- More work than anticipated
- The men's increased fears at their ability to act as support for their wives
- Hiding their fears and emotions from their wives
- The men's lack of inclusion and the feeling that they were only being tolerated
- Increased excitement as the birth became imminent
- Relief at the birth of the baby
- Time to get acquainted as a family.

This qualitative study by Chandler & Field (1997), whilst small, has produced rich data. The men were satisfied with the overall outcomes but had specific concerns about

how they were treated by some of the staff. Chandler & Field (1997) recommend the fathers should be included in devising the labor management plans and need support in their role as coach to their wives. It is important that the men take regular breaks to eat and get some exercise, at appropriate times, during their wives labor.

If the labor and birth is perceived as being a worthwhile experience by the expectant couple it may have a positive impact upon their behavior in the postpartum period (White, 1998). There is a blanket assumption in the research that all fathers wish to be present at the birth of their child. It would seem that research investigating these socialized beliefs that may or may not reveal a conflicting picture, could be warranted (Connell 1995).

### *Postpartum*

The historical picture shows changing trends in the delivery of the child from the father being "midwife", to co-jointly the father with the midwife, and then only medical men with fathers exempted and midwives relegated to doctor's aide (Martell, 1995). In recent times midwives have seriously challenged the patriarchal dominance of medicine and childbirth became consumer driven as women demanded choices in their care in the antepartum and postpartum period (Littlewood & McHugh, 1997). A changing role for men too is revealed. As they become fathers there is often a mismatch between their expectations and their experiences through the antepartum to labor and postpartum periods.

### *Psychiatric Morbidity*

Tensions between biological theories and sociological theories about masculinity may manifest themselves by affecting relationships within the family and the wider social context. Marital discord has been shown to have a profound effect on the partners of women with postnatal depression. The men appear to show as much mental distress as women following the birth of their child and this may result in their inability to be supportive (Holden, 1991). In contrast, other researchers of women suffering postnatal depression state their partners as their first and main support in the nuclear family unit (Cutrona & Troutman, 1986; Bishop, 1999).

As a result of the disequilibrium in some men's emotional status, psychiatric morbidity maybe manifested in the antepartum and postpartum period. Identifying men's experience of stress may present as a low level in one man but that same level could cause

extreme distress in another. Buist (1996) proposes that paternal psychiatric morbidity can be considered in three different forms.

- First, the man has a known psychiatric illness prior to the conception.
- Secondly, when he develops a psychiatric illness associated to the birth of his child.
- Thirdly, when he develops a psychiatric illness in conjunction with his partner's psychiatric illness.

Under any of these circumstances, the father needs appropriate monitoring and ongoing treatment as the stresses associated with fatherhood may prove to be more than he can cope with (Fowler & Tseung, 1975; Alanen & Kinnunen 1975; Parnas, 1988, in Buist 1996).

In addition, researchers have reported that the transition to parenthood creates stress upon other members of the family besides the mother. For example, Jeffcoate, Humphrey & Lloyd (1979) in their retrospective qualitative study, investigated parental stress in two groups of families, a group of parents with pre-term infants and a control group matched for parity of parents with full-term infants. The control group was selected by drawing from the birth register the name of the next mother on the register, whose full-term baby weighed more than 2.5 kg. The groups did not differ in their social, educational or ethnic backgrounds. Interviews were held with all of the mothers and most of the fathers. The findings highlighted emotional disturbance causing loss of self-esteem and self-confidence in the mothers, problems in mother-baby attachment and management problems in the preterm group necessitating the father taking an active role in the care of his wife and child. The more stressful experience of giving birth to a preterm infant was attributed as the reason for the mother's loss of self-esteem and self-confidence.

A retrospective study such as this is at risk of the participants forgetting important data or remembering selectively. However, recalling happenings after sometime has elapsed does allow for a more unemotional viewpoint and a clearer impression of the whole sequence of events. More attention needs to be paid to the impact of a pre-term delivery and the stress related to such an event, on the father's mental status, if he is to function as the main support and carer of the family. The man's perspective of the pre-term birth is going to be different and therefore health professionals must recognize present different needs when dealing with men in these circumstances. Jeffcoate, Humphrey & Lloyd (1979)

posit that juggling commitments to his family and work can become very stressful to the new father and the need for flexible working shifts should be brought to the attention of governments and employers.

In contrast, self-efficacy in the parenting role maybe manifested through parent/child interaction. The American study by Zaslow, Pederson, Cain & Suwalsky, (1985) of thirty-seven families with first-born four-month-old infants, examined the associations between two groups of parents of parent/infant interaction. The findings showed 62% of the fathers experienced mild depression at some point after the birth of their baby. Observed behaviour was found to differ when the fathers reported eight or more days of the blues (Group 2 fathers) as opposed to no blues (Group 1 fathers).

- Group 2 parents vocalized less with their infants.
- Group 2 fathers showed less contact with their babies, whilst the mothers contact with the baby was heightened.
- Fathers in Group 2 did less caregiving.
- The Group 1 fathers did more than their wives.
- Topics of conversation by the parents in Group 2 were less likely to centre on the baby than the Group 1 parents.

Few differences were found between the two groups on interview questions addressed to the fathers. However, the differences that were found coupled with the father's descriptions of the blues pointed to relationship problems as an area of concern. Zaslow, Pederson, Cain & Suwalsky's (1985) research indicated, the greater involvement the father had with the baby was directly related to positive relations with the mother and a positive psychological state. Their research highlights that when the father registers his attention on his partner and the mother looks to the baby, the subsequent result was in all three persons involved having an impaired psychological state.

Turner & Kowalenko, (1997) posit that lack of involvement of the father with his wife and child, renders the father feeling isolated and lonely and acting as though he is not needed in the care of his child. This in turn puts added pressure upon the mother to compensate for the lack of support she receives. As a result mental illness manifested in the parents has been shown to have significant effects upon the child, whose emotional, behavioral and cognitive development is jeopardized. The child may quickly imitate parents

who no longer laugh and talk to their child with the consequence that the child may experience difficulties interacting with others.

In like manner, psychiatric morbidity in one partner may precipitate psychiatric illness in the other partner. Lovestone & Kumar (1993) in their English longitudinal study of the spouses of twenty-four women with postnatal depression, found twelve had psychiatric illness as defined by RDC or DSM-III criteria. Three groups were compared, a study group, a second group of partners with non-puerperal illness, and a third group of partners of well mothers. Associated variables, such as social networks, marital relationships, adverse life events and chronic social difficulties were also included in the study. The data was collected via questionnaires and telephone interviews. The principle finding of the study parallels that recorded by Harvey & McGrath (1988) showing that many (42%) husbands of women with postnatal depression do present themselves with a psychiatric illness and the rate of disturbance is higher (4%) than in partners with a psychiatric disorder in the general setting. The findings are supported by the fact that as the women's mental health improved, so did the men's.

The conclusions that can be drawn from this research are that if a woman is diagnosed with postnatal depression the reactions of health professionals are usually to enlist the help of the partner. Therefore it would seem important to ascertain the partner's mental health status before loading anymore responsibility upon him, if he is to enjoy good mental health. Rarely, if ever is the partner asked by health professionals how he is feeling after the birth of his baby (McIntyre, 1996).

Weymouth, (1996) used a grounded theory approach in her study of seven men's experience of having a partner with postnatal depression. The men revealed significant distress as they tried to engage in the transition to fatherhood and retain some measure of stability in their own and their family's lives. The findings show how the men moved from feeling out of control to gaining control in their lives through coming to realize that something was wrong, making sense of it and finally getting on the road to recovery. This study provides a framework for health professionals to understand that the man's perspective is crucial in helping the woman to recover.

As a consequence, the various roles that the father undertakes whilst his wife is disabled with postnatal depression can be considerable and is examined in the following

study. Barclay & Lupton (1999) provide a socio-cultural analysis of the experiences of new fatherhood. The participants in this longitudinal qualitative study were fifteen Australian men who were interviewed on four occasions, using semi-structured interviews, from a few days before the baby was born to five and six months later. The findings of this study found first-time fathers were expected to be provider, guide, household help and nurturer. The men were challenged in the demands of these many roles. The tensions that were produced with their partners, their work and their own competence was at times considerable. Almost all the men found the first months of fatherhood uncomfortable, rather than rewarding, despite having looked forward positively to becoming a father.

Contemporary social trends support the ideology that all fathers should be present at the birth of their child. However, some fathers are questioning this concept preferring to make choices in the part they play at the birth of their child. They do not wish to appear as the 'sensitive new age man' that is meant to present a softer and more caring form of masculinity that has arisen from feminist theory and the rise of the women's movement (Connell, 1995). Furthermore, it may be culturally inappropriate for some societies such as the Australian aborigines who perceive the labor and birth of the child as 'women's business' and leave the laboring woman to the care of the other women in the tribe (Anderson, in Grbich, 1996).

Sociological factors alone during childbirth do not account for men's depressed state during the postpartum period. The social implications for some men of their expectations as fathers were a mismatch with their experiences in the transition to parenthood. This is illustrated by the negative interactions of fathers with health professionals, (Barclay, Genovese & Donovan, in McIntyre, 1996). Also the tensions arising from competing roles within the family, workplace and the socialization of masculinity appear to cause severe distress to men in the postnatal period (Turner & Kowalenko, 1997). Nevertheless, gradually it has been demonstrated in the literature on postnatal depression in women, that the men's perspective is beginning to be heard via the voices of these women who are suffering postnatal depression and the subsequent forming of men's support groups (Bishop, 1999).

Webster, Markou, & Huxley (1999), in their Australian pilot study of a psychotherapeutic group of six married men, looks at the needs of the male partner, the

parent/child relationship, marital relationship and the women's clinical course. The men had one or two children whose ages ranged from three months to five years. The psychotherapeutic group met for one and a half-hours weekly for six sessions facilitated by two psychiatrists. An evaluative focus group was conducted two weeks after the conclusion of the therapeutic group. The study employed repeated measures and produced descriptive data. The Beck Depression Inventory (BDI) (Beck, Ward & Mendelson, 1961), General Health Questionnaire-30 (Goldberg & Williams, 1988), Significant Others Scale (Power et al, 1988), Parenting Stress Index (Abdin, 1983), and Dyadic Adjustment Scale (Spanier, 1976) were used pre and post intervention and three months post intervention. The female partners were also asked to complete the same scales at the same times. The findings revealed that no statistical conclusions could be drawn but significant chronic psychopathology was demonstrated in all domains examined. There was no significant change in these measures following the group intervention, which conflicted with the men's self-report at the focus group of significant benefit. Webster, Markou, & Huxley's (1999) suggested that six sessions were inadequate for this group. Themes that emerged included the extent to which the men's lives were dominated and constricted by their partner's depression, their confusion and powerlessness and their lack of and need for support for themselves was confirmed. It was concluded that a short-term psychotherapeutic group had limited benefit. The recommendations of more research into the experience and needs of men with partners of women with postnatal depression and an evaluation of longer term group intervention was proposed, together with consideration of alternative interventions such as a cognitive-behavioural therapy group.

In the study by Morgan, Mathey, Barnett & Richardson (1997) a group programme for postnatally depressed women, and for their partners' was examined. The program consisted of seven separate sessions each for the women only and one session for the couple together. The couple session is divided up into three parts: the first (about half an hour) is the introductory phase, with every one present. The women explain their difficulties and the men give their perceptions. The second part (about 1 hour) is for mothers and fathers separately, and the third part is with all the couples back together for a group discussion. The concerns of the women, their anxieties and feelings towards their partners, their own mothers and their infants were recorded. Psychotherapeutic and

cognitive-behavioural strategies were used to assist them in dealing with their anxieties. The men recorded their attempts to provide emotional and practical support to their partners and the invariable tensions that arose between the two parties. The programme helped the men to understand why this happened. Overtime a decrease in maternal distress and an increase in the women's level of self-esteem was shown. About half the men showed elevated levels of distress when attempting to address their partners problems during the program. It seems significant that, in only one session allocated to the men, a high proportion of them felt comfortable with voicing their emotional status, given that men are not known for publicly acknowledging their mental health status. It would appear that more time needs to be allocated to listening to what the men have to say concerning their experiences and whether they too would like to feel supported by their partners in the postnatal period as their mental health may be in jeopardy too. It appears as a disservice to women and men to define women in the postnatal period as being in a solely dependent mode. Token lip service is displayed to the partners that there might be benefits for them in attending this programme for one meeting only. By attending more than one meeting, the men may be better able to voice their concerns about their mental health as it could impact on the rate of recovery for the woman (Weymouth, 1996).

Andrees (1999) posits in her research that early intervention work with fathers is often difficult but a series of eight meetings were offered to men whose partners were experiencing depression and anxiety. The objective of the meetings was to create an opportunity for men to think about their experiences on becoming fathers. The fathers were then encouraged to express their emotional reactions to their experiences. Andrees (1999) discusses common issues for health professionals setting up support groups for men, for example, a convenient time away from the responsibilities of family and work. The men also reported on the links they perceived between the parenting styles they received and the expectations and fears they became aware of for themselves as fathers.

Whilst important issues are raised in this paper that allow men to voice their concerns in a safe environment, time should be made available when these concerns are shared in a parental group setting, so that spouses are made aware of the difficulties that men are experiencing on becoming fathers. Communication between the couple is vital and too often seems to be sadly lacking.

### *Summary*

This review has explored the available literature on postnatal depression to identify and justify the need for the present study. Although a paucity of literature on the man's perspective of childbirth and the postpartum period was revealed, a framework has been established to identify the concept of men and postnatal depression through the antenatal, labor and birth, and postnatal periods.

It is revealed in the research literature that in the last twenty years the emphasis on biological factors associated with postnatal depression as being more real because of their scientific basis has given way to an increased emphasis on the psychosocial aspects. Role changes in our society have blurred the boundaries of responsibility for household tasks and parenting, through the upsurge of interest in the women's movement and economic necessity. In addition, men are demanding greater involvement in the role of fathering (Jordan, 1990). However, the main concern of the researchers has remained firmly centered on the mother/infant dyad.

Factors have emerged which identify gaps in the research into postnatal depression. Cox, (1988) suggests that postnatal depression is a disorder of the Western world and recommends that more cultural studies are undertaken. Conversely if further research were undertaken maternal and paternal emotions may be recognized as a normative occurrence in the puerperium by other ethnicities. Most of the studies in this review reinforced the notion of the single nuclear family unit where the relationship is based on Judeo-Christian principles and marriage has been deemed sacrosanct. Redefining the characteristics of the family unit may be necessary in order to examine gaps in the research. That is to say, that the participants in the studies in this review were invariably white middle-class and educated, mainly because these people generally have the time, level of education and interest in taking part in research. These factors would appear to suggest that there is a proportion of people in our society that are excluded from research that may hold differing perspectives and even worse may not be receiving equal opportunities in the health arena.

Finally, there is a paucity of literature on which to base clinical nursing practice concerned with men and postnatal depression. Nowhere in the research literature could I identify any study that describes one man's experience of postnatal depression from a phenomenological perspective. The in-depth knowledge gained through the

phenomenological approach establishes the experience as a single person activity wherein the co-researcher brackets all previous knowledge of the phenomenon and the essence of the phenomenon is revealed. If one man's voice is heard to convey meaningful discourse to his partner, family and the wider community, it may encourage others to come forward to add to the body of knowledge surrounding men's experience of postnatal depression.

The next chapter presents the underpinning philosophy for this study. The philosophy of phenomenology is introduced and an overview of the research design is given. Some discussion also takes place about phenomenology as presented by Crotty(1996) and why it was felt his method was best suited to this study.

## CHAPTER THREE

### *Phenomenology*

In this chapter phenomenology is defined and the historical and philosophical development of phenomenology is presented. The key concepts of phenomenology are introduced and the interrelatedness of phenomenology to the lived experience of postnatal depression for the man who is the focus of this research is discussed. It is acknowledged that there is a vast amount of philosophical, theoretical and research literature surrounding phenomenology. Yet within the confines of this small project, it was decided that the five step method offered by Crotty (1996) was best suited to form the research design. The research design, Crotty (1996) suggests, encapsulates the common core of the phenomenological movement, which is the study of the phenomenon as the object of the human experience. Crotty (1996) refers to “new” adaptations of phenomenology in nursing research. Some of the examples of this phenomenological approach within nursing research are examined. These examples are followed by a justification for applying Crotty’s (1996) method to this study.

### *Defining Phenomenology*

A phenomenon is defined in the Oxford Dictionary (Hawker & Crowley, 1997) as “1) a fact, occurrence or change perceived by the senses or the mind. 2) Remarkable person or thing”. The word phenomenology is derived from two Greek words; they are *phaenesthai*, to appear and *logos*, meaning to reason (Moustakas, 1994, p.26). These definitions describe something that is manifested in the psyche through the use of all our senses. Something that appears (we experience) and which we interpret in order to make sense of it. The immediacy of that experience and its relationship to the world around us is accomplished before any interpretations are placed upon it. Thoughts are then interpreted as objects of the experience. With regard to researching a phenomenon or an experience, Omery (1983,p.62) states “consider all that is available in the experience under study, both subjective and objective, and strive to understand the total meaning that the experience has had for the participants”.

In this study there is an undertaking to present the objective and subjective experience of one man and postnatal depression. This is accomplished by the researcher

working with the participant (in this case, the co-researcher Paul), through the notion of language (to interpret) and thought (reflection).

Reflective practice in nursing education has become one of the touchstones of clinical practice (Pierson, 1998). One of the aims of this study therefore, is to inform nursing practice; thus a definition of phenomenology relating to nursing is appropriate. Writing about a phenomenological approach to nursing research, Meleis (1997, p.11) defines a phenomenon as “ an aspect of reality that can be consciously sensed or experienced. Phenomena within a discipline are the aspects that reflect the domain or the territory of the discipline”. Nursing is based on a humanistic philosophy that deals with the person’s everyday experience either in sickness or in health, in life and in death. Understanding of these phenomena in their immediate state, as they present to our consciousness as a concept, is presented in phenomenology. A holistic approach to care, as espoused in nursing, incorporates elements that have a phenomenological perspective. According to Oiler (1981) the phenomenological perspective presents methods that are readily available to nurse researchers to assist understanding of the everyday lived experience of the recipient of nursing care. However, Crotty (1996), whose method guides this study, maintains that what nurse researchers present is not mainstream phenomenology but an adaptation. He declares that although there is nothing wrong with this form of phenomenological research, it should be recognized as such.

In mainstream phenomenology Crotty (1998, p.84) proposes that “phenomenology of the phenomenological movement is a first-person exercise”. Only the person involved can examine and understand their own experience. No other person can do it for them, which means that there is always the possibility of further interpretations of experiences by others. Within this study this man’s experience of postnatal depression is his reality only and thus offers a basic understanding of the phenomenon. The participant looks upon the phenomenon as the object of their experience before any interpretation is placed upon it, for example, in love what is loved and in hate what is hated.

The object of the experience is then perceived in the consciousness through the interaction of our senses and this interpretation of the phenomenon becomes the “lived experience”. Phenomenology, as a philosophic discipline, has developed over many years with numerous points of view that may be better classified under an umbrella called the

phenomenological movement. In the next section the historical and philosophical development of the phenomenological movement is examined.

### ***Historical and Philosophical Background***

Historically, Kocklemans (1967) informs us that the term phenomenology was used as early as 1765. Spiegelberg (1972), Cohen (1987), and Reeder (1987) all offer extensive historical guides of the phenomenological movement. Although the German philosopher Kant (1724–1804) makes reference to phenomenology, it was Hegel (1770-1831) who defined it as knowledge as it appears to the consciousness (Moustakas, 1994). Giorgi, (1983, p.134) considers that “within a phenomenological framework consciousness is considered to be the principal realm since anything whatsoever that we can know or speak must come through consciousness”. The consciousness is the reality wherein the objective and subjective experience exist. These two approaches to experience are inextricably interwoven.

The mathematician Edmund Husserl (1859–1938) is attributed as being the founder of the modern phenomenological movement prior to World War 1 in Germany. He was deeply affected by the philosophies of earlier times, in particular the prevailing positivist philosophies of the 19<sup>th</sup> century (Walters, 1994). Husserl challenged traditional philosophical thought to build phenomenology as a creditable rigorous science. Husserl advanced the philosophical assertions of his tutor Franz Brentano. Brentano developed a philosophical notion of intentionality from the Scholastic movement as he prepared for life as a Catholic priest, having found that religion could not supply the answers that he sought in life (Crotty, 1996). The development of transcendental phenomenology by Husserl is concerned with the discovery of consciousness, essences, and ego that are derived from the notion of the objective and subjective experiences. The birth of transcendental phenomenology is described as “a science of pure possibilities carried out with systematic concreteness and that it precedes, and makes possible, the empirical sciences, the sciences of actualities”(Moustakas, 1994, p.28).

### ***Objective Experience***

The objective approach to experience is a theoretical one that is detached from human interaction. In examining a phenomenon all the everyday concerns of life are set to one side in an attempt to gain a totally new meaning of the phenomenon or rather as Crotty

(1996, p.4) describes it “ a renewed meaning”. Whatever is examined or looked upon is that which immediately presents itself to the consciousness. Thus the object is scrutinized to obtain knowledge from an objective stance of the thing itself. The object in this study is postnatal depression. Initially subjectivity is not allowed to encroach on the examination of the phenomenon.

### ***Subjective Experience***

According to Husserl’s transcendental phenomenology there is a subjective approach to experience. The subjective approach arises from consciousness within which the object of the experience, of what is real, may be found and understood (Crotty, 1996). The consciousness is a sensory awareness of and response to the environment (Merleau-Ponty, 1962). The subject in this study is the co-researcher, who is called upon to relate the experience of the phenomenon of postnatal depression as though he was experiencing it for the first time. Therefore, knowledge of the phenomenon is examined at its most fundamental level before any judgements or assumptions are placed upon it and a picture of the person’s lived world is conceptualized. In Husserl’s search for a logical structure the marriage of consciousness (subjectivity) and reality (objectivity) occurs. Giorgi (1982, p.145) states “the chief significance of this fact is that consciousness cannot be interpreted as a substance enclosed upon itself but rather as an openness to that which transcends it”.

### ***Embodiment***

When contemplating concepts appertaining to phenomenology, it is important to consider the work of later phenomenologists such as Sartre, Merleau-Ponty and Ortega y Gasset. Working from the perspective of existential philosophy, they found Husserl’s transcendental phenomenology too idealistic (Crotty, 1996). For the existential phenomenologist, “reflection is the dialogue between the subject and the object in order for meanings to be renewed or possibly created” (Crotty, 1996, p.71). It was Merleau-Ponty who created the concept of “being-in-the-world” or embodiment (Crotty 1996, p.47). The concept of embodiment refers to the fact that as bodies in the world we find the reality of that world within our consciousness. This conscious awareness, as described by existentialist phenomenologists, are the beliefs that Husserl argues should be bracketed (or “rather than finding consciousness in the universe, we find the universe in consciousness” Crotty, 1996, p.47). This awareness of our world is first conceived from within us and not

as a reaction to external events around us. It is a special level of consciousness that is the immediate awareness of the experience. Thus Crotty (1996, p.29) repeats Husserl's cry of "Back to the things themselves" in developing mainstream phenomenology.

### ***Mainstream Phenomenology***

Mainstream phenomenology is the study of a phenomenon, as the object of the person's experience. The phenomenal experience is the unique interpretation by the individual of the experience before they try to make sense of it. The focus in mainstream phenomenology is the quest for knowledge that answers the question *what is?* (Crotty, 1996). *What is?* is the common core of understanding of phenomenology that Spiegelberg (1982) refers to and suggests should be present in all phenomenologies.

Mainstream phenomenology is ideally suited to a small study such as this, on a man's experience of postnatal depression, where rich data is generated simply because it is the very real everyday life-world of one man. It is unique because it is one man's story and will never be repeated by any other man. Yet it is to be hoped that others will be able to relate to this man's experience of postnatal depression and gain greater understanding of it. Thus mainstream/traditional phenomenology forms the philosophical underpinnings of this study. The phenomenological method devised by Spiegelberg (1982) provides a framework of concepts that expand the understanding of mainstream phenomenology. The key concepts used are intentionality, intuiting, essences, and epoche or bracketing.

### ***Intentionality***

Intentionality is a concept derived from medieval philosophy that differentiates between psychic and physical phenomena, that Husserl was taught by his tutor Brentano (Crotty, 1996, p.37). Intentionality is not a purposeful or deliberate act, rather it is when the mind becomes conscious of a phenomenon (object) it reaches out into the object. What intentionality evokes is an inter-relationship between subject and object. There is an "active relationship between the conscious subject and the object of the subjects' consciousness. Consciousness is directed towards the object; the object is shaped by consciousness" (Crotty, 1998, p.44). Intentionality is the philosophical marker as the beginning of a phenomenological experience.

"But Descartes tried to work forward from this zero point.

He doubted everything, and that was the only thing he was certain of.

But now something struck him: one thing had to be true, and that was that he doubted. When he doubted, he had to be thinking, and because he was thinking, it had to be certain that he was a thinking being.

Or as he himself expressed it: *cogito, ergo sum*" (Gaarder, 1996, p.198).

The interrelationship provides an experiential internal knowledge of the object, "*I know, what I know*". For example, there is an understanding of "what is fear" in that which is feared or "like in that", which is liked. In this study, the phenomenon of postnatal depression is experienced by Paul as "a mental war". To be able to determine with absolute certainty, "*I know, what I know*", intuiting of the phenomenon commences.

### ***Intuiting***

The concept of intuiting indicates the grasping of the general essences of the phenomenon (Crotty, 1996, p.32) Writing about intuiting, van Manen (1984, p.38) proposes the definition as "insight which brings us in more direct contact with the world". Different perspectives of the phenomenon provide a blending of the real with the imaginary to arrive at the combination of "the real and the ideal" (Moustakas, 1994, p.27). Intuiting utilizes all of our senses and exposes the characteristics or essences of the phenomenon. This is the phenomenon as it originally presents itself to the consciousness before any reasoning is placed upon it. Thus the participant in this study is asked to describe the phenomenon of postnatal depression in its pre-reflective state, before suppositions are placed upon it. All the every day knowledge of the experience is peeled away layer by layer to arrive at the core of understanding. Such insights of the phenomenon are "self-evident and as it is given" (Crotty, 1996, p.52).

### ***Essences***

van Manen (1984, p.38) defined essences as the nature of the phenomenon. Understanding what the essence is may be judged by the immediate effect it has upon us. This striking effect of the essence is what we seek to comprehend. Thus to ascertain the essence of the experience in this study the question is asked, "what is the nature of postnatal depression?" As the essences emerge it is possible to reflect upon the phenomenon of postnatal depression and determine what it is and what it is not. Reflection leads to a state of wonderment about the phenomenon and it provides awareness and deeper

understanding of what it means to be human. This acuity of perception indicates an insight into self and may enable us to better empathize with others (Munhall, 1994), reminding us that our interaction with the phenomenon is the immediate experience of the object in its very ordinary state.

### ***Immediate Experience***

The influence of Husserl upon phenomenological philosophy sought to “get back to the things themselves” (Crotty, 1996, p.51). This was the first goal of phenomenological inquiry, to experience the phenomenon in its original state before any sense is made of it. Through the fusing of body and mind experience is created (Munhall, 1994, p.14). For example listening to the continual negative conversations of the mother with postnatal depression may lead to experiencing feelings of anger and frustration for her partner.

The empirical experience of the phenomenon based on pure observation is recorded before it is rationalized, theorized or assumptions put in place. The difficulty with practicing pure phenomenology is that socialization has become important in our everyday world. Within each society are the beliefs and values that characterize our various cultures and influence our lives. Our existence is cluttered with unnecessary ideas erroneously borrowed from others life-worlds, so that it is no longer possible to encounter the immediate intuitive experience. Thus the next step in “doing” phenomenology encompasses the concept of epoche or bracketing. This is probably the most important phenomenological concept but also the most difficult to put into practice.

### ***Epoche, Bracketing or Phenomenological Reduction.***

Influenced by Descartes (1596-1650), Husserl adopted the concept of epoche or bracketing. Descartes posited that epoche raised the knowledge of the experience beyond all possible doubt (Moustakas, 1994, p.26). Epoche requires all pre-judgements, preconceptions, assumptions, beliefs and prior knowledge to be set aside. The terminology, epoche, bracketing or phenomenological reduction are synonymous in the phenomenological method. As a mathematician, Husserl may have been familiar with the use of bracketing in algebraic equations. This led him to introduce two concepts known as natural attitude and philosophical attitude. Husserl’s view of the natural attitude, or our everyday experience, is bracketed, whilst the philosophical attitude is examined, and questions our suppositions about the world. All known beliefs and values are rejected so

that interpretation of the phenomenon is pure. However, Crotty (1996) argues that even though we may attempt bracketing, our interpretation is still biased by our cultural norms because we know no other way of perceiving the phenomenon.

### ***The Foundations of Phenomenology***

Clarifying and refining the phenomenon of human experience as the basis of phenomenology continued throughout Husserl's life and has become the basis of the phenomenological approach. Husserl described phenomenology as "a science of Beginnings, a "First" philosophy, such that all philosophical disciplines, the very foundations of all science whatsoever, spring from its matrix" (Husserl, 1931, p.28).

Phenomenological philosophy has influenced many disciplines. Psychological phenomenological analysis of the experience of "Really Feeling Understood", was carried out with a group of high school students to examine instances when the students had really felt understood by someone (Van Kaam, 1959), and a study into being anxious was carried out with undergraduate students in a personality theory class (Fischer, 1989). In education, a concern for practicing phenomenological research and writing was examined in a course on "Pedagogical Theorizing" (van Manen, 1984), whilst the discipline of sociology presented a phenomenological approach to our social world, in which, Schutz (1967) suggests, the natural attitude is a way in which consciousness interprets experiences.

Nursing, underpinned by humanism, has also embraced the philosophy of phenomenology. It is ideally suited to nursing research as phenomenology is based on human experience. However, Crotty (1996) proposes that much of nursing research is concerned with the subjective experience wherein thoughts and feelings become more important than the phenomenon itself. As previously noted, according to Crotty studies by authors such as Oiler (1982), Omery (1983), and Benner (1985), whilst they have much to offer, are adaptations of phenomenology. In order to return to the roots of philosophical phenomenological inquiry Crotty (1996) proposed the five step method of mainstream phenomenology.

### ***Crotty's Method***

Crotty (1996) provides a five-step method with which to approach phenomenological research. It is this approach that is used in the following study. The philosophical underpinnings of mainstream phenomenology propose a return to pure

phenomenology, wherein the common core of understanding, concerning the essence of the phenomenon, is allowed to emerge, rather than the co-researchers's feelings about the phenomenon. The researcher tries to capture as much of the original meaning of the phenomenon to ascertain what the very nature of the experience is for the person.

***The Five Step Approach***

Crotty (1996, pp.158-159) provides a model of individual steps that the co-researcher can work through to study the phenomenon. These are presented here but will be discussed in depth in chapter four.

- Step 1. Focus on the phenomenon.
- Step 2. Concentrate only on the phenomenon.
- Step 3. Describe exactly what has appeared.
- Step 4. Look closely at what is being described and ascertain that no other previous knowledge is influencing the description.
- Step 5. Describe the very essence of the phenomenon, the parts that go to making the phenomenon what it is.

Indeed, in Steps four and five of the method Crotty (1996) advocates that following reflection and meditation, the description should be re-examined as to whether it is solely the essence of the phenomenon or if it is prior knowledge of the experience. The description must be unique to the phenomenon and through testing could not be mistaken for a description of something else or a similar phenomenon. When the purity of description is attained both the researcher and co-researcher are aware as it produces one of those unique "aha's" of research when the phenomenon is revealed in its pure state.

In mainstream phenomenology, because the experience is unique to the subject or participant and not to anybody else, there is a sense of ownership of the research that makes it appropriate for the person whose story it is, to be known as the co-researcher. This does not infer that the researcher is in any way excluded from the process only that his/her job is that of asking challenging questions and through probing make clear the experience of the phenomenon. The researcher can compare and contrast with their own experience but ultimately the story belongs to the co-researcher. The appeal of using Crotty's (1996) mainstream phenomenological approach is that it is ideally suited to a small study as it produces rich data. The phenomenal experience is the interpretation, by the individual, of

the phenomenon, with no truth-value attached. Thus no two accounts of a phenomenon will be the same so a fresh encounter will be experienced in each study that is undertaken. The circumstances within which the phenomenon occurs will reveal individual interpretations as well.

The philosophy of phenomenology is presented both as an art and a science. As an art form it allows the phenomenologist to use whatever form of communication they wish to describe the phenomenon. Crotty (1996) advocates the co-researcher poetizes as if examining the phenomenon for the first time. Through poetizing the co-researcher will reject the mundane everyday description through the process of epoche or bracketing, and provide startling new evidence of dimensions of the phenomenon of their experience. The co-researcher raises his/her thoughts to a heightened level of awareness as the following poem describes.

***On A Criticism of J.K.Baxter's Poem 'Old Man'***

*"A thought in words arranged  
In rhythm is true poetry  
If you can only hear the wind  
Or feel a poignant loneliness  
Or hidden in a metaphor  
See crystal clear a poet's thought  
Then you have read the words arranged  
For you have heard the poet's voice."*

*E.V.M. McKenzie (1971).*

***Summary***

In this chapter phenomenology has been addressed from historical and philosophical perspectives. Whilst paying tribute to Husserl's transcendental phenomenology as founder of the phenomenological movement, it has allowed the reader to make the phenomenological journey to the present day. Husserl's cry of "Back to the things themselves"(Crotty, 1996, p. 29) advances the use of Crotty's (1996) mainstream phenomenological research approach as the guiding methodology for this study. Key concepts have been identified that serve to highlight traditional/mainstream

phenomenology that exists alongside the many adaptations of phenomenology. Both can add to the body of nursing research.

In the next chapter the researcher and co-researcher are introduced and the specific method used based on Crotty's five-step approach is described. Matters of trustworthiness and ethical considerations complete the process.

## CHAPTER FOUR

### *Method*

In this chapter an overview of Crotty's (1996) approach to the phenomenological method that guided the study is provided. The reader will meet the researcher, whose dual role is acting as author and participant, and the co-researcher as the participant/narrator who allows the reader to be privy to the story of his life-world before, during and after the experience of postnatal depression. Crotty's (1996) step-wise approach employing steps one to five in the method are identified and the means of data collection and organization are presented. Concerns for trustworthiness of the research and general ethical considerations are also discussed.

Phenomenological research demands more than just grasping the underlying philosophy as highlighted in the previous chapter through reference to the work of Husserl, Spiegelberg, Merleau-Ponty and Crotty. In order to inform nursing practice and other health care professionals, this study of the life-world of one man and his experience of postnatal depression aims to increase the body of knowledge by providing insights that are not immediately available on this topic.

### *Research Design*

My involvement brings to the research another set of thoughts and values concerning postnatal depression. It is these assumptions that I expose to question my fundamental beliefs about postnatal depression. This procedure is to assist in the process of bracketing (Crotty, 1996). A transition should occur that allows the researcher (myself) to set aside previous assumptions and through imaginative and attentive listening be aware of the co-researcher as a total person. Writing these assumptions in a journal enables me to reflect and set them down as part of the research process, to be able to "Step outside the circle of taken for granted. Be ready to receive being as it is. Stretch out our minds to existence" (Crotty, 1996, p.152). It has been documented that journalling is a useful means of professional and educational development for nurses (De Vore, 1993, Hodges, 1996, Neville, 1997). Thus the following assumptions concerning postnatal depression I set down in a journal to be included in the research as field notes.

### *Assumptions*

- Men and women experience postnatal depression.

- Men suffer postnatal depression secondary to their partner's postnatal depression.

I have never knowingly previously nursed any men experiencing postnatal depression so bring no clinical knowledge with me that could bias the research. Lack of father/child attachment as discussed in the literature may be contributory to postnatal depression in men.

### *Sampling*

The most important factor in undertaking this study was selecting the participant. There is no direct referral system within the New Zealand health care context for men experiencing postnatal depression except possibly through their general practitioner. There are no rigid criteria to adhere to when searching for the right participant for a phenomenological study. The essential criteria are that the participant must have experienced the phenomenon under scrutiny and be willing to share that knowledge. The participant must have an intense interest in, and an ability to convey the very nature of the phenomenon. In this study this may mean returning again and again to the man's experience of postnatal depression to elicit the true essence of the phenomenon.

In mainstream phenomenology, as described by Crotty (1996), the participant must be able to bracket all previous knowledge and assumptions surrounding their experience, and be able to engage in reflection and intuit the phenomenon. Crotty (1996) recommends that the participant is able to poetize and be creative in their description. For the purposes of this study the participant had to be able to speak English in order for an in depth analysis to be possible. A willingness to take part in one or two lengthy interviews and agree to have those interviews audiotaped and the data analyzed for publication was also required. Under the Crotty (1996) framework the participant must be willing to be a co-researcher.

### *Procedure*

As this study was to have only one co-researcher the person must be carefully chosen to have the time and ability to focus completely upon the study and all its many demands. Nurses working in a Maternal Mental Health Team were instrumental in bringing together the researcher and co-researcher for this study. These nurses are acutely aware that there are men who equally require their expertise whom they are not at liberty to attend to, i.e. paternal mental health. They knew of my interest in postnatal depression in men and as the man in this study was insistent that there must be someone who would listen to his

story, one of the nurses suggested we meet. In the course of a telephone conversation with the co-researcher I was invited to his house. From the initial exploratory meeting, where I was privileged to meet his wife, five-month-old baby and his wife's grandmother who lived with them, my co-researcher was an obvious choice. I needed to look no further, as he displayed a total commitment to the task of wanting to tell his experience of postnatal depression.

An explanation was given concerning the need for ethics approval for the study to be undertaken. Due to the sensitive nature of the topic, the application for ethics approval was carefully compiled to ensure that the co-researcher, his wife and family, would be in a safe environment and that the ethical principle of beneficence would prevail throughout the entire study. This was particularly important as the co-researcher wished to identify himself in the study by name and this of course would have implications for his wife and family. Following a formal letter, a meeting was arranged with the co-researcher and his wife. My supervisor accompanied me to ensure all matters concerning the research were fully discussed and any questions that the co-researcher and his wife may have were addressed. The co-researcher was given an information sheet to keep (Appendix 1) and time to consider the proposal before signing a consent form (Appendix 2). In signing the consent form the co-researcher, with his wife's support, gave permission for the co-researcher to use his first name in the research. Prior to final consent, the couple asked questions appertaining to the format of the study and the process of the interviews that the co-researcher would take part in.

### ***Data Collection***

Qualitative research according to Baker, Wuest & Stern (1992, p.99) must "focus on the richness of human experience, seek to understand a situation from the subjects own frame of reference and use flexible data collection procedures. Phenomenology is the methodology used in this research. It is a qualitative research approach that constructs the meaning of life out of the experience of those who are living the experience, through dialogue with the person. Thus a series of interviews were conducted with the co-researcher as I facilitated his construction of what the phenomenon of postnatal depression meant for him.

Written data, such as a reflective diary or journal is often collected. Interviews are usually audio-taped. Information gathered from public documents such as archives may also be included as a data source (Parahoo, 1997). Data is accepted that has meaning for the co-researcher and the researcher, provided it is an accurate description of the phenomenon. It is not expected that it will be a carbon copy of someone else's experience. However, there may be similarities in the meanings expressed by others that are generalizable. The data is examined in its entirety to gather an overall picture of the experience. Then the data is considered as individual parts. The meaning gained from the whole data may change when analysis of the individual parts is undertaken. Like panning for gold the person's thoughts are swirled around till only the gold nuggets of pure experience are left in the pan.

As the person opens to the experience he/she draws upon language that adopts the singular tense. The first taped interview with the co-researcher was something of a catharsis as the words and emotions just poured out like piercing a boil. It was recorded when the baby was five months old and whilst their emotional and psychological health had improved, the co-researcher and his wife were still treading the unsteady waters of new parenthood together. As the story unfolded there was an amazing moment of realization when the researcher and co-researcher reached an understanding of the fundamental experience of the research into postnatal depression for a man. The purpose of the research at this point was achieved to gain some insight into another person's life-world. Invariably these moments were greeted with either a burst of laughter or a big sigh of relief or even tears, as the co-researcher and I finally grasped the meaning of his experience of postnatal depression. Such is the power and intensity of "doing" phenomenological research.

In order to gain some semblance of order and do justice to the co-researcher's story I produced the worksheets that I had crafted, based on Crotty's (1996) five-step method for phenomenological research (Appendix 3). The co-researcher replied to them, as seen in the results chapter, using the medium with which he was most comfortable, that is via his computer. This medium gave him the space to be isolated and meditative with his thoughts, not to produce models or theories but as a means to produce pure phenomenology.

### *Crotty's (1996) Method*

First, the research approach is guided by the research question and secondly, the perspective of the researcher. The research question for this study is "what is the essence of

postnatal depression for this man?" The subject in this study is one man, and the object is the phenomenon of postnatal depression as it appears in his consciousness. The act of epoche or bracketing is undertaken so that the subject is fully aware of the object and is able to describe the experience accurately

- In Step One of Crotty's (1996) method, the co-researcher is required to focus on the phenomenon of postnatal depression to determine as accurately as possible just exactly what the phenomenon of his immediate experience is, (or was).
- In Step Two he must bracket all previous knowledge, feelings, beliefs and judgments concerning postnatal depression and concentrate on the phenomenon as the thing itself.
- As the co-researcher becomes more accomplished at this task, he is able to describe what appears as the phenomenon of his experience in Step Three.
- In Step Four it is important to ascertain that what is described is a phenomenological description of the human experience of postnatal depression and could not be mistaken for anything else.
- Step Five determines what the very essence of the phenomenon of postnatal depression is for the co-researcher.
- Steps Four and Five require the co-researcher to indulge in reflective practice, concentrating on the thing itself to intuit its basic structures so that a unique picture of the experience is formed. The suggestion is that he allows himself to become totally immersed in his thoughts on postnatal depression, so that his mind grasps at the very essence of what postnatal depression is for him.

### ***Organising the Data***

Qualitative research produces rich amounts of data. The systematic analysis of volumes of data is reduced to themes in a progressive fashion. Through reduction and interpretation the information maybe displayed in matrices, identifying the relationship between the different themes from which the reader is able to understand the process of analysis (Cresswell, 1994).

The researcher must remain true to the data. Data analysis required thorough reading of the co-researcher's transcript and sensitivity to the meanings that he was trying to convey. For this reason it is best to commence the analysis whilst the interview is still fresh in the interviewer's mind.

Identifying the different meaning units is a useful exercise to sort the relevant segments and the themes arising out of each segment. There are various steps when analyzing the data as previously indicated.

- I started by reading through all the transcripts to gain a sense of the whole meaning of the story.
- Then I took individual interviews and tried to grasp the underlying meaning of each new subject that arose and wrote down my thoughts in the margin of the transcript. According to Van Kaam (1959) these subjects must have two requirements:
  - a) a moment of the experience that might eventually be a necessary and sufficient constituent of the experience under study
  - b) the potential for abstracting the moment and labeling it, without violating the formulation presented by the subject.
- I then clustered the thoughts into topics with similar meanings or ideas.
- Major themes, using richly descriptive statements started to arise.
- I numbered these statements, and attached the numbered units to the sentences in the transcripts.
- I then clustered the themes and reduced them again to those that interrelated to each other to provide meaning to the whole data material. As Creswell (1994)
- indicates, I found it took several attempts at reducing the themes, to gain the complete meaning of the phenomenon under scrutiny.

Maintaining academic rigour is essential in order to establish trustworthiness in any research. Establishing rigour in qualitative research, Koch (1994, p.976) proposes, occurs “if the reader is able to audit the events, influences and actions of the researcher”. Thus an audit trail was established for this research based on the conceptual paradigm recommended by Guba & Lincoln (1981).

### ***Trustworthiness***

To attain trustworthiness of this study the reader must be able to see that the method of analysis is guided by the research. Trustworthiness is achieved in this study through using four concepts recommended by Guba & Lincoln (1981), auditability, credibility, dependability and fittingness. Fittingness may not be applicable to this study, as it is a one-

person exercise, and thus the data will not 'fit' to anyone else's experience. Readers will be able to assess fittingness if the interpretation has resonance for them. Trustworthiness is confirmed via an audit trail that allows the reader to follow the researcher's structuring of the research to provide insight into the data.

### *Auditability*

Auditability concerns remaining true to the data. The reader must be able to follow the information from the research question to the raw data, through the analysis to the interpretation of the findings (LoBiondo-Wood & Haber, 1985). The findings must reflect the true meaning of the co-researcher's experience.

Crotty (1996) calls into question research that purports to being based on phenomenology that merely identifies the subjective experience by describing it and understanding it. In mainstream phenomenology the themes must arise from the data themselves. A large proportion of the findings are manifested as direct quotations from the data. Also the Appendix 3 may be seen as an example of themes arising from the transcripts. Bracketing is the only criteria that Crotty (1996) proposes before analyzing the data. If the audit trail can be followed the reader can proceed to determine the value of the research.

### *Credibility*

Undertaking this qualitative study has meant spending considerable time with the co-researcher, getting to know him. A great deal of time was invested in going over the transcripts again and again to elicit the essence of his experience. Guba & Lincoln (1981) propose these actions to promote credibility of the research. Credibility of the study was established as the co-researcher validated the journals and tapes in order that his voice was heard. According to Sandelowski (1986), a qualitative study is deemed credible if the co-researcher is able to recognize the descriptions and interpretations as being a true account of his experience. I returned to the co-researcher to discuss the findings with him to confirm credibility of the data when the analysis was completed. I provided him first with a model of the structure of the analysis and secondly, the completed chapter on the analysis to read.

From a personal perspective, my responsibility in bringing credibility to the research was accomplished by keeping a journal in which all my assumptions concerning

postnatal depression were listed to comply with Crotty's (1996) process of bracketing. I was therefore able to ensure the co-researcher's voice was heard and not my own.

### *Dependability*

Dependability of qualitative research was achieved in this study through the unwavering commitment by the co-researcher to provide in-depth data. Many of the quotes were taken directly from the transcripts and are included in the findings. Another manner of establishing dependability is to have the data independently judged. As this study is part of the Master of Nursing degree program it has been overseen by my supervisor who has in-depth knowledge of phenomenological analysis.

### *Ethics*

As a researcher and a nurse I realized I had considerable responsibility in the form of ethical considerations to the co-researcher and his family, to the research project and myself. A great deal of time and effort went into consideration of ethical issues to ensure that no harm should come to the co-researcher and his family particularly as he was given the option to be recognized publicly by his name in the study. This decision had particular implications for his wife and family's anonymity. Thus my supervisor and I met with the co-researcher and his wife to ensure that this matter and the whole research process was fully understood and any questions that they wished to ask were fully addressed. Further to the co-researcher and his wife signing the consent forms for the interviews to commence, his verbal consent was always obtained prior to each session as a moral obligation on my part. Although not a participant in the study, the co-researcher's wife also signed the consent form in order to protect her right to autonomy.

It was not envisaged that any physical harm would befall the co-researcher directly related to the study. In the event of distress arising from the revealing of painful information, strategies were put in place to enable the co-researcher to receive counseling through his church. No harm did eventuate for the co-researcher whilst undertaking this study, quite the opposite. His thoughts on taking part in the study are included at the conclusion of this study.

The names of the co-researcher's wife and family, other health professionals and any institutions have not been documented in written form to retain their anonymity. The audiotapes, computer discs and all written material were securely stored at my home. All

the audiotapes were transcribed *verbatim* by myself. My supervisor was the only other person who had access to the material, thereby further preserving anonymity. The co-researcher requested that the tapes be returned to him. This research is based on the belief that meeting appropriate ethical requirements is an essential part of the research process.

***Summary***

An attempt has been made in this chapter to address the method of data collection through which an understanding of the experience of postnatal depression for the co-researcher was described. My concerns about protecting the co-researcher, his wife and family and other ethical considerations have been explicated.

In the next chapter Paul is introduced as the co-researcher. A presentation of the findings of the study follows and the phenomenon itself is revealed.

## CHAPTER FIVE

### *Paul*

*When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they are revealing truths. These truths don't reveal the past "as it actually was," aspiring to a standard of objectivity. They give us instead the truths of our experiences. They aren't the result of empirical research or the logic of mathematical deductions. Unlike the reassuring Truth of the scientific ideal, the truths of personal narratives are neither open to proof nor self-evident. We come to understand them only through interpretation, paying careful attention to the contexts that shape their creation and to the world views that inform them (Personal Narratives Group, 1989, p.261).*

In this study Paul's thoughts are revealed from a phenomenological perspective about his life as he makes the transition to fatherhood. As the phenomenological essence of postnatal depression appeared, Paul was able to recognize and verify that this is the phenomenon of his lived experience of postnatal depression. The essence of the phenomenon of postnatal depression I discussed with others more knowledgeable in the field of phenomenology than myself such as my supervisor, other lecturers in the nursing department at Massey University and Waikato Polytechnic Institute. They were able to clarify and confirm that a phenomenological perspective of postnatal depression was emerging.

Hence, as the past, present and future all interweave (van Manen, 1984), vital descriptions come together as four different themes of Paul's experience of postnatal depression emerge. The themes whilst treated as separate entities, and sometimes appearing to produce conflicting information, are nonetheless closely interrelated. Each theme points to what comes into view revealing the phenomenon that is Paul's experience of postnatal depression as he describes his life world in the postpartum period.

Reference to other literature is made to allow the process of intentional analysis to take place. "Phenomenology seeks an intentional analysis that embraces both object and subject, the noematic and the noetic" (Crotty, 1996, p.125). The phenomenon contrives to

be within the person's consciousness and their experience. Thus the phenomenon is related by these two elements i.e. "on their being-in-the-world and their being-with-others" (Crotty, 1996, p.125).

The literature illustrates that a phenomenological perspective portrays the spiritual and temporal perspectives of our life-worlds (Merleau-Ponty, 1962). "It is the task of phenomenology," says Marton, (in Crotty 1997, p.151) "to depict the basic structure of our experience of various aspects of reality and to make us conscious of what the world was like before we learned how to see it".

Paul begins his narrative on the transition to fatherhood in the antenatal period. His first thoughts arise from a spiritual basis concerning fatherhood and depict the inner conflict that he is attempting to rationalize. Paul was close to tears as he describes the depth of his emotions at this time as he is torn between wanting to become a father and yet scared of the unknown paths of parenthood that he was about to embark upon:

*"Quite scared actually. I had all these thoughts, well what if I lose this person that I love so much... and me being very family focused and wanting that family unit so much. I found that very very hard. (10:2)*

The next dimension of Paul's experience, reveals the temporal aspects of his becoming a father. Paul's ambivalent feelings were manifested and form a link from his past life to the present one before he "learnt how to see it".

*"I felt two emotions, first, I was ninety-five percent rapt, and second, five percent, a bit later would have been better, to be able too get the flat finished.' (2:1)*

The "flat" referred to was to house Paul's wife's grandmother who had raised her since childhood and was now too infirm to live on her own. So for this young couple an extended family was already part of their social network. Thurtle (1995) has cited the lack of kinship support in the postpartum period as a contributory factor in postnatal depression, but it also meant added responsibilities for Paul now acting as sole provider for the family unit. So the sole supporter of the family may be caught in a double bind situation in these circumstances, in doing that which is socially expected whilst coping with the added stress in his life.

Paul is not alone as he expresses his feelings regarding the uncertainty of impending fatherhood. Other men have voiced similar sentiments towards fatherhood as corroborated by Brien (1993, pp.13-14):

“Of course, almost all of my old-home-towners, wartime comrades, fellow students, drinking companions, upwardly striving, over-achieving by-liners and telly faces, admen and backbenchers, actors and authors, naturally aspired to sire a child some time, eventually. They were only waiting for the right job, the right state of the market, the right international situation, the right house, possibly the right spouse – for this was the first generation of our sort to begin to accept divorce as commonplace”.

Sean French (1993, p.4) contributes, “ Our view of property, marriage and sexual morality is now hopelessly muddled but the paternal anxiety survives.” van Manen (1984, pp.51 – 52) also remarks, “The next time the topic of having children came up (I might have brought it up myself), I still resisted, but weakly. I doubted my ability to be an enthusiastic father.”

Paul continues with a description of the pregnancy as uneventful and proudly announces that his “wife blossomed” with good health. As intending parents, Paul and his wife enjoyed actively entering into educating themselves about the impending birth of their baby by attending antenatal classes regularly. However, it is interesting to note that as Paul retrospectively considers the subject of antenatal education, he acknowledges his anger at the lack of information that was imparted. A comparison of his final perspective of the antenatal classes is in conflict with his initial statement where his perception was that postnatal depression does not occur in educated people. This appears to confirm the need to return to the phenomenon itself again and again to allow the different dimensions to arise in order to gain its implicit meaning. Paul starts by finding the classes informative and whilst postnatal depression was briefly alluded to at the antenatal classes, he relates:

*“You never think that it is going to happen to you, being both intelligent, professional people” (2:1).*

*“Antenatal classes didn’t touch very much on it. They only skim through it in half a lesson or something pathetic like that” (44:2).*

*"I guess I feel pissed off that I didn't know more about it at first. I just had to sort of wallow around and just try and get through it" (3:3).*

Paul's various statements summarize the antenatal period where information given at the antenatal education classes does not prepare the parents for the postnatal period and is at odds with their real life experience. The literature supports the turmoil that takes place in Paul's life for example, the dysfunctional ways of thinking that he copes with and the general lack of order in his home, following the birth of his daughter (Bishop, 1999).

For Paul, the birth of their daughter was not to be as eventful for him as his wife. The day before the birth, Paul was admitted to hospital with abdominal pain and underwent surgery for appendicitis. One of his greatest regrets is that he was unable to take a more active part in assisting his wife in labor due to his restricted mobility and had to leave this role to a friend who acted as a support person. Discharged from hospital the following day, Paul attributes the increased travelling to visit his wife and new daughter in hospital, to the breakdown of his wound and his subsequent re-admission to hospital for a further five days for intravenous antibiotics. Again he regrets the lack of support he was able to give his wife with the baby, in those early postpartum days.

On reflection Paul realizes that from his perspective the birth experience was less than ideal and whilst he knows he cannot change anything that happened, he was disappointed with the limitations that were placed upon him. Societal beliefs about gender roles tend not to see men as fathers in their own right, rather they are viewed as the breadwinner and therefore validation as a parent does not take place (Jordan, 1990).

Paul's desire to play an active role in the birth and have recognition of his social status as a father is referred to in the literature as "couvade". Researchers Mason & Elwood (1995) as previously cited, describe couvade as the male experience of pregnancy.

The couvade produces a range of signs and symptoms that are usually attributed to the pregnant woman. However, the etiology of the couvade in men is unknown. Couvade was a familiar phenomenon in preindustrialised Western societies. These rituals and taboos that form the couvade, are still observed today by some Asian cultures and some tribal societies and provide social status for the father in his new role. Summersgill (1993) postulates that in modern day Western society, the couvade is re-enacted in the labor ward as new fathers gain an increased knowledge of all the technical aspects of the birth, for

example, ensuring that their partner gets adequate pain relief. They also may assist their partners to make decisions for the labor and birth of the baby. Paul did not take part in the labour rituals, which may have been a contributory factor in his dissatisfaction with the birth experience.

Discourses on masculinity in our society today identify the biological and social constructions of fatherhood. A biological perspective of expectant fathers is currently being researched by Storey (in Motluk, 2000). The preliminary findings reveal that the male hormone testosterone mimics the rise and fall of their pregnant partner's hormones. Storey (in Motluk, 2000) speculates, following empirical research on birds, rodents and some primates, that a combination of behaviour and pheromones from the pregnant female prompts the father to anticipate the birth of their child too.

Social determinism establishes the role of the male as the breadwinner. Paul acknowledged that he underwent some behavioral adjustment to parenthood, and whilst he was willing to undertake the house work, he still clung to the idea of having a household that is run in exactly the same way as it was before the baby was born. Thus within the new dimension of fatherhood Paul experienced confusion and conflict which he illustrated with the following anecdotes:

*"I knew there would be a culture shock there but... so it was just my job to come home and relax and have dinner made and the baby looked after, so this needed a change in attitude." (8:1)*

*"Even right from the beginning I put her straight on that one, I said to her because, I do most of the cooking in the house anyway, I don't care if I have to come home and do the cooking. I do not care if I have to come home and there's clothes everywhere and the mess is terrific if it means that you have had a relaxing day doing things with the baby."*

Targett (1993, p.137) states "He who is not busy being born is busy dying. I am not dying, but a young and selfish part of me is, and I will mourn it when it goes." Paul confirms these sentiments as he struggled to reconcile the different lifestyle he enjoyed before becoming a father. Awareness of a sense of urgency and a need to achieve in his new role is manifested as he says:

*"I think I'm pretty efficient as well and can come home and throw the clothes in the washing machine and dryer, do the dishes and get tea under way" (16:1).*

### *Summary*

To summarize, Paul as the co-researcher is introduced as he makes his transition to fatherhood. Psychological, sociological and biological perspectives that present emotional and behavioral dimensions of his story commencing in the antenatal period are provided. The study reveals that there is conflict between Paul's expectations and actual experience as a father. He felt he was inadequately informed, particularly concerning postnatal depression in the antenatal period. The literature referred to has offered a theoretical dimension to Paul's experience.

The next chapter presents Paul's phenomenology of his experience of postnatal depression, as the analysis of the research is presented.

## CHAPTER SIX

### *Analysis of the Research*

The aim of this chapter is to follow the process of analysis of the data for this study. The process of data analysis reduces volumes of information to themes and categories, through reduction and interpretation. Data analysis requires thorough reading of the co-researcher's transcripts and being sensitive to the meanings that he is trying to convey. To do this the role of the co-researcher and researcher takes on other dimensions as analysts and recorders of Paul's lived experience of postnatal depression. The task of reading and re-reading the transcripts has enabled us to gather together every word and phrase to establish each evolving nuance in the data.

In transcribing the audiotapes I remained true to Paul's words, thus as he speaks, the true expression of his meaning is illustrated as I present his story. Systematically sorting all the data was a useful exercise into relevant segments and then the themes arising out of each segment. Three themes emerged from the data:

- *Postnatal depression: "It's a bit of a mystery"*
- *Interpreting real life: "Keep on, keeping on"*
- *Discovering real life: "who am I?"*

Phenomenologists refer to the term "pattern" to describe one overarching theme that links other themes. In the model that presented from the analysis of the research on Paul's experience of postnatal depression, these three themes were linked by an overarching pattern entitled: "*It's a mental war*".

#### ***"It's a mental war"***

In the pattern "*It's a mental war*" Paul reflects upon his experience of postnatal depression. He spoke of how postnatal depression affected his life as the link between the past, the present and the future was forged. Paul acknowledged that his life both at home and at work had changed and he perceived his life as being utterly relentlessly drab. It was no longer a life with high and low emotional moments but a continuous limbo that he was existing in. He said:

*"You're not going forward or back, it's just a constant gray" (38:2).*

*"It would be wavy, like a snake and long. Long being the feeling and time it takes to work your way through it. And the waviness 'cos you think you're getting somewhere and*

*you're not. And the constant sort of emotional ups and down in yourself to try and weave your way through it" (39:2).*

The debilitated state both mentally and physically that Paul was slipping into fast, with the onslaught of postnatal depression caused him to lash out verbally to vent his feelings of anger. As so often happens he realized that he achieved nothing positive by doing so and reflected that he was surprised that he reacted in this way as he considered himself an emotionally well-controlled person usually.

*"A few times I've actually shown it a little bit to [my wife] and I can hold in a lot of that because of the type of person I am, but it's made me very, very angry sometimes. And a few times because it's got me so wound up that much some of the things I said to [my wife] didn't help the situation at all" (39:1).*

Paul spoke of his activities in the wider community, as he tried to continue with his work in the corporate side of a retail business. By this stage Paul had been living with postnatal depression for a number of months and his emotional status was becoming overwrought. The stress he tried to cope with at home produced unfamiliar feelings of anger. The only respite he experienced from these feelings was by going to work. He recounts:

*"What was hard for me was coming home to a mental onslaught which was something I did not like and started to find hard. I didn't mind coming home to do physical work but coming home to a full on mental onslaught after having a mental onslaught at work, I handled it very well I think probably for two or three months and then it got to the point where I started getting a bit angry with it" (11:1).*

*"To me postnatal depression ended up being a mental war of trying to talk through every issue that came up. And its bloody hard when you come home from work and get THAT, till you go to bed and its quite a relief to go to sleep and you know that you have to go to work again" (7:2).*

As well as experiencing anger, the mental war that Paul spoke of also produced the following descriptive passages that evoked feelings of fear in him. The clarity, with which Paul expressed his fear generated by the flashbacks, illustrated Crotty's (1996) call to poetize when embarking upon a phenomenological study. In this way unusual words and phrases are used and seek to convey to the reader the breadth and depth of the experience of

postnatal depression for that person. Paul spoke of the incidence of flashbacks in which a word or a phrase would conjure up memories of postnatal depression for him.

*"It just drops you down to a quick low. Probably the only thing I could say is the odd little word or the way a phrase may come out or the way it's spoken which will take me back to a memory. That memory is there and its sort of like going through that video in my mind as such, of whatever that scene might be" (21:2).*

Paul used his descriptive powers to incorporate colours and sounds that presented graphic pictures that are inextricably bound to his experience of postnatal depression. His perception of frightening phenomena was connected to the colour black. Paul equates the colour dark purple to the level of fear he experienced whilst engulfed with postnatal depression.

*"I would say purple for some reason. It's a colour for fear, dark purple, because black is for a very bad fear... I guess black for me is the fear of when you are just about to hit something [sudden hand clap] or you're falling off something [sudden hand clap] and it's just before that impact. I used to be scared of heights, used to being right on the edge and thinking you were going to fall off. Really mentally thinking you were mentally going to fall off. Or ever so scared of just losing balance even though your feet are planted perfectly. Yes for me its definitely just before the impact [sudden hand clap] or just before the inevitable, - its going to happen - oh god"(21:3:4).*

Noises were also a catalyst to Paul's experience of fear connected to postnatal depression. As he went over recent events, Paul renewed his acquaintance with his fear as he says:

*"No, I wouldn't say it was a physical thing. With me it's more like a mental drone, sort of like a droney fear. It's not a physical thing, it's a mental fear"(20:2).*

*"The memory comes when I get that droney thump sort of fear. And I sort of feel, "oh, god!" and then its gone and the real fear part is gone. But then the memory just ticks over for thirty seconds to a minute and then I'll go on thinking about something else. And thinking, "thank god, that's over with" (23:2).*

Such unpleasant episodes have been described as post traumatic stress and have been linked to negative past experiences surrounding childbirth. (Littlewood & McHugh, 1997). Definitions of post traumatic stress as a disorder are identified in the DSM 1V

(1995) proposing that an event be experienced that is outside of the normal range of life happenings, resulting in extreme levels of stress to the person. Often this stress is associated with war. The event may be re-experienced on several occasions producing a broad spectrum of responses ranging from avoidance techniques to hyperarousal to the stimuli.

Persistent recollections of postnatal depression made a huge impact on Paul, that caused him to think about the future and any further children they may have. He was aware that the distress postnatal depression caused could re-occur in subsequent pregnancies. Paul says:

*"I guess when those flashbacks come its just a quick, "God, I'm glad that's flipping over and done with, you know, but then there's always that possibility that its going to happen again when we have number two child but hopefully we'll be on to it next time"(22:2).*

Paul spoke of the paradox that as unwelcome as the flashbacks were in his life, it did cause him to acknowledge that postnatal depression was occurring in his life.

*"For me it's been like a re- act. I had to react to see it"(44:2).*

In summary, Paul acknowledged the mental war of postnatal depression and the conflict the flashbacks caused in his life. He identified the feeling of fear from his experience of postnatal depression that was intertwined with confused feelings at the possibility of postnatal depression recurring if they have any more children in the future. Paul tried hard to rationalize this fear by maintaining that he was no longer ignorant of what postnatal depression was and how it afflicted his family. Thus, the past, present and future meld into one another.

***Postnatal depression: "It's a bit of a mystery"***

Paul's emotional, physical and psychological responses and those he interacts with emerge in the theme "*It's a bit of a mystery.*" This dimension reveals Paul trying to identify what his experience of postnatal depression was. So many strange and conflicting emotions emerged that he was at a loss to distinguish reality. These sentiments are confirmed in the literature as Brown (1993, pp.131-132) writes, "Tonight we can speak of the Mysteries, of the deep truths, of the real meanings of things. Tomorrow it will be all nappies and baby blues", whilst Crotty (1996, p.45) so aptly remarks, " On the other hand,

people do hold mysteries. People have different understandings and reactions. Pinning down their highly individual perceptions and responses is where the effort should go.”

Paul recalls his new family settling back once more into their own home following the birth of their baby, after a recuperating period at their friend’s home. He acknowledged the frightening and bewildering fact that his family was in distress. It was at this point that Paul demonstrated the intuitive knowing that Crotty (1996) referred to wherein the phenomenon of postnatal depression was identified. Paul states:

*“ It starts off as being a bit of a mystery. What is going on? What do I do? Help? Where do we get help?”(Appendix 3: Step 2).*

An interesting factor to notice here was Paul’s use of the first tense, *“What do I do?”* which suggests a primeval sense of self-preservation. This was then quickly superimposed with the second person, *“Where do we get help?”* to incorporate the needs of his family. It also demonstrated that *“phenomenological analysis involves both the act of the subject (the noetic dimension) and the content or object of the act (the noematic dimension)”* (Crotty, 1996, p.33)

Paul’s story continued as he spoke about the physical aspects of postnatal depression from environmental and physiological perspectives. The speed at which postnatal depression occurred caused Paul a great deal of anguish. He says:

*“Its so quick, you’ve got all these things – great new baby and new things going on and then all of a sudden, THAT happens, [“oh my god, how am I going to cope?”]*

*“Things were beginning to happen, things were starting to show”(2:1).*

*“I’d say probably over a couple of weeks, it hit pretty hard, pretty quick...from seeing the doctor was probably a bit longer than I said, its hard to remember back the time frame now...”(4:1).*

A great deal of Paul’s life had changed and he recalled his feelings as he embarked upon an emotional roller coaster. Paul remembered feeling scared, as he could not place a finite time upon his experience of postnatal depression:

*“It is pretty scary because you think to yourself, how bad is this going to get?” (Appendix: Step 2).*

Looking back Paul found life as a new father was sad and dispiriting. The monotony of his life at this time caused him to express highly charged emotional feelings that he was

careful to explain are vented at the disequilibrium in his life and not at members of his family. He was conscious of the need to vent these feelings of frustration as he says:

*“Just to say okay you try and talk through it but it would just end up going round and round and round in circles. We could, many times, actually even in this room, we’d sit down and like we’d sort of gone over one point, spoken for one and a half hours, gone over one point and got absolutely nowhere with it you know?” (3:2)*

*“It seemed I was repeating the same old things over again, bla, bla, bla.” (11:1).*

*“Sometimes it would help for a few hours, half a day, or even a day but the next day you’d be back to square one again so it was kind of like a repetitive thing, same old things again” (13:1).*

*“I think one thing is when you are going through the thick of it and your partners upset and you are down and feeling negative and all the rest of it, many many many times I’ve had the absolute feelings of being frustrated with postnatal depression not with (my wife) but with that depression, it’s pissing me off basically” (38:1).*

Nothing prepared Paul for the desperate feelings of loneliness and isolation and subsequent hurt that he felt, associated with postnatal depression. These feelings that he experienced particularly effected his relationship with his wife and further increased his isolation:

*“When it’s happening, you can forget intimacy, it’s gone” (4:3).*

*“It’s a time of hurting, as it is very hard to see someone that you love with all your heart going through all the stuff that they do.” (Appendix3: Step 1).*

*“I cut myself off from the rest of the world and her. I guess it was a natural progression for whatever reason, it just happened that way” (42:2).*

*“It’s something that does isolate you” (21:2).*

The emotions that Paul described at this time clearly answer the question “Right now my experience of postnatal depression is?” wherein Paul starts to identify what was the phenomenon that he was experiencing. The literature on postnatal depression confirms these emotions that Paul described (Turner & Kowalenko, 1997; Bishop, 1999; Webster, Markou & Huxley, 1999). The mental and physical barrage that had attacked his mind and body reducing him to such a depressed state, was indelibly printed in his memory as he says:

*“[I felt] Very alone and very exhausted, once again mentally and even to a point physically. Sort of started to affect me like that. I started to get run down, just very tired all the time and lethargic and all those things started to come through after a while” (13:2).*

In summary, Paul’s use of the word “*mystery*” shows a reluctance to recognize that he was experiencing postnatal depression. He knows that there was a state of disequilibrium in his family, but was chary of giving it a name. Paul recognized that some disorder was afflicting his family and he starts to try and figure out what was happening in his life-world as he feels he has lost touch with reality. Paul described his perception of his individual reactions to discovering that he cannot determine the reality of his world. He lacks synchronization with reality, made explicit by his descriptions of the fear, hurt, loneliness, anger and feelings of being scared that he experienced. It would appear that pertinent communication and action relative to all parties would have been desirable at this point but it does not occur.

***Interpreting real life:” Keep on, Keeping on”***

In this dimension, Paul revealed his interpretation of his experience of postnatal depression. He has moved on and has started to figure out what was happening in his new life as a father. Paul had started to realize what his reality had become in the transition to fatherhood. The word reality is defined in The Oxford Minireference Dictionary & Thesaurus (Hawker & Cowley, 1997) as a “1. quality of being real. 2. something real and not imaginary”.

The distress Paul experienced spreads to incorporate his interactions with friends and family and health professionals. The reactions from them cause Paul to reflect that they did not understand what was happening in his life and therefore could not offer any help. This only serves to increase his feelings of loneliness and isolation. He remarked:

*“And I really couldn’t feel like I could off load to anyone ‘cos no one else really understood what was going on” (11:2).*

*“To me it was a lonely time even though we know other people, it is hard to find friends that understand. So it is easier to distance yourself from others” (Appendix3: Step 2).*

*"I tried to talk to [my best friend] about it a bit and that and the odd time I did get to talk to him, he could listen but he had no input at all to support me with. It's just no good" (12:2).*

Looking to their families for help proved to be of little value for Paul either, except for one occasion when Paul's father offered his support in the following way:

*"Dad said he'd booked me into a motel for the weekend just to get out of the house and away from that whole mind trap thing"(11:3).*

Paul's loneliness and isolation from friends and family appeared to have the psychological effect of enabling him to look at things in a detached manner. And by doing this it could be interpreted as acting as a coping mechanism which smothers the anxiety he felt by concentrating in depth on the myriad details of daily living.

*"I think it's the not knowing and then having to learn how to deal with it at the time... (34:1).*

*" You have just got to get on and give and do, do, do, do"(11:3).*

*"Yes, this constant do battle"(14:3).*

However, it was at this point Paul realized he was stretched to the limit of his endurance physically, spiritually and emotionally. Paul with his family, sought help from their general practitioner who diagnosed Paul's wife as having postnatal depression and initiated the referral to the maternal mental health team. No inquiries were made as to Paul's health status. This could be lack of recognition on Paul's part that anything was wrong with himself, plus a greater concern for his wife and family being foremost in his mind at the time. Social constructions of masculinity provide a picture of men not seeking help from their general practitioners or other health professionals concerning their health and this is evident in Paul's behaviour:

*"I never thought that I needed to see a psychiatrist or anything like that, its more just the anger would work up in me and sometimes the feeling that "Oh just leave me alone for a little while and let me have a bit of space"(42.1).*

*"Not that I could do it but you know I'd feel I could slap you silly if you don't snap out of it. You don't do it of course but kind of that's how you feel"(47:2).*

Paul exposed the paradox that emerged concerning his recognition that he needed help from someone but was not sure whom he should approach. This uncertainty produced conflicting emotions, which he demonstrated in the following way by stating:

*“I always thought that they couldn’t give jack-shit about me at all. They came in here at a clinical level – the team. They’d say okay, just say we’ll do this bla, bla, and carry on. And I’d feel like – “give me something” – it wasn’t very relieving at the time” (33:2).*

*“Walking into that place with the sign above the door, maternal mental health – that psychological, yuk, mental health thing. Sort of, doesn’t worry me, you think, but you see that phrase and you think, “shrink”. That someone’s got a screw loose” (30:2).*

However, not all of Paul’s interactions with health professionals produced negative emotional responses from him. He spoke very highly of the maternal mental health nurse who attended his wife and the incidental support she extended to him:

*“But actually it was bloody good having [the nurse] in some ways even though I couldn’t ring her all the time. I could ask her and find out anything I wanted to know, but it took a long time to do that. Obviously it was her job to be more focused on [my wife], not me but I had to draw all the information I wanted out of it. She [the nurse] reckoned I had sucked her dry but I got all I wanted to know” (29:2).*

From a phenomenological perspective the process of bracketing eventuated in this dimension where all previous knowledge was set aside so that the essence of the phenomenon of postnatal depression was revealed. Paul’s potentiality becomes heightened to such a degree concerning his environment that he was “doing phenomenology” and sees the thing itself, his lived experience of postnatal depression (Crotty, 1996, p.158). The theme *Keep on, Keeping on*, Paul believed produced the very essence of his experience of the phenomenon of postnatal depression. The following description illustrated his experience of the phenomenon itself as he states:

*“Postnatal depression is something that makes you not see reality is what it is. Looking at, you know, I see it as looking at everything in a different way from a totally different angle and not seeing the all over perspective on life issues and things” (5:2).*

Such a revelation seems to be in conflict with other elements of postnatal depression that Paul described but it was the fundamental basis from which his thoughts flowed. This seemingly contradictory perspective only adds to the utter bewilderment that Paul was

feeling and was emphasized by the use of the negative form in this statement. It was the following reality, which was Paul's life that he wished to share:

*"There might have been the odd day, something like that when I couldn't be bothered talking about it, but I never have a problem sharing information. And sometimes the best time to share information is when you are in the thick of it 'cos hey, this is what is happening at home at the moment. I mean its not necessarily talking about your problem but telling someone this is your life experience and here it is right in your face"(37:1).*

In this dimension Paul continued to create a highly descriptive picture of his life-world which illustrated the metaphorical balancing act that he was trying to perform with all his commitments. Paul recreated this picture as he says:

*"You have a bubble and in that bubble you have your wife, the baby, finances and the house and all these things are bouncing around in the bubble and there's me underneath trying to hold this bubble up" (2:3).*

The depiction of the bubble gives a clear indication just how fragile his whole life world had become whilst experiencing postnatal depression and the disastrous effect it was having upon his physical and mental health. The picture of the bubble captures the concept of an aerial dimension that prohibits Paul from being able to take a firm grasp upon his life. The inability to rationalize this aerial element and the recognition that it was a concept that was unknown to him produced feelings of fear in Paul, which he gave voice to. However, as Paul was able to identify and communicate his fear, it had a cathartic effect upon him. The concept of the bubble provides an ethereal quality that was not entirely an experience of this world where rational explanations supposedly can be made for everything. Thus, whilst postnatal depression can be conceptualized both scientifically and artistically, Paul's focus was upon the aerial and ethereal dimensions that are gradually revealed and forms the essence of postnatal depression for him. Paul linked the aerial and ethereal dimensions together with the scientific dimensions of his experience, as he related:

*" I guess I kept trying to make my mind race ahead to try and think but I felt so exhausted with it, find it hard to think of something unique that would really help"(16:2).*

*"At the end of it, I felt just very very..., just bla, just mentally zapped and just, STOP! You know I just had enough really. But I said "No, I can't do that, I just got to keep on, keeping on. I love this woman and its not going to last forever but... "(4:2).*

The ethereal quality of the bubble maybe interpreted to represent Paul's indomitable spirit that was epitomized in his words, *keep on, keeping on*. An awareness of that spirit and how he chose to use it in his life was put to the test for Paul. Being able to recognize and rise to the challenge of postnatal depression was critical in Paul's life.

As Paul continued to grapple with what his reality was during his experience of postnatal depression, he extended the palm of his hand uppermost and stared at it hard, and said:

*"I guess how I would explain it, it's a funny way of doing it, but imagine a flower with a nice strong stem, its beautiful and it looks everything you expected it to be. And it's strong and you collect that flower and you put it in the palm of your hand and if you imagine, it turns to honey and it drips through your fingers and it sort of slips away from you. And it feels like its slipping away from you, but there's still some residue there and that's for me how to explain what I'm going through, what its like, you know."*

This emotionally charged moment wherein Paul feels that he was struggling to keep a grasp on life, rendered both of us incapable of carrying on. It necessitated the tape recorder being turned off, till we were able to gather our thoughts and feelings together in order to continue with the interview.

To summarize, Paul admits that he was at his lowest ebb mentally and physically but paradoxically, it also seems to signal the turning point at which recovery was able to take place. Paul manifests a single-minded belief in himself. This gives him the strength of character to pronounce the love that he feels for his wife. He cherishes her above everything else and this was the one phenomenon in his life that he clings to that gives him the necessary physical and psychological support to carry on. He displayed utter conviction to this one concept that enabled him to move on. The state of equilibrium experienced by Paul was consistent with the preliminary findings by Weymouth (1996) in her study of men's experience of having a partner with postnatal depression.

***Discovering real life: "Who am I?"***

In the final theme there are two concepts that run parallel to each other and were immensely important to Paul. They were the reasons that he undertook to convey his story for this report. There was Paul's wish that other people would learn from his experience of postnatal depression. This in turn enabled Paul to reflect on who he was in the past,

discover who he is now and a great deal of the man who will go forward into the future. He believed that he was ill prepared for the life he was to lead in the transition to fatherhood and forewarns others as he says:

*“It’s going to be that you have to prepare yourself for the mess you are going to live in at home for awhile till you get yourself sorted out into some kind of a routine and get used to having a little baby” (33:1).*

Paul had become deeply sensitized by postnatal depression and was able to dig deep to arrive at new levels of awareness to add to the rich tapestry of description that he had provided thus far. As he described the fear he lived with during his experience of postnatal depression, the reader becomes aware of the paradox of Paul enduring a horrific experience in his life in order to grow as a person. It highlights the fact that whilst at the time it all seems to be such a hopeless, negative phase in his life, eventually positive things do materialize. The reader gains a sense of Paul’s desperation as he longed

*“To see some light at the end of the tunnel” (15:3).*

and release from the all-consuming fear that arose from his experience of postnatal depression. Paul’s strength was born out of his needs, his love and his pain at the suffering that he and his family have undergone. His vulnerability arises from his deep sensitivity and was conquered through his power to survive his experience of postnatal depression. He related this to any further children that they may have in the future. He says:

*“If it was to be still a real wall that’s there that I’m quite scared of climbing again as such” (19:2).*

*“If I was a weak person I think I wouldn’t want to have another child” (20:2).*

However, in total contrast to these fears of what might happen if another child was conceived, Paul confirms that he does not feel that their baby was neglected in anyway. It was as if it was possible to turn postnatal depression on and off when dealing with the baby. Just as if the tension was removed whilst dealing with his daughter and then put back on again in his relationship with his wife:

*“It was weird, that shift was there you know... I was always hopeful to see that there but then it would flip back again and I’d think, ‘far out’” (32:2).*

Paul continued with offering some salutary comments about himself and his interpersonal and intrapersonal interactions with his wife, family, friends, work colleagues and health professionals, in the hope that it will benefit all those who read it, as he says:

*“I think in many ways it has actually grown me as a person...I’ve learnt how patient I have to be, and can be and will be... But I feel much stronger as a person and feel more confident with what I know and what I can achieve” (40:2).*

Paul’s choice of the words “grown me” gives a sense that postnatal depression was a living force that he had grappled with and that had rendered enormous change in his life. He affirmed that he has become a more loving husband, kinder and more compassionate

*“I thought I was [before], but I wasn’t” (41:2).*

Paul found he was able to communicate better with his wife on a one on one basis, enabling him to talk about the real issues in his life:

*“There’s the love connection underlying it, I feel that she knows how much I love her. She always tells me how much she loves me, but this is so hard – this being supportive bla, bla, bla, is getting at me. I would say that she knew it was there except on the real bad nights when she felt like taking her life a couple of times. So I always felt that even if it wasn’t coming from her, I was definitely giving that out” (26:2).*

*“I think postnatal depression is like, the shit hits the fan, and has helped me see the real someone. I think it’s shown just how much patience I really do at times have and I can just keep on keeping on. Just to keep things going and not having that love reward, no intimacy there, just keep on, keeping on because you know that I love you and that’s the depth of my love just because I have carried on” (45.1).*

As Paul continues, an eclectic approach becomes apparent that presents the different facets of Paul’s character encompassing the physical, psychological, emotional and spiritual perspectives of his experience. A synthesis has taken place as Paul highlights the importance of self-esteem and self-efficacy. The conviction of his own worth based on the love he feels for his wife enabled Paul to have confidence in himself at work and in his dealings with his church. Paul reflects:

*“At the time when I was going through it, I sort of, you learnt these things but I guess I wasn’t applying them then” (42:2).*

Postnatal depression is a bitter, sweet pill to swallow as Paul has demonstrated in recounting his story. Whilst he recognized the value of the services by health professionals for women, he had some highly emotive words to record about the lack of any form of care for fathers. He recounts:

*“As soon as it’s picked up on by the G.P and he says you’ve got postnatal depression – you need to get on to it and then the support should come in straight away for both. As I mentioned it’s a really one sided sort of affair at the moment – Gee, I feel really strongly about that” (7:3).*

Paul emphasized the importance of keeping a balance between his commitments at home and at work as a preventative measure that would stop postnatal depression becoming all consuming in his life. He confirmed the necessity for taking the time to do something that he enjoys, to enable him to relax at the end of the day. It was the ability to make an independent choice about what he would do with his time that he feels was an important factor in creating him into an autonomous human being and which he believed others needed to be made aware of.

*“I haven’t had the chance to be home from work and just relax and do what I want to do. So that’s when I might go and do something on my computer or whatever and so I come to bed late. That’s self-inflicted but I need to do that. I want to do it even if it goes to 1a.m, I need time out to achieve something or do nothing and make my own choice” (19:1).*

### **Summary**

In this chapter, Paul and I have formed a partnership as co-researchers, to record and analyze the data from a phenomenological perspective of one man’s experience of postnatal depression. Paul has taken the reader on the journey of his life experience in which the very essence of the phenomenon of postnatal depression is revealed through four different but interrelated themes, through the postpartum period. The four themes *“It’s a mental war”*, *Postnatal depression: “It’s a bit of a mystery”*, *Interpreting real life: keep on, keeping on*, *Discovering real life: “who am I?”* evolve to produce a mine of information to add to the body of knowledge surrounding postnatal depression.

Paul’s learning experience of postnatal depression has incorporated biological, psychological, and social domains. His accumulated knowledge about his experience of postnatal depression depicts temporal, spiritual and ethereal aspects of his life-world and

the intrapersonal and interpersonal interactions he has with family, friends and health professionals. Paul has emerged from emotional extremes and invited the reader to be privy to his innermost private thoughts in the hope that others will learn and benefit from one man's phenomenological experience of postnatal depression.

The next chapter provides a discussion of the findings of Paul's phenomenological experience of postnatal depression.

## CHAPTER SEVEN

### *Discussion*

In this chapter, the findings of this study of one man's experience of postnatal depression from a phenomenological perspective are examined. Various aspects of the data, with reference to the literature, are offered incorporating biological, social and social psychological, psychological and spiritual dimensions that affected Paul's life as he made the transition to fatherhood. The philosophy of phenomenology as first recorded by Edmund Husserl, forms the basis of Crotty's (1996) mainstream phenomenology that has formed the framework for this study. The limitations of a phenomenological approach with particular reference to Crotty's (1996) mainstream phenomenology are considered. Finally, some discussion takes place of the barriers I encountered using this particular research method.

### *Biological Factors*

Boyce, Staneck, & Gilchrist (1999) propose greater classification of postnatal depression where all depression is the same but varies in intensity or distinct types in categorical group form, presenting biological and non-biological causes. These same standards could be extended to incorporate the experiences of postnatal depression in men as well as women. Bishop (1999) estimates that between 2 to 8% of men suffer postnatal depression. Given that men are not known for seeking help from professional sources for their health issues, these figures could be seen to err on the conservative side (Turner & Kowalenko, 1997). The New Zealand midwives' philosophy of "being with woman" could produce a socio-psychological barrier that excludes men during childbirth.

It is a poor indictment of our health system that health professionals actively administer care and attention upon one member of a family whilst totally ignoring the needs of another.

Bishop (1999) defines postnatal depression in men as suffering similar stresses to women but without the hormonal and biological changes. The latest research from Storey (in Motluk, 2000) suggests that these factors too maybe open to conjecture. The preliminary biological findings by Storey (in Motluk, 2000) propose that the male hormonal levels mimic the fluctuations in the female hormonal levels, due to the emission of pheromones during the antepartum and postpartum period. These findings may endorse

Boyce et al's (1999) beliefs that psychosocial factors play a lesser role in postnatal depression.

It is interesting to note that there appears to be no literature surrounding any genetic links to the male experience of postnatal depression, as is proposed for women. The enormous amount of research that is being advanced in the field of genetics today may recommend this area of research worthy of future study.

### *Social and Socio-Psychological Factors*

Paul's thoughts are like the tangled fibres of a ball of wool that criss cross over each other, back and forth with seemingly no beginning or end as he provides his experience of postnatal depression from a phenomenological perspective. He articulated that his life world had become a mental war that commenced with the concept of mystery in which he was at a loss to recognize reality. Eventually this was followed by an interpretive period in which he endeavored to figure out his reality. Finally, when he was so mentally and physically exhausted, he experienced an ethereal dimension that allowed him to understand his reality, and in the process, he discovers who he is.

In this qualitative study postnatal depression is a disorder in Paul's life and it is evident that the influence of societal expectations placed upon Paul was a mismatch with the reality of his experience in the transition to parenthood. The data from the interviews in this study show that the notion of one man's experience of postnatal depression has manifested the need for changes in his behaviour, attitudes and emotional responses. Thus sociological and social psychological factors form a theoretical framework for interpreting his experience.

Socially constructed gender roles of masculinity and femininity with the man as the breadwinner and the woman as the nurturer (Connell, 1995), is at variance with the reality of Paul's experience. Paul appears to be echoing what many women feel about housework and being a parent, that there is no social value attached to these roles (Morse, 1993). The nurturant role that a woman is expected by society to assume means that she has to be more responsive to the demands of others (Miles, 1988). Thus the responsibility of teaching social values to the child is largely the mothers. Men enjoy more fixed roles whereby their personal time is protected and as a consequence they do not experience role strain in the same way that women do (Margo, 1996). Paul presents the opposite to these stereotypical

roles as he becomes responsible for running his household on a daily basis and the subsequent conflict that this produces as he juggles the dual role of breadwinner and nurturant.

According to Zaslow, Pederson, Cain, & Suwalsky (1985, p.136), when the pregnancy is confirmed, fatherhood confronts men with issues surrounding the “loss of homeostasis in relationship with his wife, feelings of rivalry with the new child, anxiety about expressions of affection to a male if the baby is a son, reopening of oedipal issues and anxieties in the breadwinner role”. Finding an optimal time to start a family may create problems with career-conscious couples. The lifestyle that they have become accustomed to with two incomes, change as they learn to cope on one income. The feelings that this engenders should be seen as part of the normative process if the couple have had a Western middle class upbringing, and heralds maturational growth development in the relationship. Conversely, those couples who do not adjust will go on experiencing difficulties.

Historically, men’s role has changed through the institutionalizing of childbirth in the Western world since the 19<sup>th</sup> century. The loss of couvade rituals, which clearly recognized the caring functions that the expectant father carried out gave him social recognition for his changed role and status on becoming a father, states (Summersgill in Alexander, Levy & Roch, 1993). The evidence provided by Osofsky (1982) in which it is shown that traditional roles have been challenged, for example fathers being present at the birth, has overtaken the socialization process in men’s role change, leaving them uncertain and confused as to the expectations of their partner, family and friends. He may be seen as a slightly comic figure that is likely to faint and get in the way at the birth or at best his position as support person is paid lip service to by being allowed to cut the umbilical cord at the birth. Paul’s own ill health prevented him from playing a prominent role in the birth of his baby. Cutrona & Troutman (1986) propose that having no definite role to play can be self-perpetuating and men further isolate themselves from the birth and in the ensuing care of the child.

It should be acknowledged that in Western society today, the father, throughout the pregnancy and birth, plays a secondary role to the woman. Three roles that men may assume during the birth have been identified, as coach, teammate, or witness (Chapman, 1992). Circumstances show Paul in the role of witness to his baby’s birth, with no active

participation and he consequently found the birth experience lacking and did not feel fulfilled. One study shows that the higher the father rated the birth experience the more childcare activities he took part in postnatally (Chandler & Field, 1997), which indicates that men should articulate, to health professionals, the need for a more active role in childbirth. This can be accomplished by realistic birth plans being designed with input from both health professionals and the expectant couple. However, the social misconception that all fathers wish to be present at the birth of their child, may be placing unwarranted levels of stress upon the male partner as they do not wish to see their wife in pain (McIntyre, 1996). The presence of a doula can help to alleviate some of the anxiety experienced by the father on seeing his partner in pain as she labors, as these professionally untrained women are aware of hospital procedure and support the pregnant woman through the labor and birth (Niven, 1995).

Discourses on masculinity and femininity still present social attitudes that would appear to reinforce the stereotypical role of masculinity, that they do not vocalize their need for help from health professionals, often to the detriment of their own health and well being (Turner & Kowalenko, 1997). Thurtle (1995) proposes that gender differences in socialization may make it easier for women to engage in seeking help for their health needs without losing face. Due to the social stigma attached to mental illness people can be prevented from acknowledging their deteriorating health status early and seeking help from health professionals (Turner & Kowalenko, 1997). Paul's reaction to the lack of help extended to him by health professionals, is also echoed by McIntyre (1996, p.1) as she reports different father's reactions of frustration, sadness and anger as their role as a father is not given any recognition e.g. "What about me? It's my baby too," he wants to yell. "Don't you want to know how I'm feeling?" Such was Paul's experience and as a consequence produced the damning report on the lack of health services offered to him personally. In support of this is the overwhelming view of the maternal mental health team who voiced their concerns regarding the lack of resources that were available for the fathers (member of the Maternal Mental Health Team personal communication, May1999). The nurses reported that it put them in an invidious position when attending to the mothers, knowing that they were not funded to offer help to their partners, and at the same time being unable to ignore the needs of another human being that desperately needed help. Paul

was able to access information on postnatal depression from the maternal mental health nurse to support some of his health needs. However, the actions of the maternal mental health team only serve to emphasize the overt and covert methods of caring for people by health professionals in our present health care system.

It has been documented in the literature that a lack of an extended family network maybe a contributory factor in postnatal depression (Wood, Thomas, Droppleman, & Meighan, 1997). However in this instance there was a large social network involved but they did not have the knowledge resources to call upon to offer aid to Paul and his family. Father to son role models as a parent appeared to be absent for Paul, through the veil of secrecy that surrounded talking about childbirth in his father's generation. This only serves to perpetuate the level of ignorance surrounding the subject from one generation to another (Barclay & Lupton, 1999). Therefore, the rules of society, that Paul is seeking from a previous generation, to guide him through the transition to fatherhood, do not exist. Balanced family relationships are presented as societal norms but a measure of disequilibrium may well be the reality today (Weymouth, 1996). Nonetheless, the marriage of societal expectations with the reality of experience for Paul, do not provide the complete picture.

### *Psychological Factors*

The notion of psychological trauma experienced by Paul initially provoked open denial from him. Immediately following the birth becomes an important time for the couple to be alone with each other and the new baby, a feature that may be forgotten in the routine of a busy institution, and may contribute to whether the parents' experience of the birth has been good or bad. The enormity of this experience for Paul, coupled with his own ill health in which he underwent abdominal surgery at the time of his baby's birth, emphasizes the physical and emotional aspects for new fathers. Future research, particularly nursing and midwifery, needs to consider the very real needs for support of fathers at this time.

Paul appears to use various strategies as coping mechanisms to protect himself from becoming emotionally vulnerable. These include work, and alienation, particularly from his wife. Yet the paradox exists that he longs to be able to talk to someone that will offer him help to acknowledge the phenomenon of postnatal depression as he experienced it.

Bishop (1999) refers to behavioral changes that take place in the father that act as coping mechanisms in dealing with daily living activities in the postpartum period. The notion of change in Paul's behavior arises as he uses work as a coping mechanism. Work for Paul is the very essence of being into which all his energies are channeled. Work at home is a never-ending round of household chores, care of his wife whose mental health is also in a vulnerable state, and care of his daughter. Work is his commitment to his full-time job, into which he pours more mental energy. Work is also his commitment to his family, friends and the church. Paul confirms the findings by Barclay and Lupton (1999) that not all men see household work as gender-related and because he is competent and efficient at these tasks he does not resent this role.

Paul attempts to center these vague concepts of the phenomenon of postnatal depression on more concrete evidence as he refers to the alienation he feels from his wife. Paul's use of the word alienation conjures up the picture that before the birth of the baby their relationship had been one entity, now because of the experience of postnatal depression, its as if they have become separated from that union. The alienation that he is experiencing from his wife is infinitely different from the feelings of loneliness that he described from his family and friends. The word loneliness springs from the realization for Paul that his friends and family have no understanding of what he is going through and cannot provide role models that will assist him which are issues that are reflected in the McGill report on male intimacy (McGill, 1985).

It is interesting to note that no other subject is more likely to produce information to be handed on to others than parenthood, once we perceive ourselves as an authority on the subject. However, until that authoritative moment arrives a shroud of silence surrounds us as we shy away from publicly demonstrating our ignorance. Human beings do not have an inherent knowledge on parenting and because they no longer live in pack formation, as do other animals, the skills required for parenting are not handed down by role models in our society. Thus as Oakley (1972) points out, that although sex roles appear to have changed, the basic differences still persist, and where individuals claim to have changed, the traditional ways of thinking and behaving are still adhered to.

### *Spiritual Factors*

The findings from the analysis of Paul's experience of postnatal depression provided a further dimension of his spirituality that adds to the research on men and postnatal depression. The primary distinguishing characteristic in Paul's experience of postnatal depression is the ethereal dimension that produces an out-of-body experience. The Oxford Dictionary & Thesaurus (1997), defines spirituality as being of the human soul with religious connotations. The essence of Paul's spirituality is divided first into a temporal component and secondly into an ethereal dimension, that are worthy of discussion. The temporal component of Paul's spirituality encompasses his work with the church. Religion gives help and support to him through a belief in a higher being. In practical terms Paul's spirituality also gives him the opportunity to grow as a person through a belief in himself. The ethereal dimension of Paul's spirituality exposes two phenomena. First, is Paul's love for his wife, and the realization that the family unit is the most important thing in his life. The love he feels for his wife is what enables him to keep going because he knows that love is reciprocated. Paul is ill prepared for the impact of the fear he feels that arises when she attempted to take her life.

The second dimension that challenged Paul is his fear of losing his grasp on life manifested through being overloaded mentally and physically, and is conjured up in his imagination by a picture of "honey dripping through his fingers" (p.89). This is consistent with the findings in Weymouth's (1996) research of the problems associated with men whose partners are suffering from postnatal depression. Paul becomes sensitized to such a degree that his heightened perceptions take him to levels that he has never reached before that oscillates between the aerial and supernatural. Such is the power of his imagination where dream-like qualities get dragged into his everyday life. As Paul attempts to distance himself from his experience of postnatal depression, he drifts from the real to the unreal like a will o' the wisp, as shown in his use of the metaphor of the fragile "bubble" (p.88) that he used to describe his life-world. Until the moment of cognizance, which is like flicking on a light switch when the unreal now becomes the real. The fathers in Weymouth's (1996, p.6) study pinpoint this same moment when their wives health starts to improve and they refer to it as a "circuit breaker". Paul proposes the ancient analogy of light and darkness with good and evil as he refers to "seeing a light at the end of the

tunnel”(p.91) that signals his spiritual growth. At this moment Paul accepts that his life has changed and a new way of living has begun, and he wishes to share that life experience with others. The pattern forms in which the bigger picture in life is revealed to Paul and he is at last able to center himself on some material thing, once more giving meaning to his life and enabling him to move on. He has nothing to fear through a rock solid belief in himself. Paul’s phenomenological experience of postnatal depression is a single person exercise as described by Crotty (1996).

### ***Phenomenology***

The purpose of the following discussion on phenomenology is to offer some of the limitations and benefits, with particular reference to using Crotty’s (1996) method and the appropriateness of the design. I was introduced to Crotty’s (1996) mainstream phenomenology through listening to excerpts of Giles (1998) thesis whilst undertaking postgraduate study at Massey University. My interest was captured by Crotty’s (1996) mainstream phenomenology and this continued interest encouraged me, in conjunction with my supervisor’s enthusiasm, to add to the building blocks of knowledge on mainstream phenomenology. This has gathered even more importance since Crotty’s untimely death.

### ***Methodology***

A qualitative research design was employed based on the appropriateness to nursing knowledge and scholarship in this study. It could be argued that an interpretive design might lose some of the characteristics of the study and a need to maintain a tight control is necessary in scientific research so that the study remains methodologically untainted. In this study a phenomenological methodology was used to study one man’s experience of postnatal depression, which is characterized by the use of rich descriptive data. Mainstream phenomenology, as employed in this study, is not concerned excessively with the subject as the new phenomenologies widely embraced by nursing researchers such as Oiler (1982), Omery (1983), Benner (1985) and Diekelmann (1992). Rather, mainstream phenomenology provides a degree of objectivity to recording the human reality. This is accomplished through the process of bracketing where everyday thoughts, values and beliefs, that are taken for granted, are set aside to arrive at a fresh meaning of the experience. This is accomplished through meditation and reflection of the phenomenon under study and by returning again and again to arrive at the very essence of its meaning. Employing a

phenomenological methodology ensures that the every day reality of the phenomenon for the co-researcher is revealed. Thus the importance of the researcher's capacity (as facilitator) to act as the instrument to interpret the data becomes paramount.

### *Method*

Phenomenology, as a philosophy to be used in nursing, is not without its problems. The important work of Crotty (1996) searches for a frame of reference, incorporating the works of Husserl, and seeks to demonstrate the inherent difficulties of using phenomenology in nursing research. Crotty provides a step by step framework from which to work and define phenomenology. The model that Crotty (1996) provides is a logical progression for the beginning phenomenologist such as myself to follow. It clearly refers to the human action and outcomes that have taken place for the co-researcher and the meanings that they hold for him. Thus the everyday commonsense experience of the co-researcher is revealed as his reality.

This single person exercise that Crotty (1996) advocates in mainstream phenomenology, seems to be at variance with the much-discussed theory-practice gap in nursing. Nursing practice comes from a traditional cultural basis of

- a) assuming that something is wrong, "the bodies of people and the problems of living in bodies which do not work properly – much of which is done under less than ideal conditions"(Lawler, 1998, p.106) and
- b) that it must necessarily be fixed. The outcome is a job successfully accomplished, in the nurse's estimation, but through a total lack of insight often renders the person whose experience it is alienated and dehumanized.

With these two notions foremost in mind nursing practice tends to overpower research as some nurses persist with task-orientated behaviour that relinquishes their ability to question the care that they provide by asking the questions "why am I doing this?" and "is it the best option for this person?"

A further criticism leveled at Crotty's (1996) method is that by following a step by step approach the researcher may be in jeopardy of not understanding the theory behind it (Lawler, 1998). For a beginner researcher such as myself to be able to follow a step by step approach provided a fuller understanding of the underlying theory. Through critiquing the Step-wise approach, as recommended by Crotty (1996), I have amassed the following

points that may be seen sometimes as limitations in this study and at other times the outcomes provided moments of wonderful encouragement:

- As only one co-researcher was required for the study, this could have put the research at risk of being completed, should situations beyond the control of the co-researcher befall him/her.
- As Paul has chosen to identify himself in this report it places the data on a very personal level and raised ethical concerns for the rest of his family and their safety that necessitated full and complete informed consent to be maintained throughout every stage of the study.
- Whilst Crotty (1996) provides a step by step approach, it should also be noted the phenomenological question will vary depending on the researcher's cultural approach. It should be stressed that in order to remain true to the method, the interpretive framework is that of the co-researcher and should be closely adhered to by the researcher.
- In Step I the participant must describe the phenomenon as precisely as possible. Finding the participant who can provide an accurate and detailed account of the phenomenon relies heavily on the capabilities of the participant's fluency with the language used for the study and could be seen as a barrier to gaining the experiences of those who perhaps are not as linguistically able.
- Step 2 required the co-researcher to put aside all preconceived knowledge concerning the phenomenon under study. I found the process of bracketing very hard, yet I was asking the participant who had no previous knowledge of mainstream phenomenology, to do the same thing. It is all too easy, I discovered when conducting the interviews, to "lead" the co-researcher. Steps 3 to 5 are necessary to mitigate this possibility.
- Step 3 required the participant to dig deep for a description of the immediate experience. I had concerns for Paul's health and that of his family that by delving right to the core of the experience it would upset his finely balanced emotional status. I had no wish to provoke memories that he would not wish to relive. Eyes filled with tears and voices choked with emotion were not comfortable for us to start with but it did break down barriers and reduced the strangeness of sharing innermost secrets with a stranger. Phenomenology is not a process wherein the researcher and co-researcher can remain

removed from each other. It produces heart-wrenching data and defies any degree of anonymity by those involved. Paul's reassurance that I had indeed revealed the truth of his experience through the four themes that arose out of the data, was the justification I needed for continuing with the report.

- Step 4 The data must be scrutinized closely to ensure that the description holds phenomenological characteristics. The four main themes that arose were Paul's phenomenology arising directly from the words that he used, and could not be mistaken for the themes that arose out of Weymouth's (1996) grounded theory study, for example, because this is a single person exercise.
- Step 5 Paul must be sure that he has described the very essence of the phenomenon. This is confirmed by the appearance of the elements that go to making up the phenomenon that cannot be mistaken for anything else. This was accomplished by staying true to Paul's words and by ascertaining from him that I had not misinterpreted anything that he had said. The aha's of research arise that confirm the essence of the experience is revealed.

The benefits accrued from partaking in research interviews may be seen as a cathartic episode in the co-researcher's life which enables that person to come to terms with their perience. The healing that takes place by being able to express his innermost feelings may be empowering for the man experiencing postnatal depression. As he assimilates the changes in his life Paul is able to grow as a person. It gave him confidence in himself and acknowledgement of his own self-worth and personal integrity. The self-awareness that is engendered in the exercise allows him to recognize the needs of others in similar circumstances (Hutchinson, Wilson, & Wilson, 1994). Therefore I believe the use of Crotty's (1996) method has been successful and Husserl's concept of phenomenology being recognized as a rigorous science of knowledge, that must display a commitment to remaining methodologically true, was maintained (Walters, 1995).

### ***Trustworthiness***

Maintaining academic rigour is essential to establishing validity and reliability of this study to justify the methodology and have this work accepted as scientific research. The interviewer is the data gatherer and primary research instrument and as such the reliability of the data is dependent upon the skills of that person. It should be acknowledged

that at each subsequent interview my skills in this direction improved and thus the level of data improved from the early pilot study in which Paul had taken part. In the pilot study he spoke of his experiences on first learning that he is to become a father and the data from that study forms chapter five of this project. On completion of the pilot study Paul still felt that he had more to impart concerning his experience of postnatal depression and urged me to continue to write. Thus the seeds were sown for this research project. A secondary instrument in the research process was the use of a tape recorder, which also ensured accuracy of the data collected (Appleton, 1995). The concepts of auditability, credibility, and dependability as proposed by Guba & Lincoln (1981) were applied to this study.

### ***Audit Trail***

Auditability was made explicit as themes arose from the data themselves that are grounded in the research. The reader is able to follow the trail of information from the research statement, "what is the essence of postnatal depression for this man?" to the findings, as the four themes emerge that are closely interrelated:

- *"It's a mental war"*, in which Paul's past, present and future was affected by his cheerless existence.
- *Postnatal depression: "It's a bit of a mystery"*, in which Paul identified the unreality of his life.
- *Interpreting real life: "Keep on, Keeping on"* in which Paul recognized his reality and the very essence of the phenomenon of postnatal depression is revealed; and
- *Discovering real life: "Who am I?"* in which Paul discovered who he is.

The description in the research stays as a first person exercise as recommended by (Crotty, 1996). Bracketing occurs by the researcher and co-researcher so that all previous values and beliefs are set aside prior to analysis of the data. It is at this point that the co-researcher enters a meditational state and is able to poetize in order to convey the phenomenon as it speaks for itself. The co-researcher opened himself to that moment and listened to the phenomenon without attempting to reason. At that moment of dislocation from the everyday world the ethereal dimension of the phenomenon of postnatal depression was revealed to Paul, in the final theme *Discovering real life: "Who am I?"*

### ***Credibility***

Credibility of this study was achieved by testing for validity and reliability by remaining true to the method. Through handing back to the co-researcher the transcripts and having him confirm that a true account of his experience had been recorded reveals that the interpretive framework, as set down by the co-researcher, is adhered to. Since there is a considerable amount of recorded data it is apparent that most of the descriptive data is present in this study. The co-researcher is able to recognize the experience as his own and thus gain personal insight. Paul is eager to share his experience with others so that they may gain insight into his experience of postnatal depression and can perhaps relate some of the findings to their own similar experience.

### ***Dependability***

A means of establishing dependability is to have the research independently judged. As this research project is part of the Master of Nursing programme it has been overseen by my supervisor who has in-depth knowledge of phenomenological analysis and has offered comment. Incorporating many of the quotes from the data also provides rich descriptive data that is dependable. By placing the findings in context through the postpartum period, I have endeavoured to remain true to the data. These findings are part of a trilogy wherein the phenomenological perspective of the experience of postnatal depression from the man's perspective and his wife's experience, is followed by an integrated analysis of these two studies. So there is an expectation of further research.

Paul's wife's experience has remained independent and at my request the findings have not been made known to me to avoid bias on my part. Paul and his wife did not communicate concerning the study until the analysis of the findings had been finalized.

### ***Insights I have gained from the research***

I have felt a huge responsibility towards Paul to complete this study. There have been many times when I have found the task extremely daunting and have wanted to give up. The syntactical framework required to do justice to writing Paul's story has been the biggest hurdle for me to overcome as I struggle to write in an academic manner. At the same time it has been arduous establishing a balance and writing in such a manner as to make it beneficial reading to members of the public who do not come from an academic

background. This is in fulfillment of my promise to Paul to honour his wish that others would benefit from hearing his story.

The benefits of this study to me have identified that men can take an equal role with their partner in running the household thereby breaking down the stereotypical discourses on gender roles of masculinity and femininity. This has important ramifications for changing things at a political level since the majority of members of parliament are male (Brannen, 1993). This may have implications for changing the laws surrounding parental leave, employment and worksite conditions. It has shown that men are as capable in the nurturing role as their partners are and should be allowed to voice the role that they wish to play in the transition to parenthood without fear of rejection.

Finally, I feel very humbled and privileged to be privy to Paul's innermost thoughts and feelings and the things that have caused him so much anxiety and distress in his experience of postnatal depression. The concepts of enduring and suffering (Morse, 1996) are manifested by Paul in his experience. In his enduring state he shows no emotion as he literally holds himself together in order to survive. His suffering is highly emotional and is evidenced by his behavior where he freely expresses what is happening in his life. This experience has taught me to have a greater perception and understanding of men's issues in my nursing career and to continue to help break down the wall of ignorance that surrounds men's health.

In conclusion, with reference to the literature surrounding women's experience of postnatal depression, it has made possible the opportunity to provide evidence that evaluates one man's experience of postnatal depression. Discussion has highlighted biological, sociological and socio-psychological, psychological and spiritual factors which conclude that whilst there are differences in the experiences of men and women suffering postnatal depression, that similarities do exist. Within the design of this study, the perspectives of these different disciplines have been treated as separate entities, as they manifested themselves in Paul's experience of postnatal depression. However, it should be realized that in many instances these dimensions overlap and interweave to provide a total picture. Discussion of the philosophy of phenomenology underpinning this study has enabled the reader to be aware of these perspectives. The method devised by Crotty (1996) has provided the framework upon which this report rests. Identifying the limitations and

benefits in this study is crucial in reaching health professionals and men, to improve their understanding of postnatal depression. The study sets out to fill a gap in the research as referencing is made to previous research. Trustworthiness of this study has identified that it should be possible for nurses to replicate this study in a similar setting to build a body of phenomenological research into men's experience of postnatal depression.

The last chapter presents a summary of the research and its findings in which the essence of Paul's experience of postnatal depression was revealed. The conclusion of this study identifies the implications for education, nursing research and clinical nursing practice.

## CHAPTER EIGHT

### *Conclusion*

This study has revealed the very essence of Paul's experience of postnatal depression, what that experience means to him and how that experience has altered his life. The method used, to assist him articulate the essence of the meaning of postnatal depression as he experienced it, was underpinned by an approach described by Crotty (1996). Crotty (1996) based his phenomenological approach on the fundamental principles of Husserl's traditional phenomenology, whilst also incorporating the ideas of existentialist phenomenologists such as Merleau-Ponty and Sartre.

Paul as the co-researcher and myself as the researcher had first to set aside all preconceived beliefs and judgements concerning postnatal depression through the process of bracketing. The focus of Paul's phenomenology, wherein the very essence of his experience of postnatal depression was allowed to unfold through several taped interviews, was recorded. Paul also used his computer as another means of communicating his thoughts. He was asked to reflect and meditate and return again and again to the subject matter to ensure the authenticity of these conversations. Revisiting the conversations with Paul meant that I could probe and challenge the meanings that he wished to convey. As he progressed rich descriptions emerged that were to form the main themes of his experience.

The outcome of the research portrays one predominant theme "*It's a mental war*" that is interrelated to three other themes, *Postnatal depression: "It's a bit of a mystery"*, *Interpreting real life: "Keep on, keeping on"*, and *Discovering real life: "Who am I?"*

The themes began with "*It's a mental war*" in which Paul described how postnatal depression entered every facet of his existence so that his mental and physical state was deteriorating rapidly. His past, present and future are all severely affected and the mood swings that he experienced provoke unwelcome emotions through the sheer monotony of living with postnatal depression. Describing the flashbacks of his experience, Paul provided some richly descriptive data that revealed that all his senses were bombarded and had become raw with the constant battering they received so that he no longer recognized the life he once enjoyed. The theme, *Interpreting real life: "Keep on, keeping on"*, shows that Paul was fearful of identifying his experience of postnatal depression. Eventually he realized that he could not distinguish the reality of his world and this was the very essence

of his experience of postnatal depression, because he was so overloaded mentally and physically. Acknowledging and expressing his sense of emotional and physical loss allowed Paul to move on and try to come to terms with his reality as a father through displaying various coping mechanisms. But most importantly Paul reached the ethereal dimension exposed in the final theme, *Discovering real life: "Who am I?"* wherein he discovered who he is and affirms a total commitment to himself and his family. Paul's character has grown and the need to inform others of his experience becomes evident so that further suffering, through the experience of postnatal depression, can be prevented. My part as the researcher was to analyze the data with Paul, developed from his unique life-world, and act as writer of his experience of postnatal depression.

### ***Education***

If health professionals are to hold a privileged position as educators then it is imperative that they are well educated themselves. The data identifies that Paul felt he was poorly informed by health professionals concerning postnatal depression. Providing information throughout the puerperium and not just in the antenatal period is critical. Whilst demonstrable skills such as nappy folding and bathing the baby, have value attached to them, it is unlikely that anyone will suffer a life-threatening disorder because of a deficit in their knowledge about folding a nappy. It is quite possible, however, that someone's health and life could be at risk through lack of knowledge concerning postnatal depression.

Paul has identified, through his views on antenatal classes, that an approach is required to dispel the notion that childbirth is solely a celebratory time. The new parents need to know that they will be called upon to deal with the reality of high and low emotional moments in the postpartum period. Realistic information must be imparted. Involving men who have experienced postnatal depression is one way in which this can be accomplished.

Every birth is unique and how each individual reacts at the time will be different. Paul's disappointment at the birth experience of his daughter confirms that health professionals must become innovative in their approach to each birth to ensure that it is a worthwhile experience for all parties concerned. Being fully informed as the birth progresses demands a high level of communication skills by health professionals and is time consuming, but to the parties involved it may avoid feelings of isolation and

loneliness. Time spent to allay fears concerning medical interventions may be necessary as a worthwhile preventative strategy to avoid postnatal depression.

Health professionals, concentrating solely on the mother/infant dyad in childbirth increase the father's feelings of exclusion and the opportunity for them to gather knowledge on parenting. Effective communication is vitally important to overcome these feelings for men (Buist, 1996).

### *Nursing research*

The aim of nursing research is to build on the body of knowledge that will inform and assist nursing practice. A phenomenological perspective employing Crotty's (1996) method as the framework offered an in-depth understanding of this man's experience of postnatal depression.

All too often nursing research is guilty of identifying a problem but does not always provide measures to assist other nurses. In the culture of nursing, behaviorist approaches by nurses demonstrate task oriented procedures, making the nurse feel that something worthwhile is being achieved comment Weiler, Buckwalter & Titler (in McClosky & Grace, 1994), but these same procedures may be in conflict with the patient's perspective of his/her needs. There must be an on-going commitment by nurses to read and write research to improve the health status of those they care for. Conversely, nursing research could be accused of problematising an issue that could otherwise be seen as a norm within our society. Thus it becomes imperative that nurses enhance the health status of men through listening to their experiences of the phenomenon of postnatal depression and assisting them in their individual needs.

Nurses need to be aware of the ethical issues that may become apparent when undertaking a qualitative research design. Socially sensitive issues may become available to public scrutiny, when undertaking a phenomenological research study, that may not be disclosed if a quantitative research design were employed. The ethical issues attached to this study were unique since in telling the co-researchers story, his wife and family were implicated. Being sensitive to their needs for privacy and confidentiality required that at all times throughout the study they were kept fully informed and at any time could request for information to be withdrawn or the study cease altogether.

### *Clinical Nursing Practice*

Funding is lacking in the present day health forum making it difficult to locate the men directly who are suffering from postnatal depression and to subsequently provide initiatives to address their health problems. It is to be hoped that further research will situate the health needs of men with the funding authorities so that their problems may be addressed. Men's health statistics appear to show that men are getting more than their fair share of the health dollar and that constructive health initiatives are operating in men's health (Woods, 1997). Many of men's health problems are preventable and relate to societal expectations and risk-taking behaviors (Tacey, 1997). However, men's morbidity statistics are likely to be under-reported as men remain reluctant to voice their health issues.

Postnatal depression is not just a disorder that affects women. Currently men are caught in a double bind situation where they are expected to assume the responsibility of their partner and child's emotional and physical needs whilst attempting to assimilate their own health needs. Careful monitoring of vulnerable couples in their childbearing phase of life, by health professionals, is essential, as often the diagnosis of postnatal depression is made too late.

Men are asking critical questions concerning postnatal depression "what is postnatal depression?" "What are the signs and symptoms?" "Where do I get help?" "How long will it last?" and "will it occur again?" Health professionals can play a major part in supplying the answers to these questions.

This research report has implications for nurses in general but particularly in the fields of child and family, general practice and maternal mental health. Nurses and midwives should allow time to advise on strategies for dealing with stress, so that the postnatal father can vent his feelings in a safe environment and learn how to deal with well-meaning but sometimes inappropriate advice from family and friends. Ensuring that the people in the networks, available for the new parents, are knowledgeable too, concerning postnatal depression, is vital. Involving the grandparents or other members of the family may help to combat this form of depression. Including information about postnatal depression in school health education curricula could also be useful.

In conclusion, Paul's wish to write this story has identified the essence of the phenomenon of postnatal depression as he experienced it. Whilst the literature shows that

postnatal depression is a disorder related to women, Paul has equally exposed the fact that men too, suffer a similar depressive state (or major mood disorder). The socialization of our Western culture, that prevents men from engaging in health seeking behaviors with professionals, to voice their needs in the postpartum period, must be avoided to prevent men from becoming prey to postnatal depression. It has become apparent in writing this report, as Paul shared his experience of postnatal depression, that there is a need to spend more time on emphasizing the similarities between men and women and not highlighting the differences. In this way I would speculate that we will arrive at a greater understanding of each other's needs, and barriers of ignorance will be broken down.

Writing this phenomenological study has presented a unique story of Paul's experience of postnatal depression. Understanding Paul's experience of postnatal depression has epitomized what nursing is for me. It is the ability to hear the "voice" of the people that I care for and to value what they are saying to me. This study is a small contribution that has the potential for enhancing nursing practice and furthering research into men's experience of postnatal depression. Thus the voice of one man's experience of postnatal depression has been heard.

"This above all – to thine own self be true,  
And it must follow, as the night the day,  
Thou canst not then be false to any man.  
Farewell: my blessing season this in thee!"  
(Shakespeare, in Alexander, 1965, p.1034).

### PAULS REFLECTIONS ON THIS STUDY

Paul shared his thoughts with me in one of the many conversations that we had as the interviews took place on his reflections about taking part in the study and what it has meant to him. I feel that it is fitting that Paul has the last word in the study of his phenomenological experience of postnatal depression.

***Paul:***

‘Yes, at that time it actually felt really good at the end of it, that I was able to get some of it [postnatal depression] out into the open. It’s kind of like, you go through this thing by yourself and, god, I wouldn’t want anyone else to go through that. In some ways it was quite a relief just to talk about it. I said to my wife, I probably should go to counseling at the end of postnatal depression just to get it off[my chest] and out[in the open] but in this way its actually better because its going to be exposed and in the right way to people who need it and to those who have the potential to do something about it. It felt really good to get it out. I felt so relieved to be able to talk about it, it wasn’t going on deaf ears, and it was going to someone who cares. Yes, it was really good. I knew it was going to be good not just because it was going for a good cause [the study] but I knew eventually it was going to get to someone who would read it and that its going to help them and that’s very much in my heart’.

## REFERENCES

- Alexander, J., Levy, V. & Roch, S. (1995). Aspects of midwifery practice: A research based approach Hampshire; Macmillan Press Ltd.
- Anderson, I. (1996). Aboriginal well-being. In Carol Grbich (Ed.) Health in Australia sociological concepts and issues. Sydney; Prentice Hall.
- Andrees, E. (1999). What about Me? The experience of dads. Paper delivered at the Australasian Marce Society Bi-Annual Scientific Meeting.
- Appleton, J. V. (1995). Analysing qualitative interview data: addressing issues of validity and reliability. Journal of Advanced Nursing 22, 993-997.
- Baker, C., Wuest, J., & Stern, P. N. (1992). Method slurring: The grounded theory/phenomenology example. Journal of Advanced Nursing 17, 1355-1360.
- Ballard, C.G., Davis, R., Cullen, P.C., Mohan, R.N., & Dean, C. (1994). Prevalence of postnatal psychiatric morbidity in mothers and fathers. British Journal of Psychiatry, 164, 782-788.
- Barclay, L. M. & Lloyd, B. (1996). The misery of motherhood: Alternative approaches to maternal distress Midwifery 12, 136-139.
- Barclay, L. & Lupton, D. (1999). The experiences of new fatherhood: A socio-cultural analysis Journal of Advanced Nursing 29, (4) 1013-1020.
- Beck, C. T. (1996). A meta-analysis of predictors of postpartum depression Nursing Research 45, (5) 297-303.
- Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. Advances in Nursing Science 8, (1) 1-14.
- Bishop, L. (1999). Postnatal depression: Families in turmoil. New South Wales; Halstead Press.
- Bowlby, J. (1951). Maternal care and mental health. Schroeken, New York.
- Boyce, P., Stanek, S. & Gilchrist, J. (1999). Postpartum melancholia: Clinical descriptions of a distinct type of postnatal depression. Paper delivered at the Australasian Marce Society Bi-Annual Scientific Meeting.
- Brannen, J. (1993). The effects of research on participants: Findings from a study of mothers and employment. The Editorial Board of the Sociological Review, 328-345.

- Brown, S. (1993). Heart to heart. In Sean French (Ed.) Fatherhood. London, Virago Press.
- Buist, A. (1996). Psychiatric disorders associated with childbirth: A guide to management. Sydney; McGraw-Hill Book Company.
- Chandler, S. & Field, P. A. (1997). Becoming a father: First-time fathers' experience of labor and delivery. Journal of Nurse-Midwifery 42, (1) 17-24.
- Chapman, I. (1992). Expectant fathers' roles during labor and birth. Journal of Obstetric, Gynecologic, and Neonatal Nursing 21, (2) 114-120.
- Cohen, M.Z. (1987). A historical overview of the phenomenologic movement. Image: Journal of Nursing Scholarship 19, (1) Spring, 31-34.
- Connell, R. W. (1995). Masculinities. New South Wales; Allen & Unwin.
- Cox, J.L. (1986). Postnatal depression a guide for health professionals. Edinburgh; Churchill Livingstone.
- Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression development of the 10-item Edinburgh postnatal depression scale British Journal of Psychiatry 150, 782-786.
- Cox, J.L. (1988). The life event of motherhood. In Motherhood and mental illness 2: Causes and consequences. ( Kumar, R. & Brockington, I. F. Eds. ), Wright, London, pp.66-75.
- Cox, J. L. (1989). Can postnatal depression be prevented? Midwife Health Visitor & Community Nurse 25, (8) 326-329.
- Creedy, D. & Shochet, I. (1996). Caring for women suffering depression in the postnatal period Australian and New Zealand Journal of Mental Health Nursing 5, 13-19.
- Cresswell, J. W. (1994). Research design: Qualitative and quantitative approaches. London; Sage Publications Ltd.
- Crotty, M. (1996). Phenomenology and nursing research. Melbourne; Churchill Livingstone.
- Crotty, M. (1998). The foundation of social research. Sydney; Allen & Unwin.
- Cutrona, C. E & Troutman, B. R (1986). Social support, infant temperament, and parenting self-efficacy: A mediational model of postpartum depression Child Development 57, 1507-1518.

Dalton K. (1989). Depression after childbirth. 2nd Ed. Oxford, Oxford University Press.

Dalton, K. with Holton, W. M (1996). Depression after childbirth: How to recognise, treat, and prevent postnatal depression Oxford, New York: Oxford University Press.

De Vore, C. (1993). Evaluation and nursing education: Where to now? Nursing Praxis in New Zealand, 8, (1) 16 – 24.

Diekleman, N. (1992). Learning-as-testing: a Heideggerian hermeneutic analysis of the lived experience of students and teachers in nursing. Advances in Nursing Science 14, (3): 72-83.

DSM III (1980). Diagnostic and statistical manual of mental disorders (3<sup>rd</sup> Ed.) Washington DC: American Psychiatric Association.

DSM IV (1995). Diagnostic and statistical manual of mental disorders. Washington DC: American Psychiatric Association.

Fein, R. (1976). The first weeks of fathering: The importance of choices and supports for new parents Birth and the Family Journal 3, (2) 53-58.

Fischer, W. F. (1989). An empirical-phenomenological investigation of being anxious. In R. S. Valle & S. Halling (Eds.), Existential-phenomenological perspectives in psychology (pp. 127-136) New York: Plenum.

Fisher, J. (1999). The impact of operative interventions in childbirth on psychological functioning during subsequent pregnancy and postpartum period. Paper delivered at the Australasian Marce Society Bi-Annual Scientific Meeting.

Fowles, E. R. (1997). The relationship between maternal role attainment and postpartum depression Journal of the Society of Pediatric Nurses 1, 83-94.

Fowler, C. (1999). Learning about motherhood. Paper delivered at Australasian Marce Society Bi-Annual Scientific Meeting.

Friedewald, M. (1999). Fathertime – A discussion forum for men approaching fatherhood. Paper delivered at the conference Clinical Skills in Men's Health – Healing Men in Practice.

Gaarder, J. (1995). Sophie's World. Great Britain. Phoenix House.

- Gerzi, S. & Berman, E. (1981). Emotional reactions of expectant fathers to their wives' first pregnancy. British Journal of Medical Psychology 54, 259-265.
- Giorgi, A. (1983). Concerning the possibility of phenomenological psychological research. Journal of Phenomenological Psychology 14, (2) 129-169.
- Guba, E., & Lincoln, Y. (1981). Effective evaluation. San Francisco: Jossey-Bass.
- Harvey, I. & McGrath, G. (1988). Psychiatric morbidity in spouses of women admitted to a mother and baby unit British Journal of Psychiatry 152, 506-510.
- Henderson, A., Gregoire, A., Kumar, R., & Studd, J. (1991). Treatment of severe postnatal depression with oestradiol skin patches. The Lancet 338, 816-817.
- Hobbs, D. (1965). Parenthood as crisis: A third study. Journal of marriage and the family, 27, 367-372.
- Hobbs, D., & Cole, S. (1976). Transition to parenthood. A decade replication. Journal of marriage and the family, 38, 723-731.
- Hodges, H. F. (1996). Journal writing as a mode of thinking for RN – BSN students: A levelled approach to learning to listen to self and others. Journal of Nursing Education, 35, (3) 137 – 141.
- Holden, J. M. (1991). Postnatal depression: Its nature, effects and identification using the Edinburgh Postnatal Depression Scale. Birth 18, (4) 211-221.
- Hrobsky, D. M (1977). Transition to parenthood: A balancing of needs Nursing Clinics of North America 12, (3) 457-467.
- Husserl, E. (1931). Ideas: General introduction to pure phenomenology. London; George Allen & Unwin.
- Hutchison, S. A., Wilson, M. E., & Wilson, H. S. (1994). Benefits of participating in research interviews. IMAGE: Journal of Nursing Scholarship 26, (2) 161-164.
- Inch, S. (1982). Birthrights. Rendlesham, Green Print.
- Jeffcoate, J. A., Humphrey, M. E & Lloyd, J. K (1979). Role perception and response to stress in fathers and mothers following pre-term delivery Social Science & Medicine 13A, 139-145.
- Jordan, P. L (1990). Laboring for relevance: Expectant and new fatherhood Nursing Research 39, 11-16.

- Kendall, R. E., Wainwright, S., Hailey, A. & Shannon, B. (1976). The influence of childbirth on psychiatric morbidity. Psychological Medicine 6, 297-302.
- Klaus, M. H. & Kennell, J. H. (1976). Maternal-infant bonding. Mosby, St. Louis.
- Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. Journal of Advanced Nursing 19, 976-986.
- Kocklemans, J. J. (1967). Phenomenology: The philosophy of Edmund Husserl and its interpretation. New York; Doubleday.
- Lawler, J. (1998). Phenomenologies as research methodologies for nursing: From philosophy to researching practice. Nursing Inquiry 5, 104-111.
- Lealaialoto, R., & Bridgeman, G. (1997). Pacific Island postnatal distress Mental Health Bulletin, (Autumn).
- LeMasters, E.E (1957). Parenthood as crisis. Marriage and family living, 19, 352-355.
- Littlewood, J. & McHugh, N. (1997). Maternal distress and postnatal depression. Hampshire; Macmillan Press Ltd.
- LoBiondo-Wood, G. & Haber, J. (1994). Nursing research: Methods, critical appraisal, and utilization. St. Louis, Missouri; Mosby-Year Book Inc.
- Lovestone, S. & Kumar, R. (1993). Postnatal psychiatric illness: The impact on partners British Journal of Psychiatry 163, 210-216.
- Lucas, J. (1993). The nature of nursing. Health Care Analysis 1, (1) 84.
- McGill, M.(1985). The McGill report on male intimacy. United States of America, Harper & Row Publisher.
- McIntyre, D. (1996, April 25). Family Ties. The New Zealand Herald, Section 3,p.1.
- McKenzie, E. V. M. (1971). Poems 1949-1969. Auckland; City Press Ltd.
- Maloni, J. A & Ponder, M. B. (1997). Fathers' experience of their partners' antepartum bed rest Image; Journal of Nursing Scholarship 29, (2) 183-188.
- Margo, J. (1996). Man maintenance. Australia, Penguin Books Australia Ltd.
- Martell, L. K. (1995). Response to change: Maternity nursing after World War II MCN 20, (May/June), 131-134.

Mason, C. & Elwood, R. (1995). Is there a physiological basis for the couvade and onset of paternal care International Journal of Nursing Studies 32, (2) 137-148.

Mauthner, N. S. (1995) Postnatal Depression: The significance of social contacts between mothers. International Forum 18, (3) 311 – 323.

Mauthner, N. S (1998). “ It’s a woman’s cry for help”: A relational perspective on postnatal depression Feminism & Psychology 8, (3) 325-355.

Meleis, A. (1997). Theoretical Nursing: Development and Progress. Philadelphia; Lippincott-Raven Publishers.

Mercer, R. J. (1981). Factors impacting on the maternal role in the first year of motherhood. Birth Defects Original Articles Series XV11, (6) 233-252.

Merleau-Ponty, M. (1962). Phenomenology of perception. London: Routledge & Kegan Paul.

Miles, A. (1988). The neurotic woman. New York, New York University Press.

Morgan, M., Matthey, S., Barnett, B., Richardson, C. (1997). A group programme for postnatally distressed women and their partners. Journal of Advanced Nursing 26, pp. 913-920.

Morse, C. (1993). Psychological influences in postnatal depression Australian Journal of Advanced Nursing 10, (4) 26-31.

Motluk, A. (2000). Fatherly love. New Scientist January 8<sup>th</sup>.

Moustakas, C. E. (1994). Phenomenological research methods. California; Sage.

Munhall, P. L. (1994). Revisioning phenomenology: Nursing and health science research. Texas; Publications Development Company.

Neville, S. (1997). A view of nursing knowledge development through postmodern glasses. Nursing Praxis in New Zealand, 12, (3) 16 – 23.

Nichols, M. R. (1995). Adjustment to new parenthood: Attenders versus nonattenders at prenatal education classes. Birth 22, (1) 21-25.

Nicolson, P. (1990). Understanding postnatal depression: A mother-centered approach. Journal of Advanced Nursing 15, 689-695.

Niven, C. A. (1995). Psychological Care for Families: Before, During and After Birth. Oxford; Butterworth-Heinmann Ltd.

Oakley, A. (1972). Sex, gender and society. London, Temple Smith.

Oiler, C. (1982). The phenomenological approach in nursing research. Nursing Research 31, (3) 171-181.

Omery, A. (1983). Phenomenology: A method for nursing research. Advances in Nursing Science 5, (2) 49-63.

Osofsky, H. (1982). Expectant and new fatherhood as a developmental crisis. Bulletin of the Menninger Clinic, 46, 3, 209-230.

Paige, K. E. & Paige, J. M. (1981). The politics of reproductive ritual Berkley; University of California Press.

Parahoo, K. (1997). Nursing research principles, process and issues. London Macmillan Press Ltd.

Pierson, W. (1998). Reflection and nursing education. Journal Of Advanced Nursing 27, 165-170.

Reeder, F. (1987). The phenomenologic movement. Image: Journal of Nursing Scholarship 19, (3) 150-152.

Riley, D. (1995). Perinatal mental health: A source book for health Professionals. Oxford Radcliffe Medical Press.

Rossi, A. (1969). Transition to parenthood. In Marriage and family in the modern world. Cavan Ruth Ed. New York Thomas Y. Crowell Co.

Sandelowski, M. J. (1986). The problem of rigour in qualitative research. Advances in Nursing Science 8, (3) 27-37.

Schutz, A. (1967). The phenomenology of the social world. Evanston: Northwestern Universal Press.

Slater, L. (1999). Childbirth education: prenatal classes which recognise the needs of men. Paper delivered at conference Clinical skills in men's health; Healing men in practice. The University of Newcastle, Australia.

Spiegelberg, H. (1972). Phenomenology in psychology and psychiatry: A historical introduction. Evanston Northwestern University Press.

Spiegelberg, H. (1982). The phenomenological movement: A historical introduction. (3<sup>rd</sup> edition.) Boston Martinus-Nijhoff. >

Stern, G., & Kruckman, L. (1983). Multi-Disciplinary perspectives on post-partum depression: An anthropological critique. Social Science And Medicine 17, (15) 1027-1041.

Tacey, D. (1997) Remaking men: The revolution in masculinity. Australia Viking Penguin Books Australia Ltd.

The concise Oxford dictionary of current English (1958). (Eds.) W. Fowler & F. G. Fowler Oxford, Oxford University Press.

The Oxford minireference dictionary & thesaurus (1997). (Eds.) S. Hawker with C. Cowley. Oxford; Oxford University Press.

The Tudor edition of William Shakespeare: The complete works (1965). (Ed. Peter Alexander) London & Glasgow Collins.

Thurtle, V. (1995). Postnatal depression: The relevance of sociological approaches. Journal of Advanced Nursing, 22, 416-424.

Turner, B. & Kowalenko, N. (1997). The impact on the family of the mental health of fathers whose partners experience postnatal distress and depression. Paper delivered at The Second National Men's Health Conference, Fremantle Western Australia.

Unterman, R. R., Posner, N. A. & Williams, K. N (1990). Postpartum depressive disorders: Changing trends Birth 17, (3) 131-137.

Van Kaam, A. (1959). Phenomenal analysis: Exemplified by a study of the experience of "really feeling understood". Journal of Individual Psychology 15, (1) 66-72.

Van Manen, M. (1984). Practicing phenomenological writing. Phenomenology & Pedagogy 2, (1) 36-69.

Vickers, M. C. (1994). The meaning of successful breastfeeding. Journal of Human Lactation 10, (4) 225-226.

Wadsworth, B. J. (1984). Piaget's theory of cognitive and affective development. New York, Longman Inc.

Walters, A. J. (1994). Phenomenology as a way of understanding in nursing. Contemporary Nurse 3, 134-141.

Walters, A. J. (1995). The phenomenological movement: implications for nursing research. Journal of Advanced Nursing 22, 791-799.

Webster, E., Markou, P., Huxley, M. (1999). Psychotherapeutic support group for the partners of women with postnatal depression. Paper delivered at the Australasian Marce Society Bi-Annual Meeting.

Weiler, K., Buckwalter, K. C., Titler, M. G. (1994) Is nursing research used in practice? (Eds. Joanne McClosky & Helen Grace) In Current Issues in Nursing. St. Louis, Mosby-year Book, Inc.

Weintraub, T. A., Paine, L.L. & Weintraub, D. (1996). Primary care for women comprehensive assessment and management of common mental health problems. Journal of Nursing – Midwifery 41, (2) March/April.

Weymouth, E. (1996). Men's experience of having a partner with postnatal depression Preliminary findings of master of nursing thesis presented at conference "Daring to Change" nursing research into the health of children and their families. University of Tasmania, Hobart.

Whalley, L. J., Roberts, D. F., Wentzel, J. & Wright, A. F. (1982). Genetic factors in puerperal affective psychoses. Acta Psychiatry Scandinavia 65, 180-193.

White, M. B. (1998). Men's concerns during pregnancy, Part 1: reevaluating the role of the expectant father. International Journal of Childbirth Education 13, (2) 14-25.

World Health Organisation (1992). International Classification of Diseases 10 (ICD 10). (Geneva : WHO).

WHO. World Health Organisation, (1996). Investing in health and research and development: Summary report of the ad hoc committee on health research relating to future intervention options.

Wood, A. F., Thomas, S. P., Droppleman, P. G. & Meighan, M. (1997). The downward spiral of postpartum depression MCN 22, (November/December) 308-316.

Woods, M. (1997) The parameters of men's health – Rediscovering class. Paper delivered at The Second National Men's Health Conference, Fremantle, Western Australia, October 1997.

Zaslow, M. J., Pederson, F. A., Cain, R. L., Suwalsky, J. T. D. & Kramer, E. L (1985). Depressed mood in new fathers: Associations with parent-infant interaction. Genetic, Social and General Psychology Monographs 111, (2) 133-150.

## APPENDIX 1

### *Information Sheet For Participants Taking Part In Research*

#### **INTERVIEWS**

#### **Title: One man's experience of postnatal depression**

My name is Elizabeth Moore and this year I am completing my Master in Nursing degree at Massey University. I am also currently employed in a part time capacity as a district nurse with Waitemata Health Ltd.

My research supervisor is:

Dr. Gillian White

Senior Lecturer,

School of Health Sciences,

Massey University, Albany.

Thank you for your interest in taking part in the proposed research study on one man's experience of postnatal depression/unhappiness.

The proposed study has two major aims:

- a) To explore one man's experience of postnatal depression/unhappiness.
- b) To increase understanding of the complex phenomena that postnatal depression/unhappiness presents.

Your participation in the study would involve:

- a) A series of interviews with me (Elizabeth Moore) of approximately 1-2 hours duration at a date, time and venue to be mutually agreed.
- b) Maintaining a journal and providing feedback to the researcher on the interpretation of the data.
- c) Acting as a co-researcher on the study through free and open discussion at all stages of the research including the final report and any papers for publication.

#### **Risks and benefits**

There are no anticipated physical risks. In the event of distress arising from revealing of painful information, strategies will be put in place to enable you to receive counseling if you request it.

#### **Benefits of the study**

You will have an opportunity to:

- a) Tell your story of one man's experience of postnatal depression/unhappiness.
- b) Take part in research that may lead other men to voice their own experience of postnatal depression/unhappiness.
- c) Take part in research that will inform health professionals about men's experience with postnatal depression/unhappiness.

**Participation:**

- a) Your participation is entirely voluntary. You do not have to take part in this study.
- b) If you do agree to take part you are free to withdraw without prejudice, at any time without giving a reason.
- c) You may refuse to answer any questions or have information deleted from the tapes, or ask for the tape recorder to be turned off.
- d) As the research is of a sensitive nature and has implications for your family, the researcher and her supervisor Dr. Gillian White would like your wife to be informed about the study and give her support.
- e) You may ask any questions at any time during participation in the study.

**Anonymity:**

- a) In matters where there may be an ethical concern you may contact the Chairperson of Human Ethics Dr. Mike O'Brien on telephone 09 443 9799 Ext. 9768.
- b) Only the researcher and her supervisor will know your name unless you choose otherwise.
- c) No material that could identify your family or health professionals/agencies will be used in this study.
- d) Taped interviews will be transcribed by the researcher and will have identifying data deleted.
- e) All records (tapes and transcripts) will be kept in a locked cabinet at the researchers home. The tapes and transcripts will be returned to the participant or destroyed on completion of the study.
- f) The journal belongs to the participant and will only be accessed by the researcher during interviews.

**Research Findings:**

- a) The research supervisor will check all data.
- b) The research will be written up as a report and submitted for examination.
- c) A paper will be written with your consent, and submitted to a journal aimed at informing nurses about postnatal depression.

At all times you will be acknowledged as a co-researcher.

**General:**

More information can be obtained by contacting Elizabeth Moore on telephone 09 426 5231. You may also, at any suitable time and for any appropriate reason regarding this research contact Dr. Gillian White on telephone 09 433 9373.

**Statement of Approval:**

This study has received ethics approval from the Massey Human Ethics Committee.

Yours Sincerely,

Elizabeth Moore.

## APPENDIX 2

*Consent Form***Title: One man's experience of postnatal depression/unhappiness.**

RESEARCHER \_\_\_\_\_

PARTICIPANT \_\_\_\_\_

I have read and understand the information sheet inviting me to participate in a research project, and I have had time to consider whether to take part. I have had the opportunity to discuss questions related to this study and I am satisfied with the answers I have been given. I understand that participation in the study is my choice and I am able to withdraw at any time, plus withdraw any information provided in the interviews and/or ask for the tape to be turned off. I understand this will end the study.

I understand that I can choose to either have my identity kept confidential or to choose to use my own name in any audio-taped or written material. I understand that to be recognized as a co-researcher my wife must give her permission on completion of the research.

I agree to make the journal available for the interviews only..... YES/NO

I agree that my wife should be informed about the study and give her consent..... YES/NO

I consent to my interview being audio-taped..... YES/NO

I wish to use the name..... as a pseudonym in all written material arising from the interview.

I wish to use my first name in all written material arising from the study..... YES/NO

I..... hereby consent to take part as a single participant in this study.

**Participant:****Signed**.....**Name**.....**Date**.....**Participants Wife:****Signed**.....**Name**.....**Date**.....

### APPENDIX 3

#### *Participant Worksheets*

Crotty (1996) provided a framework of individual steps that the researcher could work through to study the phenomenon.

Step 1 Focus on the phenomenon.

Step 2 Concentrate only on the phenomenon.

Step 3 Describe exactly what has appeared.

Step 4 Look closely at what is being described and ascertain that no other previous knowledge is influencing the description.

Step 5 Describe the very essence of the phenomenon, the parts that go to making the phenomenon what it is.

For.....

The following is a guide for you to follow and discover what is your experience of postnatal depression. The suggestion is that you allow yourself to become totally immersed in your thoughts on postnatal depression. So that your mind grasps at the very essence of what postnatal depression is for you.

#### **Step 1.**

Clear your mind of all other thoughts and concentrate on the phenomenon of postnatal depression.

Ask yourself:

*What is postnatal depression for me?*

This is like sitting quietly having a conversation with you.

Imagine your mind is like an open book upon which your original thoughts are to be written.

Focus solely on your experience of postnatal depression and allow whatever thoughts you have to emerge.

#### **Step 2.**

Now ask yourself:

*What is postnatal depression like?*

*What does postnatal depression strike me as being?*

Think about postnatal depression as if it is the first time you have ever thought about it.

Be careful to disregard any previous knowledge you have concerning postnatal depression. Any prior assumptions, judgments or feelings about postnatal depression must be set aside. Write only about postnatal depression as if it were the first time you encountered it.

**Step 3.**

**Right now my experience of postnatal depression is.....**

Describe exactly what you immediately experience as postnatal depression.

Be careful to describe postnatal depression, not yourself. You are characterizing postnatal depression.

**Step 4.**

Now look carefully at what you have written.

*that I have written must be beyond any doubt my description of the human experience of the phenomenon of postnatal depression.*

If any part can be connected to prior knowledge or socialization concerning postnatal depression it must be discarded.

**Step 5.**

I ask myself:

*What is it in my experience of postnatal depression that makes me know that the phenomenon is postnatal depression?*

*What is it in my immediate experience that lets me know that this is postnatal depression?*

If postnatal depression has appeared to you in a certain way, how essential to the description of postnatal depression is it? If a descriptive item were to be removed would you still recognize it as your experience of postnatal depression?

The step by step process recommended by Crotty (1996) is complete. Phenomenologists refer to the setting aside of all previous knowledge as bracketing. A summary is provided to clarify that process.

Summary

I must concentrate on *what* I am experiencing and not on myself experiencing postnatal depression.

I must *set aside* all previous knowledge concerning postnatal depression. Using all of my senses, I must relate the human phenomenon of postnatal depression as *I experience it*.