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RESEARCH

Couples' Experiences of Maternal Postpartum Depression

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ABSTRACT

Objective: To understand the processes that couples navigate as they cope with maternal postpartum depression (PPD) in early parenthood.

Design: Qualitative, interpretive phenomenological study.

Setting: Community setting in the western United States.

Participants: A convenience sample of 10 couples ($N = 20$, 10 mothers and 10 fathers) who indicated they had maternal diagnoses of PPD after the births of their first children within the last 3 years.

Methods: Couples were interviewed together and then individually with the use of a semistructured interview guide. Narrative and thematic analyses were used to understand couples' lived experiences of PPD.

Results: Participants cocreated their experiences of maternal PPD. Three primary phases in the pattern of coping with PPD were identified: *Dismissal* (couples attempted to normalize their experiences and protect the mother from judgment), *Acknowledgment* (couples revealed their concerns, the first step in the process of seeking help), and *Accommodation* (process of trial and error used to find a way to meet the needs of the mother).

Conclusion: Our findings suggest that practitioners must support the needs of the entire family, including fathers, when mothers have a diagnosis of PPD. Fathers support mothers during this difficult experience but not without an increased burden of stress to themselves.

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The early postpartum period is a stressful time for new mothers and fathers (Epifanio, Genna, De Luca, Roccella, & La Grutta, 2015). New parents must adapt to decreased sleep, the demands of parenting an infant, the financial strain associated with work leave and the addition of a new family member, and other lifestyle and role changes. When coupled with other risk factors, such as perceived lack of social support, low relationship satisfaction, perinatal depression, and anxiety in mothers and fathers, maladaptation to these changes can result in poor family and child developmental outcomes in the first year after birth and beyond (Barker, Jaffee, Uher, & Maughan, 2011; Doss, Rhoades, Stanely, & Markman, 2009; Ramchandani & Psychogiou, 2009). Support for new parents is crucial for the family, and couples often depend on each other and the help of trusted family, friends, and care providers (Leahy-Warren, McCarthy, & Corcoran, 2012). The complexity of the transition to parenthood makes it important to tailor supportive interventions to the needs of the couple, and researchers and clinicians continue to develop innovative ways to meet the nuanced needs of parents during this time (Mihelic, Morawska, & Filus, 2018).

An additional complication for the transition for many new parents is a diagnosis of maternal postpartum depression (PPD). The transition to motherhood is a culturally normative event, but it can pose an increase in physical and psychological distress in women. PPD is a common complication that affects 1 in 7 women in the United States and is associated with poor family and child development outcomes (Netsi et al., 2018; O'Hara & McCabe, 2013). Women and their partners reported a variety of causes for PPD, including child health and temperament, transition to parenthood, maternal personality and health, unmet care needs, and social connectedness (Habel, Feeley, Hayton, Bell, & Zelkowitz, 2015). The role of partner support and social

The experience of maternal postpartum depression also affects the father in early parenthood.

connectedness suggests a relational aspect of PPD that needs further exploration.

Recent research shows that new fathers also experience depression and anxiety in the perinatal year and beyond, and it is estimated that the rate of depression during the first postpartum year in fathers is double the rate of depression in men in the general population (Cameron, Sedov, & Tomfohr-Madsen, 2016; Paulson & Bazemore, 2010). Like maternal PPD, paternal PPD was associated with less-involved parenting, infant-bonding concerns, and child developmental issues (Paulson & Bazemore, 2010; Ramchandani et al., 2008). Overall, paternal PPD is not well understood; lacks a clear set of risk factors; and needs additional study in the context of family health, coping, and support (Paulson & Bazemore, 2010). Although it has been established that fathers who experience PPD are more likely to have partners who are also depressed, there is a need for more research that explains the interplay between maternal and paternal PPD. Even when fathers do not have PPD, they experience distress at their partner's diagnosis of PPD. Parents must take on new roles and reevaluate previous roles within the family after the birth of a new child. When PPD is diagnosed in a mother, the routines within the family are changed again (Epifanio et al., 2015).

With mounting evidence that shows a relationship between perception of partner support and PPD in mothers and fathers, and the increased risks to child and family outcomes associated with having a PPD diagnosis when a partner also has PPD, there is a need to further understand the interpersonal factors associated with PPD to improve couple and family interventions (Leung et al., 2017). With this study, we aimed to describe the patterns of response couples reported when coping with maternal PPD. We highlight the interpersonal nature of this experience and the many ways that couples supported each other. We describe the key role that the partner relationship plays in the response to maternal symptoms and recovery of PPD and acknowledge that maternal PPD affects mothers and fathers in early parenthood. Our overarching aim, guided by our theoretical stance that couples are engaged in the transition to parenthood together, was to suggest how these findings can help practitioners develop family-centered screenings and interventions for PPD.

Methods

Design

Through this qualitative interpretive phenomenological (IP) study, we sought to learn how couples responded as they navigated the mother's PPD diagnosis in early parenthood. Methodologically, the use of IP enabled appreciation of couple-level phenomena because both members of the couple were invited to express individual and shared concerns (Chesla, 1995). As a qualitative method of study, IP is deeply rooted in the Heideggerian philosophical perspective of the person as situated in the world. The aim of IP work is to explain patterns of meaning in life events, relationships, and practices for people in similar contextual experiences (Chesla, 1995). The method, as used in nursing research, is systematic and based on reflective and narrative questioning to ask participants to convey a situation or experience (Benner, 1994). This allows for the understanding of couple and family patterns of response to life transitions and illness through an examination of what matters most or what couples care about. Institutional review board approval was obtained before beginning the study, and ethical conduct for human participants research was followed. All participants signed written informed consent forms before interviews were conducted.

Setting and Participants

Participant couples were recruited through online and community advertisements in a major metropolitan area in the western United States. Purposive sampling resulted in a sample of 10 couples ($n = 10$ mothers and $n = 10$ fathers), which was adequate to identify patterns and processes of engagement during the early postpartum period. The term *couple* was conceptualized as a birth mother and father pair who were living together and were in a committed parenting and intimate relationship. Although same sex couples were not excluded from this study, none were enrolled. To participate, the mother had to have PPD diagnosed by a health professional after the birth of her first child, which occurred between 3 months and 3 years before enrollment. Further inclusion criteria included that the pregnancy and birth were medically uncomplicated; the mother and her child were in good health after birth and at the time of the study; and the mother and father were at

Table 1: Participant Demographics, Relationships, and Timing of Postpartum Diagnosis

Participant Characteristics	Mean	Minimum	Maximum
Age, years	35.1	26.0	45.0
Education, years	16.1	13.0	18.0
Monthly household income, U.S. dollars	$9,430	$3,600	$16,000
Relationship length, years	8.9	5.0	17.0
Weeks postpartum at PPD diagnosis	8.3	6.0	12.0
Months postpartum at enrollment in study	17.1	8.0	30.0

Note. PPD = postpartum depression.

least 18 years of age, English speaking, living together, and in a committed intimate relationship with each other. During the initial screening phone call, potential participants were asked about current maternal mental health and well-being and the mental and physical health of all family members living in the home. Previous history of bipolar or schizoaffective disorders in a mother or her partner were criteria for exclusion.

Procedure

We used semistructured interviews to elicit narratives from participants by asking open-ended questions, including *At what point did you first realize that PPD may be an issue?* and *Can you share the story of how you first discussed this with each other?* This allowed us to understand how couples engaged in the everyday routine of coping with the mother's depression. In this format, narratives were obtained and then analyzed for patterns of response and expressed concerns. Couples were first interviewed together, followed by individual interviews with the mother and father separately. This format allowed couples to co-narrate their experiences but also afforded them privacy to provide information they did not want to openly share with each other. The follow-up individual interviews also allowed for the revisiting of narratives shared during the couple interviews and allowed a check of interpretive notes with participants, thus increasing the credibility of our interpretations (Whittemore, Chase, & Mandle, 2001).

Interviews most commonly took place in couples' homes during evenings or weekends. This allowed for the observations within the home, including couple interactions, care of children, and completion of household tasks. All participants responded to questions about demographics at the first meeting. Transcripts of the interviews were deidentified, reviewed for accuracy, and entered, along with all field notes and interpretive memos, into Atlas-ti (Version 6.1) for data organization and analysis. Data collection continued until we identified a broad range of similarities and differences of experience.

Analysis

We completed narrative and thematic analyses of the interview data. The first author read the text of each interview multiple times in its entirety. Notes were taken, and journaling was used to outline initial impressions of the concerns and meanings of the couple (Benner, 1994). The first author wrote case summaries for each couple to summarize all sources of data. These notes and summaries, as well as identified sections of the text, were shared with the other authors during analysis meetings and discussions. The method of interpretation included taking a holistic perspective on the text while simultaneously moving through a more detailed reading of the text. This movement from the whole to the detailed parts and back to the whole, also known as the *hermeneutic process*, is the foundation of the IP method, and use of this process allowed for the identification of specific patterns of lived experience. Analyses were shared among the authors throughout the study to ensure that a shared understanding was established and that all interpretations were rooted closely in the data. Because data collection and data analysis took place concurrently, the first author was able to share emerging interpretations with participants to determine if these interpretations made sense and were characteristic of their own experiences. This critical practice of member checking and the use of narratives to maintain the authenticity of participant voices allowed us to maintain rigor and validity within the work (Whittemore, Chase, & Mandle, 2001).

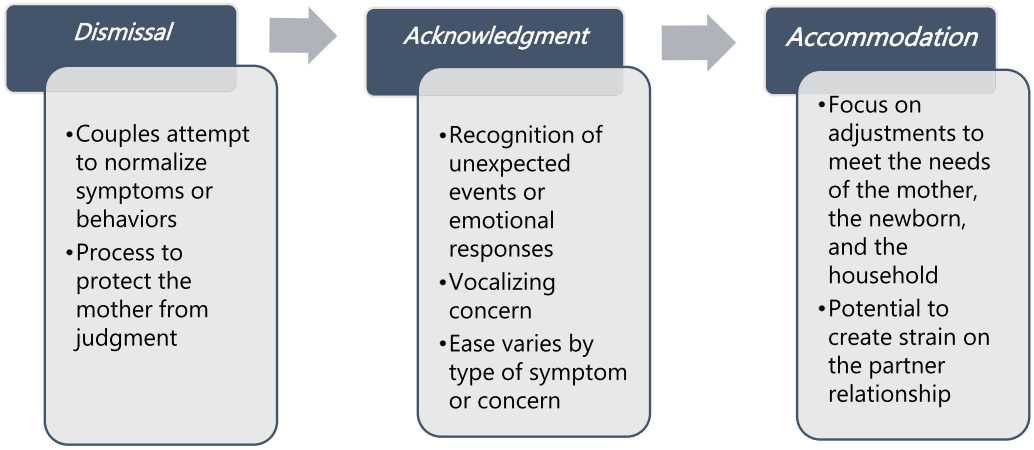

Figure 1. The stages of coping with maternal postpartum depression.

Results

Demographics

The couples who participated were mostly born in the United States and of European descent. On average, they were highly educated, had high levels of income, and were in long-term, committed relationships (see Table 1). Sixteen participants were of Western European decent, two participants described themselves as American-born Chinese, and two participants described themselves as ethnically and culturally Jewish. Nine of the 10 participant couples were married, and half of the participants had graduate or professional degrees.

All participant mothers had a diagnosis of PPD within 6 to 12 weeks postpartum; at the time of enrollment, each of the women felt that they were still dealing with their PPD. Six of the 10 mothers were still regularly seeing therapists for their depression, and seven of the 10 were trying to taper off their medications. Three of the fathers had received support and counseling, and two had experienced diagnosed depression episodes.

None of the couples had children enrolled in school or daycare full-time; their children spent most of their time at home in the care of a parent or a trusted care provider. At the time of the interviews, two of the mothers were expecting their second children, and two couples already had second children. Although extended family members had lived with several of the families during the first few weeks after the birth of the child, none of the couples had other family members living with them at the time of the study.

Patterns of Response to PPD

Couples shared a range of experiences in coping with maternal PPD. Three patterns of response to PPD were identified as *Dismissal*, *Acknowledgment*, and *Accommodation*. All participant names and identifiable details have been changed (see Figure 1).

Dismissal. *Dismissal*, an attempt to normalize the early symptoms of PPD and shield the mother from judgment, was the earliest response to the symptoms of PPD. During this stage in the process, which varied in length of time, couples did not openly discuss their emotional struggles or their concerns with each other. Some couples were quicker to initiate conversations about concerns, and other couples continued to dismiss symptoms for weeks and months before they disclosed their concerns to each other.

Alice and Albert, a participant couple with an 18 month-old child, used dismissal to protect each other. Alice experienced psychological and physical symptoms related to her depression but did not want to reveal them to Albert or her health care providers. She was afraid of the judgment that such "unacceptable" emotions about motherhood would bring to her, and she was worried about adding more stress to Albert's new experience as a father:

> I remember at one point I was just lying in bed with the covers over my head and I was just trying to get sleep and I had this huge sort of panic attack. And I got up and, we have these huge old sash windows in our bedroom, and I threw open the sash

> window and I stuck my head outside because I felt like I couldn't breathe. And that was all going on behind closed doors in the bedroom. Because you know, I used to close the doors so that I wouldn't be able to hear the baby. And he was sitting out there with her and he thought that I was asleep. I still don't know if he knows all that, really.

In addition to the strain of becoming a mother and having depression, Alice was trying to protect her husband. However, Albert revealed retrospectively that he knew Alice was struggling the day that their daughter was born but did not want to reveal this to her for fear that she would feel judged and upset.

> And then we went to the recovery room where Alice was coming to and she was feeling pretty beat up. And she seemed pretty focused on that, on feeling tired, on being uncomfortable. Which I get, I get that, but there was none of that apparent happiness, that euphoria that sort of takes you through the hard parts, through the difficult things. She didn't have that and I could see that almost immediately. We sort of took that baby and gave her to Alice and I was expecting this glow, this happiness and she just... she seemed to me to be going through the motions.

David, a father in his thirties, considered himself luckier than most new fathers because he could stop working temporarily and stay home when his wife, Donna, had their first son. However, within weeks, Donna returned to work and started to experience classic signs of PPD, including insomnia, feelings of sadness, and being overwhelmed. David did not recognize this as PPD at first. It was easier to dismiss the symptoms as similar to what all new parents might experience and because Donna had similar symptoms before they had a child.

> I don't think that I thought it was normal, but I also didn't think that it was abnormal in a bad way. I was doing more than most dads, and I was definitely doing more than Donna was, but our situation allowed me to do way more than the normal first-time dad would do.... I don't think that I thought that there was anything wrong with her. I didn't necessarily think that. I just thought that this was normal for Donna. Then, I also, we were both so sleep deprived, so I figured that a lot of it was probably the sleep, a brand new baby and being completely tired.

Fathers played key roles by acknowledging concerns and finding ways to accommodate the needs of mothers.

Fathers did not dismiss symptoms because of a lack of care, and mothers didn't hide symptoms to manipulate the situation. Instead, couples engaged in a process of dismissal because they were concerned that their admissions of symptoms and concerns aloud would make matters worse by seeming judgmental or burdensome. Couples were also confused about normal versus abnormal patterns of response to the transition to motherhood. They recognized some symptoms as potentially normal, such as feelings of exhaustion that all new parents feel. They also recognized symptoms that required immediate attention, such as the urge to hurt the newborn, which none of the participants experienced. Ambiguity about normalcy resulted in a process of dismissal that could last 8 weeks or longer, which allowed mothers to sink deeper into their depression.

Acknowledgment. Acknowledgment was the acceptance by the couple that their experiences were outside of a normal set of responses to motherhood. Acknowledgment often occurred in the first few months postpartum when couples were no longer able to normalize or hide concerns that were previously dismissed. At times, it took place after treatment for PPD had already started and was a process whereby mothers and fathers admitted the concerns that they previously kept secret from others. A key theme that emerged from discussions with couples was that some things were easier for couples to discuss or acknowledge, whereas others were not as easily shared.

Betty, a 37-year-old mother whose PPD was diagnosed 4 weeks after the birth of her daughter, knew that when her depression began to cause physical symptoms, such as shaking that she could not control, she needed to ask her husband for help.

> And I had a panic attack. I had a few actually. I sat on the couch and I'd shake all over. It lasted 10 minutes or more and I was just really, really, really shaking.... It's the worst feeling. It felt like I'm turned inside

> out. Those are the times when you kind of wonder if you are better off dead. It's really difficult to suffer through a panic attack. I didn't have any thoughts of hurting myself or anything, but it was no fun and it was difficult. When the weeping and the crying periods continued well into the third week and I started with the panic attacks, I approached Bob and I said, "This is not OK and I need help." He was receptive.

Although none of the participants reported that they ever considered harming themselves, Betty was not the only mother to express that she felt that she would be better off dead. Most often, this realization around death, "disappearing," or feeling that life would be improved if she had not had any children, was enough to prompt the mothers to reach out for help. Alice explained that although she was already in treatment for her PPD, she had yet to reveal thoughts that were most concerning to her. She was fearful to express them because she felt that these were inappropriate thoughts for a mother to have. However, when Alice was able to express these feelings to her therapist, the acknowledgment was a major step in her recovery process.

> I thought, "I need to tell her this. I need to." But the whole session I couldn't do it. I was having so much inner turmoil about it. But I knew that I needed to; this is scary stuff. But I didn't want there to be consequences to admitting that.... I didn't look at her because she had her back to me; she was writing a record for our next appointment down. And I said, "Sometimes I wish that she had never been born." And I could see it sink in, and she kind of turned to me and said, "Well, OK Alice, that makes sense." I was completely ready for her to look completely repulsed and horrified and to just have her say, "That makes sense." You know that was so powerful for me; it lead to my being more ready to express this to Albert.

The process of acknowledgment was a relief and great source of anxiety and concern for couples. There was a sense of relief that things that were hidden were being revealed, but there was also a sense of fear and concern about how to handle what had come to light. Acknowledgment was an ongoing process, and not everything was revealed at once. Those feelings that were thought to be more shameful or further outside of the range of normal were often kept secret longer and were revealed under circumstances in which mothers felt safe and not judged. Mothers were most concerned that they would be viewed as horrible mothers or "monsters" who did not love their children or were unhappy with their families. This created situations in which they held on to their concerns longer and only revealed their true feelings when they felt safe and accepted.

Acknowledgment of a mother's symptoms by the father often occurred after the mother began to reveal her struggle or when the father encountered something that he could no longer dismiss as normal maternal experience. It was safe to reveal their concerns after the mother began to express her own struggle; essentially, the mother's disclosure put the issue on the table for shared discussion. Hank, a 45-year-old, first-time father, shared the moment when he knew his wife Hanna was really struggling.

> The baby wasn't crying and I walked down and she was standing on the balcony, right there, in the dark. I could see her through the windows. She had opened all the shades. I asked her what was going on. She said she couldn't be in the house anymore. She said, "I can't handle the house." I asked her what she meant and she told me she felt trapped.... I knew that night that it wasn't a normal hot flash, and that everything was leading up to this. It was worse than I had realized, and we needed to get help.

Although Hanna had already begun to see a therapist and was going to group support sessions, Hank did not understood the depth of her depression or how much she was struggling until this point, and he worried that she wasn't capable of handling recovery on her own. He told Hanna that he was concerned for her and subsequently took on a more active role to provide her with the emotional and physical support that she needed.

The process of acknowledgment of concerns was the most varied aspect of the patterns of response to maternal PPD. However, it was identified repeatedly by the couples as the most important part of the process for them. Without an admission of the problem, there could not be a discussion about what needed to be done to support the mother's healing.

Accommodation. The process of treating PPD frequently resulted in a period of adjustment and

planning to accommodate the care of the mother and newborn and still complete normal household tasks. *Accommodation* was a period of fluctuation and trial and error when couples tried different approaches until they found a pattern that worked best. When couples sought assistance from their health care providers for the mothers' PPD, there was a period of adjustment and acceptance of an unplanned and unexpected diagnosis. This period of time highlighted the mothers' needs for support. Initially, there was uncertainty in the home, and couples repeatedly tried new approaches to everyday infant care, household tasks, and scheduling until they found a rhythm that worked for them. Couples looked outside their own relationships for support from friends and family. Some of the fathers took on specific tasks in which they felt they would be most successful but requested other care and assistance from friends or family.

Frank, a father in his 30s, explained that he and his wife, Felecia, continued to make adjustments 20 months after the birth of their son. Required adjustments often led to tension in their relationship, but he took on more household tasks because Felecia needed more time for herself.

> I've just always done those things anyways. She's got the things that she has always done, and we definitely had more of a balance before the baby came on what she did and what I did. Once the baby came, then it was kind of clear that those were mine now too, my responsibilities for sure. So, I got things done, and I still do. I come home from work and usually do some laundry and make dinner. She might take a shower or go to yoga. It is a lot with the added responsibilities, but we are still working it all out. We argue from time to time but try to make changes.

Accommodating the PPD aroused many complex emotions. Mothers expressed guilt and sorrow for the disruption that PPD caused in their households. Fathers reported occasionally feeling frustrated with mothers or with their situations in general, but they focused on ensuring a supportive environment to the best of their abilities. Couples suggested that everyone was doing the best they could.

Ira's wife, Isabella, was diagnosed with PPD at 10 weeks postpartum. The couple struggled to follow the sleep schedule recommended for Isabella by her therapist.

> I would wake for all the feedings until Ian woke between 5 and 6, and Isabella would take over. I would aim for that block of sleep, which was usually about a 4-hour block straight.... I was waking up at least a few times a night. At the time, Isabella was still on maternity leave, and I was back at work and school.... I just remember being so tired a few times that I thought I was losing it. Looking back from now, I wonder who the therapist thought would be getting up with the baby at night.

After the families made the necessary accommodations and found a daily rhythm that worked, and once the symptoms of PPD started to improve, the couples expressed feeling that something positive had come from their experiences. They felt that as a family they had made improvements in how they communicated and accomplished day-to-day tasks.

Couples frequently reported that they were still adjusting their routines months or years after the diagnosis of PPD. The process of accommodation was one of trial and error that couples revisited often to find what worked for their families. Evident within their adjustments was a commitment that they had for each other and a love for their children. Fathers made sacrifices, sometimes begrudgingly, to their own needs during this time and gave up sleep or hobbies to devote their time to caring for their children or taking on more household tasks. These adjustments were made so that mothers could have the space, time, and support they needed to recover from depression.

Discussion

Our study is among a small number with a couple-focused approach to understanding PPD in early parenthood. Researchers have begun to recognize that the transition to parenthood also affects the mental health of new fathers (Biehle & Mickelson, 2011; Letourneau et al., 2012). Although our study consisted of a small sample of couples, when paired with previous findings, the results suggest that there is a relational dynamic present and that it is important for researchers to adjust the focus beyond the mother–infant dyad toward the couple relationship within the context

Nursing assessments and interventions should take a family-centered approach to care for couples coping with maternal postpartum depression.

of PPD and the transition to parenthood (Paulson & Bazemore, 2010; Paulson, Bazemore, Goodman, & Leiferman, 2016).

Participants in our study expected challenges as they transitioned to becoming new parents, but they did not expect to experience PPD. Couples felt that they were not well-informed in the prenatal or postpartum period about PPD risks and how PPD could change their relationships. However, they did receive extensive education about self- and infant care. Despite taking steps to become more transparent with each other and finding ways to accommodate the needs of the mother during her treatment and recovery, couples continued to express feelings of guilt and frustration many months later, and this resulted in changes to their relationship. They felt unprepared for these changes and for expressing their feelings about this part of parenting. Couples indicated that they wanted to learn more about PPD and the expected changes in their relationships.

Participants were proud of themselves for finding the courage to be more open about their fears and requests for support, and they strived to establish homes in which the needs of all were protected. Their ongoing efforts were directed to allowing each other space to be supported and have their own personal needs met. However, this was not a simple process, and all couples felt they would have benefited from a better understanding of how to cope together to help the mother. Couples also reported that they felt poorly prepared to understand how their relationship with each other would change. This points to a need for better prenatal education with regard to how relationships change after the birth of a child, improving couple communication, and coping with difficult emotions and possibly PPD after birth. Many hospital-based perinatal education classes are focused on the birth process and infant care skills and not as focused on relationship changes between the new parents (Deave, Johnson, & Ingram, 2008; Woolhouse, McDonald, & Brown, 2014).

Participants were clear that the diagnosis of PPD affected mothers and fathers directly. Fathers were key players in acknowledging the PPD and making accommodations for the mother. Previous research findings indicated that when mothers perceived partners as unsupportive, the severity of their PPD symptoms increased, suggesting that a supportive relationship can help in the recovery from PPD (Gremigni, Mariani, Marracino, Tranquilli, & Turi, 2011). Researchers posit that the father's involvement in the mother's PPD recovery can act as a protective agent for the child and a source of support for the mother (Letourneau et al., 2012). Previous research and our findings suggest that interventions for maternal PPD must include the father, because this can directly benefit the mother's recovery and the overall health of the family.

Throughout their transitions to parenthood, couples admitted that they struggled with depression symptoms and finding ways to accommodate the needs of the mother while still providing a space for the fathers to feel supported. The process of acknowledging their concerns and the trial and error of accommodating the diagnosis created new opportunities for couples to better understand themselves and their relationships. However, this process was not easily navigated by the couples, and there were often breakdowns in communication. Antenatal education about how to express needs and expectations is warranted. Participant couples admitted that they were still working on smoothing out the process of communicating more openly but felt that they gained skills through coping with PPD that left them better prepared for future difficulties that may arise in their personal health and in their relationships.

Implications for Nursing Research

In many of the position statements that have been developed by professional associations over the past 20 years to address PPD, the partner is relegated to a secondary role. For example, in a position statement on perinatal mood and anxiety disorders, the Association of Women's Health, Obstetric and Neonatal Nurses (2015) indicated that the relationship between the father and the mother may be affected by PPD. However, the statement does not mention screening the father for depression, offering support for the father, discussing how the diagnosis of PPD may change the intimate partner relationship, or helping parents focus on the strengths within the relationship so they can cope with the concerns related to this diagnosis.

As our findings indicate, fathers experience a great deal of strain and difficulty adapting to

maternal PPD and occasionally feel frustrated by the needs of the mother. Nurses and health care professionals should ensure that fathers are also assessed for their response to the transition to parenthood and their partners' diagnosis of PPD and that they receive needed support. The transition to parenthood, particularly in the presence of PPD, is deeply relational. Participants rarely spoke about their experiences without discussing their relationship and their deep concern for the other. Mothers regularly revealed concerns that their depression negatively affected their entire family. Fathers expressed concern for the mother. Our theories and our interventions should acknowledge this connection and move from a patient-centered focus to one that is family-centered during this time that is critical to the development of the family.

To further understand the interrelationship between maternal and paternal PPD and how health care providers can support couples in early parenthood, future research must be focused on interventions around perinatal education and support services that include the partner. Research is needed around the development of educational interventions that support couples to advance their interpersonal communication skills and find ways to express their concerns and needs without fear of judgment or relationship strain. New prenatal education programs should move beyond the birth process and infant care skills to encourage couples to explore how parenthood and events outside their expectations, such as maternal PPD, may change their relationship with each other, how they have coped with conflict and change in the past, and the availability of a support system so that they feel better prepared during the postpartum period. This focus on relational skills is particularly important to prepare couples for the possibility of PPD. With advance preparation, couples may not dismiss symptoms and may more quickly acknowledge their experiences as existing outside of the normal postpartum adjustment.

Researchers should also turn their attention toward the development of creative systems of support in the postpartum period for all couples, but especially those at risk for or those experiencing PPD. New recommendations from the American College of Obstetricians and Gynecologists (2018) call on practitioners to view postpartum care as an ongoing process and not a single follow-up appointment. These changes could help to improve screening for PPD in mothers and fathers throughout the first postpartum year. It also provides an opportunity for an expanded time line of support for new families coping with maternal PPD. Newly developed interventions need to be tested and policies need to be updated for these recommendations to be incorporated into family-centered practice.

Limitations

We used a convenience sample of parents living near a large metropolitan area on the U.S. West Coast. Participant demographics were reflective of this geographic location, which resulted in a sample that comprised individuals who were mainly of Western European descent; were highly educated; had a high mean household income; and were in long-term, committed relationships. Although the repeated interview process allowed for deeply personal and cocreated narratives that showed a range of experiences, it is possible that not all patterns of response to PPD are represented in the data. In this sample, nine of the mothers and four of the fathers were treated by a therapist, an indication of their resources and access to care. Although therapeutic techniques and the length of time in therapy varied greatly, therapists may have guided couples to make certain decisions or engage in new practices to cope with the PPD, and as a result, their experiences may differ from those who do not have access to these resources.

Conclusion

The birth of a new child and the transition to parenthood changes the established practices and habits within the relationships of partnered couples. This transition is often expected and welcomed. However, when a mother also has a diagnosis of PPD, new concerns must be addressed and new routines established to provide space for the mother to cope with the symptoms of her diagnosis and heal. Coping with the mother's depression during early parenthood is complex, and couples need support that is tailored specifically to their needs. The couple relationship plays a key role in the processes of the diagnosis of PPD and coping with the symptoms. Fathers feel a strong commitment, rooted in concern and love for their growing families, to assist mothers in the healing process and to make the process as smooth as possible. However, couples feel ill-prepared for the experience of PPD, and fathers in our sample reported frequent feelings of uncertainty and frustration. Our findings highlight the relational aspects of PPD, which show that mothers and

fathers cocreate their experiences of early parenthood and work together to adjust and cope with PPD.

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