

Men's Voices: Postnatal Depression From the Perspective of Male Partners

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Postnatal depression (PND) is a serious and debilitating condition that is recognized as being disruptive to women's lives at a time when they are already under stress adapting to the demands that a new baby creates. What has not always been fully acknowledged is that PND is linked with elevated levels of depression in male partners. In this article, the authors report on men's experiences of PND and of participation in a 6-week group treatment program specifically designed for male partners. The men experienced their partners' PND as overwhelming, isolating, stigmatizing, and frustrating. Coping with PND was assisted by participation in the men's group. Men reported lowered levels of depression and stress, and higher levels of social support, as a result of their participation. The men valued highly the opportunity to share experiences with peers, to hear strategies for engaging in their relationship, and to gain factual information.

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Postnatal depression (PND) is the most common mood disorder associated with childbirth and is defined as any major unipolar depression occurring within the first postnatal year (Holden, 1991; Kowalenko, Barnett, Fowler, & Matthey, 2000; National Health and Medical Research Council [NHMRC], 2000; O'Hara, 1995). Controversy over the classification or definition of PND and its onset time and measurement has led to difficulties and confusion in differentiating between "normal" physiological and psychological changes after childbirth and what is "abnormal," by both the lay and the professional community (O'Hara & Zekoski, 1988). This potentially has had the effect of deterring women and their partners from seeking help because of the mixed messages they receive and the minimization of the significance of PND (Cox, 1994; O'Hara, 1995).

Currently, the diagnosis of PND is based on the presence, for 2 weeks or more, of depressed mood, loss of interest and enjoyment in usually pleasurable activities,

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and any four of the following: loss of energy, agitation or retardation, changes in appetite, feelings of worthlessness or inappropriate guilt, diminished concentration or indecisiveness, or frequent thoughts of suicide or death. Additional symptoms that are commonly reported include feelings of extreme anger, often directed at the partner; excessive disappointment centered on labor and delivery, breastfeeding, or expectations surrounding motherhood; decreased libido and desire for physical contact with the partner; obsessive thoughts and compulsions; fear for the infant and sometimes of the infant; fear of being alone with, or going out with, the infant; fear of being rejected by the partner; and thoughts about wanting to run away or escape (Kowalenko et al., 2000; NHMRC, 2000). Given this extensive list of incapacitating symptoms, it is not surprising that, aside from the debilitating impact on the new mother, the new father might also be adversely affected by PND.

For about half of women diagnosed with PND, it represents their first episode of depression (Stowe, Landry, & Porter, 1995). This means that for about half of their male partners, it is the first experience they have had of living with their partner when she is depressed. Furthermore, about half the women suffering from PND can expect to relapse with subsequent babies (Bagedahl-Strindlund & Ruppert, 1998; Davidson & Robertson, 1995; O'Hara, Schelte, Lewis, & Varner, 1991). Thus, if the couple chooses to have more children, they risk revisiting this experience.

As is obvious from the symptoms described above, PND affects the relationship between the mother and her infant and the mother's ability to function effectively and, hence, her relationship with her other children. Another participant in this complex web of interactions is the man who is attempting to adjust to the transition to fatherhood, to the presence of a new baby, and to the distress of his partner.

The expected role of the father in the childbirth and childrearing process has changed dramatically over the past 50 years (Perry-Jenkins, 1993). Indeed, it has been only since 1955 that fathers have been allowed into the labor and delivery rooms. Prior to that, parturition was seen as a female- or health professional-only domain (Brockington, 1995). Changes in this view have led to increased expectations of paternal involvement in prenatal education, childbirth, bonding, and child care. Some fathers are taking up this challenge. Some reduce their work commitments to spend time with their family. Many recognize the need to increase the status of the paternal role, which, at times, is in direct competition with other male roles (Barnett & Baruch, 1987; Brockington, 1995; Sherr, 1995). Even without the difficulties of PND, the transition to fatherhood is accompanied by a period of adaptation during which the change in lifestyle and roles are assimilated (Buist, 1996b).

Risk factors for development of PND that consistently appear in the research include marital or relationship conflict or dissatisfaction, low social support, and stressful life events in the period leading up to the birth of the infant (Boyce, Hickie, & Parker, 1991; Cutrona, 1983; Gotlib, Whiffen, & Wallace, 1991; Kumar & Robson, 1984; Murray, Cox, Chapman, & Jones, 1995; O'Hara, Neunaber, & Zekoski, 1984; O'Hara, Schelte, Lewis, & Wright, 1991; O'Hara & Swain, 1996; Watson, Elliot, Rugg, & Brough, 1984). In the Australian context, risk factors have been found to include living in a rural community, unemployment, and housing and financial difficulties (Griespsma et al., 1994). One implication that can be drawn from these risk factors is that many couples might already have been under strain before the development of PND and that the experience of PND might exacerbate previously existing relationship dysfunctions.

Internationally, prevalence rates for depression in men whose partners have PND vary from 3 to 33%, dependent on the measures used and when these measures were taken (Ballard, Davis, Cullen, Mohan & Dean, 1994; Lane et al., 1997; Lovestone & Kumar, 1993; Morse, Buist, & Durkin, 2000; Raskin, Richman, & Gaines, 1990; Soliday, McClusky-Fawcett, & O'Brien, 1999). What is common to these studies is that the rate of depression in the men is elevated over the "normal" rate in the general population and that this increase in depressive symptoms tends to occur some months after the onset of their partners' experience of PND.

Very few researchers have attempted to explore vigorously the experiences of men whose partners have been diagnosed with PND, but clinical reports suggest that men experience a number of distressing effects. These include being depressed and stressed, losing intimacy in their relationship, feeling excluded from their infant, fearing that their partner will not recover, and being confused about what PND is (often believing it is related to hormonal changes; Williams, 1994). These observations were reinforced in a recent phenomenological study of 8 men conducted by Meighan, Davis, Thomas, and Droppleman (1999). Following the delivery of their baby and the onset of their partners' depression, the men reported that their partners had changed significantly; they reported experiencing fear, confusion, and concern for their spouse; and they felt unable to help in her recovery from PND. The inability to "fix it" created frustration, anger, and a sense of helplessness. All the men reported stress from increased demands and fatigue, and many of the participants described feelings of anger and resentment. The men in Meighan et al.'s (1999) study also highlighted a reluctance to reach out to others because of the perceived stigma of PND. Thus, the new father is additionally stressed because of his partner's difficulties, at the same time as having the stress of attempting to cope with the demands of a new baby and possibly other children, and employment commitments. Coupled with these findings is the fact that for many men, their spouse is their main source of social support (Harvey & McGrath, 1988). In these circumstances, it is not surprising that male partners also experience elevated stress and depression levels.

In light of these findings, further research directed toward increased understanding of the male partner's experience of PND; the impact it has on them and their ability to function as a caregiver, husband, and worker; and the effect of including partners in treatment aimed at recovery needs to be undertaken. However, the male partners of women suffering PND have not traditionally been seen as being a group that also requires primary clinical care. Generally, the interventions that have been provided to these men are single information evenings for partners (e.g., Morgan, Matthey, Barnett, & Richardson, 1997; Pope & Watts, 1996; Zanetti, Sullivan, & Evers, 1998). A recent exception to this is Misri, Kostarus, Fox, and Kostarus (2000), who provided a series of four psychoeducational sessions with couples in their own homes, with mixed outcomes.

Indeed, we were able to locate only two studies in which the qualitative experiences of male partners of women with PND have been examined and reported, one being the Meighan et al. study (1999) discussed above, the other being Kowalski and Roberts (2000). Kowalski and Roberts delivered a one-off 2-hour session to 5 male partners in conjunction with a 10-week, closed support group for women with PND. This unstructured, open discussion forum led to two further unstructured forums being scheduled. The men were reported to have found relief in sharing

their experiences with other men and an increased awareness of their partners' emotional needs and how best to offer support. The women reported improved communication and delight in the support demonstrated by their partner in attending the men's group.

The paucity of research investigating the qualitative experiences of male partners of women suffering PND, together with the fact that they have not traditionally been seen as being a group that also requires primary clinical care, has meant that professionals who might provide care to them (e.g., clinical psychologists, medical practitioners) remain unaware of the nature and extent of their difficulties.

In this article, we report the experiences of men whose partners had been diagnosed with PND. The data reported here were collected from men who completed a 6-week group treatment program specifically designed for the male partners of women suffering PND. The development of that intervention formed part of a much larger study, which is not reported here. The focus in this article is on the qualitative reports of the men themselves. Our aim here is to provide data that will underpin clinical insight in the relevant professional communities which might provide services to these men.

METHOD

Setting

This study took place in the Peel region of Western Australia. At the time this study was conducted, this area embraced a coastal-rural community of almost 77,000 people, the vast majority of whom resided in the city of Mandurah. It was a relatively young community, with 37% of the population under 25 years. At this time, the Peel region had one of the highest unemployment rates in Western Australia—8.3% compared to the state average of 5.9%—and the inferred youth unemployment rate was calculated to be the highest in Australia at 39%. The region was characterized by low levels of uptake of university education and reduced levels of infrastructure and resources (Australian Bureau of Statistics, 1998; Lucks & Durack, 2001).

Design

Sixteen men began the intervention phase of the study. Two treatment groups were conducted, with 5 men completing one group (Group 1) and 8 completing the other (Group 2). The data reported in this article were taken from focus groups that were conducted after the conclusion of the treatment intervention. Ethics approval for the study was obtained from both Murdoch University and Fremantle Hospital.

There were no statistically significant differences between the two treatment groups on age, marital status, number of children, or level of education. The 3 men who dropped out of the study all cited work commitments as the reason for their inability to continue with the intervention sessions (2 of these men worked in the mining industry, and 1 was in the navy).

Participants

The men in this study were partners of women who had been diagnosed with PND in the first 12 months postdelivery of a live infant. All the participating couples in this study were recruited from the local community, through either self-referral or referral from health and allied-health agencies. The mean age of the 13 men who participated in the focus groups was 29.8 years ($SD = 5.4$), and the mean number of children per family was 2.0 ($SD = 1.0$).

Preintervention Measures and Confirmation of Diagnosis

The diagnosis of PND in the female partner of each of the men was confirmed using clinical interviews and reliable self-report measures, namely the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) and the Beck Depression Inventory–II (BDI-II) (Beck, Steer, & Brown, 1996). Formal measures of anxiety (Beck Anxiety Inventory; Beck & Steer, 1990), relationship satisfaction (Dyadic Adjustment Scale; Spanier, 1989), parenting stress (Parenting Stress Index; Abidin, 1995), and social support (Social Support Network Inventory; Flaherty, Gaviria, & Pathak, 1983) were also completed by the women. The men also completed the depression, marital satisfaction, parenting stress, and social support measures prior to undertaking the treatment intervention.

Preintervention, the mean BDI-II score for men who completed the intervention group sessions and the subsequent focus group reported here was 14.76 ($SD = 6.82$), falling in the mildly depressed range (Beck et al., 1996). The men in this study had a lower mean score on levels of social support than that of the student sample investigated by Flaherty et al. (1983). Flaherty et al. found that the mean total Social Support Network Inventory score for their student sample was 3.92, whereas the men who participated in this study scored 2.89 ($SD = 0.92$). Mean pretest relationship adjustment for the sample, as measured by the Dyadic Adjustment Scale, was 99.69 ($SD = 16.25$), indicating this sample of men fell into the category of slightly below average to average relationship functioning. The mean Parenting Stress Index score was 84.46 ($SD = 15.57$), which falls just below the 85th percentile, suggesting they were experiencing a clinical elevation of stress related to parenting.

The Treatment Intervention

The treatment intervention groups were held once a week in the evening, for a 2-hour period, over 6 consecutive weeks. The treatment groups were conducted in the group therapy room at the Peel Mental Health Service.

The objectives in offering a men's program included providing male partners with an opportunity to learn factual information about PND, allowing them the opportunity to have their experiences heard and acknowledged, and providing them with an opportunity to gain skills and strategies to enhance their functioning and combat potential feelings of stress and depression.

The program consisted of a combination of psychoeducational and cognitive behavioral components, and included material developed specifically on the basis of recent literature written for men about parenting in modern society and the challenges this brings (Australian Association for Infant Mental Health, 1997; Biddulph,

1995, 1996, 1997; Family and Children's Services, Government of Western Australia, 1999). Specifically, the six-session program included factual information about PND and maternal mood disorders, including symptoms and theories about its cause and known risk factors; perspectives on and exploration of personal belief systems surrounding fathering; relaxation and stress management strategies; communication skills and conflict resolution training; the cognitive behavioral models of depression (Beck, 1970; Lewinsohn, Youngren, & Grosscup, 1979); and an introduction to cognitive therapy, wherein clients are systematically taught to evaluate their beliefs with the aim of reducing depressive thinking styles (Kovacs & Beck, 1979).

Treatment Group Facilitators

Both treatment groups were jointly facilitated by a male and a female therapist. The 30-year-old female therapist was a registered psychologist who had worked for 8 years with families and children in mental health arenas and had several years' experience working with, and appropriate professional training in, group and individual therapy. The male cofacilitators were both experienced mental health professionals in their 40s; one was a senior social worker and manager of a regional mental health service, the other was a mental health nurse. Both cofacilitators had several years' experience working in the mental health field as clinicians.

Procedure

As has already been noted, the development of the intervention described above formed part of a much larger study, which is not reported here (Davey, 2002). After the completion of the 6-week treatment group intervention, a focus group interview was conducted with each of the two treatment groups. Group participants were asked about their interest in participating in a focus group interview early in the treatment group program and then again in Week 4. The purpose of the interviews, how they would be conducted, and what would be expected of the participants was outlined at these times. Participation was entirely voluntary, and participants completed a signed consent form. All treatment group members agreed to participate in the focus group interviews. The focus groups were conducted in the second half of the final treatment group session in the group therapy room at the Peel Mental Health Service and lasted between 30 and 60 minutes. At the end of the focus group interviews, the men also provided additional written feedback on the program, and on what, if any, aspects of it were useful to them.

The focus group moderator was the female therapist from the treatment groups. The cofacilitators acted as scribes and assisted the moderator in teasing out issues that arose in the focus groups. The conversation was guided by the moderator. A variety of open and closed questions and probes were used, and the desirability of open, honest feedback was emphasized. As recommended by King, Lyons Morris, and Fitz-Gibbons (1987), the focus group interview questions were rehearsed by the moderator and cofacilitators prior to the interviews. The first men's focus group interview was recorded by handwritten notes taken by the cofacilitator. In addition to handwritten notes, audiotaping was also used in the second focus group interview.

We adopted a phenomenological approach for the analysis of the data from the focus group interviews, as the purpose of the interviews was to obtain an understanding of the experience of PND and what participation in the intervention program had been like from the men's point of view. Immediately after each focus group interview, the moderator and cofacilitator reviewed the written notes and made additional notes regarding mood and other nonverbal information obtained from the interview. We adopted the analytical procedure advocated by Krueger (1994), Carey (1995), and Vaughn, Shay Schumm, and Sinagub (1996). First, the "big ideas" (Krueger, 1994; Trierweiler & Stricker, 1998; Vaughn et al., 1996) that emerged from the interviews were discussed and teased out by the moderator and the cofacilitator in debriefing sessions conducted immediately after the interviews. Then, the audiotape was transcribed and checked for accuracy. Subsequently, each interview was reviewed and the data classified into units of information of the smallest size that were informative. These units were then categorized into themes.

FINDINGS AND DISCUSSION

The mood for both the focus group interviews was relaxed, open, and friendly. Overall, the men demonstrated an understanding of the deeper issues in, and implications of, PND. In general, the men showed a willingness and motivation to learn and change their behavior. The strength of commitment the men had to their partners and their children was apparent.

A number of themes emerged from the interviews. These themes are presented in conjunction with representative quotations from the men. The quotations are coded by group (G1, G2) and by speaker, and have been drawn from 10 speakers (V1 to V5 in G1, and V6 to V10 in G2). The moderator's (M) voice is also included in some quotations.

Theme 1: Men's Experience of PND

The enormous sense of frustration the men experienced in dealing with the impact of PND was obvious in both groups and confirms similar findings emerging in the published literature.

M: What has been the most challenging for you dealing with PND?

G1-V1: The sense of frustration, everything I do is wrong, if I say "Has the baby been fed?" when I hear him crying she takes it as a personal insult.

G1-V2: I'm at a loss to know what to do, we argue over and over about the same things, again and again . . . I spend time listening, talking about options over and over again. Finally, I get to sleep and think it's all resolved, and then a few days later she brings it up again and says we didn't finish discussing such and such.

G1-V3: This is the second time my wife has had PND. It's been really hard. I have avoided going home at times.

Frustration occurred at the miscommunication that emerged within the environment of PND:

G1-V4: Our communication is not good . . . L. said the other day that it was easier for her when I'm not there, that hurt . . . I try to take the pressure off her by looking after the kids and letting her go out . . . to the movies or whatever, but I get so frustrated and then she gets upset with how I handle the kids.

G2-V10: I cause a lot of arguments and I admit that. When I was . . . when she points it out to me I can see that I've caused them, but at the time you don't. But when you sit back and think about it and they point it out to you, you do. Which winds them up and when they're depressed anyway, it just adds to it, eh.

PND was also experienced as isolating and affecting all aspects of life, including their interactions with their children.

G1-V4: I have become a lot more irritable and less patient with the kids . . . I just find it hard to deal with them. I try to help out, bathing them, taking them out . . . even just driving them round in the car . . . I never seem to do the right thing . . . I don't do things the way L. does them.

G1-V5: Everything takes so much longer to get done. It's like our life has slowed right down. It takes much more effort and organization to go anywhere. . . . Things that used to take my wife two minutes, now take two hours . . . I have to be a lot more patient.

The changing role and expectations of men in Australian society was highlighted in the discussions the groups conducted. The struggle between the views, beliefs, and rules their fathers and grandfathers lived by and the ones they are attempting to integrate was apparent. Some of the men appeared to find this more difficult than others, and some believed that their struggle was not being acknowledged. The men in this study described being expected to be far more rounded individuals, as the base standard. These findings echoed the assertions of Barnett and Baruch (1987), Brockington (1995), Buist (1996a, 1996b), and Sherr (1995).

G1-V1: I'm not sure about you guys, but I think the women tend to put, um, like it was always a big issue for the man to go and make the money. Now it's more expected now. I don't know whether the rest of you will agree that, like, they don't—I feel that there's not enough—like if I'm out working, when I come home I'm expected to—to take over, and take over that role and they put less emphasis, well it's like they take it for granted that you're going to—that the job is nothing, you know?

M: Yep.

G1-V1: Do you know what I mean? Whereas when we first—when S. first was pregnant, she said "Oh, you're going to resent me because I'm not working." You know?, and I thought "That's great," you know, at least she's going to appreciate the fact that I'm still working and she's not. And now, like, she doesn't resent—she resents me when I'm not working, like to get out there and but—but it's like—it's not appreciated as much. The fact that you've got two lives. You haven't just got that one at home; you've got to deal with all the crap at work and then come home and deal with her crap as well . . . they seem to [have] lost sight of appreciation.

In brief, the men in these groups experienced PND as a condition that unraveled their usual functioning and coping skills. This resulted in overwhelming feelings of frustration and helplessness, which is in keeping with, and elaborates on, the work of Kowalski and Roberts (2000), Misri et al. (2000), Morgan et al. (1997), and Meighan et al. (1999).

Theme 2: How Blokes Usually Operate

The men displayed insight into the lack of organized support for men and the limited avenues and forums for men to address issues troubling them.

G2-V7: I found at work, a lot of people at lunchtime comes up, you know? Oh you know, this happened and that happened . . .

G2-V6: But we're not organised, not the way girls seem to do it.

G2-V7: Yeah, you get sort of groups of fathers, I mean groups of single men, you know, and when the child talk start comes up with the groups of fathers, single men, are like "Oh, I've finished my lunch . . ."

G2-V8: Yeah, that's right. [Laughter.]

G2-V7: Yeah: "I don't want to talk about that crap."

There is a reluctance to reach out to others for help, yet once they do, they experience a sense of sharing of the burden. The men revealed a desire to keep up appearances that "everything is fine." It appears there is a common understanding among the men that "it's not okay to let on we are not coping," perhaps forming the basis of their reluctance to discuss what is going on at home.

M: What has helped you cope?

G1-V5: Mates. I can go over to my mates and go out the back of their place. They also have kids and they have some idea what it's like.

G1-V4: I have only two guys at work that I can talk to about things. They both have kids. One has just had a baby. They seem to have ups and downs. The other never talks about anything.

G1-V3: They're like the Barbie family.

G1-V4: What? . . . oh yeah . . . like the Barbie family . . . [Laughs.]

G1-V3: Do you think there really are families out there who don't have a problem?

Group: No, nup . . .

G1-V4: No, probably not, but that's how it looks.

M: . . . do you all have someone other than your partner you can talk to about how it's been for you?

G1-V1: No, not really, it's not the kind of thing you talk to your parents about, they wouldn't understand. They have their own problems. You try to keep it to yourself. It's better not to get too many people involved.

G2-V7: You know, I thought, man!, it's like there's a burning coal up their arse or something or another. They really need to talk. But I think, I think men in general, like over the last five years do talk more.

Theme 3: Experiencing the "Men's Group"

The men's initial expectations regarding participation in the group appeared to be in direct contrast to their actual group experience. The men soon discovered, as one participant said, that "everyone's in the same boat here." The opportunity to have their experiences acknowledged within a group of peers who were having similar experiences seemed to have a powerful normalizing effect, and not only for the men; it also appeared to legitimize and provide a perspective on the experiences of their partners.

G2-V6: Remember when you first mentioned the idea of a men's group, and I said, you know, "What are we going to do? All sit down and talk about our feelings and shit like that?"

G2-V10: I think everyone's in the same boat here, that's the main reason. We are all having problems at home or putting up with wives that aren't real happy, and then putting up with babies that demand a lot of your time.

G2-V9: Coming in and finding out that everybody, that lots of other guys, they're all different. They've got different jobs than you and you're all arguing with their missus as well, but the actual coming and acknowledging it with the other guys.

G2-V10: To me, everybody here's got a marriage issue! Do you know what I mean? It's not just postnatal depression here . . .

G2-V8: . . . it seemed to me that we, in this group, had an understanding anyway, although blokes don't sit down in groups of their own volen, you know, volunteer themselves.

The written feedback from the men in both groups was consistent with their comments in the focus group interviews. The men in both groups reported that being involved in the program had been of great benefit to them, not only in providing support for their partners and children but also in reducing their own stress levels and in becoming mindful of the impact that a prolonged exposure to a stressor such as PND can have. The men reported that attending the group had increased their understanding of their partners, and had resulted in fewer arguments and more open communication with them.

Theme 4: Disclosing Group Participation to Others

Some of the men were initially embarrassed to disclose their participation in the men's group to their relatives and friends. Others commented on the stigma surrounding PND. These are remarkably similar findings to those reported by Meighan et al. (1999).

M: Were they curious?

G2-V8: I haven't been able to say "men's group"! [Laughter.]

G2-V7: The closest I got to saying "I'm going to me men's group" was I told the boss I was knocking off early one Tuesday, and he said, "Well, what's more important than work?" I said, "Oh, me missus." I still couldn't quite get "men's group" out.

G2-V6: I've had the full turn around. I'm quite happy to say now.

M: Yeah. What about the rest of you? Is it something that you are, you do feel okay talking to other people about, or it's something that you kind of keep confidential?

G2-V8: I'm not embarrassed to say if anyone asks. You know, "Where you been going on Tuesday nights?" I wouldn't say, "I've been going to the pub by myself" or something, saying that I haven't been going to this, you know. Yeah, that was cool.

G2-V2: Yeah, I said I was going to a fathering group, you know and how to become a better father, and stuff like that, because it's a bit of a sensitive topic saying you're going to a post natal depression group. Depression gets people a bit. Yeah, well my wife, she's sensitive about that, you know?

M: Mm.

G2-V7: Because it's more, I guess it affects them directly and their perceived image, rather than us.

The reactions of others to these disclosures surprised some of the participants, as did the amount of respect others had shown them.

G2-V6: And then, it's funny now that we've actually been here and done that, I've sort of said to me brother and that; well, last week I was working with him and I said "I've got to go to my men's group," and he said, the reaction . . . [Laughs.]

M: What was the reaction?

G2-V6: Well no, actually I'm very surprised. I thought, at first I thought everyone would be looking at you like you were mad, you know?

M: Yeah.

G2-V6: Like, you know, but from the women they were like, they seemed to give you a bit more respect!, and the guys were really receptive!

G2-V2: . . . I just said I was doing a fathering group, you know, and they said "What do you learn?" And I said how to, you know, manage the situation better and how to fight fair.

G2-V10: Yeah, fisticuffs and that! [Laughter.]

G2-V6: Yep.

G2-V7: It's just how to spend more time with your kids and contribute more, and, and be able to look after the issues in the family as they come up, type of thing.

M: What was the response you got from the people that you shared that with?

G2-V7: Oh pretty interested, because um, some of them are from America. So it's like pretty unusual thing to do, you know, and being sort of sixty-plus, that wasn't available to them and I think, going through their forties, they would have thought it was really crazy. But now they're in their sixties they're like, well "God damn, I wish I had that available," you know? . . . and especially saying it was like a fathering thing . . . how to be a better parent, type thing.

M: Yeah, yeah.

G2-V7: Because I think there is a lot of interest in that.

G2-V6: I was extremely surprised. I thought people would react completely, they reacted completely different. You think they are going to ridicule you and take the piss! Especially the blokes, you know, and the, the guys say "What do you do there?" you know, and you can talk about it, and they're actually quite interested in it, you know?

Some of the men were surprised at how much they enjoyed the program and felt proud of their involvement. Both groups of men were questioned about whether they found the program useful and, if so, what it was about the program that was of use to them. Both groups declared the program had been useful. For some, this had been a surprise; for many, it was their first experience with group work. Once again, the written feedback was consistent with the comments made in the focus groups. Almost unanimously, the relationship strategies, the opportunity to be heard and to share experiences and the psychoeducational information were highly valued by the men. It appeared that these men were keen to soak up information and try strategies for change.

CONCLUSION

It was evident from the focus group interviews that the experience of being involved in a men's group program that gave them the opportunity to raise concerns and be listened to was a novel experience for all the male participants. The inclusion of a men's program in a treatment approach to PND was regarded posi-

tively by the men; they were pleased to have been included and were surprised at how useful and enjoyable the experience had been. This supported the assertion of Barrows (1999) that men are increasingly prepared to engage in therapy.

Discussion over the course of the groups and during the focus group interviews, and comments in the written feedback the men provided included subjects such as the lack of available forums for men and the isolation they feel in their work and social lives when they are faced with family difficulties that are perceived to be psychologically based. A deeper theme of the conflict and uncertainty in the roles and expectations for men at this time in Australian society was underlined.

One of the important issues the larger study investigated was the impact of including partners in a 6-week intervention program for women with PND. What can be seen from the focus group data is that men are eager and enthusiastic about being included, even though they might need encouragement initially. Not only are men keen, once they have a taste of fairly rudimentary psychotherapeutic strategies, they want more. This is very encouraging for future clinical research in this area, if researchers are prepared to embark on interventions that might go beyond the usual call of duty: Working with men requires after-hours work and some persistence in coaxing them along to begin with. The ability to be flexible in offering additional psychotherapeutic interventions, if required, is recommended.

The men in this study reported that an improved community awareness of PND and its impact on the family system was needed. They suggested that if factual information about the disorder were more widely promoted, the stigma and shame surrounding PND might be reduced, and more families might then come forward for treatment. There is no easy way to determine the exact number of women in the Peel region who had PND at the time of this study. However, the community profile is somewhat similar to that described in Griepsma et al. (1994), where figures much higher than the usual 10 to 20% prevailed. This suggests that ways to improve willingness to seek treatment certainly need to be addressed. The men also strongly recommended that community antenatal education classes be reviewed with the aim of improving participants' understanding of PND, and their preparedness to recognize and seek help with PND, should it eventuate. These comments reinforce the views of researchers who have also suggested that there is a need for such a review (Buist, 1996a, 1996b, 1998; Buist, Westley, & Hill, 1999; Holden, 1991). It might be that improvements in community antenatal classes will facilitate a decrease in the stigma associated with PND and lead to an improved awareness of PND and consequently to early detection and treatment.

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