A phenomenological exploration into the lived experience of fathers living with new mothers diagnosed as PND

Word count: 80,481
Submitted by: Farasat Sadia
Student Id: M00512810
Date submitted: 24 Feb. 2020

Supervisors: Emmy Van Deurzen and Claire Arnold-Baker

In partial fulfilment of the requirement for the D.C.PSYCH in Existential Psychotherapy and Counselling Psychology

Table of Contents

Acknowledgements

First of all, I am greatly indebted to my supervisors Claire Arnold-Baker and Emmy Van Deurzen. Your support has been invaluable throughout my research journey. You have been my guiding light, there all along, encouraging me and steering the project in the right direction. Generous thanks for sharing your extraordinarily broad and deep knowledge about existentialism and phenomenology. You have inspired and motivated me all the way for which I will be grateful forevermore.

I also want to express my gratitude to the fathers who kindly took time out to participate in the research and shared their personal experiences.

A special thanks to Liz Wise for extending support when I was struggling in the data collection phase.

Last, but not the least, thanks to my loving children: Abdullah, Zauraiz and Eshaal for bearing with my absence patiently while I was busy with my research. Also a special thanks to my loving husband Umer. You are the wind beneath my wings. I wouldn't have accomplished this project without your support. Thank you for being there, loving and supporting me.

Abstract

Postnatal depression (PND) is a widely studied area of research but limited research can be found pertaining to partners of women suffering from postnatal depression. The current research aims to explore the lived experiences of the fathers and consider the impact that it has on all dimensions of their existence. For this purpose, van Manen's approach based on hermeneutic phenomenology was utilized blended with Structural Existential Analysis (SEA) to uncover the deeper meaning and to develop a more nuanced understanding of their lived experience. The study was limited in terms of sample size and demography, and consisted of seven participants who were all White, British, first-time fathers, working full-time, falling within the 30-40 years of age with no access to familial support. Data was collected through semi-structured interviews. The major findings of the study were grouped under eight universal themes, viz. *Emotional roller-coaster, Suffering as a couple, Lack of support, Surviving the situation, Living with her PND, Personal challenges, Meeting expectations and Being with others*. The findings showed the fathers being ill-equipped to deal with the situation because they were not aware of PND's impacts and implications. Communicating with their partners effectively became impossible and the relationship of the partners started to suffer. It was found that sources of support were not easily identifiable or accessible by the fathers. The fathers ended up having to find their own personal ways of coping with the situation and their emotional as well as physical wellbeing came under immense pressure. The study has significant implications for both the healthcare practice and service provision to vulnerable individuals as well as for therapeutic work with clients in similar situations.

Chapter 1 Introduction

The topic of my research is the 'Lived experiences of fathers living with women diagnosed with Postnatal Depression (PND)'. PND refers explicitly to the depression suffered by women after childbirth. Its effects on the mental health of the mother are varied and various (Beck, 1992, 2006, 2008; Dennis & McQueen, 2011). There is a large body of work available regarding PND and the mothers' mental health but what tends to be forgotten is the fact that the fathers also face a challenging and unfamiliar situation after childbirth, especially if the mother is suffering from PND. Compared to the work available on mothers' mental health, relatively little work seems to have been done on the fathers' experience. For my study, I have aimed to look at that area, to find out what it is like for fathers to live with a partner who is experiencing PND.

1.1 Rationale of the study

My interest in conducting research about postnatal depression began when I gave birth to my first child. Becoming a mother for the very first time without any extended family support (and also without any community support) was a significant change in my life and of course a very intense experience as well. I had to not only bear my physical pain but also had to take care of the household chores as well as taking care of the baby and learning to be a mother. It was a tough time for me, but now on looking back, I realise that I was not the only one who was facing all these difficulties alone and for the first time; my husband was also experiencing an equally unfamiliar situation. I remember that at times, when I was very exhausted and in a low mood, I used to give him a very hard time. Although I was not diagnosed with postnatal depression, it was definitely a very stressful period, and I feel that it was a stressful period for my husband too. My husband had to not only learn to be a father - to cope with the situation where the young child needs a lot of care and attention - but also take care of me. In addition, as the only bread-earner of the family, he had to go to work as well. Given that it was extremely hard to cope even without PND, I want to develop an understanding of the experiences of the fathers who have had to cope with partners who are suffering from PND because the situation is most probably even worse for them.

Another relevant aspect when considering the question of fathers' experiences is that in social discourse, being a male is typically associated with being strong both in the physical sense as well as emotional sense, being self-sufficient, not being vulnerable etc. These perceived traits can potentially act as barriers against seeking professional or medical advice and care, e.g.

Tammenite (2004), has noted that the fact that men find it difficult to express their needs and experiences has a significant impact on their willingness and ability to seek professional help. This makes it even more important that research is conducted to provide the background and data that can help in making more informed decisions about the prioritization of making support (clinical or otherwise) available to partners of women diagnosed with PND. Services also need to be devised while keeping in mind the needs of partners of women diagnosed with PND, potentially including the creation of dedicated mental health services/programmes. I hope that my research will help to furnish some of the background data and information and provide a basis for further exploration of clinical implications and identification of potential improvements in service provision.

Chapter 2 Literature Review

2.1 Introduction

The birth of a child inevitably results in a major transition in the life of new fathers. Transformation into a father is one of the significant life-changes for a man as it has a profound impact on his perception of his role and identity, as well as on his lifestyle (Cooper, 2005; Kowlessar, 2012). It is a major developmental event not only for the fathers but for both the parents. Its effects on parents – both as individuals and as a couple – are profound. Both the mother and the father learn new skills, develop new relationships and absorb the impact on existing relationships. Given the expansive scope of changes brought by the transition to parenthood and the challenging nature of some of those changes, it is not surprising that some parents run into issues that they are not able to cope with successfully, resulting in mental health problems. The leading mental health complication associated with childbirth is Postnatal Depression (PND), which is the name given to the depressive symptoms in mothers, that may occur during the prenatal and postnatal period. While it is true to say that mothers are the primarily affected persons by PND, it cannot be considered to be just a mother-specific problem. The fathers are intimately related to the mothers, and any challenges that the mothers face, are bound to affect the fathers as well. Thus, PND affects the whole newly formed family (Halbreich, 2005). Even though PND is an issue for the whole family, a vast majority of research studies concentrate only on the mothers' experience of PND, and it is hard to come across literature that pertains to the lived experience of fathers who are living with partners suffering from PND. For the current study, a comprehensive literature review was conducted utilizing full-text search of the databases Medline, PEPweb, PsycARTICLES, PsycINFO, PsycTESTS, PubMed, Science Direct, Web of Science and Wiley Online Library. Articles considered to be potentially relevant were obtained using keywords, phrases, and Boolean operators of the search terms "postpartum", "postnatal", "depression", "experience", "new fathers", "first-time fathers", "paternal", "maternal", "partners", "wives", "support" and "fathers" in order to discover previous research articles involving fathers with partners suffering from postnatal depression. The search was initially limited to articles published between January 1999 and January 2019. However, this was later relaxed to include articles published at any time. Only articles specifically focused on both postnatal depression and fathers and written in English were chosen. Due to the limited number of relevant studies that were discovered, the scope was broadened to include existing literature that examines aspects of how PND affects mothers, in order to be able to infer and link the effects of the mothers'

PND on fathers. In addition, I have leaned upon existential philosophical thinking to delve deeper into the nature of the experiences of fathers, and to probe the social and relational aspect of their lives, as they enter this life-changing period of their lives when they carry a new human being into existence.

2.2 Existential Perspective on parenthood

The subject of becoming a parent or bringing a life into the world naturally lends itself to existential thought as existentialism concerns itself with issues of being and existence. The chapter on Procreation written by Claire Arnold-Baker and Miriam Donaghy in the book "Existential Perspectives on Human Issues" (2005), discusses the themes of freedom, responsibility, mortality, anxiety and the body in relation to the topic of procreation. They describe how becoming a parent is the start of a transition stage in the life of an individual, which affects all dimensions of their existence. On the side of the physical world, there are physical changes associated with pregnancy which mostly affect the mother but the father being the intimate-other in the mothers' life is naturally affected by them to a certain degree as well. On the social side, the addition of a new family member, of course, has a significant impact on the immediate family unit itself, but there are also secondary effects associated with the extended family and indeed the broader community around the parents as well. On the personal dimension, both parents have to contend with their fears and hopes regarding how the new human-being being brought into the world will affect them personally. On the spiritual dimension, the parents have to grapple with thoughts about what being a parent means and what kind of world the child will be brought into. In particular, for the mothers, transitioning into parenthood can be considered as an existential crisis that presents women with a multitude of challenges. Most mothers live through this transformational experience without succumbing to depression, but unfortunately, for some mothers, this is a time of despair. Claire Arnold-Baker (2014), recently conducted a study on the experience of early motherhood, where she showed that becoming a mother is a complex transition and elucidated in detail that, as mentioned above, the transition to motherhood has a profound impact on all four dimensions of existence. These changes brought by the transition to motherhood affect the mothers' social relationships and the way they relate to their babies and to others. They experience challenging changes in the way they relate to their physical being and their temporality, and even the mothers' sense of themselves. Becoming a mother also means that the mothers' values, beliefs and expectations are challenged. The sheer magnitude of the changes and challenges makes mothers prone to lapsing into a negative, depressive cycle at this point. Fathers who are living

with the mothers are by no means isolated from any of these changes, because any changes pertaining to the mothers' physical and mental well-being such as their values and their choices, require the fathers to respond to those changes to a larger or smaller degree. In many ways, the fathers' social, personal, spiritual and physical worlds are impacted as well. Furthermore, parenthood has a significant impact on the fathers' personal growth, their identity and their life in the social and physical domain independent of the changes in the mothers. This is explored in more detail in section 2.4 Fatherhood and Transition to Fatherhood below.

Going back to the discussion about procreation in "Existential Perspectives on Human Issues" (2005), becoming a parent is a choice, especially given the far greater control over pregnancy made possible by the recent advances in the field of birth control. Although for most individuals, the choice is more about when to become a parent, for others, it is more fundamental, that is, whether to become a parent at all or not. From the viewpoint of existential thought, it is a given of existence that we as humans are free in our choices, but that means we must take responsibility for those choices as well (Sartre, 1943). While the mother is pregnant, she is the primary bearer of the responsibility for the physical development and safety of the baby, but even then, through taking care of the mother, the father shares this responsibility to a certain degree. After birth, the responsibility of both parents increases in scope to include the child's emotional well-being and development as well. However, the responsibility that both parents take is not limited to just aspects related to the baby itself. Parents must take responsibility for their own selves as well, as the choice to become a parent means that there will be personal sacrifices of numerous types that the parents have to be ready to face. These sacrifices include their potential achievements in the world, the freedom of choice with respect to their time and physical comforts as well as various other commitments. In particular, the personal sacrifices with respect to their potential achievement in the world impinge on "moral anxiety" (Tillich, 1952), which arises from the feeling that a person has not achieved or become what he or she could have, and thus has not translated the potentialities that he or she was in possession of, into reality. Parents must take responsibility for facing up to their moral anxiety based on their choice to enter into parenthood, as this choice entails the inherent loss of potentialities because of the various sacrifices and constraints that parenthood brings as mentioned above.

Parenthood also challenges the identity that parents associate with themselves; whom they believe themselves to be. Existential thinkers assert that human beings are continuously

involved in the process of becoming, and as such, there is no fixed self (Heidegger, 1927; Sartre, 1943; Kierkegaard, 1980). Significant life changes can cause a person to alter what they believe themselves to be. For mothers, physical bodily changes start with pregnancy and continue post-birth. Moreover, for both parents, new emotional links are established, and there is a very large re-distribution of their effort, time and energy associated with the process of becoming a parent. In some cases, the work they do is affected as well as life inside the home. Changes of such magnitude can cause individuals to question the very meaning and purpose of their existence, and invoke feelings of depression and despair, what Tillich (1952) has termed "spiritual anxiety". As parents, at the same time when the father and mother say bonjour to their new child, they say adieu to their own old selves; and the joyful feelings on the fresh beginning are entwined with grieving for the end of their past selves and lives.

2.3 Postnatal Depression

As discussed above, the transition to parenthood can be overwhelming enough to push the parents and in particular, the mothers towards despair and depression. Postnatal Depression (PND) in women was characterized by Louis Victor Marcé as early as 1858, in his accounts of psychiatric disorders of women during and following pregnancy (Trede et al., 2009). The symptoms of PND in mothers can include low energy, sadness and despair, fears, feelings of inadequacy, feelings of being overwhelmed, changed sleeping and eating patterns, irritability, isolation and dependency (APA, 2000). It has been discovered that 10%-15% of women are affected by PND after giving birth for the first time (Lanes et al., 2011). There are numerous potential causes affecting the likelihood of a mother suffering from PND and the list of predictive factors includes the previous incidence of depression, life history, lack of support both in the social as well as physical sense, the quality of relationship with the spouse and the financial and social status (Nagy et al., 2011). The commonly held perception is that depression affects women after childbirth, but that is not strictly true, and depression can affect women during pregnancy as well and sometimes up to a year after the birth (Inwood, 1994). Although PND often appears within the first 2-3 months after childbirth, 30% to 70% of the depressed women continue to experience depression at six months to one year after delivery. Overall about 19.2% of women experience at least one episode of PND during the first three months after childbirth (Beck, 2006). This means that for about 19.2% of the fathers, they end up facing their first experience of living with their partner when she is depressed.

2.3.1 Perspectives on Postnatal Depression

PND has been considered from the biological perspective since James C. Prichard's early nineteenth century assertions in his book "A treatise on insanity and other disorders affecting the mind" (1835). The scientific understanding of PND has developed over time changing from emphasis on the vascular system to hormonal changes (Bloch et al., 2000; Bloch, Daly, & Rubinow, 2003; Bloch et al., 2005) and genetic reasons (Jones & Craddock, 2007; Mahon et al., 2009; Murphy-Eberenz et al., 2006). The focus, however, has very much remained on biological issues inside the body and it is assumed that such causes probably distinguish PND from other types of depressions.

From the social-evolutionary perspective, Stern's (1995) theory of mother-child interaction is informed by the phenomenological perspective. He posits a "motherhood constellation", which is characterized by a state, where the mother's sense of self is organized around the presence, the well-being, and the connection between herself and the baby (Stern, 2004). The mother readies herself in this state as part of the transition to motherhood, and the safety of the baby becomes her primary concern. This specific motherhood self-organization and how a disturbance, such as postpartum depression, is manifested in the interactions within the father-mother-baby triad needs to be taken into account.

From the psychodynamic perspective, the transition to motherhood is considered to be related to important issues related to how the self is defined and how this is impacted by the birth of the baby which possesses the potential to make the mother enter PND (Antonucci & Mikus, 1988; Belsky, 1991). It is theorized that self-critical individuals are more susceptible to becoming depressed as they can more easily become increasingly self-critical at the beginning of the transition into motherhood. Moreover, pregnancy and childcare are considered to compromise the autonomy that is craved by the more self-critical women (Priel & Besser, 1999). Raphaël-Leff (2001) posits that pregnancy and childbirth may invoke in the mother latent traumatic memories from the past that have not been processed, including loss or mourning.

2.3.2 Existential Perspective on depression

Existential philosophy squarely confronts the fact that a significant element in life is strife. Thus, feelings like suffering, anxiety, and guilt are inescapable (Jaspers, 1951). The existential approach, however, takes a holistic view and places any feelings that an individual has in the

overall context of their existence and their life and how the individual is connected to the world around them. As Laing (1960) says, what is happening in the mind of a person needs to be considered in the context of the broader tableau of their life, the others near them, and indeed the world around them. Thus, when considering issues of depression and despair, existential thought does not single out any particular negative thoughts or any particular feelings like anxiety, guilt or loss; instead, it encourages the individuals to look at all aspects of their life and evaluate any feelings they have in that context.

Depression can be considered as a mood that has descended upon a person. Even in medical jargon, depression is characterized as a "mood disorder". For Heidegger (1927), our being-in-the-world is always oriented or disposed in a specific manner at any particular time and how we are oriented or attuned to the world is what is described as our mood at that time. Thus, we are always in a certain mood, or Befindlichkeit in Heidegger's words, 'which means roughly "how one finds oneself', "how one is to be found" or "how one is doing"' (Inwood, 1997, p. 36). Hence, it is through looking at how we are experiencing the world around us that we become aware of what our mood is, and when everything looks dull, drab and dreary, we realize that we are depressed. An important distinction here is that a mood is not something that comes from within the individual; it arises out of our interactions with the world. We cannot learn anything about ourselves from our moods; we can only learn about our interactions with things in the world. A person's depressed mood cannot be changed purely by introspection about what is going on inside them. It can only be affected by adopting a different approach to being-in-the-world or interacting differently with the world. It has been posited that depression results in diminished ability to relate to the world with the basic existential elements of spatiality and temporality. Research reveals that for depressed individuals, "Of the three temporal existential extensions of past, present, and future, the first and third are nearly totally covered up in such patients, so much so that their existence is practically reduced to the present" (Boss, 1994, p. 213). Thus, the depressed individual cannot envisage the future, and his present becomes meaningless. Loss of future inevitably translates to the loss of meaning as well; as Strasser (1999), considering the loss of meaning in the lives of those seeking therapeutic help, says "When clients lose their meaning, depression ensues". Individuals suffering from depression experience existential guilt in the sense that they are not living up to what they could be, what their potentialities are. They are at a "standstill in the flow of personal becoming" (Jaspers, 1997, p. 540). In the context of losing the ability to attune oneself differently to the world, the desire to end one's life can be seen as one last act of free will against the inability to overcome

the numbness, and the feeling of being "stuck" in this mode of being where there is no future and nothing seems possible.

Frankl views depression as existential anxiety because of the tension between what is present and what is desired. When the gap between the two becomes un-bridgeable, then the person becomes depressed. "It becomes clear that the melancholic's anxiety of conscience arises out of an intrinsically human experience: that of heightened tension between the need and the possibility of fulfilment" (Frankl, 1955). What can bring a person out of that state of being is the "courage to be" (Tillich, 1952), but that is not straightforward for the depressed person to see because their whole existence is subsumed by depression when they are in that state.

Looking back at the discussion on existential perspective on parenthood, we find that both the themes of loss of meaning and existential anxiety discussed just now in relation to depression are quite likely to feature prominently in a person's life during the transition to parenthood. The transformational experience of parenthood can impact the identity of the self to the degree that requires new meaning to be attributed to the self's existence, thus resulting in "spiritual anxiety" (Tillich, 1952); but equally, existential anxiety due to other reasons, for example, the "moral anxiety" (Tillich, 1952) mentioned earlier, are important as well. Thus, it is not hard to understand that the postnatal period is often also a time when depression and despair get hold of the mother (and maybe the father as well in some cases).

2.4 Fatherhood and Transition to Fatherhood

2.4.1 Facets of Fatherhood

Fatherhood unquestionably brings fundamental changes to a man's life. It is a momentous occurrence; a portal that opens up on to a novel vista, and which transports a man to the next stage of his life-cycle. A detailed exposition of the transition to fatherhood is found in Martin Greenberg's book "The Birth of a Father" (1985), where the author discusses all the important aspects pertaining to a new father's development during the pre- and postnatal period. Beyond the initial phase of the transition, which includes the prenatal period and the actual event of the birth itself, Greenberg coins a new term called "engrossment" to describe the bonding and attachment of a father to the newborn. He outlines seven separate but related aspects, describing them as integral parts of the "engrossment" process, starting from the development of visual and tactile awareness of the baby. Next, the father becomes aware of the unique features of his baby so that the baby appears distinctly different from other babies. Then, despite the unsightly

aspects, the baby appears to the father as the epitome of perfection, the baby looks "just right" to the father. The father feels a strong attraction towards the baby and focuses his attention on it. All of this brings elation and exhilaration for the father, who, in Greenberg's words "feels stunned, stoned, dazed, off the ground, ten feet tall, taken away, taken out of himself". The final step is the enhanced self-esteem gained by the new father, whom all of a sudden feels proud and more mature. An important point to be noted here is that "engrossment" can develop at different times and different rates for different fathers. Some are immediately besotted and smitten straight after the birth by the baby, while others move through the various stages of engrossment at a later time, triggered by some other event or experience. For all fathers though, parenthood alters how they perceive themselves and the world around them. For Greenberg, the birth of the baby is in many ways also a birth process for the fathers, who leave their identity as a child of their own parents behind and gain a new identity as they envisage themselves passing from boyhood to manhood.

The development of fatherhood identity is, of course, a complex undertaking, and Tina Miller in her book "Making Sense of Fatherhood" (2011), discusses related but different facets of fatherhood identity. She considers the effect of the presumptions about positioning women as naturally maternal with caring instincts, which can leave fathers confused about expectations of their role with respect to the baby (p. 13). She goes on to consider how fatherhood identity has evolved over the centuries, with "the tender father" and "nursing father" of eighteenth-century England being later supplanted by the unemotional and disciplinarian father of the Victorian era because emotional involvement was seen as "too effeminate" (p. 14). Nowadays, of course, the opposite trend is being witnessed, with more and more calls for fathers to be involved, and to be hands-on, and partake in childcare to a greater extent than before. It seems that there is a constant undercurrent of the evolution of fatherhood identity over time, and the societal norms are not even close to being static in time. The temporal aspect is interesting here, for example, where previously "care" constituted being a provider and breadwinner, expectations are now shifting, even though there is recent evidence that fathers still retain a secondary role in caregiving (Plantin et al., 2003; Doucet, 2006). Gaertner et al. (2007) put this as "despite significant increases in paternal involvement in recent decades, fathers still spend considerably less time in parenting activities than do mothers". As Miller says "Clearly, men's understandings and practices of caring can shift as circumstances – both personal and structural – change, but research suggests that often they do not" (p. 15). Going back to Greenberg, the development of "engrossment" is not a given for every father. There is always a population of

fathers who, as a consequence of their beliefs and assumptions, fail to jump into the role of being a father to the full extent. It may be because they believe it is their partner's role, or in some cases because they think there is a particular age when the role of the fathers become more critical for the child. Gender-based expectations about caring and responsibilities can, thus, play an essential role in determining the outline of the identity of a new father.

Greenberg (1985) asserts that even though life changes a lot for the new father, there is a sense of satisfaction and pride to go with being a parent and life gets a new meaning: there is a new sense of fulfilment in knowing that as a father you are now connected to your partner and child. Together the family is embarking upon a new journey and are free to chart their own course. Thus, there is new-found freedom here to go with the changing identity for the man transitioning into fatherhood. Of course, along with freedom, there are responsibilities. It is crucial for a man to view himself as "being able to provide" (p. 83). A related aspect is the protection of the family, and this also mostly manifests itself as providing protection in the financial sense. Focussing on work also gives the father a role, a direction in the early part of the transition to fatherhood when things are generally very confusing and chaotic. The father feels as if everything rests on his shoulders. Responsibility is one of the core aspects of fatherhood. The dilemma that faces the fathers is that work and other responsibilities need them to spend time and effort away from the family. "It seems that there are just not enough hours in the day, and you may feel you have no choice but to spend most of them working" (1985, p. 87). The natural feelings of protectiveness that develop in the father all through pregnancy and especially near childbirth find expression in ensuring the family is covered against hardship, both now and as much as possible in the future through careful financial responsibility and planning, even when that means not being with the family as much as they would like to be.

Miller (2011) also discusses at length, the interplay between the responsibilities of life for the new father and the possibilities that emerge at the start of fatherhood, in the milieu of the societal norms and practices especially with regards to mothering. These responsibilities can have an impact on ability of the fathers to be the "breadwinner", which still constitutes a significant foundation for the personal and social identity for the men (Crouter et al., 2001; Marshall, 1993; Brandth & Kvande, 1998). Miller uses the term "a new normal" to describe the different ways of being there, sharing care and generally doing fathering as life settles into the new routine when the child reaches the age of around one year (p. 111). For almost all the fathers in Miller's study, fathering at that point revolved around fitting it in - around the early

mornings, the evening and the weekends - as the men juggled fathering and work. In the UK, the societal expectations are laid bare right from the start, with lots of fathers citing the "derisory" length of two weeks of paternity leave, while the average with respect to maternal leave is, of course, a much more extended period of six months to a year. In Miller's words "In very powerful ways the periods of time allocated in the UK to paternity and maternity leave have consequences for societal ideas of what men and women do: how caring and work inside and outside of the home and responsibilities to our children are envisaged and organised" (p. 120). It seems that men are allowed, nay, encouraged to prioritise work outside the home and to remove themselves from the minutiae of daily childcare. Of course, that is not how things play out all the time, with many fathers stating that their daily routine is very full, time-pressured and demanding because of having to interleave work responsibilities with childcare and home-care tasks which hardly leave any time at all for anything else. "Keeping things together" while trying to "be there", and to be involved in more hands-on fathering, raises the stress levels quite a lot (p. 122). Men are pressured into "proving" themselves through paid work because proving themselves through fathering alone is "not valid or recognised". Even when fathers and mothers had, before the birth of the child, planned a lot more equal sharing of care, the time men actually end up spending on caring activities gets eroded as their lives unfold (p. 123-124). Nowadays, men do have "discursive resources" available to them - in the form of "flexible working policies", "family friendly" routines and "work-life balance" - with which they can communicate with the employers, but even then, the deeply ingrained role of the breadwinner usually ends up trumping other considerations. Although in some cases, men are successfully able to interweave a flexible working routine with more caring, for others it is either not successful at all or is just about manageable (p. 127). It is clear, though, that even when men do not explicitly re-work their working routines, they are a lot more involved in hands-on caring for the children compared to earlier generations. However, to Miller, it is also clear that fathering practices still do not equate to the all-encompassing responsibilities and the thinking that primary caring involves (p. 129).

The relationship between the father and mother naturally changes after the birth of the baby as well. As Greenberg (1985) emphasises, instead of two, now there are three persons involved in the intimate relationship (p. 107). The mother is probably focusing most of her energy and time on the care of the new-born, and this can result in the father, sometimes feeling pushed out of the picture. Also, the steep physical effort required to take care of the child can adversely affect the couple's sexual relationship. A certain feeling of jealousy can germinate here with the father

silently wishing to be treated as well as the child. Greenberg advises the parents to consciously find opportunities to spend time outside the house together as a couple without the baby intruding and freely sharing their feelings rather than keeping them inside. I believe in many instances, the fathers probably do not even recognize the feelings described by Greenberg above, and these remain latent. Bringing these up and processing them, especially discussing them with the partner will likely have the effect of clearing up how the fathers feel.

To Greenberg, the primary and foremost thing that parents need to do is spending time with the spouse. It does not matter where or how that time is spent, but taking a break, maybe handing over the baby to a carer or grandparents or to friends on a reciprocal basis, and finding opportunities to "go out to dinner, take a long walk, go for a drive" (p. 128) allows you to recharge the batteries. The other thing that can be helpful is interaction with other new parents, and the support and reinforcement received from them. Couples can help each other by contributing aspects of their unique experiences to relieve the feelings of stress for the others. Realising that friends are there to help and enjoying the company of other parents can be "a powerful battery recharger" (p. 137).

Looking at the expositions of both Miller (2011) and Greenberg (1985), it is evident that while fatherhood entails a multitude of - often challenging - developments, all of these also elicit significant personal growth as well. It is also evident that fatherhood is a revitalising transformation which results in a man developing a new, more connected and richer identity in both the personal and social domains.

2.4.2 Recent Research on men's transition into fatherhood

Several recent studies have looked at the needs and experiences of men as they transition into fatherhood. Chin, Daiches and Hall (2011) analysed the findings of six qualitative studies published between 2002 and 2008, all exploring fathers' experiences of early fatherhood. They identify three overarching themes in relation to the shared experiences of fathers: "(1) emotional reactions to phases of transition: 'detached, surprise and confusion', (2) identifying their role as father: the 'approachable provider', and (3) redefining self and relationship with partner: the 'more united tag team'" (p.1). Chin et al. posit that fatherhood introduces men to a range of new emotions as they develop their understanding of their role as a father. One of the reasons fathers struggle during this process is the dearth of knowledge and father-specific resources to help them along with many fathers expressing their dissatisfaction about the

scarcity of information or programs which focus on their needs (p.13). Fathers suffer from many uncertainties and doubts as they adjust between the roles and responsibilities as a partner for their wives, father to their child and their role as a worker outside the home. Their natural tendencies to be more involved in taking care of the child and family conflict with their compulsion to be the breadwinner for the family (p.12). The relationship of the fathers with their partners, especially the intimate relationship suffers, with fathers reporting it becoming hard to find private time with the partners (p.14). Shortage of time makes it hard for fathers to take part in parent-child shared activities, and over time, it creates feelings of detachment and exclusion (p.14). On the positive side, some fathers find their relationship with their spouses increasing in cohesiveness and depth. Also, new fathers express a greater desire for self-care and generally seem more motivated about personal growth (p.14).

Toity Deave and Debbie Johnson (2008) have concentrated in particular on the needs of first-time fathers in relation to the care, support and education in their study. The themes that emerged from that study were: "support, both received and available; the sources and quality of the information received; and experiences of antenatal healthcare provision and lack of involvement in it" (p. 626). Fathers found after the birth of the child that they were ill-prepared for the postnatal period; there was not enough practical information that they knew about baby-care (p. 626), and they were not anticipating the changes in their relationships with their spouses (p. 628). Feelings, including fear, excitement and joy were quite common (p. 628). Instead of having useful information available through the healthcare system fathers had to make do with information from their spouses mostly. The other sources of information were colleagues at work and general internet search. Family and friends who were more experienced were considered valuable (p. 629). Most fathers suffered from a lack of a sound support system. In some instances, they felt they had no one to lean upon at all. The fathers saw the way the partners got information and support from their mothers and other female relatives in contrast with their experience with their fathers who were not lending the same type of support (630-631). Lack of knowledge and lack of preparation for the practicalities of parenting were common issues. Fathers were amazed, surprised and confused in relation to the newborn. However, they could perceive their love and a sense of great responsibility. The relationship with the partners was seen to be suffering because of lack of time to spend with each other and to talk to each other (p. 631).

Kowlessar, Fox and Wittkowski (2015) have also recently addressed the question of first-time fathers' experiences of parenting in a qualitative study using interpretative phenomenological approach (IPA). They interviewed ten first-time fathers, 7–12 months after the birth of their baby. Most of the results of their study agree with and uphold the results of Chin, Daiches and Hall's (2011) study. They note that long hours spent at work result in fewer hours with the baby and the fathers struggle to meet the needs of work, their spouse and their child at the same time (Kowlessar et al., 2015). New fathers fail to receive effective support during the early postpartum time and end up having to seek knowledge and support from their work colleagues and partners. Work colleagues who have children of their own act as good sources of support and information for new fathers, helping them to learn how to meet the challenges of work and family life (Kowlessar et al., 2015). Another important facet is new fathers attaching little importance to their personal needs during the early postpartum period because they perceive the needs of their child and spouse to be of higher importance (Kowlessar et al., 2015).

2.4.3 Men in caring roles

Cultural expectations and social norms pertaining to fathers' role in child rearing have been changing over the years and fathers are increasingly expected to take on more responsibilities and are seen as playing a role similar in importance to that of the mothers (Fenwick et al., 2011). This is reinforced by the need for women to return to their professional lives after childbirth to mitigate the negative impact on their careers as well as to alleviate the financial burden. These societal undercurrents have generated new interest in fathers as a subject of research for areas that traditionally have been limited to mother-only research in the past. This has started highlighting the importance of the fathers' role in the psychological wellbeing and growth and progress of their children (Wilson & Prior, 2011) and their role in enabling their spouses to cope with the stressful pre and postnatal period (Burgees, 2011). There is gathering evidence that fathers are taking on the responsibilities of caring, and it is resulting in specific as well as general issues related to roles (Hirst, 2001; Beaupré, Dryburgh, & Wendt, 2010). Men sometimes feel uncomfortable in caring roles because they contradict pre-ordained ideas about masculinity which imply that men are biologically not disposed towards the emotional tasks of caring or that society's norms do not condone men taking greater responsibility in parenting (Marshall, 1993; Mauthner, 1998). In the case of PND, the fathers need to adopt a different role where they increase the amount of work they do, related to household chores to support their partner and child (Boath et al., 1998; Mauthner, 1998; Meighan et al., 1999). This possesses the potential to conflict with gender and relationship expectations, and the transition

to parenthood is thus, much more difficult for men whose partners are suffering from PND (Marshall, 1993).

In addition to the demands of caring for the child, the burdens in relation to caring for a partner with a mental health issue can generate dissonance between caring and the primary relationship role. Supporting their partners "in sickness and in health" still seems to be an underlying notion that keeps setting expectations for partners even in the face of the evolution of societal norms and social relationships that have over time reworked the expectations from partners in intimate relationships. The men "see their spouse's illness as something from which there is no escape, and their caregiving is also perceived as an inevitability caused by the promises made" (Boeiji & Ven Doorne-Huiskes, 2003, p. 232). On the social side, the men feel "normative" pressure to care, from the circle of friends, the family and the spouses themselves (Gosling & Oddy, 1999; Wiles, 2003). However, the balanced relationship dynamics where both partners' needs are met is disrupted to a substantial degree because of the demands of the situation, as the men in caring roles are frequently required to put aside their own needs. They can also be negatively affected by concerns for the spouse's well-being. Overall, it appears that the very real stresses and the effects of the demands placed on men in the scenarios described above must not be underestimated.

2.5 Effects of Maternal PND on fathers

Maternal PND can result in multiple severe and debilitating issues like low energy, sadness and despair, fears, irritability, isolation and dependency. Given this far-reaching and portentous list of issues, it is not surprising that in many aspects, PND will have an incapacitating impact on the mother, and the cohabiting father will inevitably also be negatively affected by PND. As the relationship between the mother and child, the mother's ability to function effectively, and her relationship with all the others around her gets affected, the father is closely impacted by the whole scenario; additionally facing the challenge of adjusting to the new realities of fatherhood, and to the child as a new person in his life. Thus, although mothers are the primarily affected persons as far as PND is concerned, it has an effect on the whole newly formed family (Halbreich, 2005).

A handful of studies have considered the subject of the lived experience of fathers living with partners suffering from PND. One of the early qualitative studies in regard to the effect of maternal PND on fathers was conducted by Meighan, Davis, Thomas and Droppleman (1999),

which aimed to study the impact of PND on the family through the experiences of eight fathers whose partners were suffering from PND. This is one of the only pieces of research that studied the lived experience of the fathers in detail and identified common thematic patterns. The themes identified included “She becomes an alien”, “He attempts to fix the problem”, “His world collapses”, “Loss of control”, “Loss of intimacy” and “Altered relationship”, among others. “She becomes an alien” implies that the partner’s personality abruptly and radically changes in such a way that the fathers cannot either recognize or relate to the new person. The next theme is “He attempts to fix the problem”, to discover the reason for the problem, and help his partner in recovery. However, most fathers’ experience was that nothing they did seemed to be able to change the situation. In the end, the fathers realized that they could not fix the problem, so then they started making sacrifices, stopping to take care of their own needs in order to help the family get through the crisis. The men took on greater responsibilities in caring for their partners and children while continuing to be the breadwinner at the same time. After lengthy periods of stress “His world collapses” around him. The men feel frustrated and resentful over the scenario but often feel guilty for having that feeling as well. The fathers explained their losses such as loss of control over the situation, feeling powerless and helpless, frustration, anger, isolation, anxiety and fears and concerns about the partner that she might harm herself. The fathers also mentioned the loss of intimacy with their partners when she was suffering from PND. Even when the partner recovered, the fathers reported that their relationship with their partner had significantly changed and was never quite the same as it was before PND. It was also felt by more than half the participants that healthcare staff and even others were inclined to minimize the problem and disregard their concerns increased the feeling of isolation. The study concluded that treatment and counselling should focus on the couple rather than just the woman suffering from PND. Focussing on the fathers is necessary as they not only influence the overall treatment outcome, but they may also have been significantly impacted themselves. Furthermore, support groups for men whose partners are suffering from PND could help the fathers in the crisis that they find themselves in (Meighan et al., 1999).

Subsequently, Davey, Dziurawiec and O’Brien-Malone (2006) researched men’s experiences of their partners PND and their participation in a 6-week group treatment program for male partners. The fathers in that study reported PND to be overwhelming, isolating, stigmatizing, and frustrating. Support for fathers was seen as not organized in a visible fashion and readily available forums for fathers to express their issues were not there. Lack of support was exacerbated by the tendency of men to appear strong and their reluctance to appear in need of

support. Participation in the group was considered to be very helpful in coping, resulting in lowered levels of stress and higher levels of social support. It was also considered highly valuable to have the opportunity to share experiences with other fathers and to hear other perspectives on the spousal relationship as well as obtaining factual information.

A study conducted by Letourneau, Duffet-Leger, Dennis, Stewart and Tryphonopoulos (2011) elucidated further facets of the effects of maternal PND on fathers. They studied experiences of 11 fathers living with partners suffering from PND with particular focus on the support needs of the fathers. The fathers in that study reported suffering from anxiety, lack of time and energy, irritability, feeling sad or down, and thoughts of harm to self or baby. In addition, all of the fathers reported running into issues when seeking support with the most common barriers being lack of information regarding PND, lack of resources and the difficulty of seeking support. Letourneau et al. (2011) also discussed issues that fathers faced with regards to maintaining a healthy balance between their work life and home life when their partners were suffering from PND. For dual-earning families, an obvious concern was the reduced family income because of the mother taking maternity leave. At the same time, the addition of a new family member increased the expenses beyond the earlier level. In the case of PND, the mother was in no position to help out in any way, so in addition to worrying about supporting their partner, the fathers ended up facing earning pressure as well. The previous freedom that the fathers enjoyed in terms of their activities and their time as well as financial situation was thus reduced considerably in most cases. Some fathers did describe work as beneficial because it allowed them to "escape" and thus helped in coping, in some cases helping them to avoid becoming depressed themselves.

A recent study has pointed out that impairment of the close personal relationship with their partners seemed to affect the fathers in a significant fashion with some fathers accepting the loss of the partner relationship and devoting more time to cultivating an exclusive father-child relationship. (Beestin et al., 2014). However, another study (Goodman, 2008) designed to fill the gap in knowledge about how father-infant interaction is affected by the mother's PND has painted a slightly different picture. This study sought to gauge the importance of maternal PND in determining fathers' behaviour towards their infant children and it compared 128 families with depressed and non-depressed mothers to determine whether significant maternal and paternal factors that shape father-infant interaction could be identified. The conclusions indicated that the way fathers interacted with their infants exhibited distinguishing

characteristics including paternal depression correlated with maternal PND and pointed towards the fact that fathers could mask or shield against the adverse effects of maternal PND on their interaction with their infant children. Furthermore, it has been noted that if both parents end up suffering from depression, the likelihood of having a negative effect on children's healthy development, is considerably more compared to when only one parent is suffering from depression (Dierker et al., 1999; Brennan et al., 2002).

2.5.1 Relationship between Maternal and Paternal Postnatal Depression

Mothers' PND has a significant effect on their partners, e.g. Goodman (2004) found that the incidence of depression in fathers could be in the range between 24% and 50% for those whose partners were suffering from PND. Paternal PND has been correlated with maternal PND by multiple studies (Letourneau et al., 2011; Nishimura et al., 2015). Further studies indicate that fathers generally suffer from mood disorders, including depression and feelings of anxiety during the early postnatal period (Scott-Heyes, 1984; Lewis, 1989). Some men end up being overwhelmed by all the stress and changes associated with the transition to fatherhood, and negative emotions take over which result in depression (Matthey et al., 2000; Zelkowitz & Milet, 1996; Bergström, 2013; Canadian Mental Health Association, 2014). 10.4% of new fathers experience depression as against 4.8% of the general male population, but this is not uniform and varies with the timing of when the studies take place and the location (Paulson & Bazemore, 2010). Paternal Postpartum depression is also poorly documented in men, and the prevalence may thus actually be higher than reported (Stadtlander, 2015). A study focused on paternal postnatal depression found an association between financial troubles and the incidence of depression. The depressed fathers were also younger and less satisfied with the level of social support they had access to (Batorowicz & Petrycka, 2006). Furthermore, parenting stress was found to be a risk factor (Soliday et al., 1999). This is not unexpected because the postnatal period brings about a major change in the life of the new fathers and alters their pre-existing routine significantly (Wilson, 2008). Mothers are not alone in facing the challenges such as lack of undisturbed sleep, exhaustion, relationship worries and economic stresses; the effects of the same factors on the fathers are also substantial (McCoy, 2012).

Kim and Swain's study suggests that 10% of fathers report experiencing anxiety and stress after their first child is born (Kim P & Swain JE. 2007). Considerable variation has been reported regarding the proportion of fathers experiencing feelings of depression, e.g. Lewis (1989) has reported that 43% of his clients were affected during the early postnatal period, but

Elliot et al. (1985) have reported that less than 3% of fathers were characterized as facing severe difficulties in adjusting during the first year after the birth of the child. It has been noted that the fathers' psychological state has got a strong connection to the mothers' psychological state (Ramchandani et al., 2005). Fathers often start showing symptoms of depression soon after PND starts to affect their spouses and the symptoms typically become more pronounced and severe over time, frequently associated with a worsening condition on the mothers' side (Pinheiro et al. 2006) and worsening state of marital relationship (Dudley et al. 2001, Buist et al., 2002, Bielawska-Batorowicz & Kossakowska-Petrycka, 2006). Further effects of continued maternal depression include the fathers having to bear the bulk of parenting responsibilities (Goodman 2004), resulting in exhaustion and aggression (Roberts et al., 2006). Other factors that may exacerbate the situation include substance abuse and financial hardship (Tannenbaum & Forehand, 1994; Ram & Hou 2003).

There is thus, mounting data pointing towards the fact that the effect of maternal PND on fathers is quite likely to be paternal depression or at least paternal stress and anxiety (Milgrom & McCloud, 1996; Soliday et al., 1999; Matthey et al., 2000; Zelkowitz & Milet, 1996, 2001; Goodman, 2004; Pinheiro et al., 2006; Roberts et al., 2006). The paternal stress can manifest itself in various forms and can include emotional distress and feelings including frustration and anger, fear and anxiety, being overwhelmed, concerns for their partner, isolation and helplessness (Boath et al., 1998; Meignan et al., 1999; Davey et al., 2006) as well as spousal relationship issues (Hock et al., 1995). In the study by Letourneau et al. (2011), three out of eleven fathers living with partners suffering from PND identified themselves as depressed because of the overwhelming negative emotions. When maternal PND was present, some fathers also experienced symptoms of depression including "anxiety, sleep disturbances, fatigue, irritability, sadness, changes in appetite, and thoughts of bringing harm to self or baby" (Letourneau et al., 2011, p. 43). The relationship with their partners was suffering. They felt powerless and lacked confidence in their ability to support their partners and to cope with the demands of the situation. Frustration and anger were prevalent emotions as well. Other concerns included the child's health, relationship with other family members and job-related stress factors (Letourneau et al., 2011). Overall fathers seemed to be getting squeezed by many stressors simultaneously no doubt making it easier for them to fall into depression.

Goodman (2004) asserts that although fathers tend to suffer from depression when the mothers are suffering from PND, the causal influence is not established. However, some of the issues

mentioned by fathers in regards to the problems that they face seem entirely relevant, e.g. a hostile environment at home filled with tension where the fathers end up bearing a lot of the burden without receiving any recognition of their contributions (e.g. Meighan et al., 1999; Webster, 2002). Furthermore, their efforts to help out with childcare are often criticized and undermined (Morgan et al., 1997). In addition, Meighan et al. (1999) note that fathers believe their partners had changed in a significant way and that they (the fathers) were striving to "fix" the problem but found that they were unable to help and this, in turn, created feelings of anger, hopelessness and frustration. The fathers saw their own life as having become unstable; with lasting harm caused to their relationship with their spouses and a loss of the desire to have more children in such a fragile environment. Goodman (2004) has identified the salient factors here as additional responsibility and factors such as sleep deprivation, extra household chores, increased financial burden and altered relationship with the spouse. The fathers either end up feeling as if they are themselves unable to cope with the additional responsibility and change of lifestyle or they end up feeling as if they are unable to support their partner effectively (Goodman, 2004). The twin sources of stress, that is, taking care of a depressed partner and taking care of the young child in the tense household environment, often affects the mental health of the fathers, resulting in depression in the fathers themselves (Areias et al., 1996; Roberts et al., 2006; Roy, 2006). The division of labour and the roles in the family are affected by the transition, and this can be especially relevant in the case of dual-earning families (Olsen & DeFrain, 2000).

To further compound the problem, while some fathers are aware that their lives will have to undergo a major upheaval during the postnatal period, many do not fully appreciate the extent of the impact (McKellar et al., 2009). In addition, there might be other contributing factors, e.g. some fathers not having had the benefit of seeing their own fathers in the child-caring role (Condon et al., 2004) or growing up in single-parent families where their mother was solely responsible for all child-care tasks. These factors can exacerbate the anxiety level and heighten the likelihood of depression in fathers (Veskrna, 2010). It is imperative to understand this space as paternal PND has also been associated with psychological issues that emerge in children in later years (Edward et al., 2015). While onset in women usually occurs early in the postpartum period, the onset of depression in men begins later and is more gradual, often following the onset in women (Goodman 2004; Letourneau et al., 2012). Both the mothers and fathers who are suffering depression report marital difficulties as a result of poor communication and less

than optimal interactions with their children; additionally, they experience feelings of being overwhelmed, isolated stigmatized, and frustrated (Letourneau et al., 2012).

2.5.2 Effect of PND on the couple relationship

Doss et al. (2009) have conducted a longitudinal study to examine the effect of the birth of the first child on relationship functioning using data from 218 couples (436 individuals) over the first eight years of marriage. Prior to this, other studies had found conflicting results about how becoming a parent affects the relationship between the spouses e.g. Cowan and Cowan (1995) state that the "transition to parenthood constitutes a period of stressful and sometimes maladaptive change for a significant proportion of new parents". However, Huston and Holmes (2004) come to a different conclusion, i.e. that the "preponderance of the data fail to support the view that parenthood typically undermines marital satisfaction". The longitudinal study by Doss et al. (2009) indicated that parents showed sudden deterioration following birth on all measures of positive and negative aspects of relationship functioning. The magnitude of the deterioration was small to medium but tended to persist throughout the study. No aspect of relationship functioning showed a positive effect of the transition to parenthood on average. Specifically, mothers showed sudden deterioration in relationship satisfaction, self-reported problem intensity, and poor conflict management, observed negative communication, and relationship confidence. Fathers showed significant sudden deterioration in marital satisfaction, dedication, and good communication; additionally, fathers showed significant gradual increases in problem intensity. Furthermore, results showed significant variation in the changes in the relationship. This variability was related to multiple factors associated with the individual, the marriage, and characteristics of the birth itself.

Kluwer (2010) has conducted a review of relationship change across the transition to parenthood. Adverse changes in the relationship were not seen as inevitable based on the review of extant research up till that time. Even when negative changes were present, the magnitude of change was considered to be small to moderate (p. 107). However, where negative changes do occur, they tend to be permanent (p. 108). Doss et al. (2009), whose findings are discussed above, bring up the question of whether the sudden decline in relationship satisfaction is related to the increase in satisfaction before the birth especially during the first pregnancy with couples experiencing a ‘‘honeymoon’’ of cooperation and togetherness during their first pregnancy. However, other studies (Lawrence et al., 2008) did not find any evidence of relationship satisfaction increasing substantively after pregnancy

which makes the question raised by Doss et al. (2009) less relevant. It appears that roughly half the couples go through negative changes in the relationship after the birth of the child, and in order to understand why half the couples fare better than the others, it is crucial to understand the factors that determine how couples deal with significant changes to life. Adaptive processes, i.e. "the ways couples deal with conflict and marital difficulties", and personal and situational characteristics, are the major factors identified here by previous research (Kluwer, 2010, p. 109).

Horsch and Ayers (2016) look at relationship satisfaction and conclude that many factors including biological, psychological and social, all combine to make the couple relationship hard to manage during the transition to parenthood, with the newborn's health and sleep issues further complicating the situation. Parental stress increases because of multiple concurrent and unfamiliar demands and responsibilities. In line with the findings of Doss et al. (2009) and Kluwer (2010) above, many couples find that they were not expecting lack of sleep and lack of time together to the degree that they have to face (Mitnick et al., 2009). Montgomery et al. (2009) refer to various studies that associate couple relationship factors such as conflict, dissatisfaction and support with the risk for PND. PND is known to strain the relationship with issues like fear of rejection, misallocated anger, withdrawal, poor communication of needs and expectations (Davey et al., 2006; Tammentie et al., 2004; Paley et al., 2005). Similarly, Kung (2000) compares marital dissatisfaction between depressed and non-depressed women and concludes that poor communication, disengagement and sexual problems result in a higher degree of marital dysfunction.

2.5.3 Existential Perspective on the couple relationship

It is quite instructive to look at the existential perspective on couple relationship because some important principles and thoughts are very relevant in the context of the relationship between the partners during PND. One of the tenets of existential philosophy is that human beings define themselves in relation to others. We are never but an element, a part of the broader context. As such, we are always in a context, a relation; always connected to what is around us. As Deurzen (1997, p. 95) says "Relationship is essential to our very survival and inspires everything we do." We cannot call ourselves truly human unless we view ourselves in the context of others or being-with-others. We only come into being located in the world around us, both in the physical sense but equally importantly, in the social sense as well. Heidegger calls this "Dasein" or being-in-the-world, the idea being that there is never a moment when we exist

without the context of the world around us. We originate in a physical and social world with other humans in it and remain firmly related to the world, nay we are always a part of the world. Even though we are always, since conception, entangled in a web of social interactions, our self-awareness allows us to surpass the said web and liberates us to choose whom to relate with and how to relate to them.

Heidegger (1927) shows how Dasein is always in relation to others. The being-with-others (Mitsein), begins with anonymously relating to ourselves and others. At this point, we act with our own self and with the others as we believe the others would act. This is the inauthentic way of being where we are trying to hide behind anonymity. In Heidegger's view, the inauthentic way of being with others is just a forerunner of authentic way, and they remain connected to each other. This brings into question the ability to maintain perpetual authenticity in relationship. As Heidegger says, "Authentic Being-one's Self does not rest upon an exceptional condition of the subject, a condition that has been detached from the "they"; it is rather an existential modification of the "they" — of the "they" as an essential existentiale" (1927, p. 130). Being in relation is, thus, so fundamental to our being that our authentic being is always a manifestation of how we relate to others. Levinas (1987) took this further and suggested that the "other" should become the focal point of our existence. The "other" will always, in a certain fashion, remain a stranger for us. Hence, having an ethical relationship to the other is of utmost import.

In their book "Existential Perspectives on Relationship Therapy" (2013), Emmy Van Deurzen and Susan Iacovou survey existential philosophical thought about relationships. They assert that as the span and profundity of existential philosophical thought are immense, and it contains within itself an amazing variety of perspectives on all aspects of human existence, it becomes hard to condense the key foundational principles succinctly. However, looking at the views of the most prolific existential writers and thinkers and studying some of their thoughts turn by turn can give us a good starting point.

Nietzsche was wary of the "herd mentality" (Nietzsche, 1973) following what others are doing without taking the time to make an individual assessment and decision. His thinking is close to Kierkegaard here. He believed that just following the lead means we are not being brave enough to take the risk to stand out from the crowd, so we keep doing what others are doing. Nietzsche's thought was more focused on facing up to the realities of the world around us. He

posited that being influenced by others goes against our own well-being, which lies in protecting our own distinct existence and our own personal domain. This is very relevant in the case of the spousal relationship as well because both the partners need to learn how to preserve their own individual time and space and keep their self-esteem and individuality intact. We can love the other much better once we start loving ourselves and our own lives first and have the courage to be responsible for our choices and our lives rather than making others responsible for those.

Simone de Beauvoir had a different take on this, as she was acutely aware of the power imbalance in relationships where one of the individuals seems to possess the notion of entitlement or primacy. Her concepts were mainly in the context of the relationship between the man and woman, where, in many cases, the woman gets reduced to the “other” to be possessed and thus at that point becomes less important, secondary and reduced (de Beauvoir, 2011). In many relationships, this dynamic is quite significant and can result in mistrustfulness, apprehension and anxiety. When considering relationships from the existential perspective, an essential factor is a freedom that is afforded to each participant, so that they are unconstrained when choosing to be with some other, instead of being driven by some notion of obligation or restraint.

Buber’s distinction between I-It and I-Thou relations is relevant here as well. As he says, we can never say I, without implying 'It' or 'You' (Buber, 1970). We are perpetually entangled in relationships. No individual is isolated, and no one can continue their existence without addressing or being addressed by others. We are, however, free in terms of how we take others into account. Our lives are going to involve being embroiled in a multitude of relationships to others around us, no matter what we think about it. Furthermore, our approach towards the other will be determined to a large extent by how we relate to the natural world, including our bodies and our environment. For Buber, a person’s life is meaningful only in the context of relationships. He marks the difference between I-Thou and I-It ways of relating. In I-Thou form of relating, we are, indeed, “with” the other to whom we are relating. We are not after getting something from them, nor are we even making an attempt to examine them in any way or even trying to understand them. At those time, we are just opening ourselves entirely to the other, and are ready to face the totality of the other, allowing the other to be fully themselves, in turn, allowing ourselves to be our true selves as well, in the fullness of who we are. We want to relate to them as another I, rather than as an object or an It.

Buber's characterization of the I-Thou relationship is quite like Binswanger's interpretation of the dual mode of relating (Binswanger, 1963) or to Hegel's accounts of intersubjectivity. If as a result of our interaction with the other person in the I-Thou mode of relating we change, then this change is only based on that interaction, rather than any particular project that we might have for ourselves or the other. I-It mode of relating, in contrast, implies that we are relating to the other as an individual "out there", distinct from us, thus considering them as an object or an It. Here, we can only ever view a part of the other, and we become inhibited and less than what we are in our entirety as well. When objectifying the other, we become objectified at the same time. Of course, relating in the I-Thou mode all the time is impossible for anyone given the practical realities of life — the necessary demands of living in the physical world mean that we have to relate to lots of people in the I-It mode in many, indeed in most instances. However, according to Buber, a life, or a relationship which does not know of the I-Thou mode of relating is a penurious one. For him, the encounter is an essential part of the human existence: "without It man cannot live. But he who lives with It alone is not a man.". (Buber, 1970, p. 34).

Kierkegaard's take on relationships also centres around objectivity and subjectivity. As he says, "Most people are subjective toward themselves and objective toward all others, frightfully objective sometimes — but the task is precisely to be objective toward oneself and subjective toward all others." (Kierkegaard, 1998, p. 72). Many people in the world lose sight of themselves, their uniqueness and their sense of ultimate purpose or meaning of their life. Sometimes, they attempt to merge with the significant other in their life, something against which Kierkegaard is quick to warn us. He warns us against not learning to be objective about oneself. His suggestion of becoming able to be subjective about others is equally helpful in reminding us to teach partners to imagine putting themselves into each other's position.

The thoughts of the existential philosophers discussed above contain many themes that are of considerable significance to the research question of my study. The spousal relationship dynamics are closely related to the topic because how the partners relate to each other most probably changes when PND takes hold of the mothers. Moreover, the notions of self-esteem, freedom, authenticity, subjectivity and openness discussed above have a direct bearing on how, for the fathers, their way of being in relation to their intimate others gets affected as they deal with the changing circumstances after the birth of their child.

2.6 Surviving Maternal PND

With fathers stretched to the limit by the challenges they are facing when their partners are suffering from PND, it becomes crucial to learn how to cope with the situation and survive the difficult period to emerge at the other end of the tunnel. Elaine Bennet and Dawson Cooke (2012) have conducted a detailed study focussed on the subject of surviving PND from the perspective of the male partners. They have used Grounded theory to explore the experience of seven fathers whose partners were suffering from moderate to severe PND. Their research aimed to develop a conceptual framework to understand the experience of "surviving PND" from the fathers' point of view. The study posits that survival and coping involve considerable misery and distress for the fathers as they struggle through the transition process to reclaim control of their personal and family life. Bennet and Cook's analysis discovered four stages or categories of experiences: "out of control", "coming to the realisation", "making sense of it", and "the road to recovery". The beginning of PND is deceptively hard to decipher and insidious. It is confusing for the fathers who feel powerless and helpless as they see their partner change because of the effects of PND. This is the "out of control" phase when things feel chaotic and impossible to understand. It is followed by the next stage of the survival process, i.e. "coming to the realisation" that there is a real issue that needs help and support to be sought. As they seek support for themselves and begin to find their feet again, the fathers start "making sense of it" and the primary consideration at that time is staying "solid" all through the trying times. Slowly, their viewpoint changes and "the road to recovery" is revealed as both the fathers and the partners begin to see the way out of the suffering. Most fathers report many losses and a few gains with the complete picture becoming clear as time passes. Confusion and distress figure prominently, especially at the start. As the process of survival progresses, the emotions start to become less important and a "rock solid" and "non-emotional survival state" takes over where they are fully concentrating on providing support and care to the partner. However, as the partners improve, fathers start suffering from "emotional drain" and become more vulnerable, also experiencing guilt for having feelings like sadness, anger, lack of motivation, tiredness and for prioritizing some of their own needs. The relationship with the partner is generally affected negatively, but mutual understanding increases and fathers gain insight about their own personal world, about parenting and their relationship with their child/ren. The experience gives them a much better understanding of PND and its effects on themselves and the family as a whole and makes them better equipped to cope with and survive adjustment crises in the future.

It is interesting to explore why some individuals are better able to cope with their partner's PND and survive, compared to others. An important factor here is the effect of perceived typical masculine characteristics like being goal-oriented, confident and autonomous on the coping style (Matud, 2004). Societal norms, and the way in which social relationships are constructed, mean that men are not encouraged to be overtly sad or seek support (Matud, 2004), making it more likely for men to lean towards drug and alcohol abuse in an effort to avoid emotion focused coping and instead focussing on instrumental coping style (Addis, 2008; Cochran & Rabinowitz, 2003; Matud, 2004). In addition, responses such as letting work suffer, and showing more cynical and hostile behaviour are also reported (Spector, 2006). Gender-based role definition and expectations play an essential part in shaping how fathers define and perceive their role and even how their partners define their expectations from the fathers (Davey et al., 2006). Letourneau et al. (2011) has described how certain behaviours help fathers who are living with partners suffering from PND. These behaviours include being able to "escape" to work, engaging in exercise or having an active lifestyle and being able to separate themselves for some time or leaving the house for some time. In addition, both Letourneau et al. (2011) and Deave and Johnson (2008) have mentioned sharing with friends as helpful. However, in many cases, men are likely to suppress their feelings to cope with the scenario rather than sharing, and gender-specific expectations, for example suffering in silence and holding themselves together are frequently found when studying the behaviour of fathers whose partners have PND (Meghan et al., 1999). Overall, as described by Moos (2004), in contrast to women who tend to engage more in emotion-focused and approach coping, men are generally likely to engage more in avoidance coping, and this seems in line with other studies (Meghan et al., 1999; Davey et al., 2006; Letourneau et al., 2011).

2.6.1 Seeking support and barriers to support

Several studies have been conducted exploring the role of support for fathers, and specifically in the context of fathers who are living with partners suffering from PND. Fathers can benefit from having support when they are facing challenging circumstances due to their partners' PND as described earlier.

In a study conducted by Davey et al. (2006), the researchers looked at fathers' experiences of partners' PND where fathers were reported to be under significant stress especially on the emotional side, including being frustrated, overwhelmed and isolated. Participating in support groups was seen as beneficial, reducing stress and depressive feelings. Stress for the fathers

was seen as compounded by the fact that societal norms have changed over time, and they were expected to take on roles not familiar to them by looking at their own fathers and grandfathers. The feeling of being overwhelmed is corroborated by multiple related studies, e.g. Kowalski and Roberts (2000), Misri et al. (2000) and Morgan et al. (1997). Support for fathers was seen as not organized in a visible fashion, and readily available forums for fathers to express their issues were not there. Lack of support was exacerbated by the tendency of men to appear strong and their reluctance to appear in need of support. However, when participation in support groups happened, it was found to be eye-opening in the sense that all the fathers discovered that they were all "in the same boat". Opportunities for sharing the experience had an important normalizing and legitimizing effect and was considered significantly beneficial. It increased the understanding of fathers with regards to their partners as well as improving the communication between partners. Some fathers did comment on the stigma associated with participating in support groups when talking to friends and relatives, but when they did share the fact, they were surprised at the amount of respect shown by others. Generally, it was evident that support extended by groups was a helpful experience for most fathers, although it was also a new experience for most of them.

In a relatively more recent study, Letourneau et al. (2011) have studied the experiences, support needs and barriers to support for fathers whose partners were suffering from PND. They reported that that fathers find it hard to find information about the available support resources and face difficulties when they try to seek support. Lack of awareness about PND and not being able to identify resources and services that would allow early discovery and recognition of PND in their partners are significant issues. For quite a few fathers, seeking help from family and friends is difficult because they live too far or are not aware of the issues related to PND. All the fathers experienced some barriers to support, which hampered their efforts and ability to find support for themselves and their partners. The stigma associated with PND caused both the partners and the fathers to delay and deny the issue, but often they also ended up too exhausted and overwhelmed to seek help effectively. Competing demands on time and energy, including childcare, work and transportation challenges make it hard to seek appropriate support. Also, the prevalent customs in the society act as a barrier because generally fathers were asked about how their wife and child were doing but never asked about how they are coping themselves. Later on, Letourneau et al. (2012) conducted a wider study throughout Canada. The fathers who participated in that study all agreed that the main barrier to early discovery and treatment of PND was insufficient public information and awareness about PND.

Support preferences included arrangements to share more information about PND as well as practical tips on coping. Programs for support were desired to be broad spectrum and reach a larger audience as well as being flexible and accessible (Letourneau et al., 2012).

2.7 Prevalent attitudes and practices in healthcare

The limited research that is available on the subject of standard healthcare practices with regards to fathers living with partners suffering from PND points towards a substantial deficit in the healthcare services available to the fathers (Buist et al., 2002; Letourneau et al., 2011). In the study by Letourneau et al. (2011) discussed above, in addition to the findings regarding barriers to support, it was found that all the fathers reported being ignored by healthcare professionals and in some instances, they were not even allowed to accompany the mothers during their treatment. It was also reported that the healthcare professionals did not give proper consideration to or in some cases, even downplay symptoms on the fathers' side (Letourneau et al., 2011). These findings are in line with the findings of the earlier study by Meghan et al. (1999) discussed previously, where it was found that four out of eight fathers reported that healthcare staff and others tended to ignore their issues when their partners were suffering PND (Meghan et al., 1999). Although it has been established that fathers are at an increased risk for depression and other mental health issues during the transition to fatherhood, perinatal healthcare is mostly focussed on mothers' needs, and fathers' needs, and the increased risk of mental health problems mostly does not receive enough attention. This is exacerbated by the fact that men are less likely to access healthcare by themselves (Goldenberg, 2014). They do not view therapy in a positive light, are not disposed towards visiting doctors and are more likely to stop mid-way any treatments they have been prescribed (Addis & Mahalik, 2003; Primack et al., 2010). Being self-reliant and stoic are also considered to be "traditional" norms for men, which acts as a further hindrance (Addis, 2008; Primack et al., 2010). Moreover, fathers generally find it hard to devote time to therapy because of the conflicting demands on their time (Fletcher & St George, 2011).

Research in the healthcare field has devoted less importance to mental and sexual health issues of fathers as well, even though an increasing percentage of fathers are adopting the role of primary caregiver. In contrast, mothers' reproductive health and sexual health are considered to be fundamental aspects of their mental health care. At the same time, fathers are facing increasing pressure to be supportive partners and to be more engaged with all aspects of parenting, with most of the fathers responding to that positively and desiring to be more

supportive and engaged (Goodman, 2004; Steen et al., 2011). However, men find that when they attend antenatal classes, they do not benefit because the content is wholly focussed on mothers and their needs (Kowlessar, 2012). Generally, the role of fathers and how it is affected by the mothers' mental health issues, has not been examined to any considerable extent even when society is transitioning towards more equally distributed parental responsibilities.

Provision of better and more bespoke response to the healthcare needs of the fathers requires the healthcare professionals to be more aware of the said needs. It seems important that research is conducted to paint the picture of fathers' experiences better so that service-provision can be tailored towards equipping the healthcare staff with better frameworks, practices and guidelines in light of that research. In case of mothers' mental health issues being identified, the broader consideration of how the whole family is going to be affected will need to figure prominently especially given the propensity for fathers' mental health to suffer in these contexts (Paulson and Bazemore, 2010). Mental health service-provision should cater to the whole family rather than concentrating only on the mother. Exhaustive screening is understood to be one of the critical factors in identifying and establishing maternal and paternal PND (Letourneau et al., 2012). Addressing the needs of the fathers would likely require a paradigm shift: from focussing mostly on mothers' psychological disorders and issues, towards a more holistic, family-oriented perspective. Both parents' adjustment parenthood needs to be given careful consideration, both mother-child and father-child relationships should be supported and nurtured, and the various roles that both the parents have to adopt all need to receive due support and attention. This would have to encompass the full spectrum from primary healthcare to secondary and tertiary services with fathers' well-being considered all along (Letourneau et al., 2012).

2.8 Research focussed on fathers and its challenges

Initially, most of the research related to PND (or indeed any depression, pre-partum or post-partum) was centred on mothers because of their perceived role as the primary caregiver in the family (Gopfert et al., 2004). However, this is changing as evidence accumulates about the significance of the impact of fathers on their children (Jaffee et al., 2003; Flouri, 2005; Sarkadi et al., 2008) and even on the parenting by the children's mother (Eiden & Leonard, 1996; Guterman & Lee, 2005). In addition, there is growing public awareness about issues such as gender equality, women's integration into professional life and the prevalence and importance of fathers' role in directly taking care of children, the importance of the parental alliance and

parental relationship on children etc. All this has resulted in fathers and their participation in parenting being topics that have received more attention in recent times.

As research focussed on fathers has started to become increasingly common, it seems that paternal postnatal depression has received an increased level of interest from researchers especially since more men have started to take on the primary caregiver responsibility. Not only is this an active area of research, but it is also a popular topic of discussion generally, and social media is playing an important role in this context. A lot of discussion threads and groups have surfaced, e.g. fathers reaching out, PND daddy, Father's network etc. that serve to generate more awareness about paternal depression. Research has demonstrated that perinatal depression is a real contemporary issue (Condon et al., 2004; Paulson & Bazemore, 2010) even to the extent that 10.4% of fathers are affected between the first trimester and the end of perinatal year, and this ratio rises to 25% if we look at the period between three to six months after delivery (Paulson & Bazemore, 2010). Paternal PND has been associated with poor quality of parenting and adverse effects on children (Tambelli et al., 2014; Wilson and Durbin, 2010; Ramchandani et al., 2005, 2008) especially since fathers tend to mirror the negative mood of their spouses so that both parents can start showing depressive symptoms at the same time (Deater-Deckard, 1998; Nishimura & Ohashi, 2010).

Even though father-focussed research and paternal PND are receiving more attention, the exploration of the lived experiences of fathers who have not been formally diagnosed as depressive themselves but whose partners have been diagnosed as depressive is still severely lacking. Proper consideration of men's experiences needs to acknowledge their role in the family and assesses whether the support and information available to them are appropriate or not. As Goodman (2004) has noted, the level of awareness about this gap in the research has increased, and it seems that there has been an increase in the amount of research related to this topic (Morgan et al., 1997; Meighan et al., 1999; Webster, 2002). However, to this day, data focused on the experiences of men whose partners are suffering from PND continues to be scarce. There are several reasons that make it difficult to focus on this area of research, e.g. the attrition rates tend to be high which may have an adverse impact on the fidelity of statistical testing of findings (Ramchandani et al., 2008), and also men are generally less keen on support-seeking behaviours, displaying the tendency to prefer self-management instead. This can, in turn, be influenced by societal norms which encourage self-reliance (Ramchandani et al., 2008). Men traditionally behave differently from women when it comes to letting others know

about their psychological problems and stresses. They are less inclined to gravitate towards health services for support, and even when they do approach services, they tend to have a different way of expressing themselves and describing their symptoms and needs (Robertson et al., 2015). At present, there is not enough information for healthcare professionals to be able to devise the ideal practices that cater to fathers' psychological wellbeing because of multiple reasons. The primary reason being that not a lot of research is available on fathers' psychological issues exploring how they are affected during the perinatal or postnatal period and what psychological stressors exist and how they develop over time. Additionally, more information is needed to identify the potential obstacles that may be present in the path of fathers gaining access to the needed help (Hammarlund K et al., 2015). Also, as mentioned above, because of the lack of knowledge about fathers' perinatal and postnatal experience, not a lot of clarity exists about how to address the psychological wellbeing of men and whether indeed they have unique needs which need to be handled differently (Pilkington et al., 2015).

2.9 Importance of further research

The lack of research focus, in turn, leads to an underestimation of the population needs and misconceptions about the prevalence of the issue. This is unfortunate given the fact that mothers' PND might have severe consequences for the whole family, including the fathers and the children. A mental health disorder of any family member can have a profound impact on other family members, affecting their personal as well as the social world (Beck, 2002). Lower marital satisfaction also seems to possess a strong correlation with high parenting stress (Hawkins et al., 2008). Some estimates suggest that only 20% of mothers suffering from PND are diagnosed and treated, which still leaves thousands who continue to suffer. Early identification and treatment of PND are crucial in minimizing its effects on the whole family. The best option, of course, is prevention rather than treatment. Developing a deeper understanding of the experiences of men living with partners diagnosed with PND is very important. These experiences have a profound effect on new parents' views and attitudes, and they influence their behaviour in regard to seeking help as well, which is crucial for the health and wellbeing of the new family.

2.10 Research question

During recent times there has been a marked change in the role of fathers with respect to the care of children. Their responsibilities have shifted from being just the source of material provisions to an active participant who partakes in all aspects of early age childcare. This

necessitates a corresponding shift in childcare research priorities as well so that the challenges and issues faced by fathers are explored in sufficient detail. Given the background discussed above, it seems clear that there is a gap in the research in this area and exploring "What is the lived experience of fathers living with new mothers diagnosed with PND?" can help fill that gap. This is a vital need because it will provide new data where there is a dearth of available information, and this can help augment the knowledge base of health practitioners, counsellors and support providers which might result in the provision of better-targeted care for the new fathers.

The next chapter will consider the methods that are best suited to explore the research question and elucidate how I have utilized my chosen methodology to examine the lived experience of the fathers.

Chapter 3 Methodology

3.1 Introduction

This chapter will discuss the methodology chosen for the current study and present the details of how the chosen methodology is utilized. The philosophical foundations of phenomenology will be examined because phenomenology underpins van Manen's (1990) qualitative approach towards researching lived experience, which I have adopted for my research. Phenomenology is rooted in the works of Edmund Husserl and Martin Heidegger. Heidegger was originally one of Husserl's students but went on to lead his own independent school of thought quite distinct and in certain ways at odds with Husserl's philosophy. Below, I examine the thoughts of both the philosophers and elucidate how Heidegger's ideas about hermeneutics laid the foundation of hermeneutic phenomenological approaches like van Manen's approach and IPA. Afterwards, I explain the detail of how I utilize the various aspects of the chosen methodology for my exploration of the lived experience of fathers who are living with partners suffering from postnatal depression.

3.2 Methodology

3.2.1 Choice of Qualitative Phenomenological Research Methodology

The choice of research methodology is primarily based on the research question and the research objective, including what type of data would be required, and useful, to answer the research question. There are two fundamentally different categories that research methodologies can be placed into, viz. quantitative research and qualitative research. A few fundamental differences between the two types delineate the boundaries of each. The choice of the deductive method in the case of quantitative research as against the choice of the inductive method in case of qualitative research is one of the basic differences. The deductive method gives primacy to the reasoning based on "cause and effect", and chooses to consider whether the tentative assumption, that is, the hypothesis, can be "proven" to be true or false based on the reasoning. In essence, quantitative research is population-focused and chooses to measure pre-defined variables to establish their statistical significance and bases its conclusions about a hypothesis on those measurements. In contrast, qualitative research is individual-focused and chooses to explore individual experiences and studies the meaning attributed and derived from those experiences. It needs to happen in more naturalistic settings where the participant feels at home in their own territory. Qualitative research generates a deeper and more nuanced understanding of experiences and events focused on specific aspects. Additionally, it includes

the researcher as part of the analytic process and explicitly recognises the fact that the subjective meaning attributed to the experience is created during the research process between the researcher and the participants. A fundamental requirement here is for the researcher to be open and receptive to whatever the outcomes and findings of the research are and not pre-judge the results in any way. For the current study, a qualitative phenomenological approach was considered to be the best-suited approach because the chosen topic itself, that is, the lived experience of fathers, requires that the focus is on the exploration of the individual experiences of fathers. A quantitative research methodology would have made it very hard to create a textured, nuanced understanding of the experience of the fathers to be captured. Additionally, one of the objectives of my research was to explore the experience of the fathers from the existential perspective and here again; it was necessary to let the meaning emerge from the account and descriptions of the lived experience captured during the research process. Within the realm of qualitative research, one of the most important approaches, which seeks to uncover knowledge and discover the hidden meanings and essences of the experience through critical and intuitive thinking is phenomenology (Omery, 1983). At the root of the phenomenological philosophical tradition lie the ideas of Husserl and Heidegger; who address the epistemological question "how do we know?" and the ontological question "what is being?". The subsequent sections on epistemology and ontology elucidate my approach and understanding further about these aspects.

3.2.2 What is Phenomenology

The word phenomenology is a derivative of the Greek word "phenomenon" which in turn means "thing appearing to view" ("phenomenon | Definition of phenomenon in English by Lexico Dictionaries", 2019), which is quite instructive because, in research, phenomenology is the approach that seeks the essence or core of the experience. Various researchers have attempted to define phenomenology. Parse (1981) says that phenomenology studies phenomena as they evolve, aiming to capture the mercurial nature of human experience. To Field & Morse (1996), it is the study of experience, while to Roberts & Taylor (1997), it is the study of an entity. On the other hand, Polit & Hungler (1997) define phenomenology as a qualitative research method that is focussed on the lived experience of human beings. To van Manen (2007, p. 12), "phenomenology is also a project that is driven by fascination: being swept up in a spell of wonder, a fascination with meaning". Moreover, it "directs the gaze toward the regions where meaning originates, wells up, percolates through the porous

membranes of past sedimentations—and then infuses us, permeates us, infects us, touches us, stirs us" (van Manen, 1990, p. 11).

3.2.3 Phenomenology and the Naturalistic Paradigm

At the time when phenomenology was evolving in the nineteenth century, there was a philosophical paradigm which was quite prevalent, namely, the positivist paradigm about the objective nature of reality. This paradigm asserted that reality was independent of the observer or human interaction; it was "out there" and could be determined and measured through rational and logical means completely. Thus, when researchers were designing their methods of analysis, they could rely upon the principles of empiricism and reductionism and collect data and build up knowledge which was deemed objective and not influenced by human subjectivity in any manner. This was countered by the naturalistic paradigm, which asserted that reality is subjective and individual; it is not fixed and independently deterministic, and every human being creates their own version of reality. Phenomenology, on the other hand, transcends the naturalistic paradigm, aiming to surpass both objectivity and subjectivity; combining the object, the subject and the intentional arc between them in a dialectic movement towards capturing the experience. It argues for the primacy of the world of meaning in the order of philosophical inquiry and understanding, over the world as characterized by the naturalism.

3.2.4 Philosophical origins of phenomenology

Historically, phenomenology developed in the milieu of the philosophical traditions established by Kant (1724-1804) who in his seminal work "Critique of Pure Reason" (1781), outlined two forms of reality, namely the noumenal and phenomenal. To Kant, the reality as it exists is the noumenal world where the things exhibit their true nature as they are. However, whenever human beings conceptualize things, we do that through our understanding of things, and our perception or view of the world is the phenomenal world. The noumenal world was thus considered forever out of reach; the best we could hope was to study the phenomenal world (Fitzgerald, 1995), as that was the only way we could conceptualize anything. Going even further back in time, Rene Descartes (1596-1650) posited that scientific learning is abstract, rational, and atemporal, but this was subsequently contested by humanistic and critical approaches (Fitzgerald, 1995). Kant's thinking was later challenged by Hegel (1770–1831), who asserted that the distinction between noumenal and phenomenal was inadvertently broken by the very act of delineating the difference between the two because in making the distinction between them we are conceptualizing the noumenal itself. Subsequently, Carl Stumpf (1848-

1936) built his theory of phenomena, characterizing them as either sensory or imaginary. However, phenomenology really blossomed in the work of the philosopher Edmund Husserl (1859–1938) who can be considered the founder of contemporary phenomenology. Husserl's phenomenology is often characterized as 'descriptive', and it included the development of important notions like epoche and the eidetic reduction. Heidegger's (1889-1976) take on phenomenology, which came slightly later after Husserl is equally important and is closely aligned with 'interpretive' or 'hermeneutic' approach. These two approaches (descriptive and interpretive) have shaped the landscape of modern phenomenology to a large extent, and below I discuss these in more detail.

3.2.5 Epistemological and Ontological position

Epistemology originates from the Greek word epistêmê, which means 'knowledge', and the word logos, which means 'study of'. Thus, epistemology is concerned with the nature of knowledge. The fundamental questions of how we know anything and what knowledge is, fall in its domain. Epistemology provides a foundation for the research because the objective with every research is to generate and disseminate knowledge. It also delineates the assumptions about how the world is understood. In contrast, the related concept of ontology concerns itself with the nature of reality itself, while epistemology defines how we can know that reality. Methodology, on the other hand, illuminates the way by which that knowledge can be obtained. In my research, I have leaned upon Heidegger's interpretive approach towards phenomenology as my ontological position, and his ideas about what Being means and how it relates to the world have provided the perspective with which I have viewed the experience of the fathers. The epistemological position I have taken for this research is based on Husserl's phenomenological ideas because he has explored the question of how we come to know things in a systematic way as described below.

3.2.6 The Phenomenology of Husserl and Heidegger

Edmund Husserl can be considered the founder of the phenomenological method. He wanted to uncover the essence of every type of experience. He aimed to create a descriptive scientific discipline dedicated to the study of phenomena of experience, as he famously said, "Zu den sachen selbst" or "To the facts (or things) themselves" (Husserl, 1911, p. 116). He posited that the main objective of phenomenology is to bring to the fore the assertion that the "primordial meaning of the objective world is its mode of engaging human consciousness" (Kearney, 1994, p.15). Husserl wanted to address the problem of scepticism whilst establishing the foundations

of his philosophy but rather than trying to find a solution to the problem, his approach was to suspend the problem altogether. Hence, for Husserl, epoche became a necessary component of the introduction to phenomenology (Lewis & Staehler, 2010). Epoche holds back from positing any assumptions about existence of an external world, and encourages us to “bracket”, that is, to leave behind all pre-conceived ideas, theories, beliefs and learnt behaviours. “Bracketing" seeks to distinguish the phenomenon itself from the researcher’s views and experiences by holding back the pre-conceived feelings and notions; thereby exposing the essence of the lived experience (Gearing, 2004; Colaizzi, 1978). Another component of phenomenology is "looking at". This involves phenomenological intuition and imagination, looking at the phenomenon like a child looks at something new, with open eyes, inducing the feeling of wonder (Oiler, 1982). The key here is not to cogitate based on any pre-learnt notions, concepts and theories. Whether this is, in fact, ever possible is one of the main discussion points about Husserl’s philosophy. For Husserl, "Intentionality" acknowledges the existence of material reality, answering the concerns of the positivistic paradigm. Husserl believed that consciousness was always "intentional" because it was cognizant of the existence of the outside world and connected an individual's consciousness directly with experiences in that outside world: the separation between subject and object being bridged by the intentional arc (Baker, 1992). Husserl advocated the use of bracketing, acknowledgement of the intentionality of consciousness, and phenomenological intuition to achieve "transcendental subjectivity" (Ray, 1994).

Husserl’s phenomenology paves the way for me to address the research question while being open and obtaining full descriptions of the experience of living with a partner suffering from PND from the fathers who were participating in the research. During the analysis stage also, Husserl’s phenomenology provides the framework within which knowledge is gleaned from the transcript of the interviews. By putting aside previous biases and pre-conceived ideas and looking at the descriptions of the lived experience as a completely new phenomenon, I obtain the focus for uncovering the multi-faceted elements of the experience as the participants describe it.

Husserl had hoped that his student, Heidegger, would build upon his work, but Heidegger's initial ideas in Being and Time (1962) moved in quite a different direction even though they were based initially on Husserl's ideas. Husserl was quite unhappy about Heidegger's philosophical divergence form transcendental aspects of his phenomenology and their relationship changed significantly. Heidegger did not agree with Husserl's phenomenological

reduction. He had difficulty believing that bracketing could ever actually be achieved given the assertion that the self is part of the world and this intimate relationship between the individual and the world is a fundamental part of conscious experience. Heidegger asserts that right from the moment we become conscious, we find ourselves thrust into the world and that being part of the world precedes our consciousness (Walsh, 1996). Heidegger did agree with the spirit of the tenet "to the facts (or things) themselves" but he did not agree that facts could exist in the absence of interpretation. To him, facts could never be viewed except through the lens of interpretation. Furthermore, this lens is not unique; it depends on the viewer and their experience. Thus, while Husserl aimed to get to a phenomenology devoid of any interpretation, Heidegger's phenomenology fully embraced the interpretative and hermeneutic approach. His philosophy removed the desire to uphold objectivity and encompassed an individual's natural viewpoint as a primary part of Being. For Heidegger, lucidity lay not in being separate from the world, but in Being-in-the-world, so he was interested in studying the modes of Being, that is, "Dasein" or "Being There". Hence, while Husserl sought a description of the essence of phenomena, Heidegger's objective was to understand the essence of being and to find the universal or ontological qualities of human existence, although he has been criticised for extrapolating from his own experience to universals.

3.2.7 Hermeneutic (Interpretive) Phenomenology

Hermeneutic phenomenology's primary distinguishing characteristic, when compared to Husserl's descriptive phenomenological approach, is the denunciation of the notion of setting aside personal opinions and instead, turning to an interpretive account of the description of a phenomenon. Taking the position that reduction is impossible and thus accepting that all interpretations of a phenomenon should be considered valid, this school of thought aims to uncover the true objective nature of the phenomena as recognised by an individual. Thus, it concentrates on the subjective experience of human beings whose life world stories are the means used to shed light upon the nature of the experience. Hermeneutic phenomenology believes that interpretations are all we have. As Smith (1997) says, the hermeneutic phenomenological approach is a "research methodology aimed at producing rich textual descriptions of the experiencing of selected phenomena in the life world of individuals that are able to connect with the experience of all of us collectively" (Smith, 1997, p. 80). For Cohen (2001), the objective of hermeneutic phenomenology is to understand texts where the researcher tries to generate a rich description of a phenomenon through intuition while concentrating on discovery rather than correctness. The difficulty of bracketing is

acknowledged up front and to counter that an attempt is made to make the researcher's implicit assumptions, explicit. Hermeneutic research focuses on the meaning of experience, and the development of meaning is considered to take place between researcher and participant.

For the current study, the objective is to develop an in-depth understanding of the lived experience of partners of women suffering from Postnatal Depression. A qualitative hermeneutic approach is particularly well suited for this purpose because the research topic involves exploring human interaction and experience. As explained above, the hermeneutic approach does not suppress preconceptions and beliefs; rather it considers them to be a fundamental part of the process of analysis and interpretation (van Manen, 1997). The fact that preconceived ideas and feelings will affect the outcome of the study is embraced, and an effort is made to utilize the unique perspective of the researcher when reflecting on and interpreting the data (Koch, 1996). As Wertz emphasizes, the researcher's subjective experience can be gainfully utilized during the analytical stages of phenomenological reduction, and the researcher has an intersubjective horizon of experience that allows access to the experiences of others. (Wertz, 2005).

When applied to hermeneutical phenomenological research, reality is perceived as an individual construct dependent on different situations. The overlap between the life-worlds of the researcher and the research participants will necessarily vary depending upon the previous experiences of the researcher and the research question at hand, but in all cases the reality, while being external to individuals, is produced by individual consciousness (Cohen et al., 2000). What is important here is that the researchers should bring a "critical self-awareness of their own subjectivity, vested interests, predilections and assumptions and to be conscious of how these might impact on the research process" (Finlay, 2008).

By conforming to the hermeneutic phenomenological approach, van Manen's methodology seems to provide a methodological framework that allows me to remain faithful to my understanding of the nature of being and knowledge (as per the ontological and epistemological traditions above). This is also important in my case as my experience of the postnatal period is close to the research question and I want to embrace my subjective experience whilst uncovering the subjective experience of the research participants and the meaning they make of their experiences.

3.2.8 Existential philosophy and phenomenology

Over the years, many phenomenologists have combined the ideas of existential philosophy with the ideas of phenomenology to devise a distinct way of investigating the lived experience of individuals. Existential philosophers like Kierkegaard, Buber, Heidegger and Sartre solidified the foundations of existential thought and built a towering edifice that addresses the fundamental question of Being, that is, human existence but also of human freedom; and with the recognition of freedom comes recognition of responsibility and then subsequently anxiety. A key concept in existential philosophy is the individual's relationship with the world. Going back to Heidegger's seminal work, Being and Time (1927), human beings are never not in the context of the world. This was echoed in the ideas of Merleau-Ponty, who is known for embracing the combination of existentialism and phenomenology (Smith-Pickard, 2006). Merleau-Ponty's thinking is very close to Heidegger's when he says, "there is no inner man, man is in the world, and only in the world does he know himself" (1962). This is in contrast to Husserl's more strict phenomenological tradition of epoche and trying to rid one's self of all knowledge about the world when looking at the phenomenon being studied. Existential researchers generally place a great deal of emphasis on the importance of context with van Manen (1990) outlining the four existential grounds of the lifeworld of an individual, viz. space, body, time and others. Being an existential psychotherapist, I am guided by the principles and philosophical underpinnings of existential thought. Existential philosophy furnishes the structure from which I fashion my comprehension of the world and the others, including, in case of the current study, the research participants. Whilst existential philosophy guides my understanding and thinking, my way of working is guided by phenomenology and I lean upon both in my research. This is evidenced in the way I have used a blended methodology and incorporated the Structural Existential Analysis framework (further explained in section 3.9.2) in my study. The use of blended methodology allowed me to achieve the depth of analysis required to delve into the existential dimension whilst at the same time averting the difficulty of managing the breadth of analysis that I would have encountered if I utilized both van Manen's method and SEA in full.

3.2.9 Alternate approaches and rationale for the choice of methodology

Qualitative research can be conducted using many different methodologies and the phenomenological approach that I have chosen is one of those. As such, each methodology will have its own leanings towards a particular epistemological position and an ontological position. Below, I consider some qualitative research methodologies distinct from van Manen's

approach to hermeneutic phenomenological research and discuss why they were not preferred over my chosen approach.

3.2.9.1 Grounded Theory

Grounded Theory came out of the work of Glaser and Strauss (Glaser, 1978) with their objective being to develop the related concepts around a particular phenomenon. Data manipulations like coding and sorting feature prominently in the methods of Grounded Theory to help with the development of concepts. The result of the development of the concepts, originating from the manipulation of data is the creation of a hypothesis. Proving the hypothesis leads to the development of a theory about the original phenomenon that is under investigation. An important consideration here is that the concepts that underlie the hypothesis must be grounded in data rather than any biases that the researcher might have or any pre-conceived ideas or assumptions. Grounded theory advocates the use of analytic procedures (Strauss and Corbin, 1990, 1998), where the researcher aims to develop a theory that explains the process or interaction systematically. This can result in quite detailed and complex terms being created, specific diagrams and conceptual maps being generated, and other set procedures to be followed.

Positivist methodology has been posited to be closely aligned with Grounded Theory (Charmaz, 2006) and the difficulties which present themselves when using positivist methodology are very real here as well. For example, the fact that formulating concepts from coding and utilizing the data, is not a given; it can take a long time and even then there may or may not be a good hypothesis that results from the work. Also, the ability of the researcher to be utterly open to concepts and ideas and not be guided by any pre-existing biases is an important factor. With my focus being on the exploration of lived experience rather than creating a theory, my objectives would be better served by a methodology leaning upon descriptive and experiential methods addressing the subjective experience of participants living with partners who were suffering from PND. An additional factor here is that Grounded theory adopts a more systematic, and rigid approach towards analysis as mentioned above and for the current research a more adaptable methodology would be a better fit to capture the finer shades of meaning from the various participants' lived experience.

3.2.9.2 Case Studies

Research following case study methodology involves investigating an issue and exploring it through studying one or more specific cases within a specific setting and context. It involves detailed data collection through various sources, for example, researcher's own observations, existing reports and other documentation, interviews and other sources of information. One or a few cases are described in detail, and the themes pertinent to those are identified. Multiple researchers have elucidated slightly different methods around this methodology (Merriam, 1998; Yin, 2003; Stake, 2005). Broadly, the methodology comprises firstly, the researcher identifying the case or cases that they need to study. If choosing multiple cases, it would be appropriate to select ones that portray different aspects of the overall phenomenon being studied, i.e. purposeful sampling. Then, in-depth data is collected for each of the selected cases utilizing as many sources of information as possible. This results in a comprehensive description of the case. Next, as Yin (2003) explains, either the whole case is analysed, or a particular facet is chosen for detailed analysis. When multiple cases are being analysed, the key issues or themes from each case are examined alone (within-case analysis) and the ones that are common amongst the cases are then analysed (cross-case analysis). This is followed by the last interpretive phase where the learnings from the case are reported, and the researcher elucidates the meaning of the research.

The challenges faced when following the case study methodology include identifying appropriate cases which are really worthy of study as well as the decision of whether to use multiple cases or not. Use of multiple cases dilutes the analysis to a degree because the depth of analysis achievable is reduced with an increasing number of cases. Furthermore, bounding the case in terms of the overall period to study, and choosing which processes to explore also becomes challenging. There are various advantages to this methodology, of course. For example, it furnishes us with a detailed description of the particular phenomenon or phenomena that are being studied, and it also has the potential to develop novel hypotheses which can be validated by future studies.

With regard to the current research, a case study would have given us a detailed description of one father's experience of living with a partner suffering from PND. However, the current research also is endeavouring to examine what is shared between the experiences of various fathers, and case studies, on the other hand, tend to be used to address unique phenomena.

3.2.9.3 Interpretative Phenomenological Analysis (IPA)

Another important approach towards hermeneutic phenomenological research is the Interpretative phenomenological analysis (IPA). It adopts an idiographic focus, that is, it considers the question of how a specific person makes sense of a specific phenomenon in a specific context. Frequently, the phenomenon or phenomena under study possess some personal significance for the participants of the research, for example, a major event in their lives or a change in a relationship that they consider very important. Research based on IPA can involve looking at the experience of a single participant, but more commonly, it considers the experiences of a small number of participants. In both cases, though, purposive sampling is utilized, which means that the participants are requested to join the study because they are deemed to be able to provide meaningful insight into the phenomenon being researched. In their simpler form, IPA studies aim to seek commonality of experience, i.e. the participants' experience is expected to have some shared aspects. This is called homogenous sampling, and it provides insight into how a phenomenon is understood in a particular context from a shared perspective. However, IPA studies can bring together different perspectives on a shared experience, for example, include the experiences of both teachers and students, or both patients and healthcare professionals. Another option is to gather the descriptions of the experiences over a prolonged time interval to conduct longitudinal analysis.

IPA does embrace the researcher's bias and previous experiences much like the van Manen method because it is also based upon the Hermeneutic phenomenological approach (Smith & Osborn, 2011, p. 56) but there is a difference in terms of the degree of flexibility afforded by IPA versus van Manen. According to van Manen, the success of a phenomenological description depends upon whether the readers feel addressed by it or not (van Manen, 2007). He suggests introducing an artistic element when writing up the research to "stir our pedagogical, psychological or professional sensibilities" (van Manen, 2007, p. 25). I believe that it is important that research takes into account and resonates with the needs of the audience that it is addressing. It is wise for phenomenological researchers to strive to be reflexively aware of the wider context and the extant strategic as well as incidental interests, political or otherwise when they are describing their research (Finlay, 2006).

3.2.9.4 Choosing van Manen's approach

I have chosen van Manen's approach because when compared to the other research methodologies I considered; such as grounded theory, case studies and IPA, it provides a more

flexible depictive format and methodology that allows itself to be adapted (or instead encourages the researcher to adapt it) to the particular needs of the subject under study (van Manen, 2002). The methodological framework incorporated in van Manen's approach has allowed me to remain faithful to my understanding of the nature of being and knowledge. In addition, the existential dimension also features more prominently in van Manen's approach compared to other approaches, because of the explicit focus that van Manen's method places on the four existential themes of lived space (spatiality), lived body (corporeality), lived time (temporality) and lived human relation (communality). This aligns well with Binswanger's 'worlds of existence' (1946), and the four worlds' model utilized in SEA (van Deurzen, 2015). This was important since I wanted to undertake an in-depth exploration of the research participants' experience and as part of that exploration, examine the experience from an existential perspective as well. I also wanted to consider whether there are any underlying themes (e.g. absurdity, anxiety, responsibility, authenticity or others) concerning our existence that feature prominently in the experiences as described in the interviews.

To be able to elucidate the existential themes further, I have used a blended methodology approach and incorporated aspects of Structural Existential Analysis (SEA) method while retaining the overall approach of van Manen's method. The reason SEA is particularly useful in this context is that van Manen's method places emphasis on "a methodologically informed inventiveness" and on inventing "a flexible narrative rationality, a method for investigating and representing the phenomenon" (van Manen, 2002). However, this broad remit leaves open the question of exactly how the narrative and method intertwine and bring to the fore the existential dimension. SEA on the other hand, by its very nature, is infused with and encourages exploration of existential concerns particularly when considering emotional movement and the compass, and this has allowed me to sharpen the focus on existential themes when tailoring the methodology to target the phenomenon under consideration.

3.3 Method

Van Manen's approach refers to the concept of the hermeneutic circle; the idea that the whole phenomenon and its individual parts are related to each other. Furthermore, the whole can only be understood by developing an understanding of the individual parts and the individual parts can only be understood in reference to the whole (van Manen, 1997). The work by the Duquesne School (Pittsburgh University) during the 1960s and 70s also influenced van Manen's method of analysis appreciably. This allowed overcoming the limitations of empirical

approach commonly used in phenomenological research at that time. Psychologists like Colaizzi, Georgi and van Kaam proposed a three-step approach involving the division of the original description into units, the transformation of the units into meanings expressed in phenomenological concepts by the researcher and finally the transformations being combined to create a general description of the experience (Polkinghorne, 1989). The synergy between Colaizzi's work and van Manen's approach is particularly pronounced because of the additional connection between "Bibliotherapy" which is related to Colaizzi's work and the role of reflective awareness in the transformation of an individual (Bildung) which is mentioned by van Manen (1990).

3.4 Design

Van Manen's approach defines a "methodical structure" (van Manen, 1997), which divides the process of hermeneutic phenomenological research into six steps. I have used van Manen's method for isolating thematic statements to identify the themes and sub-themes from the data. I discuss these six steps below and provided some detail about how I have utilized them in the current research.

3.4.1 Turning to the nature of lived experience

Step one involves formulating the research question. Before we are able to formulate that though, van Manen says that we have to identify our own interest in the nature of the selected phenomenon or experience (1990, p. 42). For my research, the question was "what are the 'lived experiences' of partners of women diagnosed with PND". Throughout the research process, the emphasis was on this question so that the suitability for exploring and answering this question was the main focus when choosing the research methods, during the interview and also during the subsequent analysis phase. Again, going back to van Manen, I was always aware that during the research I had to "be constantly mindful of one's original question and thus to be steadfastly oriented to the lived experience that makes it possible to ask the "what is it like" question in the first place" (van Manen, 1990, p. 42).

3.4.2 Investigating experience as we live it

Step two is where various approaches may be utilized to "gather" or "collect" information about the lived experience. For the current study, I have conducted an in-depth, semi-structured interview for data collection. According to van Manen (1997), the researcher should themselves investigate the lived experience and not base it upon other sources, and the method

followed, i.e. in-depth interview, conforms to this condition. The participants were asked to express their experiences in their own words in the first place, and during the conversation they were prompted to describe their experiences fully, thinking about particular details to explore what their experience was like to live through. I was guided by van Manen's assertion here that "As we interview others about their experience of a certain phenomenon, it is imperative to stay close to the experience as lived. As we ask what the experience is like, it may be helpful to be very concrete. Ask the person to think of a specific instance, situation, person, or event. Then explore the whole experience to the fullest" (1990, p. 67).

3.4.3 Reflecting on the essential themes

Step three involves a thoughtful reflective grasping of what it is that lends a lived experience its special significance. According to van Manen, phenomenological research "makes a distinction between appearance and essence, between the things of our experience and that which grounds the things of our experience" (1990, p. 32). For this study, I identified the main themes that emerged from the interview transcript in light of van Manen's method for isolating thematic statements (van Manen, 1990, p. 92) and specifically utilizing the selective or highlighting approach. Here a relevant aspect was making the distinction between the essential and incidental themes. This needed careful consideration because this is one of the most intricate and difficult aspects of phenomenological research. My method and criterion here was, of course, reflecting on the theme and on the nature of the overall experience to see if a particular theme was expressing "aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is" (van Manen, 1990, p. 107). The method of free imaginative variation (van Manen, 1990, p. 107) was helpful here to identify the incidental themes and isolate them.

3.4.4 Describing the phenomenon in the art of writing and rewriting

This step is an essential component of the analytical phase of the research process. The main objective during this phase is to elucidate and illuminate the emotions, way of thinking and attitude of the participant. The writing of the narrative "strives for precision and exactness by aiming for interpretive descriptions that exact fullness and completeness of detail, and that explore to a degree of perfection, the fundamental nature of the notion being addressed in the text" (van Manen, 1990, p. 17).

My focus during the process of writing and re-writing and reading and re-reading was on refining the depiction of the thoughts and feelings so that the thoughts expressed during the interview became clear and were faithfully represented.

3.4.5 Maintaining a strong and oriented pedagogical relation to the phenomenon

This step involves the researcher maintaining a strong, oriented, rich and deep relationship to the phenomenon throughout the research process, not getting side-tracked by everyday life details and remaining focussed on the research question and the lived experience (van Manen, 1990). At times retaining focus on the phenomenon did become challenging because whilst some of the details of the story tended to grab attention, they were not pertinent to the essence of the lived experience. I made a conscious effort to conform to the phenomenological approach when working on the findings. This started with creating the themes and distilling them, going through cycles of reading and re-reading and writing and re-writing, taking help from multiple cycles of review by my supervisor as well as colleagues to make sure that the description is concentrated on the aspects relevant to the phenomenon (*oriented*). Furthermore, I strived to make sure that the text is engaging and involving the reader (*rich*), brings to the fore the learning to be gained from the phenomenon and communicates it to the reader (*strong*) and retains the openness required to develop a meaningful understanding of the phenomenon beyond the obvious and the superficial (*deep*).

3.4.6 Balancing the research context by considering the parts and the whole

The last step is where the objective is to "constantly measure the overall design of the study/text, against the significance that the parts must play in the total textual structure" (van Manen, 1990, p. 33). For this research, the parts were the individual themes and issues identified in the transcript and the whole was the complete description of the lived experience. At each step during the analysis, e.g. identifying the themes, grouping them, and distillation, I went back and read the individual parts and details to see if they related to the whole phenomenon seamlessly.

3.5 Ethical Considerations

3.5.1 Ethical Approval

The ethical guidelines specified by BACP and BPS for collecting and using research data have been followed during this study. Before any participant interviews and data collection, the ethics committee of Middlesex University/New School of Psychotherapy and Counselling

conducted a full ethical review of the proposal and granted approval for the research in July 2016. The final approval from the committee is attached as Appendix E: Ethics Approval. National Health Service (NHS) ethical approval was not sought or required because the participants were not recruited through NHS hospitals/surgeries or other treatment centres.

3.5.2 Informed Consent

Before the interview, the participants were asked to complete a consent form, which was used to record the formal consent from the participants' side. Potential participants were provided with a flyer about the general outline of the study first to familiarize them with the scope, context and rationale of the research. Interested participants who came in contact were given a participant information sheet (PIS), which provided them with more detailed information about the research and explained what the process would be from the participants' perspective. This included information about the interview format, duration, potential venues and options about face to face or online/Skype interviews. This was completed at any point before the interview, in some cases, right at the venue for the face to face interview but in all cases before the actual interview being conducted. The participant information sheet contained information to allow the participants to contact me at any point to clarify the details, ask any questions and address any concerns related to the research. Participants were given the option to withdraw from the research at any point until the transcription of the audio recording. After transcription, data became anonymous, and it was not possible to remove it from the database. Copies of the consent form and participant information sheet are attached as Appendix A: Consent Form and Appendix C: Participant Information Sheet.

3.5.3 Anonymity and Confidentiality

Complete anonymity and confidentiality were maintained throughout the research process. The audio recording of the original interview, and the real names, contact information and other participant-specific information was only accessible to the researcher at various stages of the research process. The interviews were recorded on a digital recorder, and the files were transferred to an encrypted USB stick for storage, deleting the files from the recorder. All participant information was identified only with a project code and stored either on the encrypted USB stick or in a locked filing cabinet. The key that linked the participant details with the project code was kept in a locked filing cabinet. The information is to be kept at least until 6 months after completion of my degree, being treated as confidential throughout. Data

storage followed the standard according to the Data Protection Act and the Freedom of Information Act. The audio of the interviews was professionally transcribed. The full name or last name of the participants was not used during the interview process so the person transcribing the interview could not know the identity of the participant. During transcription, all the participants' identifying information including their own first name, the name of their spouse or child, the names of any locations like places they stayed at, or identifying information about their workplace etc. were replaced either with generic descriptive words or with pseudonyms which were unrelated to the original ones in all ways. Confidential information like the participants' name, email, phone, and work and home address were not used for any purpose except to facilitate the data collection and interview process.

3.5.4 Participant Wellbeing during the interview

Participant wellbeing was an important consideration, given the fact that the topic of the research required the participants to recall and describe their experiences from a period where they, as well as their family, went through a multitude of emotions and stresses. Although this process of asking the participants to delve into a potentially emotive subject was inevitable, I was particularly careful about the way the questions were posed and the way any emergent observations and rationale from the clients was approached. The list of interview questions was reviewed by both myself and my supervisor to make sure the questions were open-ended and brought up various topics in a sensitive fashion. Given the background of psychotherapeutic practice for both myself and my supervisor, the experience and skills gained over the years in relation to seeing clients in therapeutic settings and discussing highly sensitive and emotive subjects with them were very useful in this regard. I was careful to adopt an empathic attitude and build rapport with the participants to enable them to share their experiences in a non-threatening and safe environment. It was emphasized throughout the process of interacting with the participants that their data will be handled safely and confidentially and that they can choose to withdraw from the research completely, or choose to decline to answer any particular questions that they were not comfortable with, without having to provide any reason. The Participants Information Sheet (PIS) outlining the research aims, process and contact information both for myself as well as my NSPC supervisors and Middlesex University was provided to the participants beforehand to enable them to seek additional help, clarification or support if they needed to. However, none of the research participants needed any support after the interviews had been conducted.

3.5.5 Debriefing

At the end of the interview, there was a verbal debriefing where the participants were given the opportunity to talk about their experience of being interviewed. A Debriefing Information sheet was also handed over which thanked the participants for taking part in the research, reiterated the scope, the aims and potential utility of the research, and provided my contact information and my supervisor's contact information. It also provided a list of organizations that can provide additional support in case the participants faced any emotional stress after recollecting their emotive experiences during the interview. The information about the relevant support organizations was modified according to each participant's geographic location to enable them to find local support resources.

3.5.6 Personal wellbeing and risk mitigation

In addition to the participants' wellbeing, any potential effects on my personal wellbeing, and any other risks associated with the process of conducting the research were also evaluated. Since the interviews were preferably going to be conducted with the participants in-person, some potential risks associated with that were identified. These included arranging safe and secure premises where the interview could be conducted confidentially, and travel to and from the place where the interview was to be conducted. Also, having adequate equipment available to make the audio recording of the interview along with a backup plan in case of any malfunction of the electronic equipment before, during or after the interview was considered. It was made sure that a third person was always available who was aware of the time and place for the interview and who contacted me before and after the interview. For the Skype interviews, it was made sure that the computer and other electronic equipment including audio recorder and USB stick for storage were free of issues and a backup plan was available to mitigate any unforeseen problems at the time of the interview. Although the subject matter of the interview could be sensitive and emotive, my background in psychotherapeutic practice was helpful to mitigate the need for any potential support in that regard. However, my supervisor was available to provide further support in case any help was needed, and also, I have been continuously engaged in on-going personal therapy in parallel for additional support.

3.6 Participants

3.6.1 Sample Size

Given the chosen methodology and approach, that is, the use of van Manen's method, the number of participants had to be limited to a small number to allow an in-depth exploration of

the lived experience of each of the participants. Initially, a target of securing eight research participants was identified, and multiple recruitment methods were employed in parallel to find potential participants. However, the sample size had to be reduced to seven later on because it was very hard to reach the participant group, and it proved impossible to find eight participants. With the agreement of my research supervisors, we waited for an additional period of five months from March 2018 to July 2018, to try to find the eighth participant with redoubled efforts, before reverting to seven as the final figure.

3.6.2 Participant selection criteria

The target of the research were participants who fell in the designated 'midlife' age group of thirty to forty years of age, and who were working full-time. This confined the variation of the circumstances and background of the participants in order to allow for a more focused exposition of the lived experience of the participants to be conducted. The time period for the partner being diagnosed with PND was limited to three years to allow the participants to be able to recollect the pertinent details of the lived experience more accurately. The full selection criteria were as follows:

1. Living with a partner/wife diagnosed with PND within the past three years
2. Being a first-time father aged between 30-40 years
3. Having only one child
4. Working full time
5. Not an adoptive father
6. Having no extra, familial support

Having no extra, familial support was also a critical factor because I felt that having significant involvement and support from the family in addition to the spouse and child makes the variation in lived experience too great to allow to more well-defined and targeted findings and conclusions to be established. All the selection criteria were clearly specified in the initial research flyer and the more detailed Participant Information Sheet that was sent to the participants before finalizing the interview arrangements.

Demographic data were collected from the participants before the start of the interview. In terms of socio-economic status, all participants were asked to describe which class they belonged to. The group was not symmetrical in terms of the socio-economic classes and this

was not prevented by targeting any specific quota in terms of the socio-economic classes of the participants. Targeting symmetry in terms of the various classes was not deemed possible because of the difficulty of finding participants.

3.6.3 Recruitment

Recruitment of participants was approached through multiple parallel strategies employed concurrently. I contacted some public and private organizations (Mind, NCT, PANDA, APNI and others) as well as individuals who had previously been involved in research on related topics and professional colleagues and staff in my university to disseminate information about the research. The initial information was circulated with the help of a short flyer inviting potential participants to take part in the research. The flyer included participant selection criteria in addition to my contact information and a short description of the purpose of the research. My colleagues and supervisors were very helpful in forwarding the information to suitable groups both online as well as otherwise. Online resources including social media, that is, Facebook and Twitter pages were utilized for the dissemination of information about research as well. Multiple support groups that were helping women suffering from PND were contacted because the women who had been suffering were able to forward the message to their husbands and partners about the research, and a few of those were willing to take part in the research. In particular, Liz Wise – who is an experienced PND counsellor and PND trainer, and who was running a support group (Cedar House Support Group) for women suffering from PND – was very helpful in identifying multiple research participants.

3.6.4 Response Rate

The initial flyers were circulated in September 2016 and efforts to recruit participants continued until August 2018. However, no further participants were found in the last eight months or so. About ten potential participants contacted me, but unfortunately, three of them did not fully meet the criteria for participant selection so I ended up with seven research participants in total. Initially, the research scope was limited to in-person interviews only. However, this had to be modified later on because of the difficulty of finding participants, and permission was sought from the Chairman of the NSPC Board of Ethics to broaden the scope to include online/Skype interviews as well. This helped to find the last three participants. As is evident from above, it was a struggle to find participants because of multiple reasons including the finely targeted selection criteria, the general difficulty of conducting research based on male participants only,

and the fact that the potential participants were supporting a young family and working full-time in parallel.

3.7 Data collection

3.7.1 Interview Questions

The initial list of interview questions was developed based on the subject area of the research and ideas about what potential aspects the lived experience of the participants should be probed in order to facilitate the participants' recollection of pertinent aspects of their experience and to help elicit rich and deeper data about their experience. The initial list was then discussed with and reviewed by my research supervisors. In addition, the interview questions were tested on my husband to get the male perspective about them as both my supervisors were female.

The final list of interview questions was as follows:

1. Tell me about your experience of living with your partner who was diagnosed with PND
2. Can you tell me more about how your experience of living with your partner changed over time before and after she was diagnosed with PND?
3. Can you talk about the emotions that you experienced during that time?
   (Prompt: Envy, Guilt, Anger, Embarrassment, Shame, Joy, Pride, Love)
4. What were your fears and anxieties at that time?
5. What were your hopes and desires at that time?
6. Can you describe the impact on your relationship with your partner when she started suffering from depression?
7. Describe any change in the dependency on each other after she was diagnosed with PND?
8. How would you describe the feelings between you and your partner after she was diagnosed with PND?
9. Describe how your communication with each other was affected by your partner's PND.
10. Did you have any moral or other support? What effect did it have on you?

In addition, a few of the prompting question are listed below:

- Can you tell me more about that?
- Tell me more about your experience with this?
- What concerned you most during that time?

- Were there any areas of your life other than your direct relationship with your partner which were affected?
- How did you cope with the whole situation?
- Was there anything you found easy or difficult to cope with?
- Are there any specific thoughts that you would like to share?
- What were your other emotions during that time?
- Can you describe what the whole experience meant to you? How do you make sense of it?

3.7.2 Interview procedure

As I was interested in eliciting information rich with the details of the lived experiences of the participants, semi-structured interviews were conducted, utilizing open-ended questions. A safe and private location was secured for all the in-person interviews. A private location ensuring the confidentiality of the participant's information was used for all Skype interviews. Before the start of the interview, the participants were allowed to settle down and ask any questions that they had about the research or the interview process. The purpose of the research was reiterated, including what benefits can be gained from it and the potential risks for the participants were explained, that is, the possibility of having to face emotional distress on account of recalling past experiences. The limitations of confidentiality were also explained, for example, circumstances where sharing information with a third party might be required (including the risk of self-harm or harm to others), were mentioned. The consent form was read and signed by the participants. Three out of seven participants opted for Skype interviews rather than face-to-face interviews, on account of various reasons including the difficulty of arranging suitable time slots for the interview and the difficulty of travelling to the interview location because of the long distances from their usual place of abode. In all cases, a convenient time from the perspective of the participants was chosen after confirming the options with them. Throughout the interview, participants were provided with the opportunity to ask any clarifying questions. They were also made aware that they were free to stop the interview or choose not to answer any particular question if they did not want to. Each interview was digitally recorded, using an audio recorder and later on professionally transcribed. The interview length varied from 50 minutes to 70 minutes, except for the first interview, which lasted for 90 minutes. At the end of the interview, the participants were thanked for taking part in the research and given verbal research debrief and provided with the Debriefing information sheet.

3.8 Reflexivity

As mentioned above van Manen (1990) suggests identifying the researcher's previous related experiences, knowledge or beliefs and trying to understand how these may influence the data collection, analysis and interpretation phases. I considered myself to be an insider as well as an outsider in this study and accordingly this needed careful handling because to a certain degree it was personally challenging to relive my own previous experiences whilst reading and re-reading the interview transcript. I was aware of this possibility all through the process and took advantage of the opportunities provided by the supervision as well as personal therapy to help retain my emotional balance.

I was also aware that I was susceptible to subjective bias because I had come close to experiencing PND myself and thus my own ideas, feelings and opinions could have had an impact on the research. To this end, I have been maintaining a journal of personal reflections to develop an enhanced understanding and awareness of my own experiences. To make sure that such influences are known, I have had my own interview conducted by a colleague which has helped me to uncover and document the details of my lived experience and my previous beliefs and ideas related to the phenomenon. I have also been maintaining a separate journal of personal reflections about my thoughts. This has served to record my own early thoughts and feelings, captured my initial understanding of concepts and over time it has also documented the evolution of thought processes during the research.

I have also been mindful of the potential gender issues between myself and the participants, i.e. it could potentially have been challenging to gain enough trust so that they fully shared their lived experience with a female researcher. Here, I leaned upon my skills developed as a therapist by re-emphasizing my role of being non-judgemental and neutral and reassuring them that whatever is being shared will be used for the research purposes only.

3.8.1 Researcher's place in the research context

The researcher is an important part to play in qualitative research using van Manen's approach, and researchers are urged to reflect on and be aware of their own personal interpretation and viewpoint on the topic at hand (van Manen, 1990). Below, my prior experience and understanding of PND and mental health problems are considered, including personal

information about my past, my family background, as well as my academic and professional experiences.

I am a female in my late thirties, and the participant group targeted by the research falls in the same age bracket (30 to 40 years old). I come from an Asian, middle-class family, and was born outside the UK but have lived here for more than a decade, with frequent visits to other countries in Europe and Asia in the past. All of the participants taking part in the research lived within England. I am married and have been with my husband for more than ten years and had three children at the time of the research. Although I have never been diagnosed with Postnatal Depression, my experiences after childbirth did take me close to depression at various times. I come from a close-knit family with three other siblings and have a good understanding of the relationship dynamics within the family, as well as extended family. In the past, I have experienced how emotionally arduous and strenuous events can stress the whole family and result in shifting the balance and dynamics of the family system.

Before conducting this research, I had no direct experience of working and interacting with individuals suffering from PND or individuals whose partners were suffering from PND, either in professional or academic capacities. Hence, I have approached the research primarily from the methodological perspective. Looking at the magnitude of the challenge both for myself and my husband after the birth of our first child, I became interested in exploring how the husbands of women who are suffering from PND, manage to live through and cope with an even more challenging scenario after the birth of their first child.

3.9 Method of Analysis

As mentioned above, a professional transcription service was used to generate a transcript from the digital audio recording of each interview. The transcripts were compared with the original digital audio recording by the researcher to maintain the accuracy of the information and any parts of the audio that were not fully lucent and intelligible were clearly identified and marked. Concerns about the loss of immediacy because of using a professional transcription service were limited by measures such as listening to the audio recording multiple times when comparing the transcript with the recording and making notes to augment the notes that I had already taken during the interview. The objective of the first part of the analysis was to identify the emergent themes from the transcript. As per van Manen's approach, here, my role as the researcher was critical in the identification of the meaning behind the statements. As Arminio and Hultgren (2002) mention there is an "unloosening that occurs only as the researcher spends

a great deal of time seeking to understand the text" (p. 456), which forms the basis of thematic analysis. van Manen (1990) has outlined three approaches for isolating thematic statements:

1. Detailed reading approach: The researcher goes through all the text, considering a sentence or a few sentences at a time and asks, "What does this sentence, or sentence cluster, reveal about the phenomenon?" (van Manen, 1990, p. 93)
2. The selective or highlighting approach: The researcher whilst going through the text asks the question, which statement or statements reveal the most about the phenomenon under consideration?
3. The wholistic or sententious approach: The researcher looks at the text as a whole and asks how can we capture the fundamental meaning of the whole text?

The use of all three approaches simultaneously is not what van Manen has suggested or encouraged. For the current study, I adopted the selective or highlighting approach (as elucidated later in this section) for the identification of the themes. According to van Manen, "the task is to hold on to these themes by lifting appropriate phrases or by capturing in singular statements the main thrust of the meaning of the themes" (van Manen, 1990, p. 93). Of course, lifting the "appropriate phrases" to identify "the main thrust of the meaning of the themes" is a process where my role as the researcher is critical and where the meaning is being generated through the process of my interaction with the transcript. The process started even before the analysis of the transcript as my interaction with the participant during the interview followed the principles of dialogical and hermeneutic interviewing. Although I was conscious not to attribute my own meanings to the description provided by the participant, yet my interaction with the participants was encouraging them to examine their experience more fully and come back with a richer and more descriptive account of their lived experience. Thus, there was a co-creation of meaning through the interaction I had with the participants and later on the interaction I had with the text of the transcript. The important aspect here was to remain open to the development of any possible meaning and not direct the process in any way consciously. I needed to let the meaning emerge by immersing myself in the interaction with the participant and the text of the transcript and engaging in deep reflection on the possible emergent meaning. In addition, self-reflection was an important part of this process because keeping an open mind and not letting my previous experiences dictate the emergent meaning in any significant way was critical as well. As I explain below, I have also utilized the existential perspective to delve deeper into the meaning of the themes and come back with a richer and more nuanced

understanding of the existential aspects of the thought processes of the participants and their lived experience. This is another form of interaction between the researcher and the participant through the intermediary of the description of the lived experience where again meaning was co-created together.

Once the initial list of themes has been created, van Manen suggests evaluating whether any particular theme is fundamental to the nature (or meaning) of the phenomenon or not "without which the phenomenon cannot be what it is" (1990, p. 107). He suggests using free imaginative variation to determine whether a theme possesses the quality of being universal or not, for example, asking whether or not the removal of a particular theme will change the actual nature of experience, or in his words, asking "Does the phenomenon without this theme lose its fundamental meaning" (1990, p. 107). I utilized the criteria promoted by free imaginative variation frequently during the evaluation of essential versus incidental themes as described in section 3.9.1.1 below.

The themes are, of course, ultimately expressed in the form of written text by the researcher. Writing then, is critical in capturing and expressing the lived experience, nay to van Manen, "human science research is a form of writing. Creating a phenomenological text is the objective of the research process." (1990, p. 111). As explained below, I wrote the initial descriptions and re-wrote them multiple times to distil the essence of the experience and to express the lived experience as faithfully as possible.

3.9.1 Analysis Procedure

The process of analysis began with individual transcripts being analysed separately. The same process, explained below, was followed when analysing each transcript. Reading, and re-reading the transcript was, of course, necessary to make myself completely familiar with the participant's description of the lived experience. I was mostly able to recall the pertinent details in terms of unspoken cues and details of my interaction with the participant which were not captured in the text of the transcript because I began the analysis not too long after the actual interview was conducted in most cases. However, sometimes it was necessary to listen to the audio recording again to remind me about the emotional and non-verbal aspects. I chose the selective approach for the research as I felt that it would be hard to capture the multifaceted, rich details of the lived experience through the wholistic approach and the detailed reading approach was not feasible given the amount of data that I had to process.

The inherent loss of fidelity that is a result of the process of identification and description of themes has been highlighted by van Manen (1990). Themes can never capture the full lived experience or the full meaning of the phenomenon and as such are a simplification, but what they do accomplish is to give a certain tangible form to the phenomenon or lived experience. To van Manen, this is all that can be achieved because it is, in fact, impossible to capture the actual full meaning of the experience.

I employed the selective/highlighting approach by following three successive steps which are explained below.

Step 1: For the first step I read and re-read the interview transcript in detail and underlined the important passages that seemed to reveal the most about the lived experience. For example, in the text below I picked up the participant's concerns about himself including his state of mind (just being in survival mode where his own self took secondary importance) and his anxieties about the long-term implications of his partner's mental health problems:

> *Example*
> *A little bit, yeah. Yeah, you can't… You hear about stories, you hear about what parents do, desperate parents, and you can't help but sort of acknowledge those and think that they might be applicable to your situation. So there's a little bit of that. There's also concern for yourself. I'm starting to feel quite desperate about myself. I knew that I was starting to feel… I don't know if the word is depressed, but I knew that I wasn't feeling myself and I knew that I was starting to… My self defence mechanism switched off, and just shut down from things around me, so I've become very internal. And I could feel that was happening to me. I could feel that I was just getting up and surviving, and that worried me because obviously when there's three of you, and my child is vulnerable, and my wife is vulnerable, you start thinking, well I can't really be vulnerable myself. So you start worrying about how much stamina you've got and how much more you've got to, you know, to give to the situation. And I guess you're also… And finally I think I was worrying that it was not postnatal any more, that maybe this was just a permanent thing. You know, I was aware she was very close to having a breakdown if she hadn't already had one, and what were the long-term implications of that? Was I gonna to live with someone who never got better? Thinking about it that was probably my biggest worry in a way, was that I would have to look after a wife as well as a child.* (P1, 132-147)

Step 2: After picking up the important sentences throughout the whole text, I moved on to the second step where I organized all the sentences with similar meaning under a theme so that each theme was exposing a certain facet of the lived experience. To take the example provided above, the underlined sentences were grouped under the following themes

A. *There's also concern for yourself. I'm starting to feel ……. and just shut down from things around me, so I've become very internal.*
   These sentences were related to the participant's concerns about himself so they were grouped under the theme "**Concerns about his own self**".
B. *I could feel that I was just getting up and surviving, and ……. how much more you've got to, you know, to give to the situation.*
   These sentences were depicting the participant being is survival mode so they were grouped under the theme "**Just getting up and surviving**"
C. *I was worrying that it was not postnatal any more, that maybe this was just a permanent thing ……. I would have to look after a wife as well as a child*
   These sentences were related to the participant's concerns about when and if his wife's health would improve and what effects that would have on their life, so they were grouped under the theme "**Long terms implications**"

There were other passages in the transcript which had sentences that fell under the themes described above, and those sentences were also grouped under these same themes so that a given theme pulled together all the related sentences from the whole transcript. Additionally, I looked at reducing the length of the sentences by combining similar sentences to form shorter ones whilst preserving the words from the original transcript.

Example: Theme "Long term implications"

And finally I think I was worrying that it was not postnatal any more, that maybe this was just a permanent thing.
I was aware she was very close to having a breakdown if she hadn't already had one, and what were the long-term implications of that? Was I gonna to live with someone who never got better? Thinking about it, that was probably my biggest worry in a way, was that I would have to look after a wife as well as a child.

It obviously wasn't going to go away quickly, but whether it would go away at all and whether I'd… Whether I would have a mental, in inverted commas, wife, and whether Lucy would have a mental mother and all the… You know, what did our life look like? I thought it didn't look… It looked a lot different from how I imagined our life would be.*
Yeah, because I made a commitment to my wife to look after her. But when I said that, I didn't think that would be someone who had a permanent mental health illness, you know, had lost their mind and was a very different and a much needier person to the person that I said I would look after.

** Lucy is the pseudonym of the participant's daughter.*

The above sentences were reduced into the following description:

> *My biggest worry was whether I will have to permanently live with someone who will never get better and that I would have to look after a wife as well as a child. That I would have a "mental" wife and my daughter would have a "mental" mother. It looked a lot different from how I imagined our life would be. When I made a commitment to look after my wife I didn't think that would be someone who had lost their mind and was a much needier person to the person that I said I would look after.*

Step 3: Once all the themes had been identified throughout the whole text, the third step was distillation, where I extracted the essence of the experience in a few sentences. Here, although I tried to preserve the original description as much as possible, there were some inevitable changes in the language to combine the sentences into a short paragraph meaningfully. For example, the essence was extracted from the reduced description of the theme "Long Term Implications" as follows:

> *My biggest worry was whether I will have to permanently live with someone who will never get better and that I would have to look after a wife as well as a child. It looked a lot different from how I imagined our life would be. When I made a commitment to look after my wife I didn't think that would be someone who had lost their mind.*

The steps described above were followed for each participant's transcript separately to arrive at the themes specific to each participant.

3.9.1.1 Identifying Subordinate and Universal Themes

The process of identification of themes for the individual participants described above generated about twenty or more themes for each participant. For the next step of the analysis,

I aimed to identify common experiences from various participants. This meant looking at the descriptions of the themes for each participant and assembling similar themes under the heading of one subordinate theme and writing a short description to capture the essence of the experience. Some themes were specific to a participant which were not shared by other participants, hence did not fall under any subordinate theme, and these were put to one side. In total, about 31 subordinate themes emerged. The criteria for the creation of a subordinate theme was that at least three participants had similar statements from their individual themes that could be grouped in the subordinate theme. I have copied below an example of the subordinate theme "Frustrated by the support network" where four participants had similar experiences expressed in different but related themes.

Subordinate theme 2: Frustrated by the support network

P5	It is annoying that even though we sought help in all possible ways we did not get it earlier otherwise this phase could have lasted much less. If we had found the right help at the beginning for both of us the impact on our lives would have been much less.	
P4	It was frustrating to be let down by my wife's therapist and midwives and even her sister when she was having a crisis since we did not have their support when we expected it.	Subordinate Theme: The lack of support and neglect by the professional and personal support network causes a lot of frustration and disappointment.
P3	I am frustrated and upset at the system because they have pushed aside my wife to carry on herself when on a deep personal level I know she is not fixed.	
P1	No one, including our parents wanted to talk about it. People just want to move onto the next issue because they think postnatal depression is women struggling to love their children and they don't want to delve into the details.	

Looking at the 31 subordinate themes, I observed that multiple subordinate themes were expressing diverse facets of the same category of experiences. Here, the whole category was, of course, an indispensable part of the overall lived experience, but the subordinate themes could in some cases be incidental. Going back to van Manen, I strived to find the universal or

essential themes, where "In determining the universal or essential quality of a theme our concern is to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is." (van Manen, 1990, p. 107). As an example, the subordinate theme "Frustrated by the support network" was experienced by four of the participants but using the method of free imaginative variation I considered whether not experiencing this frustration would change the nature of the participants' experience. I found that this was not the case, because other themes like "Lack of support for dads", "Seeking support and reassurance" and "Missed opportunities for support" were depicting other facets of the same experience where the universal aspect was the lack of support. Thus, "Frustrated by support network" became part of the universal theme "Lack of support" along with the other subordinate themes mentioned above. Here, the feeling of "Lack of support" expressed by this universal theme was an essential part of every participant's experience who was living with a partner diagnosed with PND and who did not have any obvious sources of assistance and help available to them.

Universal Theme 3: Lack of support

lack of support for dads (P7, P6, P4, P3, P1)	Fathers feel ignored as compared to their partners when it comes to professional as well as familial support.
Frustrated by the support network (P5, P4, P3, P1)	The lack of support and neglect by the professional and personal support network causes a lot of frustration and disappointment.
Seeking support and reassurance (P7, P5, P4, P1)	Fathers yearn for someone from whom they can seek support and reassurance whilst they are facing a tough and challenging situation.
Missed opportunities for support (P5, P3, P2,)	Some fathers believe that they missed opportunities for getting support because they did not feel comfortable seeking it.

3.9.2 Use of Structural Existential Analysis Method

As mentioned above, I have aimed to use a blended methodology approach and incorporated aspects of the Structural Existential Analysis (SEA) method whilst retaining the overall

approach of van Manen's method. SEA is a research method developed over several decades (van Deurzen 1988, 2012), which weaves together many layers of phenomenological work to espouse a more structured approach towards phenomenological existential research. It comprises various components such as use of the three reductions, dialogical and hermeneutic interviewing, working with bias, the four worlds' model, working with the timeline and making use of the emotional compass. van Manen's methodology can benefit from SEA because some aspects of SEA can be leveraged to provide better definition and sharper characterization of results. Also using SEA enables me to explore the four dimensions of existence and how they relate to the participants' experiences. I have interwoven the following aspects of SEA during the various phases of research to refine the analysis further and bring out the existential perspective to the fore.

3.9.2.1 Dialogical and hermeneutic interviewing

Here I aimed to create dialogue, interaction, and close and intense scrutiny of the phenomenon I was studying. The objective was to sharpen the focus so that the participants scrutinise their experience more closely. I have found the existential-phenomenological psychotherapeutic methods to be useful for this purpose because these helped me to engage with the participants' experience. Following the principles of hermeneutic interpretation, I was conscious not to apply my own theoretical meanings to the description of their experience because their source of understanding was unique and needed to be communicated. A short excerpt from the interview transcript (with the answers abridged) below provides an example of the application of this method:

Example

> ***So what were you worried about? Because you said you were worried at that time.***
> *I was… Well… I was worried because… I mean I was worried at that time. I think I was okay, I knew I would be okay, ...so a little bit of you is just hoping that everything's all right when you get back.*
> ***So there was a fear as well? What would happen when I go back home…***
> *A little bit, yeah. Yeah, you can't… You hear about stories, you hear about what parents do, desperate parents, and you can't help but sort of acknowledge those and think that they might be applicable to your situation.....*
> *Thinking about it that was probably my biggest worry in a way, was that I would have to look after a wife as well as a child.*
> ***So you were worried that you will have to look after your wife and a child, and how you were feeling internally yourself.***
> *Yeah, because I made a commitment to my wife to look after her. But when I said that,*
> *… It looked a lot different from how I imagined our life would be.*
> ***Yeah, and also you mentioned that you were starting to worry about yourself as well because you're not labelling the feelings as depressed, but you were sort of feeling internally…***
> *Yeah, I was running out of energy, yeah, yeah. That was a concern for me, and…*
> ***Can you tell me more about that?***
> *Yeah, well I think at about eight, seven, eight months, though I was brought up in the country, in one of the most rural, remote parts of England …*

3.9.2.2 Working with bias

Recognizing our bias as well as the potential bias of the research participants is an important aspect of phenomenological research work. Bias is unavoidable because every person has their own world-view, belief system, orientation towards particular phenomena as well as the world in general, and a particular way of responding to different situations. The main focus when working with bias is to recognize our own as well as others' bias and then be aware of those during the research work including being able to suspend our own bias when necessary (Van Deurzen, 2015). In my case, an aspect that I was aware of throughout the interviews was my own potential bias because of my experience as a mother. I was conscious not to interpret the participants' situation or their partners' behaviour through the lens of my own experience because that might have prevented me from getting to the essence of the lived experience being described by them. I found that following the principles of phenomenological and eidetic reductions was very useful in this regard. Utilizing epoche, I suspended my previous assumptions; locating, observing, tracking and bracketing my potential bias. Being a woman, I had to make sure that I did not start favouring the women when hearing critical comments about partners of the participants. My views about PND being mostly about suffering and having almost no positive connotations were also a potential bias that I had to be careful about, as during the analysis I found pride, joy, hopes, personal growth and resiliency as positive outcomes. I also paid close attention to the phenomenon under consideration in a careful manner placing it in the participants' lived-world context instead of my own. Qualitative research benefits from bracketing as a method to safeguard the validity (Ahern, 1999). The impact of the researcher's professional and personal experiences during data collection and analysis can be explored by bracketing interviews (Rolls & Relf, 2006). Being aware of those biases and their potential impact allows the researcher not to let the participants be affected by the same during their interviews. Chan et al. (2013) have also considered the role of bracketing in qualitative research and also the methods used for bracketing. Maintaining a reflexive diary is one such method that they mention, which helps to note down all perceptions, feelings, opinions and other experiences during the data collection as well as analysis process. This is the method I chose to utilize during all stages of the research to allow me to consider and record my views, perceptions, feelings and experiences that I thought to be relevant in any way to the research.

Another aspect of bracketing is not to let extant literature and prior studies influence the data collection, analysis and other research processes of the current research in unintended ways.

Here, I chose to conduct a more in-depth literature survey and review of prior research after the point when all data had been collected, and all the participant interviews were complete. During the interviews themselves, I used semi-structured interview methodology and allowed the participants to take the discussion into their preferred direction by asking open-ended questions and then following up with prompts to help the participants to delve deeper into the various aspects. I was also conscious to not let the findings of extant research influence the data analysis process. It was found that there were only a few qualitative studies directly relevant to my research topic, that is, looking at the lived experience of partners of women who were suffering from PND. Therefore, being biased by existing research was not found to be a problematic issue.

Moreover, each interview in the study was conducted, recorded and analysed completely separately from the other interviews. None of the participants had any connections with each other. Each interview being considered separately, I made sure that the data collection and analysis process for the later interviews was not affected by the earlier interviews in any way. Although it was not enforced deliberately or intentionally, it turned out to be the case that the participant interviews that were conducted were spread over a period of two years, so there was enough separation between the individual interviews to allow me to process them in isolation from each other.

3.9.2.3 Four Worlds' model

One of the challenges faced during phenomenological exploration of the lived experience is to maintain objectivity and to make sure that all the facets of the phenomenon have been adequately explored. SEA is helpful here by providing us with the structural framework for the investigation that allows the adoption of a systematic rather than arbitrary approach and allows us to ensure sufficient coverage as well as avoidance of subjective observations. One of the components of the structural framework is the four worlds' grid (Van Deurzen, 2015), illustrated in the chapter Findings, Figure 2. The basic observation behind this heuristic device is that human experience is multi-dimensional. Of course, there is the physical domain or world where we interact with the physical objects, including other human beings in the objective sense as well. There are specific ways and physical laws that dictate the interactions that occur in this world. However, as humans, we are also able to interact with other human beings in an intersubjective, interpersonal way. We can be open and convivial and choose to engage with some people, but we can also be closed and inimical to others at the same time. This is the

domain of social interaction or the social world. There also exists another dimension of human experience which is entirely private and internal, the personal world, where our most profound, internal thoughts and feelings are intimately laid bare and where we can move forwards and backwards in time by recalling past experiences or anticipating the future. The last dimension is the world of ideas and ideals, the spiritual world, where we assign meanings and define our purpose and our understanding of the world around us (Van Deurzen, 2015). SEA provides us with this framework of the four worlds' model to enable us to grasp all the dimensions of the lived experience and not to inadvertently ignore, for example, the spiritual or the social aspect whilst considering the experience. An important aspect here is to understand that the four worlds' model does not in any way imply any separation between the various domains of experience. The challenges faced by the individuals cannot be neatly allocated to any one particular dimension; rather any challenge will involve facets spread over multiple dimensions of existence. However, the model does allow us to be more thorough in our analysis, especially by considering the tensions and polarities that almost all individuals struggle within each dimension of existence. The four worlds' model delineates some common tensions but also reminds us that it is impossible to avoid either the positive or negative side of these and for any individual accepting that fact allows a more balanced response to be embraced.

I have found the four worlds' model to be very useful during both the analysis stage and whilst documenting the findings of my research. When I had identified the subordinate themes delineating the common aspects of the lived experience of the participants, I went back to the table that was listing all the universal and subordinate themes and mapped each subordinate theme to the four worlds. For this purpose, I added an additional column to the combined table to explicitly map the four dimensions, which looked like the example below:

Major universal theme	**Universal themes**		**Four dimensions of existence**
Emotional roller-coaster	Pride and pleasure (P7, P5, P4, P3, P2)	Fathers continue to feel joy in fulfilling their perceived role as a father and take pride in what they and their family are achieving together even when	Personal world

		challenged by tough times due to PND.	
	Frustrations (P7, P6, P4, P3, P2, P1)	It is really frustrating to have frequent disagreements with the partner especially about relapses and needless argumentation over small things. You feel frustrated about having to spend a lot of time on supporting the partner without improving the overall situation.	Social world
	Hopes (P7, P5, P4, P3, P2)	Fathers hang on to their sense of hopefulness about getting back to an improved and happier state of family life.	Personal world
	Sadness (P5, P4, P3, P2)	Fathers experience a lot of sadness because of their partner's emotional state and missing the joyous family life.	Personal world
	Guilt (P7, P5, P3, P1)	Fathers feel guilty because they consider themselves responsible for being the cause of their partner's emotional state and feel that they are unable to support them appropriately.	Social world
	Unfairness (P6, P4, P3)	It seems unfair to fathers that they have to deal with their partner's conduct as well as maintain the new way of life.	Social world

This helped me in two ways. Firstly, it acted as a check that I had considered all the dimensions of the lived experience and was not inadvertently ignoring some aspects from the descriptions

of the lived experience of the participants. Secondly, it forced me to reconsider the essence of the experience described by each subordinate theme, which in many cases, helped me to refine the description as well as the definition of the subordinate theme.

3.9.2.4 Emotional movement and the compass

Husserl posits that we are always connected to the world around us in the form of our relation with others and furthermore that this relationship involves a movement either towards the other or away from the other; where the other could be a person, an idea or even an inanimate object (Husserl, 1911). The movement towards some other is an indicator of us valuing it more and conversely movement away from some other indicates loss of value. In his book "Being and Nothingness" (1943), Sartre says "my acts cause values to spring up like partridges". The metaphor emphasizes that values are involved in anything and everything that we do. Emotions spring up whenever there is loss of a value or gain of a value. In essence, then, emotions are pervasive; we can never live or exist without emotions being there. A slightly different way of talking about this is found in Heidegger's discussion about "Befindlichkeit". He asserts that one of the fundamental "Existentialia" of Dasein, or being, is "Befindlichkeit", which represents the inherent aspect of our nature to be oriented towards the world in a certain manner or be attuned to it in a particular way. This can be called our mood in simple terms. We are always in a mood, like emotions that are always there without us even being conscious of them. It is thus, important to be able to work on the analysis of the emotional aspect systematically. SEA introduces the concept of the emotional compass (Van Deurzen, 2015), where the multitude of emotions that we feel are represented in the shape of a compass. In Emmy Van Deurzen's words (2015) "the model allows us to plot the way in which a particular individual is located in relation to specific values. We can be anywhere on the emotional compass at any time and move from there to anywhere else, though certain trajectories are more likely than others". The compass is inspired by Spinoza's work on how humans position themselves in relation to things that they value or fear. The four quadrants of the compass show the "cycle of attunement" (Van Deurzen, 2015) where at the top we are in a joyful, happy state of union with a value, and conversely, at the bottom, we are in despair at the loss of a value. In between, we are either fearful about the loss of a value, mourning the loss of a value, beginning to have hopes about gaining a value or near attaining the value.

I have used the emotional compass in two ways for my research. Firstly, I have used it as a guide while designing the interview schedule. I tried to make sure that the participants are

encouraged to consider the emotional angle and the emotional journey by asking probing questions and following up with prompts that urged the participants to elucidate their feelings, fears, anxieties and hopes further so that the various dimensions of the lived experience can be brought forward. This was helpful in the next step, where during the analysis, I have attempted to adopt a systematic approach towards analysing the emotions of the participants. For this purpose, I have plotted the 31 subordinate themes that were identified as common experiences between various participants on the full-colour version of the emotional compass. This graphical illustration (Figure 1 Themes on the emotional compass) has allowed visualizing the overall emotional orientation of the participants' lived experience and I have made use of the graphic at numerous points in the Findings and Discussion chapters later. In addition to being a very quick way of visualizing the emotions, the plot has a dynamic aspect as well because it portrays the emotional journey of the participants over time. It has allowed me to interweave the temporal aspect into the analysis by examining how the participants' accounts show the downward emotional spiral that takes them into the depths of despair themselves when their partners are suffering from PND. Moreover, I examined how the participants find the courage and resolve to hold on to hope even in desperate times and how they manage to cope successfully with the overall challenge. The graphical illustration of subordinate themes on the emotional compass also associates each subordinate theme with the emotions experienced by the participants. To capture this mapping, I added a column to the table of universal and subordinate themes, which now took the final shape clarified by the example below. Overall, the use of the emotional compass has been very useful to provide additional depth of analysis when looking at the findings of the research.

Major universal theme	**Universal themes**		**Existential dimension**	
			Emotional compass	**Four dimensions**
Emotional roller-coaster	Pride and pleasure (P7, P5, P4, P3, P2)	Fathers continue to feel joy in fulfilling their perceived role as a father and take pride in what they and their family are achieving together even when challenged by tough times due to PND.	Pride Joy	

				Personal world
	Frustrations (P7, P6, P4, P3, P2, P1)	It is really frustrating to have frequent disagreements with the partner especially about relapses and needless argumentation over small things. You feel frustrated about having to spend a lot of time on supporting the partner without improving the overall situation.	Anger Despair	Social world
	Hopes (P7, P5, P4, P3, P2)	Fathers hang on to their sense of hopefulness about getting back to an improved and happier state of family life.	Hope	Personal world
	Sadness (P5, P4, P3, P2)	Fathers experience a lot of sadness because of their partner's emotional state and missing the joyous family life.	Sorrow	Personal world
	Guilt (P7, P5, P3, P1)	Fathers feel guilty because they consider themselves responsible for being the cause of their partner's emotional state and feel that they are unable to support them appropriately.	Guilt	Social world
	Unfairness (P6, P4, P3)	It seems unfair to fathers that they have to deal with their partner's conduct as well as maintain the new way of life.	Anger	Social world

All the themes were analysed both from the phenomenological perspective as well as the existential perspective to uncover the deeper meaning and implications and are presented in the next chapter.

Chapter 4 Findings

4.1 Introduction

The purpose of my research was to explore the lived experience of fathers who were living with partners suffering from Post Natal Depression (PND). I have adopted the phenomenological approach while conducting the research, and within that, van Manen's methodology has provided the structure to allow me to exploit my unique perspective as my experience of the postnatal period is close to the research question. As explained earlier in the description of the methodology, I have strived to exploit my subjective experience effectively during the process while remaining true to the principles of the hermeneutic approach (van Manen, 1997; Wertz, 2005).

During the research, seven interviews were conducted and then van Manen's approach for isolating thematic statements to identify the themes and sub-themes from the data was followed. Thirty-one subordinate themes were identified, and these were later grouped into seven major, and one minor, universal themes. The universal themes are **Emotional roller-coaster, Suffering as a couple, Lack of support, Surviving the situation, Living with her PND, Personal challenges, Meeting expectations and Being with others (minor theme)**. All the themes and sub-themes are listed in Table 2 Universal Themes Table. The universal themes each contain three to six subordinate themes where each subordinate theme has been expressed by at least three participants. The minor universal comprises only one subordinate theme.

In this chapter, I discuss the findings related to each major theme. The themes pertain to all four dimensions of existence (Personal world, Physical world, Spiritual world and Social world). The emotional compass has been utilized to further bring out the trajectory of the fathers' lived experiences.

This chapter begins by introducing the participants before delving into the description of their experiences.

4.1.1 Introducing the participants

Demographic data were collected from the participants before the start of the interview. As Table 1 below shows, all the participants belonged to a homogenous population and described

themselves as white and British. The age of the participants ranged from 30-40 years. All the participants were married to their partners and were living together at the time of the interview, even though this was not part of the selection criteria. The majority of the participants did not have any history of depression themselves, except one who had suffered from depression more than ten years before the time of the interview. All the participants were in full-time employment at the time of interview, but their partner's employment status varied. The partners of two participants were working full time when they were diagnosed with postnatal depression, whereas two were working part-time, and a further two were not working at all. One participant's partner was on maternity leave. In terms of socioeconomic status, all participants were asked to describe which class they belonged to and almost all of them described themselves as belonging to the middle class; however, one participant described himself as belonging to the upper class. The group was not symmetrical in terms of the socio-economic classes as only one participant belonged to the upper class. This was not deliberate but was not prevented by targeting any specific quota in terms of the socio-economic classes of the participants. Targeting symmetry in terms of the various classes was not deemed possible because of the difficulty of finding participants. The findings suggest that there was no significant difference in terms of the experience of participants depending on the class.

Table 1 Demographic Details of the participants

Participant code	Age	Ethnicity	History of depression	Partner's employment status	Socio-economic status	Relationship status
P1	35	White British	No	Working Part-time	Middle class	Married, Living with wife
P2	31	White British	No	Working Full-time	Middle class	Married, Living with wife
P3	38	White British	No	Not working	Upper class	Married, Living with wife
P4	33	White British	No	Not working	Middle class	Married, Living with wife
P5	31	White British	Yes	Maternity Leave	Middle class	Married, Living with wife
P6	40	White British	No	Working Part-time	Middle class	Married, Living with wife
P7	33	White British	No	Working Full-time	Middle class	Married, Living with wife

4.1.2 Introducing the themes

Seven major universal themes were identified following van Manen's method of analysis. For every major universal theme, all the participants have expressed at least one theme in that cluster. There is one minor universal theme, Impact on close relationships, which was expressed by only three out of the seven participants. At least three participants expressed each universal theme. All the themes captured various facets of the experience of fathers living with their partners who were suffering from postnatal depression. The themes demonstrated the multidimensional, often challenging and prolonged struggle that the participants had to face. Each major and minor universal theme has been discussed individually, and excerpts from the interviews of the participants have been used to further elaborate the details of the experience. For each major and minor universal theme, an existential perspective has also been sought using Structural Existential Analysis (Van Deurzen, 2015). As part of SEA, the four worlds' model and emotional compass have been utilized to illustrate and bring out the richness of the lived experience.

Table 2 Universal Themes Table

Major universal themes	**Universal themes**		**Existential dimension**	
			Emotional compass	**Four dimensions**
Emotional roller-coaster	Pride and pleasure (P7, P5, P4, P3, P2)	Fathers continue to feel joy in fulfilling their perceived role as a father and take pride in what they and their family are achieving together even when challenged by tough times due to PND.	Pride Joy	Personal world
	Frustrations (P7, P6, P4, P3, P2, P1)	It is really frustrating to have frequent disagreements with the partner especially about relapses and needless argumentation over small things. You feel frustrated about having to spend a lot	Anger Despair	Social world

		of time on supporting the partner without improving the overall situation.		
	Hopes (P7, P5, P4, P3, P2)	Fathers hang on to their sense of hopefulness about getting back to an improved and happier state of family life.	Hope	Personal world
	Sadness (P5, P4, P3, P2)	Fathers experience a lot of sadness because of their partner's emotional state and missing the joyous family life.	Sorrow	Personal world
	Guilt (P7, P5, P3, P1)	Fathers feel guilty because they consider themselves responsible for being the cause of their partner's emotional state and feel that they are unable to support them appropriately.	Guilt	Social world
	Unfairness (P6, P4, P3)	It seems unfair to fathers that they have to deal with their partner's conduct as well as maintain the new way of life.	Anger	Social world
Suffering as a couple	Communicating with each other (P7, P6, P5, P4, P3, P2, P1)	Having open and clear communication with their partners becomes challenging for fathers due to lack of time as well as partner's emotional vulnerability.	Misery	Social world
	Dependency on each other (P7, P6, P5, P4, P2,)	Most fathers noticed an increased dependency on them by their wives and some felt that they had also become more dependent on their wives.	Misery	Social world

	Changes in relationship (P7, P4, P3, P2, P1)	Fathers experience drastic changes in their relationship with their partners and in most cases it deteriorates significantly.	Misery	Social world
	Intimacy became challenging (P6, P5, P4, P1)	Physical and emotional intimacy suffers because partners feel distant and isolated. Quality time together as a couple disappears even more. Stressful circumstances cause further complications for the sexual relationship.	Misery	Physical world
lack of support	lack of support for dads (P7, P6, P4, P3, P1)	Fathers feel ignored as compared to their partners when it comes to professional as well as familial support.	Jealousy anger	Social world
	Frustrated by the support network (P5, P4, P3, P1)	The lack of support and neglect by the professional and personal support network causes a lot of frustration and disappointment.	Despair Anger	Social world
	Seeking support and reassurance (P7, P5, P4, P1)	Fathers yearn for someone from whom they can seek support and reassurance whilst they are facing a tough and challenging situation.	Desire	Social world
	Missed opportunities for support (P5, P3, P2,)	Some fathers believe that they missed opportunities for getting support because they did not feel comfortable seeking it.	Confusion	Social world
Surviving the situation	What helped in coping	To cope with the situation it helps to have a positive	Hope Resolve	Spiritual

	(P7, P6, P4, P3, P2, P1)	outlook and relish the little joys of life. At times, the ability to switch off the brain also becomes vital.		
	Impossible not to let people down (P7, P6, P2, P1)	It is impossible not to let some people down in order to be able to cope with the demands of the situation.	Vigilance	Social
	Talking about the experience (P7, P6, P5, P2,)	The need to share the experience with others and maybe get some encouragement is satisfied by talking to friends, family or work colleagues or even talking anonymously online.	Courage Resolve	Social
Living with her PND	Concerns about recovery (P7, P5, P4, P2, P1)	Fathers worry about the longer lasting effects of depression on the family as a whole including their wives recovering and functioning normally again and whether their relationship would survive and return to what it was.	Worry	Social world
	Fears about losing wife (P6, P4, P3, P2, P1)	One of the biggest fears is about your wife becoming suicidal or just disappearing and leaving the family. You worry about not being there when she is feeling awful. The effect on the child is a further source of apprehensions.	Fear Worry	Social world
	No embarrassment (P6, P5, P4, P3)	There is no feeling of embarrassment or guilt because your wife is	Confidence	Social world

		suffering from PND. You may not disclose it to prevent negative responses but you don't feel ashamed.		
	Challenging to be strong for the wife (P7, P5, P3, P1)	Supporting wife during PND is deemed to be a very hard task. On top of the physical effort, providing emotional support whilst having very little reserves themselves becomes a big challenge.	Courage	Personal world
	Being careful about what I say or being reticent (P7, P6, P5, P2)	You are forced to be reticent about expressing your feelings because of the fear of putting pressure on your wife and having a harmful effect on her. Also, she may view it in a different way and react adversely.	Vigilance	Social world
Personal challenges	Tough to deal with the situation (P7, P6, P4, P3, P3)	It is very tough to deal with as life becomes chaotic with all sorts of physical burdens and emotions piling up together. You cannot make sense of what is affecting you and how it is affecting you. You become despondent thinking you can't have any impact on the situation.	Despondency	Personal world
	Not knowing how to deal with it (P7, P6, P5, P3, P2, P1)	You find yourself ill-equipped to deal with the situation and are surprised about how horribly bad it is. You never know enough	Confusion worry	Personal world

		about it beforehand and feel lost, not knowing how to cope with it or how to support your wife.		
	Day to day survival (P6, P4, P3, P1)	It feels like you are passing through a crisis and just day-to-day survival becomes your concern. You just push yourself and try to do the right things in the hope that things will settle down but it feels like you are desperately fighting for survival.	Despondency Resignation	Personal world
	Feeling powerless (P6, P4, P3, P1)	There is a strong feeling of powerlessness and incompetence because you cannot do anything to make your wife feel better.	Despondency	Personal world
	Not opening up (P5, P3, P2)	You don't open up to others unless you feel they will understand or be able to help somehow. Also, you feel you are supposed to be strong enough to cope with the situation.	Misery	Social world
Meeting expectations	Work-life balance (P6, P5, P4, P3, P2)	It was very exhausting to meet the demands of both work and family life. You feel stressed and it becomes hard to concentrate fully at work.	Misery	Physical world
	Unable to put own needs forward (P6, P4, P1)	You cannot put forward your own needs because you don't want to put extra pressure on your wife. You feel that you have no existence of your own	Vigilance Despair	Personal world

		which feels unfair and frustrating.		
	Not having enough time (P7, P6, P1)	There was more work and less time. You don't have any time as a separate entity because your wife is completely dependent on you and you want to be supportive of her even at the cost of everything else.	Misery	Personal world
Being with others	Impact on close relationships (P7, P4, P3)	There were not many opportunities to spend time with the child or close relations like parents and finding ways to compensate for that was really hard.	Resignation	Social world

4.1.3 Themes on Emotional Compass

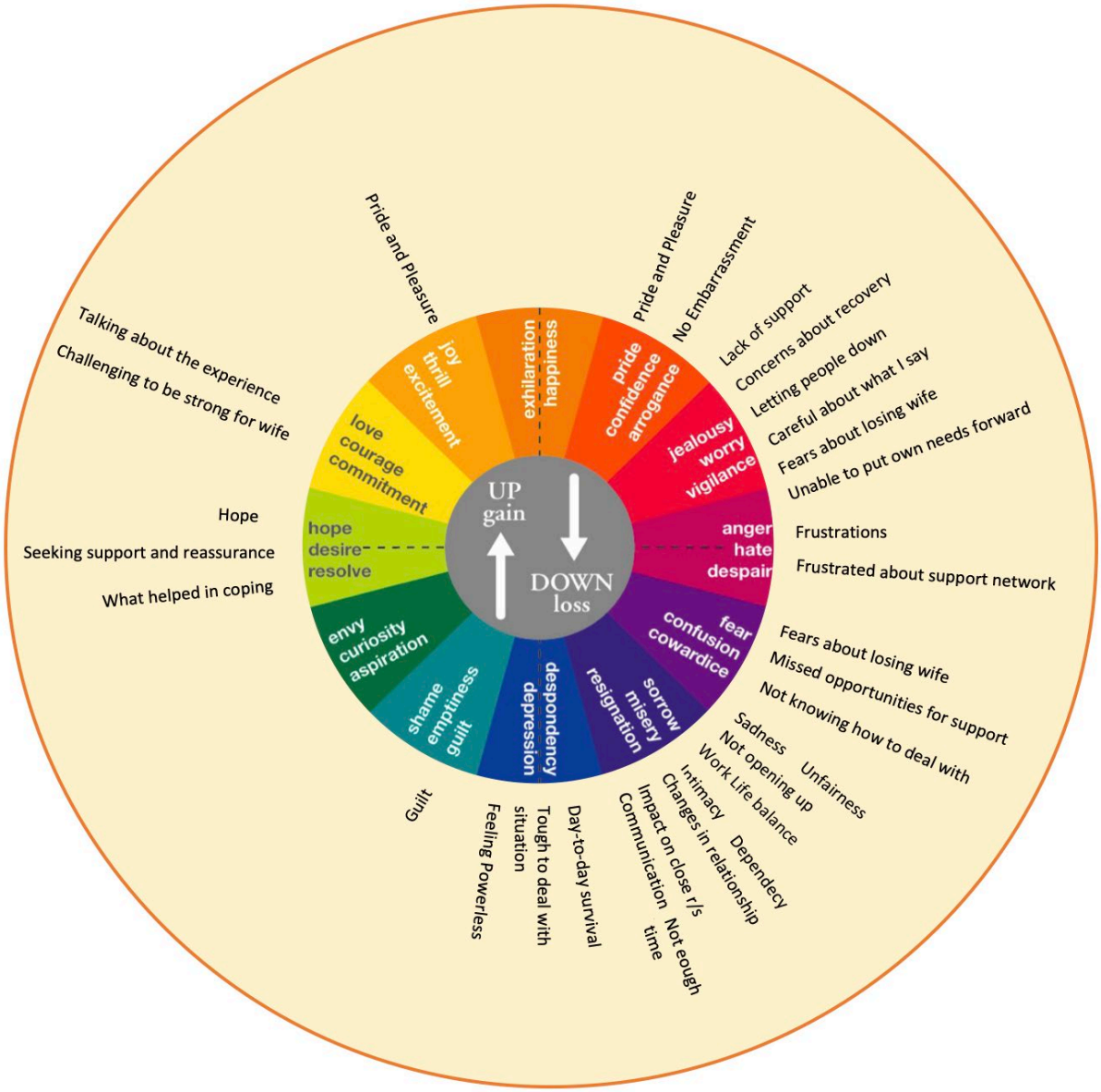

Figure 1 Themes on the emotional compass

Looking at the emotional compass, there is a general scarcity of positive, gainful experiences and feelings and an abundance of negative loss-related experiences and emotions. The tableau painted here is of loss and coping with that loss. Looking at the description of the themes, what is lost is their cherished relationships and life activities before their partners' PND as well as their freedom, like the freedom to address their own needs, the freedom to maintain the balance

between work and family life, even the freedom to express their feelings and emotions. The loss of these valued activities, relationships and freedoms, pushes the participants towards despondency and despair.

4.1.4 Themes on the dimensions of existence

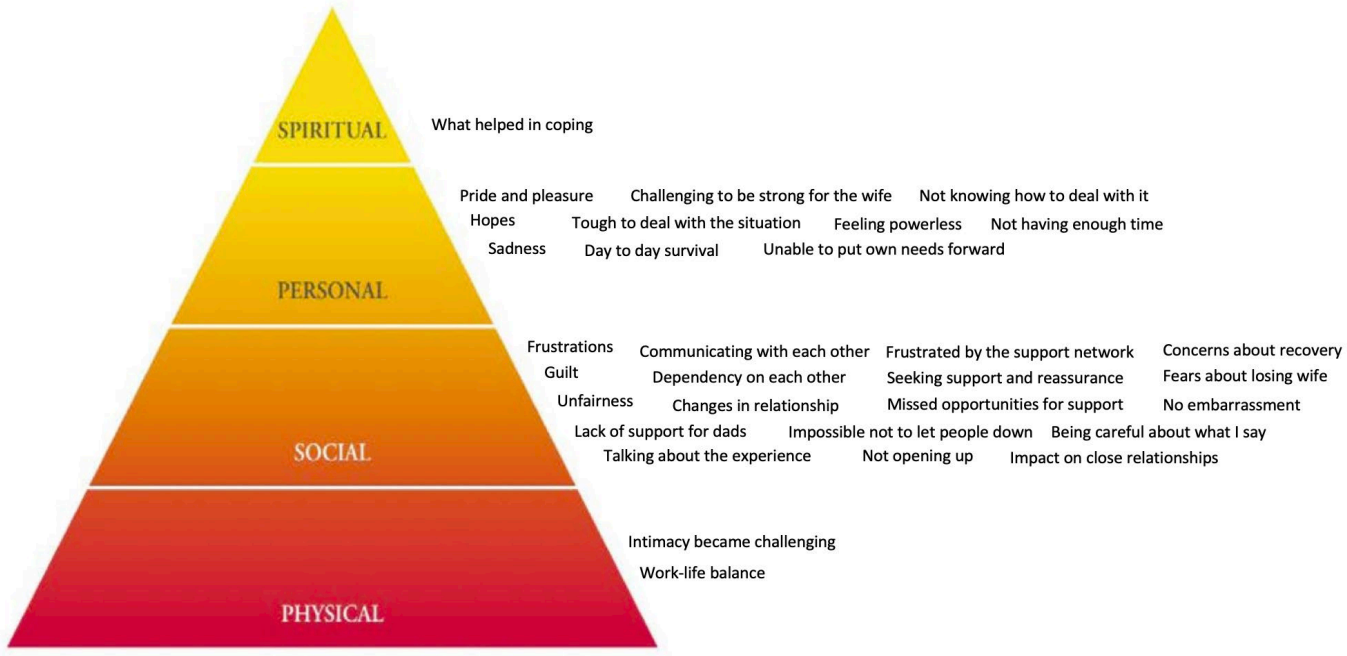

Figure 2 Themes on the dimensions of existence

The figure above maps the themes on the four dimensions of existence. The personal and social worlds of the participants were affected to a much greater degree than the other dimensions of existence. The social world was impacted the most, where the effect on the relationships of the participants and their interactions with others were the major considerations. The second most impacted dimension was the participants' personal world, where they faced their inner fears, confusions, concerns, and hopes. They expressed the severity of the challenge that they encountered and described the feelings it generated. The spiritual dimension was drawn in when the participants' expressed how their beliefs and faith in themselves and their partners helped them to cope with the situation. The physical dimension was not impacted to a large extent.

Below, I am going to look at each major and minor universal theme and discuss them in more detail.

4.2 Universal Themes

4.2.1 Universal theme one: Emotional roller coaster

Almost all the participants included in the study believed that when their partner was suffering from PND, they themselves lived through a tumultuous experience and went through the full spectrum of feelings from pride and pleasure to sadness and desperation. All seven participants reported feeling negative emotions like frustration, sadness, unfairness and guilt. Five of the participants reported feeling positive emotions like pride, joy and hope as well. However, two participants did not express any positive emotions at all. Overall there were six different themes based on different emotions that constitute this major theme. These are Pride and Pleasure, Frustrations, Hopes, Sadness, Guilt and Unfairness. Out of these, the predominant emotion was Frustration, which was experienced by all participants except one. The frustrations were mostly about their partners or about not being able to improve the overall situation.

Below, I discuss each of the themes individually and then utilize the emotional compass to elucidate the fact that the experience of the participants spans the full range of emotions. I will also discuss where each theme falls in the four dimensions of the world.

4.2.1.1 Pride and pleasure

Fathers continue to feel joy in fulfilling their perceived role as a father and take pride in what they and their family are achieving together even when challenged by tough times due to PND.

Almost all the participants interviewed expressed the feeling of taking pride in their role as a father. Most of them also pointed out that even though being a father was unexpectedly hard work, there were nevertheless many reasons to feel good about themselves, and their own or their partners' achievements.

The main reason for feeling proud of their efforts was the fact that most participants perceived their role as really hard to fulfil, especially when they had to cope with the issues that arose when their partners were suffering from PND. This naturally generated perceptions about managing to overcome a very challenging situation, which was quite rewarding in itself.

"Every day I knew I wanted to look after her. I just always wanted to go home. I wanted her to be better. I wanted to see my daughter. But even though I might get shouted at … I never felt that I didn't want to do it. So that was kind of affirming, and I knew that I… It made me feel like a good husband, which was really nice" (P1, 272-277)

"… after a while you start to cope and you feel proud that you're coping. Even though it's hard, you start to feel I'm doing this, I'm doing this, and you take pride in the hardship of it." (P2, 80-84)

Participants also believed that it was a significant achievement that they together with their partners could survive the period of postnatal depression, and it was a source of pride for them individually and as a family:

"Everything we've done and achieved I thinks worth it and I'm very proud of both what we've been through and where we are today", (P7, 294-297)

"I'm very proud and now I'm proud of my wife as well because she gave birth to our daughter and whatnot, just seeing her come through her PND …", (P3, 307-309)

"I'm definitely proud … yes, just seeing her almost get to the finish line as it were. I'm proud of her. She's had to work very hard to get there. It's been hard work getting her there", (P3, 314-316)

A few of the participants mentioned interspersed moments of joy and pleasure that punctuated the otherwise challenging situation and those moments helped them feel better about the overall scenario. The encouragement received from their partners about doing the "right" things seemed to help the participants a lot because it was affirming that their efforts were being spent in the right direction:

"There was more joy and pride later…there was pride when she told me I was doing the right thing. I was feeling really good. When she start to feel better and we basically analysed back what happened and she told me, 'yes, you always did the right thing. You've been very helpful for me.' That was something that made me really happy and really proud, you know, because it's so good to hear that" (P5, 240-245)

One participant mentioned the satisfaction gained by the perception that he was doing a better job than what he believed most fathers would do in similar circumstances; thus, the joy obtained from being good at his "job" of being a father was also a source of pleasure:

> *"It made me feel really good about being a husband. It felt like I was doing it properly and that… It made me feel good as a man. I guess I thought that lots of people wouldn't do it, so I thought I was… You know, lots of men are quite competitive. I felt like I was doing well at something, which was rewarding" (P1, 279-282)*

4.2.1.2 Frustrations

It is really frustrating to have frequent disagreements with the partner especially about relapses and needless argumentation over small things. You feel frustrated about having to spend a lot of time on supporting the partner without improving the overall situation.

More than half the participants reported that they felt very frustrated when their partners were suffering from PND. The common factor amongst all the participants' experiences was that the behaviour of their partners was deemed to be the main reason for the frustrations rather than general or external factors outside family life. Within the domain of family life, though, the experiences of different participants varied significantly.

Two of the participants felt frustrated because of the support burden. Firstly, the time which the participants were supposed to have spent on their other responsibilities, including work was instead being spent on supporting their partners. Secondly, the support burden was not getting lighter over time, even when they believed that their partners' PND had subsided significantly:

> *"you're frustrated because I can't help, you know, not wanting to speak emotion. I'm frustrated because I'm not getting any kind of time to just be myself, that's another", (P6, 641-643)*

> *"Suddenly you don't have time for anything else. You don't have time for anybody else. That I think on its own, not that I've had that experience, but without postnatal depression is a challenge to any couple. Then when you throw postnatal depression in amongst the mix then there's no time.", (P4, 378-382)*

The frustration because of the belief that the partners were not picking up the household chores when their condition had improved already was the other aspect. Here the spouses failed to agree about relapses and the participants could not readily accept the fact that their partners seemed to have been better occasionally without actually recovering permanently:

> *"Ben was born in the March, by the January I thought Emily was back to normal, but Emily she really didn't think that and we had quite a lot of difficulty discussing issues around the fact that I thought she was largely better and she still felt she wasn't right"(P4, 266-270).*

> *"also frustrated of the question of going why aren't you coping in a way as well. Why is it that I'm coming home and doing all this stuff as well as … yes, that, kind of, frustration at my wife for not being able to do things as well, which is unfair, but it's how you feel and, you know, … And, then kind of that feeling of taking on more and more responsibility and not necessarily and not really having the time or the reward for doing it", (P6, 645-654.)*

One participant was particularly frustrated by the needless argumentation and the effort required to abstain from frequent arguments when there was no real reason behind those:

> *"she would get annoyed or frustrated with me, take it out on me and then there's a bit of...for me I didn't really want to, not quite enter into the argument, but I went with it and accepted that she's just trying to vent and get her frustrations out, which is very frustrating for me because you know you haven't done anything wrong, but it can be very hard not to enter into an argument where there's nothing to argue about, it's just a lot of frustrations." (P7, 150-155).*

Another participant reported being frustrated because he and his partner could not communicate in a worthwhile fashion, and he could not figure out how to help:

> *"Sometimes you feel like, what's the point? Sometimes I'd call her and be like, 'why are you feeling sad?' and she's be like, 'I don't know.' I understand that it's difficult to explain, but sometimes it used to frustrate me because she used to be like, 'I don't know why I'm feeling sad' and I'd be like, 'well, I can't help, so why are you telling me?'", (P2, 229-233).*

"she'd be in, say like, a bad mood all day and it would always frustrate me because you'd go, 'are you okay?' and she'd go, 'yes.' 'You okay?' 'Yes.' 'You okay?' 'Yes.' Then it would turn out she wasn't okay and it would annoy me because I'd say, 'just tell me the first time.'", (P2, 416-419).

4.2.1.3 Hopes

Fathers hang on to their sense of hopefulness about getting back to an improved and happier state of family life.

Most of the participants interviewed shared that even during the challenging times when their partners were going through post-natal depression they clung on to the hope that things were going to get better sooner rather than later and that their partners would be returning to being "normal" again so that the whole family could start enjoying their life together.

The desire that the post-natal depression would just disappear and finish quickly, was expressed by three out of the seven participants interviewed:

"Yes, just that she'd…I think my hopes and desires, kind of, have been realised, just that it would resolve quickly" (P2, 397-398)

"The hope was it was going to be over and done with quickly and everything would be back to normal." (P3, 413-414).

"obviously the hope was, like, for this to be finished straight after… I mean, sorry, for this to be finished super early, soon and for her to be back to normal basically …" (P5, 356-361).

One of the strong desires was for the situation to improve so that both the parents could enjoy the early years of their baby's life and not lose out on the chance to relish the moments that only a young baby can provide to his or her parents. This was mentioned clearly by some participants but was implicit in the feelings of all the participants:

"There's a lot of hopes of expanding the family, kind of, enjoying the early years as much as we could and a lot of new things for the first time, a lot of excitement for that, the first time she starts to crawl and smile and everything else really" (P7, 288-291)

"... for her to be back to normal basically, which is what I needed so we could enjoy the baby because the baby in all the time was amazing." (P5, 256-258).

One participant expressed the hope that the hardship faced during PND was going to make both spouses stronger and protect them from a relapse:

"I suppose you can, kind of, hope that actually you come out of the other side a bit better off in that if you've dealt with it, dealt with depression then you, kind of, have ways of dealing with it after having had it. So, you kind of have a bit of protection against that sort of thing happening again potentially" (P2, 398-401).

One of the participants pinned his hopes on his partner's ability to work out her problems. For him, the big source of hope was that his partner had always put serious effort into sorting out whatever challenges she had been facing in the past so he hoped she would be able to replicate her success in case of post-natal depression as well:

"Emily is a real worker at getting her problems solved. She will always be able to work at solving problems because that's how she's managed to survive and that was really probably a big hope for me that she would always put the work in" (P4, 450-453).

4.2.1.4 Sadness

Fathers experience a lot of sadness because of their partner's emotional state and missing the joyous family life.

Sadness was a common theme mentioned by the majority of the participants interviewed. The main reason that participants reported feeling sad was that the joyous family life that they expected after the birth of the child did not materialize. In particular, seeing their partner suffer extreme sadness, which was often part of post-natal depression, just made the participants feel sad as well. The sadness stemmed from the fact that the partner that they loved was suffering instead of enjoying her role as a mother. Both spouses were not able to appreciate the child's very early life well, which is a chance that they were not going to get again, and this further deepened the feeling of sadness.

Some participants distinctly made a connection and articulated the relationship between sadness and missing out the potentially joyous family life when the child is young:

> *"So, going back the other feeling was the sadness about the fact that the whole joyous, loving, family thing just didn't happen. Expectations weren't met really" (P4, 393-395).*

> *"I'll be sat looking at my daughter or whatnot and I start getting full of sadness, you know, thinking how my wife and I've both missed out on that first year of her life almost where it was so consumed with the PND. I get sad about it now because the first year of a child's life is supposed to be this magical thing, but we've both missed out on that now." (P3, 253-259).*

The partners going through a very hard time and the sadness generated because of witnessing that was also expressed clearly:

> *"she wasn't enjoying being a new mum, That was the main thing, that you kind of feel bad for her and also feel bad for, you know, she's alone all day with the baby and that was what was making her depressed. I felt sad about that." (P2, 68-73).*

The degree of sadness felt by the participants varied quite significantly. Most of them were affected, but not all said that they were extremely sad. However, one of the participants reported feeling very sad to the point where he feared he might become depressed himself:

> *"I was sad. I was very sad. As I said, we had a lot of tears, especially the first year. I was sad. I was anxious, you know. There was almost a point where I thought I was depressed, but I could tell I wasn't. I think I might have been borderline at one point because it was relentless. It was every day, the tears, the anger, the frustration, so the whole experience has just been sadness basically." (P3, 343-349).*

Another point brought up by one participant was that even when both parents might have been feeling sad, it was not apparent to most of their friends or parents. Thus, the sadness was mostly an internal within-the-close-family affair:

> *"you might be the saddest person in the world and going through this postnatal depression and a lot of people wouldn't have a clue to what you're going through because you still look normal from outside" (P5, 391-398).*

4.2.1.5 Guilt

Fathers feel guilty because they consider themselves responsible for being the cause of their partner's emotional state and feel that they are unable to support them appropriately.

The feeling of guilt was expressed by quite a few participants either in the context of somehow being responsible for their partners' emotional state and PND or in the context of not being able to provide effective and timely physical and emotional support to their partners. Social activities, as well as long work hours, were mentioned as the primary reasons for not being able to spend enough time with their partners. The sense of being somehow responsible for the PND mostly stemmed from the fact that the participants were part of the decision to have the child in the first place and now if their partners were not able to handle the emotional and physical burden then some participants thought they should be partly blamed for creating the circumstances:

> *"I was working 12 hours a day, well I was at least away for 12 hours a day, so my wife was on her own for 12 hours a day, five days a week, so I felt quite guilty about that" (P7, 265-268).*

> *"financially it was better to stay where I was and work the longer hours to make sure we had the money for when my wife's money would run out … but it was the guilt of being away" (P7, 385-390).*

The feeling of guilt was particularly pronounced if for some reason, the partner had to endure an episode of anxiety while the participant was away. This depended on how severe the episode was but generally every time the participant was unable to provide timely support resulted in more guilty feelings:

> *"I was watching a football match and she was home alone and she told me to go out …. The baby wasn't going to sleep, so she got another anxiety attack and she again punch herself and stuff, so I was rushing home. I asked a friend to drive me back and those were really bad moments because you feel guilty. You feel like you shouldn't have done it" (P5, 198-207).*

Two participants expressed the feeling of guilt because they were part of the decision to have a child. In the case of one participant, it was particularly important because he pushed to have a child and he had pushed to move out of London to the country, which eventually turned out to exacerbate the issues because his partner was used to living in London:

> *"it takes two to create life and I'm the other one of that, which I'm not quite sure how PND starts originally, but I've contributed to it in the sense that we had our daughter" (P3, 295-298).*

> *"I definitely had guilt that I knew that I had been… I had pushed to have a child. I knew that I had pushed to create our environment. I knew that she wanted me to come with her somewhat different, to an environment that she would be happier in. I felt guilty that I couldn't do that" (P1, 550-553).*

4.2.1.6 Unfairness

It seems unfair to fathers that they have to deal with their partner's conduct as well as maintain the new way of life.

The feeling of unfairness was expressed by three of the participants. The feeling emanated from various diverse reasons. The distribution of household responsibilities, leaving no time for anything else, was mentioned by two of the participants as a cause. One participant mentioned the way his partner put him on a pedestal, but for the wrong reasons, being the cause of the feeling of unfairness. Another participant felt like he had to deal with the challenging circumstances even though he was not playing a big role in creating those circumstances. One participant felt that he had been pushed aside by his partner in terms of taking care of the child, and he was isolated, which did not seem fair. Because only three of the participants out of seven expressed feelings related to this theme, there is not a lot of generalization or commonality in terms of the causes or details of the experiences. However, the feeling of unfairness is common amongst all the experiences. It also appears that the common factor with regards to unfairness was the fact that the fathers ended up having to comply with their partners' wishes; some feeling excluded from childcare or tasks that they wanted to do, and some being burdened with tasks and responsibilities that they did not immediately want to have.

The feelings of unfair distribution of labour with respect to day-to-day household chores and also of unfairness in the sense of questioning the sincerity and motives behind the support lent was clearly expressed:

> *"it was a case of, you know, coming home as soon as I could because I needed to … to look after my daughter in order to free the time up so my wife could just sit and have that time to herself. Then I'd put my daughter to bed and then I'd carry on looking after my wife, and I think in one way that's had a knock-on effect because that's set a status quo and whilst we've recovered from the depression it meant that habit is continued … and I was, sort of, like, arghh. You kind of feel like you're just doing the job of one and a half people" (P6, 413-423).*

> *"I don't mind doing any of these things, this is all good, this is all positive, this is all good things, but you're kind of questioning really why…questioning the other persons motives, you know, which is unfair." (P6, 633-638).*

One of the participants could not help feeling that he had to suffer even though it was not his doing in any way even though he appreciated that it was not his partner's fault in any way as well:

> *"I, kind of, felt cheated out of a wonderful experience and I did feel that this was something that was not my doing and it was…not unfair, but I kind of felt…you know, unfair maybe is not quite the right word, but that sort of thing … I knew that postnatal depression as an illness and not something that was her doing or her want, but it's still difficult" (P4, 201-209).*

Another participant felt pushed to one side and felt that it was not fair that he was unable to get any time with his daughter because his partner took care of all the needs of the child:

> *"A couple of times I waited until my wife was asleep and then cried because, you know, I wanted us to have this baby so much and then when she was here I hardly had any time with her at all, which that was difficult to deal with" (P3, 474-477).*

4.2.1.7 Existential perspective

This theme delves deep into the emotional experience of the participants living with partners who are suffering from PND. From an existential perspective experiences can pertain to different spheres or dimensions of existence. Binswanger (1963) and van Deurzen (1988) outline four separate dimensions i.e. the Personal world (Eigenwelt), the Social world (Mitwelt), the Physical world (Umwelt) and the Spiritual world (Uberwelt). The themes that constitute this universal theme are split evenly between the personal and social worlds.

The experiences of participants described in these themes suggest that they go through the full spectrum of emotions while living with their partners who suffer from PND. They learn to be a new father as well as a good and supportive husband at the same time. Where their experience is composed predominantly of negative emotions, undoubtedly some positive emotions are very much there as well. Van Deurzen's (2015) emotional compass unambiguously illustrates this when the constituent themes that are part of this universal theme are plotted against the compass (Figure 1).

The primary source of joy for the participants was that they were being meaningfully supportive to their partners, and that they were able to be there for them at the time of the greatest need. This gave them not only joy that they hold on to during periods of suffering but also a sense of pride about who they are as a father and as a husband. The feeling of pride was further enhanced when they saw that their partners had been able to successfully navigate the worst of their PND phase and together as a family they had conquered the extreme challenge posed by PND. This resulted in various levels of elation and pride in the different participants. The joy felt by the participants was mostly a personal feeling mainly coming from having achieved a certain proficiency at being a competent father and husband. However, there were joyful moments as a family and a couple as well, which mostly got pushed into the background because of the negative emotions. The other emotion that helped participants to keep going was the hope that there would be an end to this time of suffering and that the PND is a finite illness that would finish in due course of time. Sometimes though (when they had pinned their hopes on being rescued from the situation either by direct external help or guidance and then realized over time that this was not forthcoming), it resulted in deep sadness. This sadness was both about the lost hopes as well as about the lost opportunities of enjoying the first year of their family life together with their young child.

Given the fact that the overwhelming majority of the experience of participants was centred on how hard the challenge was that they were facing and the suffering they had to endure, there were bound to be hard times and a lot of negative emotions. When things seemed to be out of control, the participants felt very frustrated, sometimes with their partners, sometimes with the system and sometimes with themselves. The feelings of being unable to make an impact or of helplessness led to the feeling of despair and anger. Most participants also experienced guilt, triggered by thinking about their choice of starting a family for which they ended up blaming themselves. At the same time, the natural pressures of providing support not only to their partners at home but also bearing the burden on the financial side alone as well made the participants feel very miserable. It seemed like all the pressure of the world was on their shoulders alone, which felt very unfair.

Looking at the graphical representation of the emotional compass, the emotions span the whole boundary and whilst there are undoubtedly more negative emotions and feelings of loss, a few rays of hope and joy, do shine through, to make the participants' personal world bright, even if briefly.

4.2.2 Universal theme two: Suffering as a couple

Life as a couple suffers drastic changes when the partner is suffering from PND, and almost all the changes make it harder for the father to cope with the situation and fulfil his role as a husband and father. Every participant who was interviewed talked about changes in the way the partners communicate with each other, and generally, it was clear that various causes make it much harder to have good communication with their partners during the PND phase. Five participants mentioned changes in dependency on each other and reported that their partners were increasingly dependent upon them. The quality of the relationship was discussed by five participants, and they identified that in most cases, the relationship had deteriorated significantly. Overall there were four different themes based on different aspects of the couple's relationship that constitute this major theme: *Communicating with each other, Dependency on each other, Changes in relationship* and *Intimacy became challenging* which I discuss individually below to capture some details of the participants' experiences. The emotional compass was utilized afterwards to identify and relate the participants' experiences with their state of being and their predominant emotions.

4.2.2.1 Communicating with each other

Having open and clear communication with their partners becomes challenging for fathers due to lack of time as well as partner's emotional vulnerability.

Every participant who was interviewed mentioned the challenge of communication with his partner. Almost all of them found that the way they talked to their partners changed and mostly it had become harder to have clear and open communication when their partners were suffering from PND. Although the details of the experiences varied, the common themes of time pressure and their partners being emotionally fragile were considered to be the main culprits.

For most participants, it was harder to talk to their partners because they ended up not having constructive and helpful communication; rather, it ended in arguments. In some cases, it generated a complete breakdown of communication. This loss of the open and fulfilling communication that the participants were used to having with their partners, nay the loss of the person that the participants were used to having as their partner provoked feelings of anger. It seems like at least one of the participants was trying to rationalize something which was emotional, and which could not be understood in a rational sense. It could be that he was trying to find a solution to the problem, whereas the mother just needed to be heard and accepted. The few excerpts below paint the general picture:

> *"When I tried to rationalise with her and we couldn't communicate on that basis I would get frustrated and then angry" (P4, 354-356).*

> *"it got to the point where I just didn't talk to her, you know, if I could see things were going to escalate into a big argument. That was then when I was trying to walk away, that's what I was taught, and that would then make it worse and then the arguments would pick up." (P3, 551-554).*

The communication between the participants and their partners was also hampered because of the reluctance to talk to each other as that might bring up painful memories. It was felt that the partners would not be ready to talk about most things because it would cause distress and may be taken as criticism or denunciation:

"I feel I can't talk about it to my wife because she was the one who suffered from it and I don't want to talk about it in fear that it brings things back or it upsets her or it feels like I'm putting stuff on her because I don't want her to think that I'm talking about these things because I'm pointing a finger or trying to do that" (P6, 295-299).

"I had to be really careful not to blame or not to say throwaway things like, "You don't know what you're talking about because you're mental ...nervous laugh..." You know, because it's really easy to jump to those things when someone is being irrational or is what you believe is being irrational." (P1, 357-350).

For some participants, talking to their partners became less frequent, but it was not a big issue, instead both partners understood that with the new way of life after the birth of their child, they would have to change the way they communicate. Still, it was clear that the quality of communication was affected:

"I would stay an extra half an hour at work because I knew my daughter would be put to bed by the time I got home, so I could just speak to my wife without having the little one involved at the same time" (P7, 168-173).

For one participant, the quality of communication was quite good, and it helped the couple to get through the tough times together. This was the exception compared to all the others:

"Yes, it has hopefully helped us be more open, maybe her, in telling me how she feels, probably both ways. I think it's strengthened us because we've, kind of, supported each other hopefully through the worst of it, so you feel good in that sense, yes" (P2, 419-423).

4.2.2.2 Dependency on each other

Most fathers noticed an increased dependency on them by their wives and some felt that they had also become more dependent on their wives.

Five out of the seven participants interviewed discussed the dependency of their partners on them and vice versa. Out of the five, three noticed that their partners had become increasingly dependent upon them whilst two did not notice any big changes in dependency. The extent of the change in dependency varied widely with some noticing a change whilst others barely

noticing any change at all. Also, the extent of the change was quite dynamic and varied over time during the different phases of post-natal depression.

For two participants, it was quite clear that their partners needed them a lot more than before. The dependency of the partners increased because firstly they needed the fathers to help out in regards to childcare but also because during the worst phase of PND some partners were unable to even take care of themselves and the husbands had to assume a paternal role for their partners as well as for their children. They had to provide the same kind of comfort and love to their partner that they were providing to their child:

> *"I think probably the thing that's changed the most is that dependency thing … I had quite a paternal relationship, or I looked after my wife a lot. And obviously there was a period then during this journey where I looked after her completely" (P1, 625-628).*

> *"it's made me feel at times, like, I'm looking after two children. I don't mean that in a dismissive way towards my wife, I mean, with caring for the needs of one individual and another individual and those needs are very similar to comfort, hugs" (P6, 163-166)*

For another participant, his partner depended on him a lot during the worst phase of PND, but then as she got better, she became more independent. He also noticed that he himself had to become a lot more independent when his partner was suffering from PND because previously he used to depend on her during their day-to-day life:

> *"she's become less dependent subsequent to the PND ending. She's much stronger. I was very dependent on her…not very dependent, but I depended on her as a partner and when she was in the PND I lost that support from her" (P4, 574-576).*

Another participant noticed a change but not a dramatic one. It was more like the practical reality of the situation that his partner needed him more than before, and he also depended more on his partner to manage the situation:

> *"I wouldn't say that I was more dependent from her or the other way round. It's just that we were aware we had this problem and we were trying to fix it and being together as a couple was obviously helping that to be addressed and fixed earlier" (P5, 576-580).*

Whilst most participants experienced a change in the dependency, two of them did not notice any big change, either way, i.e. the partner changing how dependent she was on them or how dependent they were on their partners. For these two participants, their daily life remained mostly as it had been on the practical side with the only changes being the ones necessitated by the need to accommodate the needs of the baby or things like therapy and counselling. It seems like a complex dynamic was being created between the partners with the mother depending on the father to help her and take care of her, and the father depending on the mother to be well enough to take care of the baby and herself:

> *"I think it probably stayed the same. Yes, actually maybe before we were more independent and we're probably a little bit more dependent on each other, but actually I think that's more to do with the baby than depression because we depend on each other to look after the baby together, whereas before we could be independent adults with our own lives" (P2, 436-440).*

There is a possibility here that there was a kind of co-dependency being created, where the support and help that the participants were trying to extend towards their partners was ending up having the effect of enabling their partner's PND or not helping their recovery.

4.2.2.3 Changes in relationship

Fathers experience drastic changes in their relationship with their partners and in most cases it deteriorates significantly.

Most of the participants interviewed stated that their relationship with their partners sustained a lot of damage during the course of postnatal depression. Inevitably, during PND, there were drastic changes in their partners' behaviour and feelings, and this naturally affected the way the partners interacted with, and felt about, each other. Most participants used words like isolation, lack of affection, withdrawal, boredom, frustration and annoyance to describe how their relationship with their partners was affected. The participants were aware that their partners had a condition which was not anybody's fault, so they tried to be compassionate and make sure that the relationship remained as good as it could be. However, it became hard because the partners were unable to take part in joyous activities or to respond to their feelings the same way that they used to before the postnatal depression.

For one participant, the relationship quality had constant ebbs and flows and involved a lot of frustration and annoyance. At times the relationship felt non-existent:

> *"At times it was very much just we were just living together rather than being husband and wife. On the good days there'd be (unclear 0:22:24) quite a happy couple, but a lot of the time it's just cohabitation between me and my wife" (P7, 208-211).*

Another participant thought that his relationship with his partner had started to fall apart and break down as they could not rebalance and find the right way of approaching their relationship with the inevitable changes to their lives due to a child now being involved. Exhaustion and having to take care of the baby in the night were some of the contributing factors. Even after two years, they were still trying to undo the damage to the relationship:

> *"Our relationship really started to fall apart a little bit because we were affected by it. I did start to feel…not resent about Ben, but resentment about the fact that this wasn't as joyous as it should have been" (P4, 300-303).*

One participant described the changes in relationship dynamics and life together as really big and hard to digest. Before childbirth, they had a very close relationship as a couple, and they were aware of each other's thoughts and feelings all the time. However, with PND, the participant felt like they had lost that closeness to the extent that he felt like he did not know his partner anymore, as if she was not the woman he had fallen in love with. Additionally, they were unable to continue all their previous social and outdoor activities and were stuck at home most of the time. All of these combined to make the whole experience difficult to deal with:

> *"all of a sudden the dynamics of our relationship changed, you know, with our child being born. I wasn't her number one anymore, which for me was quite a bitter pill to swallow" (P3, 35-38).*

One participant faced the dilemma that his partner wanted to stay in an environment which was too hard for him to cope with, but at the same time he was unable to leave his partner and child alone during the PND; ultimately this led to almost a complete breakdown of relationship:

> *"Even though she was getting better, as a couple we probably had our most challenging couple of months at that point. Because I didn't want to leave her, and I didn't want to*

leave my daughter, but I also knew that I didn't want to live in the environment she said she wanted or needed at that time" (P1, 202-205).

There was one exception, where a participant described that the quality of relationship had improved as far as being more open and being stronger together was concerned, unlike the other couples. It seems that improvement in openness and communication can be a critical factor in changing the relationship for the better, rather than the worse. However, this was a more retrospective point of view after having come through the worst of it:

"It has hopefully helped us be more open, maybe her, in telling me how she feels, probably both ways. I think it's strengthened us because we've, kind of, supported each other hopefully through the worst of it, so you feel good in that sense, yes" (P2, 419-423).

4.2.2.4 Intimacy became challenging

Physical and emotional intimacy suffers because partners feel distant and isolated. Quality time together as a couple disappears even more. Stressful circumstances cause further complications for the sexual relationship.

Four of the participants indicated that physical and emotional intimacy with their partners was a lot harder during the postnatal depression and that it was very tough to deal with that. PND was very detrimental to the affective as well as the sexual side of being husband and wife. The challenges mentioned by the participants included feeling disconnected and isolated, the partners being withdrawn and wanting to be left alone, no time left to have their activities and moments together as a couple, emotional tiredness, physical tiredness, the need to support their partners and focus on their condition, and participants needing to have some time on their own. Most participants accepted the fact that intimacy will suffer after having a child and tried to cope with the situation by sacrificing their need for intimacy, but over time it became a challenge, and it was hard to live with their partners like that.

The fact that the mental state of their partners was not such that they could accept or partake in activities involving intimacy was clearly articulated by multiple participants. The sexual life suffered quite badly in all cases, but even activities like going out, hugs and kisses and anything

involving affection were also affected. For many participants, sexual intimacy was utterly impossible for very long intervals of time:

> *"Emily struggled with the sexual side of things, which initially was not a problem. But, then after a while it was frustrating for me as well that I wanted to normalise things and Emily had lots of feelings of problems with her self-worth and that affected her sexuality and that I found frustrating as well because I desired her and she wasn't in a place to be desired" (P4, 473-478).*

> *"it was a big, big impact, but how you can imagine it is more like…yes, basically not having time for yourself, even kissing would have been a problem because she wanted her space, she wanted to be left alone, so, yes, that was something I was really suffering about because it was already tough enough and I'm quite affective myself, I'm quite romantic and that. That was…yes, that was bad" (P5, 418-424).*

It seems that for one participant, just the reinforcement of the feelings of love for their partners was enough to be able to live without their need for intimacy being fulfilled in any other way:

> *"Physically it was very detrimental, you know, as a sexual relationship. I mean it was probably a year without being a man and a wife… Yeah I think for some people it would be a real burden and it would maybe lead them to places that they don't want to go. That really wasn't a problem for me actually at all … I knew that I loved Kate and that was reinforced a lot by going through it" (P1, 257-269).*

For one participant, the fact that he and his partner were not as comfortable as before in each other's physical space and wanted to have their own time was particularly significant. He felt like his partner was more withdrawn and wanted her own personal space compared to the time before PND:

> *"I'm wondering if we're less…when I say close, I don't mean emotionally or anything else like that. I mean, just physical and I don't mean from a, sort of, romantic entanglement way, I mean, just physically we don't, sort of, sit and cuddle up like we used to" (P6, 122-126).*

4.2.2.5 Existential perspective

This theme falls in both the social world (Mitwelt) as well as the physical world (Umwelt) of the four dimensions of existence. The findings suggest that when mothers go through postnatal depression, it has a huge impact on their relationships with their partners, and hence, the element of belongingness and how it is affected during PND ties this theme strongly to the social world. However, the other element at play here is the physical need for intimacy and how that affects the participants' experience. This discussion falls in the physical world (Umwelt) of the participants.

The dominant emotion for this theme is misery. The misery stems from and spans the issues the partners face in communicating with each other during their day to day life to the way the dependency of the partners on each other changes during PND and includes the way their relationship changes for the worse and intimacy becomes challenging. Participants feel miserable when they see their relationship suffering, and when they feel they cannot do anything about it. They felt wretched because of the ebbs and flows of the relationship, where sometimes there was a complete absence of any connection between the partners, and at other times things seemed to have returned to normal. All the participants in the study felt that connecting with their partners like they used to before PND became much more challenging for them. This led to them feeling very lonely and frustrated. This was further exacerbated by the fact that in some cases the partners became much more dependent on the participants and the participants felt almost trapped because they felt obliged to fulfil their role as supportive husbands, but at the same time they did not have anyone to lean on to themselves. All these feelings ultimately culminated in misery and suffering both for the participants at a personal and emotional level as well as for the partners suffering together as a couple, straddling the social and personal worlds.

The participants' response to the misery was multifaceted and diverse. When it came to communication with their partners suffering, some participants responded by accepting that this was going to remain hampered by necessity in the milieu of their changed reality. However, others were not able to passively accept this change and reacted with anger at the loss of their cherished partner with whom they were previously able to share the burdens and joys of life. The response of the participants to misery because of the change in the relationship dynamics with their partners was almost universally centred on frustration. In almost all cases, the participants strived to improve the situation, but none succeeded in the short term, resulting in

them tolerating the transformed life with a latent feeling of resentment due to the unfairness of the situation. The response to the misery because of the loss of intimacy with their partners was the complete converse of the above though because here there was an almost universal acceptance that this aspect of their being-with their partners was going to take time to recover. In almost every case even when the participants felt miserable because of it, they did not feel that their need warranted preference over the need to be responsive and empathic to their partners' needs which did not include intimacy at that point.

4.2.3 Universal theme three: Lack of support

Participants suffered from a lack of support when their partners were going through PND. Even though they yearned for someone that they could approach to seek support and get reassurance that they were fulfilling their role appropriately in the face of the harsh and challenging circumstances, participants were rarely able to find people around them who could help them in this regard. Even the people whom the participants believed should be the natural candidates for providing support, that is, professionals and the extended family, failed to address the participants' feelings and concerns in most cases and this ultimately resulted in a lot of frustration and disappointment. Some participants also reported that they themselves played a role in making support difficult because they did not feel comfortable seeking it at the appropriate time. This major theme has four themes as part of it including, *Lack of support for dads, Frustrated by the support network, Seeking support and reassurance* and *Missed opportunities for support*. These are discussed in more detail below, together with the usage of the emotional compass to identify and relate the participants' experiences with their predominant emotions and the existential perspective on that.

4.2.3.1 Lack of support for dads

Fathers feel ignored as compared to their partners when it comes to professional as well as familial support.

Five out of the seven participants who were interviewed felt that because of the impression that their partners were the ones who were suffering from PND, both the professionals, as well as the friends and families, focused on providing support to the partners. Thus, the participants got wholly ignored, even though they were very much part of the family that needed support

in reality. This was especially true as far as the mental health side of things was concerned, i.e. participants were expected to be able to cope with the emotional drain, the frustrations, the anxiety and the emotional tiredness. However, equally, on the physical side, they were expected to be able to provide effective support to their partners even when they were facing the challenges of lack of sleep, tiredness, being left alone to take care of the child and mother, and so forth:

> *"I was surprised that people were letting me get as tired and as, you know, run down as I was getting" (P1, 586-589).*

Some participants reported being envious of the fact that their partners were able to get a lot more support and help. It was hard for the participants to find anyone to talk to about the issues specific to them like the emotional and mental strain that they had to face coupled with physical challenges like tiredness and lack of sleep while at the same time there seemed to be a lot more resources available to the partners:

> *"I couldn't pick up the phone to someone and say, like a support worker or something and say, 'look I'm struggling. Can I talk this through?' That option wasn't there and at that point I think it's something that I could have really, really used at the time, so…I think I was almost angered by it" (P3, 581-585).*

> *"I think there's a good support for the mothers, but I don't think the fathers are necessarily thought of when it comes to help and support or learning about after the child's here and arrive" (P7, 326-328).*

The parents of the father as well the mother, were mostly reluctant to step in and offer advice, support or take on any responsibilities. This was particularly surprising for some participants who had expected their parents to be able to provide more help and support:

> *"I think we're both maybe a little surprised about how easily our parents let us get on with it. I mean, my wife's parents have their own things to deal with. So I guess maybe I personally was more surprised at my parents, that they kind of let me… Yeah. I thought maybe they'd jump in" (P1, 672-675).*

> *"I remember phoning my mum and my mum's response to me saying I've got a baby daughter and she's perfect my mum just said, 'well, every parent says that.' Thanks,*

cheers, you know. That was the sort of... It was heart-breaking. It was just that level of, kind of...I mean, that was only about an hour after she was born. I mean, you know, all these tears and a bit of an emotional wreck and my parents just hang up, just hang up, okay, bye, no problem" (P6, 472-479).

One of the participants was of the view that he would have benefitted a lot from having more support groups, more resources and advice being available, and more proactive attitude from various people who were available and around. Part of the challenge was that men were not comfortable discussing their problems unless it was a more formal arrangement, and all informal chat was diverted away from real issues:

"They used to get the dads together to try and talk about issues. We'd all get together. We'd go to the pub, have some dinner and a drink. They'd almost descend into chaos. People would stop talking about their problems and they'd be talking about football or golf or stuff like that. It was tough trying to find a proper support group for dads" (P3, 359-363).

However, as discussed below in the themes "Frustrated by the support network" and "Seeking support and Reassurance", the fact that the participants were desiring and seeking help is a recurrent theme, and although in some cases they did not find it easy to share their issues, this did not generally prevent them from seeking sources of help.

4.2.3.2 Frustrated by the support network

The lack of support and neglect by the professional and personal support network causes a lot of frustration and disappointment.

Four of the participants expressed their frustration about the fact that they were expecting their families and the professionals involved to support and help both the new mother as well as the father much better throughout the difficult phase of PND. It was a cause of major disappointment that no one informed them about the possibility and risk of suffering from PND or stepped forward to lend timely support on their own accord. In some cases, even after actively seeking help and support, it was not forthcoming for a considerable time which resulted in prolonging the period where both the participants and their partners had to endure quite a tough and challenging situation.

For two participants, the major source of frustration was the healthcare staff like the therapists, the doctors and the midwives who were involved and who did not adopt a proactive or helpful attitude. The participants felt that the professional should have known about the intricacies and should have provided advice and explained things upfront, which would have equipped the participants to cope with the upcoming challenges in a much better way. Also, some of the frustration was there purely because when the healthcare professionals were needed the most, at that time, they were not there to extend help:

> *"the whole thing could have been solved much more quicker if we would have found the right help at the beginning for both of us and that's something that was particularly annoying for everybody" (P5, 620-624).*

> *"It just suddenly felt like everything came crashing down and… not to have had the professional support is not great. The midwives we had, we did a hypnobirthing course, and the midwives all knew about Emily's problems and I think that they let us down as well. They should have been aware of it and it should have been targeted as being somebody at high risk" (P4, 104-113).*

Another source of frustration was the fact that in some cases the healthcare system considered the partners to have been "cured" as far as they were concerned and yet it was clear that a lot of work was still needed before they recovered to where they were before the start of PND. This left the participants feeling abandoned mid-way:

> *"The frustration is the worst one because as far as doctors and whatnot are concerned my wife is fixed, but knowing her on such a deep personal level I know they're not. I'm frustrated by a system that seems to, kind of, like, think they're done, push you off to one side and then you carry on" (P3, 247-251).*

In addition to the professionals, the parents of the fathers were considered to be an important part of the support network. Here again, a few of the participants felt frustrated by the fact that the parents were not as keen and proactive in offering help as they had hoped. It was understood that parents did not have any obligation to do so, but it was more the fact that the participants felt that this part of the support network could have stepped forward especially others were not as helpful as expected and yet, this expectation was also not fulfilled:

"I don't particularly have that relationship with my mum. I'm thirty-something now, you know. With either of my parents, I don't… I'm not particularly cuddly, which is fine, you know, that's kind of the relationship I have with my wife. But at that stage, you know, I'd had probably the toughest eighteen months, two years of my life, and probably hadn't sort of had a, you know, just a simple hug or something throughout that period. So I knew that I was lacking that, and that it was hard" (P1, 379-384).

4.2.3.3 Seeking support and reassurance

Fathers yearn for someone from whom they can seek support and reassurance whilst they are facing a tough and challenging situation.

Although seeking help and support was a recurring theme amongst most participants' experiences, four of them explicitly mentioned that they sought help and reassurance when their partners were suffering from PND. This was mostly triggered by the fact that the participants were facing a very tough situation, and they felt that they had been left alone to sort things out rather than being appropriately supported. In some cases, the participants were entirely passive and did not go out and share their difficulties to try to gain help or reassurance. They did desire support and reassurance about what they were doing, i.e. to know whether their acts were fine or not given the circumstances, but they were not actively seeking to fulfil that desire. However, two participants actively shared their situation and hoped to gain reassurance about their actions. The degree of importance attached to support and reassurance varied quite a lot as well. For a few participants, it was just something nice to have, but for others, the reassurance was a critical factor.

In one case, the participant reported utilizing available channels, e.g. the NHS as well as general internet resources to seek help and reassurance actively. He was quite keen to get confirmation from someone who was either in a professional role where they had to deal with mental health problems or from someone who had previously gone through the experience of PND. The excerpt below mentions an episode where he tried to call 111 in the middle of the night:

"even if it was midnight, I still call the 111, I think, to try to seek for help, basically reporting the episode and saying, 'what shall I do?' because I was thinking maybe it's a case of getting a jab of calming, something to calm you down. I thought that was the…I

mean, I thought that was a definite because she was still…even when she calmed down she was still anxious, so I thought maybe I should call the doctor" (P5, 187-193).

As mentioned earlier, the degree of importance attached to support and reassurance varied widely. For some participants, not being able to receive support at the right time resulted in strong feelings of being let down and even anger. Others were only looking for someone they could talk to, to lessen the feeling of being alone. Some were looking for emotional support and reassurance mostly and hoping that somebody could help them get their partner better somehow or lighten the load of responsibilities that the participants had to bear in isolation. Generally, the underlying feeling for all of them seemed to be the desire for someone to help them:

"The overriding thing was the anger that I felt towards the lack of support from family and most…from the therapist I think we felt really let down by him as well" (P4, 609-611).

"The most difficult thing, I think, is not having the support for myself, apart from talking to my parents really. I mean, a bit like (unclear 0:33:26) stuff for my wife, someone actually just asking and checking that I'm okay, how am I doing, sort of thing, to give me a chance to say, no, I need help or everything's fine and such forth from there really" (P7, 309-315).

"I hoped that someone would come up and help in terms of our life in our house. But probably more, I hoped that someone would turn up and make her better, that someone would know how to treat her illness" (P1, 533-536).

4.2.3.4 Missed opportunities for support

Some fathers believe that they missed opportunities for getting support because they did not feel comfortable seeking it.

The feeling that they could have made better use of some resources and opportunities was mentioned by a minority of the participants interviewed (three out of seven). The main reasons for not making effective use of opportunities were firstly, some reluctance to go into the required level of detail about their experiences and sharing them with others and secondly, not thinking deeply enough about the options to make use of them at that time. Participants felt

that the information about their experiences was not easy to share as it pertained to not only their personal domain but also to their family domain.

Sharing their experience even with close friends was deemed ok only if they were confident that they were going to get useful advice, in particular, if there was someone who had had prior experience of similar circumstances. For one participant, aversion to being considered a victim was the main source of reluctance. He did not even consider asking for support because he did not want others to know about his difficulties as that could potentially lead to people treating him differently:

> *"You don't want to try to speak with someone and they say, 'oh, I don't know anything about it' and then they know all your business and be no help basically" (P5, 405-407).*

> *"I don't want to be a victim or someone who needs to be given special treatment for whatever reason. Yes, I don't want to, sort of, make it like I'm a victim of something" (P2, 321-323).*

Unlike the others, one participant was reluctant even to go the GP and speak about his experience because although he would have welcomed help to fix the problem, he thought it was more something that he wanted rather than needed. However, reflecting during the interview, he thought it might have been a good idea to have done that:

> *"In my eyes there wasn't a problem with me. There was a problem with my wife that I needed help to fix, so I didn't want to go to a doctor and take up an hour slot where someone who is sick might've needed that instead of me" (P3, 393-396).*

4.2.3.5 Existential perspective

This theme falls squarely in the social world (Mitwelt) of the participants as it pertains to the deep-seated need for interaction with others and the desire for support from others that the participants craved in the face of the harsh circumstances when their partners were suffering from PND. The social aspect, of course, underpins all the themes that are part of this universal theme. The behaviour of others around them strongly influenced the essence of the participant's experience. All the feelings and emotions occurred in the backdrop of how the participants perceived the actions of both friends and family as well as professionals and how they responded to them.

Participants experienced a variety of feelings and emotions when it came to seeking or wanting support from others ranging from their hope and desire for support to anger about the way they felt ignored by both professionals as well as friends and family. This turned into frustration when they felt as if they had been left alone in challenging circumstances which they were not able to overcome and improve themselves and over time some participants started to feel desperate about the situation. At the same time, they saw their partners getting a lot of attention and support, and this inevitably generated some feelings of envy and even jealousy. Some participants partly held themselves responsible and were confused about their own role in making support challenging to obtain because of their own reluctance to make use of potential opportunities. Looking at van Deurzen's emotional compass, from the starting point of hope and desire the participants' experience undergoes a progressive downward spiral through the negative emotions of jealousy, anger, frustration, despair and confusion. While this paints a sorry picture of struggle and misery, the degree to which participants craved support did vary quite significantly and not all participants were affected by all the negative emotions with the same severity. However, generally, the perceived lack of support affected almost all the participants negatively during the time that their partners were suffering from PND. The next universal theme discusses how the participants coped with the downturn and held on to their strength to survive the situation.

4.2.4 Universal theme four: Surviving the situation

Coping with the challenging situation was a major theme discussed by all seven participants. Whilst the actual strategies and mechanisms used to survive the tough circumstances varied according to the details of the situation and the individual, some general factors were identifiable. These included the ability to occasionally forget about all the challenges and get on with what needed to be done, as well as focusing on the positive aspects and keeping all the negative factors from overwhelming their thoughts. Four participants stated that for them at times, it was unavoidable to disappoint their partners or work colleagues because it was not possible to meet all demands at the same time. Four participants out of the seven considered sharing their experiences with others to be essential to be able to cope. Overall, there were three different themes based on slightly different aspects of coping that constitute this major theme, including *What helped in coping, Impossible not to let people down* and *Talking about the*

experience. Below, I discuss each of the themes individually and then utilize the emotional compass to further illuminate the experience of the participants and the range of emotions.

4.2.4.1 What helped in coping

To cope with situation, it helps to have a positive outlook and relish the little joys of life. At times, the ability to switch off the brain also becomes vital.

Almost all the participants described their own particular ways of coping with a difficult situation when their partners were suffering from PND, and only a few things were common, notably the ability to bury the emotions and to adopt a practical approach. Most of the coping strategies were different and depended on the individual circumstances, from having one night on their own each week, to shouting in the soundproof freezers at work. The activities could be quite routine and straightforward as long as they were things that the participants enjoyed doing, for example, something as simple as cycling to work or listening to podcasts were enough to help give participants a break that they needed. The underlying common element for most of the strategies was to do something which was not part of the responsibilities of work, taking care of household chores and supporting their partner and child. For some participants, the coping strategy did not involve any physical or practical activity at all; for them, it was more centred on self-counselling, reminding themselves not to lose hope and thinking about past experiences where they got through adversity or had their family support them through a tough time; generally, having a positive outlook even during the worst circumstances. The participants felt that they could not allow themselves to be emotionally down when their partners were suffering from PND, so they just had to get on with everything.

Thinking about positive and joyful things and participating in pleasurable activities was mentioned by multiple participants as good ways to relieve the stress and recoup their ability to manage. In addition, just forgetting about negative experiences and pushing them to the back of their minds was also an effective strategy for some participants:

> *"I force myself to look at the smaller wins, the smaller happy side of things. Sometimes it takes a good hour or so to see that, but I always try and…when I find myself at the bottom of the well I always try and look up and see what we've achieved so far, even just throughout that day" (P7, 84-89).*

"I'm very forgetful [chuckle]. I think in this situation it can be because I can just go, that happened last week and it's no longer part of my memory and motivation, so I can't dwell on little things because I just forget about them so easily" (P6, 200-206).

"I think I probably look for support by switching my brain off and doing things that I enjoy, you know, like reading, just turning my attention to other things like reading or working on my bike" (P2, 502-504).

Professional life was described as an important factor by quite a few participants. It allowed them to take part in an activity that they liked or that at least posed a different set of requirements on the participants compared to the role that they had to play at home. Specifically, support from the bosses at work was termed quite helpful by the participants, including in one case providing the participant with an opportunity to express his pent-up emotions by having a shout in soundproof freezers:

"For me work was an escape, you know. I didn't have to talk about the depression that was going on at home. I didn't have to talk about the arguments. I could almost forget it at work, which was quite nice because we're always busy it meant that I had something to preoccupy my mind with" (P3, 108-112).

Generally convincing themselves that they had to get on with life even if there were challenges at the point in time when the partners were going through PND, was a common response from several participants. They had to stop worrying about the longer term and started to take it one day at a time. For some participants, prior experiences from their own childhood were helpful in the present situation as well:

"it was a case of just bury…you know, doing the traditional male, British, thing of just forgetting my emotions and just burying them over there and ignoring them from now on and hoping that solves the problem, hopefully. Anyway, that was where…yes, I'd say that was my biggest coping strategy" (P6, 318-323).

"growing up with ADHD I got taught ways of dealing with my emotions without…because when I was a young child I was quite physical with people when I got angry and I'd cry if I got upset, but I learnt mechanisms of that of how to deal with it, so to an extent I kind of

self-counselled myself through it. Even now I still do it now, nearly two years down the line. It's hard" (P3, 59-64).

It appears that the experience that the participants went through, although painful and challenging, actually helped them to grow in themselves, and to develop their capacities to cope with life's difficulties.

4.2.4.2 Impossible not to let people down

It is impossible not to let some people down in order to be able to cope with the demands of the situation.

Four of the participants expressed the feeling that they had to let people down to be able to cope with the stresses of the situation in which they found themselves. Out of those, three were mostly concerned about letting their partner or child down. Participants felt that they had not been able to extend support to their partners to the degree that they desired. The issues preventing the participants from being able to do more were the limits of physical and emotional reserves that they possessed as well as limitations like availability of time and the demands of professional life.

It was quite clear from the descriptions of various participants that PND posed a lot of stress on the emotional state of the participants. Even when they tried to shoulder the responsibility for supporting their partners to the limit of their abilities, over time, it took its toll on the participants. The participants reached the point where they needed to push back a little bit, for example about things like the time when they went to bed, how often they were able to listen to their partners and other such support activities. The key was finding a balance between keeping themselves functional and providing support to the partner and family at the same time. Whilst most participants could not shake the feeling that they should have done a better job of supporting their partners, they also realized that there were not that many options available to them and the push-back to some extent was a necessity:

"there were points where I had to not give my wife what she wanted in order to keep within the boundaries of what was acceptable to me" (P1, 422-425).

"Occasionally I think I came across as very uncaring to her because at times I thought I couldn't take anymore on. I felt like at times I couldn't listen to my wife because I had nothing to…she would give me more emotional, and I don't mean this in a rude way, but more emotional baggage that I just couldn't deal with" (P6, 710-718).

"in hindsight when I look back there wasn't much more I could have done to help, but at the time you feel like…I felt like I should have done more to help her, I suppose, the thoughts of there always must be something more I can do to help, but you don't know what to do to help her more" (P7, 202-205).

Whilst for most of the participants work, or professional life helped them to cope with the situation and allowed them to recharge themselves, one participant mentioned the demands of work and family life competed with each other and it became impossible to meet all the demands placed on him at the same time. This was the exception though rather than the experience of the majority of participants:

"You feel guilty because you want to spend all your time with your wife and child, but then you want to spend more time at work because people are going 'we need this, we need this.' Yes, it wasn't stress. It was, like, guilt that you couldn't do both at once" (P2, 155-158).

4.2.4.3 Talking about the experience

The need to share the experience with others and maybe get some encouragement is satisfied by talking to friends, family or work colleagues or even talking anonymously online.

Four of the participants discussed the need to share their experience with others. None of them reported any negative connotations associated with sharing whilst two of them stated that sharing had a positive impact on them. The participants shared their experience with a wide variety of people, including friends, work colleagues, family members and people not really known to the participants but whom they met anonymously on the internet.

Friends and close colleagues both seemed to be good choices as far as sharing was concerned. Hearing some encouraging words from someone even when they did not know all the details seemed to have a positive impact on the participants. One of the participants was actively

encouraged by his partner to find some help for himself and talk to someone because she could see that he was trying to keep everything in and it was becoming too much for him to bear:

> *"I've got some very close colleagues, work colleagues, who I could talk to and they were parents and things like that, so I was able to bounce things off them and turn to them a lot and I probably did that more than I should have done… I didn't share my feelings, but sort of the situation I was in" (P6, 308-313).*

> *"I was so desperate in the end I spoke with some of my friends because it was so hard to keep everything in. Yes, that's something I shared the emotional experience" (P5, 319-321).*

Even briefly discussing their experience a little bit with unknown people on the internet was helpful for one participant as he was able to get some tips anonymously. Another participant wanted to share his experience with his brother because his brother's wife was going to have a baby soon and he wanted his brother to be better prepared mentally for the potential hardship that he might have to experience. Generally, for the fathers who were interviewed, sharing the experience almost always resulted in a positive outcome with the caveat that almost all of them were careful about how and whom they shared the experience with:

> *"sometimes I go on, like, a web forum for bikes, like cycling, so nobody knows me there. I did mention…there's a discussion about parenting and I have talked about it there, but like anonymously" (P2, 354-357).*

> *"I try to be quite a brutally honest person, so I had it with my brother where I've turned around to him and told him a lot of the downs and a lot of the ups at the same time. His wife's emotionally fragile. She's not depressed or anxious at all, but she's a bit emotionally fragile, so I've shared a lot of my experiences with the frustration and feeling down the well, so he's more prepared" (P7, 336-343.)*

4.2.4.4 Existential perspective

This theme touches upon both the social and spiritual worlds of existence (Mitwelt and Uberwelt) as the experience of participants is influenced by how they could or could not interrelate with others. However, it is also clear that to a large extent, what helped in coping was to think about what the participants held as important and what they valued in their lives.

Irrespective of the details specific to each situation and individual, the common element in the experience of all the participants was adopting a positive outlook and holding on to hope with courage and resolve when they were facing some of the most challenging times of their life as a father. The participants focused on every little joy and every small win that they could find, and it helped to tide them over tough times. Things which could have been considered inconsequential previously now helped participants when everything else around them seemed to be disintegrating. For some participants, it was a case of self-counselling, not losing hope and participating in any pleasurable activity no matter how small. However, coping involved a lot more than just the inward facing strategies. It had a distinct element of social interaction and leaning upon sharing the experience with others to hear some words of encouragement to reinforce their courage and resolve. Another important aspect was being vigilant about how to balance their needs and responsibilities. Participants realized that it was impossible to meet all expectations and discharge all responsibilities as a husband, father, breadwinner and homemaker at the same time. Compromises were bound to be there, and occasionally, the participants had to disappoint someone to be able to cope with the demands of the situation. Being aware and finding the middle-ground was very much part of the successful coping strategies of all the participants.

Looking at van Deurzen's emotional compass (2015), this universal theme is strongly attracted towards the positive emotions of hope and holding on to that hope with courage and resolve. This is evident in the positive outlook adopted by participants as well as in gaining encouragement and freshening up their resolve by sharing their experience selectively with others. Whilst the aspect of inevitable compromises did pull the experience downwards in the direction of worry and watchfulness; the overall experience remains tied firmly to hope and courage in the face of challenges and overcoming the adversity to survive as a father and partner. The attraction to courage seemed very important for the participants. In a way, there is equitability here with other great struggles that people face during their lives. We can find a homologue for the struggle of the participants to cope with the challenges thrown their way, in the struggle of individuals who go to war. It conjures up images of men being tested, and of them discovering that they need other men to stand with them. As the experience matures and is assimilated, they also discover the importance of doing something so character forming, something which enhances the make-up of their self and results in personal growth.

4.2.5 Universal theme five: Living with her PND

Life with their partners who were suffering from PND presented enormous challenges for the participants on the emotional as well as the practical side. On the emotional side they were extremely worried about how, when, if and to what extent their partners would recover, there was a deep-seated fear of losing their partners, and that they could end up having to dig deep to gather the courage to face all the relentless physical and emotional problems that kept cropping up. On the physical and practical side, they had to overcome the challenges of lack of sleep, extreme tiredness, learning new skills and finding a way to support the family as well as the work life. In addition, they had to be vigilant and monitor everything they said or did and see it through the glasses of what effect it would have on their partners. This major theme was discussed by all seven participants, and there are five themes that constitute it including, *Concerns about recovery, Fears about losing wife, No embarrassment, Challenging to be strong for the wife* and *Being careful about what I say*. It is clear from the discussion of the themes below that participants go through a turbulent time with respect to their emotions whilst facing the challenge of life with their partners who were suffering from PND. The nature of the emotional turmoil is further analysed with the help of emotional compass below.

4.2.5.1 Concerns about recovery

Fathers worry about the longer lasting effects of depression on the family as a whole including their wives recovering and functioning normally again and whether their relationship would survive and return to what it was.

The majority of the participants interviewed were worried about the longer-term implications of their partners having PND. Their worries were universally centred around whether the partners would recover fully to what they used to be earlier. However, they were also concerned about whether their relationship with their partners would be able to survive until the end of PND, how long the whole process would take, whether the medication and treatment would be successful and what its side-effects were going to be. They also worried about whether their child was going to be affected in any way, what the financial implications were going to be for the family if the partners did not return to work as before and so on.

Just having the confidence that PND was a finite illness and would end at some point was very encouraging for some participants, especially the ones who had not thought about PND in those

terms before. This did not fully alleviate their longer-term concern about whether the partners would be going back to being completely "normal" or back to what they were before PND, but it did give them hope that PND would end eventually. However, the worries about whether they would be able to sustain the family until it ended were still very real for some participants. Also, even when the participants were mostly convinced that their partners had recovered to a certain degree, the fear of the worst events and experiences kept lingering on. They were still apprehensive about leaving their partners alone for fear of the worst type of episodes recurring:

> *"Biggest concerns are that she wasn't going back to normal, I would say, and that this would take a long time to recover or…sorry, that she would never be back to the same level or that it would take a long time to go back to the same thing and so basically, I was fearing that in the end we was going to split or something for whichever reason. Not necessarily from my side, but because she wasn't herself and I was fearing that in the long term we would not exist as a couple, but that wasn't an option in the end." (P5, 605-613).*

> *"I think the biggest problem for me was once I felt that she was getting through the postnatal depression, perhaps she wasn't". (P4, 317-321).*

Two of the participants were significantly worried about successfully recovery, e.g. wondering if they would have to live with a different person to the one that they had married or whether the treatment and medication would be useful or not and the side effects it would have. They also worried about their baby in the sense that PND was going to have long term effects on it. One of the participants expressed his particular concerns about the financial outlook for the family and how it would change if his partner were not able to successfully restart the job she had been doing before PND:

> *"you worry that it will affect the baby, because baby's pick up on…you know, he's at important developmental stages, so developing all the time and, you know, he's got to learn about emotions and behaviour and stuff. You worry that if, you know, your wife's really depressed then it will affect him in some way" (P2, 403-407).*

> *"I was aware she was very close to having a breakdown if she hadn't already had one, and what were the long-term implications of that? Was I gonna live with someone who never got better? Thinking about it that was probably my biggest worry in a way, was that I would have to look after a wife as well as a child" (P1, 144-147).*

This theme pertains to the dimension of time because the concern and worry here are about the tableau in the future era, with the realisation that the present situation is only transient. It was vital for the participants to all retain faith in their life mutating into a new reality when the current constraints and limits will no longer dictate the make-up of their family life, but they wondered what that future held in store for them.

4.2.5.2 Fears about losing wife

One of the biggest fears is about your wife becoming suicidal or just disappearing and leaving the family. You worry about not being there when she is feeling awful. The effect on the child is a further source of apprehensions.

The majority of participants interviewed described one of their biggest apprehensions and fears being about their partners leaving or disappearing or in quite a few cases, committing suicide. This feeling was rooted in the fragile state of mind of the partners when they were suffering from PND. Participants could not trust their partners about not making an impulsive or irrational decision on account of their deep sadness and inability to find any joy in life, and because there appeared to be no way to "fix" the situation. This led the participants to believe that the partners may choose to leave or give up. As a natural part of this apprehension, participants became anxious and reluctant to leave their partners un-cared-for for any length of time because they could not predict the reaction to any difficulties that the partners might have to face even in their normal day-to-day life. This made it hard for the participants to spend time on their own or even in some cases spend time at work because they were worried about how the partners felt when alone:

> *"we'll be texting all day and sometimes she'd not text for half a day or a day and that was usually like if she was feeling really bad. Sometimes she'd send me a message and be like, 'oh, I feel really bad' then it's just worry because you're not there" (P2, 218-222).*

> *"I do sometimes worry about my wife's life because she disappeared off for time on her own and I was worried she was going to do something stupid. I was very worried" (P6, 440-442).*

"There was times especially at the beginning there was fear where I worried that we couldn't get through this as a couple because I've been through a divorce. There were one or two occasions where I thought Emily could become suicidal" (P4, 356-359).

Participants felt that it was their responsibility to keep the family unit together and not let their partners decide to leave because they were all safer and better together. This meant they had to try to convince and manage the fragile emotional state of their partners. In addition to the main worry about the couple not being able to survive the period of PND and still be a couple at the end of it, the other big fear was the effect on the child in case of the mother leaving or separating from the father. Most of the participants tried to convince themselves that their partners would never make a decision that adversely affected the child, but they could not lose the feeling of lack of confidence about this. Overall, this further contributed to the anxiousness and fear of the participants:

"That was a huge fear, was that she'd just up and go and leave me and my daughter behind. There were several times that she'd spoken about it, just saying it's not fair on either of us to have to put up with her the way she was and…but, luckily, I talked her out of it, pretty much. I had to for the sake of all of us" (P3, 321-326).

"I remember often thinking, you know, you might get home and there might be no one there. I guess I started becoming a bit apprehensive about my daughter. I didn't think that she would do any harm to our daughter, but it was clear that she was really struggling with her mental health, so a little bit of you is just hoping that everything's all right when you get back" (P1, 126-130).

4.2.5.3 No embarrassment

There is no feeling of embarrassment or guilt because your wife is suffering from PND. You may not disclose it to prevent negative responses but you don't feel ashamed.

Almost half the participants (four out of seven) mentioned that they never felt ashamed or embarrassed about the fact that their partner was suffering from PND. A few felt that having PND was quite "normal" in the sense that quite a few women suffered from it after childbirth whilst the others thought it was just like any other illness; in either case, there were no associated feelings of shame, rather feelings of respect and admiration for having come through adversity:

"I was no way embarrassed. It was obviously overwhelming love for my daughter, respect for my wife for going through all of this, yes, massively and serious massive respect she's gone through so much stuff that I couldn't" (P6, 616-619).

As far as disclosing or discussing with others was concerned, the attitudes differed. One participant thought it was better to be careful about whom to disclose the information to because he wanted to avoid getting inappropriate and maladroit feedback from others who did not fully understand and appreciate the intricacies of the situation. Another participant could not care about who knew because, in his view, people whose behaviour was inappropriate were themselves at fault, and he or his partner should not have to care about them. One of the participants even felt that attitudes were changing in the society about PND; it was almost becoming a rite of passage and people were proud rather than embarrassed by it:

"You try to hide it a bit to keep it private, but not because you…I wouldn't call that shame though. It's more protection I would say… Protection from having the wrong feedbacks of people start to think, oh she's depressed or should be avoided or she's a bad mother" (P5, 295-302).

"If people are going to discriminate against you because you've got a mental health issue then that's their problem. You don't discriminate against somebody who has cancer or who breaks their leg, so I didn't have any shame over it" (P4, 422-425).

"there's more and more women out there that are coming forward, the embarrassment stigma of it, I think, is gone almost, the embarrassment of PND. It's almost like…you know, you hear these parents talking about it now almost like it's a trophy. I've had it, I've come through it, you know, there is another side to it" (P3, 273-277).

4.2.5.4 Challenging to be strong for the wife

Supporting wife during PND is deemed to be a very hard task. On top of the physical effort, providing emotional support whilst having very little reserves themselves becomes a big challenge.

It was evident from the interviews that it was a very hard task to be strong and keep providing the emotional and physical support required by their partners. Stress, induced by the physical effort and tiredness coupled with stress because the participants could not lean upon their partners emotionally, and had to manage their own emotions alone all added up to making it very challenging. Financial stress was also mentioned as a factor by one participant.

On the physical side, the main factors that made it hard for participants to spend quality time with their partners or support them properly included missed sleep, lack of energy, day-to-day household responsibilities, looking after the child, getting no down-time for themselves and generally being extremely tired most of the time. On the emotional side, the main factors were managing their own frustration and sadness, trying to be sympathetic, overly positive and happy all the time and absorbing all of the partners and their own emotions and not getting any opportunity to express or offload them. One participant reached the point where he started thinking about giving up, but then the feeling of being there for his partner overcame other feelings:

> *"I was just there trying to be strong for her, but as I said, I was almost like a sponge just absorbing all her emotions as well as all of mine" (P3, 166-168).*

> *"it was quite a challenge to know what to take on. Because if you're going to work and you get home, you can either look after the child, or you can make the meal, or you can spend time with your partner, but you can't really do all three" (P1, 440-443).*

> *"I thought about giving up a couple of times or even more, but obviously it's normal. I don't even know what it means, giving up, like, I felt like being somewhere else or something, but it wasn't an option. Obviously, things are like come on this isn't going to go anywhere or something. Yes, then at the same time I was having some other emotion about being strong, being stronger for her and being there for her and that was something that overcome the other feelings" (P5, 142-149).*

Although it was not common for most participants, the professional life and financial stress was a factor for at least one participant, which made it harder to provide stability and support to his partner whilst she was suffering from PND:

"It's quite stressful, a lot of missed sleep. It cost me one job as well and also quite a financial…it cost me more financially, I think, yes, just in terms of spending money" (P7, 11-13).

Learning how to be strong in the face of adversity was an important personal learning for the participants. The primary feeling was being strong for their partners because the wellbeing of the partners was most at risk immediately. The participants have mentioned elsewhere that they could not let themselves be vulnerable for the sake of the child who was also involved in the scenario. They were prepared to sacrifice their own needs and give precedence to the needs of their partners during the crisis period. However, the focus of the experience described in this theme is on that precedence taking over and being the deciding factor in their lives at that point in time.

4.2.5.5 Being careful about what I say or being reticent

You are forced to be reticent about expressing your feelings because of the fear of putting pressure on your wife and having a harmful effect on her. Also, she may view it in a different way and react adversely.

Expressing their feelings or even making queries about general day-to-day affairs was not straightforward for the participants when their partners were suffering from PND. The primary concern was not pressurising the partners who were already mentally stressed and very anxious about everything. Anything said by the participants that could be perceived in a negative light was always picked up on and ultimately generated frustration for both partners. This made the participants very wary of expressing their thoughts and feelings or even asking questions. They had to be careful about what they said and how they said it:

"I didn't want to put any more pressure on her. With her depression and anxiety if I started saying I feel low then it could have a negative effect on how she is and how she's feeling" (P7, 228-230).

"you kind of worry about something else, you know, not wanting to put pressure on her, not putting pressure on my wife, knowing that the last thing she needed was any more stress, pressure or…you know, so I was just having to, sort of, try my best to be there for

her while doing everything else, you know, without ever trying to…without there being a complaint, but it did feel like if I ever did mention anything that I wasn't happy with or anything else, then that would…that'd be the worst thing I can do" (P6, 427-434).

The reaction of the partners to any queries was quite adverse sometimes and whilst the participants knew that this was because the partners were feeling bad themselves it still became somewhat of a challenge to even talk about everyday life matters in some cases because everything was perceived as a criticism. Even for the participants whose partners were not affected by PND in a severe way they still had to be more aware of how the partners might be feeling:

"I was asking her something about the baby, for example, 'why did you do this?' not because I wanted to criticise, because I wanted to know because I wanted to learn myself for example and her perception was always that I was criticising her or was going to say something bad" (P5, 544-548).

4.2.5.6 Existential perspective

This theme is expansive, and it spans multiple dimensions of existence, including the Social world (Mitwelt) and the Personal world (Eigenwelt). The essence of the experience here is struggle and challenge to such an overwhelming degree that participants are in danger of being overcome by mostly loss-related, negative emotions and thoughts which affect most spheres of their existence. Plotting the themes against van Deurzen's emotional compass and looking at the experience of participants as a whole, it appears that not only do they have to face enormous personal challenges, they have to take responsibility for most of the social and outward-facing aspects of family life because their partners are not able to help them with those at that time. In addition, they have to evaluate what they consider to be important and worthwhile in the milieu of their changed realities and make a conscious choice to prioritise spending their physical and emotional reserves on things that would benefit the whole family.

With their partner suffering and struggling to an extreme degree with her PND, most participants started wondering when and indeed if ever they will see their partners fully recovered to what they were before PND and whether their relationship and family will survive the experience. In addition to this constant worry, in most cases, the participants also became apprehensive about losing their partners forever, either because of the partners leaving the family or deciding to take their own lives. Confronting, or facing up to the existential given of

death was a very important facet brought to the fore by this apprehension of the participants. The risk of suicide of their partners was not only a facing up to death for the participants, but they were also continually confronting the possibility of the loss. All this emotional fragility did not come alone, however. The participants had to gather their courage to concurrently deal with the day-to-day realities and needs of life, supporting both their partners and child as well as taking care of work and financial aspects. They could not be vulnerable themselves and stay strong in the face of physical tiredness and effort was complicated by factors such as lack of sleep and the constant need to be vigilant about how they behaved and what they said, in case it had a negative effect on their partners. It appears that participants found real strength only when they noticed their weakness and vulnerability. Despite all the struggles, most participants held on to their sense of pride and felt no embarrassment or shame because their partners were suffering from PND.

4.2.6 Universal theme six: Personal challenges

All the participants who were interviewed reported being personally stretched to the limit by the magnitude of the challenges facing them while living with partners who were suffering from PND and almost all of them felt confused and lost in the face of the problems that they had not envisaged and which they could not figure out how to tackle. For four participants, this ultimately resulted in feelings of powerlessness and incompetence to such an extent that they became despondent about the situation. It felt like they were dealing with a crisis so that their main concern at times was just getting through each day and surviving. One factor that resulted in increased misery for a few of the participants was their own reluctance to open up to others unless they were confident that the other person would be able to help. Here what can be thought of as traditional male characteristics of being strong and being able to cope without seeking help worked against the participants and resulted in increased wretchedness. Five themes constitute this major theme including, *Tough to deal with the situation, Not knowing how to deal with it, Day to day survival, Feeling powerless* and *Not opening up*. These are discussed in more detail below, together with the usage of the emotional compass to identify and relate the participants' experiences with their predominant emotions and the existential perspective on that.

4.2.6.1 Tough to deal with the situation

It is very tough to deal with as life becomes chaotic with all sorts of physical burdens and emotions piling up together. You cannot make sense of what is affecting you and how it is affecting you. You become despondent thinking you can't have any impact on the situation.

The magnitude of the challenge faced by the participants was quite clear from their descriptions about how hard it was to deal with the scenario when their partners were suffering from PND. Multiple sources of stress all acting at the same time made it very difficult to make sense of what was happening around them and how they were getting affected by it. Hit by the mounting demands on the physical as well as the emotional side and with the lack of time to stop and make sense of anything, participants started to lose hope that they could have any effect on things which further exacerbated the emotional burden. They started wondering how the whole thing would ever end or how the family was going to cope. The things that their partners were responsible for in the day-to-day life earlier now became their responsibility, and they had to become independent. Furthermore, the fact that they did not see a way of making an impact on the situation made the participants feel like they were not in control of the situation, as if they were mere passengers, just going along for the ride:

> *"Tough, very tough. If I had to pick one word it would be tough. It's a bit of a roller-coaster. There's a lot more downs than there were ups throughout it" (P3, 4-5).*

> *"I wasn't number one priority anymore. I had to learn to fend for myself, you know. Where we'd always been together she'd always done the clothes washing and the ironing. That was just how it was. I did everything else. But, now even that's had to switch because she's the main carer of our daughter. I had to become independent. I had to almost learn again how to do these things" (P3, 429-434).*

> *"I think it's probably not able to impact on it and again you just feel you're just going along for the ride and you're not actually part of it, part of the change" (P4, 256-259).*

A factor pointed out by multiple participants was the inability to logically think through the problem when they were going through the tough times. Both the participants as well as the partners, were unable to rationally analyse the issues which made it harder for the whole family to find the way out. It was day-to-day, short term thinking rather than long term planning:

"You can get lost in the moment of frustration a lot, thinking this is never going to end, how are we going to cope? It, sort of, all floods in when you're trying to calm down my daughter or my wife when they have moments of franticness, I suppose, or depression. You get a bit sucked into how are we going to cope? What's going to happen next? The, sort of, flooding emotions of how are we going to cope in the next hour, next day and such forth from there really" (P7, 70-76).

"I mean, now it's coming up to just over a year since my wife's counselling finished and there's still residues of the emotion and everything leftover, you know, that's not something that just heals and goes away. But, at the time not really thinking about this because it's not something that starts and finishes, it's just a gradual change and because it's an emotional welfare you don't really have time to stop and think about it and work out how you're feeling" (P6, 657-64).

4.2.6.2 Not knowing how to deal with it

You find yourself ill-equipped to deal with the situation and are surprised about how horribly bad it is. You never know enough about it beforehand and feel lost, not knowing how to cope with it or how to support your wife.

Every participant who was interviewed except one mentioned that they were unprepared for their partner's PND and did not know how to deal with the situation. For a few of them, it was a completely new thing: they had never had any mental health issues or been with anyone in the family who had mental health issues. Hence, they were very unsure about how they were supposed to respond to the situation where they were mostly in charge of the family's welfare and taking care of their partner who was dealing with mental health issues:

"That's something that we did struggle with was how to support her because I had no idea, absolutely no idea because, you know, at the same time we're trying to look after a child" (P6, 276-278).

"It was tough. Well, mostly because it was something I have no clue about, literally I don't know how to help, what was it, like, what could I do. I was doing something based on my pure instinct" (P5, 39-43).

For others, who were aware of the fact that quite a few women suffer from PND, they were still unable to appreciate how bad it was going to get and how challenging the whole situation was going to be. None of the participants reported that they had even a reasonably good idea about what PND was going to look like or mean for them and the whole family. Thus, faced with this situation, they felt unable and unqualified to deal with it. The participants were surprised that they had been left in charge when they did not feel as if they were ready:

> *"I always thought it was a bit of a myth, to be honest. Until it personally affected me I, kind of, thought it's because you're at home all day with the kid and you don't have a lot of adult interaction. I didn't quite believe it if I'm perfectly honest. Then when my wife got it there's no denying it's horrible. It's really not nice. Before I knew nothing about it other than it's something ladies got after having a child" (P3, 16-21).*

> *"I was sort of half prepared. I knew it was going to be quite tough and quite hard going, but until it happens I didn't really know how bad it was going to be or not" (P7, 320-322).*

Multiple participants also mentioned the feeling of shock and surprise. One of them was utterly shocked that his partner could be diagnosed with PND because even when he knew she was feeling sad, in his mind, she was very far from having a fully diagnosed mental health problem. For another participant, the surprise that he was the only one taking care of his partner day-to-day was tough to come to terms with. He felt that with him having no prior experience, training or professional qualification it was very surprising that no one except him was monitoring his partner and supporting her even when she was suffering from quite severe depression:

> *"Yes, that was kind of quite a shock because you go from, you know…in the morning she was like, 'oh, I might have depression' and then I came home in the evening and she had antidepressants, so that was quite a shock" (P2, 32-34).*

> *"I think it was more frustrated maybe that I was just… Yeah, that this was… That there wasn't someone more qualified dealing with it. So I didn't really feel helpless. I knew that we kind of could be helped, I was just surprised that wasn't happening and I didn't know how to get it" (P1, 576-579).*

4.2.6.3 Day to day survival

It feels like you are passing through a crisis and just day-to-day survival becomes your concern. You just push yourself and try to do the right things in the hope that things will settle down but it feels like you are desperately fighting for survival.

Four out of the seven participants stated that at times, their main concern ended up being day-to-day survival. Even after their best efforts to improve the situation, they were not able to have any real impact. Rather than trying to solve the issue or find a solution their attention had to focus on trying to do what they needed to, to get through the difficult times in the hope that things might take care of themselves over a more extended period. The daily routine was aimed at doing the necessary jobs like taking care of the child, the daily domestic chores, sleep and work and the cycle was repeated without any opportunity for the partners to spend quality time together. There was no time or cause for celebration, no real emotional connection, no thought about the future, just crisis-management, and an effort to keep the family unit functional:

> *"There wasn't the cause to celebrate. It was, sort of, yes, there were…yes, you know, there were minor things, but there wasn't ever that feeling of milestones, you know, so sort of birthday came and went, and it was just constantly…we never stopped really to smell the flowers. It was just, sort of, one day and then the next day then the next day, sort of, hoping…from my point of view hoping that in a week or in a month or whatever we'd be feeling better and that" (P6, 593-601).*

> *"When we were in the thick of it we were literally crisis managing and I didn't think about the future" (P4, 196-198).*

> *"Yes, so it was hard. Again, it was putting more pressure onto myself to do what I could to help my wife, so that was really hard" (P3, 454-455).*

The participants were pushing themselves all the time to do the right things, pushing themselves at work and pushing themselves at home to support their child and partner until things became really challenging and hard. Some participants started to feel quite desperate about themselves at that point. They felt like rather than supporting the family effectively, they were just surviving themselves, and this was alarming because with their partner and child being vulnerable, they could not afford to be vulnerable themselves:

"My self defence mechanism switched off, and just shut down from things around me, so I've become very internal. And I could feel that was happening to me. I could feel that I was just getting up and surviving, and that worried me because obviously when there's three of you, and my child is vulnerable, and my wife is vulnerable, you start thinking, well I can't really be vulnerable myself" (P1, 137-141).

4.2.6.4 Feeling powerless

There is a strong feeling of powerlessness and incompetence because you cannot do anything to make your wife feel better.

Not being able to have a substantial influence or impact on the situation resulted in some participants feeling powerless and helpless. The primary reason participants felt they could not have any appreciable impact was that the core issue was related to the mental health of their partners and no matter how hard they tried, there was no direct way to influence their partners' internal thoughts and feelings. Even though participants were fully cognizant of that fact, yet they could not stop feeling powerless and useless:

"If someone's got a problem I like to try and fix it for them, but obviously with mental health issues you can't. There's only so much you can do. Obviously, all of that was out of my control, which made me feel useless because there was nothing I could do" (P3, 197-200).

"She'd just sort of sit there rocking and she'd have little phrases like "I don't wanna go home," or, "I just want someone to make it better," and she'd just sort of say them over and over and over. And there's not really much you can do in that situation" (P1, 323-325).

One participant kept coming back to the feeling of his hands being tied because he did not know of anything that he could do to make his partner see things from a rational, logical viewpoint or change the way she felt about their relationship even when she tried to accommodate his needs. For another participant, the stress on the financial side was a big contributor to the feeling of powerlessness and incompetence:

"this person can't change and you have to just accept that, that's the way it is. You can't…you know, if you could change it you would, but you can't so you just have to accept it. Again, it's that feeling of your hands are tied" (P4, 497-500).

"When we discovered how much nursery cost we were horrified, we didn't realise that was a life changing moment as much as our daughter being born was, because we suddenly go, oh, okay, so in other words we're never going to have a holiday again … because of our finances, which makes you feel a bit, sort of, worthless". (P6, 503-508).

4.2.6.5 Not opening up

You don't open up to others unless you feel they will understand or be able to help somehow. Also, you feel you are supposed to be strong enough to cope with the situation.

Out of the seven participants who were interviewed, three talked about the difficulty of opening up to others about their experience. The main reason mentioned for not opening up was that they did not believe others would be able to understand the scenario or help because the effects of PND on family life were of a private nature and others would not have the opportunity to influence those aspects in any way. As far as close family, e.g. the parents were concerned, all three participants believed that they would not be able to help much except maybe by offloading the baby for some time. However, telling the parents was considered to have the downside of making them worry and ask questions. Participants believed that they would be ok to talk about their experience if they knew that the other person was capable of helping, either a professional or someone who had had experience of PND and who had come through it successfully, but they did not get many opportunities to talk to such people:

"I don't know if family would have helped so much. it's something so intimate to the couple really that you really need more professional help rather than family" (P5, 262-265).

"if somebody had gone through it themselves, either a father or a mother's gone through it, then maybe I'd be willing to talk about it" (P2, 330-333).

Another aspect here was the sense of responsibility felt by one participant who believed that it was his role to absorb all the stress and support his partner and child through a difficult time. In his view, he was supposed to stay strong and bear the load but over time absorbing all the

emotions and not speaking to anyone had the effect of making him feel like a pressure pot ready to explode:

> *"I never speak to anybody about it. I think the way I look at it is I'm supposed to be the strong one of the two, so I'd never talk to anybody about how I was feeling, which was hard, sort of, keeping everything on my shoulders. It started to become a bit of, like, a pressure pot where I just felt like I was just going to explode. I had all these emotions and no one to talk to about it, so it was hard, very hard" (P3, 49-54).*

4.2.6.6 Existential perspective

As is evident from the title of this universal theme, it is almost completely focused on the personal world (Eigenwelt) of the participants. However, there is one theme, viz. Not Opening Up, which mostly pertains to how participants related to others and thus falls in the Social world. All the constituent themes of this universal theme delve into the experience of the participants from the perspective of their own selves and try to illuminate what was happening in the hearts and minds of the participants as they were living with their partners who were suffering from PND. The gist of the experience here is participants finding themselves unable to cope with the arduous ordeal thrown their way with any degree of confidence or assurance. Van Deurzen's emotional compass elucidates the experience of the participants wonderfully here: starting with the participants finding themselves ill-equipped to deal with the situation and being surprised about how horribly bad it was, thereby generating feelings of worry and confusion. From this point, a downward journey of loss starts: progressing through misery and resignation with participants reporting they felt as if they were supposed to be strong enough to cope with the situation but did not find themselves actually able to deal with it, resulting in them feeling miserable and sorrowful. Then finally, the journey culminates in resignation and despondency, where the participants felt wholly powerless and incompetent and felt like all they could hope for was day-to-day survival only. To them, things felt chaotic because they were not in a position to make sense of what was happening around them and they felt they did not have any control or ability to make an impact on the situation, thus exacerbating the feeling of despondency.

The experience described here is so focussed on the negative, depressive emotions that it seems like participants had lost all hope. However, this is not really true because this universal theme is peeking into the dark personal world of the participants. In their other dimensions of existence, participants found the courage to continue to support their partners and children and

remained able to function socially as well as meeting the physical needs of themselves and their families. It is only in their internal world that they gave free rein to their emotions and thus found themselves sinking deeper and deeper without any ray of hope illuminating the way for them to get out of that state. It is interesting to note that the participants seemed unable to find a way for their other worlds, especially the social and physical worlds, to have a bearing on, or to illumine their dark personal world in any significant manner and the possibility of engaging more on the relational side did not get explored or exploited by the participants.

4.2.7 Universal theme seven: Meeting expectations

All the participants who were interviewed discussed the weight of expectations and how it affected them. There were three major sources of expectations which combined to place an enormous burden on the participants. Firstly, the professional life where participants were expected to continue to deliver against their work objectives. Secondly, the partners at home who expected the participants to be able to alleviate some of their work-load concerning the household responsibilities and in relation to taking care of the baby. Finally, the participants themselves who expected their needs to take second priority and to be able to bear the load of extra support for at least some time until their partners were able to recover. These factors working in unison created a situation where the participants were really stressed and miserable to the point where they started to despair. The need for constant care and support resulted in some participants even wanting to disappear for a while. There were three different themes related to the three factors described above that constitute this major theme, that is, *Work-Life balance, Unable to put own needs forward* and *Not having enough time*. The first one was related to the expectations from work, the second theme relates to the participant's expectations from themselves, and the last theme pertains to the partners expecting to be relieved from responsibilities at home. Below, the themes are considered individually, and then the various emotions involved are sifted utilising the emotional compass and considering the whole experience form the existential perspective.

4.2.7.1 Work-life balance

It was very exhausting to meet the demands of both work and family life. You feel stressed and it becomes hard to concentrate fully at work.

The majority of the participants interviewed experienced severe difficulties in maintaining a healthy work-life balance when their partners were suffering from PND. In addition to the expected extra work-load at home, the participants reported difficulties concentrating at work with their thoughts being distracted or receiving messages or phone calls from home which resulted in interruptions and sometimes having to take extra time off work in addition to the usual holidays. The work-day also became stressful for most participants because they felt things were piling up even for those who had their own business. Stress induced by work deadlines coupled with exhaustion, lack of time, lack of sleep, lack of concentration and multiple demands from colleagues conflicting with demands from their partners all added up to make it very hard for the participants to meet the expectations. For each participant, one or a few of the factors mentioned above were more dominant compared to others, but the result in all cases was that they felt like they had no chance of being able to do justice to the responsibilities on the work and domestic side at the same time:

> *"It was tiring, very tiring. I mean, if I wasn't at work all I wanted to do was sleep, but obviously with a new-born baby you don't get that luxury. Then obliviously trying to sort the wife out, hospital appointments, doctors' appointments, getting the little one's doctor appointments and just running life, you know, I had no work-life balance at one point. It was completely gone because I was working myself so hard to fix everything, so I had nothing. I was constantly working in my mind" (P3, 222-228).*

> *"I had to get back to work and I had a new role and other things going on, so I had to go back to work and then…we, sort of, planned it all out in advance, the amount of money and time that we could have, of course, that bombshell dropped, my wife being so ill, that it just made that quite complicated" (P6, 29-33).*

For one participant who had his own business and who took two months off as paternity leave, it was still very stressful and exhausting when he returned to work. He ended up prioritising support for his partner and child instead of being able to devote normal time to work even after having taken a lot of paternity leave. Another participant described the relentless cycle of demands being placed on his time during the daily routine both at work, and at home, and feeling the pressure to keep meeting all the expectations from him. For him, even though it was possible to be able to meet the demands barely, it felt like he was stuck in this endless cycle and it was exhausting and stressful with no time left for anything else:

"It was very stressful at work because even when you're having some time off I was exhausted" (P4, 334-342).

"That was the time when he was not sleeping, so I would then keep the baby as long as possible to give my wife, more time in bed. Then give her the baby as late as possible and then I'd ride a bike to work, then ride my bike as fast as I can to work, work all day and then work people were, 'oh, we need this, we need this, we need this' working and then, kind of, doing as much as possible and then leaving as early as possible to get home as quickly as possible to look after the baby again to give her a break" (P2, 119-130).

4.2.7.2 Unable to put own needs forward

You cannot put forward your own needs because you don't want to put extra pressure on your wife. You feel that you have no existence of your own which feels unfair and frustrating.

Three participants discussed their experience of not being able to prioritise or even put forward their own needs. All three felt that they themselves thought it was the best course to take at that point in time. They acknowledged that there were other needs, both the need for physical and emotional support for their partners as well as the joint needs of the new family to allow the family life to survive and continue, for example, the need to do the laundry, the cooking, the cleaning, taking care of the child's needs and so on. However, the participants could not help feeling that they did not have any existence outside the support role, no say on what they personally needed or wanted. They had to put themselves aside for some time to just let the family survive the difficult period, and this was a conscious choice, and they were ok with that. However, they felt that their needs would start being addressed when the partners had started to recover from the worst phase of PND. This turned out to be difficult because it is not easy to determine when a person has recovered from a mental health issue, and the participants could not be certain when to start asking for some of their needs to be addressed:

"I don't know if I did manage myself. I guess you sort of just let yourself go a bit. I don't particularly remember having any interest during that period. I don't particularly remember doing anything during that period. So you basically put yourself aside for a period of time" (P1, 460-462).

"Sometimes I felt very much, like, a crutch in a situation, I daren't say ought, through no one's fault, you know, just my wife needs this and therefore I need to provide that or do that on top of everything else. And, I don't get a say on what I personal want on things and I don't want to put that on her because (unclear 0:35:57) of the pressure that's there and you don't want to put her in a situation that might get her upset or, sort of, reawaken anything. So, at times I was a little bit, not exactly treading on eggshells, but giving into or, you know, putting her needs first at times I feel like I should be maybe putting myself first. That, sort of, leads to this feeling of little bit like I'm just here to serve other people" (P6, 397-406).

"I was quite happy to accept that for a period I had to put my needs aside and I had no problem with that. Then when things were getting better my needs weren't being heard. Emily might argue that she was still in the postnatal depression, but for me at that point it was unfair and I don't think I was overly demanding" (P4, 528-536).

Getting any outside support or help from others also became difficult for some participants because they felt like they should not be taking time away from their main role of providing support to the family. They also felt that taking time out to discuss their personal needs should not get priority as it would be demeaning towards their partners. However, it was still within the context of when their partners were going through the worst part of PND:

"Taking time for myself away from time that I needed and at the time it felt like I was being demeaning towards my wife, why should I take time to talk about my relationship when she needs that more than me? What's the best use of my time, is it to get laundry done so we've got clothes? Is it to cook dinner? Is it to clean the house? Is it to spend some time with my wife and daughter or separately or together? Or, is it to go and, you know, talk about how I'm feeling? I think it would have been beneficial, but I just don't think it would have been an option" (P6, 729-737).

4.2.7.3 Not having enough time

There was more work and less time. You don't have any time as a separate entity because your wife is completely dependent on you and you want to be supportive of her even at the cost of everything else.

It was a common feeling that the participants did not have enough time to do everything that they needed to do. This was mostly related to the fact that too many things were left to do in

the evenings after work as their partners were unable to take care of the daily chores like making dinner, washing clothes or general cleaning and the child also needed to be taken care of at the same time. Thus, the participants faced the prospect of having to choose to de-prioritise some things by necessity and over time, it generated the feeling of a never-ending workload. Additionally, there was the worry about their partners having enough rest and support so that they would be able to take care of the child when the participants were away at work:

> *"I do a lot of the early mornings and late nights to help my wife sleep to be able to cope with every day, sort of, ventures or being awake and looking after the little one. It's trying to take the pressure off her to make sure that she's in a good mental state to be able to function throughout the day" (P7, 29-33).*

If the participants tried to take care of all the household chores, then there was no time left to spend with their partner and child which was again not ideal because that meant a lack of emotional connection and support. Some participants reported the constant need for support and outstanding work created mounting pressure to the degree where they just wanted to be able to disappear for a while so that they could have a little time on their own and a break from the constant need to support someone:

> *"I felt I just had to disappear and walk off and not come back for quite a while. I just need five, ten minutes just to not be caring, just to turn off. I think that's been the biggest burden" (P6, 183-185).*

> *"It's that level of having someone very dependent upon you all the time and not having any support for yourself and I think everyone needs…you know, the majority of people need their own time, as a separate entity" (P6, 383-386).*

Bedtime was another issue for some participants because their partners wanted them to stay awake with them when the participants were already tired after the routine of the day and the evening and knew that they would need to be awake in the night as well. The participants appreciated the fact that ideally, they should spend more quality time with their partners but no amount of arranging or re-arranging the routine allowed them to do that:

"she didn't wanna go to bed without me. So I remember having bizarre arguments. There were lots of arguments about going to bed which was quite strange. And she'd be like, why are you being… You know, I'd sort of be there on the chair, you know, making it really obvious that I was really tired …laugh… and she'd be going, "Why are you," you know, just… "Why don't you just," you know, it's half an hour or whatever and that was something I had to escalate into an argument. I guess I felt, yeah, I felt that I didn't quite have enough time and there was too much to do" (P1, 477-483).

4.2.7.4 Existential perspective

This universal theme mostly pertains to the Personal world (Eigenwelt) of the participants, but one of the themes does touch upon the Physical world (Umwelt) to a degree. The focus here is on the expectations placed on the participants from many sides, including from themselves. The participants mentioned three sources of expectations. The first was related to expectations from the outside world or physical world, i.e. the reality of continuing to fulfil the responsibilities of their role as the breadwinner for the family and balancing work and family life. The second was related to the personal world of the participants where they placed expectations on themselves about not letting their needs be fulfilled and to prioritise the needs of their partner and child above themselves. The third related to the personal world again, where despite wanting to relieve their partners of a lot more responsibilities, the participants ran into situations where it was impossible to meet their partners' expectations.

Looking at van Deurzen's emotional compass, it is clear how participants are pushed downwards into the depths of sorrow and misery over time as multiple factors work together to give potency to the negative emotions. The predominant feeling here was that of misery because of the physical and emotional hardship due to the excessive simultaneous responsibilities placed upon the participants and an element of despair coupled with vigilance due of being unable to put their own needs forward and not having enough time to deal with everything that was expected of them. There does not appear to be any ray of hope in the darkness from the participants' perspective as they cannot see how they can find a way to be successful in the face of what seemed overwhelming odds. Overall, this universal theme depicts the magnitude of the challenge faced by the participants when their partners were suffering from PND.

4.2.8 Universal theme eight: Being with others

4.2.8.1 Impact on close relationships

There were not many opportunities to spend time with the child or close relations like parents and finding ways to compensate for that was really hard.

A few of the participants discussed the impact of the daily routine and their partners' need for support on how much interaction the participants were able to have with other close relationships like their parents and even their own child. Although the experiences of different participants had little in common in this regard, the underlying feeling that they were unable to have as much time and contact with other close relations as they wanted was present in all cases. In some cases, the relationship with the parents was affected because they could sense that the father and mother were under a lot of stress and there was a lot of frustration, and the spousal relationship was suffering:

> *"My relationship with my parents was changing ever so slightly as well because they could see how frustrated I was, how frustrated my wife was, so that changed" (P3, 99-101).*

For one participant, his daily routine left little time to spend with his daughter, so he ended up trying to compensate by spending a lot of time with his daughter when the weekend arrived. Another participant had to reluctantly ask his parents to leave when they came to visit the family very soon after childbirth because his partner was not able to take the pressure of having them in the house because of her social anxieties. This was obviously quite awkward for the participant and did not allow him to have a happy start to family life after the birth that he had envisaged. Generally, the participants believed that their close relationships always got affected by the challenge of trying to meet the demands of the situation when the partners were suffering from PND:

> *"we'd make every weekend extra special or as special as we can, try and do as much as we can in a weekend to catch up. Also, I would take my daughter out for the day, just me and my daughter, to give my wife a rest for the day, but also give me a lot more bonding time with my daughter because I'd get up before she'd wake up and I'd get home after she'd gone to bed, so you lose a lot of interaction, a lot of time, a lot of bonding time" (P7, 369-377).*

"I said to my parents that they need to be understanding that Emily's really not in a good place and they need to give her space and not be in the house, give her as much space as possible, which is quite difficult for me to do" (P4, 160-164).

4.2.8.2 Existential perspective

This is a minor universal theme and consists of only one theme dealing with how the close relationships get affected, from the participants' perspective, when their partners are suffering from PND. It is quite clear that the theme falls in the Social world (Mitwelt) because the main consideration here is how the relationship with others changes as a consequence of the demands of the scenario being faced by the participants. The three participants who discussed this theme all seemed resigned to the fact that they would be unable to maintain the type of contact and relation with close family members, e.g. their parents or even their own child, because they were pre-occupied with other urgent and frequent demands ranging from work responsibilities to emotional support required by the partners. Additionally, the fact that participants had to cope with a lot of negative emotions during that period and their relationship with their partners was suffering meant that they were sometimes unable to be as open to other family members or share their feelings freely because of fear of leaving a negative impression and worrying others. Generally, this theme continues to paint the picture of the loss and hardship faced by fathers when their partners are suffering from PND.

The following chapter will discuss the themes in light of the existing research literature and further explores the existential dimensions of each universal theme.

Chapter 5 Discussion

The research looked at the experiences of seven first-time fathers whose partners suffered from postnatal depression (PND). The major goal was to explore the lived experience of the fathers using a phenomenological research method. 31 themes were identified from the descriptions of the fathers' experiences and these were later grouped into seven major universal themes and one minor universal theme. The universal themes are *Emotional roller-coaster, Suffering as a couple, Lack of support, Surviving the situation, Living with her PND, Personal challenges, Meeting expectations* and *Being with others (minor theme)*. This section will discuss the findings above in light of the extant research literature. An existential philosophical perspective will also be explored in order to reach a more profound and meaningful understanding. The current research found that partners' PND has a wide-ranging impact on almost all facets of fathers' lives. All dimensions of the participants' existence (Umwelt, Mitwelt, Eigenwelt and Uberwelt) were affected, as they lived and coped with their partners' PND. The findings showed that the participants also suffered alongside their partners when postnatal depression took hold of the mother, and in their own way each participant ended up learning how to live with their emotions whilst extending effective support to their partner and child. Below, I discuss each major theme exploring the connection to extant research and analysing the existential implications.

5.1 Universal theme one: Emotional roller coaster

5.1.1 Pride and pleasure

The feeling of taking pride in their role as fathers was expressed by almost every participant who took part in the study. Even if being a father was unexpectedly hard work, they found many reasons to feel good about themselves and their own or their partners' achievements. Previous research highlights that fathers feel a profound sense of connection and affection for their baby (Barclay & Lupton, 1999; Anderson, 1996). This close sense of being part of a family unit, and the close relationship that it implies, is a source of satisfaction and joy for the fathers (Shefaly et al., 2017; Ahlborg & Strandmark, 2001). Fathers feel as if they are fulfilling the needs of the child by being there in their capacity as a parent and by being sensitive to the child's potential requirements (Kaila-Behm & Vehviläinen-Julkunen, 2000; Ahlborg & Strandmark, 2001), and all these feelings are sources of gratification and fulfilment, thus providing pleasure and joy to the fathers. In the current study, what made some participants proud was the thought that their role and responsibilities were quite hard to fulfil. Being able

to cope with that and achieve self-efficacy was a source of both joy as well as pride. This is in alignment with literature where the self-sufficiency of fathers has been reported as connected to positive feelings, including self-assurance (Åsa et al., 2008). The participants considered being able to survive PND a big achievement and a source of pride for them individually and as a family. Children have been reported as being a source of pride, contentment, and joy for fathers (Karen M. & Joyce Magill-Evans 2014; Åsa et al., 2008). This, in conjunction with the fact that the participants of the current study felt their family was surviving the tough period which accompanied the postnatal depression of their partners and emerging successfully from that ordeal, naturally reinforced their pleasure. This also suggests that the participants became aware that living with their partners' PND was a phase that was limited in time, although presumably many of them might have initially felt that their troubles would be never-ending. The encouragement received from their partners about doing the "right" things also seemed to help the participants feel happy because it affirmed that their efforts were being spent in the correct direction. Overall, compared to previous research, the assertion by participants of this study, that being able to survive the challenging period of their partners' PND was a big achievement which they were proud and happy about, is distinctive and particularly relevant to the experience of fathers who are living with partners suffering from PND.

5.1.2 Frustrations

Almost all the participants who were part of the current study expressed that they felt frustrated, both by the frequent and needless arguments with their partners over what they considered small things, and because they did not see any of their efforts producing positive outcomes. Argumentation between the spouses has previously been shown to be related to PND (Johnstone et al., 2001; Zhang et al., 1999). Furthermore, research shows that the birth of a child immediately increases the stress level for the whole family (Spector, 2006). Any pre-existing vulnerabilities in family members, whether emotional or psychological, can be exacerbated at this time, creating problems for both the partners, and it also takes time for the family unit to adjust to the new lifestyle (Misri et al., 2000). Thus, relationship satisfaction suffers generally for new parents (Page et al., 2007), and this is further accentuated when the wives or partners are suffering from PND.

Participants also felt frustrated because of the burden they had to bear in terms of supporting their partners. Firstly, the participants' time was divided between what they felt were their responsibilities, including work, and supporting their partners. Secondly, the burden was not

getting lighter over time, even when the participants thought that their partners had improved significantly. Previous phenomenological studies looking at the lived experience of fathers living with partners suffering from PND have also outlined similar experiences where the fathers' task-load being increased caused issues for the couple (Meghan et al., 1999). Furthermore, the maternal PND has been shown to adversely affect the fathers (Buist et al., 2002; Matthey et al., 2000), with the depressed mothers providing less support to the fathers whilst expecting the fathers to take on more responsibilities with respect to childcare (Matthey et al., 2000). In the current study, participants expressed their frustration regarding a large amount of time consumed by support, which meant not leaving enough time for anything else. This was coupled with the fact that their partners seemed to have occasional periods of being better without actually recovering permanently, which felt unfair to the participants because the support burden was not getting lighter even when their partners seemed better.

5.1.3 Sadness

Sadness was a common feeling expressed by the majority of the participants interviewed. One of the reasons for feeling sad was that the participants had expectations of joyous family life after the birth of their child, and they felt they were losing those precious moments due to PND. Whilst becoming a parent is commonly associated with joyful and positive emotions, it can turn out to be a very stressful event, having a negative impact on both spouses (Whisman et al., 2011; Kluwer, 2010). In previous research, fathers have expressed their sadness after the birth of the child on account of not having intimate relations with their partners (Ahlborg et al., 2001) as well as expressing the opinion that women were generally behaving in a less warm and intimate fashion in the postnatal period (Lija et al., 2011). Also, the child does not get the same attention that it would get in the absence of PND (Lija et al., 2011). This further contributes towards generating an atmosphere of sadness in the family life because the general feeling is that the family is not enjoying the time as they would have expected. In the current study, participants distinctly made a connection and articulated the relationship between sadness and missing out on the potentially joyous family life when the child was young. Also, as their partners were suffering extreme sadness during PND, the previously happy life of the couple together became impossible, and this loss was felt acutely by the participants. In addition, the freedom and time that the participants had before their partner's PND also went missing, and this further deepened the feeling of sadness. Although none of the participants in the current study suffered from paternal depression, maternal PND along with other factors like anxiety, lack of social support and poor spousal relationships has been shown to be associated with, and

to be a potential cause of, paternal postpartum depression (Ramchandani et al., 2008; Paulson et al., 2010; Edward, et al., 2015). Fathers who are suffering from sadness could potentially be associated with the same factors. Furthermore, Inger & Nilsson (2011) have shown that as time progresses, the initial eagerness of making an effort to help their partners gradually changes, and the feelings of fathers start becoming more negative, including sadness and even detestation at the wretched state of their lives. This is reflected by Muchena (2007), who reported that fathers experienced episodes of anger and feelings of sadness as their life went through these inevitable changes. It appears that fathers experiencing sadness during the time after the birth of their child is quite a common occurrence, even when their partners are not suffering from PND. However, most of the factors associated with fathers' sadness are further aggravated when their partners are suffering from PND, and the expression of sadness by the majority of participants interviewed in the current study is not unexpected when viewed in this context.

5.1.4 Guilt

Quite a few of the participants included in this study harboured feelings of guilt on account of either being responsible for causing their partners' PND or because of not being able to provide the required amount of physical and emotional support that they wanted to provide to their partners. The participants felt they had an equal part in deciding to have the child in the first place. They felt that if their partners were not able to handle the emotional and physical burden, then they should also shoulder the blame for creating the circumstances. Inger & Nilsson (2011) have previously shown that fathers blame themselves for somehow being the cause of the deteriorating situation when their partners are suffering from PND without fully comprehending what is wrong. This seems to be quite well aligned with the experience of participants in the current study. It is important to note though that not all the participants ended up blaming themselves, and even for those who did, the potential for development and the personal growth of both the participants and their partners was understood later as discussed in section 5.4. Here, the feeling of blaming themselves was during the phase when participants felt out of control and lacked an understanding of the situation which they came to understand later. Another relevant factor seems to be that fathers who are under stress and suffering themselves are more likely to feel excessively guilty and build a negative image of themselves and then find opportunities to reinforce that negative image (Swann et al., 1992; Beck, 1967). Whilst it is hard to establish whether this was a factor in the current study or not, as this was not explicitly probed for, this cannot be entirely discounted as a possibility for some of the

participants. However, since the emotion of shame is associated with negative feelings for the person we have become (Panayiotou, 2006) and none of the participants reported feeling ashamed, it suggests that this is less likely to be a factor here.

One of the important reasons mentioned by the participants for not being able to spend enough time with their partners were social activities and long work hours, ultimately resulting in the feelings of guilt. The feeling was particularly pronounced if, for some reason, the partner had to endure an episode of anxiety etc. while the participant was away. Muchena (2007) has discussed how the failure to detect the deteriorating condition of mothers brings much guilt for the fathers. In addition, Edhborg et al. (2016) showed that work-related stresses and responsibilities which did not allow fathers to spend enough time at home taking care of the child results in the fathers feeling guilty towards their spouses. This is especially true in the cases where the mothers have to take responsibility for the child during the nights since most fathers start working after the ten-day paternity leave and are not able to take responsibility for childcare during the night after spending the day at work (Edhborg et al., 2016). Whilst the participants in the current study mostly did not discuss the division of labour with respect to night-time childcare duties, some did mention that being awake for their partner during the night was a challenge. This, in turn, generated feelings of not being able to support their partners as well as they wanted to. Guilt is also generally reported by burdened-caregivers who are not in a position to offload their responsibilities (Rose et al., 2006; Kasuya et al., 2000). This was true for all the participants in the current study who did not have access to external help but felt that they needed the help as they were not able to cope with the burden alone. This feeling of somehow not being able to bear the responsibility without outside help probably increased the feelings of guilt.

5.1.5 Unfairness

Some of the participants interviewed as part of the current research mentioned the feeling of unfairness caused by various reasons. Only three participants out of the seven mentioned unfairness and for those three the causes were essentially different rather than common, but this is not surprising given the fact that only a small number of experiences were relevant and discussed. However, despite the variety of circumstances, there was a shared experience of unfairness generated by the situation that they were placed in.

One of the participants could not help feeling that he had not played any role in creating the scenario where his partner was suffering from PND, and yet he had to bear the burden of his partner as well as supporting his child at the same time which did not seem fair to him. Another participant mentioned the distribution of labour with respect to day-to-day household chores as the cause for his feelings of resentment and unfairness, especially when he felt that his partner had recovered to a certain degree. Prior research points towards inequity in terms of childcare tasks and household chores to be related to deteriorating quality of the spousal relationship (Buunk & Van Yperen, 1991; Joyner, 2009; Lennon & Rosenfield, 1994; Van Yperen & Buunk, 1990), and generally, for all relationships equity is considered to be a desired and valuable state (Walster et al., 1978). However, it is not clear whether inequity is the cause of deterioration in relationship quality or if perceptions of inequity come to the fore when relationship quality has deteriorated for some reason already. One pertinent study here is by Grote and Clark (2001) where it has been argued that once the relationship is under stress, people start looking for causes of their distressed state and the feelings of unfairness come up during that process and this may well have been the case here as well. Looking back at the experiences of the participants who mentioned unfairness as an issue, it appears that two out of the three also stated that their relationship had deteriorated significantly. However, when talking about the relationship deterioration, they mentioned other factors, for example, exhaustion, inability to rebalance the daily routine so that both partners get time to spend as a couple or partake in activities together, and the loss of the cherished partner because of changes after childbirth. It seems that for the participants of the current study, the feeling of unfairness was not a dominant factor or dominant cause for relationship stress; instead, this feeling was probably exacerbated due to relationship distress.

One of the participants of the current study felt that it was not fair that he was pushed to the side and was unable to get any significant time with his daughter because his partner took care of all the childcare tasks. In this case, the division of responsibilities went utterly against his preferred choice, and he was quite distressed because of it. This perception about the choices being forced rather than consensual has been reported in previous research when the relationship between the partners is distressed (Settersten et al., 2010). This is in line with the experience of this participant because his relationship with his partner was suffering due to PND. There was no real conversation between him and his partner about how the family was going to ‘work’ as there was an almost complete breakdown of communication between the partners. He felt like every discussion was going to result in a big argument. In this scenario, it

is quite possible that there was a lack of clarity about expectations with respect to the division of labour, for instance, the mother may have only chosen to take on all childcare tasks herself because she was trying to fulfil her own expectations of being a mother. However, with no effective negotiation happening between the partners due to PND, this could easily have resulted in perception on the father's side of the choice being forced on to him; thus, feeding the feelings of resentment and unfairness.

Looking at the participants' experience and their feelings regarding unfairness, one factor that seems to be an underlying common factor is that the participants ended up having to comply with their partners' wishes. The actual manifestation of how they ended up having to bend their will varied, e.g. in some cases the participants were discouraged from taking care of their child, but in other cases, they had difficulty balancing other responsibilities because they had to take care of the child as well. However, there was a loss of autonomy and requirement for un-negotiated acceptance of the partners' point of view, which contributed to the feeling of unfairness in the participants. The fact that the communication between the participants and their partners was severely impaired during this time was a contributing factor here. This is further discussed in section 5.2.1, in the discussion of the theme "Communicating with each other". The experience of the participants suggests that in the backdrop of the challenging circumstances the participants had to rebalance the responsibilities, but lack of good communication between partners made it nigh-on-impossible for any meaningful discussion to happen, and thus the participants felt that they were being asked to take on additional responsibilities without having any say in the matter. The compliance with their partners' wishes was the participants' way of managing the situation when communication had broken down. They did not feel powerless or impotent in this situation but chose not to try to go against the partners because it was impossible to explain and come to an agreement with the partners at that point in time.

5.1.6 Hopes

Participants described how they clung on to their sense of hope that things were going to get better and that there would be a "light at the end of the tunnel" when their partners would recover, and they could all start to enjoy their life together as a family. They hoped that this would happen early enough so that they did not lose out on the chance to relish the moments that only a young baby could provide his or her parents. Participants described the feelings of hope and desires that the experience of postnatal depression would make both the father and

the mother stronger and more able to withstand future challenges and protect against a relapse. Bennett & Cooke (2012) who conducted a qualitative study of the experiences of fathers living with women suffering from PND delineated a category of experiences called "road to recovery" where the fathers start feeling hopeful about their partner recovering from PND. During this phase, the fathers feel as if they know the direction that they have set for themselves, especially in regard to the nature of support they need to provide for their partners. In addition, they feel like they know how professionals and others are helping with their partners' recovery as well (Bennett & Cooke, 2012). The way in which the participants of the current study described their hopes seemed well aligned with the "road to recovery" phase but with the exception that in some cases the participants of the current study described not losing hope even in the worst of circumstances, even when they were quite far from seeing the recovery of their partners.

In some cases, they pinned their hopes on the partner's ability to work out her problems because they had faith in their partner. Prior research has indicated that even just having a name for the issues that the women were going through and that this is identified by professionals, starts to provide some hope to the fathers that their partner's issues will be understood and she will have a path to recovery (Boddy et al., 2017). This seems to align well with the experience of the participants in the current study where even when there were no outward signs of improvement just knowing that the partners were suffering from PND allowed the participants to pin their hopes on ultimately finding a way for their partners to become "normal" again.

5.1.7 Existential perspective

The themes that constitute this universal theme pertain to the personal and social worlds of the participants. As Binswanger (1963) and Van Deurzen (1988) outline, experiences can pertain to different spheres or dimensions of existence with four separate dimensions identified as the Physical world (Umwelt), the Social world (Mitwelt), the Personal world (Eigenwelt), and the Spiritual world (Uberwelt). Out of these, the Eigenwelt represents the 'own world' or the world of the self (May, 1983) and the Mitwelt is the world of fellow human beings, where we relate to and learn to live with others. The themes Pride and Pleasure, Hopes and Sadness fall wholly in the personal world as they delve deep into the emotional experience of the participants, and those emotions are fundamentally an internal, personal feeling. The themes Frustrations, Guilt and Unfairness, pertain to the social world because these feelings are mostly related to others around the participants rather than being purely personal and internal emotions.

In a sense, this universal theme is a microcosm of the whole experience of the participants as it provides a full survey of all the emotions and feelings from their inner world. What was found were dark clouds of frustrations, sadness, guilt and feelings of unfairness. However, all is not entirely lost because the clouds are punctuated by rays of light where pride, joy and hopes do shine through. The joy here comes mainly from having discovered a new skill as a husband and father. However, this joy is not a celebrated joy where the whole family can join. Most of the joy was experienced in the internal, personal world of the fathers, and it seems that the husbands and wives were split apart by the experience as the husbands became self-sacrificing.

Heidegger (1927) and Sartre (1939, 1943) have both discussed emotions in quite some detail. They have chosen to take the phenomenological approach to try to unveil the subtleties behind these very potent agents. When referring to emotions, Heidegger mentions the weather, but Sartre prefers to allude to it as the magic that possesses the potential to change our relationship to the world around us. Sartre (1939) posits that "When the paths before us become too difficult, or when we cannot see our way" this results in an emotional response. For him, frustration is the fundamental bedrock upon which all other emotions germinate and flourish. At first, the positive emotions seem exempt to the above premise, until we realise that in our personal world there is no happiness or joy that is completely fulfilling beyond momentary bliss; thus, every fulfilled craving leaves a feeling of hollowness behind it, taking us back full-circle to frustration. However, frustration need not be considered solely as the instrument of tragedy here because there is an ontological significance behind frustration, which exposes a certain facet of our personal and social existence. The presence of frustration innately signifies the presence of personal investment, personal cherishing for what is desired, i.e. that which frustrates us possesses the potential to satiate us as well. Looking back at the experience of the fathers in this universal theme, the fact that a lot of frustration manifested itself is not surprising in the least. It is an indicator of the degree to which the participants were invested in the achievement of keeping the family unit together and healthy and maintaining the well-being of their partners and children as well as themselves.

Emmy van Deurzen says (whilst describing Spinoza's views) that "emotions are an expression of our values and our position in relation to the things that we value or fear" (Van Deurzen, 2014). We feel high when we are united with a value and we despair when we lose a value. The emotional compass (Figure 1 Themes on the emotional compass), plots the emotions of the participants of the current study, and as is evident, most of the emotions are on the east and

south sides, indicating loss and deprivation of a value. The values that were lost here included the relationship the partners had before PND, the freedom the participants enjoyed before the birth of the child and before the onset of PND, the well-being of all family members, the confidence of keeping the family unit intact, and importantly, the cherished person that the participants had chosen as their wife and partner. It is not just a narrative about loss though, because there are emotions on the other side indicating gain of values as well. The values that were gained were not as numerous as the losses but did include fatherhood itself, the ability to survive through the challenging period of PND and the strength to support themselves and their partners. In a way, the emotions of the participants were signposts; marking that which they valued and held dear in their personal world. Looking at it this way, the emotions themselves were less important in the longer term than what the emotions were felt for, as the participants shed light upon what was significant for them personally by feeling either positive or negative emotions about it.

5.2 Universal theme two: Suffering as a couple

5.2.1 Communicating with each other

Almost all the participants in the study found that the way they communicated with their partners was affected and mostly it became harder to have clear and open communication when their partners were suffering from PND. The partners were not able to assimilate and process the information from the participants and respond in the way that they did before PND. Jaspers (1941) noted that it is always annoying and confusing when one is confronted by the 'rigid inaccessibility', that is, being averse to really listen to the other person, often raising barriers in the way of honest and clear communication and being reluctant to connecting and coming closer. For Jaspers, the real connection only takes place when both the individuals who are communicating become receptive to each other's views, ideas and rationale (Jaspers, 1941). Looking at the experiences of participants who were interviewed, it is clear that all of them were facing the inaccessibility of their partners to varying degrees and the resulting annoyance and frustration was thus a very real issue for them.

Another important aspect here is that for some participants, it was bemusing to try to make sense of the changed state of mind of their partners even though they were keen to try to understand that. This has previously been seen in studies such as Morgan et al. (1997) as well. When the participants tried to communicate with their partners, in most cases, they were unable to get a clear and explicable account of what their partners were going through. This is probably

related to the fact that men are reported to be unable to comprehend PND as a crisis of the self (Webster, 2002; Everingham et al., 2006). The participants who were interviewed, all seemed to rue the disappearance, to a degree, of their trusted partner and felt unable to do anything to bring them back. This, coupled with the fact that wives are considered to be the primary social partner and the mainstay of men's social life (Harvey & McGrath, 1988), ultimately resulted in a big impact on the participants' social interaction and quality of life. The findings here are in agreement with previous research which establishes that depressed mothers retreat into their own self in both the emotional as well as social sense and this withdrawal has a serious effect on the fathers (Meighan et al., 1999). For the participants of the current study, the primary effects manifested in how they felt deprived of the love and care of an intimate partner, and in how they lost the ability to share their troubles with a trusted companion. Also, they felt deprived of the freedom to engage in social activities outside the immediate family because of the inability to communicate openly and agree to lean upon the partners when they needed to.

5.2.2 Dependency on each other

The partners became increasingly dependent upon the participants generally when they were suffering from PND, but the extent of dependency varied and was much more pronounced for some couples. Additionally, the dependency also varied over time during the different phases of postnatal depression. Providing effective support to their partners is deemed critical to be able to have a stable spousal relationship especially when one of the partners is suffering from stress (Brock & Lawrence, 2008), and in the case of the wives suffering from PND, this was probably true to an even greater extent. To a certain degree, participants fully expected to take on the additional responsibilities associated with their partners becoming more dependent upon them. Literature suggests that providing sufficient support, emotional as well as otherwise, to the person under stress does result in increased satisfaction and perception of the other partner as being responsive to their needs (Cutrona et al., 2007). Moreover, this support is essential and cannot be replaced by any other sources of support (Coyne & DeLongis, 1986; Brock & Lawrence, 2008). Most of the participants in the study were naturally aware of the fact that their partners will need to be more dependent on them once they realised that they were suffering from PND and were fully committed to providing the needed support. However, it was clear that in some cases, fathers were carrying the full burden of the day-to-day family life responsibilities and various previous studies have reported the same (Boath et al., 1998; Barclay & Lupton, 1999). In these cases, feelings of having very little choice about what additional tasks and responsibilities the participants had to undertake were engendered. Even

though the dependency of the partners was not perceived as a problem per se, the participants did suffer the effects of having to take on tasks traditionally associated with motherhood. This has previously been shown to be related to depressive and negative feelings (Perlick et al., 2012) and disrupts the ideal scenario where both parents discharge parental responsibilities but remain sensitive to the adult partnership demands at the same time (Tach et al., 2010). In the case of the current study, though, none of the participants reported that the additional burden caused by their partners' dependency resulted in them going into depression.

5.2.3 Changes in relationship

The relationship between the spouses deteriorated significantly when the partners were suffering from PND. There was a lot of damage to the relationship with drastic changes in the partners' behaviour and feelings, and this naturally affected the way the partners interacted and felt about each other. Existing research indicates that having a stable romantic relationship and sustaining that over time is one of the most important personal objectives for an individual (Roberts et al., 2000) and this has a direct association with the psychological and physical well-being of a person (Whisman, 2013). In the case of a new family with a young first-born child, this also affects the mental and physical health of the family and the child as well (Redshaw et al., 2014). Unfortunately, this is the same time when the quality of the spousal relationship usually starts suffering (Horsch & Ayers, 2016). Studies indicate that the spouses want to learn about potential changes to their relationship earlier than the postnatal period and that even though the feelings of love are still present as before, the actual time partners have with each other and the way they interact and connect changes quite significantly (Fägerskiöld, 2008; Deave et al., 2008; Condon et al., 2004; Ahlborg & Strandmark, 2001). In particular, this includes the sexual relationship (Ramchandani et al., 2005; Fletcher et al., 2006) as well as lack of sleep (Mitnick et al., 2009). Overall, after the birth of the first child, a decrease in joyful, healthy contact is reported, and disagreements and dissatisfaction start becoming more common (Doss et al., 2009; Kluwer, 2010).

New parents have to face many challenges even in the absence of PND including issues like the sleeping routine, the health of the baby, the biological changes for the new mothers, and lack of time (Horsch et al., 2016; Mitnick et al., 2009). This in itself creates a stressful environment for both parents, and they have to recalibrate their lifestyle and daily routine. Thus, for most of the couples, the relationship before birth has to adapt to the unexpected

realities of the situation which can feel overwhelming even in the absence of PND. Some deterioration of the quality of the relationship and how satisfied the partners are with each other is often reported, and the frequency of positive emotions and feelings reduce, being replaced by conflict (Doss et al., 2009, Kluwer 2010) and this is particularly true in the case of the partners suffering from PND.

Relationships generally, and the spousal relationship, in particular, can provide a framework in which the partners find meaning in their lives, resulting in a happy state of being (Stillman et al., 2009; Seligman, 2002). However, it does require a balance to be maintained with separate spheres and domains to fulfil the different needs of each individual (Sirgy & Wu, 2009). The experience of the participants suggests that uncertainty and anxiety started dominating the experience when the partners were suffering from PND. The positive and joyous aspects of the relationship retreated into the background as the boundaries of the roles and domains blurred and disappeared. Thus, the healthy relationship which was once the source of strength and joy starts to turned into a difficult relationship which was more prone to conflict and a source of distress.

5.2.4 Intimacy became challenging

The experience of the participants indicated that physical and emotional intimacy with their partners was a lot harder during the postnatal depression period and that it was very tough to deal with that. PND was very detrimental to the affective as well as the sexual side of being husband and wife. This is in line with previous studies which document an interruption of intimate contact and fathers finding it much harder to find exclusive time with their wives (Chin et al., 2011). Fathers experience a profound feeling of having lost their partner, including losing the intimacy that they had previously enjoyed. They feel lonely and isolated as the mothers withdraw from the ways of interacting that were previously the norm (Barclay & Lupton, 1999; Boath, Pryce, & Cox, 1998; Meighan et al., 1999). There appears to be a close connection between intimacy in the married life and meaning in the personal life, and multiple studies have highlighted the importance of meaning in intimate relationships (Sells, Giordano, & King, 2002; Schulenberg et al., 2010). For the participants interviewed as part of this study, the loss of intimacy was not explicitly related to the lack of meaning in life. However, several participants did report not being clear about what their role was and how they could fulfil it, which hints at the inability of participants to find purpose and meaning. The subject of intimacy

between the couple during the postnatal period was not reported as something that the participants had a good awareness of before the birth of the child. Previous studies have recommended that healthcare professionals should spend more effort on discussing and explaining how intimacy between the spouses will be affected after the birth as part of the antenatal training (Polomeno, 2006, 2007, 2014; Ahlborg et al., 2001). The birth of the child is a single event and yet it receives quite a lot of attention while the question of how the intimate life of the couple will be unsettled is of much longer lasting significance. The love between the marital partners, which binds them together is precisely the aspect that is the most vulnerable during the postnatal period for the new parents (Polomeno, 2006). Healthcare staff are in an excellent position to impart useful knowledge and information here because the parents inevitably come in contact with the healthcare professionals multiple times during the antenatal and postnatal period (Hawkins et al., 2002).

5.2.5 Existential perspective

Most of the themes in this universal theme fall in the social world (Mitwelt) except the last theme (Intimacy became challenging) which mostly falls into the physical world (Umwelt) of the four dimensions of existence. The findings suggest that when mothers go through postnatal depression, it has a huge impact on their relationships with their husbands. Thus, the element of the marital relationship and how it is affected during PND ties this theme strongly to the social world. However, the other element at play simultaneously here is the effect that the lack of healthy interaction with their partners has on the fathers' emotional self. The fathers feel not only lonely, frustrated and isolated but most significantly they feel miserable, and the way the emotional self of the fathers is affected pertains most strongly to the personal world (Eigenwelt) of the fathers. In addition, most aspects of the themes here concern the intimate relationship between fathers and mothers. Here again, the personal world of the fathers is most relevant because intimate partners do not merely respond to each other, but they carefully open themselves up to each other in order to gain a better understanding of the intimate-other. What comes to mind here is Buber's I-Thou relationship: "The primary word I-Thou can be spoken only with the whole being" (Buber, 1923, p. 11) and "True marriage always arises out of "the revealing by two people of the Thou to one another. Out of this a marriage is built up by the Thou that is neither of the I's" (Buber, 1923, p. 46). Thus, the intimate relationship between the partners is about openness towards each other, responding to each other, and together creating an interpersonal space between themselves which transcends each of their personal

worlds and pertains to their spiritual dimension of existence. The partners relate to each other with their whole being so that, in Buber's words, they fill the heavens for one another (Buber, 1923, p. 8), and in relating to each other in this manner they also address the spiritual experience of addressing the eternal Thou. The lived experience of the participants indicated that before their partners started suffering from PND, they were blissfully used to having the intimate I-Thou relationship with their partners. It is important to note, though, that this was not the only mode of relating. When they were experiencing their partners as separate human beings with their own specific characteristics cognised separately, at that point the fleeting I-Thou relationship evaporated, and the partners became a separate "thing" for the fathers to interact with. Buber was also fully cognizant of this fact when he said that "Every Thou in the world is by its nature fated to become a thing, or continually to re-enter into the condition of things" (Buber, 1923, p. 17). In an intimate relationship, the husband and wife must be able to, at times, meet each other fully and openly in the I-Thou relationship, and be receptive to each other's actions and responses, even though at other times they need to be able to know each other in the I-It way. Unfortunately, the experience of all the participants showed that maintaining the I-Thou way of communication and connection with their partners became much harder for them once their partners started suffering from PND. The openness and closeness needed to sustain that mode of relating went missing as the PND developed.

At that point in their lives, the partners were just not ready to accept the genuine encounter with others that Jaspers (1941) has advocated, where he posits that the opportunities for reciprocal discovery afforded by communication allow the revelation of the full self. Looking at the experience of the participants, it seems that as their partner's PND developed, they faced the prospect of an impoverished existence with gloomy loneliness exacerbating their misery because it became impossible to achieve the reciprocal discovery when the partners had "closed" their selves and effective communication had become impossible. Some participants reported feeling anger in response to the suffering, especially when the communication between them and their partners became difficult, and it is interesting to see what that anger was rooted in. As Emmy van Deurzen says, "anger can be understood as an emotional response that provides the energy for a person's struggle to prevent the loss of important values" (Deurzen, 2012). I believe here the participants' anger can be best understood in the milieu of the loss of the cherished relationship and the valued intimate-other that they treasured above most other things. The frustration of participants was further aggravated by the fact that in some cases, the partners started to depend a lot more on them, and the participants felt almost

trapped. They felt obliged to fulfil their role as supportive husbands without having much say or choice in what was happening around them. Examining the experience of the participants, it appears that there was a kind of co-dependency being created, where the participants had made up their minds that their partners were going to be much more dependent upon them and thus, by intent or otherwise, they enabled their partners to become more and more dependent upon them over time. However, it is hard to affirm the issue of co-dependency definitively. Firstly, we only have the fathers' accounts to lean upon. Secondly, the circumstances surrounding the partners when they were suffering from PND made it really hard for both partners to find the capability and time for the self-examination and contemplation required to achieve clarity with respect to their feelings and responses.

However, in all the suffering that the couples had to endure together, there was a joint project which was highly desirable for both the partners, viz. that of procreation and looking after the offspring. A distinctive aspect of this project is the sense of transcending beyond the tribulations and limitations of their current state of being and working for something that is ahead of them, which brings in the spiritual dimension. As Emmy van Deurzen (1988) says, "raising the offspring allows them to remain in touch with this sense of wonderous union and commitment to something greater than themselves". This seems to be very relevant here because when going through all the woes discussed above, the partners all still found a way to navigate the tricky waters and survived the experience, and having the anchor-point of shared responsibility and joy in the care and bringing up of the child played a very important role, at least for the fathers.

5.3 Universal Theme Three: Lack of support for dads

5.3.1 Lack of support for dads

The majority of the participants of the current study felt that both the professionals, as well as the friends and families, focused on providing support to the partners due to the prevalent impression that their partners were the ones who had the major mental health issue, viz. PND. Thus, the fathers got wholly ignored even though they are very much part of the family that needed support in reality. This was especially true in case of the support provided with respect to the mental health, with the fathers expected to be able to cope with the emotional drain, the frustrations, the anxiety and the emotional tiredness. Although the research conducted on this subject has been limited, existing studies show that there is a significant gap when it comes to healthcare professionals dealing with fathers (Letourneau et al., 2011; Buist et al., 2002). In

particular, Letourneau et al. (2011) found that all eleven fathers who were part of that study faced issues in finding information about PND; they could not find the resources themselves, and they did not get the attention they wanted from healthcare services, sometimes even discouraged from attending the appointments together with their partners. In addition, when fathers brought up their experiences with the PND of their partners, the healthcare professionals tended to minimize their experiences (Meghan et al., 1999).

The parents of the participant as well the mother, were mostly reluctant to step in and offer advice, support or take on any responsibilities. This was particularly surprising for some participants who had expected their parents to be able to provide more help and support. One of the participants thought that he would have benefitted a lot from having more support groups, more resources and advice being available and a more proactive attitude from various people who were available and around. This is in line with previous research where it was found that support groups for fathers increase the knowledge of the fathers, make it easier for them to understand their partners' experiences and generally end up decreasing the relationship stress faced by both partners (Premberg et al., 2006; Purdom et al., 2006).

Participants felt that they were expected to be able to cope with the emotional stress, as well as stress on the physical side and it was hard for them to find anyone to talk to about the issues specific to them. Research supports the notion that fathers generally struggle with their new parental responsibilities because of inadequate knowledge and information available to them and that they would benefit a lot from more knowledge and information about childcare and the paternal role and how spousal relationship will be affected by childbirth (Kowlessar et al., 2015; Thomas et al., 2011). They desire to partake more in the care of the newborn but are uncertain about how to go about it (Chin et al., 2011; Kowlessar et al., 2015). For the fathers, there is a lack of good advice and general guidelines to help them make sense of the newly changed scenario (Barclay & Lupton, 1999) and they receive very little support from friends and relatives whilst a lot of their existing activities and interests end up being disrupted (Hall, 1994, 1995).

It is important to note that the participants, in most cases, actively sought help. They were aware that they were suffering both physically as well as mentally and emotionally, and they considered themselves entitled to receive help and support. It was not a case of them locking themselves away and just resenting the situation. However, they still failed to receive adequate

support in all cases. Fathers also voice their dissatisfaction and frustration about the fact that there is a dearth of father-specific support initiatives and readily available knowledge bases that they could lean upon and consult, resulting in them having to depend upon their partners or people close to them for guidance (Chin et al., 2011, Thomas et al., 2011). Even the antenatal and postnatal training and education by healthcare staff ended up mostly ignoring the father's needs because of the assumption that fathers were not going to be the primary caregivers (Cosson & Graham, 2012; Kowlessar et al., 2015).

5.3.2 Frustrated by the support network

Participants included in the study reported being frustrated by the people they were hoping to lend support to them during a difficult time when their partners were suffering from PND. They were hoping to get support and information from professionals including healthcare staff and therapists as well as their close family including parents, but no one informed them about the possibility of suffering from PND or stepped forward to lend timely support on their own. The therapists, the doctors, and the midwives, who were involved, did not have a proactive approach and were not particularly helpful for the fathers. The quality of the support network being below expectations has been reported in previous research (Kowlessar et al., 2015; Thomas et al., 2011). Fathers have expressed their dissatisfaction and disappointment with the assumption made by healthcare staff that the they did not possess the required level of proficiency to be the primary caregiver to the child (Cosson & Graham, 2012). Also, father-focused training is not imparted by professionals regarding potential issues after the birth of the child (Kowlessar et al., 2015; Thomas et al., 2011). Thus, the main source of fathers' frustration, which is aligned with the experience of the participants in the current study as well, seems to be that even though the postpartum period and its problems are a well-known problem area, the dissemination of those findings and the way the guidance and knowledge should be distilled to new fathers is gravely neglected. Engqvist et al. (2011) describing men's experience of postpartum issues of their partners report similar experiences with the particular assertion that not knowing what is happening and being unprepared generates frustration in new fathers because they expect to have been better prepared by the professionals involved in the perinatal period.

In addition to the professionals, the participants considered their parents and their partners' parents to be an important part of the support network. Unfortunately, the parents were also not seen as keen and proactive in offering help as the participants had hoped. In contrast, it has

been reported that work colleagues offer more advice and guidance about the issues and intricacies of how to be a working father (Chin et al., 2011; Kowlessar et al., 2015). This is in line with the experience of the participants in the current study who additionally mentioned support from their managers as being an important and beneficial factor.

5.3.3 Seeking support and reassurance

Roughly half of the participants included in the current study expressed that they sought support and reassurance when their partners were suffering from PND. How the participants went about seeking the support and reassurance varied quite a bit with some of them just desiring and hoping but not actively pursuing support while others actively utilizing all available channels to seek help and reassurance. This seemed to be mostly a personal choice based on their approach. Also, for some, it was a question of just seeking some support, or even just finding someone to talk to, but for others, there was a lot more importance attached to having the support and not being able to secure it resulted in feeling let down or even angry. Literature suggests that fathers, especially those who are becoming fathers for the first time, report the lack of support as a concern even though they acknowledge getting some support from midwives but that is not deemed adequate (Deave, et al., 2008; Premberg et al., 2008). Furthermore, although they understand that most of the help and support has to be directed at the mothers, they desire their needs to be addressed as well and especially want healthcare staff to involve them more in discussions (Deave, et al., 2008; Premberg et al., 2008; Fenwick et al., 2012). In the current study, one participant reported having to work hard to utilize all available channels of help, including the NHS and online internet resources to actively seek help and reassurance. Looking at his experience, it seems that fathers need to proactively seek support in order to obtain it. This is in line with prior research findings where it is reported that although professional support is desired and considered important by the fathers, they find it hard to secure it in a lot of instances (L. Huusko, et al., 2018) and that they feel excluded from regular healthcare visits, instruction sessions and examinations (Deave et al., 2008; Premberg et al., 2008). The degree of importance attached to the support needs was different for different individuals in the current study, and the lack of support resulted in varied reactions. It has previously been shown that most of the fathers miss out on the available opportunities because of their own reluctance to recognize their needs and asking for help with regards to those needs (Shelley et al., 2012). This may well have been a factor for the participants involved in the current study as well. It seems that the general lack of understanding about fathers' needs means that support is neither offered not sought effectively as both healthcare staff and the fathers

themselves do not fully appreciate those needs. It is interesting to note that none of the participants found themselves enabled to create a support group for themselves. It appears that there was a lack of time and energy, and the emotional reserves required even to plan an endeavour like that were missing. Hence, the participants found themselves to be at the mercy of the existing sources of support rather than actively creating and nurturing their own support network.

5.3.4 Missed opportunities for support

A few of the participants included in the current study felt that they could have made better use of some resources and opportunities. The main factors affecting the effective use of the opportunities were some reluctance to go into the required level of detail about their experiences and sharing them with others and secondly, not thinking deeply enough about the options to make use of them at the right time. Participants felt that the information about their experiences was of a personal nature, and thus, it was not easy to share it. Literature suggests that when faced with challenges, individuals adopt either the approach coping style where they tend to seek resources to redress whatever is amiss or the avoidance coping style where the individual tends to adopt behaviours that allow them to evade and circumvent the issues (Matud, 2004; Moos, 2004). Women have been shown to be more likely than men to seek social support when facing emotional issues (Felsten, 1998; Moos, 2004). For the participants interviewed in the current study, sharing their experience even with close friends was deemed ok only if they were confident that they were going to get useful advice, in particular, if there was someone who had had prior experience of similar circumstances. The conventional family arrangements and norms do not always invite the men to take an active part in what are considered to be traditionally maternal roles (McBride et al., 2005). The healthcare staff tends to also focus on the problems and issues faced by the mother and infant during the postnatal period (Deave et al., 2008), thus creating an environment in which the fathers are not encouraged to bring up their problems and issues with respect to familial support and infant support as well as partner support. The traditional male characteristic of self-sufficiency also plays a role here, and aversion to being considered a victim can be one of the primary sources of reluctance. However, research is gathering evidence that both professional, as well as social support for fathers, is important to avoid adverse outcomes for the family (Mc Auley, 2004) and that when fathers are supported, it does result in a positive impact on maternal health as well (Plantin et al., 2011). Mounting evidence in this regard possesses the potential to result in changes that improve fathers' approach towards support over time.

5.3.5 Existential perspective

This theme is related to the deep-rooted desire for contact with others and the desire for support from others. From an existential perspective, this universal theme falls within the Mitwelt or social dimension. As Heidegger states, "Dasein" is not independent or self-contained; it is closely related to "Mitsein" or being-with-others, and Mitsein is an inherent, structural part of Dasein. Thus, we can never be isolated in our nature from others around us, and in the current study, the participants reported experiencing several different emotions all related to connecting and being-with-others. There were hopes that others would be there to support and guide them, but there was also frustration and anger at being ignored by others around them. Participants felt that they needed to draw upon social support during this critical time, which seemed important to them for their, as well as their family's psychological well-being. As Emmy van-Deurzen says, we are interdependent with the world and are linked with people outside ourselves (Deurzen, 1988), and this interdependency and link with others were what the participants desired to lean upon.

How one sees and responds to life events has been shown to be related to how much social support is available in addition to other factors (Brown et al., 1978; Brown et al., 1973). For the participants included in this study, they felt as if they had been ignored and left alone in challenging circumstances which they were not able to overcome and improve themselves; and this, in turn, generated feelings of frustration and even desperation. Almost every individual needs to have a sense of being part of a community and being a member of a community provides social support and collective coping (Wong & Wong, 2006) with the individual's life being enriched in proportion to the vitality and harmony of the overall community. The support of the community that the participants craved for was painfully missing in their case. Even in a gathering of other fathers whose partners were suffering from PND, the men did not explore each other's experiences and did not develop collective wisdom that may have helped in collective coping.

Emmy van Deurzen's emotional compass (2014) is very useful in putting all of the fathers' experiences in context here, as it shows how the fathers felt a progressive downward spiral rooted in desire and hope but going through the negative emotions of anger, frustration, confusion and despair. Although the severity of the emotions felt by the fathers was not intense in most cases, it was clear that the perceived lack of support affected almost all the fathers negatively when their partners were suffering from PND.

5.4 Universal Theme Four: Surviving the situation

5.4.1 What helped in coping

As is evident from almost all the themes in the current study, the participants were faced with quite a challenging scenario when their partners were suffering from PND. Hence, the ability to cope with the situation was a critical factor. The birth of a child generally results in fathers having to draw upon their coping skills, which are essential in the face of stressful circumstances (Beutler et al., 2001). Some factors influence both partners simultaneously, for example, reduced intimacy, difficulties in communication, and anxiety. The fathers whose partners are diagnosed with PND also face the uncertainty about their partners' recovery and have fears about the well-being of the whole family as well as the difficulty of understanding their partners' PND itself (Davey et al., 2006). Almost all the participants interviewed in the current study described their own ways of coping with a difficult situation. While only a few things were common, including the ability to bury the emotions and adopt a practical approach, most of the coping strategies were different in terms of details, often depending on the individual circumstances. In this regard, previous research also does not help to provide broad categories of coping styles because while it mentions the need and the fact of fathers having to adopt coping strategies (Letourneau et al., 2011; Meghan et al., 1999) it does not elucidate the differences in coping styles. It may well be that it is challenging to find categories of coping styles because ultimately, everyone is different, and the details will always vary based on the individual and the circumstances. Some studies do mention particular facts, for example, Davey et al. (2006) find that participation in father-centric groups was beneficial.

In the current study, some participants found that the coping strategy did not need to involve any practical activity at all. Instead, for them, the coping was more centred on reminding themselves not to lose hope and thinking about past experiences where they got through adversity and having a positive approach. The participants felt that they could not allow themselves to become depressed when their partners were already going through PND, so they decided not to let themselves feel down. Previous research shows psychological support by their spouses is a strong factor in the ability of the partners to be able to cope with PND (Kim et al., 2007; Page et al., 2007; Paulson et al., 2010). It appears that the participants of the current study were leaning more on the personal strength and spiritual beliefs for coping, rather than focussing on concrete, practical activities. One contributing factor could have been the lack of time and resources to partake in any activity beneficial for coping or the lack of awareness about how physical activities might help in coping.

However, not all the participants emphasized the coping style described above. For some participants, more specific physical ways of busying themselves were important. Professional life was described as a significant factor by quite a few participants for the current study. Also, doing something which was not part of the daily routine of work, taking care of household chores and supporting their partner and child was described by multiple participants in the current study as beneficial. This is in line with previous research by Letourneau et al. (2011), where it was shown that the work provided a welcome escape for some participants whose partners were suffering from PND. Socializing with friends and sharing their experiences has been shown to be beneficial in terms of coping strategies by previous studies (Deave et al., 2008; Letourneau et al., 2011) and two of the participants in the current study also reported sharing with friends having a positive impact.

5.4.2 Impossible not to let people down

Almost half of the participants included in the study expressed the feeling that they had to let their partner or child down to be able to cope with the multitude of demands placed on them. One of the participants was concerned about letting his work colleagues down because of not being able to meet the demands of professional life and personal life at the same time. In her book Making Sense of Fatherhood, Miller (2011) describes experiences of multiple fathers where work commitments clash with the demands of family life. One father describes the catch-22 situation where the financial needs of the family compel him to concentrate on his work, but spending more time on work means less time is left to spend with the family. Another father expresses his desire to be a better father but realizes that any steps he takes would result in work or other commitments suffering (Miller, 2011). The degree of the challenge facing the fathers becomes clear when we consider that in most cases the fathers felt the need and strong desire to do more for their partner and child, but they were running into the limits of their physical or emotional reserves or were running out of time. Research indicates that fathers are stretched in terms of their physical needs, including sleep in particular. Although both mothers and fathers generally get less sleep after the birth of the child, fathers have less 24-hour sleep than mothers (Montgomery-Downs et al., 2013). Meighan et al. (1999) have also discussed the experience of fathers living with mothers who are suffering from postnatal depression. They concluded that the new father's life includes multiple sources of stress, including coping with the issues due to their partner's mental health, child-care and the demands of professional life. This again brings us back to the experience of participants included in the current study, where

it was quite clear that PND posed a lot of stress on the emotional as well as the physical state of the participants. Over time, this scenario took its toll on the participants, and they reached the point where they needed to push back a little bit. The most important aspect was finding a balance between keeping themselves functional and providing support to the partner and family at the same time.

5.4.3 Talking about the experience

Sharing their experience with others was not reported to have any negative connotations by any participant, and for two of them, sharing had a positive impact. The participants shared their experience with friends, work colleagues, family members and people they met anonymously on the internet. Friends and close colleagues both seemed to be good choices and encouraging words from anyone even when they did not know all the details seemed to have a positive impact on the participants. Existing studies indicate that fathers seek assistance from family and friends and internet resources like YouTube and other sources and at the same time they also seek professional advice from healthcare providers (Shorey et al., 2017). In addition, sharing is associated with lessening of the burden as felt by the fathers once they muster up the courage to talk (Evans et al., 2001). However, sharing is reported to be difficult for fathers because although they can be affected by the PND, fathers are generally reluctant to talk about it with others because they want to give the impression that everything is all right as far as possible (Evans et al., 2001). This might be related to the fact that only about half the participants included in the current study reported talking to others about their experience. One of the participants included in the research was urged by his partner to find help and to talk to someone because she could see that he was trying to keep everything in, and it was becoming too much for him to bear. It turned out that sharing his experiences indeed proved to be helpful for him. This is in line with the findings of prior studies where talking about the experience is shown to be of benefit to most fathers (Letourneau et al., 2011) especially in a group setting where hearing the experiences of other fathers helps to normalize an individual's experience (Davey et al., 2006). Generally, for the participants, sharing the experience almost always resulted in a positive outcome, but it needs to be noted that the participants were selective in sharing their experiences.

5.4.4 Existential perspective

There are three themes in this universal theme. The first one (What helped in coping), is mostly related to the spiritual world (Uberwelt) of the participants as the participants re-evaluate their

outlook towards what is meaningful and valued to them. The other two themes (Impossible not to let people down and Talking about the experience), mostly pertain to relating and being with others and thus fall in the social world (Mitwelt). The experience of all the participants had some common features here, notably the adoption of a positive outlook and holding on to hope with courage and resolve when they were trying to cope with some of the most challenging times of their life. Existential philosophy holds in high regard the value of the choice that an individual possesses and the individual's responsibility in the face of challenging circumstances. It is the philosophy of discord and strife, but also one of coping, boldness and managing (Kobasa, 1982). For the participants interviewed in this study, coping with the challenge of circumstances facing them and finding ways of managing their own suffering as well as managing expectations and responsibilities on them from the social sphere of existence, helped them grow as individuals and find a new depth of their own self. Existential theorists have discussed a multitude of examples of individuals who grow as a result of their sufferings and find meaning from the suffering. If at the personal level, an individual responds to suffering in the right way, with courage and resilience, then it possesses the potential to even bring many benefits (Frankl, 1962; Nietzsche, 2005). A few of the participants in the current research mentioned their growth and their partner's growth as a human being in terms of being able to better deal with strife and suffering in the future and being more resilient in the face of future hardships coming their way.

The participants in the current study reported focussing on every little joy and every small win that they could find, and it helped to tide them over tough times. Previously the very things that they considered to be unimportant, inconsequential, or not having any meaningful purpose, now helped participants whilst everything else around them seemed to be crumbling. Meaning is theorized as a stress buffer by many existential philosophers (Frankl, 1962; Yalom, 1980; Maddi, 1967). The individuals who can discover meaning and purpose in the things around them possess a resiliency against disintegration in the face of stress, whilst those low in meaning are more vulnerable to emotional problems that can be a result of stress (Mascaro & Rosen, 2005). Having a sense of personal meaning played a vital role for the participants in this study, especially when the situation they found themselves in became very stressful. As long as they could maintain a sense of personal meaning in the face of the reality they were challenged with; they were able to hold on to hope. The meaning here was of course discovered in forging an identity as fathers. They figured out what being a father meant to them, which was not necessarily expected or understood earlier. They realized that supporting and

sustaining the family in itself was a worthwhile and meaningful goal, and this, in turn, better equipped them to be able to survive and cope without losing hope.

However, coping involved a lot more than just the inward facing strategies. It had an unambiguous element of adjusting quickly to the unexpected crisis, being adaptable and being vigilant about how to balance their needs and responsibilities. It was impossible to meet all expectations and discharge all responsibilities as a husband, father, breadwinner and homemaker at the same time. They were faced with some hard choices where they had to choose between things which all seemed important to them. Facing dire circumstances, the participants had to be flexible and promptly adapt their routine, the balance between work and home life and the balance between personal needs and the responsibilities thrust upon them. The participants realized over time that they were free in their choices about how to respond to the difficulties and survive. The freedom of choice possessed by the individual is a fundamental existential concept, even though people may not be ready to accept the reality of this choice, and may instead become depressed and desperate (Kierkegaard, 1992; Nietzsche, 2005) or adhere to concepts that liberate them from the responsibility (Fromm, 1941; Sartre, 1996). The participants realized that when they made their choices about what to prioritize, compromises were bound to be there, and occasionally the participants had to disappoint someone to be able to cope with the demands of the situation; however, acknowledging the reality and responsibility for these choices liberated them from feelings of depression and despair. The essential elements that allow an individual to cope with the most difficult of circumstances are commitment, control, and challenge; and taken together, these are very close to what existential thinkers, such as Tillich (1952), meant by the "courage to be". For Tillich, the "courage to be" is the act of self-affirmation in the face of overwhelming anxieties about death, meaninglessness, and guilt or condemnation. The particular aspect which is more relevant here is the anxiety about guilt because that is generated because of not being able to live up to a self-imposed moral code, or to the individual's own universal standards. In having to let people down as described above by the participants, they were facing the prospect of not living up to their own self-imposed moral code, thus resulting in anxiety about guilt and condemnation. Here, the "courage to be" allows the individual to accept forgiveness and healing and to accept oneself "as being accepted" (Tillich, 1952). Looking back, the participants included in the study all unknowingly traversed the route of surviving in their situation by displaying the "courage to be", through taking responsibility for making the choices involving sacrifices of their own standards to be able to cope. Furthermore, they also discovered their capacity for

tolerating threats and losses and learnt how to reclaim their freedom and creativity to find meaning in the reality they were facing.

5.5 Universal Theme Five: Living with her PND

5.5.1 Concerns about recovery

The participants' concerns and worries about long-term effects of PND were mostly centred around whether their partners would recover fully and whether their relationships would be able to survive, how long it would take, and whether the child was going to be affected in any way. Some participants were quite worried about being able to sustain the family unit until the PND ended. In previous qualitative studies of fathers living with mothers suffering from PND, the men have described their experiences of fear, confusion, concern for their spouse, uncertainty about the future, disrupted family, social and leisure activities and financial problems (Boath et al., 1998; Meignan et al., 1999). In the current study, one of the fathers expressed his particular concerns about the financial outlook for the family and how it would change if his partner were not able to successfully restart the job she had been doing before PND. A few of the participants were significantly worried about successful recovery, i.e. wondering if they would have to live with a different person to the one that they had married. They also worried about their baby especially the long-term effects that PND was going to have on it. Research shows that as early as the first year of age, the cognitive, as well as the emotional development of the child, is affected by PND (Beck, 1998). Studying children up to five years of age, Murray et al. (1999) conclude that PND is associated with behavioural disturbances of the children, including their social adjustment and their behaviour at home. Going even further, Hay et al. (2001) looked at the IQ levels, the attention issues and the reasoning ability of children at eleven years of age whose mothers suffered from postnatal depression, and they found lower IQ levels, lower reasoning ability, and more significant attention issues. Similarly, PND had a negative effect on caregiving, which in turn affected language, (Stein et al., 2008). All of this seems to corroborate and legitimize the concerns of participants from the current study because they could instinctively predict the potential longer-term adverse effects of PND on their child. Overall, for the whole family, PND does seem to pose a significant challenge both in short and the longer term.

5.5.2 Fears about losing wife

Most of the participants interviewed as part of the current research were worried about their partners leaving the family and, in some cases, committing suicide because they perceived the

state of mind of the partners to be very fragile when they were suffering from PND. The participants had lost trust in their partners not making an imprudent decision. The result of these fears was heightened anxiety in the participants about their partners and the reluctance to leave the partners unattended long. This meant other activities which needed solitary time from the participants like having a break alone suffered and, in some cases, they also spent less time at work because they could not leave their partners alone for too long. The fears that the participants reported in the current study were based on their personal experiences, but looking at previous research, it seems that these fears have indeed turned out to be true in some cases. One example is the fact that the rate of suicidal ideation is reported to be higher for women suffering from postnatal depression (Henshaw, 2007) and it is one of the leading causes for mortality in postpartum women (Lewis et al., 2011; Oates, 2003). In particular, women who are suffering from anxiety in addition to PND are at significantly increased risk (Busch et al., 2003; Fawcett et al., 1990). The participants included in the study felt that they were responsible for managing to keep the family together while their partners were suffering from PND. Additionally, they were worried about the effect on the child if the partner were to leave the family or separate from the participant. Richman et al. (1982) have found that depressed mothers have faced difficulties managing the child and have thoughts of leaving their home and child altogether. Although the participants in the current study tried to convince themselves that their partners would not do anything that would not be in the best interests of the child, their anxiousness and lack of confidence about the state of the mind of their partners did not allow them to keep their fears at bay.

5.5.3 No embarrassment

Almost half of the participants included in the current research stated that they never felt embarrassed about the fact that their partner was suffering from PND. It was felt that PND had become quite "normal", with quite a few women suffering from it after childbirth. Additionally, PND was considered by the participants to be an illness, just like any other, that takes its course, and eventually, the person starts feeling better. This is corroborated by recent studies (Engqvist et al., 2011), where fathers consider PND to be an illness that affects the whole family and for which the whole family must plan and share the pain and joy. Thus, the overall feeling was more of pride and joy once the partners had started to feel better rather than embarrassment when they were going through it. In contrast, it has been reported in the past that fathers feel embarrassment in addition to guilt, frustration and confusion (Beck, 1999). However, a considerable time has passed since that study was conducted, and it may reflect the changing

attitudes in society towards PND that none of the participants in the current study reported that feeling. In contrast, participants did report fear of stigma concerning opening up and discussing their personal struggle and personal challenges when their partners were suffering from PND. This is in accord with the fact that awareness about fathers' experiences is still much more limited compared to the awareness about the fact that the mothers go through PND. Thus, there seems to be still a stigma attached to disclosing the personal struggle and issues of the fathers whilst there is no such stigma attached to the fact that their partners are going through PND. As far as disclosing or discussing with others was concerned, some participants avoided that in order to be safe from getting inappropriate feedback from others. However, other participants did not care about disclosing the fact that their partner was suffering from PND at all, and one even considered it to be almost a rite of passage nowadays with feelings of pride and joy being more apparent at having overcome adversity and been successful at surviving the challenge. The confidence and pride in the capacity for survival was a big gain for the participants.

5.5.4 Challenging to be strong for the wife

The fact that it was a very hard task to be strong and keep providing the emotional and physical support required by their partners was quite evident from the interviews. Stress, induced by the physical effort and tiredness, coupled with stress because the participants could not lean upon their partners emotionally and had to manage their own emotions alone all added up to making it very challenging. Financial stress was also mentioned as a factor by one participant.

Several studies have looked at how it becomes challenging for the spouses when the partners are suffering from depressive symptoms. In the PND context, the factors which have been found to be important include changes in the way the household tasks and responsibilities are assigned, how much time the partners are able to spend with each other and how they feel about their relationship (Dew et al., 2011; Shapiro et al., 2000). Also, the generation of stress because of negative interactions with the depressed individual has been mentioned as a factor (Davila et al., 1997). In the current study, the main factors on the emotional side for the participants were managing their own frustration and sadness, trying to be sympathetic, overly positive and happy all the time and absorbing all of the partners and their own emotions and not getting any opportunity to express or offload them. Thus, the PND of the partners ended up creating a stressful environment at home in terms of the emotional aspect and the spousal relationship generally suffered as a result. Previous work in a variety of contexts points towards the connection between stress and depression including in children as well as adults (Pianta et al.,

1994; Sandier et al., 1994) with the depressive symptoms in partners found to be particularly important in regard to marital relationship (Davila et al., 1997).

On the physical side, the main factors included lack of sleep, lack of energy, day-to-day household responsibilities and looking after the child at the same time with the result that they got no downtime for themselves and generally ended up being extremely tired most of the time. The lack of sleep was a particularly problematic factor for the participants primarily because with a young child their sleep was disturbed already, and they also ended up doing a lot of the early mornings and late nights to help their partners get enough rest to cope with the day. Also, as mentioned in section 5.2.4, the physical side of intimacy and the sex life suffered, which deprived the participants of another pleasurable shared activity with their partners. The day-to-day household responsibilities have been shown to be a factor by previous research on PND, where a connection between the burden placed on the spouses of women suffering from PND was found to be important. Furthermore, the absence of joyful activities involving both spouses and financial stress in case of the partners being unable to work has also been mentioned (Whisman et al., 2009; Benazon et al., 2000). In the current study as well, one participant did mention that financial stress made it harder for him to provide stability and support to his partner while she was suffering from PND.

5.5.5 Being careful about what I say or being reticent

The participants interviewed as part of the current research, stated that it was not easy for them to express their concerns or feelings or even discuss everyday affairs with their partners when the partners were suffering from PND. Anything that could be considered even slightly negative was always picked up on by the partners, and ultimately generated frustration for the couple. This made the participants necessarily careful about what they said and how they said it, including even simple questions about day-to-day life. Recently, Shorey et al. (2017) mention that fathers feel like they cannot talk to their partners about their experiences when partners are suffering from PND. Also, PND has been shown to generate relational stress and distress including concerns about being rejected, unexpected anger, dissatisfaction and poor communication of needs and expectations between partners (Davey et al., 2006; Tammentie et al., 2004). Offending the partner being a barrier against sharing the feelings has also been mentioned as a factor (PostpartumDepression.org, 2019). All of these seem to align well with the experience of the participants in the current research who felt like they need to be very careful about if and how they could express their feelings or expectations.

When the partners were going through the worst phases of PND, everything was perceived as a criticism. Even after the partners had ceased to be affected in a severe way, participants still felt that they had to be more aware of their partners' feelings while they were talking to them. Meghan et al. (1999) describe how fathers tend to sacrifice their own feelings when the partners are going through PND and suffer in silence, hoping to support their partners until they get better. Also, Chesler and Parry (2001) describe similar feelings where fathers feel like they should be a stoic source of support for their partners. This also aligns with the traditional perception of men being physically and emotionally strong and self-contained (Tammentie et al., 2004). It seems like fathers (including the fathers in the current research) are pushed towards suppressing their feelings, concerns and queries both because of their perception of their traditional role as well as because of the condition and expected response of their partners. The implications for therapeutic work could be interesting here because the behaviour patterns described above, whether engaged in knowingly or more unconsciously, could result in increased levels of stress and relationship issues. This may be especially important if the scenario persists for a significant time. It may well be that exploring this domain during individual and relationship counselling will uncover underlying issues and causes that can be resolved.

5.5.6 Existential perspective

The essence of the experience in this theme is struggle and strife to such a degree that fathers are in danger of being overwhelmed by negative feelings and emotions. All the constituent themes of this universal theme pertain to the social world of the fathers as they explore how the husbands related to their wives and the feelings and emotions of the husbands for their wives. However, one of the themes (Challenging to be strong for the wife) is almost entirely focused on the internal struggle of the participants, hence falling in the personal world of the participants as it is related to the inner sense of being a valuable person, a person of worth.

The participants' life-world, as far as family life was concerned, changed drastically. They had to assess what they considered to be important and worthwhile in the backdrop of their changed reality, and this affected almost all spheres of their existence. They also faced their fears about losing their partner, either in the sense of the partners never being close to what they were before PND, or in the sense of the partners leaving the family forever or dying through suicide. Death is one of the fundamental human concerns, according to existential philosophy. Contemplating death lends authenticity and meaning to life (Heidegger, 1927). Emmy van

Deurzen expresses this as death being an important reminder of life and says that when we come to terms with death, we start to take our lives more seriously (1997, p. 111). The deaths of near and dear ones are the first gateway through which death enters the realm of our consciousness. Looking at the participants' experiences, confronting the possibility of the demise of their partner translated into them experiencing their fear of death head-on. The death did not even need to be actual event of the demise of the partner, because as Heidegger says in Being and Time (1927), human existence is a constant movement in time with the past being where we are no longer, and therefore we die a little bit each day (van Deurzen, 1988). For the participants, the fact that their partners had changed irrevocably as a person after the birth of the child, and that their relationship with their partners had also changed irrevocably, meant that the partner from their past, and relationship that they had, was gone forever. Thus, the "deathly" fear that afflicted the participants was that of irreversible loss, either through physical death of their partners or through the loss of their partner-as-they-used-to-be and their relationship that they held close to their hearts. Different participants, of course, had their own way of coping or confronting their fear. Some felt that letting themselves become paralyzed or less functional was just not an option when their partners were already going through PND, so they resolved not to let themselves feel terrified or depressed while others found that for them, what helped was reminding themselves about past experiences where they got through adversity with a positive approach. For most participants being able to confront the fear of death resulted in increased resilience for future challenges. They discovered new stores of hardiness and strength and learned to be stronger for the sake of their partners in the first instance, but actually for the sake of the whole family if we delve deeper. With participants stretched to their limits and finding themselves becoming vulnerable, they discovered their own real strength, which had been latent until that time (Van Deurzen, 2014). Looking at the descriptions of participants' experiences in the themes that constitute this universal theme, the first two of them are firmly looking at the future dimension of time, or in Heidegger's terminology of ec-stasies, pertaining to Zukunft: longing and dreading but also being with anticipation and possibility (Van Deurzen, 2014). The participants were not only confronting death here but also longing for their partners to get better or be close to what they used to be like but equally, dreading the possibility that the partners will never return to being what they used to be like. The experiences of the participants elucidate impactful changes in their own selves in addition to the partners as a result of parenthood and PND, and there may have been an element of confronting the possibility that they the participants themselves are never going to be what they used to be like before. Most of them did believe, though, that their experience

was going to be limited in time and that there was going to be a future where they could be free of the pressures that they were facing. Even though they could not know for sure what the future entailed, they could see that it would not be endless suffering. This reminds us of the experience of the prisoners in the concentration camps that Frankl (1946) talked about; where they were able to create meaning out of their suffering because they held on to hope of a better future. The dimension of time was very important, and all participants appeared to have had a strong faith in there being a better future.

The participants also had to be cognizant of the effect on their Mitwelt, the social world of relations with the fellow human beings in general. They had to gather their courage and remain confident and vigilant because being vulnerable themselves meant the whole family became exposed and defenceless. This aspect particularly comes to the fore when participants discussed having no embarrassment about the fact that their partners were going through postnatal depression. Van Deurzen (2014) has discussed another world, the spiritual world or Überwelt, rooted in the works of Kierkegaard (1844), Buber (1923), and Tillich (1952). The Überwelt is the ideal world of values and beliefs where we create meaning and make sense of our lives. Faced with the prospect of drastic changes to their life-world, participants had to evaluate what the core values were (which they wanted to prioritize and preserve) and this, in turn, forced them to immerse themselves in re-imagining their spiritual or ideal world of existence. Several participants did hint at the internal strife and struggle within themselves regarding their values. The prolonged struggle provoked them to question the value of maintaining trust in a better future, but at the same time whilst facing despair, they held on to the value of human improvement. For some participants, not losing faith in their partner was a core value that kept their hopes alive. Almost all the participants also leaned upon their understanding about time healing all wounds, and they placed their trust in that value to lead them through the worst phases when nothing seemed to be helping.

5.6 Universal theme six: Personal challenges

5.6.1 Tough to deal with the situation

For the participants, it was a very hard challenge to deal with the scenario when their partners were suffering from PND. There were several sources of stress all acting at the same time, making it impossible to make sense of what was happening and how they were getting affected by it. Prior research shows that the period after the birth of the child involves many changes

for the parents including physical factors such as lack of good quality sleep, meeting the demands of the child and new parental obligations thrust upon the parents, which all combine to increase the stress levels (Page et al., 2007). One factor brought out particularly by the participants in the current study was the inability to logically think through the problem when they were going through the challenging circumstances so that all the efforts were limited to short-term thinking and long-term planning got relegated to the point where it never got attention. Existing research studying the fathers whose partners were suffering from PND indicates that the fathers feel unable to understand their partners' experience. They try to provide as much emotional and practical support as possible to "fix" the issue but end up feeling helpless when their efforts are not successful which in some cases results in confrontational and argumentative behaviour (Morgan et al., 1997). Fathers themselves freely acknowledge the inability to understand their partners' PND (Everingham et al., 2006). What kept the participants of the current study going despite the lack of understanding described above was the belief that they could continue to be good and loving partners, and also the fact that they got some value out of knowing that they were working hard and being good partners even when it was not easy.

The descriptions of participants of the current study made it clear how hard it was to deal with the situation when their partners were suffering from PND. Stress emanated from multiple causes, all acting at the same time. Research indicates that fathers experience a tension-filled and unfriendly household environment where they have to bear most of the responsibilities and physical work burden and still find it hard for their efforts to receive any positive acknowledgement (Meighan et al., 1999; Webster 2002). Almost all of the household responsibilities suddenly become their responsibility, and they have to manage independently. Furthermore, fathers see their parenting undercut and criticised (Morgan et al., 1997).

Multiple participants expressed the view that life changed a lot compared to the time before the birth of their child. Several research articles describe the broad, and wide-ranging changes in the way life for the fathers and the fact that they find these changes difficult and taxing (Hall, 1995; Barclay et al., 1999). They feel that they are compelled to modify their conduct and approach (Hall, 1994; Anderson, 1996) and that these forced changes and constraints cause frustration (Ahlborg et al., 2001). In extreme cases, the fathers themselves started showing signs of depression during the postnatal period (Areias et al., 1996; Roy, 2006). With the increasing demands on the physical as well as the emotional side and with the lack of time to

stop and make sense of anything, fathers start to lose hope that they can have any impact on the situation as if they are mere bystanders (Boddy et al., 2016). They start becoming frustrated and despondent, without any control over the situation which in turn generates depressive feelings. Numerous previous studies have looked at the connection between depressive feelings in fathers when the mothers are going through PND. It has been shown that fathers whose partners are suffering from PND had higher rates of depressive disorder and symptoms of depression (Roberts et al., 2006). Moreover, clinical records document the effects such as reduced intimacy, stress, confusion and fears about the partners' recovery as distressing factors that cause fathers to start feeling despondent (Davey et al., 2006). Further studies conclude that fathers whose partners are suffering from PND are 2.5 times more likely to end up depressed compared to others and there is a strong connection between mothers' and fathers' depressive feelings (Matthey et al., 2000; Goodman, 2004; Bielawska et al., 2006). Although none of the participants in the current study reported being depressed themselves, they did express strong feelings of despondency and resignation, and there is quite a close link between these feelings and depressive thoughts and symptoms (Van Deurzen, 2014).

5.6.2 Not knowing how to deal with it

Almost all the participants interviewed in the current study reported that they were unprepared for their partner's PND and did not know how to deal with the scenario. In some cases, participants had never had any mental health issues or been with anyone who had mental health issues, so they were very unsure about what they were supposed to do when they were put in charge of the family's welfare and their partner's care who was dealing with PND at that time. Literature shows that among the factors which bolster or constrain any transition, preparation and knowledge are essential factors (Meleis et al., 2000). Having enough time to prepare has a positive impact on the experience of the transition as does procurement of information about how to cope with the change before going through the transition (Meleis et al., 2000). In case of couples expecting the birth of their child, most report that parenting skills are not focused upon at all during the antenatal training classes. As such, they gain very little knowledge in this area, thus creating a situation where most of the new parents feel unprepared for the major transition into parenthood and the new responsibilities that they are expected to take care of (Wilkins, 2006; Deave et al., 2008, Fägerskiöld, 2008; Shorey et al., 2015). Barclay and Lupton (1999) have shown that fathers do not expect the newborn child to be unable to interact socially and to have the degree of demands that they end up facing from the baby, thus generating

feelings of unhappiness in fathers. Additionally, it has been shown that when mothers are suffering from PND, the social interactions between the spouses become unconstructive and complicated with the result that the fathers suffer a decline in their ability to understand and make sense of the situation or to have a positive impact on the situation (Meghan et al., 1999). In light of the research above, it is easy to see why none of the participants included in the current study felt confident about knowing the answer to the question of how best to support their partners or deal with the scenario that their family was facing. Lack of knowledge and no one providing a deep enough insight into postnatal issues before childbirth, especially the complete lack of focus on maternal PND, can potentially create feelings of being unqualified to deal with the situation and this was reported by multiple participants.

5.6.3 Day to day survival

Over half of the participants included in the current study indicated that their best efforts failed to have any impact on the situation, and the downward spiral of postnatal depression continued to affect their family life. At that time, their concern shifted to just getting through the days somehow and keeping the family unit together and functional in the hope that over time, things might improve. They focused on household chores, childcare, sleep and work cycle, and repeated the whole routine without having any time or cause for celebration, trying to manage the crisis and survive through the challenging times. Previous studies have reported the postpartum period as stressful with a substantial impact on the life cycle of the family and resulting in a crisis in some cases (Deave & Jonhson, 2008; Diemer, 1997). Also, Bennett & Cooke (2012) conducting a qualitative study of the experiences of fathers living with women suffering from PND, discuss a phase at the start of the coping process where the fathers feel "out of control". In this phase, fathers feel that they are unable to have any impact on the situation and although they do not have control over anything in the real sense, they are still expected "to hold it together" somehow (Bennett & Cooke, 2012). This seems to map well to the experience of the participants in the current research, where participants were striving to keep the family intact and functional while feeling as if they were crisis-managing and surviving day-to-day. It is quite possible that this coping style is more relevant for the fathers and if compared to how mothers cope with the scenario we would likely find a different approach but whilst that comparison might be interesting, the current study did not explore that in any detail.

The participants in the current research, whilst they were pushing themselves to do all the right things, both at work as well as at home, started to feel quite desperate about themselves at that point. However, as mentioned above, their response was to concentrate on what they could do from their side and gain time to let the situation improve. Focusing on autonomy rather than seeking more support from family or professionals or trying to reinvigorate the marital relationship has previously been reported as a coping mechanism and strategy by the fathers going through crisis management (Adler, 2012; Lilgendahl & McAdams, 2011). In particular, focusing on the relationship with the child independent of the relationship with the mother has been shown to be an important factor (Easterbrooks et al., 2007). Indeed, the experience of quite a few participants in the current study does suggest that whilst they did not completely give up trying to recover the relationship with their partners, they did put that aside for a while and focused instead on childcare and household-care. This response of focussing on the physical dimension was not unexpected, given the fact that they were facing a crisis at that time.

5.6.4 Feeling powerless

Some participants reported feeling powerless and helpless in the face of not being able to make an impact on the way their partners were feeling when they were suffering from PND. As the main issue here was related to the mental health of their partners, the participants had no direct way to influence their partners' internal thoughts and feelings, and even though the participants did realise that fact, they could not stop feeling powerless and useless. Prior research looking into the impact of mother's depression on their spouses has found similar feelings in men whose partners were suffering from depression (Boddy et al., 2016). In addition, Meghan et al. (1999) also looked at the experience of eight fathers beginning with the birth of the child and continuing through the period when the mothers were suffering from PND. They noted that the fathers felt unable to have a positive impact on the situation when they tried to "fix" the problem somehow, thereby resulting in them feeling powerless and helpless. This has also been associated with other negative emotions, including resentment, frustration, anger and fears (Meghan et al., 1999).

One particular concern expressed by some participants in the current study was the fact that they could not do anything to make their partners see things from what they thought was a rational, logical viewpoint or change the way the partners felt about their relationship even

after trying to be as accommodating as possible. This is in contrast to earlier research where a positive correlation between relationship satisfaction and being able to overcome the negative effects of PND was found (Page et al., 2007; Kim et al., 2007; Paulson et al., 2010). Generally, women's sense of well-being is positively reinforced by their perception of how supportive their partners are (Misri et al., 2000). In the current study, however, the participants seemed unaware that their support could result in improvement in their partner's feelings. One possible reason for this discrepancy could be that the participant's expectations about the degree of improvement in symptoms of PND or the time over which the improvement happened may have differed from the actual degree or period. This may have resulted in them feeling helpless, even though their support and efforts were going to result in positive developments over time.

5.6.5 Not Opening Up

A few of the participants stated that they found it difficult to open up to others about their experience. They believed that the effects of PND on family life were of a private nature, and others would not be able to understand or help much. The other barrier to opening up was the expectation they placed on themselves to stay strong and to absorb all the emotions, even though not speaking to anyone was over time making them feel like a pressure pot ready to explode. Looking at previous studies, men are generally considered to be less expressive than women (Kim & Swain, 2007). This is partly fed by the social and cultural expectations about masculinity, which emphasise strength, independence, and invulnerability (Mahalik et al., 2003). It is not surprising then that men are more likely to rely on themselves than seek help (Offer et al., 1991); especially as seeking help can be seen as a potential threat to a person's self-worth (Vogel et al., 2006). The behaviour of the participants of the current study seems to be in line with the previous research here, because they mentioned a sense of responsibility and an expectation about staying steadfast in the face of the challenge, translating to them not going out towards others and sharing the experiences and potentially seeking advice and help.

It is important to note that the participants of the current study were ready to talk about their issues if the other person was deemed capable of helping; either a professional or somebody with previous experience of PND. This seems to have been a perceptive choice because looking at previous studies, seeking informal advice and help from untrained acquaintances has been shown to be of doubtful utility (Offer et al., 1991; Rickwood, 1995), whilst seeking support from professionals on the other hand, is well established to provide significant benefits

especially when it comes to mental or psychological issues (Martin, 2002). It appears that whilst not opening up may be a judicious choice in order to protect against getting inappropriate feedback from people who do not appreciate the intricacies of the situation, it can also result in lost opportunities in multiple cases as described in section 5.3.4. Thus, the aspect of opening up and sharing needs careful evaluation to make sure it remains overall beneficial for the participants.

5.6.6 Existential perspective

As is evident from the name of the theme, this universal theme is almost wholly focussed on the personal world (Eigenwelt) of the participants, and all the constituent themes except the last one (Not opening up) fall in the personal world. The last theme has a strong element of sharing (or not sharing) the experience with others; hence, it straddles both the social and personal worlds. The basic experience here is participants finding themselves not up to the task and not able to overcome the challenge of the circumstances thrown their way. It is a journey for the participants who start off looking inward and being surprised at the magnitude of the challenge, and subsequently, it goes through the emotions of worry and confusion, followed by misery, and finally resignation and despondency. In the personal world of the participants, a sense of complete powerlessness and incompetence starts to develop. For the participants, who in most cases were previously not used to most of these feelings at least for quite some time, this results in new facets of their personal development coming to the fore. As Binswanger (1963) says, the Eigenwelt 'confronts us with life events that put our inner self at stake'. For the participants of the current study, there were sporadic instances of the realisation that the crisis management had helped them acquire new skills and better equipped them for the future. However, at the time when they were going through the thick of it, things felt chaotic to them because they did not have the time for closer examination of their personal world to see what was happening there. All their effort and time was taken up by the other more immediate needs mostly pertaining to the other dimensions of existence, so the introspection required to become cognizant of their personal world changes was impossible. They were just aware that they were faced with a huge challenge and that they were unable to do anything that would result in immediate improvement; hence, the feelings of resignation and despondency that were discussed earlier. Living differently had an impact on the participants' sense of themselves and their personal world. Where they had previously not been stretched to the extent that they run into their limits of physical and emotional endurance, the personal challenges faced when living

with their partners' PND forced them into that situation. From an existential point of view, the struggle and strife that forced the participants into despondency is, of course, a recognisable effect of the environment that the participants found themselves in, but the question of how they responded at the personal level to overwhelming challenges when giving in was not an option is very important as well. As Emmy van Deurzen has noted (1988, 1997), hardship and difficulty are "important and necessary parts of coming to ourselves in depth", and individuals need to become the architects of their lives rather than being passive victims of circumstances. The participants' response to the feelings of helplessness and powerlessness varied quite a lot in the current study, but none of them gave in, in response to the challenges facing them. For some of them, it helped them to develop as a person by gaining more resilience to adapt and cope with adversity. For others, it resulted in them realising the freedom of choice that they possessed to be able to re-define the meaning they found in the reality they were facing. This is further discussed in the Universal Theme Four: Surviving the situation.

5.7 Universal theme seven: Meeting expectations

5.7.1 Work-life balance

The majority of participants interviewed experienced severe difficulties in maintaining a healthy work-life balance when their partners were suffering from PND. The demands of employment have previously been shown to limit the time fathers have left for any parenting or support tasks (Barclay et al., 1999). The issue of lack of time was intimately intertwined with the participants' experience of work-life balance in the current study as well where the participants reported interruptions and sometimes having to take extra time off work in addition to the normal holidays. The work-day also became stressful for most participants because of things piling up. Multiple studies highlight the burden and resulting tiredness that fathers experience (Hall, 1994; Anderson, 1996). In addition to the lack of time, lack of sleep was another factor mentioned by multiple participants who were interviewed, and this is again corroborated by numerous previous research studies (Hall, 1994; Ahlborg et al., 2001). The distractions and resulting lack of concentration was another important issue for some participants, and as shown by previous work it becomes harder for fathers to maintain job responsibilities in addition to the newly added parental responsibilities (Cooklin et al., 2015). This was further exacerbated by the fact that participants were the breadwinners in most cases and thus the financial stress was mostly felt by them especially as their partners were unable to cope with those issues due to their PND. There has been quite a lot of research on the financial

burden aspect, and several researchers explain how fathers spending a longer time in the office translates into less time spent with the baby and how the partners' needs are at odds with the work needs (Kowlessar et al., 2015). Being an involved parent also clashes with financial compulsions and fathers are unable to be there many times for events where parents and children are supposed to attend together or for trips to the doctors' surgery (Chin et al., 2011) with all of this ultimately resulting in feelings of dissatisfaction and unhappiness.

5.7.2 Unable to put own needs forward

A few of the participants included in the study felt that they were not in a position to be able to put forward their own needs because, in their mind, other needs took priority over their personal needs. Examples of these included the need to support their partner, the need to take care of the child, and the need to continue doing the minimum to allow the household to remain functional like laundry, cooking, and cleaning. They were aware though that they had put themselves aside for the time being and were behaving as if they exist only to serve the family's needs and putting their own needs on the back burner. Recent qualitative research looking into the experiences and support needs of first-time fathers reported similar findings particularly with regards to the emotional needs where fathers refused to focus on their emotional needs because they felt their partners needed emotional support more at that time (Shorey et al., 2017). In the current research, the participants felt that whilst their partners were going through the worst phase of PND, getting any support for themselves even from external sources was not the right course of action if it would take time away from their main role. In this regard, Shorey et al. (2017) have described the fathers employing coping strategies such as talking to their babies or themselves or smoking more and indeed this is aligned with the current study as well where fathers describe talking to themselves as one method of coping with the emotional stress. Beestin et al. (2014) also report that fathers feel as if they are cut-off from being able to gain access to external support for their own needs, both because of the fear of stigma and perceived judgement from external sources as well as the fear of the effect it might have on children. The participants in that study also felt that they should not urge their partners to take on more parental or household responsibilities, but then they were left with an imbalance, a "void" that they had to fill by sacrificing their personal needs, but against which they felt powerless and helpless (Beestin et al., 2014). An important aspect here is the temporal progression of this feeling as the partners start recovering from PND. One participant in the current study described that when he felt his partner had recovered to a degree, he felt as if his

needs should start to be heard. However, this caused discord between the partners because his partner believed she was still going through depression and therefore, should not be asked to address the participant's needs at that time. This highlighted the difficulty that participants faced when deciding to try to put forward their needs at any time because it could result in upsetting the fragile balance in the already distressed household. However, as mentioned by multiple participants in the discussion in section 5.2, the realisation that looking after themselves was essential as their strength was so vital for the whole family during the critical time was there and the participants did try to address their needs as and when they could.

5.7.3 Not having enough time

Most of the participants included in the current study reported that their partners were not able to take care of the daily household chores like making dinner, washing clothes, general cleaning and others and also take care of the child at the same time. Thus, the participants had to choose what tasks they could take care of when they returned from work, and there was not enough time to take care of everything; thus, some things were de-prioritised by necessity, and over time it generated the feeling of a never-ending workload. Also, there was an expectation to off-load the childcare tasks as well so that the partners could have a break before the next day, which again meant more pressure on the remaining time left. Recent studies looking at the experience of fathers who are living with mothers suffering from PND report that lack of time is a common issue (Letourneau et al., 2011). An additional factor here which caused emotional burden and made establishing an emotional connection difficult with their partner was the fact that spending quality time with the partner meant neglecting other important tasks. Lack of time together has been shown to result in relationship distress (Goodman, 2005), and this was reported by the participants in the current research as well. Conversely, some studies have indicated that time pressure can result in couples struggling to find time apart from each other for personal pursuits (Bradley et al., 2010) but whilst this can be inferred from the descriptions the experiences of the fathers in the current study, none of them considered this to be an important issue. What did matter to the participants of the current study, however, was that lack of time meant they felt overwhelmed by the constant never-ending demands to the extent that some of them wanted to disappear for a while. Prior research shows that long work hours do not result in marital stress and conflict, but the constant lack of time and work demands do result in deteriorating marital relationship (Crouter et al., 2001), and this is fully aligned to the fathers' experience as described in the current research.

5.7.4 Existential perspective

This universal theme mostly pertains to the Personal world (Eigenwelt) of the fathers, but one of the themes (Work-life balance) does touch upon the Physical world (Umwelt) to a degree. The focus here is on the expectations placed on the fathers from different sides, including from themselves. The first set of expectations are from the Umwelt. The fathers have to face the reality of continuing to fulfil the responsibilities of their role as the breadwinner for the family and balancing the demands of work and family life. The other expectations pertain to the Eigenwelt of the fathers, where they place expectations on themselves about prioritising the needs of their partner and child above themselves and their own needs. This expectation purely lives in the personal world of the fathers because none of the fathers mentioned that they were asked by their partners or others to de-prioritise their own needs. Finally, the third set of expectations are also related to the Eigenwelt again, where the fathers were not satisfied by the degree of support they were able to extend to their partners because, despite wanting to relieve their partners of a lot more responsibilities, the fathers ran into situations where it was impossible to meet their partners' needs. The predominant change in the personal world of the fathers is the new way in which they compel themselves to feel and behave after they become fathers. There are lots of emotions of misery because of the physical and emotional hardship, excessive responsibilities which cannot all be met resulting in an element of despair, and vigilance in terms of not putting their own needs forward; however, none of the fathers reported giving in to their feelings of despondency. The question is, how did they deal with the misery and how did they prevent themselves from sinking into despair and depression when, in many cases, they had to endure the hardest challenge of their lives? Maybe what helped the fathers here was their new-found purpose, i.e. being the last line of defence for the whole family. They knew that in not letting themselves sink into despair they were not only protecting themselves but also protecting their partner and child and maybe this lent a meaning to all their hardships, and as Frankl has said, once they discovered "why", the fathers were able to transcend their previous limits to live with the new "how". The participants discovered that they could maintain a sense of personal meaning in fashioning their identity as fathers which encompassed finding ways of improving the situation to support their family and this enabled them to sustain their endeavour even in the face of adversity.

5.8 Universal theme eight: Being with others

5.8.1 Impact on close relationships

The interaction that the participants were able to have with other close relationships like their parents and even their own child was affected by the set of circumstances when their partners were suffering from PND. Although the experiences of different participants had little in common in this regard, the underlying feeling that they were unable to have as much time and contact with other close relations as they wanted was present in all cases. Existing research is in line with the findings of the current study here as a number of researchers have outlined the adverse effects of maternal PND on the interactions parents are able to have with children (Kim et al., 2007; Bazemore, 2010; Goodman et al., 2014) and how close relationships can be harmed (Moran et al., 2006). In the current research, the relationship of the participants with their own parents was affected in some cases because the participant's parents could sense that the father and mother were under a lot of stress and that there was a lot of frustration and the spousal relationship was suffering.

For one participant, his daily routine left little time to spend with his daughter, so he ended up trying to compensate by spending a lot of time with his daughter when the weekend arrived. Prior studies on maternal PND have established that fathers becoming more involved with children can help offset some of the adverse outcomes when it comes to the child's wellbeing (Chang et al., 2007; Mezulis et al., 2004) and also that maternal PND can provoke more father involvement over the medium and longer term (Edhborg et al., 2003; de Mendonça, et al., 2012). Some relatively recent qualitative research also supports the notion that fathers become more involved in response to their partners' depression (Beestin et al., 2014). However, there is also evidence that maternal anxiety, which is often associated with maternal PND and was reported by multiple participants in the current study as well, often results in the mothers not letting fathers be responsible for infant-care tasks and end up constraining fathers to some extent in this regard (Beestin et al., 2014). In the current study, one participant did report not being able to take part in infant care to any significant degree at all, causing feelings of resentment and sadness as well. Generally, in consonance with the research literature, the participants believed that their close relationships always got affected by the challenge of trying to meet the demands of the situation when the partners were suffering from PND.

5.8.2 Existential perspective

This minor universal theme falls under the Social world (Mitwelt) because it mainly deals with how the participants' relationship with others is affected as a result of the scenario faced by them. Three participants discussed this theme, and all of them mentioned that their relationship with others suffered because of the lack of time and the need to prioritize spending their energy on supporting their partner who was most in need at that time. Irrespective of the consideration that there were constraints which were not allowing participants to devote time and energy on maintaining their relationships, they could not escape the fact that human beings are wired for relationships. Going back to Heidegger, Mitsein is an inherent structural part of Dasien, and being-with is "equiprimordial" with being-in-the-world (Heidegger, 1927). Social relationships are an innate need for us and existential therapists (Wong, 1998) emphasize the importance of building and maintaining relationships for our wellbeing. The fact that the constraints upon time available and other issues hampered the participants in their efforts to maintain relationships with others around them, had the inevitable effect of increasing the extent of the challenge confronted by the participants. Another interesting facet was how participants were apprehensive of their personal world being affected if they opened up to others and leaned upon others. They felt the need to protect their privacy and keep their personal concerns, fears and issues to themselves – or at most share those with professionals only – because if they shared more openly, they were apprehensive of receiving wrong feedback or comments which could leave a negative impact on themselves and their partners. In addition, the participants were apprehensive of others trying to help but, in the end, causing further problems rather than being helpful. Hence, it seemed like there was a subtle effect on their Mitwelt and their way of being with others due to the concerns in their Eigenwelt. In a way, the participants were looking at their relationship to themselves in terms of the ''kind of dad'' they want to be, and then trying to find a way to be it. At that point, this also bordered on the spiritual dimension as their values of wanting to be a good and loving person and creating a better world for the family were constantly driving them forwards.

Looking back at the discussion of all the themes, it is evident that living with a partner suffering from PND has a marked effect on almost all aspects of the participants' lives. All the dimensions of their existence, including physical, personal, social and spiritual, are impacted. The whole experience appears to have made the participants more aware of a philosophical dimension in life. They had to ask themselves questions like "what is a family for" and "how do I want to be in relation to my partner who is suffering". In order to respond to these

questions, their worldviews had to change or at least become more explicit. The next chapter will examine the implications of these findings, in particular how the therapeutic practice can benefit from the learnings to better support the participants, and how prevalent healthcare practices can potentially be altered to better accommodate the needs of the fathers and indeed the whole family.

Chapter 6 Conclusion

6.1 Summary

Postnatal depression (PND) is one of the most important mental health complications, affecting about a fifth of all the mothers after the birth of the child (Beck, 2006), and its effects encompass the whole family (Halbreich, 2005). While most aspects of PND have received attention in the research literature, the experiences of partners of women who are suffering from PND have only been considered by a handful of studies (Meighan et al., 1999; Smith, 2013). The current research aimed to enhance the knowledge base in this critical area because fathers are deeply affected by the PND of their partners (Goodman, 2004), and increasingly the fathers are taking on greater responsibility for childcare (Fenwick et al., 2011), playing an essential role in the psychological wellbeing and growth and progress of their children (Wilson & Prior, 2011). The present research adopted the phenomenological approach and delved deep into the experiences of the fathers, but importantly, it also examined the experiences from an existential perspective. While there have been a few studies on the experiences of fathers whose partners are diagnosed with PND, I have not been able to find any previous research that explores the experiences of partners of women suffering from PND from the existential perspective. This study aimed to plug that gap and analyze the effect of their partner's PND on all dimensions of the fathers' existence. The significant findings of the study were grouped under eight universal themes that lay beneath the fathers' experience, viz. *Emotional roller-coaster, Suffering as a couple, Lack of support, Surviving the situation, Living with her PND, Personal challenges, Meeting expectations* and *Being with others*. These themes painted a picture of fathers facing one of the most challenging times of their lives, with their personal, social, physical and spiritual worlds undergoing drastic changes. The participants were ill-equipped to deal with the situation because they were not aware of PND's impacts and implications and because PND affected their partners deeply on the emotional level making it hard to communicate openly and effectively. The relationship of both partners started to suffer. The participants ended up having to dig deep and hold on to their courage and resolve in the face of the challenges to find ways of coping with the situation. Their emotional, as well as physical wellbeing, came under immense pressure along with their partners, as the whole family tried to survive the difficult period and emerge successfully from the ordeal. The study has important implications for both the healthcare practice and service provision as well as for therapeutic work with clients in similar situations. The experiences of participants can be a valuable source of guidance to improve the way new families are supported through the

postnatal period. While these implications are further explored below, the need for improved knowledge in this area and better dissemination of existing knowledge, as well as the need for more suitable and accessible support services to be designed, is apparent. In addition, the detailed examination of the themes identified by the study uncovers various aspects to be explored during individual and couple or group counselling.

6.2 Strengths and Limitations

The current study has followed the hermeneutic phenomenological approach and conducted an in-depth exploration of the nature of the experience of the participants as perceived by themselves, aiming to capture all of its richness and complexity. Hence, the findings of the study shed light on multiple subtle aspects including the emotional struggle, the competing demands, the fears and concerns of the participants, and the conflicting forces within the various dimensions of their existence. The development of a nuanced understanding of the physical, social, personal and spiritual domains of the participants' existence along with the detailed exploration of their emotions are two of the main strengths of the current study.

Furthermore, during the analysis of the findings, leaning upon the existential perspective has allowed for a more in-depth exposition of the finer shades of meaning behind the participants' experiences. This has facilitated multiple implications for therapeutic practice to be identified, which can potentially be further explored and expanded in future studies. While the current research does not claim to be inherently generalizable, the commonality between the experiences of various participants, and the excellent alignment of the findings with previous research suggests that many of the outcomes can be useful in similar contexts and scenarios.

However, following the chosen hermeneutic phenomenological approach for the study has also meant that I have had to limit the sample size to a manageable number to keep the sheer volume of data within limits. This was further complicated by the difficulty of accessing the targeted group of participants as described in the discussion about methodology in chapter 3. Hence, the study cannot make any significant claims about comprehensiveness. Additionally, the study is not longitudinal in nature; hence, it needs to be considered as a "snapshot" of the experience of fathers living with partners diagnosed with PND, in England near the time when the study has been completed.

There are also limitations to the diversity of the demography of the participants both regarding the socio-economic class as well as ethnic makeup. Almost all the participants identified themselves as White, British and belonging to the middle socio-economic class. The participants also mostly belonged to the urban community setting. Although these were not

intended limitations, the small sample size along with the difficulty of finding potential participants meant that it was not possible to specifically aim for diversity. Fathers who had separated from their partners or had a divorce were also excluded from the study in order to standardize the sample.

6.3 Reflexivity

I have discussed reflexivity earlier in section 3.8, where the focus was on how it was considered during the process of data collection and analysis. However, it is equally important to be reflexive during the interpretation phase (van Manen, 1990) and I have strived to do that when discussing and documenting my findings and placing them in the context of existing literature. The researcher is an inherent part of hermeneutic phenomenological research and meaning is created between the participant and researcher, which is true in the writing phase as well. Hence, while I was writing the description of the themes, I was cognizant of the fact that my interpretation was unavoidably a part of the process and to be more aware of that I kept documenting my thoughts and feelings in a written journal. As I got to know more about the participants' experiences, my own beliefs about PND changed in certain ways. I became more aware of two aspects. The first was the element of pride and joy felt by the participants on acquiring the new capability to tolerate adversity and survive, and the second was the element of their personal growth: becoming more aware of the freedom of choice, the discovery of meaning in their suffering and their growth as fathers and individuals. I was also careful to go back to the original statements of the participants often to make sure that all interpretations were founded on the lived experience as described by the participants.

Being a woman who was researching men's experiences, I was also conscious that my bias might affect the process of describing the experience of the participants. This was particularly applicable with regards to the participants' experiences concerning their partners, as being a wife and a mother myself, my own related experiences could have influenced my thoughts. Research supervision also helped to identify where my bias was starting to come in. However, I was cognizant that the discussions with my research supervisor could also have acted as a source of bias, especially as my supervisor was also a woman. Bracketing was important in this context, and the reflexive journal was helpful to be able to achieve that. Another related aspect was whether the participants felt safe enough to open up entirely while expressing their thoughts as I only met them for the first time when the interview was conducted. I was aware that I had not explored me being a wife and mother with them, and that it may have an effect on how they described their experiences, feelings and emotions.

6.4 Implications of the current research

6.4.1 Implications for healthcare practice

Looking at the experiences of participants of the current study, one of the significant findings was about awareness with regards to what PND entails for the fathers themselves, as well as for the family as a whole. The participants' existing knowledge about PND proved to be much less than sufficient, and they ended up dealing with the unexpected in most cases. This points towards a lack of awareness in general about PND, but more specifically, it highlights the lack of sufficient information dissemination for the couple who are expecting a baby. There are unambiguous implications here about the need for better information provision to the parents-to-be, with healthcare staff playing an important role in that process. Communication between fathers and healthcare professionals should be improved, with more frequent contact and better rapport building between them, along with more attention being paid to the fathers' experiences and knowledge. Healthcare staff can also serve as very important sources of information to therapists and counsellors. Hence, it is recommended that ways are identified for more involvement of healthcare staff in research in this area including more organized ways of collection and dissemination of information being devised.

The study also highlighted that participants whose partners are suffering from PND found it difficult to access support. The participants' own lack of natural inclination towards asking for support and the lack of readily available options for support both contributed towards this. In light of those findings, the healthcare system and services must make support available more widely and make it clear how that support can be accessed. Moreover, they should educate the fathers about the need to access support, and its benefits both for themselves and the whole family. Antenatal classes need to take into account men's needs, and allow balancing the professional and personal life responsibilities, for example, by being cognizant of working hours. To facilitate all of the above, more funding also needs to be directed towards these activities because up till now these have been neglected to a degree.

6.4.2 Implications for therapeutic practice

An undercurrent that lay beneath the feelings expressed by multiple participants was the inability of most of them to rise above the inevitable conflicts of interest that surfaced between the partners, and to view themselves as being part of a team struggling to overcome the challenges posed by the situation resulting from PND. This was manifested not only in the expression of frustration and the feelings of unfairness by the participants but also in how they felt unable to put their own needs forward and to fulfil all the expectations. This aspect can be

further explored during therapeutic work with new fathers to see what impact it is having on family life. An additional subtlety here were the preconceived notions that the participants had about the father's role (mostly providing support to the partner and child and working as the breadwinner) and the mother's role (mostly taking care of the child and household work). There had been no real negotiation between the partners about what the father's and mother's roles were going to be. Here again, for the counsellors or therapists who are working with clients in similar situations, an important aspect to explore is whether feelings of unfairness, frustration, the weight of expectations and other related feelings are rooted in prejudiced conceptions about the roles of fathers and mothers.

The findings suggest that the key to keeping the relationship between the couple healthy during PND is good and open communication. This was supported by multiple participants identifying the communication challenges as the cause of their relationship issues. Moreover, the fact that the one participant who felt that his relationship had not deteriorated also reported having good communication between himself and his partner further corroborates this. Therapists can utilize this insight while working with clients who can potentially benefit from prioritizing better communication between the partners. This is also related to another finding where several participants reported that they had to suppress their feelings because they thought it would have a negative effect on their partner. This behaviour pattern results in an increased level of stress and bringing this up during individual and couple counselling may prove to be helpful, allowing the partners to work through the underlying causes for relationship distress.

The findings of the current study also suggest that having a clear direction about the nature of support required by their partners is very helpful in allowing the fathers to take back power and making them feel in control of the situation. The fathers who have not got through the period of PND would be helped by knowing about the importance of this.

Furthermore, for participants of the study, sharing their experiences almost always resulted in improvement, and this learning about the value of sharing can be gainfully utilized in therapeutic work.

As a practising psychotherapist, I would, of course, be making use of the findings in my work to offer support to fathers in one-to-one sessions as well as setting up support groups for new fathers.

6.4.3 Dissemination of current research

Given all the implications discussed above, it is necessary that the findings of the current study are disseminated widely enough to allow existing gaps in the research literature to be remedied and for more inclusive services to be made available to the fathers. I have contributed a chapter to the book 'The Existential Crisis of Motherhood' ed. Claire Arnold-Baker based on the findings of the current study. I would also target publishing the research in peer-reviewed journals that have previously published content related to my research topic. Journals that accept phenomenological research include *British Journal of Psychology, Psychology and Psychotherapy: Theory, Research and Practice* and *Journal of the Society for Existential Analysis*. In addition, I would target some journals, e.g. Frontiers in Psychology that are "open access" to allow the general public to become more aware of the issues that fathers face and how this can have an impact on family life.

6.5 Recommendations for future research

The lived experience of the fathers who are living with partners suffering from PND can provide valuable information that can influence new proposals for healthcare provision and practices, and result in better-targeted support services and group work. Also, the particular sources of stress and anxiety, the feelings of loss, guilt, unfairness and other emotions, highlighted by the findings of the current research can help to adapt therapeutic practices. As research on the experiences of fathers whose partners are diagnosed with PND is mostly neglected at the moment, it is recommended that further research is conducted in this area because there is an urgent need to make better quality support and healthcare available to fathers.

The findings of the study conclude that the relationship between the partners suffers significant damage as a result of PND. However, the current study was too limited in scope to allow a more detailed examination of the various facets here, including the long-term effects, to see how the relationship evolves or alters over time. Further research in this area may well reveal useful and interesting findings. One particular example is whether the learning to look after household chores and the family remains part of the fathers' contribution after the PND has been resolved. In other words, does it become a lasting asset to the couple and the family in terms of equality?

Furthermore, how fathers get affected by PND and the coping strategies of the fathers can potentially have both short- and long-term effects on the first and subsequent children. This question also needs more targeted research spanning a long enough time to be able to identify those effects.

Finally, another avenue is to broaden the coverage of both the ethnic as well as socio-economic classes targeted by the research because the current study was limited in these aspects. Also, further research could look at covering a broader variety of community settings, including metropolitan and provincial or rustic settings to facilitate the generalizability of the conclusions and recommendations.

Chapter 7 References

Addis, M. E. (2008). Gender and depression in men. *Clinical Psychology: Science and Practice*, 15(3), 153-168.

Adler, J. M. (2012). Living into the story: Agency and coherence in a longitudinal study of narrative identity development and mental health over the course of psychotherapy. *Journal of personality and social psychology*, 102(2), 367.

Ahern, K.J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research,* 9(172), 407- 11.

Ahlborg, T., & Strandmark, M. (2001). The baby was the focus of attention–first-time parents' experiences of their intimate relationship. *Scandinavian Journal of Caring Sciences*, 15(4), 318-325.

Ahlborg, T., & Strandmark, M. (2006). Factors influencing the quality of intimate relationships six months after delivery—First-time parents' own views and coping strategies. *Journal of Psychosomatic Obstetrics & Gynecology*, *27*(3), 163-172.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anderson, A. M. (1996). Factors influencing the father-infant relationship. *Journal of family nursing*, 2(3), 306-324.

Antonucci, T. C., & Mikus, K. (1988). The power of parenthood: Personality and attitudinal change during the transition to parenthood. In G.Y. Michaels & W. A. Goldberg (Eds.), *The transition to parenthood: Current theory and research* (pp. 243-258). Cambridge, MA: Cambridge University Press.

Areias, M. E., Kumar, R., Barros, H., & Figueiredo, E. (1996). Correlates of postnatal depression in mothers and fathers. *British Journal of Psychiatry*, 169(1), 36–41.

Arminio, J. L., & Hultgren, F. H. (2002). Breaking out from the shadow: The question of criteria in qualitative research. *Journal of College Student Development*, 43(4), 446-460.

Arnold-Baker, C. (2014). *How Becoming a Mother involves a Confrontation with Existence: An Existential-Phenomenological exploration of the experience of early motherhood* (Ph.D). Middlesex University.

Baker, C., Wuest J, & Stern P. N. (1992) Method slurring; the grounded theory/phenomenology example. *Journal of Advance Nursing* 17, 1355-1360.

Barclay, L., & Lupton, D. (1999). The experiences of new fatherhood: A socio-cultural analysis. *Journal of Advanced Nursing*, 29(4), 1013-1020.

Bartlett, E. E. (2004). The effects of fatherhood on the health of men: a review of the literature. *Journal of Men's Health and Gender*, *1*(2-3), 159-169.

Beaupré, P., Dryburgh, H., & Wendt, M. (2010). Making fathers "count". *Canadian Social Trends*, 90, 26-34.

Beauvoir, S. D. (1997). *The Second Sex*. London, Vintage.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. University of Pennsylvania Press.

Beck, C. T. (1996). Postpartum depressed mothers' experiences interacting with their children. *Nursing Research*, 45(2), 98-104.

Beck, C. T. (1998). The effects of postpartum depression on child development: A meta-analysis. *Archives of Psychiatric Nursing*, 12, 12-20.

Beck, C. T. (1999). Maternal depression and child behaviour problems: a meta-analysis. *Journal of advanced nursing*, 29(3), 623-629.

Beestin, L., Hugh-Jones, S., & Gough, B. (2014). The impact of maternal postnatal depression on men and their ways of fathering: an interpretative phenomenological analysis. *Psychology & health*, 29(6), 717-735.

Belsky, J. (1991). The developing family system. *Contemporary Psychology*, 36(4): 292 PsychCRITIQUES (Electronic collection).

Benazon, N. R., & Coyne, J. C. (2000). Living with a depressed spouse. *Journal of family Psychology*, 14(1), 71.

Benzies, K. M., & Magill-Evans, J. (2015). Through the eyes of a new dad: Experiences of first-time fathers of late-preterm infants. *Infant mental health journal*, 36(1), 78-87.

Bergström, M. (2013). Depressive symptoms in new first-time fathers: Associations with age, sociodemographic characteristics, and antenatal psychological well-being. *Birth*, 40(1), 32–38.

Beutler, L. E., Brookman, L., Harwood, T. M., Alimohamed, S., & Malik, M. (2001). Functional impairment and coping style. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 437.

Bielawska, B. E., & Kossakowska, P. K. (2006). Depressive mood in men after the birth of their offspring in relation to a partner's depression, social support, fathers' personality and prenatal expectations. *Journal of Reproductive & Infant Psychology,* 24, 21–29.

Binswanger, L. (1946). The Existential Analysis School of Thought in Existence. Eds: May, R., Angel, E., Ellenberger, HF (1958).

Binswanger, L. (1946). The Existential School of Thought. *Existence. New York: Basic Books*.

Binswanger, L. (1963). Being-in-the-world: Selected papers of Ludwig Binswanger.

Bloch, M., Daly, R. C., & Rubinow, D. R. (2003). Endocrine factors in the etiology of postpartum depression. *Comprehensive Psychiatry*, 44(3), 234-246.

Bloch, M., Rubinow, D. R., Schmidt, P. J., Lotsikas, A., Chrousos, G. P., & Cizza, G. (2005). Cortisol response to ovine corticotropin-releasing hormone in a model of pregnancy and parturition in euthymic women with and without a history of postpartum depression. *Journal of Clinical Endocrinology Metabolism,* 90(2), 695-699.

Bloch, M., Schmidt, P. J., Danaceau, M., Murphy, J., Nieman, L., & Rubinow, D. R. (2000). Effects of gonadal steroids in women with a history of postpartum depression. *American Journal of Psychiatry*, 157(6), 924-930.

Boath, E. H., Pryce, A. J., & Cox, J. L. (1998). Postnatal depression: The impact on the family. *Journal of Reproductive and Infant Psychology*, 16, 199–203.

Boath, E. H., Pryce, A. J., & Cox, J. L. (1998). Postnatal depression: the impact on the family. *Journal of Reproductive and Infant Psychology*, 16(2-3), 199-203.

Boath, E., Pryce, A., & Cox, J. (1998). Postnatal depression: The impact on the family. *Journal of Reproductive and Infant Psychology*, 16(2-3), 199-203.

Boddy, J., Statham, J., Warwick, I., Hollingworth, K., & Spencer, G. (2016). What kind of trouble? Meeting the health needs of 'troubled families' through intensive family support. *Social Policy and Society,* 15(2), 275-288.

Boddy, R., Gordon, C., MacCallum, F., & McGuinness, M. (2017). Men's experiences of having a partner who requires mother and baby unit admission for first episode postpartum psychosis. *Journal of advanced nursing,* 73(2), 399-409.

Boeiji, H., & Ven Doorne-Huiskes, A. (2003). Fulfilling a sense of duty: How men and women giving care to spouses with multiple sclerosis interpret this role. *Community, Work and Family Care*, 6(3), 223-244.

Boss, M. (1994). Existential foundations of medicine and psychology, *trans. S. Conway, and A. Cleaves. Northvale, NJ: Jason Aronson Inc*.

Bradley, R. P. C., Friend, D. J., & Gottman, J. M. (2011). Supporting healthy relationships in low-income, violent couples: Reducing conflict and strengthening relationship skills and satisfaction. *Journal of Couple & Relationship Therapy*, 10(2), 97-116.

Brandth, B., & Kvande, E. (1998). Masculinity and child care: The reconstruction of fathering. *Sociological Review*, 46(2), 293-313.

Brennan P. A., Hammen C., Katz A. R., et al. (2002). Maternal depression, paternal psychology, and adolescent diagnostic outcomes. *Journal of Consulting and Clinical Psychology,* 70, 1075–1085.

Brock, R. L., & Lawrence, E. (2008). A longitudinal investigation of stress spillover in marriage: Does spousal support adequacy buffer the effects? *Journal of Family Psychology*, 22(1), 11.

Brown, G. W., & Harris, T. (1978). Social origins of depression: a reply. *Psychological medicine*, 8(4), 577-588.

Brown, G. W., Sklair, F., Harris, T. O., & Birley, J. L. T. (1973). Life-events and psychiatric disorders 1 Part 1: some methodological issues. *Psychological Medicine*, 3(1), 74-87.

Buber, M. (1923). I and Thou, 2nd edn, transl. *Ronald Gregor Smith (New York: Scribner, 1958).*

Buber, M. (1970). I and thou (W. Kaufmann, Trans.). *New York: Charles Scribner's Sons, 57*.

Buist A., Morse C. A. & Durkin S. (2002). Men's adjustment to fatherhood: implications for obstetric health care. *Journal of Obstetric, Gynecologic, and Neonatal Nursing,* 32, 172– 180.

Buist, K. L., Deković, M., Meeus, W., & van Aken, M. A. (2002). Developmental patterns in adolescent attachment to mother, father and sibling. *Journal of youth and adolescence*, 31(3), 167-176.

Bunting, L., & McAuley, C. (2004). Research review: Teenage pregnancy and parenthood: The role of fathers. *Child & Family Social Work*, 9(3), 295-303.

Burgees, A. (2011). Fathers' roles in perinatal mental health: causes, interactions and effects. *National Childbirth Trust*: New Digest, 53, 24 – 28.

Busch, K. A., Fawcett, J., & Jacobs, D. G. (2003). Clinical correlates of inpatient suicide. *The Journal of clinical psychiatry.*

Buunk, B. P., & Van Yperen, N. W. (1991). Referential comparisons, relational comparisons, and exchange orientation: Their relation to marital satisfaction. *Personality and Social Psychology Bulletin*, 17(6), 709-717.

Call, J. B., & Shafer, K. (2018). Gendered manifestations of depression and help seeking among men. *American journal of men's health*, 12(1), 41-51.

Canadian Mental Health Association. (2014). Postpartum depression. Retrieved from http://www.cmha.ca/mental_ health/postpartum-depression/#.WL3whxLytsM.

Chang, J. J., Halpern, C. T., & Kaufman, J. S. (2007). Maternal depressive symptoms, father's involvement, and the trajectories of child problem behaviours in a US national sample. *Archives of Paediatrics & Adolescent Medicine*, 161(7), 697-703.

Charmaz, K., 2006. Constructing Grounded Theory: A practical guide through qualitative analysis. London: Sage.

Chesler, M. A., & Parry, C. (2001). Gender roles and/or styles in crisis: An integrative analysis of the experiences of fathers of children with cancer. *Qualitative health research,* 11(3), 363-384.

Chin R, Hall P, Daiches A. (2011). Fathers' experiences of their transition to fatherhood: A metasynthesis. *Journal of reproductive and infant psychology*. 29:4–18.

Chin, R., Daiches, A., & Hall, P. (2011). A qualitative exploration of first-time fathers' experiences of becoming a father. *Community Practitioner*, 84(7).

Chin, R., Hall, P., & Daiches, A. (2011). Fathers' experiences of their transition to fatherhood: a metasynthesis. *Journal of reproductive and infant psychology*, 29(1), 4-18.

Cochran, S. V., & Rabinowitz, F. E. (2003). Gender-sensitive recommendations for assessment and treatment of depression in men. Professional psychology: *Research and practice*, 34(2), 132.

Cohen, A., & Daniels, V. (2001). Review of literature: Responses to" Empirical and hermeneutic approaches to phenomenological research in psychology, a comparison. *Gestalt*, *5*(2), 5-2.

Cohen, L., Manion, L., & Morrison, K. (2000). Research methods in education 5th edition. *London, RoutledgeFalmer.*

Cohen, M. Z & Omery A (1994) Schools of phenomenology: implications for research. *Critical Issues in Qualitative Research Methods.* Thousand Oaks: Sage.

Colaizzi, P. (1978). Psychological research as the phenomenological views it. In Valle, R & King, M (Eds.). *Existential phenomenological alternatives for psychology.* Oxford: Oxford University Press.

Condon, J. T., Boyce, P., & Corkindale, C. J. (2004). The first-time fathers study: A prospective study of the mental health and wellbeing of men during the transition to parenthood. *Australian and New Zealand Journal of Psychiatry,* 38(1-2), 56-64.

Cooke, D., & Bennett, E. (2012). Surviving postnatal depression: the male perspective. *Neonatal, Paediatric & Child Health Nursing,* 15(3), 15.

Cooklin, A. R., Giallo, R., Strazdins, L., Martin, A., Leach, L. S., & Nicholson, J. M. (2015). What matters for working fathers? Job characteristics, work-family conflict and enrichment, and fathers' postpartum mental health in an Australian cohort. *Social Science & Medicine*, 146, 214-222.

Cooper, M. (2003). *Existential therapies*. London Thousand Oaks: SAGE Publications.

Cosson, B., & Graham, E. (2012). I felt like a third wheel': Fathers' stories of exclusion from the 'parenting team. *Journal of Family Studies*, 18(2-3), 121-129.

Cowan, C. P. & Cowan, P. A (1992). When partners become parents. New York: Basic Books.

Cowan, C. P. & Cowan, P. A (1995). Interventions to ease the transition to parenthood: Why they are needed and what they can do. *Family Relations*, 44(4), 412-439.

Coyne, J. C., & DeLongis, A. (1986). Going beyond social support: The role of social relationships in adaptation. *Journal of consulting and clinical psychology*, 54(4), 454.

Crouter, A. C., Bumpus, M. F., Head, M. R. & McHale, S.M. (2001). Implications of overwork and overload for the quality of men's family relationships. *Journal of Marriage and Family*, 63(2), 404-416.

Cutrona, C. E., Shaffer, P. A., Wesner, K. A., & Gardner, K. A. (2007). Optimally matching support and perceived spousal sensitivity. *Journal of family psychology*, 21(4), 754.

Davey, S. J., Dziurawiec, S., & O'Brien-Malone, A. (2006). Men's voices: Postnatal depression from the perspective of male partners. *Qualitative Health Research*, 16(2), 206–220.

Davila, J., Bradbury, T. N., Cohan, C. L., & Tochluk, S. (1997). Marital functioning and depressive symptoms: Evidence for a stress generation model. *Journal of personality and social psychology*, 73(4), 849.

De Beauvoir, S. (1997). Introduction to the second sex. London: Vintage.

De Mendonça, J. S., Bussab, V. S., Rodrigues, A., Siqueira, J., & Cossette, L. (2012). Postpartum depression, father's involvement, and marital and co-parental relationships from mothers' and fathers' perspectives in a low-income Brazilian sample. *Family Science*, 3(3-4), 164-173.

Deave, T., & Johnson, D. (2008). The transition to parenthood: what does it mean for fathers? *Journal of advanced nursing*, 63(6), 626-633.

Delmore·Ko, P. Pancer, M. S., Hunsberger, B. & Pratt, M. (2000). Becoming a parent: The relation between prenatal expectations and postnatal experience. *Journal of Family Psychology*, 1-1(4), 625·640.

Dennis, C. L., & McQueen, K. (2011). The relationship between infant-feeding outcomes and postpartum depression: *A Qualitative systematic review*. 123(4): 736-751.

Deurzen, E. van (1998). *Paradox and passion in psychotherapy*. Chichester: Wiley.

Deurzen, E. van (2009). *Psychotherapy and the Quest for Happiness*, London: Sage.

Deurzen, E. van (2010) *Everyday Mysteries: Handbook of Existential Therapy*, 2nd edition, London: Routledge.

Deurzen, E. van (2012) *Existential Counselling and Psychotherapy in Practice*, 3d edition, London: Sage.

Deurzen, E. van & Adams, M. (2011). *Skills in existential counselling and psychotherapy*. London: Sage.

Dew, J., & Wilcox, W. B. (2011). If momma ain't happy: Explaining declines in marital satisfaction among new mothers. *Journal of Marriage and Family*, 73(1), 1-12.

Diemer, G. A. (1997). Expectant fathers: influence of perinatal education on stress, coping, and spousal relations. *Research in nursing & health*, 20(4), 281-293.

Dierker, L. C., Merikangas, K. R., & Szatmari, P. (1999). Influence of parental concordance for psychiatric disorders on psychopathology in offspring. *Journal of the American Academy of Child & Adolescent Psychiatry* 38, 280–288.

Doss, B. D., & Rhoades, G. K., Stanley, S. M., & Markman, H. J.(2009).The effect of the transition to parenthood on relationship quality: An 8year prospective study. *Journal of Personality and Social Psychology*, 96, 601–619.

Doucet, A. (2006). *Do Men Mother*? Toronto: University of Toronto Press.

Doucet, S., Letourneau, N., & Blackmore, E. R. (2012). Support needs of mothers who experience postpartum psychosis and their partners. Journal of Obstetric, Gynaecologic & neonatal nursing, 41(2), 236-245.

Dudley, M., Roy, K., Kelk, N., et al. (2001). Psychological correlates of depression in fathers and mothers in the first postnatal year. *Journal of Reproductive & Infant Psychology* 19, 187– 202.

Easterbrooks, M. A., Barrett, L. R., Brady, A. E., & Davis, C. R. (2007). Complexities in research on fathering: Illustrations from the Tufts study of young fathers. *Applied Development Science*, 11(4), 214-220.

Edhborg, M., Carlberg, M., Simon, F., & Lindberg, L. (2016). "Waiting for Better Times" Experiences in the First Postpartum Year by Swedish Fathers With Depressive Symptoms. *American journal of men's health,* 10(5), 428-439.

Edhborg, M., Lundh, W., Seimyr, L., & Widström, A. M. (2003). The parent-child relationship in the context of maternal depressive mood. *Archives of women's mental health*, 6(3), 211-216.

Edward K. L., Castle D., Mills C., Davis L., Casey J. (2015). An integrative review of paternal depression. *American Journal of Men's Health*, 9, 26-34.

Eiden, R. D., & Leonard, K. E. (1996). Paternal alcohol use and the mother-infant relationship. *Development and Psychopathology*, 8, 307-323

Elliott, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative researcher studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Elliott, S. A., Leverton, T. J., Sanjack, M., Turner, H., Cowmeadow, P., Hopkins, J., & Bushnell, D. (2000). Promoting mental health after childbirth: a controlled trial of primary prevention of postnatal depression. *British Journal of Clinical Psychology,* 39(Pt 3), 223-241.

Engqvist, I., & Nilsson, K. (2011). Men's experience of their partners' postpartum psychiatric disorders: narratives from the internet. *Mental health in family medicine*, 8(3), 137.

Evans, J., Heron, J., Francomb, H., Oke, S., & Golding, J. (2001). Cohort study of depressed mood during pregnancy and after childbirth. *Bmj*, 323(7307), 257-260.

Everingham, C. R., Heading, G., & Connor, L. (2006). Couples' experiences of postnatal depression: A framing analysis of cultural identity, gender and communication. *Social Science & Medicine*, 62(7), 1745-1756.

Fägerskiöld, A. (2008). A change in life as experienced by first-time fathers. *Scandinavian journal of caring sciences*, 22(1), 64-71.

Fawcett, J., Scheftner, W. A., Fogg, L., Clark, D. C., & Young, M. A. (1990). Time-related predictors of suicide in major affective disorder. *The American journal of psychiatry*, 147(9), 1189.

Felsten, G. (1998). Gender and coping: Use of distinct strategies and associations with stress and depression. *Anxiety, Stress and Coping*, 11(4), 289-309.

Fenwick, J. Bayes, S. & Johansson, M. (2011). A qualitative investigation into the pregnancy experiences and childbirth expectations of Australian fathers-to-be. *Sexual & Reproductive Healthcare*.

Fenwick, J., Bayes, S., & Johansson, M. (2012). A qualitative investigation into the pregnancy experiences and childbirth expectations of Australian fathers-to-be. *Sexual & Reproductive Healthcare*, 3(1), 3-9.

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice*, 3: 6-25.

FitzGerald, M. (1995). *The experience of chronic illness in rural Australia* (Doctoral dissertation, University of New England).

Fletcher, R. J., Matthey, S., & Marley, C. G. (2006). Addressing depression and anxiety among new fathers. *Medical Journal of Australia*, 185(8), 461-463.

Fletcher, R., & StGeorge, J. (2011). Heading into fatherhood—nervously: Support for fathering from online dads. *Qualitative health research*, 21(8), 1101-1114.

Flouri, E. (2005). *Fathering & Child Outcomes*. Chichester, West Sussex: John Wiley & Sons.

Frankl, V. (1962). *Man's Search for Meaning*. New York: Touchstone Books.

Frankl, V. E. (1955). The doctor and the soul. An introduction to logotherapy.

Frankl, V. E. (1963). Man's Search for Meaning: An Introduction to Logotherapy. *American Journal of Orthopsychiatry*, *33*(2), 390-390.

Fromm, E. (1941). *Escape from freedom*. New York: Rinehart & Co

Gaertner, B.M., Spinrad, T.L., Eisenberg, N. and Greving, K.A. (2007) Parental childrearing attitude as correlates of father involvement during infancy. *Journal of Marriage and the family*, 69: 962-76.

Gearing, R. E., (2004). Bracketing in research: A typology. *Qualitative Health Research*, 4(10), 1429-1452.

Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

Goodman, J. H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. *Journal of Advanced Nursing*, 45 (1), 26–35.

Goodman, J. H. (2005). Becoming an involved father of an infant. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 34(2), 190-200.

Goodman, J. H. (2008). Influences of maternal postpartum depression on fathers and on father–infant interaction. *Infant Mental Health*. 29, 624–643.

Goodman, S. H., Lusby, C. M., Thompson, K., Newport, D. J., & Stowe, Z. N. (2014). Maternal depression in association with fathers' involvement with their infants: Spillover or compensation/buffering?. *Infant Mental Health Journal*, 35(5), 495-508.

Gopfert, M., Webster, J., Seeman, M. V., & Gullickson, T. (1997). Parental Psychiatric Disorder: Distressed Parents and Their Families. *Psyccritiques*, *42*(3), 268-269.

Gosling, J., & Oddy, M. (1999). Rearranged marriages: Marital relationships after head injury. *Brain Injury,* 13(10), 785-796.

Greenberg, M. (1985). *The Birth of a Father*. New York. Avon Books.

Grote, N. K., & Clark, M. S. (2001). Perceiving unfairness in the family: Cause or consequence of marital distress?. *Journal of personality and social psychology*, *80*(2), 281.

Guterman, N. B., & Lee, Y. (2005). The role of fathers in risk for physical child abuse and neglect: possible pathways and unanswered questions. *Child Maltreatment*, 10(2), 136-149.

Halbreich, U. (2005). The association between pregnancy processes, preterm delivery, low birth weight, and postpartum depressions—the need for interdisciplinary integration. *American journal of obstetrics and gynecology*, *193*(4), 1312-1322.

Hall, W. A. (1994). New fatherhood: myths and realities. *Public Health Nursing*, 11(4), 219-228.

Harvey, I., & McGrath, G. (1988). Psychiatric morbidity in spouses of women admitted to a mother and baby unit. *The British Journal of Psychiatry*, 152(4), 506-510.

Hawkins, A. J., Gilliland, T., Christiaens, G., & Carroll, J. S. (2002). Integrating marriage education into perinatal education. *The Journal of perinatal education*, 11(4), 1.

Hay, D. F., Asten, P., Mills, A., Kumar, R., Pawlby, S., & Sharp, D. (2001). Intellectual problems shown by 11-year-old children whose mothers had postnatal depression. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, 42(7), 871-889.

Heidegger, M. (1927). 1962. Being and time. *Trans. John Macquarrie and Edward Robinson. San Francisco: Harper and Row*.

Heidegger, M. (1977). The Question Concerning Technology, trans. W. Lovitt. *The Question Concerning Technology and Other Essays (New York: Garland, 1997)*, *24*.

Henshaw, C. (2007). Maternal suicide. *In Psychological Challenges in Obstetrics and Gynecology* (pp. 157-164). Springer, London.

Hirst, M. (2001). Trends in informal care in Great Britain during the 1990s. *Health & Social Care in the Community,* 9(6), 348-358

Hock, E., Schirtzinger, M. B., Lutz, W. J., & Widaman, K. (1995). Maternal depressive symptomatology over the transition to parenthood: Assessing the influence of marital satisfaction and marital sex role traditionalism. *Journal of Family Psychology*, 9(1), 79–88.

Horsch, A., & Ayers, S. (2016). Childbirth and Stress. *In Stress: Concepts, Cognition, Emotion, and Behavior* (pp. 325-330). Academic Press.

Hudson, D. B., Elek, S. M., & Fleck, M. O. (2001). First-time mothers' and fathers' transition to parenthood: Infant Care Self-Efficacy, Parenting Satisfaction, and Infant Sex. *Issues in comprehensive pediatric nursing*, *24*(1), 31-43.

Husserl, E. (1911). Philosophie als strenge Wissenschaft.

Huston, T. L., & Holmes, E. K. (2004). Becoming parents. In A. Vangelisti (Ed.), *Handbook of family communication* (pp. 105–133).

Huusko, L., Sjöberg, S., Ekström, A., Hertfelt Wahn, E., & Thorstensson, S. (2018). First-Time Fathers' Experience of Support from Midwives in Maternity Clinics: An Interview Study. *Nursing research and practice*, *2018*.

Inwood, D. G. (1994). Postpartum psychotic disorders. Synopsis of Psychiatry*: Behavioural Sciences, Clinical Psychiatry*, *7*, 852-858.

Jaffee, S. R., Caspi, A., Moffitt, T. E., Taylor, A., & Dickson, N. (2001). Predicting early fatherhood and whether young fathers live with their children: prospective findings and policy reconsiderations. *Journal of Child Psychology and Psychiatry*, 42, 803-815.

Jaspers, K. (1941). Reason and Existenz, tr. *William Earle (New York, 1955), pp. 77f. Otto Rank, Beyond Psychology*.

Jaspers, K. (1951). The Way to Wisdom (trans. R. Manheim).

Jaspers, K. (1997). *General psychopathology* (Vol. 2). JHU Press.

Johnstone, S. J., Boyce, P. M., Hickey, A. R., Morris-Yates, A. D., & Harris, M. G. (2001). Obstetric risk factors for postnatal depression in urban and rural community samples. Australian & New Zealand *Journal of Psychiatry*, 35(1), 69-74.

Jones, I., & Craddock, N. (2007). Searching for the puerperal trigger: molecular genetic studies of bipolar affective puerperal psychosis. *Psychopharmacology Bulletin,* 40(2), 115-128.

Joyner, K. (2009). Justice and the fate of married and cohabiting couples. *Social psychology quarterly*, 72(1), 61-76.

Kaila-Behm A. & Vehvilainen-Julkunen K. (2000). Ways of being a father: how the first-time fathers and public health nurses perceive men as fathers. *International Journal of Nursing Studies* 37, 199-205.

Kasuya, R. T., Polgar-Bailey, M. P., & MPH Robbyn Takeuchi, M. S. W. (2000). Caregiver burden and burnout a guide for primary care physicians. *Postgraduate Medicine*, 108(7), 119.

Kearney, R. (1994). Modern movements in European philosophy: *Phenomenology, critical theory, structuralism.* Manchester University Press.

Keltner D, Harker L. (1998). The forms and functions of the nonverbal signal of shame. In: Gilbert, P., & Andrews, B. (Eds.). (1998). *Shame: Interpersonal behavior, psychopathology, and culture*. Oxford University Press on Demand.

Kierkegaard, S. (1844). The Concept of Dread, trans. *Walter Lowrie (Princeton, 1946)*, *70*.

Kierkegaard, S. (1962). Works of Love, trans. Howard and Edna Hong. *Collins, London*.

Kierkegaard, S. (1980). The sickness unto death (HV Hong & EH Hong, Trans.). *Princeton, NJ: Princeton*.

Kierkegaard, S. (1992). *Eighteen upbuilding discourses* (No. 5). Princeton University Press.

Kim, J. H., Knight, B. G., & Longmire, C. V. F. (2007). The role of familism in stress and coping processes among African American and White dementia caregivers: Effects on mental and physical health. *Health Psychology*, 26(5), 564.

Kim, P., & Swain, J. E. (2007). Sad dads: paternal postpartum depression. *Psychiatry (edgmont)*, *4*(2), 35.

Kluwer E. S. (2010). From partnership to parenthood: A review of marital change across the transition to parenthood. *Journal of Family Theory & Review*, 2, 105-156.

Kobasa, S. C. (1982). Commitment and coping in stress resistance among lawyers. *Journal of Personality and social Psychology*, *42*(4), 707.

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: philosophy, rigor and representation. *Journal of Advanced Nursing*, 24, 174-184.

Kowalski, J., & Roberts, A. (2000). Postnatal depression: involving partners in promoting recovery. *Professional care of mother and child*, *10*(3), 65-67.

Kowlessar O. A. (2012). *Qualitative Exploration of Men's Transition to Fatherhood and Experiences of Early Parenting (Ph.D)*. University of Manchester.

Kowlessar, O., Fox, J. R., & Wittkowski, A. (2015). First-time fathers' experiences of parenting during the first year. *Journal of Reproductive and Infant Psychology*, 33(1), 4–14.

Kung, W. W. (2000). The intertwined relationship between depression and marital distress: Elements of marital therapy conducive to effective treatment outcome. *Journal of marital and family therapy*, 26(1), 51-63.

Laing, R. D. (1960). *The divided Self*. London. Penguin books.

Lamb, M. E. (2000). The history of research on father involvement: An overview. *Marriage & Family Review*, *29*(2-3), 23-42.

Lanes, A, Kuk, J. L., Tamin, H. (2011). *Prevalence and characteristics of postpartum depression symptomatology among Canadian women*: a cross-sectional study. BMC Public Health

Langdridge, D. (2007). Phenomenological psychology: *Theory, research and methods*. London: Pearson.

Lawrence, E., Rothman, A. D., Cobb, R. J., Rothman, M. T., & Bradbury, T. N. (2008). Marital satisfaction across the transition to parenthood. *Journal of Family Psychology*, 22, 41–50.

Lennon, M. C., & Rosenfield, S. (1994). Relative fairness and the division of housework: The importance of options. *American journal of Sociology*, 100(2), 506-531.

Letourneau, N., Dennis, C.L., Benzies, K., Duffett-Leger, L., Stewart, M., Tryphonopoulos, P. et al. (2012). Postpartum depression is a family affair: Addressing the impact on Mothers, Fathers, and Children. *Issues in Mental Health Nursing*, 33, 445-457.

Letourneau, N., Duffett-Leger, L., Dennis, C. L., Stewart, M. & Tryphonopoulos, P. D. (2011). Identifying the support needs of fathers affected by post-partum depression: A pilot study. *Journal of Psychiatric and Mental Health Nursing*, 18, 41-47.

Letourneau, N., Tryphonopoulos, P. D., Duffett-Leger, L., Stewart, M., Benzies, K., Dennis, C. L., & Joschko, J. (2012). Support intervention needs and preferences of fathers affected by postpartum depression. *The Journal of perinatal & neonatal nursing*, 26(1), 69-80.

LeTourneau, N.L., Dennis, C.L., Benzies, K., Duffett-Leger, L., Stewart, M., Tryphonopoulos, P.D., Este, D., & Watson, W. (2012a). Postpartum depression is a family affair: Addressing the impact on mothers, fathers, and children. *Issues in Mental Health Nursing*, 33(7), 445-457.

LeTourneau, N.L., Duffet-Leger, L., Dennis, C.L., Stewart, M., and Tryphonopoulos, P.D., (2011). Identifying the support needs of fathers affected by post-partum depression: A pilot study. *Journal of Psychiatric and Mental Health Nursing*, 18, 41-47.

Levinas, E. (1987). Time and the Other, trans. *Richard A. Cohen (Pittsburgh: Duquesne University Press, 1987)*, *47*.

Levy-Shiff, R., Dimitrovsky, L. Shulman, S. & Har-Even, D. (1998). Cognitive appraisals, coping strategies, and support resources as correlates of parenting and infant development. *Developmental Psychology*, 3-1, 1417 1427.

Lewis, C. (1995). In conclusion: What opportunities are open to fathers? *In Fathers Figures in the Families of the 1990s* (Moss, P. Ed.). HMSO, Edinburgh, pp. 63 – 69

Lewis, G. (2011). Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer: 2006-2008: the Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. Wiley-Blackwell.

Lewis, M., & Staehler, T. (2010). *Phenomenology: an introduction*. A&C Black.

Lilgendahl, J. P., & McAdams, D. P. (2011). Constructing stories of self-growth: How individual differences in patterns of autobiographical reasoning relate to well-being in midlife. *Journal of personality*, 79(2), 391-428.

Lilja, G., Edhborg, M., & Nissen, E. (2012). Depressive mood in women at childbirth predicts their mood and relationship with infant and partner during the first year postpartum. *Scandinavian Journal of Caring Sciences,* 26(2), 245-253.

Maddi, S. R. (1967). The existential neuroses. *Journal of Abnormal Psychology*, 72(4), 311–325.

Mahon, P. B., Payne, J. L., MacKinnon, D. F., Mondimore, F. M., Goes, F. S., Schweizer, B. et al. (2009). Genome-wide linkage and follow-up association study of postpartum mood symptoms. *American Journal of Psychiatry*, 166(11), 12291237.

Major, V. S, L. Klein, K. & Ehrhart, M. (2002). Work time, work interference with family and psychological distress. *Journal of Applied Psychology*, 87(3), 427-436.

Mansfield, A. K., Addis, M. E., & Mahalik, J. R. (2003). "Why won't he go to the doctor?": The psychology of men's help seeking. *International Journal of Men's Health*, 2, 93-110.

Marshall, R. (1993). Coping with postnatal depression: *Why it happens and how to overcome it*. London: Sheldon Press.

Mascaro, N., & Rosen, D. H. (2005). Existential meaning's role in the enhancement of hope and prevention of depressive symptoms. *Journal of personality*, 73(4), 985-1014.

Matthey, S., Barnett, B., Howie, P., & Kavanagh, D. J. (2003). Diagnosing postpartum depression in mothers and fathers: Whatever happened to anxiety? *Journal of Affective Disorders*, 74, 139-147. doi:10.1016/S01650327(02)00012-5.

Matthey, S., Barnett, B., Ungerer, J., & Waters, B. (2000). Paternal and maternal depressed mood during the transition to parenthood. *Journal of Affective Disorders*, 60(2), 75–85.

Matud, M. P. (2004). Gender differences in stress and coping styles. *Personality and individual differences*, 37(7), 1401-1415.

Mauthner, N. S. (1998). Re~assessing the importance and role of the marital relationship in postnatal depression: Methodological and theoretical implications. *Journal of Reproductive and Infant Psychology,* 16(213), 157-175.

May, R. (1983). *The discovering of being*. New York.

McBride, B. A., Brown, G. L., Bost, K. K., Shin, N., Vaughn, B., & Korth, B. (2005). Paternal identity, maternal gatekeeping, and father involvement. *Family relations*, 54(3), 360-372.

McCoy, S. J. B. (2012). *Postpartum depression in men*. http:// tinyurl.com/jbavrmb (accessed 2 June 2017).

McKellar, L., Pincombe, J., & Henderson, A. (2009). 'Coming ready or not!' Preparing parents for parenthood. *British Journal of Midwifery* 17(3): 160–7.

Meighan, M., Davis, M. W., Thomas, S. P., & Droppleman, P. G. (1999). Living with postpartum depression: The father's experience. *The American Journal of Maternal/Child Nursing*, 24(2), 202-208.

Meleis, A. I., Sawyer, L. M., Im, E. O., Messias, D. K. H., & Schumacher, K. (2000). Experiencing transitions: an emerging middle-range theory. *Advances in nursing science*, 23(1), 12-28.

Merleau-Ponty, M. (1962). *Phenomenology of Perception [Phénoménologie de la Perception]*.. Routledge & Kegan Paul.

Merriam, S. (1988). Case study research in education: *A qualitative approach*. San Francisco: Jossey-Bass.

Mezulis, A. H., Hyde, J. S., & Clark, R. (2004). Father involvement moderates the effect of maternal depression during a child's infancy on child behavior problems in kindergarten. *Journal of Family Psychology*, 18(4), 575.

Milgrom, J., & McCloud, P. (1996). Parenting stress and postnatal depression. *Stress Medicine*, 12, 177– 186.

Miller, T. (2011). *Making sense of fatherhood: Gender, caring and work*. Cambridge University Press.

Miller, T. (2005). *Making Sense of Motherhood: A Narrative Approach*. Cambridge: Cambridge University Press.

Misri, S., Kostaras, X., Fox, D., & Kostaras, D. (2000). The impact of intimate partner support in the treatment of postpartum depression. *Canadian Journal of Psychiatry*, 45, 554-558.

Mitnick, D. M., Heyman, R. E., & Smith Slep, A. M. (2009). Changes in relationship satisfaction across the transition to parenthood: a meta-analysis. *Journal of Family Psychology*, 23(6), 848.

Montgomery-Downs, H. E., Stremler, R., & Insan, S. P. (2013). Postpartum sleep in new mothers and fathers. *Open Sleep Journal*, 6(1), 87-97.

Montgomery, P., Bailey, P., Johnson, P. S., Snelling, S. J., & Kauppi, C. (2009). Women with postpartum depression "my husband" stories. *BMC Nursing 8* (8)

Moos, R. H. (2004). Coping Responses Inventory: *An update on research applications and validity*. Odessa, FL: Psychological Assessment Resources.

Morgan, M. Matthey, S. Barnett, B. & Richardson, C. (1997). A group programme for postnatally distressed women and their partners. *Journal of Advanced Nursing*, 26(5), 913-920.

Morse, J. M., & Field, P. A. (1995). *Nursing research: The application of qualitative approaches*. Nelson Thornes.

Muchena, G. (2007). Men's Experiences of Partners' Postnatal Mental Illness: This is a summary: the full paper can be accessed at nursing times.net. *Nursing Times*, 103(48), 32-33.

Murphy-Eberenz, K., Zandi, P. P., March, D., Crowe, R. R., Scheftner, W. A., Alexander, M. et al. (2006). Is perinatal depression familial? *Journal of Affective Disorders*, 90(1), 49-55.

Murray, L., Sinclair, D., Cooper, P., Ducournau, P., Turner, P., & Stein, A. (1999). The socioemotional development of 5-year-old children of postnatally depressed mothers. *Journal of Child Psychology and Psychiatry*, 40(8), 1259–1271.

Nagy, E., Molnar, P., Pal, A., & Orvos, H. (2011). *Prevalence rates and socioeconomic characteristics of post-partum depression in Hungary*.

Nietzsche, F. (2005). *Thus Spoke Zarathustra*, trans. Graham Parkes.

Nishimura, A., & Ohashi, K. (2010). *Risk factors of paternal depression in the early postnatal period in Japan*. Nurs. Health Sci. 12, 170–176.

Oates, M. (2003). Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. *British medical bulletin*, 67(1), 219-229.

OC Hall, E. (1995). From fun and excitement to joy and trouble: An explorative study of three Danish fathers' experiences around birth. *Scandinavian Journal of Caring Sciences*, 9(3), 171-179.

Oiler, C. (1982). The phenomenological approach in nursing research. *Nursing research*, *31*(3), 178-181.

Olsen, D. H. & DeFrain, J. (2000). Marriage and the family: *Diversity and strengths* (3"d Ed.). California: Mayfield Publishing Company.

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

Page, M., & Wilhelm, M. (2007). Postpartum daily stress, relationship quality and depressive symptoms. *Contemporary Family Therapy*, 29. 237-251.

Paley, B., Cox, M. J., Kanoy, K. W., Harter, K. S., Burchinal, M., & Margand, N. A. (2005). Adult attachment and marital interaction as predictors of whole family interactions during the transition to parenthood. *Journal of Family Psychology*, 19(3), 420.

Parse, R. R. (1981). Man-living-health. *A theory of nursing*. Wiley, New York.

Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: *a meta-analysis*. JAMA. 303,

Perlick, D. A., Gonzalez, J., Michael, L., Huth, M., Culver, J., Kaczynski, R., & Miklowitz, D. J. (2012). Rumination, gender, and depressive symptoms associated with caregiving strain in bipolar disorder. *Acta Psychiatrica Scandinavica*, 126(5), 356-362.

Pianta, R. C., & Egeland, B. (1994). Relation between depressive symptoms and stressful life events in a sample of disadvantaged mothers. *Journal of consulting and clinical psychology*, 62(6), 1229.

Pinheiro, R. T., Magalhaes, P., & Horta, B. L., et al. (2006). Is paternal postpartum depression associated with maternal postpartum depression? *Population-based study in Brazil*. Acta Psychiatrica Scandinavica 113, 230–232.

Plantin, L. (2001) *Men, Family life and parenthood*. Umea, Sweden: Borea Bokforlag.

Plantin, L., Mansson, S. and Kearney, J. (2003). Talking and doing fatherhood: On fatherhood and masculinity in Sweden and Britian. *Fathering*. 1 (1): 3-26.

Plantin, L., Olykoya, A., & Ny, P. (2011). Positive health outcomes of fathers' involvment in pregnancy and childbirth paternal support: a scope study literature review. *Fathering*; 1, 9.

Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods*. Lippincott Williams & Wilkins.

Polkinghorne, D. E. (1989). Phenomenological research methods. In *Existential-phenomenological perspectives in psychology* (pp. 41-60). Springer, Boston, MA.

Polomeno, V. (2006). Why is love so important in childbirth education? *International Journal of Childbirth Education,* 21(1), 35.

Polomeno, V. (2007). Marriage in the transition to parenthood: How can perinatal education help? Or can it?. *International Journal of Childbirth Education*, 22(2), 21.

Polomeno, V. (2014). The teaching of conjugal vulnerability during the transition to parenthood. *International Journal of Childbirth Education*, 29(1), 78.

Premberg, A., & Lundgren, I. (2006). Fathers' experiences of childbirth education. *The Journal of Perinatal Education,* 15(2), 21.

Premberg, Å., Hellström, A. L., & Berg, M. (2008). Experiences of the first year as father. *Scandinavian journal of caring sciences,* 22(1), 56-63.

Prichard, J. C. (1835). *A treatise on insanity and other disorders affecting the mind*. London: Sherwood, Gilbert and Piper.

Priel, B., & Besser, A. (1999). Vulnerability to postpartum depressive symptomatology: Dependency, self-criticism and the moderating role of antenatal attachment. *Journal of Social and Clinical Psychology,* 18(2), 240-253.

Primack, J. M., Addis, M. E., Syzdek, M., & Miller, I. W. (2010). The men's stress workshop: a gender-sensitive treatment for depressed men. *Cognitive and Behavioral Practice*, 17(1), 77-87.

Purdom, C. L., Lucas, J. L., & Miller, K. S. (2006). Couple type, parental status, and the mediating impact of social support. *North American Journal of Psychology*, 8(1), 1.

Ram, B. & Hou, F. (2003). Changes in family structure and child outcomes: roles of economic and familial resources. *The Policy Studies Journal.* 31, 309–330.

Ramchandani, P., O'Connor, T. G., Heron, J., Murray, L. & Evans, J. (2008). Depression in men in the postnatal period and later child psychopathology: A population cohort study. *Journal of American Child and Adolescent Psychiatry*. 47(4): 390-398.

Ramchandani, P., Stein, A., Evans, J., & O'Connor, T. (2005). Paternal depression in the postnatal period and child development: a prospective population study. *Obstetrical & Gynaecological*. Survey 60, 789–790.

Ramchandani, P., Stein, A., Evans, J., O'Connor, T. G., & ALSPAC Study Team. (2005). Paternal depression in the postnatal period and child development: *a prospective population study*. The Lancet, 365(9478), 2201-2205.

Raphaël-Leff, J. (2001). *Psychological processes of childbearing*. Revised edition. London: Chapman & Hall.

Ray, M. A. (1994). The richness of phenomenology: Philosophic, theoretic, and methodologic concerns. *Critical issues in qualitative research methods*, 117-133.

Redshaw, M., & Martin, C. (2014). The couple relationship before and during transition to parenthood.

Richman N, Stevenson J, Graham PJ (1982). Preschool to school: a behavioural study. Academic Press, London.

Roberts, B. W., & Robins, R. W. (2000). Broad dispositions, broad aspirations: The intersection of personality traits and major life goals. *Personality and Social Psychology Bulletin*, 26(10), 1284-1296.

Roberts, S. L., Bushnell, J. A., & Collings, S. C., et al. (2006). Psychological health of men with partners who have post-partum depression. *Australian & New Zealand Journal of Psychiatry.* 40, 704–711.

Robertson, S., Bagnall, A., & Walker, M. (2015). Evidence for a gender-based approach to mental health program: identifying the key considerations associated with being male: *an Evidence Check rapid review*. Sax Institute.

Rose, L. E., Mallinson, R. K., & Gerson, L. D. (2006). Mastery, burden, and areas of concern among family caregivers of mentally ill persons. *Archives of Psychiatric Nursing*, 20(1), 41–51.

Roy, K. M. (2006). Father stories - a life course examination of paternal identity among low-income African American men. *Journal of Family Issues*, 27(1), 31-54.

Sandler, I. N., Tein, J. Y., & West, S. G. (1994). Coping, stress, and the psychological symptoms of children of divorce: A cross-sectional and longitudinal study. *Child development*, 65(6), 1744-1763.

Sarkadi, A., Kristiansson, R., Oberklaid, F., & Bremberg, S. (2008). Fathers' involvement and children's developmental outcomes: a systematic review of longitudinal studies. *Acta Paediatrica* 97 (2), 153–158.

Sartre, J. (1939). *Sketch for a Theory of the Emotions*. Trans. P. Mairet. London: Methuen.

Sartre, J. P (1943). *Being and Nothingness - An Essay on Phenomenological Ontology*, trans. H. Barnes, New York: Phil. Library 1956.

Schulenberg, S. E., Schnetzer, L. W., Winters, M. R., & Hutzell, R. R. (2010). Meaning-centered couples therapy: Logotherapy and intimate relationships. *Journal of Contemporary Psychotherapy*, 40(2), 95-102.

Scott-Heyes, G. (1984). *Childbearing as mutual experience*. Unpublished M.Phil Thesis. New University of Ulster.

Seligman, M. E. (2002). Positive psychology, positive prevention, and positive therapy. *Handbook of positive psychology,* 2(2002), 3-12.

Sells, J. N., Giordano, F. G., & King, L. (2002). A pilot study in marital group therapy: Process and outcome. *The Family Journal*, 10(2), 156-166.

Settersten Jr, R. A., & Cancel-Tirado, D. (2010). Fatherhood as a hidden variable in men's development and life courses. *Research in human development*, 7(2), 83-102.

Shapiro, A. F., Gottman, J. M., & Carrere, S. (2000). The baby and the marriage: Identifying factors that buffer against decline in marital satisfaction after the first baby arrives. *Journal of family psychology,* 14(1), 59.

Shorey, S., Chan, S. W. C., Chong, Y. S., & He, H. G. (2015). Perceptions of primiparas on a postnatal psychoeducation programme: the process evaluation. *Midwifery*, 31(1), 155-163.

Shorey, S., Dennis, C. L., Bridge, S., Chong, Y. S., Holroyd, E., & He, H. G. (2017). First-time fathers' postnatal experiences and support needs: A descriptive qualitative study. *Journal of advanced nursing*, 73(12), 2987-2996.

Sirgy, M. J., & Wu, J. (2009). The pleasant life, the engaged life, and the meaningful life: What about the balanced life?. *Journal of Happiness Studies*, 10(2), 183-196.

Smith, J. A,. & Osborn, M. (2015). Interpretative phenomenological analysis. In: J.A. Smith (ed.) Qualitative Psychology: *A Practical Guide to Methods*, 3rd edition. London: Sage.

Smith, J. A., Flowers, P., and Larkin, M. (2009) Interpretive Phenomenological Analysis: Theory, Method and Research. London: Sage.

Smith, J.A. and Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (ed.), Qualitative Psychology. *A Practical Guide to Research Methods* (pp. 51– 80). London: Sage

Smith, S. J. (1997). The phenomenology of educating physically. In D. Vandenburg (Ed.), *Phenomenology and educational discourse* (pp. 119-144). Durban: Heineman

Soliday, E., McCluskey-Fawcett, K., & O'Brien, M. (1999). Postpartum affect and depressive symptoms in mothers and fathers. *American Journal of Orthopsychiatry*, 69(1), 30–38.

Spector, A. Z. (2006). Fatherhood and depression: A review of risks, effects, and clinical application. *Mental Health Nursing*, 27(8), 867-883.

Spillman, B., & Pezzin, L. (2000). Potential and active caregivers: Changing networks and the "sandwich generation." *Milbank Quarterly*, 78, 347-374.

Stadtlander, L. (2015). Paternal postpartum depression. *International Journal of Childbirth Education*, 30(2), 11–13.

Stake, R. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.

Steen, M., Downe, S., Bamford, N., & Edozien, L. (2012). Not-patient and not-visitor: A metasynthesis fathers' encounters with pregnancy, birth and maternity care. *Midwifery*, 28(4), 422-431.

Stein, A., Malmberg, L. E., Sylva, K., Barnes, J., Leach, P., & FCCC team. (2008). The influence of maternal depression, caregiving, and socioeconomic status in the post-natal year on children's language development. *Child: care, health and development*, 34(5), 603-612.

Stern, D. N. (1995). The motherhood constellation: A unified view of parent-infant psychotherapy. New York: Basic Books.

Stern, D. N. (2004). The motherhood constellation: Therapeutic approaches to early relational problems. In A.J.E. Sameroff, S. C. E. McDonough, & K. L. E. Rosenblum (Eds.), *Treating parent-infant relationship problems: Strategies for intervention*. (pp. 29-42). New York: Guilford.Press.

Stillman, T. F., Baumeister, R. F., Lambert, N. M., Crescioni, A. W., DeWall, C. N., & Fincham, F. D. (2009). Alone and without purpose: Life loses meaning following social exclusion. *Journal of experimental social psychology,* 45(4), 686-694.

Strasser, F. (1999). *Emotions: Experiences in Existential Psychotherapy and Life.* London Duckworth.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Swann, W. B., Wenzlaff, R. M., & Tafarodi, R. W. (1992). Depression and the search for negative evaluations: More evidence of the role of self-verification strivings.

Tach, L., Mincy, R., & Edin, K. (2010). Parenting as a "package deal": Relationships, fertility, and nonresident father involvement among unmarried parents. *Demography*, 47(1), 181-204.

Tambelli, R., Odorisio, F., & Lucarelli, L. (2014a). Prenatal and postnatal maternal representations in no risk and at-risk parenting: exploring the influences on mother-infant feeding interactions. *Infant Mental Health* 35, 376–388.

Tambelli, R., Vismara, L., Odorisio, F., & Figuereido, B. (2014b). Understanding the impact of paternal depressive and anxiety symptomatology on infant-parent relationship: a study on parental representations and caregiver-child interaction. *Infant Mental Health*. 35, 34–35

Tammentie, T. (2004). Family dynamics and postnatal depression. *Journal of Psychiatric and Mental Health Nursing*; 11: 141-149.

Tammentie, T., Tarkka, M. T., ÅSTEDT-KURKI, P., Paavilainen, E., & Laippala, P. (2004). Family dynamics and postnatal depression. *Journal of Psychiatric and Mental Health Nursing*, 11(2), 141-149.

Tannenbaum L. & Forehand R. (1994). Maternal depressive mood: the role of fathers in preventing adolescent problem behaviours. *Behaviour Research & Therapy*. 32, 321–325.

Thomas, J. E., Bonér, A. K., & Hildingsson, I. (2011). Fathering in the first few months. *Scandinavian journal of caring sciences,* 25(3), 499-509.

Tillich, P. (1952). *The courage to be*. New Haven, CT: Yale University Press

Tillich, P. (1954*). Love, Power and Justice*. Oxford University Press.

Trede, K., Baldessarini, R. J., Viguera, A. C., & Bottéro, A. (2009). Treatise on insanity in pregnant, postpartum, and lactating Women (1858) by Louis-Victor Marcé: A Commentary. *Harvard Review of Psychiatry*, 17 (2). 157-165.

Van Deurzen-Smith, E. (1988). *Existential counselling in practice*. Sage Publications, Inc.

Van Deurzen, E. (1997). Everyday Mysteries Existential Dimensions of Psychotherapy.

Van Deurzen, E. (2012). *Existential counselling & psychotherapy in practice*. Sage.

Van Deurzen, E. (2014). Existentialslides11. [Online] Slideshare.net. Available at: https://www.slideshare.net/emmyzen/existentialslides11 [Accessed 12 Jun. 2019].

Van Deurzen, E. (2015). *Paradox and passion in psychotherapy: An existential approach*. John Wiley & Sons.

Van Deurzen, E. (2015). Structural Existential Analysis (SEA): A Phenomenological method for Therapeutic Work. *Journal of Contemporary Psychotherapy*, 45(1), pp.59-68.

Van Deurzen, E., & Arnold-Baker, C. (2005). Existential perspectives on human issues. Palgrave Macmillan.

Van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*. (2nd ed.). London: The Althouse Press.

Van Manen, M. (2002). *Writing in the dark: Phenomenological studies in interpretive inquiry*. London, ON, Canada: Althouse Press.

Van Manen, M. (2007). Phenomenology of Practice. Phenomenology & Practice, Volume 1, pp 11-30

Van Manen, M. (2016). *Researching lived experience: Human science for an action sensitive pedagogy*. Routledge.

Van Yperen, N. W., & Buunk, B. P. (1990). A longitudinal study of equity and satisfaction in intimate relationships. *European Journal of Social Psychology,* 20(4), 287-309.

Veskrna, L. (2010). Peripartum depression – does it occur in fathers and does it matter? *American Journal of Men's Health*, 7 (4): 420–430.

Walsh, K. (1996). Philosophical Hermeneutics and the project of Hands Georg Gadamer: Implications for nursing research. *Nursing Inquiry* 3: 231-237.

Webster, A. (2002). The forgotten father: the effect on men when partners have PND. *Community Practitioner*, 75(10), 390.

Webster, J., Pritchard, M. A, Liannane, J. W., Roberts, J. A, Hinson, J. K. & Starrenburg, S. E. (200 I). Postnatal depression: Use of health services and satisfaction with health-care providers. *Journal of Quality in Clinical Practice*, 21(4), 144-148.

Wee K. Y., Skouteris H., Pier C., Richardson B., Milgrom J. (2011). Correlates of ante- and postnatal depression in fathers: A systematic review. *Journal of Affective Disorders*, 130, 358-377.

Wertz, F. (2005). Phenomenological research methods for counselling psychology. *Journal of Counselling Psychology*. 52(2), 167-177.

Whisman M. A., Davila J., Goodman S. H. (2011). Relationship adjustment, depression, and anxiety during pregnancy and the postpartum period. *Journal of Family Psychology*, 25, 375-383.

Whisman, M. A. (2013). Relationship discord and the prevalence, incidence, and treatment of psychopathology. *Journal of Social and Personal Relationships*, 30(2), 163-170.

Whisman, M. A., & Uebelacker, L. A. (2009). Prospective associations between marital discord and depressive symptoms in middle-aged and older adults. *Psychology and aging*, 24(1), 184.

Wiles, J. (2003). Daily geographies of caregivers: Mobility, routine, scale. Social Science & Medicine, 57(7), 1307-1325.

Wilkins, C. (2006). A qualitative study exploring the support needs of first-time mothers on their journey towards intuitive parenting. *Midwifery*, 22(2), 169-180.

Wilson, K. R. & Prior, M. R. (2011). Father involvement and child well-being. *Journal of Paediatrics and Child Health*, 47(7), 405 – 417.

Wilson, S., & Durbin, C. E. (2010). Effects of paternal depression on fathers' parenting behaviours: A meta-analytic review. *Clinical Psychology Review*, 30(2), 167–180.

Wilson, W. J. (2008). The economic plight of inner-city Black males. *Against the wall: Poor, young, Black, and male,* 55-70.

Wong, P. T., & Fry, P. S. (1998). *The human quest for meaning*. Mahwah, NJ: Erlbaum.

Wong, P. T., Wong, L. C., & Scott, C. (2006). Beyond stress and coping: The positive psychology of transformation. *In Handbook of multicultural perspectives on stress and coping* (pp. 1-26). Springer, Boston, MA.

Yalom, I. D. (1980). Existential psychotherapy. New York: Basic Books.

Yin, R. K. (2003). Case study research: Design and method (3rd ed.). Thousand Oaks, CA: Sage.

Zelkowitz, P., & Milet, T. H. (1996). Postpartum psychiatric disorders: Their relationship to psychological adjustment and marital satisfaction in the spouses. *Journal of Abnormal Psychology*, 105(2), 281-285.

Zelkowitz, P., & Milet, T.H. (2001). The course of postpartum psychiatric disorders in women and their partners. *Journal of Nervous and Mental Disease,* 189(9), 575–582.

Zhang, R., Chen, Q., & Li, Y. (1999). Study for the factors related to postpartum depression. *Zhonghua fu chan ke za zhi*, *34*(4), 231-233.

Chapter 8 Appendices

8.1 Appendix A: Consent Form

Written Informed Consent

Supervisor: Claire Arnold-Baker

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.

_____ _____

Print name Sign Name

Date: _____

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

8.2 Appendix B: Debriefing Sheet

New School of Psychotherapy and Counselling
61-63 Fortune Green Road
London
NW6 1DR

Middlesex University
The Burroughs
London NW4 4BT

Debriefing information for participants

Researcher's name _____
Dated _____

A phenomenological exploration into the lived experience of fathers living with new mothers diagnosed as PND

Thank you for participating as a research participant in the present study. The general purpose of this research was to collect data and study the experiences of fathers who have lived with partners diagnosed with Post Natal Depression (PND). In relation to PND a lot of studies are available on mothers' mental health but relatively little work seems to have been done on the father's side of the picture and that's why I am aiming to look at this area.
I invited people who are first-time fathers, aged between 30 and 40 years, who are working full-time and who have had the experience of living with a partner who has been diagnosed with PND within the last three years. In this study, you were asked to relate your experiences of living with your partners diagnosed with PND during a one hour long interview. The results from this study will increase awareness and understanding about the experiences of new fathers and might help in making more informed decisions about making support available to partners of women diagnosed with PND.
If you feel especially concerned that talking about personal experiences has been distressing or challenging please feel free to contact me at FS441@live.mdx.ac.uk. Alternatively, you could seek additional help from the following organisations:

- **British Association for Counselling and Psychotherapy (BACP)**
  http://www.bacp.co.uk/seeking_therapist/right_therapist.php
  BACP is the main body in the UK representing counselling at national and international levels. It provides *Find a Therapist* database that can be used to locate a therapist in your area.

- **Mind**
  www.mind.org.uk or www.mindincambs.org.uk Tel: 01223 311320
  Mind is a dynamic, county-wide charity that supports local people in their recovery from mental health issues, promotes wellbeing, provide advice and support to empower anyone experiencing a mental health problem.
- **The Cogwheel Trust**
  www.cogwheel.org.uk Tel: 01223 464385

A charitable orgnaisation offering a wide range of counselling and consultancy resources for individuals, couples,families and groups. Sliding scale according to income.

- **Cambridge Counselling Services**
  www.cambridgecounsellingservice.co.uk Tel: 01223 261061
  Cambridge Counselling Service works with people across Cambridgeshire. It offers both individual and couples counselling. Reduced fees are also available in some cases.

Thank you for your participation in this study. If you have further questions or concerns please contact my supervisor:

Claire Arnold-Baker
nspcclaire@gmail.com

8.3 Appendix C: Participant Information Sheet

New School of Psychotherapy and Counselling
61-63 Fortune Green Road
London
NW6 1DR

Middlesex University
The Burroughs
London NW4 4BT

Participants Information Sheet

Dated: _____

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

What is the purpose of the research?
This study is being carried out as part of my studies at NSPC Ltd and Middlesex University. The focus of the study is on the experiences of new fathers who are living with women diagnosed with PND.The birth of a child inevitably results in a major transition in the life of new mothers and fathers. Its effects on parents both as individuals and as a couple, are profound and therefore it has an important impact on family life. The leading mental health complication associated with childbirth is Postnatal Depression (PND) i.e. the depressive symptoms that occur during the postnatal period. There is a large body of work available regarding PND and the mothers' mental health but what tends to be forgotten is the fact that the fathers also face a challenging and unfamiliar situation after childbirth. Not enough research seems to have been done on the father's side of the picture and that's why I am aiming to look at this area and find out what it is like for the fathers to live with women who are experiencing PND. It is very important that research is conducted in this area because it will provide the data that will help in making more informed decisions about making support (clinical or otherwise) available to partners of women diagnosed with PND. I hope that my research will help to create awareness in this area and increase the understanding of the lived experience of new fathers.

What will happen to me if I take part?
The interview will take about an hour and will be conducted either at the premises of Middlesex University or University of Cambridge Counselling Services (UCS). It will include open-ended questions in order to guide but not direct the conversation. You will be given the opportunity to express your beliefs, understandings, experiences and opinions. A private room in the offices of the organisations mentioned above will be allocated for the interviews. The information obtained from the interview will be combined with the information from other participants for statistical analysis. I will use a qualitative research method to extract the main themes of what you and other people tell me about your experiences.

What will you do with the information that I provide?

The interview will be transcribed by myself or a professional transcriber. I will not use your full or last name in the interview so that the person transcribing the interview will not know who

you are. I will be recording the interview on a digital recorder, and will transfer the files to an encrypted USB stick for storage, deleting the files from the recorder. All of the information that you provide me will be identified only with a project code and stored either on the encrypted USB stick, or in a locked filing cabinet. I will keep the key that links your details with the project code in a locked filing cabinet.

The information will be kept at least until 6 months after I graduate, and will be treated as confidential. If my research is published, I will make sure that neither your name nor other identifying details are used.

Data will be stored according to the Data Protection Act and the Freedom of Information Act

What are the possible disadvantages of taking part?
It is unlikely that the interview or study will cause you any harm. However, talking about personal experiences may be distressing or challenging. If so, please let me know, and if you wish, I will stop the interview. Although this is very unlikely, should you tell me something that I am required by law to pass on to a third person, I will have to do so. Otherwise whatever you tell me will be confidential.

What are the possible benefits of taking part?
Being interviewed about your experiences has no direct benefit, although some people may find it an opportunity to reflect on their experiences and could find this beneficial. However, by participating in this research you will be providing valuable data that may help in better decisions being made regarding provision of support and services to partners of women suffering from PND.

Consent

You will be given a copy of this information sheet for your personal records, and if you agree to take part, you will be asked to sign the attached consent form before the study begins.

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw at any time without giving a reason.

Who is organising and funding the research?
This research is self-funded.

Who has reviewed the study?

All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The NSPC research ethics sub-committee have approved this study

Thank you for reading this information sheet. If you have any further questions, you can contact me at: FS441@live.mdx.ac.uk

If you any concerns about the conduct of the study, you may contact my supervisor:

Claire Arnold-Baker
NSPC Ltd. 61-63 Fortune Green Road
London NW6 1DR
nspcclaire@gmail.com

Or

The Principal
NSPC Ltd. 61-63 Fortune Green Road
London NW6 1DR
Admin@nspc.org.uk
0044 (0) 20 74358067

8.4 Appendix D: Ethical Approval and Risk Assessment

Middlesex University

Middlesex University Department of Psychology Ethics Committee
Application for Ethical Approval and Risk Assessment

No study may proceed until approval has been granted by an authorised person. For collaborative research with another institution, ethical approval must be obtained from all institutions involved. If you are involved in a project that has already received ethical approval from another committee or that will be seeking approval from another ethics committee please complete form **'Application for Approval of Proposals Previously Approved by another Ethics Committee or to be Approved by another Ethics Committee'**

UG and MSc STUDENTS: Please email the completed form to your supervisor from your University email account (...@live.mdx.ac.uk). Your supervisor will then send your application to the Ethics Committee (Psy.Ethics@mdx.ac.uk). You should NOT email the ethics committee directly.

PhD Students and STAFF: Please email the completed form to Psy.Ethics@mdx.ac.uk from your University email account (...@mdx.ac.uk)

This form consists of 8 sections:

1) Summary of Application and Declaration
2) Ethical questions
3) Research proposal
4) Information sheet
5) Informed consent
6) Debriefing
7) Risk assessment (required if research is to be conducted away from Middlesex University property, otherwise leave this blank. Institutions/locations listed for data collection must match original letters of acceptance)
8) Reviewer's decision and feedback

Once your file including proposal, information sheet, consent form, debriefing and (if necessary) materials and Risk Assessment form is ready, please check the size. For files exceeding 3MB, please email your application to your supervisor using WeTransfer: https://www.wetransfer.com/ this will place your application in cloud storage rather than sending it directly to a specific email account. If you/ your supervisor have confidentiality concerns, please submit a paper copy of your application to the Psychology Office instead of proceeding with the electronic submission.

FOR OFFICE USE ONLY

Application No.:	Click here to enter text.	**Decision:**	Click here to enter text.	**Date:**	Click here to enter a date.

RISK ASSESSMENT *(complete relevant boxes)*:

Required:	☐ **Yes** ☐ **No**	**Signed by:**	☐ **Student** ☐ **Supervisor** ☐ **Programme Leader**
Date:	Click here to enter a date.		

LETTER/S OF ACCEPTANCE/PERMISSION MATCHING FRA1 (RISK ASSESSMENT) RECEIVED (SPECIFY):

	Date	From	Checked by
All	Click here to enter a date.	Click here to enter text.	☐ Supervisor ☐ Ethics Admin
Part	Click here to enter a date.	Click here to enter text.	☐ Supervisor ☐ Ethics Admin
Part	Click here to enter a date.	Click here to enter text.	☐ Supervisor ☐ Ethics Admin

DBS Certificate(s) Required? *(complete relevant boxes)*:

DBS certificate required?	Click here to choose an item.	**Seen By:**	Choose an item.
DBS Certificate Number:		**Date DBS Issued:**	Click here to enter a date.

Middlesex University

1 Summary of application (researcher to complete)

Title of Proposal:	A phenomenological exploration into the lived experience of fathers living with new mothers diagnosed as PND		
Name of Principal Investigator/Supervisor	Claire Arnold-Baker		
Name of Student Researcher(s) and student number(s)	Farasat Fatima Sadia M00512810		
Please click one of the following:			
○ UG Student	◉ PHD/MPHIL Student	○ MSc Student	○ Staff
Proposed start date	14/06/16	**Proposed end date**	31/12/17
Details of any co-investigators (if applicable)			
1. Name: Click here to enter text.	Organisation: Click here to enter text.	Email: Click here to enter text.	
2. Name: Click here to enter text.	Organisation: Click here to enter text.	Email: Click here to enter text.	
3. Name: Click here to enter text.	Organisation: Click here to enter text.	Email: Click here to enter text.	

Topic/Research Area (tick as many as apply)

☐ Social/Psychosocial ☐ Occupational ☐ Forensic ☐ Developmental ☐ Sport & Exercise
☐ Cognition & Emotion ☐ Psychoanalysis ☑ Clinical ☐ Psychophysiological ☐ Health

Methodology (tick as many as apply)

☑ Qualitative ☐ Experimental ☐ Field Experiments ☐ Questionnaire
☐ Observation (humans and non-humans) ☐ Analysis of Existing Data Source/Secondary Data Analysis

1.1	Are there any sensitive elements to this study?	YES
1.2	If the study involves any of the first three groups above, the researcher may need a DBS certificate (Criminal Records Check). PG students are expected to have DBS clearance. Does the current project require DBS clearance? *Discuss this matter with your supervisor if you unsure*	YES
1.3	Does the study involve ANY of the following? *Clinical populations; Children (under 16 years); Vulnerable adults such as individuals with mental or physical health problems, prisoners, vulnerable elderly, young offenders; Political, ethnic or religious groups/minorities; Sexually explicit material / issues relating to sexuality; Mood induction; Deception*	**NIO**
1.4	Is this a resubmission / amended application? *If so, you must attach the original application with the review decision and comments (you do not need to re-attach materials etc if the resubmission does not concern alterations to these). Please note that in the case of complex and voluminous applications, it is the responsibility of the applicant to identify the amended parts of the resubmission.*	YES

By submitting this form you confirm that:

- you are aware that any modifications to the design or method of the proposal will require resubmission;
- students will keep all materials, documents and data relating to this proposal until completion of your studies at Middlesex, in compliance with confidentiality guidelines (i.e., only you and your supervisor will be able to access the data);
- staff will keep all materials, documents and data relating to this proposal until the appropriate time after completion of the project, in compliance with confidentiality guidelines (i.e., only you and other members of your team will be able to access the data);
- students will provide all original paper and electronic data to the supervisor named on this form on completion of the research / dissertation submission;
- you have read and understood the British Psychological Society's *Code of Ethics and Conduct,* and *Code of Human Research Ethics.*

2 Ethical questions – all questions must be answered

2.1	Will you inform participants of their right to withdraw from the research at any time, without penalty?	YES
2.2	Will you provide a full debriefing at the end of the data collection phase?	YES
2.3	Will you be available to discuss the study with participants, if necessary, to monitor any negative effects or misconceptions?	YES
2.4	Under the Data Protection Act, participant information is confidential unless otherwise agreed in advance. Will participant anonymity be guaranteed?	YES
2.5	Is this research or part of it going to be conducted in a language other than English? *Note, full translations of all non-English materials must be provided and attached to this document*	NO
2.6	Is this research to be conducted only at Middlesex University? *If not, a completed Risk Assessment form - see Section 8 – must be completed, and permission from any hosting or collaborative institution must be obtained by letter or email, and appended to this document, before data collection can commence. If you are conducting an online survey or interviews via skype or telephone whilst you are at Middlesex University you do not need to fill in the risk assessment form.*	NO

If you have answered 'No' to questions 1, 2, 3, 4, and 6 above, please justify/discuss this below, outlining the measures you have taken to ensure participants are being dealt with in an ethical way.

I will be conducting interviews at the premises of Middlesex University and University of Cambridge Counselling Services (UCS) where a safe place like a private room will be allocated for the interviews. I will make sure that confidentiality is maintained and my personal safety is also considered whilst choosing the time and venue. A letter of consent from UCS is attached with the application.

Are there any ethical issues that concern you about this particular piece of research, not covered elsewhere on this form? If so please outline them below

Middlesex University

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA1

This proforma is applicable to, and must be completed in advance for, the following field/location work situations:

1. *All field/location work undertaken independently by individual students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
2. *All field/location work undertaken by postgraduate students. Supervisors to complete with student(s).*
3. *Field/location work undertaken by research students. Student to complete with supervisor.*
4. *Field/location work/visits by research staff. Researcher to complete with Research Centre Head.*
5. *Essential information for students travelling abroad can be found on www.fco.gov.uk*

FIELD/LOCATION WORK DETAILS

Name:	Farasat Fatima Sadia	**Student No** **Research Centre:(staff only)**	M00512810
Supervisor:	Claire Arnold-Baker	**Degree course**	PhD

NEXT OF KIN Telephone numbers and name of next of kin who may be contacted in the event of an accident	**Name:** Muhammad Umer Khan **Phone**: 07523202121
Physical or psychological limitations to carrying out the proposed field/location work	No
Any health problems (full details) Which may be relevant to proposed field/location work activity in case of emergencies.	No
Locality (Country and Region)	United Kingdom
Travel Arrangements NB: Comprehensive travel and health insurance must always be obtained for independent overseas field/location work.	Car, Bus
Dates of Travel and Field/location work	Autumn 2016-Summer 2017

PLEASE READ THE FOLLOWING INFORMATION VERY CAREFULLY

Hazard Identification and Risk Assessment

List the localities to be visited or specify routes to be followed **(Col. 1).** For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern **(Col. 2).**

Examples of Potential Hazards :

Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)
Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.
Demolition/building sites, assault, getting lost, animals, disease.
Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.
Lone working: difficult to summon help, alone or in isolation, lone interviews.
Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.

Middlesex University

Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime. Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task. Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury. Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage. Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

1. LOCALITY/ROUTE (specify here the exact name and address of each locality/organization)	2. POTENTIAL HAZARDS
Middlesex University The Burroughs London NW4 4BT University Counselling Services-University of Cambridge. 2-3 Bene't Place, Lensfield Rd, Cambridge CB2 1EL	Lone interviews Lone interviews

The University Field/location work code of Practice booklet provides practical advice that should be followed in planning and conducting field/location work.

Risk Minimisation/Control Measures **PLEASE READ VERY CAREFULLY**

For each hazard identified **(Col 2),** list the precautions/control measures in place or that will be taken **(Col 3)** to **"reduce the risk to acceptable levels",** and the safety equipment **(Col 5)** that will be employed.

Assuming the safety precautions/control methods that will be adopted **(Col. 3),** categorise the field/location work risk for each location/route as negligible, low, moderate or high **(Col. 4).**

Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

Providing adequate training, information & instructions on field/location work tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements).

Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of field/location work area.
Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

3. PRECAUTIONS/CONTROL MEASURES	4. RISK ASSESSMENT (low, moderate, high)	5. SAFETY/EQUIPMENT
I will call my next of kin before starting the interview to let them know that the interview is starting. I will call them again after the end of the interview. If they don't receive my call after the end of the interview they will check on me within two hours.	Low	Mobile phone

PLEASE READ THE FOLLOWING INFORMATION AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the field/location work period and additional precautions taken or field/location work discontinued if the risk is seen to be unacceptable.

Signature of Field/location worker (Student/Staff)		**Date:**	07/05/16
Signature of Student Supervisor	Click here to enter text.	**Date:**	Click here to enter a date.
APPROVAL: (ONE ONLY) **Signature of Director of Programmes** (undergraduate students only)	Click here to enter text.	**Date:**	Click here to enter a date.
Signature of Research Degree Co-ordinator or Director of Programmes (Postgraduate)	Click here to enter text.	**Date:**	Click here to enter a date.

Signature of Research Centre Head (for staff field/location workers**)**	Click here to enter text.	**Date:**	Click here to enter a date.

FIELD/LOCATION WORK CHECK LIST

1. Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

☑ Safety Knowledge & Training?	☑ Awareness of cultural, social & political differences?
☑ Personal clothing & safety equipment?	☑ Suitability of field/location workers to proposed tasks?
☑ Physical & psychological fitness & disease immunity, protection & awareness?	

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to

☐ Visa, permits?	☐ Weather conditions, tide times and ranges?
☐ Legal access to sites and/or persons?	☐ Suitability of field/location workers to proposed tasks?
☐ Vaccinations and other health precautions?	☐ Safety equipment and protective clothing?
☐ Financial and insurance implications?	☐ Travel and accommodation arrangements?
☐ Health insurance arrangements?	☐ Arrival times after journeys?
☐ Civil unrest and terrorism?	☑ Emergency procedures?
☐ Crime risk?	☑ Transport use?
☐ Political or military sensitivity of the proposed topic, its method or location?	

Important information for retaining evidence of completed risk assessments:

Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue a copy of it to the field/location worker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.
RP/cc Sept 2010

Middlesex University

1st Reviewer's decision

Click here to choose a decision

For Revise and Resubmit decisions, particular attention should be paid to the following:

☐ Section 1 details incomplete ☐ Clarity of Research Proposal ☐ Risk Assessment

☐ Professionalism and presentation of participant documentation (information sheet, informed consent, debriefing)

☐ Completeness of ethical approval form (individual questions requiring clarification may be identified here)

Additional comments from Reviewer 1:

Click here to enter text.

FOR DOUBLE REVIEW ONLY – Reviewer 2

Click here to choose a decision

For Revise and Resubmit decisions, particular attention should be paid to the following:

☐ Section 1 details incomplete ☐ Clarity of Research Proposal ☐ Risk Assessment

☐ Professionalism and presentation of participant documentation (information sheet, informed consent, debriefing)

☐ Completeness of ethical approval form (individual questions requiring clarification may be identified here)

Additional comments from Reviewer 2:

Click here to enter text.

8.5 Appendix E: Ethics Approval

28th July 2017

Dear Farasat,

Re: Ethics Approval

Your application has been reviewed by the Chair of the research ethic sub-committee and the following decision was made.

Ethics Approval
Your application has been approved by Chair's action.

Yours sincerely

pp

Prof Digby Tantam
Chair Ethics Committee
NSPC

8.6 Appendix F: Analysis of Themes Step 3

Themes step3P5

Tough to deal with PND	Dealing with PND was very tough because I had no clue how to help or when it would ever finish. I didn't expect the extreme anxiety, insomnia and fears. I felt useless as didn't know what to do.	**1**
No one to talk to	Speaking with someone who experienced the same thing could have helped me massively but you do not want to admit failure and want to keep it private. I was struggling to find anyone to talk to as none of my friends even have a baby.	**2**
Prepared to be a father	I was prepared for my role as a father and expected that I would need to help. Actually I was prepared for much worse but she has been a pretty good baby so it is absolutely fine.	**3**
Suffering as a couple	The affective side of being a couple was suffering after the baby anyway but living with my wife in her postnatal phase was even worse because you are used to all your moments together and now there was no time for me at all; it was just me supporting her and taking care of her condition rather than having our life as a couple.	**4**
Being stronger and not giving up	Having some thoughts like giving up was obviously normal but the emotion of being stronger for her and to be there for her overcame all other thoughts and feelings.	**5**
Feeling guilty	I felt guilty about leaving her alone in case she had an anxiety attack or crisis when I was out because there were two or three episodes where she punched herself which made me feel really bad and guilty.	**6**

Shocked by self-harming	I was really shocked by my wife punching herself because I never thought that could happen, so that was the toughest thing to go through but I reacted rationally without emotion and stopped her. It's a really bad situation that I hope to never experience again.	**7**
Feeling proud	It made me feel really proud and happy when she told me that I was doing the right things. I felt that I have proved that I was there for her and she appreciated that.	**8**
Not telling family	I didn't tell my family because although seeing family would have been nice as a distraction or to offload the baby, they would have tried to help and probably cause more mess than helping and it is something so intimate to the couple that you need more professional help than family.	**9**
More protection than shame	I did not feel ashamed because it is normal. I was conscious not to talk about my partner's condition with people to protect us from wrong feedback and negative thoughts.	**10**
Sharing with my friends	It was too hard to keep everything in and I was so desperate in the end that I had to speak to some of my friends about the emotional experience. I wanted to get a little encouragement to be able to start again and not give up.	**11**
Fears and anxieties	My anxieties and fears were about how long it would take for my wife to recover and if she was going back to normal at all or whether we were going to split as a couple. I still have anxiety about going out and leaving her alone.	**12**

Hopes	My hopes were that we would get some help like medication or therapy to end the PND very soon so that we could enjoy the baby. I also hoped to talk to other people with the same experience.	**13**
Looking normal from outside	Going through postnatal depression you still look normal from the outside even when you might be the saddest person in the world. It's hard to imagine and a lot of people wouldn't have a clue about what you are going through.	**14**
Communication was key	Communication was the key to not lose the plot for both of us. We expressed our feelings to each other. Hearing what I was doing good or bad and also that I myself wasn't the problem was massively helpful, otherwise I would have struggled and doubted myself.	**15**
Seeking support and reassurance	My instinct was to seek help and find solutions and support my wife during the crisis situations. I wanted to have reassurance about my actions being fine and things being normal and expected to end from a professional or someone with previous experience because I was not as confident about my wife's reassurances or knowledge from internet.	**16**
Stepping out for her	I felt that I needed to step out for my wife and be more careful and affective towards her, just like you are when dealing with any other sickness.	**17**
Careful about what I say	I had to be careful about the way I talked to my wife as I was aware that she will perceive it differently and will give a bad answer because she was feeling bad herself.	**18**
Anger	Sometimes I felt angry with my wife but I calmed down, got over it and moved on because I knew she was afflicted and did not mean it.	**19**

No change in dependency	My wife was a little bit more dependent on me but not too much. Being together just helped to make the problem more manageable.	**20**
Impact on work and social life	My work and social life were affected as I was concentrating a bit less at work and sometimes didn't go out in order to support my wife.	**21**
Feeling annoyed	It is annoying that even though we sought help in all possible ways we did not get it earlier otherwise this phase could have lasted much less. If we had found the right help at the beginning for both of us the impact on our lives would have been much less.	**22**

8.7 Appendix G: Analysis of Themes Step 1 and Step 2

Participant five

Step 1: Black coloured text
Step 2: Green coloured text
Step 3: Blue coloured text

1. Tough to deal with PND

It was tough. Well, mostly because it was something I have no clue about, literally I don't know how to help, what was it, like, what could I do. I was doing something based on my pure instinct, you know, like, trying to cheer her up and…I often wonder if I was doing the right thing, which then it turned out it was the right thing,
It was more dealing with PND that was much harder. It was not what am I doing now or how…but is this ever going to finish or something? Is this ever going to finish? Is this ever going to stop?
The hardest thing about all this thing for both of us is not knowing what to do, is having something you never experienced in a form that you never experienced because I was expecting…I heard about postnatal depression.
It's not like it's something totally new, but I thought that would have been being very sad, very depressed, not wanting to do anything. I thought it was nothing to do with anxiety or being extremely insomnia, fearing about everything because in those days she was fearing about literally everything like that the baby could die for whatever, that I could die, you know, all these things
I was a bit worried in that time because I didn't know what to do and I didn't know…I mean, for a little while I didn't see any improvement. I only see her getting worse actually and she was a bit desperate herself because she couldn't find any help, so I was feeling a bit useless myself at all. Even if I was…in the end, I found out later, that I wasn't actually, but still you can't help the way you feel, you know.

Dealing with PND was tough as I had no clue about how to help and I was doing things based on pure instinct which later turned out to be the right things to do. Both of us not knowing what to do or when this was ever going to finish was the hardest. I thought PND would be about being very sad and about not wanting to do anything but nothing to do with the anxiety, extreme insomnia and fears about everything. I felt useless because for a while she was only getting worse and I didn't know what to do.

Dealing with PND was very tough because I had no clue how to help or when it would ever finish. I didn't expect the extreme anxiety, insomnia and fears. I felt useless as didn't know what to do.

2. No one to talk to

I had no one to ask or to tell. Even, I was feeling bad to talk with my friends about it because I don't want…you know, it's something that you want to keep a bit private and my partner always said, like, 'if you want to speak with them…' but, even if I was speaking with my friends it's not like they've experienced something like that because the majority of my friends they don't have a baby anyway. So, yes, it was a little bit…but, obviously I researched the net about it and what I found was kind of useful, that basically made me think, yes, I'm doing the right thing, but it's not the same as
You don't want to [s.I admit failure 0:34:13]. You don't want to try to speak with someone and they say, 'oh, I don't know anything about it' and then they know all your business and be no help basically, going back to what we were talking about before that would be something they have no clue about and you want to keep it private in a way
If you're in that situation and somebody would tell you, 'oh, you can meet someone that had this before and they came out of it' I mean, I don't see anyone not wanting to speak with that someone. That could have helped massively, I think
Possibly, possibly, but I was actually struggling to find someone that could have possibly had an experience like that because, as I said, all my friends in here have no babies, so it was definitely none of
I would have struggled to find someone that I could have possibly think they would have experienced the same thing because you want to…if you talk with someone about it and you want to share it and you want someone that reasonably could have experienced that, but I don't know who could have done it of my friends, you know.

I was struggling to ask or talk to someone because you want to keep it a bit private unless you find someone who had experienced the same thing. None of my friends have experienced anything like this or have a baby anyway and you don't want to admit failure or share it with someone who have no clue about it. I researched the internet and it made me think I'm doing the right thing but if I could speak with someone who had it and came out of it that could have helped massively.

Speaking with someone who experienced the same thing could have helped me massively but you do not want to admit failure and want to keep it private. I was struggling to find anyone to talk to as none of my friends even have a baby.

3. Prepared to be a father

That was okay. I mean, it was something you expect when you have a baby. It's not like…I'm not saying it's amazing, obviously, but it wasn't too bad. She's always been a good baby, so…obviously, we had a couple of tough nights, but generally it's always been pretty good since the beginning, so we were lucky with the baby itself that she wasn't a tough baby or, you know, crying all the time. That was good. She doesn't take the bottle. She never took the bottle, so I mean she needed to be mostly breastfeeding even in the night time when she was little, but I could still rock her sometimes if she just had a breastfeed an hour before it was enough to just rock her back. So, no, I was fine. It was absolutely fine. I mean, it's my role as a father to help her. I would have done that anyway, so that wasn't a problem for me. I was prepared. Actually, I was prepared for much worse because obviously, you never know how they are and…no, the fact that she was a good baby it was actually…I was like, oh. In terms of waking up in the night and that, like I said, it's not amazing, but [s.I at all 0:07:43] it's not actually too bad for me.I was expecting even worse, you know, crying all the night. So, yes, that wasn't terrible.

It is my role as a father to help with the baby so I was prepared for it and it was absolutely fine. Actually she has always been a good baby and we have had a couple of tough nights but it wasn't too bad and generally it's always been pretty good since the beginning. It was something you expect when you have a baby. Actually, I was prepared for much worse so this wasn't terrible and I was fine with it.

I was prepared for my role as a father and expected that I would need to help. Actually I was prepared for much worse but she has been a pretty good baby so it is absolutely fine.

4. Suffering as a couple

Will I have her back, because I was missing also the affective side, you know, like being a couple. That was suffering after having a baby in general and with her in that condition was even worse

Yes, because obviously even if she would have been absolutely fine a lot of things would have changed in terms of, like, a couple. I would say in terms of postnatal depression is more what I said to you, like, I know she would have had more time for me, but when she was diagnosed with postnatal depression was basically no time for me at all, whereas now obviously we still have our little moments and that

it was hard. It's tough enough even when it's absolutely fine because obviously you're used to all your moments and, you know, having dinner out, going to the movies and stuff like that, you know, kisses, hugging and even in terms of sexual life and that, so that was a bit tough. Obviously, that has improved since she's back to normal, but it's never going to be back to what it used to be, which is a bit sad,

It wasn't very enjoyable living with her at that time, but that's why we are a couple. I mean, there's always happiness, it's easy for everybody, you know, so I just thought about that.

Yes, I kind of already did it, but, yes, it was tough enough having a baby. Having a baby impacts massively your relationship. Nothing is as it was before in terms of affection and that. Yes, being in the postnatal depression phase is even worse because having a baby impacts, let's say 60-70%, this impacts 100% on that, where basically every time there's no baby around you still have to go support her and focus on her condition rather than your life as a couple, if you see what I mean. So, yes, it was a big, big impact, but how you can imagine it is more like…yes, basically not having time for yourself, even kissing would have been a problem because she wanted her space, she wanted to be left alone, so, yes, that was something I was really suffering about because it was already tough enough and I'm quite affective myself, I'm quite romantic and that. That was…yes, that was bad, but at the same time I know she wasn't doing it because it was me. It wasn't me.

The affective side like being a couple was suffering after the baby but with her in postnatal phase it was even worse. Having a baby is tough enough and impacts your relationship massively but postnatal depression phase is even worse and even when there's no baby you still have to support her and focus on her condition rather than having your life as a couple. It wasn't enjoyable living with her when she was diagnosed with postnatal depression because there was no time for me at all. She wanted her space and to be left alone and it was hard because you are used to all your moments like having dinner, movies, hugs, kisses and sexual life, and I'm quite affective and romantic myself so that was tough. It is better now but it's never going to be what it used to be which is a bit sad.

The affective side of being a couple was suffering after the baby anyway but living with my wife in her postnatal phase was even worse because you are used to all your moments together and now there was no time for me at all; it was just me supporting her and taking care of her condition rather than having our life as a couple.

5. Being stronger and not giving up

Well, yes, I kind of told you already it's like I was a bit sad and I was little bit down myself. I thought about giving up a couple of times or even more, but obviously it's normal. I don't even know what it means, giving up, like, I felt like being somewhere else or something, but it wasn't an option. Obviously, things are like come on this isn't going to go anywhere or something. Yes, then at the same time I was having some other emotion about being strong, being stronger for her and being there for her and that was something that overcome the other feelings. Then obviously I was much more relieved once I see that she was coming back, that the cure was actually working

I was a bit sad and down myself and a couple of times I thought about giving up or being somewhere else but obviously that's normal and it wasn't really an option. At the same time the emotion of being stronger for her and to be there for her overcame other feelings and to see her coming back was such a relief.

Having some thoughts like giving up was obviously normal but the emotion of being stronger for her and to be there for her overcame all other thoughts and feelings.

6. Feeling guilty

I felt a bit guilty sometimes because obviously I couldn't be with her 24/7 and sometimes she had some little crisis I would say and, yes, then you feel guilty for not being there obviously. I remember one time I had to rush back home because, yes, she couldn't handle the baby because she wasn't going to sleep, something normal, but every little thing triggers more anxiety. And, basically, she had two or three episodes which is what I was going to tell you in terms of details that were really bad and they made me feel really bad

One other time the same thing happened, but I was out. I was watching a football match and she was home alone and she told me to go out. It's not like I went out without asking her. I actually went out and there were some friends visiting us at that time, so I thought they would…because they've always been at home every night I thought they would have been with her anyway if there was any problem, but for some reason they decided to go out that night as well, so she was left alone. The baby wasn't going to sleep, so she got another anxiety attack and she again punch herself and stuff, so I was rushing home. I asked a friend to drive me back and those were really bad moments because you feel guilty. You feel like you shouldn't have done it and then when I got there I needed to calm her down and something

Yes, yes, just purely that like I definitely made a mistake going out. I should have been there and I shouldn't have left her alone. Yes, that guilty feeling. Nothing bigger than that.

I felt guilty about not being there for her and leaving her alone in case I went out and she had some little crisis back at home, something normal like not being able to handle the baby but every little thing triggers more anxiety. There were two or three episodes that made me feel really bad like once I left her with friends and went out but the friends decided to go out as well and she was alone when she got an anxiety attack and punched herself and I had to rush home to calm her down; that made me feel really bad and guilty.

I felt guilty about leaving her alone in case she had an anxiety attack or crisis when I was out because there were two or three episodes where she punched herself which made me feel really bad and guilty.

7. Shocked by self-harming

She was punching herself with this anxiety and that happened I would say three, four times through the whole period. Yes, that was really tough. That was…well, a couple of times it happened when I was here and one or two times it happened when I wasn't here. It's not like I was the other side of the world, but, you know -

Yes, that was the toughest. That was something I've never thought could happen. I couldn't believe my eyes. I was shocked in a way, but then my instinct kicks in straightaway, like, when I saw her doing that I immediately went to stop her and to, sort of, immobilise her as she was

Well, it was so quick that basically I was stood in shock, but then as I said to you, the instinct kicked in straightaway and I was like…you become straightaway rational, at least for me it works like that. It's like you're in shock, but you feel like you need to react straightaway, so I went straightaway rational with no emotion and just think, like, okay you have to be calm and do this, you know, literally in the space of one second, which means I went and stopped her from causing self-harming. Yes, I wasn't even sure I was doing the right thing because I was like, maybe I should let her do it. I don't know, but that's just the way it works

I said I was shocked. When I had the time to think about it I was really shocked. It's one of the time where I thought is this ever going to finish or will this ever improve?

Yes, then there was a problem because obviously, when you punch yourself she had bruise around her eyes and that, so that needed to be justified somehow. It's weird. It's just a really bad situation to be with because you want to, sort of, hide it, but at the same time you want to seek for help, but you don't want the whole world to know. It's really different. It's really something I would never thought to go through and definitely something I never experienced before in my life and I hope never to experience that anymore, but if I do we obviously both know how it works and we can probably handle it in a different way

It was toughest to deal with my wife punching herself with anxiety and that happened a couple of times when I was there and once or twice when I was not. I never thought it could happen. My instinct kicked in and I went to stop her. I was really shocked but you need to react straightaway, acting rational without any emotion. It's just a really bad situation because the bruise had to be justified without the whole world knowing, definitely not something I thought to go through or experienced and I hope never to experience that anymore but if we do we obviously both know how it works and we can probably handle it in a different way.

I was really shocked by my wife punching herself because I never thought that could happen, so that was the toughest thing to go through but I reacted rationally without emotion and stopped her. It's a really bad situation that I hope to never experience again.

8. Feeling proud

There was more joy and pride later…there was pride when she told me I was doing the right thing. I was feeling really good. When she start to feel better and we basically analysed back what happened and she told me, 'yes, you always did the right thing. You've been very helpful for me.' That was something that made me really happy and really proud, you know, because it's so good to hear that. To be honest, even just after the various attack I asked her almost just after the time where I stopped her from punching, 'did I do the right thing or did you want me to make you punch yourself?' She said, 'no, you definitely did the right thing' because at the moment I stopped her she was actually abusing me, she was saying like, 'no, let me do it' but she wasn't herself, so…that was good. That was something that really made me feel better as well. No, other emotion I would say mostly sadness, feeling of helpless, feeling useless sorry, feeling helpless myself in terms of a couple there was no help for a while and that wasn't very pleasant

Obviously, I feel like I've proved something to her as well, that I was there when she needed me and when she was in…I think she really appreciated that.

There was pride when she told me I was doing the right things. That was something that made me really happy and really proud. When I stopped her from punching herself she was actually abusing me saying I should let her do it, but just after that I asked her if I did the right thing and she said I had definitely done the right thing and that really made me feel better as well. I feel like I've proved that I was there for her when she needed me and she really appreciated that.

It made me feel really proud and happy when she told me that I was doing the right things. I felt that I have proved that I was there for her and she appreciated that.

9. Not telling family

Well, I didn't tell me family because I didn't want them to think, (unclear 0:22:05) they would have been the classic, they would have come here and tried to help and probably cause more mess rather than helping. Whereas, (unclear 0:22:13) family knew it because she's been diagnosed with depression before, so she basically told them. In the end, her mum actually came over for a month, but that was when she was already recovering, so obviously that helped, but it wasn't in the toughest moment where…but, I don't know if family would have helped so much. it's something so intimate to the couple really that you really need more professional help rather than family because when one these episodes happen we were actually in Italy where my family was, but they didn't…I don't think they have any perception of what was going on obviously…well, they obviously had the hint that she was having a bit of postnatal depression, but they don't really have a clue what was the anxiety and that

No, I don't think anyway the family would have helped that much, not with the problem. They would have helped more by saying…offloading the baby to them a bit and maybe trying to relax, but offloading the baby in that period for her would have been something to worry about anyway, so I don't know how much would have been to be honest. I don't feel like…obviously, it would have been nice to see your family in terms of distractions and stuff, but in terms of pure help with the problem I don't know how much it would have helped.

I didn't tell my family because they would have come here and tried to help and probably cause more mess than helping. It's something so intimate to the couple that you need more professional help than family. They only had a hint that she was going through postnatal depression. Her mum came over for a month, but that was when she was already recovering, so obviously that helped, but it wasn't in the toughest moment. It would have been nice to see your family in terms of distractions or to help with offloading the baby or trying to relax but I don't think they would have helped much with the problem itself.

I didn't tell my family because although seeing family would have been nice as a distraction or to offload the baby, they would have tried to help and probably cause more mess than helping and it is something so intimate to the couple that you need more professional help than family.

10. More protection than shame

No, no, I wouldn't say so. If you ask (unclear 0:24:50) she wasn't shame about that. I wasn't feeling shame about having a partner in that condition because it's normal. It's more the shame is obviously…I wouldn't say shame though. I would call it more consciousness. It's not like something you

talk about with everyone or not even with your friends. You try to hide it a bit to keep it private, but not because you…I wouldn't call that shame though. It's more protection I would say

Protection from having the wrong feedbacks of people start to think, oh she's depressed or should be avoided or she's a bad mother, you know, people made up their mind and it's something…this particular thing is something that I doubt a normal person has heard about, like I was…I was even thinking myself if my friend would tell me, 'oh, yes, my partners been diagnosed with this. She's really (unclear 0:25:54)' I would probably have a negative thought about it or try to help them in the wrong way or maybe even spread the voice. So, it's more something you want to keep private. I wouldn't call it a shame. It wasn't a shame. If I was speaking with a friend I would have been certain they would help or wouldn't have no problems speaking about it. It's just more a protection thing because a lot of people have no clue of the problem

I wasn't feeling ashamed about having a partner in that condition because its normal but it's not something you talk about with everyone or even with your friends. I would call it consciousness and trying to keep it private. It's about protection from having people think negative thoughts and having wrong feedbacks like she's a bad mother because it's something that I doubt a normal person has heard about.

I did not feel ashamed because it is normal. I was conscious not to talk about my partner's condition with people to protect us from wrong feedback and negative thoughts.

11. Sharing with my friends

I did share in the end with some people. I was so desperate in the end I spoke with some of my friends because it was so hard to keep everything in. Yes, that's something I shared the emotional experience. I was trying to keep everything in and not talking with anybody about the problem for as long as I could because of the reason that I said, to the point where even my partner was saying, 'you should probably talk with someone and get some help yourself because I know it's hard for you too.' So, in the end I actually spoke with some people about it, not in details. I never told anybody, for example, that she was punching herself, but I was trying to hint that she was a bit postnatal depression, depressed and basically even just get a little support in terms of being encouraged and to not give up and that sort of thing. I'm normally a really positive person and sometimes I have really negative moments and I just need some cheering and if I hear some cheering I start again basically, so that's one of the reason why I said that.

She always knew it was tough for me as well and she encouraged me to try to find some help for myself as well, in terms of talking with someone because she knew that I was struggling a bit because I was trying to keep everything inside

I was so desperate in the end I spoke with some of my friends about the emotional experience because it was so hard to keep everything in that even my partner was saying I should get some help. I never told anybody the details but I gave a hint that she was depressed just to get a little encouragement to not give up. I'm a really positive person and if I hear some cheering I start again basically, so that's one of the reasons why I did that.

It was too hard to keep everything in and I was so desperate in the end that I had to speak to some of my friends about the emotional experience. I wanted to get a little encouragement to be able to start again and not give up.

12. Fears and anxieties

Well, mostly it was like when this was finishing and how long would it take. Will it ever finish? These things I, kind of, already talked to you about it. But, that was about the only thing. Oh, yes, the other anxiety was like if I was going out even just for a beer or something that for a long time actually, and still a little bit now, I was fear like I'd have another call like the one I received when she was punching herself or something. I was, like…I'm still doing that, text me when she's asleep or if you have any problems call me before the whole thing goes bad. I know it's not going to happen anymore now because she's fine, but that's something that's still there. Yes, I would call that as a little bit of anxiety for myself, but it's purely based on that single bad experience where I had to rush back home and I felt so bad after it. Yes, I know that rationally it's not going to happen anymore, for now at least, but, yes, that's something I fear a little bit whenever I'm out that I might be needed and I might be…I mean, she had a big go at me that time, so I was feeling bad about it.

Biggest concerns are that she wasn't going back to normal, I would say, and that this would take a long time to recover or…sorry, that she would never be back to the same level or that it would take a long time to go back to the same thing and so basically, I was fearing that in the end we was going to split or something for whichever reason. Not necessarily from my side, but because she wasn't herself and I was fearing that in the long term we would not exist as a couple, but that wasn't an option in the end. It was a little bit of a fear. It was there. I know rationally thinking it would never happen, but you can't help your emotions, so...but it wasn't something there every day and I was like, oh my god we're going to split. Yes, it's a little bit (unclear 0:53:01) or when you have a really bad moment, I wonder if this is ever going to end or I don't know she needs a different kind of help and maybe she's better without me or something like that.

My anxieties were about how long it would take to recover, and if she was going back to normal or will it ever finish? Whenever I was outside I was afraid that I would receive another call like the one I got when she was punching herself. I still fear that. I'm still telling her to text me when she is asleep or if she has any problems before the whole thing goes bad. I would call that as a little bit of anxiety for myself. It is all based on that single bad experience. I also feared that in the end we were going to split and not exist as a couple. I know rationally thinking it would never happen, but you can't help your emotions

My anxieties and fears were about how long it would take for my wife to recover and if she was going back to normal at all or whether we were going to split as a couple. I still have anxiety about going out and leaving her alone.

13. Hopes

Definitely, yes. Yes, obviously the hope was, like, for this to be finished straight after…I mean, sorry, for this to be finished super early, soon and for her to be back to normal basically, which is what I needed so we could enjoy the baby because the baby in all the time was amazing. She's always been a really good baby and we were loving it. The fact that she had a good baby obviously helped her as well. Yes, my hopes and desires were purely that. I was hoping for this to be finished. Well, more concretely I was hoping for someone to give us some help and tell us what was the right thing to do and give her the right medication because I felt that the only way to get out of this was either for some really deep analysis and talking, talking, talking with a psychologist and/or through medication I would say, and that's kind of what happened in the end.

Another minor hope I would say would have been helpful to have other people with the same experience to talk with. I could be one of them now, you know, if someone is in my situation I could help giving some advice and some of the right thing to do and reporting my experience.

My hopes were that the PND would be finished very soon so we could enjoy the baby. I hoped that someone would help us, tell us what the right thing to do was or give my wife medication because I felt the way out of this was either talking to a psychologist or through medication and that's kind of what happened in the end. Another minor hope was to have other people with the same experience to talk with.

My hopes were that we would get some help like medication or therapy to end the PND very soon so that we could enjoy the baby. I also hoped to talk to other people with the same experience.

14. looking normal from outside

I have some friends in Italy, some good friends in Italy who do have babies, but…I don't know. It's hard to imagine. I can actually see from outside that you might be the saddest person in the world and going through this postnatal depression and a lot of people wouldn't have a clue to what you're going through because you still look normal from outside. Both us, me and my partner, I think we were looking quite normal. I mean, we've been there when she was at the peak of that, we went to Italy and stayed a few days with my parents and they weren't…I mean, they didn't have a clue that we were going through that. She was hiding it and I was obviously a bit worried for her, but I wasn't showing that, so in the same way that was all my friends as well, so…yes, it's weird.

Going through the postnatal depression you still look normal from the outside so both me and my partner were looking quite normal from outside. It's hard to imagine. I can actually see from outside that you might be the saddest person in the world and going through this postnatal depression and a lot of people wouldn't have a clue to what you're going through. I was obviously a bit worried for her but I wasn't showing it so when we stayed with my parents for a few days and visited friends, no one had a clue that we were going through that.

Going through postnatal depression you still look normal from the outside even when you might be the saddest person in the world. It's hard to imagine and a lot of people wouldn't have a clue about what you are going through.

15. Communication was key

The good thing was like she was always communicating with me when she was normal. She always told me what was going on and that helped me a lot. If she was completely closing herself then I would literally have struggled. I would have gone nuts myself because I would have started to doubt about myself, I would have started to say maybe it's me the problem or maybe I'm not doing the right things. But, the really good thing and that's a super fair point to her and something I will recommend is like, for as bad as something could be and for as bad as basically you don't want to hear that it's still good that she's telling you what's going on and what she's feeling

She always told me that. She always told me if I was doing something good or if I was doing something bad or if she wanted to be left alone that night completely. That was extremely helpful and she always told me it wasn't me the problem and it wasn't like she wasn't attracted by me. In my case even if she tell…I needed to hear that many times. She tell me that once and then two weeks after I feel sad again, you need to tell me again, I'm that kind of person and she always did that, so that was really good and that helped me to feel better and carry on what I was doing. That's something important to note I would say, yes

so communication like I said communication has always been pretty good. It's really massively helpful. I think communication was the key to not lose the plot in both of us. Yes, that was extremely helpful as I said. Without communication, I would have struggled way more for the reason I told you before.

I feel like we always had a pretty good relationship in terms of communication. We're always been pretty open about everything, talking about everything, which is one of the things I always appreciate about my partner since we got together. So, yes, obviously in some moments it was effected. It's not like she felt like talking about it all the times and obviously sometimes she don't feel like talking at all, but generally it was very good to have it. It's not something like I would speak with her every minute about it because sometimes like I said she just wanted to be left alone and that, but that's what I…in general it was good, yes

Yes, I was as well. We were talking openly I would say. I was like, 'I'm feeling a bit sad about it. I'm not happy that we don't have any intimacy anymore' and that, but then at the same time I wasn't telling her that roughly. I was, like, 'let's seek some help because our relationship sucks at the moment' you know 'it's also for the sake of our relationship. I'm not saying it's your fault or my fault. I know why, but it's not nice to be in this condition.' Yes, I was saying that to herself too. I was like, 'I wouldn't mind talking about this with someone, seeking some help for me.

I feel like we always had very good communication. We talk openly about everything, and I think communication was the key to not lose the plot for both of us. I told her about my sadness or need to seek help to improve our relationship and she always told me what she was feeling and whether I was doing something good or bad or if she wanted to be left alone. It was extremely helpful that she always told me I wasn't the problem, I needed to hear that many times to help me to feel better and carry on what I was doing. That's something really good that I will recommend and a super fair point to her because good communication has been massively helpful and without it I would literally have struggled because I would doubt myself, to say maybe I am the problem.

Communication was the key to not lose the plot for both of us. We expressed our feelings to each other. Hearing what I was doing good or bad and also that I myself wasn't the problem was massively helpful, otherwise I would have struggled and doubted myself.

16. Seeking support and reassurance

But, again instead of starting to think and, you know, crying or being sad my instinct is always to try and find solutions, so for example one night that happens, even if it was midnight, I still call the 111, I think, to try to seek for help, basically reporting the episode and saying, 'what shall I do?' because I was thinking maybe it's a case of getting a jab of calming, something to calm you down. I thought that was the…I mean, I thought that was a definite because she was still…even when she calmed down she was still anxious, so I thought maybe I should call the doctor and they should come here and give her an injection to make her sleep, something like that. Nothing major, but you know…I thought that would have been an obvious thing to do because…but, yes, no, she calmed down and she went to sleep eventually that night, but, yes, it was something weird that I won't forget easily

basically what I was trying to do was seeking for help and seeking to do the right thing and support her in the meantime

It what I said before, it's in terms of like even just being reassured myself that this would have been normal and there would have been an end and the thing to do would have been this, this and this and the things that I've done were fine and that, because, obviously she was reassuring me on that. But, it would have been also good to have that from either someone who did it…sorry, that went through the same thing and got out of it or from, I would say, a doctor or a psychologist and someone that knows about the problem. For as much as she can say that I was doing the right thing she was obviously never experiencing stuff like that, so maybe what she thinks was right wasn't right for the problem, so something like that. But, yes, I don't know if…it's quite far away now in time because it's almost a year ago and a year after I feel like it was not that bad, but I know it

was bad. It's the classic human thing, even when you have a massive thing after the time helps to heal it. The other good thing is it wasn't that long, I think. It would have been from March to August, but it wasn't at the same level because March things started to go down

Well, I got it off the internet, some knowledge, but it was pretty much what I was doing already. It was not like something useful I found, but it was still good to be reassured that I was doing the right thing and, you know, supporting and trying to seek for help and…yes, well when we get to the details I'll tell you better what I did. I don't know if you wanted me to go down them details already or if it's your next question or something, then…because, yes, basically she was more and more anxious, she couldn't sleep because…alright, apart from the fact we had the baby right here next to do us was obviously the first year she was sleeping in the same room with us, so every time the baby was moving she was waking up, but then she was anxious to the point where she couldn't sleep and obviously thinking about bad stuff and things like that. So, yes, I was trying to reassure her and calm her down and obviously take care of the baby when I could. When she was waking up we was alternating rocking her back to sleep, even if she's breastfeeding.

My instinct was to try and find solutions instead of crying or being sad. I was trying to seek help and support my wife in the meantime; so even at midnight, when things happened I called 111 asking what I should do. Generally, my wife was always reassuring me that I was doing the right things but it would have been good to have reassurance from someone who went through it or a doctor or psychologist that this is normal and there would be an end and the things I've done were fine. I got some knowledge from internet but it was pretty much what I was doing already. I was also trying to reassure her and calm her down and taking care of the baby because she was anxious to the point where she couldn't sleep.

My instinct was to seek help and find solutions and support my wife during the crisis situations. I wanted to have reassurance about my actions being fine and things being normal and expected to end from a professional or someone with previous experience because I was not as confident about my wife's reassurances or knowledge from internet.

17. Stepping out for her

Yes, you mean if my feelings changed? Well, I felt more careful. I felt more careful. I felt like I needed to step up for her and help her, but that's definitely the first feeling that kicked in and try to be more careful. I mean, trying to be more affective, like, trying to make her feel like there was always someone there and try to be even nicer to her like giving massage to calm her down or brining her breakfast to make her sleep a bit more in the morning whilst I was taking care of the baby. The other good thing was she always had anxiety, for example, especially the baby needed to be around her, but if the baby was with me she would have been fine. Not that I take the baby away, but if she was with me in the other room and she was in the bedroom sleeping she was okay. It's not like she was feeling particularly anxious, but it could only be me. Any other person she would have been feeling anxious, but that was good anyway. Yes, so that was definitely the feeling that kicked in and then well I was…no, feelings towards her, no, I wouldn't

It's a bit like when you are sick with any other sickness…because in the end it's a condition, it's a sickness, so if she was staying in bed for three months because, I don't know, she had broke a bone or something it would have been the same thing. Little bit tough, and go ahead. Yes, that's how it changed I would say and then it changed back.

I was trying to be helpful, not a problem because she had enough problems

Definitely the first feeling that kicked in and changed was to try to be more careful. I needed to step out for her, help her, and be more affective, and try to be even nicer to her like giving massage or to make her sleep a bit more whilst I was taking care of the baby. It's a bit like when you are sick with any other sickness because in the end it's a condition. She was anxious about the baby so with any other person she would be anxious and only I could take care of her but that was good anyway. I was trying to be helpful, not a problem because she had enough problems.

I felt that I needed to step out for my wife and be more careful and affective towards her, just like you are when dealing with any other sickness.

18. Careful about what I say

It's obviously with the PND it's more likely that she gives you bad answers or something because she feels bad herself, so it's like having a bad day at work every day [chuckle], so it's more likely. So, you have to be more careful in what you say and that, but at the same time you know she's doing it because she effected, not because she hates you or anything, so…

if you have to make a little critique of something or even just a question…because, for example, I was asking her something about the baby, for example, 'why did you do this?' not because I wanted to criticise, because I wanted to know because I wanted to learn myself for example and her perception was always that I was criticising her or was going to say something bad. Sometimes I did and I was like thinking, oh, yes, why you doing that, but I still try to be nice and ask her in a nice…sometimes it wasn't like that. I literally wanted to know why she did it, even because it might have been me who (unclear 0:47:28), so that's what I mean about being careful about what to say.

With PND you know she is giving you bad answers because she feels bad herself not because she hates you or anything so you have to be careful in what you say. Even if I ask a question because I want to learn something her perception was that I was criticising her so I had to be careful and ask everything in a nice way.

I had to be careful about the way I talked to my wife as I was aware that she will perceive it differently and will give a bad answer because she was feeling bad herself.

19. Anger

Sometimes you feel angry with her if she gives you a bad answer or something, but she just don't mean it, you know.

But, you just get over it, you know, in a second and say, 'calm down.' I'm not somebody that keeps grief on me for that, you know, I just move on, especially if I know she's afflicted by a condition, you know. I might be getting angry for five minutes or very angry and not talking to her and then in the next ten minutes it's all normal again. I'm like that, I get angry very easy, but then it doesn't last for much

Sometimes you feel angry with her but you get over it because you know she does not mean it. I tell myself to calm down as I know she is afflicted by a condition and I'm not somebody that keeps grief on me so I just move on and my anger does not last for much.

Sometimes I felt angry with my wife but I calmed down, got over it and moved on because I knew she was afflicted and did not mean it.

20. No change in dependency

I wouldn't say there would be much change. She was maybe a little bit more dependent on me because at that time I was the only person who could possibly help her in any way, but it's not like much. Yes, but I was going to work every day, for example, and she was on her own. It's not like she was calling me every time, 'come home' or anything because she could stay on her own. It was always (unclear 0:49:15) around. So, yes, that's

something I wouldn't have too much to say about because in terms of dependency I wouldn't say that I was more dependent from her or the other way round. It's just that we were aware we had this problem and we were trying to fix it and being together as a couple was obviously helping that to be addressed and fixed earlier. Yes, I was trying to help her in any possible way and as much as it's obviously not fixing the problem it was still making a little bit better the problem

She was maybe a little bit more dependent on me but it's not much, and she was on her own when I went to work every day. I wouldn't say that I was more dependent on her or the other way round. We were trying to fix the problem and being together as a couple was obviously not fixing the problem but helping to make it a little bit better.

My wife was a little bit more dependent on me but not too much. Being together just helped to make the problem more manageable.

21. Impact on work and social life

So, well a little bit at work obviously I was a little bit less concentrating because, obviously, this is a problem I was thinking about and how to fix it and maybe I was a little bit researching on Google or something even when I was at work, so maybe a little bit at work, but not majorly. It's not like I didn't do any work or…I mean, I was still carrying on and doing my stuff. It's not like I wasn't working, but obviously a bit I was thinking about it and losing a bit of focus or concentration. Other than that, I wouldn't say so, like, because I didn't speak about it with many other people, as I said, so it wouldn't affect friendships or…a little bit my social life in the sense that I would have gone out less, but having a baby I'm still already going out less, so it was a sensible change. But, yes, maybe in that period two or three times I could have gone out, but I didn't because I wanted to be with her and support her, so, yes, that maybe could have been something. Some other case, the same thing, I wouldn't go out because she asked me to stay in, but it's not like I had a major nightlife [chuckle] or anything. Yes, I would say that's the only thing

I was concentrating a bit less at work and losing a bit of focus because I was thinking about this problem and how to fix it and maybe researching a little bit on Google but it's not like I wasn't working, I was still doing my stuff. My social life was affected a bit as two or three times I could have gone out, but I didn't because I wanted to be with her and support her, or because she asked me to stay in but that's the only thing and having a baby it was a sensible change.

My work and social life were affected as I was concentrating a bit less at work and sometimes didn't go out in order to support my wife.

22. Feeling annoyed

Yes, I think my experience was that the annoying bit out of all the thing actually, maybe this is something, is the whole thing could have been solved much more quicker if we would have found the right help at the beginning for both of us and that's something that was particularly annoying for everybody. Especially for her because she obviously had the hardest bit, but also for me because it could have lasted much less and could have had much less of an impact on our life, and it's not like we didn't seek for help. We actually did all the things that we seen to be done, you know, you go to your GP, you search the internet, we tried even private, eventually they sent a nurse to address her and they referred her to the right specialist and stuff, but that took three months and that was a bit bad. Now they're still calling for the NBT, I think, it's like we applied for that a year ago and they called her about 10 months later to go for a group or something. That's something that is particularly annoying because we go through a phase it's not nice and it could have lasted much less

The annoying bit is actually that the whole thing could have had much less impact on our life if we had found the right help at the beginning for both of us. It's not like we didn't seek help like going to GP, searching internet, even tried private but it took three months to get her referred to the right specialist and when we applied to go for a group they called her about 10 months later. It was particularly annoying because we went through a phase that's not nice and it could have lasted much less.

It is annoying that even though we sought help in all possible ways we did not get it earlier otherwise this phase could have lasted much less. If we had found the right help at the beginning for both of us the impact on our lives would have been much less.