Support for male partners of women with postnatal mental health problems: A qualitative investigation

A thesis submitted to the University of Manchester for the degree of Doctor of Clinical Psychology in the Faculty of Biology, Medicine and Health

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Beth Ruffell (formally Turner)

School of Health Sciences, Division of Psychology and Mental Health
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Stage 1.2: National survey of MBUs in the UK  
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Paper 2 (Stage 3): Empirical paper  
Overall impact of the research  
References  

TOTAL WORD COUNT  
28,0002

Excluding references and appendices
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Abstract

This thesis explored the experiences and support needs of male partners of women with postnatal mental health problems using qualitative methodologies. The thesis consists of three papers: 1) a systematic literature review, 2) an empirical study and 3) a critical reflection of the research process.

The systematic review (paper 1) is a qualitative meta-synthesis of the experiences of men whose partner had postnatal mental health problems, and the impact on men’s emotional wellbeing, relationships and support needs. Twenty studies from six countries including the views of 277 men were included and analysed using the thematic synthesis approach. Five main themes, containing 19 subthemes were derived from the analysis: 1) Being a father, 2) Being a partner, 3) Experiencing negative emotions, 4) The ways in which men cope, and 5) Where support is needed. The results suggested that participants’ emotional wellbeing, and their roles as a partner and a father are affected by maternal postnatal mental health problems, and their coping can be both hindered and enhanced by the support they receive. In light of these findings recommendations were made for increased awareness of mens’ support needs and improvements in the delivery of perinatal mental health support.

The empirical study (paper 2) reports a qualitative exploration of the support preferences of male partners of women admitted to specialist mother and baby units (MBUs) relating to the content, delivery and timing of support. Ten men were interviewed and data were analysed using thematic analysis. Five main themes, with 15 corresponding subthemes were identified: 1) A smoother journey to and from the MBU, 2) Feeling included, 3) Uncertainty about “what is going on”, 4) Barriers to support and 5) Facilitators of support. Men described practical, emotional and social support they would have valued, and suggested how this could be delivered. The findings were considered in relation to the existing literature to make recommendations for improvements in the delivery of MBU support.

The critical reflection (paper 3) provides a description and appraisal of the research processes, including discussions pertaining to the methodological approached taken. This paper also includes details on the entire body of work, including supplementary projects upon which this research was built, and the impact of the work as a whole.
Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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Acknowledgements

The ClinPsyD training has proven to be one of the most challenging, memorable and rewarding personal journeys I have experienced to date. It would have been a much greater challenge were it not for all the people who have supported me along the way, sharing in my triumphs and my concerns.

I would firstly like to thank all the University staff members and NHS employees who have supported me through the ClinPsyD training. I am especially grateful to Dr Anja Wittkowski, whose expertise in perinatal mental health, dedicated support, and enthusiasm has inspired and sustained me throughout this research. I am also grateful to Dr Debbie Smith, who has devoted many hours to supporting the research, and offered her expertise in perinatal mental health and qualitative methodologies, which have been crucial to this project. I would also like to thank Dr James McManus for his support from the very start of training, which has been invaluable to my remaining resilient in the face of personal challenges.

I would like to thank all the friends and loved ones who have stuck by me throughout this journey, for offering me an understanding ear, being my cheerleaders when doubts have crept in, and for giving me light-hearted relief when I have felt overwhelmed. I would also like to thank all the trainees from my cohort. Training alongside such a supportive and understanding group of people from day one has been instrumental to maintaining my wellbeing and perspective throughout this journey.

The empirical study would not have been possible without the ten men who gave their time to complete the interviews. Your bravery and strength in sharing your experiences is inspiring. We share the same hope: that your stories will inform the improvement of support for men in the future.

Lastly, I would like to dedicate this thesis to the strong woman who raised me; my mother, Jacqueline Ruffell. Thank you for teaching me the value in working hard, encouraging me to dream big, and for being proud of each of my achievements, big or small. I wouldn’t have come this far without your unwavering love and belief that I can achieve all that I set my mind to.
Paper 1:

The experiences of male partners of women with postnatal mental health problems: A systematic review and thematic synthesis

Manuscript prepared for submission to Social Science & Medicine

(See Appendix A for details for the main submission criteria)

Word count: 10,414

(Including abstract, main text, figures and tables and excluding references)
(Journal allows up to 15,000 words for systematic reviews including references)
Abstract

**Background and aim:** Maternal postnatal mental health problems impact women and their infants. Recognition of the role that men play in supporting women’s’ recovery and infants’ development is growing. However, less is known about how maternal postnatal mental health problems affect men and how they wish to be supported. This systematic review sought to synthesise qualitative research exploring the experiences of male partners alongside their support needs.

**Method:** A systematic review of the literature was conducted in January 2018 by searching five electronic databases (PsycINFO, EMBASE, MEDLINE, PubMed and Web of Science). Qualitative research studies published in English exploring mens’ experiences of having a partner with postnatal mental health problems were included. Twenty papers met the inclusion criteria and were appraised for methodological quality. Data were thematically synthesised.

**Results:** In addition to 19 subthemes, five main themes were identified: 1) *Being a father*, 2) *Being a partner*, 3) *Experiencing negative emotions*, 4) *The ways in which men cope*, and 5) *Where support is needed*. Maternal postnatal mental health problems impacted on men’s roles of being a father and a partner, and gave rise to negative emotions. Men coped with these experiences in a number of ways, which were both helped and hindered by personal, social and professional factors.

**Discussion:** This systematic review thematically synthesised qualitative research exploring mens’ experiences of their partner’s postnatal mental health problems. Participants’ coping methods were understood in relation to Coping Theory (Folkman & Lazarus, 1980). Clear recommendations were made for perinatal mental health services as well as increased public awareness of postnatal mental health.
Research highlights

- Being a father and partner in the context of maternal postnatal mental illness causes negative emotions
- Men cope in diverse ways, which can be understood within the Coping Theory literature (Folkman & Lazarus, 1980)
- Men’s coping can be both facilitated and hindered by the response of their support networks.
- Improvements to professional support and increased public awareness of perinatal mental health were emphasised
- The findings provide solutions to the exclusion and marginalisation of this population reported in other studies

Keywords

Men, spouses, fathers, barriers, facilitators, support, perinatal mental health, qualitative
**Introduction**

Mental health problems during pregnancy and the first year postpartum are common among women (Howard et al., 2014). To date, research has focused primarily on the impact of postnatal mental health problems on women and their relationship with their baby and attachment (Bowlby, 1969). There is a growing recognition of the important role father’s play in women’s mental health as well as in their infant’s development. The support given to women by their partner is positively correlated with the quality of the mother-child-relationship (Cummings & Watson O’Reilly, 1997). Furthermore, fathers can buffer the effects of maternal depression on children (Edhborg et al., 2003) and compensate for negative impact through positive parental involvement (Hossain et al., 1994). Yet fathers are under-represented in child development research (Phares et al., 2005). Transition to fatherhood, especially for first-time fathers, places psychosocial demands on the man, and active paternal involvement is a key influence on the father’s wellbeing (Genesconi & Tallandini, 2009; Kowlessar et al, 2014). Postnatal mental health problems may disrupt this process, and impact on the man’s involvement, and therefore his wellbeing (Goodman, 2008). Research suggests a moderate correlation between maternal and paternal depression during postnatal period (Ballard et al., 1994; Dudley et al., 2001 Paulson & Blazemore, 2010) and that the former predicts the latter (Areias et al., 1996). Furthermore, men are likely to be marginalised and excluded from services, which are focussed on the woman (Fletcher et al., 2006), and routines within perinatal services hinder father-child-interaction and attachment (de Montigny & Lacharite, 2004; Greenhalgh et al., 2000). Women have also highlighted that the information given to their partners by perinatal mental health services is often insufficient (Heron et al. 2012; Robertson & Lyons 2003). Mental
health guidelines have cited the importance of supporting partners and family members, given the impact postnatal mental health problems have on the wider family system (NHS England, 2016; NICE, 2014). However, little is known about how men should be supported during this time. Therefore, there is a need to better understand the impact women’s postnatal mental health problems have on male partners, and how they can be supported to improve outcomes for the woman, the development of the infant, and the wellbeing of the man.

To date no review has systematically synthesised the experiences of men whose partner had postnatal mental health problems. For this reason, the current review aimed to explore this, with a focus on the impact on men’s emotional wellbeing, relationships and support needs. In recognition of the marginalisation of men within perinatal healthcare, the current review focussed specifically on the experiences of male partners.

**Method**

*Search strategy and selection criteria*

A systematic search was conducted in January 2018, which adhered to PRISMA guidelines for systematic reviews and metasyntheses (Moher et al., 2015), and included all years to ensure maximum retrieval (see Figure 1). Five databases were searched (PsycINFO, EMBASE, MEDLINE, PubMed and Web of Science). Keywords were truncated; MESH terms and synonyms of search terms were used, when applicable. Broad search terms were used to capture a wide range of studies. The categories of Sample, Phenomenon of Interest from the SPIDER tool (Cooke et al, 2012) were used and are detailed in Table 1. As systematically identifying qualitative health research remains a challenge, despite improvements in indexing
(Atkins et al., 2008), a broad search that did not specify design or research type was employed.

As Figure 1 illustrates, titles and abstracts for the articles were reviewed using the inclusion criteria, and any irrelevant or duplicate articles were removed. Full text articles were then reviewed and only those that met the inclusion criteria were included. Google scholar was hand-searched, as were reference lists and the most recent issue of the journals for the eligible papers.

Table 1: Search terms used in the systematic literature search

<table>
<thead>
<tr>
<th>Category</th>
<th>Search Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>men* OR male* OR man* OR spouse* or partner* OR father* OR paternal OR husband</td>
</tr>
<tr>
<td>Phenomenon of Interest</td>
<td>postpartum depression OR postpartum psychosis OR perinatal period OR perinatal mental health OR postpartum psychiatric disorders OR postnatal period OR postnatal depression OR postnatal mental illness OR postnatal psychiatric illness OR puerperal disorders OR puerperal depression OR puerperal psychosis</td>
</tr>
<tr>
<td>Design</td>
<td>[not used deliberately to keep the search broad]</td>
</tr>
<tr>
<td>Evaluation</td>
<td>[not applicable]</td>
</tr>
<tr>
<td>Research type</td>
<td>[not used deliberately to keep the search broad]</td>
</tr>
</tbody>
</table>

Studies were included if they 1) used qualitative methodology (including mixed methods studies), 2) were published in English in peer-reviewed journals, 3) included male participants whose partner has/had postnatal mental health
difficulties and 4) explored the men’s experiences of the impact of their partner’s postnatal mental health problems and/or the men’s support needs. Studies were excluded if they 1) explored the postnatal experiences of men whose partners had a mental health problem that was not related to the postpartum period, 2) explored men’s postnatal experiences generally, without explicit link to the woman’s postnatal mental health problem, 3) did not explicitly report the voices of the male partners as separate from other people, and/or 4) did not meet the minimum requirements for methodological quality as stated by the Critical Appraisal Skills Programme (CASP) checklist (Critical Appraisal Skills Programme, 2018).

The systematic search yielded a total of 14 articles, with an additional seven articles identified by the hand search (the keywords of which did not include all search terms used). To ensure the quality of the search, 10% of articles at both the title/abstract and full text stage of screening were extracted independently by a researcher who was not connected to the study (GCY). The Kappa score for interrater reliability was 0.72 for title/abstract screening, indicating a good level of agreement. The authors agreed on inclusion of all full text articles, (Kappa score 1).

Quality appraisal

In order to assess different aspects of methodological and interpretive rigour, the included studies from the systematic review were assessed using the CASP checklist for qualitative research (see Table 2 for details). Several tools were considered, but the CASP was selected, because it is one of the most widely used tools to assess qualitative research. The studies were assessed across 10 items, which were each assigned a score of two (‘yes’), one (‘can’t tell’) or zero (‘no’). The checklist states that if the first two items (pertaining to the research aims and
qualitative methodology) are not satisfied, the remaining questions should not be considered. On this basis, one paper was excluded from the thematic synthesis (e.g., Morgan et al., 1997). Details of the CASP scores for the remaining 20 studies are summarised in Table 2. An independent rater (GCY), who was independent to the research team, assessed 25% of the included studies. The kappa score for the inter-rater reliability was 0.65, indicating a good level of agreement.

*Data extraction and analysis*

Key characteristics from the studies were extracted and tabulated. In order to check for consistency, data extraction for 10% of the studies was carried out independently by a researcher (GCY).

A three-phase thematic synthesis approach was used to synthesise the original content of the studies and develop interpretative themes (Thomas & Harden, 2008). Thematic synthesis was selected for this review due to the suitability of the realist approach, which is often used to inform policy and practice, including health services (Barnett-Page & Thomas, 2009; Tong et al., 2012). First, line-by-line coding of content and meaning of the quotes and the reported results from each study was carried out. When studies included data from participants other than male partners, only data pertaining to male partners of women with postnatal mental health problems was extracted (see Appendix B for example). Codes were compared for similarities and differences and grouped into descriptive themes, and then analytic themes were developed (Thomas & Harden, 2008). The analysis was conducted independently by two authors, with the first author (BR) leading the development of the analytic themes, which were agreed by all three authors.
Figure 1. PRISMA flow diagram of the search process

<table>
<thead>
<tr>
<th>Identification</th>
<th>Records identified by database search (n=4261)</th>
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</thead>
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<tr>
<td></td>
<td>PsycINFO (n= 338), MEDLINE (n= 1386), EMBASE (n= 2005), PubMed (n = 253), Web of Science (n= 279)</td>
</tr>
<tr>
<td></td>
<td>Duplicates removed (n=1143)</td>
</tr>
<tr>
<td>Screening</td>
<td>Title/Abstracts screened (n=3125)</td>
</tr>
<tr>
<td></td>
<td>Records excluded (n=3102)</td>
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<td>Eligibility</td>
<td>Full-text articles assessed for eligibility (n=23)</td>
</tr>
<tr>
<td></td>
<td>Full-text articles excluded (n=2): Unclear whether men have partners with postnatal mental health problems (n=1) AND Men’s extracts were not specifically related to maternal postnatal mental health problem (n=1)</td>
</tr>
<tr>
<td>Included</td>
<td>Records identified through paper search (n=7)</td>
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<tr>
<td></td>
<td>Articles included in quality assessment (n=21)</td>
</tr>
<tr>
<td></td>
<td>Full-text articles excluded by quality assessment (n=1)</td>
</tr>
<tr>
<td></td>
<td>Articles included in synthesis (n=20)</td>
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Table 2: Quality rating scores studies using the CASP tool

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<thead>
<tr>
<th>Paper</th>
<th>Clear research aims</th>
<th>Appropriate methodology used</th>
<th>Appropriate design used</th>
<th>Appropriate recruitment strategy</th>
<th>Appropriate data collection</th>
<th>Relationship between researcher and participants considered</th>
<th>Ethical issues considered</th>
<th>Rigorous data analysis</th>
<th>Clear statement of findings</th>
<th>Valuable research</th>
<th>Total score (T=20)</th>
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<tbody>
<tr>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>20</td>
</tr>
<tr>
<td>Reid et al. (2017)</td>
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<td>Yes</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</tr>
<tr>
<td>Bell et al. (2016)</td>
<td>Yes</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
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<td>Feeley et al. (2016)</td>
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<td>Yes</td>
<td>Can't tell</td>
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<td>Henshaw et al. (2016)</td>
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<td>Yes</td>
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<tr>
<td>Habel et al. (2015)</td>
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<td>Yes</td>
<td>Can't tell</td>
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<td>Study</td>
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<td>Can't tell</td>
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<td>No</td>
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<td>Yes</td>
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<td>Letourneau et al. (2012)</td>
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<td>Yes</td>
<td>Yes</td>
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<td>Engqvist &amp; Nilsson (2011)</td>
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<td>Nicholls &amp; Ayers (2007)</td>
<td>Yes</td>
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<td>Davey et al. (2006)</td>
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<tr>
<td>Webster (2002)</td>
<td>Yes</td>
<td>Yes</td>
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<td>Meighan et al. (1999)</td>
<td>Yes</td>
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<td>Yes</td>
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*Scoring: ‘Yes’ = 2, ‘Can’t tell’ = 1, ‘No’ = 0*
Results

Included studies

The characteristics for the 20 included studies can be seen in Table 3 based on a total of 277 men aged between 20 and 64 years old. The 20 studies reported on 18 samples. Nine studies recruited heterosexual couples, seven of which conducted separate interviews with men and two interviewed couples together. All other studies were conducted with men only. As expected, the diagnoses of postnatal mental health problems given to the women in the studies were diverse (postnatal depression, n=12, postpartum psychosis, n=3, childbirth-related post-traumatic stress disorder, n=1, mixed/unreported diagnoses, n=4). Four studies were conducted with partners of women admitted to a psychiatric mother and baby unit, whereas all other studies were conducted with community samples. All but one of the studies included in this review were conducted in Western countries (UK, n=8, Canada, n=6, Australia, n=2, USA, n=2, Japan, n=1, Sweden, n=1). As can be seen in Table 2, the overall methodological quality of all the papers was good with all papers presenting with very good methodological properties, as indicated by a score of 16 or above using the CASP tool (Critical Appraisal Skills Programme, 2018).

---

1 Based on six studies that reported age range
<table>
<thead>
<tr>
<th>No</th>
<th>Author(s)</th>
<th>Year</th>
<th>Country</th>
<th>Research aims/ outcomes considered</th>
<th>Sample (male participants only)</th>
<th>Woman’s postnatal mental health problem</th>
<th>Sample details (male participants only)</th>
<th>Sampling method</th>
<th>Data collection</th>
<th>Method of analysis</th>
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<tr>
<td>1</td>
<td>Boddy, Gordon, MacCallum, McGuinness (2017), UK</td>
<td>2017</td>
<td>UK</td>
<td>To explore fathers experiences during their partner’s MBU admission To explore their experiences of early fatherhood and relationship</td>
<td>7 male partners of MBU patients</td>
<td>Postpartum psychosis</td>
<td>Aged 23-42 years (mean= 31) 5 White British, 1 Black/African/Caribbean, 1 Mixed race 5 University degree, 1 postgraduate qualification, 1 A-Levels 6 employed, 1 unemployed 5 Married/engaged, 1 cohabiting, 1 ‘other’</td>
<td>Purposive sampling from two MBUs during partner’s admission</td>
<td>Semi-structured interviews (face-to-face at MBU)</td>
<td>Interpretative phenomenological analysis</td>
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<td></td>
<td>Reid Wieck Matrunola Wittkowski (2017), UK</td>
<td>To explore how fathers felt supported during their partner’s and baby’s MBU admission.</td>
<td>17 male partners of MBU patients</td>
<td>Data not collected</td>
<td>20-64 years (mean= 38)</td>
<td>No cultural or socioeconomic data available</td>
<td>No cultural or socioeconomic data available</td>
<td>Purposive sampling from one MBU during partner’s admission</td>
<td>Semi-structured interviews conducted (telephone or face-to-face at MBU)</td>
<td>Thematic analysis</td>
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<td></td>
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<td>To consider how fathers viewed 1) their partner’s mental health problem and how this had impacted on their relationships, 2) the MBU</td>
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<td>3</td>
<td>Bell, Feeley, Hayton, Zelkowitz, Tait &amp; Desindes (2016), Canada</td>
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<td></td>
<td>To explore perceived barriers and facilitators to the use of mental health services</td>
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<td>To compare the views of couples who accept and those who decline perinatal mental health services</td>
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<td>30 male partners of women with elevated symptoms of depression (EPDS ≥ 12) in the postpartum period (1 week to 6 months)</td>
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<td></td>
<td>15 Canada-born</td>
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<td>13 married, 17 common law</td>
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<td>19 new parents</td>
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<td>Semi-structured interviews (face-to-face at participants’ homes)</td>
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<td>4</td>
<td>Feeley, Bell, Hayton, Zelkowitz &amp; Carrier (2016),</td>
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<td>To explore the care preferences of women and their 30 male partners of women with postnatal depression</td>
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<td>Mean age 35 years (acceptors) and 34 years (decliners)</td>
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<td>Semi-structured interviews (face-to-face at participants’ homes)</td>
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<tr>
<td></td>
<td>Canada partners</td>
<td>elevated symptom(s) of depression (EPDS ≥ 12) up to 12 months postpartum</td>
<td>15 Canada-born</td>
<td>clinic of two tertiary care hospitals</td>
<td>Men interviewed separately from partner by a male interviewer</td>
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<td>To compare the views of couples who accept and those who decline a mental health assessment</td>
<td>13 university degree, 6 college/vocational, 11 high school or less</td>
<td>26 employed</td>
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<td>13 married, 17 common law</td>
<td>19 first time fathers</td>
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<td>5</td>
<td>Henshaw, Durkin &amp; Snell (2016), USA</td>
<td>11 male partners of women with postnatal depression (EPDS ≥ 10)</td>
<td>No separate data on men</td>
<td>Purposive sample</td>
<td>Semi-structured interviews (face-to-face at participants’ homes or alternative location)</td>
<td>Qualitative analysis closely associated with grounded theory</td>
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<td></td>
<td>To explore how women and their partners detect, evaluate, categorise and respond to maternal mood changes in the first postpartum</td>
<td>Postnatal depression</td>
<td>All employed</td>
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<td>Men interviewed separately from partner</td>
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<tr>
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<td>Data Analysis</td>
<td>Participants</td>
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</table>
| 6 | Mizukoshi, Ikeda & Kamibeppu (2016), Japan | To explore what role fathers play in this year. To explore the experiences of men in the perinatal period and to explore the difficulties they face | 7 husbands of women with mental health problems who develop postnatal depression (PDPI-R >7.5) | Aged late 20s to early 30s  
No cultural, socioeconomic or fatherhood details available for the men  
All married  
All employed | Purposive sampling from obstetric clinics in two hospitals | Semi-structured interviews (face-to-face at the hospital or university) | Not specified (process akin to thematic analysis described) |
| 7 | Habel, Feeley, Hayton, Bell, Zelkowitz (2015), Canada | To explore perceptions of the causes of postnatal depression | 30 male partners of women with postnatal depression (EPDS ≥) | Postnatal depression  
Mean age 35 years  
15 Canadian-born  
15 French, 7 English, 8 other language spoken | Convenience sampling from a larger qualitative study (Feeley et al., 2016) | Content analysis | 18 |
<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Recruitment</th>
<th>Sample Characteristics</th>
<th>Data Collection</th>
<th>Data Analysis</th>
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<td>8</td>
<td>Wyatt, Murray, Davies &amp; Jomeen (2015), UK</td>
<td>To explore how women and their partners make sense of the experience of postpartum psychosis, their relationship, and the mutual influence of these</td>
<td>5 male partners of women with a diagnosis of postpartum psychosis (no time limit since onset)</td>
<td>Purposive sampling from three perinatal mental health services and online via social media</td>
<td>Interpretative phenomenological analysis</td>
</tr>
<tr>
<td>9</td>
<td>Beestin, Hugh-Jones &amp; Gough (2014), UK</td>
<td>To explore how postnatal depression affects fathering.</td>
<td>14 men who perceive the mother of their Postnatal depression</td>
<td>Purposive sampling from support groups and an outreach worker, and snowballing</td>
<td>Interpretative phenomenological analysis</td>
</tr>
</tbody>
</table>
what men perceive as good fathering in this context, and the ways in which men adapt

<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Participants</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Marrs, Cossar &amp; Wroblewska (2014), UK</td>
<td>To explore what impact a MBU admission had on father’s role and relationship with his family</td>
<td>8 male partners of MBU patients Data not collected/report but all women were admitted to MBU Aged 28-51 years (Mean=37.5, SD=8.14) White British (n=7), Black African (n=1) Employed (n=7), Self-employed (2) Purposive sampling from two perinatal mental health units Individual interviews (example questions given, no details about setting for interviews or interviewer) Grounded theory</td>
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<tr>
<td>#</td>
<td>Authors</td>
<td>Study Aim</td>
<td>Sample Details</td>
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<tr>
<td>11</td>
<td>Doucet, Letourneau &amp; Blackmore (2012), Canada</td>
<td>To explore the support needs, preferences, accessibility to resources, and barriers to support</td>
<td>All married fathers, 3 had older children</td>
</tr>
<tr>
<td>12</td>
<td>Letourneau, Tryphonopoulos, Duffett-</td>
<td>To explore men’s perspectives</td>
<td>Aged 23-46 years Canada-born</td>
</tr>
<tr>
<td>Leger, Stewart, Benzies, Dennis &amp; Joschko (2012), Canada</td>
<td>on their support needs and support preferences for coping with their partners postnatal depression and their own depressive symptoms, and an innovative support intervention for men and their partners with postnatal depression</td>
<td>women who experienced postnatal depression within the past 10 years</td>
<td>(n=36), immigrants (n=4; USA, UK, Denmark) First language English (n=38), French (n=2). Employed (full-time, n=32, part-time, n=2, Self-employed, n=2), Unemployed (n=1), paternity leave (n=1), student (n=2) Technical school (n=11), university (n=14), graduate program (n=10) Married (n=39), divorced (n=1) No fatherhood details</td>
</tr>
<tr>
<td>13</td>
<td>Engqvist &amp; Nilsson (2011), Sweden</td>
<td>To explore men’s experience of having a partner with a postpartum psychiatric disorder</td>
<td>11 men whose partner has a postpartum psychiatric disorder (as reported by the men)</td>
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<td>14</td>
<td>Letourneau, Duffett-Leger, Dennis, Stewart &amp; Tryphonopoulpos (2011), Canada</td>
<td>To explore how men perceive and receive support when their partners have postnatal depression. To explore their experiences</td>
<td>11 men whose partners have postnatal depression (reported symptom s during their last pregnancy and were no</td>
</tr>
</tbody>
</table>
of coping, what their personal postnatal depression, demographic or descriptive factors associated with negative outcomes, support needs, support resources, barriers to supporting their partners and support preferences for themselves and their partners longer than 24 months post-partum)

degree (n=3) graduate programme (n=3) Married (n=10), Single (n=1) 6 first-time fathers and 2 had lost a child within first year of life
<table>
<thead>
<tr>
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<th>Study Details</th>
<th>Methods</th>
<th>Data Collection</th>
<th>Analysis</th>
<th>Study Length</th>
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<tr>
<td>15</td>
<td>Muchena (2007), UK</td>
<td>To explore the experience of MBU admission, understand their reactions, coping strategies, stressors, needs and expectations of the fathering role</td>
<td>8 male partners of MBU patients</td>
<td>No details</td>
<td>Purposive sampling from a MBU. Stratified sampling: Potential participants were grouped by 1) their partner’s diagnosis and 2) whether they were inpatient/post-discharge then randomly selected from these groups</td>
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<td>16</td>
<td>Nicholls &amp; Ayers (2007), UK</td>
<td>To explore the experience and perceived impact of traumatic birth and postnatal PTSD. To explore the experience</td>
<td>6 men whose partner has childbirth-related post-traumatic stress disorder (met DSM-IV)</td>
<td>No separate age, cultural or socioeconomic details for men reported All married 5 first-time parents, 1 second child</td>
<td>Purposive sampling via internet advertisements and self-help organisations</td>
</tr>
<tr>
<td>ID</td>
<td>Authors</td>
<td>Year</td>
<td>Country</td>
<td>Research Question</td>
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<td>17</td>
<td>Davy, Dziurawiec &amp; O'Brien-Malone (2006), Australia</td>
<td>2006</td>
<td>Australia</td>
<td>To explore experiences of a group treatment programme for male partners</td>
<td>13 male partners of women with postnatal depression (diagnosed in the first year postpartum)</td>
</tr>
<tr>
<td>18</td>
<td>Everingham, Heading &amp; Connor (2006), Australia</td>
<td>2006</td>
<td>Australia</td>
<td>To explore the way in which couple’s talked about PND and</td>
<td>6 male partners of women with postnatal depression</td>
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</table>

Mean age of men = 29.8 years (SD=5.4)  
No cultural, socioeconomic or marital details for men reported  
Mean children per family = 2 (SD=1.0)  
Two treatment groups (n=5, n=8) recruited from local community through self-referral or health-professional referral (specific recruitment details not reported) - focus groups conducted at the end of the treatment.
<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Characteristics</th>
<th>Methods</th>
<th>Findings</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Webster (2002), UK</td>
<td>Men’s perceptions of the effect of PND</td>
<td>8 male partners of women with postnatal depression (identified by health visitor)</td>
<td>No specific age, cultural, socioeconomic, marital or fatherhood details for men reported</td>
<td>Purposive sampling via health visitor</td>
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The discrepancies between men and women’s understanding, and the ways in which the diagnostic process had helped/hindered the couples' communication.
<table>
<thead>
<tr>
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<th>Objective</th>
<th>Sample Description</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Meighan, Davis, Thomas, &amp; Droppleman (1999), USA</td>
<td>To explore the lived experiences and impact of PND on men</td>
<td>8 male partners of women with postnatal depression</td>
<td>Postnatal depression</td>
<td>No specific age, cultural, socioeconomic, marital or fatherhood details reported for men.</td>
</tr>
</tbody>
</table>
Qualitative results

As Figure 2 illustrates, the analysis produced five themes, constituting 19 subthemes (see Appendix C for table on which studies covered each theme). The five main themes were: 1) Being a father, 2) Being a partner, 3) Experiencing negative emotions, 4) The ways in which men cope, and 5) Where support is needed. Themes and subthemes are described below, accompanied by corresponding extracts from the studies (see Appendix D for additional exemplar quotes).

Figure 2 illustrates how the themes are interconnected, namely that the experiences of being a father and partner within the context of maternal postnatal mental health problems (Themes 1 & 2) can give rise to a mixture of emotional experiences, including negative emotions (Theme 3). Participants cope with these negative feelings in diverse ways (Theme 4), and the effectiveness of their coping can be both hindered and facilitated by the response of their support networks (Theme 5).

Theme 1: Being a father

Participants reported on how having a partner with postnatal mental health problems impacted the ways in which the couple parented together, and the men’s fathering role. This theme shows how a woman’s postnatal mental health problems can provide opportunities for men to grow within the fathering role and develop positive relationship with their partner and baby. However, this experience can also have negative impacts on the fathering role, such as disrupting a man’s transition to fatherhood and his bond with the infant, as well as feelings of burden, anxiety and solitude. Theme 1 is divided into four
Figure 2. Diagram of themes, subthemes and the relationship between them

**Theme 1: Being a father**
- Subthemes:
  1.1: Parenting together
  1.2: Transition to fatherhood
  1.3: Father-baby bond
  1.4: Impact on the family

**Theme 2: Being a partner**
- Subthemes:
  2.1: Uncertainty
  2.2: Breakdown and loss
  2.3: Growing stronger
  2.4: Attributing the cause of the problems

**Theme 3: Experiencing negative emotions**
- Subthemes:
  3.1: Stress and depression
  3.2: Helplessness
  3.3: Shock and confusion
  3.4: Anxiety

**Theme 4: The ways in which men cope**
- Subthemes:
  4.1: Practical coping
  4.2: Avoidant coping
  4.3: Social coping

**Theme 5: Where support is needed**
- Subthemes:
  5.1: Personal barriers
  5.2: Support network barriers
  5.3: Professionals approach to care
  5.4: Possible solutions
subthemes: 1.1 Parenting together, 1.2, Transition to fatherhood, 1.3, Father-baby bond, and 1.4 Impact on the family.

Subtheme 1.1 Parenting together

In terms of the experience of parenting, findings were diverse, with some participants reporting harmonious parenting, in which they felt ‘in-tune’ and collaborated with their partner (Marrs et al., 2014; Reid et al., 2017; Webster, 2002), while others described feelings of being criticised and excluded by their partner (Beestin et al., 2014; Boddy et al., 2017; Davey et al., 2006; Engqvist & Nilsson, 2011). For those men who found they were parenting alone due to their partners’ physical or psychological absence, feelings of solitude and burden prevailed (Beestin et al., 2014; Wyatt et al., 2015).

“I was under a lot of pressure as well... I’m literally the one left holding the baby and obviously, I was expecting her to do everything.” (Wyatt et al., 2015)

“You do the smallest thing and, ‘oh no, you’re doing it wrong’. Let her got on with it. Ok, it might not be your way but if each of your people and us have different ways of doing it, it doesn’t mean we’re wrong it just means it’s different.” (Boddy et al., 2017)

Subtheme 1.2 Transition to fatherhood

The transition to fatherhood in the context of the woman’s postnatal mental health problems had meant a growth in confidence for some participants, who had ‘stepped up’ as fathers in their role (Beestin et al., 2014; Boddy et al.,
2017; Reid et al., 2017). Other participants reported that this transition had been thwarted or disrupted (Boddy et al., 2017; Davey et al., 2006; Marrs et al., 2014; Reid et al., 2017), leading to unfulfilled expectations of fatherhood and uncertainty around future family planning (Beestin et al., 2014; Boddy et al., 2017; Engqvist & Nilsson, 2011; Meighan et al., 1999).

“Obviously you have the double whammy. One, you have a partner who is quite poorly. Two, you loose some of the most important weeks of your life with your baby.” (Reid et al., 2017)

“She was in a really bad situation, so I said I have to do this for her and....show her how good I am, to look after the children and I want to see her...recover....She’s happy now because, I could be asked to be that person for that time.” (Boddy et al., 2017)

**Subtheme 1.3: Father-baby bond**

Participant’s opportunities to bond with their baby were impacted by their partner’s postnatal mental health problems. Participants who developed a positive bond with their baby described how spending time together bought feelings of joy and happiness, providing a distraction from the negative emotions associated with their partner’s ill-health (Beestin et al., 2014; Boddy et al., 2017; Mizukoshi et al., 2016; Reid et al., 2017). However, participants who had been separated from their baby felt their bonding had been disrupted (Boddy et al., 2017; Muchena, 2007; Wyatt et al., 2015), leading to concerns about being absent in their children’s lives, feeling like a ‘fleeting figure’
(Marrs et al., 2014; Reid et al., 2017) or not giving their children enough attention (Beestin et al., 2014).

“[H]e won’t go nowhere without his dad, and vice versa you know what I mean? [...] I love spending time with him, I love doing, so for that reason alone and er with what I get back off him now er you know cuddles and wanting to come with his dad and the smiles and you know we’re just happy with each other” (Beestin et al., 2014)

“Then there’s the issue of not being able to spend time with your baby...you only see him for a couple of hours a day. It’s as if you’re only a temporary father” (Reid et al., 2017)

**Subtheme 1.4 Impact on the family**

Participants were aware of the impact on the whole family, not just their partners (Marrs et al., 2014; Reid et al., 2017). They were concerned about the potential harm caused to their baby from their partners’ behaviours or psychological and/or physical absence (Boddy et al., 2017; Engqvist & Nilsson, 2011; Reid et al., 2017), which they tried to compensate for by bridging the gap (Beestin et al., 2014; Nicholls & Ayers, 2007) and dealing with their children’s distress (Marrs et al., 2014).

“The first four weeks in particular every night he cried. Things like that, as a father, when your wife, his mother is taken, when she is not in the environment he is used to, as in your home. Dealing with that was quite hard.” (Marrs et al., 2014)
“I know I did try to direct a lot of attention and love to [the baby] because I felt maybe [my wife] wasn’t providing that so I was trying to bridge a bit of a gap.” (Nicholls & Ayers, 2007)

Theme 2: Being a partner

Theme 2 illustrates how having a partner with postnatal mental health problems changes the man’s role within the couple relationship. In this theme, studies have highlighted how men’s role as a partner can be changed and shaped by his experiences. For some men this bought difficult feelings of uncertainty, helplessness and loss, whereas for others this had led to a growth in strength and confidence. Furthermore, a man’s understanding of what caused the postnatal mental health problems appeared to influence how he felt towards his partner and the changes in their relationship. This theme is split into four subthemes: 2.1 Uncertainty, 2.2 Breakdown and loss, 2.3 Growing stronger, and 2.4 Attributing the cause of the problem.

Subtheme 2.1: Uncertainty

Living with a person who has postnatal mental health problems can lead to feelings of helplessness and uncertainty within the couple relationship, caused by the perceived unpredictability of their spouses’ moods and behaviour (Engqvist & Nilsson, 2011; Meighan et al., 1999) and/or not knowing how to help them (Engqvist & Nilsson, 2011; Everingham et al., 2006; Letourneau et al., 2011; Meighan et al., 1999; Mizukoshi et al., 2016; Nicholls & Ayers, 2007; Wyatt et al., 2015).
The hardest part of it all is the drastic change in mood. /.../When she praises me I take it with a grain of salt because I know that it can turn on a dime.” (Engqvist & Nilsson, 2011)

“I think throughout the experience I had more or less the feeling of like I wasn’t able to help her just because I wasn’t- I couldn’t- I didn’t really understand why she couldn’t sleep so and didn’t understand how bad her anxiety was... and then you’re worried about your partner as well, that can be quite stressful.” (Letourneau et al., 2011)

Subtheme 2.2: Breakdown and loss

For some participants, their partner’s postnatal mental health problem lead to a break down within the relationship, in relation to their trust (Boddy et al., 2017; Engqvist & Nilsson, 2011; Marrs et al., 2014) and/or their communication (Davey et al., 2006; Engqvist & Nilsson, 2011; Muchena, 2007; Nicholls & Ayers, 2007; Wyatt et al., 2015), which for some ultimately lead in the relationship breaking down entirely (Engqvist & Nilsson, 2011; Marrs et al., 2014). Similarly, loss was the predominant emotion felt by men who described the loss of their partner (Boddy et al., 2017; Engqvist & Nilsson, 2011; Meighan et al., 1999; Muchena, 2007; Reid et al., 2017; Wyatt et al., 2015), the loss of their role as a partner (Boddy et al., 2017) and/or the loss of intimacy within the relationship (Meighan et al., 1999; Muchena, 2007; Nicholls & Ayers, 2007; Wyatt et al., 2015).
“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” (Davey et al., 2006)

“...I felt so lost and confused I didn’t know what to do. It was like a stranger had come and replaced my warm and loving best friend with a woman with dead eyes and a cold heart.” (Engqvist & Nilsson, 2011)

**Subtheme 2.3: Growing stronger**

Alternatively, for some participants, the challenges they faced as a couple lead to a growth in communication and collaboration, deepening their understanding of one another and building resilience within their relationship (Everingham et al., 2006; Marrs et al., 2014; Mizukoshi et al., 2016; Muchena, 2007; Nicholls & Ayers, 2007; Wyatt et al., 2015). Such experiences also led to a growth in men’s confidence in their role, which was associated with positive emotions (Bell et al., 2016; Feeley et al., 2016; Henshaw et al., 2016; Marrs et al., 2014; Mizukoshi et al., 2016; Nicholls & Ayers, 2007).

“For me it was almost natural to think that it’s our problem, not your problem...one attitude is, it’s your problem, solve it, and another one is, the problem is yours, but we have to sort it together, we have to be together in the process.” (Nicholls & Ayers, 2007)
Subtheme 2.4: Attributing the cause of the problems

In attempting to understand the changes to their relationship, men formed ideas about the cause of their partner’s postnatal mental health problem, which in turn shaped their perception of and emotional responses to their partner. Participants who attributed the problems as stemming from physical and/or birth-related events, viewed these changes as uncontrollable, and therefore placed less blame on their partner (Everingham et al., 2006; Habel et al., 2015). Similarly, when the blame was placed on the wider social context, such as social expectations and pressures placed on mothers to conform to an idealised motherhood, participants felt less negatively towards their partner (Everingham et al., 2006; Habel et al., 2015; Wyatt et al., 2015). Whereas when participants placed the cause within the woman, such as aspects of her personality or behaviour, they perceived these as more controllable, and therefore placed more blame on their partner (Everingham et al., 2006; Habel et al., 2015).

“(she) is such an anxious person, when there’s change. She’s not real big on change. So that’s probably the biggest change in her whole life.” (Everingham et al., 2006)

“Let’s say that I think that modern society asks too much... Before, a woman was staying at home and taking care of the kids. Now, a
Theme 3: Experiencing negative emotions

Theme 3 highlights how maternal postnatal mental health problems can affect men’s emotional wellbeing. This theme demonstrates that the experience of having a partner with postnatal mental health problems contributes to a diverse mix of negative emotions for men, relating to the couple relationship, family life and their imagined future. The strategies men find to cope with these emotions were likely to impact their adjustment to this situation. This theme is divided into four subthemes: 3.1 Stress and depression, 3.2 Helplessness, 3.3 Shock and confusion, and 3.4 Anxiety.

Subtheme 3.1: Stress and depression

Having a partner who was unwell created changes in men’s lifestyle, disturbed their routines and increased their responsibilities, and required them to divide efforts between work and home life, as well as having financial implications, which lead to increased stress (Engqvist & Nilsson, 2011; Meighan et al., 1999; Mizukoshi et al., 2016; Muchena, 2007; Reid et al., 2017; Wyatt et al., 2015). For participants who were unsupported, emotional and physical isolation dominated (Beestin et al., 2014; Bell et al., 2016; Meighan et al., 1999; Wyatt et al., 2015). These experiences lead to depressive symptoms, such as low mood, hopelessness, exhaustion and reduced enjoyment (Beestin et al., 2014; Doucet et al., 2012; Engqvist & Nilsson, 2011; Letourneau et al., 2011; Meighan et al., 1999; Webster, 2002).
“When you have had no sleep, you are pulling your hair out and you have bags under your eyes and you think, why have I bothered, why are we having a family, I don’t want to feel like this...is that depression? Could be, I don’t know” (Webster, 2002)

“I needed emotional support. I felt I was becoming depressed. It was everything, the long days at the hospital. I saw things that I never saw before and that affected me. I kept thinking, when is she going to snap out of it? Why is this happening? I thought having a baby was going to be the best thing to happen.” (Doucet et al., 2012)

**Subtheme 3.2 Helplessness**

Helplessness and powerlessness were other strong emotions felt in relation to helping their partner (Boddy et al., 2017; Davey et al., 2006; Engqvist & Nilsson, 2011; Everingham et al., 2006; Letourneau et al., 2011; Marrs et al., 2014; Meighan et al., 1999; Muchena, 2007; Nicholls & Ayers, 2007), keeping their partner safe (Engqvist & Nilsson, 2011) and feeling as though they are trapped within the relationship (Everingham et al., 2006; Meighan et al., 1999; Muchena, 2007; Nicholls & Ayers, 2007).

“The thought her suicide would be an answer, then I felt guilty for [having] those feelings.” (Meighan et al., 1999)

“I also had no idea how to get help. Nothin in my life has come close to causing as much worry, desperation, anger, frustration, despair, and fear as dealing with PPD” (Engqvist & Nilsson, 2011)
**Subtheme 3.3: Shock and confusion**

Shock and confusion were common experiences for participants in response to the unexpected changes in their partner and the resulting events (Boddy et al., 2017; Marrs et al., 2014; Mizukoshi et al., 2016; Muchena, 2007), including her diagnosis (Boddy et al., 2017; Engqvist & Nilsson, 2011; Everingham et al., 2006; Muchena, 2007; Reid et al., 2017). Two studies reported that participants had been traumatised by their experiences (Boddy et al., 2017; Meighan et al., 1999).

“I couldn’t understand it, really, but I had nothing to compare it with, so I just thought oh, is it just hormones an things after having the baby and it’ll settle down. But maybe somewhere in the back of my mind I knew something wasn’t quite right.” (Boddy et al., 2017)

“At first, I was just scared...I didn’t know what it was and she didn’t know what it was.” (Meighan et al, 1999)

**Subtheme 3.4: Anxiety**

The uncertainty about their partner’s treatment and recovery caused feelings of worry and anxiety for participants (Doucet et al., 2012; Engqvist & Nilsson, 2011; Marrs et al., 2014; Reid et al., 2017). Anxiety and worry were also felt within the relationship, with participants feeling as though they were ‘walking on egg-shells’ (Letourneau et al., 2011; Nicholls & Ayers, 2007). Men also reported being hypervigilant about the safety and potential harm to their partner and/or their children (Boddy et al., 2017; Engqvist & Nilsson, 2011; Letourneau et al., 2011; Meighan et al., 1999).
“In terms of anxiety, certainly some anxiety because we would actually just walk around the house on eggshells wondering if (wife) is going to have one of these episodes and what is the effect going to be on her and on our little guy.” (Letourneau et al., 2011)

“It was really scary, especially I think going home at night and things. Like just lying awake and then, I dunno, obviously I hadn’t been sleeping well as well so the thoughts that [partner] was speaking to the psychologist, I was getting the same kind of thoughts. Not wanting to kill myself but just that I couldn’t concentrate on anything. I couldn’t relax because my mind was racing...” (Marrs et al., 2014)

**Theme 4: The ways in which men cope**

Participants described various ways in which they coped with the difficult emotions when adjusting to their partner’s postnatal mental health problems. These included 4.1 *Practical coping*, which increased their sense of control, 4.2 *Avoidant coping*, which distanced them from these emotions and 4.3 *Social coping*, which reduced their isolation and increased their sense of support.

Access to effective support from social networks or professionals was an effective way of coping for partners.

**Subtheme 4.1: Practical coping**

In dealing with their uncertainty and helplessness, some participants took a problem-solving approach to increase their sense of control. This involved
seeking information about the diagnosis, treatment and recovery (Boddy et al., 2017; Engqvist & Nilsson, 2011; Henshaw et al., 2016; Mizukoshi et al., 2016; Reid et al., 2017), seeking to be involved in their partner’s care, and searching for resources (Boddy et al., 2017; Davey et al., 2006; Engqvist & Nilsson, 2011; Everingham et al., 2006; Letourneau et al., 2011; Meighan et al., 1999; Muchena, 2007). Participants also sought out professional support for their partner. Their partner receiving a diagnosis (Engqvist & Nilsson, 2011) and admission to a MBU (Boddy et al., 2017; Marrs et al., 2014; Muchena, 2007; Reid et al., 2017) were experienced as helpful and a relief. Furthermore, participants spoke about how professionals had offered them both emotional (Letourneau et al., 2011) and practical information and advice (Davey et al., 2006; Doucet et al., 2012; Engqvist & Nilsson, 2011; Everingham et al., 2006; Feeley et al., 2016; Letourneau et al., 2011).

“I called her [the doctor] and she explained to me what was happening, how these kinds of things can happen. She talked me through what I needed to do.” (Engqvist & Nilsson, 2011)

“I think at the time probably what I would...my overriding kind of emotion would have been relief that finally she was in a place where people understood what was going on.” (Marrs et al., 2014)

**Subtheme 4.2 Avoidant coping**

Participants also used avoidance strategies to manage their intense negative emotions, some of which involved the use of substances to numb feelings (Reid et al., 2017). Withdrawing from partners, families and social networks
both physically (Davey et al., 2006; Everingham et al., 2006; Letourneau et al., 2011) or emotionally (Beestin et al., 2014; Engqvist & Nilsson, 2011; Meighan et al., 1999) helped some participants avoid experiencing difficult emotions. Other participants coped by hiding their feelings from their partners and ‘putting their own feeling on hold’, as a way of distancing themselves from negative feelings (Beestin et al., 2014; Doucet et al., 2012; Marrs et al., 2014; Muchena, 2007). However, the responsibility to ‘be strong’ for their family gave some participants a sense of empowerment, even if it did mean compromising their own needs (Beestin et al., 2014; Doucet et al., 2012; Meighan et al., 1999; Mizukoshi et al., 2016; Wyatt et al., 2015).

“This is the second time my wife has had PND. It’s been really hard. I have avoided going home at times.” (Davey et al., 2006)

“...switching off my feelings... to make like your own, kind of like your own postnatal depression pills.” (Beestin et al., 2014)

4.3 Social coping
The participant’s support network was also emphasised as an effective means of coping which reduced their sense of isolation. Some participants sought support from friends and family (Boddy et al., 2017; Letourneau et al., 2011; Marrs et al., 2014; Webster, 2002), who provided emotional (Muchena, 2007; Reid et al., 2017; Wyatt et al., 2015) as well as practical help (Doucet et al., 2012; Engqvist & Nilsson, 2011; Meighan et al., 1999; Mizukoshi et al., 2016; Reid et al., 2017; Wyatt et al., 2015). Socialising and sport were effective coping strategies for some participants, and for others, peer support helped
them feel less alone and gave them hope about coping and recovery (Davey et al., 2006; Engqvist & Nilsson, 2011; Feeley et al., 2016; Letourneau et al., 2011; Reid et al., 2017). Furthermore, two studies highlighted how the woman was an important social support for men during this time (Mizukoshi et al., 2016; Reid et al., 2017).

“When I spent time with friends, I was able to relax [...] Being able to talk about other stuff and not thinking about what was happening.” (Reid et al., 2017)

“Help from the parents was so big that I could sleep completely through the night. I understood that it was hard to become a parent and thanked my parents. We were at a loss when the baby cried. Nothing could be done by us, and we felt powerless.” (Mizukoshi et al., 2016)

**Theme 5: Where support is needed**

Theme 5 illustrates how seeking support was sometimes a challenge for the men, and suggested solutions they identified in relation to this challenge. In this theme, participants described the barriers that stood in the way of them seeking much needed support during this time. These consisted of barriers inherent in the beliefs held by participants and their social networks as well as the responses of healthcare professionals. In addition to stating the barriers, participants suggested potential solutions, which they believed could reduce these barriers and therefore enable them to seek support. This theme is divided
into four subthemes: 5.1 Personal barriers, 5.2 Support network barriers, 5.3 Professionals approach to care, and 5.4 Possible solutions.

Subtheme 5.1: Personal barriers

Participants’ own beliefs around help seeking, such as feeling unable to reach out to others, feeling too overwhelmed, worrying they might burden others, and/or believing that others would perceive them as ‘weak’ were significant challenges for men in seeking support (Davey et al., 2006; Doucet et al., 2012; Everingham et al., 2006; Henshaw et al., 2016; Letourneau et al., 2011; Webster, 2002). A lack of an understanding of their partner’s needs was a barrier for some men, who did not believe professional help was necessary (Boddy et al., 2017; Everingham et al., 2006; Feeley et al., 2016; Henshaw et al., 2016; Letourneau et al., 2011; Marrs et al., 2014; Letourneau et al., 2012; Muchena, 2007; Webster, 2002; Wyatt et al., 2015). For other participants, the thought of seeking help was associated with fears of external judgement, stigma or negative consequences for their family, which prevented them from reaching out (Beestin et al., 2014; Bell et al., 2016; Boddy et al., 2017; Davey et al., 2006; Everingham et al., 2006; Letourneau et al., 2011; Reid et al., 2017).

“I didn’t know what I was looking for. I didn’t recognize there was as much of a problem as there actually was.” (Letourneau et al., 2011)
“I wish I was able to send an SOS out to bring us casseroles or to help around the house. I couldn’t do that because I have difficulty asking for support. It’s a guy thing.” (Doucet et al., 2012)

Subtheme 5.2 Support network barriers

Participants described how their friends and family’s lack of understanding and knowledge about postnatal mental health problems created a barrier to them seeking support from their social network (Doucet et al., 2012; Letourneau et al., 2011; Letourneau et al., 2012; Reid et al., 2017; Wyatt et al., 2015). Furthermore, the woman’s wish to not seek help, due to believing she did not have a problem or because she wanted to protect others was another challenge men faced in seeking support (Bell et al., 2016; Letourneau et al., 2011; Mizukoshi et al., 2016).

“She said, ‘I will be fine, it will pass.’” (Bell et al., 2016)

“Extended family should be afforded some educational sessions on what’s going on...they would like to help but if they don’t understand what is going on, what’s the point?” (Letourneau et al., 2012)

Subtheme 5.3: Professionals approach to care

The way in which participant’s perceived professional care had created a barrier to seeking support. Perceiving professionals as having a lack of awareness or knowledge about postnatal mental health problems can reduce men’s trust of services, and therefore prevent them from seeking support (Boddy et al., 2017; Letourneau et al., 2012; Meighan et al., 1999). Participants
felt as though their needs were not considered, and felt excluded by services, making it difficult to seek support (Bell et al., 2016; Boddy et al., 2017; Doucet et al., 2012; Feeley et al., 2016; Henshaw et al., 2016; Letourneau et al., 2011; Letourneau et al., 2012; Marrs et al., 2014; Webster, 2002). The quality of the support was also a barrier to how helpful the participants perceived it to be, such as when resources were insufficient (Doucet et al., 2012; Engqvist & Nilsson, 2011; Feeley et al., 2016; Letourneau et al., 2012; Muchena, 2007; Reid et al., 2017; Webster, 2002), or the communication with professionals was ineffective (Doucet et al., 2012; Marrs et al., 2014; Reid et al., 2017).

“They [health care professionals] focus a lot on the newborn. Services focus on the baby’s health, not on the mother’s health and definitely not on the father’s health.” (Bell et al., 2016)

“Erm nobody had ever really explained to me I don’t think the real purpose of her being in the unit. I don’t think anybody ever really sat me down and said, you know ‘this is what we are hoping to do. Not just keep your wife and daughter together’. Erm it felt a bit strange at times. It almost felt like you were going down to visit somebody in hospital.” (Marrs et al., 2014)

5.4 Possible solutions

Participants suggested that improvements in access to quality information about diagnosis, treatment, recovery, and relapse (Doucet et al., 2012; Engqvist & Nilsson, 2011; Feeley et al., 2016; Letourneau et al., 2011; Letourneau et al., 2012; Reid et al., 2017), and professional advice on how to support their
partner would help them feel better supported (Doucet et al., 2012; Everingham et al., 2006; Mizukoshi et al., 2016). They also suggested that professionals could provide emotional support (Davey et al., 2006; Doucet et al., 2012; Letourneau et al., 2011), including helping to improve their coping skills (Davey et al., 2006). Participants suggested that professionals should approach support proactively and flexibly, which would reduce the impact of the personal barriers to support and increase their engagement (Bell et al., 2016; Doucet et al., 2012; Letourneau et al., 2012). Peer support was cited as an effective way to reduce their sense of isolation and stigma (Doucet et al., 2012; Letourneau et al., 2012). Participants in one study also stated that increased support by their employers, such as granting them time off work, could help them cope with the demands of the situation (Letourneau et al., 2012). Greater public awareness to increase participants’ understanding and recognition of postnatal mental health problems, as well as that of professionals, support networks and employers, was suggested as a way to reduce systemic barriers to help-seeking (Boddy et al., 2017; Letourneau et al., 2012; Muchena, 2007).

“I needed advice on how to handle the illness and what to say. Also, information on the early signs of relapse to watch for and if it was to the point that I needed to get help.” (Doucet et al., 2012)

“I think taking about it is better than just pretending it hasn’t happened...My partner is quite willing...to say to people, ‘look, this is what happened afterwards’...what people need to look out for...I’m a great believer in that people need to shout about things to get people to listen” (Boddy et al., 2017)
Discussion

The themes arising out of the thematic synthesis of 20 studies (illustrated in Figure 2) show how these experiences impacted participants’ roles as fathers and partners, and their own emotional wellbeing. Participants talked about the impact on the transition to fatherhood and bonding with their baby as well as how they had parented in the context of postnatal mental health problems. Therefore, maternal postnatal mental health problems can add an additional layer of difficulties to men who are already experiencing various emotions in relation to this transition, including helplessness and hopelessness (Goodman, 2005; Kowlessar et al., 2014). According to Goodman (2008), partners of women with postnatal depression demonstrated less optimal interactions with their infants compared to partners of non-depressed mothers. Given this observation it is important to recognise that there could be an impact on the father’s relationship with his infant. The finding that participants tried to counteract the impact of maternal postnatal mental health issues on their children was comparable to previous research showing that fathers buffer or compensate for maternal mental health problems (Edhborg et al., 2003; Hossain et al., 1994). Being a partner had led to difficult feelings of uncertainty and loss in some fathers, whereas others had experienced a growth in confidence. Furthermore, the ways in which men attributed the cause of the postnatal mental health problems impacted their perceptions of their partner. These findings are important given that the strength of the couple relationship can influence women’s mental health treatment and recovery (Burgess, 2011; Grube, 2005; Plunkett et al., 2016), the mother-child-relationship and overall outcomes for the family (Cummings & Watson O’Reilly, 1997). In terms of
emotional wellbeing, participants clearly described symptoms of increased stress, low mood, helplessness and anxiety. These results are similar to Goodman’s (2008) findings that maternal postnatal depression was associated with increases in paternal depression and parenting stress, and to findings illustrating an association between maternal and paternal postnatal depression (Areias et al., 1996; Ballard et al., 1994; Dudley et al., 2001; Paulson & Blazemore, 2010). The findings demonstrated that men cope with these adverse experiences in a variety of ways, a process described in research as the person attempting to manage demands that are felt as overwhelming their individual resources, by regulating their emotions, or altering the situation causing distress (Folkman et al., 1986; Lazarus & Folkman, 1984), which has been considered crucial to families attempting to adapt to a crisis (McCubbin & Patterson, 1983). Participants’ descriptions of practical coping and avoidant coping strategies are similar to the problem-focused coping and emotion-focused coping described in the coping literature (Folkman & Lazarus, 1980). Furthermore, previous research has cited gender difference in coping styles, which should be considered when supporting couples (Matud, 2004).

Participants also highlighted barriers to seeking support, within their own held beliefs and understanding, and the knowledge and approach of their social and professional support networks. These findings therefore provide possible solutions to the exclusion and marginalisation of this population reported in other studies (Fletcher et al., 2006; Lever Taylor et al., 2017), as well as the personal barriers men experience to seeking support (Lever Taylor et al., 2017). The findings also identified key ways in which professional services could aide access to support, including improving the quality of
resources, and taking a proactive approach to support. Previous research has demonstrated that women want their partners to be supported by professionals, so that they can be better supported, including giving them information on postnatal mental health problems (Plunkett et al., 2016). Furthermore, the results are similar to studies reporting a need to improve perinatal resources for partners (Heron et al. 2012; Lever Taylor et al., 2017; Robertson & Lyons 2003).

**Strengths and limitations**

The current review represented the experiences of 277 male partners of women with postnatal mental health problems from six different countries. Consistencies were identified in themes across the studies, which suggests a potential transferability of the findings to other male partners of women with postnatal mental health problems. However, it is recognised that the countries included were mostly Western countries with established mental health care systems, which is likely to influence the participants’ knowledge and understanding of mental health and their view of mental health services. Although the goal of qualitative research is not to produce generalisable findings (Thomas & Harden, 2008), the fact that the search was limited to papers published in English, excluded research published in other languages, and from both developed and developing countries, may be considered methodological limitations.

As this review aimed at synthesising qualitative research into the broad area of male partners experiences, the populations included in these studies were diverse in terms of the women’s diagnoses, which reflects the aims of
perinatal mental health services, to address a wide range of mental health problems. However, the inclusion of both community and inpatient populations meant that the severity of mental health problems between the sample in the studies was diverse, and therefore that in drawing comparisons between these populations, the nuanced experiences linked to these factors may have been lost. As research into male partners experience of postnatal mental health is growing, future reviews should look specifically at specific populations, both with regards to diagnosis and treatment, to add to our understanding.

**Recommendations for clinical practice**

The findings from this review result in clear recommendations for male partners, healthcare professionals (including clinical psychologists), community and inpatient perinatal mental health services, and for wider society. A recommendation for male partners would be to be aware of the impacts maternal postnatal mental health problems can have on their own wellbeing, and therefore monitoring this and seeking help would be advisable. Furthermore, the results illustrate that practical and social coping, through seeking support and information can increase partners’ mastery and decrease their isolation, so another recommendation would be for men to utilise such strategies to manage the difficult emotions they experience. For healthcare professionals, improving their awareness and knowledge around postnatal mental health problems, including the impacts these have on the wider family, including male partners, would be one recommendation. Another recommendation would be for healthcare professionals to work towards effective communication with male partners and to have a proactive and
inclusive approach to supporting them. Clinical psychologists have specialist training in psychological theory and intervention for emotional difficulties, including coping and adjustment, to parenthood, diagnoses, loss and change. Therefore, clinical psychologists are in a strong position to help male partners of women with postnatal mental health problems. Psychologists could develop psychologically informed resources for partners, and provide training and supervision for healthcare professionals on how to support male partners, as well as offering psychological interventions for partners and families, if appropriate. Perinatal mental health services should improve the quality of the information and resources for male partners and work to include partners more in their spouse’s care. The findings of a recent survey on specialist Mother and Baby Units (MBUs) in the United Kingdom found that services are providing support for partners, including information (Turner, Garrett, & Wittkowsk, 2017), in line with NHS standards on support for partner’s (NHS England, 2016). In terms of wider society, partners have emphasised a clear need for greater public awareness of perinatal mental health, so public mental health campaigns are clearly valuable and should be supported by the government and other non-government agencies.

**Conclusions**

Men’s emotional wellbeing, and their relationships with their partner and infant are impacted by maternal postnatal mental health problems. In attempting to cope and adjust to their partner’s mental health problems, men draw on a number of strategies, including seeking support from others. Men’s efforts to cope are hampered by a number of barriers, relating to both internal factors,
and factors within their support network, including professional services.

Increased awareness of men’s support needs, and improvements in the delivery of support could reduce the negative impact of maternal postnatal mental health problems on male partners, and improve outcomes for men, women and their families.

Acknowledgements

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Paper 2:

Psychosocial support for male partners of women
admitted to mother and baby units

Manuscript prepared for submission to:

Journal of Clinical Psychology and Psychotherapy

(See Appendix E for details for the submission, this journal has no word limit)

Word count: 11,399
(Including abstract, main text, figures and tables and excluding references)
Abstract

Background: Research has highlighted the need to support male partners of women admitted to specialist Mother and Baby Units (MBUs). However, as yet less is known about the type of support men want and how they wish this psychosocial support to be delivered.

Aim: This study aimed to explore what support male partners of MBU patients want in terms of content, delivery and timing.

Method: Ten men whose partner was admitted to a MBU in the United Kingdom or Australia participated in semi-structured interviews. Data were analysed using Thematic Analysis.

Results: Five themes were identified: 1) A smoother journey to and from the MBU, 2) Feeling included, 3) Uncertainty about “what is going on”, 4) Barriers to support and 5) Facilitators of support. Men identified what practical, emotional and social support they would have found beneficial, and shared ideas on best deliveries models for support.

Conclusion: This qualitative study was the first of its kind to specifically explore the type of support male partners of MBU patients would like to be offered, in terms of content, delivery and timing. Participants expressed the need to be included and involved in care decisions regarding their spouse and infant, and to be offered information and advise from professionals. They also highlighted specific barriers in relation to accessing support and offered solutions to minimise those. Clear clinical implications arose for perinatal mental health services: We recommend a support package, which could be developed for MBUs to improve outcomes for male partners and ultimately for the family unit.
Key practitioners messages

- Men experience high levels of uncertainty relating to their partners’ postnatal mental health problems, treatment, and recovery; they are concerned about their partner and infant during their admission to a MBU.

- Male partners of women admitted to MBUs wish to be included and involved in their spouse’s care and to be given clear information and advice on how to support their partner before, during and after admission.

- Findings from this study point to clear recommendations about what support male partners want and how and when they wish for this to be offered. These changes can be integrated into the care offered by MBUs.

Keywords: spouse, men, father, support, postnatal mental health, qualitative
Introduction

The postnatal period is a time of vulnerability for women’s wellbeing, with possible increases in first presentations, exacerbation or relapse of mental health problems (The National Institute for Health and Care Excellence [NICE], 2014). The complex nature of postnatal mental health problems occurring at this time requires careful assessment and treatment to achieve the best outcome for the woman and her baby (NICE, 2014; SIGN, 2012). In line with NICE guidelines (2014), women requiring inpatient care for a severe mental health problem within the first year of birth may be admitted to a specialist mother and baby unit (MBU). MBUs exist in several countries worldwide, range from 4-13 beds and are staffed by multidisciplinary teams (Connellan, Bartholomeaus, Due & Riggs, 2017; Gillham & Wittkowski, 2015). Research on MBUs has grown over the years, showing the range of interventions that are offered by these services to improve maternal mental health and to enhance the mother-infant-bond (Connellan et al., 2017; Gillham & Wittkowski, 2015; Glangeaud-Freudenthal, Howard & Sutter-Dallay, 2014; NICE, 2014; Wittkowski & Santos, 2017). In their ‘Five Year Forward View for Mental Health’, NHS England has committed to increasing access to specialist perinatal mental health support in all areas of England by 2020/21 by building capacity and capability in specialist perinatal mental health services, focused on improving access to and experience of care, early diagnosis and intervention, including the right range of specialist community and inpatient care (NHS England, 2016).

The 2014 NICE guidelines pathway for managing mental health problems in the perinatal period emphasise the potential negative impact on the
woman’s mental health if her partner’s welfare, support role and/or relationship are compromised. Studies have demonstrated that male partners have an important role in supporting women’s mental health treatment and recovery (Burgess, 2011; Grube, 2005; Reid, Wieck, Matrunola & Wittkowski, 2017; McGrath, Peters, Wieck & Wittkowski, 2013; Plunkett, Peters & Wittkowski, 2016). Furthermore, fathers play a role in moderating (Mezulis, Hyde, & Clark, 2004) and buffering (Di Folco & Zavattini, 2014) the effect of maternal mental health problems during infancy and of later child behavioural problems.

A recent review of 20 qualitative studies on men’s experiences of having a partner with postnatal mental health problems identified the negative impacts on the couple’s relationship, the fathering role and the man’s emotional wellbeing (Ruffell, Smith & Wittkowski, under review). In addition, two quantitative studies found an association between women’s postnatal mental health problems and men’s emotional wellbeing (Harvey & McGrath, 1988; Lovestone & Kumar, 1993). In their cross-sectional study, Harvey and McGrath (1988) assessed 40 men whose partner had been admitted to a MBU and 25 men of partners from a general obstetric unit. Using the standardised Psychiatric Assessment Schedule (PAS; Dean, Surtees & Sashidharan, 1983) to assess mental health, they found that 42% of men from the MBU group met criteria for psychiatric disorders, compared to 4% in the comparison group. This finding was later replicated by Lovestone and Kumar (1993): An index group of 24 male partners of women admitted to MBUs was compared to a group of nine men whose partner was admitted to a general psychiatric. Scores on the standardised General Health Questionnaire (GHQ-3; Goldberg & Williams, 1988) and the Schedule for Schizophrenia and Affective Disorders
(SADS; Endicott & Spitzer, 1978) were compared. A third group of 23 male partners of women from the general population scoring <10 on the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987) (‘well’ group) also completed the GHQ-3 (Goldberg & Williams, 1988). Similar rates of lifetime psychiatric disorder in the index (38%) and in-patient groups (22%) were observed; 50% of the index group met the DSM-III score for ‘caseness’ on the SADS, compared with 33% of the in-patient group. MBU partners also had significantly higher scores on the GHQ than those in the ‘well group’, indicative of more symptoms of psychiatric mental health problems. Furthermore, nine (38%) MBU partners were assessed as having lifetime mental health problems from scores on the Schedule for Schizophrenia and Affective Disorders-Lifetime version (SADS-L; Endicott & Spitzer, 1978), eight of which developed a current disorder when their wives became unwell. Men’s wellbeing may therefore be compromised during this crucial period because they move into fatherhood with their partner and infant temporarily residing in hospital, whilst also managing the impact of their partner’s mental health difficulties and juggling other caring and financial responsibilities (Marrs, Cossar & Wroblewska, 2014; Reid et al., 2017). It appears then that the experience of having a partner with postnatal mental health problems that require MBU admission creates vulnerability for men to develop mental health problems themselves.

To date, five qualitative studies have explored the experiences of male partners of women admitted to MBUs (Boddy, Gordon, MacCallum & McGuinness, 2017; Kemp, 2011; Marrs et al. 2014; Muchena, 2007; Reid et al., 2017). These studies underscored the emotional impact on the men during their
partner’s admission, which was associated with psychological distress, compromised lifestyles and conflicting feelings. Impacts of admission on their role as a father and a partner and their experience of seeking support were also reported. Marrs et al (2014) found that fathers were concerned with practical issues relating to ‘keeping family together’, with the admission leading to fears about being a ‘fleeting figure’ in their infant’s life. Some men reported feeling powerless to help their partner and having conflicted feelings of worry for their partner and joy towards their new baby (Kemp, 2011); however, men also reported that the MBU admission resulted in more detached feelings towards fatherhood and a reduction in feelings of joy towards their baby (Reid et al., 2017; Muchena, 2007). Furthermore, Kemp (2011) reported how the admission threatened the trust within the couple relationship and men questioned the quality of their relationship. In dealing with these challenges, research has found that men seek support from family, friends and from MBU staff (Boddy et al., 2017; Kemp, 2011; Marrs et al. 2014; Reid et al, 2017).

In terms of MBU support, NICE guidance (2014) recognises the importance of meeting the needs of partners, and the NHS England Commissioning for Quality and Innovation Scheme (CQUIN) for 2016/17 requires perinatal mental health services to develop care plans to ensure that appropriate emotional, informational and practical support is offered to enhance partners’ understanding and participation in the woman’s care and promote their bond with the infant (NHS England, 2016). Three studies on partners’ experiences of MBU admission offer recommendations: MBU staff could foster the positive father-infant-bond and model sensitive parenting skills during admission (Marrs et al., 2014; Reid et al., 2017) and treatment should
include the father and be family-focussed (Kemp, 2011). A recent survey into the support offered to male partners by MBUs in the United Kingdom (UK), which included 10 of the 17 existing MBUs, identified that support was routinely offered to partners, but the type of support and how this was delivered varied across units (Turner, Garrett, & Wittkowski, 2017). For example, some MBUs offered face-to-face support sessions, whilst others offered written information packs and/or telephone support to male partners. In this survey, staff identified barriers to providing support to male partners, which included service-related issues relating to resources and difficulties in engaging fathers. A systematic review by Ruffell et al. (under review), which included both community and MBU populations, also highlighted barriers to support faced by male partners of women with postnatal mental health problems, including ineffective communication from professionals and insufficient resources and men feeling unable to seek support. Partners can feel unable or reluctant to seek support (Muchena, 2007; Kemp, 2011) or they can feel marginalised and ignored by perinatal mental health services in general (Lever Taylor, Billings, Morant & Johnson, 2017).

In summary, current research has highlighted the need to support male partners of women admitted to specialist MBUs alongside key barriers to men receiving support. MBUs have responded by offering different types of support to men during their partner’s admission (Turner et al., 2017), but as yet no study explored specifically what men wanted in terms of support during their partner’s MBU admission or how this type of support should be offered or delivered. Thus, this study aimed to explore what psychosocial support male
partners of women admitted to MBUs would welcome and find helpful in terms of delivery, content and timing.

Method

Design and ethical approval

The study employed a cross-sectional qualitative design. Ethical approval was obtained from the local National Research Ethics Committee (Ref: 17/NW/0117, Appendix F), the National Health Service Health (NHS) Research Authority (Appendix G), local NHS Trust’s research and development department and the University of Manchester Research Practice Governance Department.

Participants and recruitment

The study recruited participants who were men aged 18 years or older whose partner had been admitted to a MBU currently or in the past. All participants had to be fluent in English in order to read the Participant Information Sheet and complete the Consent Form (see Appendix H-I). To allow for a wide reach, recruitment was not restricted to UK MBUs and consisted of two pathways, namely online and via a MBU. An online advert (Appendix J), detailing information about the study and providing links to relevant documents, was posted on online forums, charities and influential bodies via Facebook and Twitter. Secondly, a UK MBU sent a letter to partners of past patients (Appendix K), providing them with study details and relevant documents. Informed consent (Appendix I) was obtained and, prior to the interview, participants also completed an adapted version of the Family Background
Questionnaire (Appendix L; Sanders & Morawska, 2010), providing information on: 1) demographic details, 2) family structure, 3) experience of their partner’s mental health and 4) social support (see Appendix M for details on scoring).

Secondary data analysis
Prior to commencing the study, a secondary data analysis of interview transcripts from Reid et al.’s (2017) study was conducted, with the aim to identify themes relating to support, which were used to inform the interview schedule for the current study. Relevant approvals for the study were obtained from the local National Research Ethics Committee (Ref: 12/NW/0187, Appendix N), and the local NHS Trust. Data were analysed at a semantic level using thematic analysis (Braun & Clarke, 2006).

The interview schedule was developed (detailed in Table 4), informed by background literature, including a recent systematic review (Ruffell et al., under review), the secondary analysis described above, and a national survey of MBUs in the UK (Turner et al., 2017). The schedule was then used in a pilot interview with a male colleague and new father. Following feedback, the interview schedule was further refined and agreed on by all authors.
### Table 4: Details of the interview schedule

<table>
<thead>
<tr>
<th>Support details</th>
<th>Question</th>
<th>Examples of prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferences</td>
<td>1. Tell me about your experience of support you have received during this time.</td>
<td>-Aspects of the support that felt helpful/unhelpful, who provided the support</td>
</tr>
<tr>
<td></td>
<td>2. What other support would feel helpful during this time?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. When would be a good time for support to be offered?</td>
<td>-During admission/after discharge home, time of day</td>
</tr>
<tr>
<td></td>
<td>4. Where do you think you would feel most comfortable receiving the support?</td>
<td>-At home/on unit/other location in community</td>
</tr>
<tr>
<td></td>
<td>5. Who would you feel most comfortable receiving the support from?</td>
<td>-Mental health staff (nurses, psychiatrists, psychologists)/people with lived experience, other organisations</td>
</tr>
<tr>
<td>Delivery</td>
<td>6. What would be the best way for you to access the support offered?</td>
<td>-1-1 sessions, meetings, group sessions, leaflets/websites/social media</td>
</tr>
<tr>
<td></td>
<td>7. What would make it easier for you to use the support?</td>
<td>-Being given resources to take away, someone explaining the information, contact details of someone you can contact if you have any questions</td>
</tr>
<tr>
<td></td>
<td>8. What would make it more difficult for you to use the support offered?</td>
<td></td>
</tr>
<tr>
<td>Content</td>
<td>9. What type of support would you value either earlier, now or in the future?</td>
<td>-Support for your own wellbeing, information about the ward, practical ways to support your partner and baby, information about your partner’s mental health diagnoses and treatment.</td>
</tr>
</tbody>
</table>

**Interview procedure**

All interviews were conducted by the lead author (BR), who could use a distress protocol with interviewees (Appendix O) if required. A debrief sheet (Appendix P) was routinely given to participants at the end of the interview. Interviews were audio-recorded using an encrypted device and transcribed.
verbatim. Field notes were taken during and after the interviews, pertaining to key themes arising, emotional content of the interview, and contextual information about the participant and their story, which were used to inform analysis. All recordings and transcriptions were anonymised and stored separately from contact details and securely in accordance with the Data Protection Act (1998).

**Data analysis**

Data were analysed using thematic analysis, which identifies themes arising out of the entire data set of what participants said, rather than focussing on how they said it (Braun & Clarke, 2006). A contextualist epistemological approach was taken, seeing knowledge as emerging from local and situational contexts and reflecting the researcher’s positions (Madill, Jordan & Shirley, 2000). According to Madill et al. (2000), completeness is an important factor of contextualist epistemology, which allows for unique responses to be included rather than consensus of opinion only. The thematic analysis involved both inductive and deductive approaches because the authors drew on past literature as well as deriving themes from the data. Data were analysed on a latent level, going beyond the semantic content to identify and interpret underlying concepts contained within the themes (Braun & Clarke, 2006).

The thematic analysis followed the six-phase protocol outlined by Braun and Clarke (2006) (detailed in Table 5). The first author (BR) conducted coding and theme development for the entire dataset, and a second author (DS) read and independently coded all transcripts to ensure reliability and validity of themes (see Appendix Q for an example of a coded extract). An agreement of
final themes was reached through collaborative discussion and refinement. Author AW reviewed the final themes to ensure they fulfilled the overall messages salient in the dataset. All authors agreed on the final themes.

As the current study aimed to identify explicit, concrete codes and outline broad thematic issues rising from the interviews, data saturation for this study was assessed at the level of core code saturation, agreed between all authors, at which point recruitment was halted. Code saturation is generally reached between seven to 12 (Guest, Bunce & Johnson, 2006) or eight to 16 interviews (Namey, Guest, McKenna, & Chen, 2016). Descriptive statistics were used for participant background information and context.

Table 5: Details of the thematic analysis (based on Braun and Clarke, 2006)*

<table>
<thead>
<tr>
<th>Phases</th>
<th>Analysis of interviews for main study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Interviews were transcribed and the transcripts were read several times and initial ideas noted.</td>
</tr>
<tr>
<td>2</td>
<td>Initial codes relevant to the research questions and aims of the study were generated by line-by-line coding of the entire dataset. All data relevant to each code was collated.</td>
</tr>
<tr>
<td>3</td>
<td>Codes were grouped into potential sub-themes. Sub-themes encompassed all codes that were deemed salient to all transcripts, and included a complete set of opinions rather than a consensus.</td>
</tr>
<tr>
<td>4</td>
<td>The sub-themes were reviewed together with the collated extracts, generating a ‘thematic map’ to check the validity of the sub-theme in relation to the data set, and to check that it accurately reflected the meanings evident in the entire data set.</td>
</tr>
<tr>
<td>5</td>
<td>The relationships between codes and sub-themes were reviewed, and overarching themes were defined and which encompassed the overall story of the sub-themes contained within it.</td>
</tr>
<tr>
<td>6</td>
<td>Selection of extract examples, and final analysis of selected extracts was completed, relating the analysis back to the research question and literature to report the analysis.</td>
</tr>
</tbody>
</table>

* This approach was also used of the secondary data analysis and the final themes were then included in the interview schedule.
**Reflexivity**

Reflexivity is the acknowledgement that research is influenced by beliefs, assumptions, experiences and interests held by authors (Berger, 2003). All authors were women with professional experience and training in psychology applied to research and/or clinical roles, including qualitative research and perinatal mental health. They held assumptions that 1) male partners influence women’s outcomes, 2) male partners have specific needs, 3) there was a gap in service provision, and 4) men want support.

**Results**

**Participants**

Ten participants agreed to take part and interviews were conducted between September 2017 and January 2018. In line with participants’ preferences, interviews were conducted via telephone (n=2), Skype (n=7) or in person (n=1). Interviews lasted between 48 minutes and 73 minutes (Median= 62 minutes).

All participants who consented to take part completed the study. Participant characteristics are outlined in Table 6. Participants’ ages ranged from 31-46 years (Mean= 36 years, SD= six years). Participants lived in different regions of the UK (n=8) or in Australia (n=2). At the time of interview all their partners were discharged from the MBU and the time since first admission varied between seven months and eight years (Median= one year and 11 months). Three families had experienced a second MBU admission for the same pregnancy, ranging from one month to five months post-discharge (Median= four months), and one family had experienced a second admission
following the birth of their second child three years after the first admission.

All participants were biological fathers to the babies admitted to the MBU, and seven participants were new fathers at the time of first admission. Eight partners were married and two were living together. For four participants, the episode of mental ill health leading to MBU admission had been the first time they had experienced their partner having mental health problems.
Table 6: Overview of participants’ socio-demographic background and MBU admission history

<table>
<thead>
<tr>
<th>ID</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Education</th>
<th>Employment</th>
<th>Financial status</th>
<th>Relationship status</th>
<th>First-time father at MBU</th>
<th>Planned pregnancy</th>
<th>MBU 1st episode of MH problems</th>
<th>MBU admissions</th>
<th>Time since admission, 1st(2nd)</th>
<th>Social support score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>31</td>
<td>White British</td>
<td>University</td>
<td>Full time</td>
<td>Comfortable</td>
<td>Married</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>1</td>
<td>8 months</td>
<td>High</td>
</tr>
<tr>
<td>2</td>
<td>46</td>
<td>White Australian</td>
<td>Trade</td>
<td>Full time</td>
<td>Somewhat comfortable</td>
<td>Married</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>1</td>
<td>5 years 1 month</td>
<td>Medium</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>South Asian</td>
<td>School</td>
<td>Unemployed</td>
<td>Limited</td>
<td>Married</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
<td>7 months</td>
<td>High</td>
</tr>
<tr>
<td>4</td>
<td>34</td>
<td>White British</td>
<td>University</td>
<td>Full time</td>
<td>Somewhat comfortable</td>
<td>Married</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
<td>1 year 2 months (10 months)</td>
<td>High</td>
</tr>
<tr>
<td>5</td>
<td>42</td>
<td>White British</td>
<td>University</td>
<td>Full time</td>
<td>Somewhat comfortable</td>
<td>Married</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
<td>8 years 1 month (5 years)</td>
<td>High</td>
</tr>
<tr>
<td>6</td>
<td>33</td>
<td>White Australian</td>
<td>University</td>
<td>Full time</td>
<td>Somewhat comfortable</td>
<td>Married</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>2</td>
<td>2 years 11 months (2 years 6months)</td>
<td>High</td>
</tr>
<tr>
<td>7</td>
<td>38</td>
<td>White British</td>
<td>University</td>
<td>Full time</td>
<td>Somewhat comfortable</td>
<td>Living together</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
<td>1 year 8 months (1 year 7 months)</td>
<td>High</td>
</tr>
<tr>
<td>8</td>
<td>29</td>
<td>White British</td>
<td>Trade</td>
<td>Full time</td>
<td>Comfortable</td>
<td>Married</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>1</td>
<td>2 years 2 months</td>
<td>High</td>
</tr>
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<td>31</td>
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<td>University</td>
<td>Full time</td>
<td>Comfortable</td>
<td>Living together</td>
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<td>1</td>
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Findings from the thematic analysis

Following analysis, five broad themes were developed with corresponding subthemes which represented what participants said during the interviews: 1) A smoother journey to and from the MBU, 2) Feeling included, 3) Uncertainty about “what is going on”, 4) Barriers to support, and 5) Facilitators to support. Table 7 displays the five main themes, 15 subthemes and corresponding extracts (see Appendix R for additional exemplar extracts). All interviews provided data to support each theme, although opinions were diverse. All views were represented in the themes to ensure a complete picture, following a contextualist approach to analysis. Themes 1 to 3 describe what support participants said they wanted, and themes 4 and 5, together with the information contained within the subthemes, describe the specifics of what support should look like in terms of delivery, content and timing. Figure 3 presents a thematic diagram of each of the main themes and subthemes and their relationship with content, delivery and timing.

Theme 1: A smoother journey to and from the MBU

All participants spoke about the challenges faced by the couple throughout their journey to, during, and after, the MBU admission. All said they wanted a private space specifically for them to allow them to process the emotional impact of their partner’s admission. Most of the participants also spoke about the ways in which MBUs can help preserve some normality in their family life. Theme 1 constituted four subthemes: 1.1 Prevention information, 1.2 MBU admission, 1.3 Post-discharge processes, and 1.4 A space for me and my family.
Subtheme 1.1: Prevention information

The participants said they had been given no antenatal information about postnatal mental health problems or what signs to look out for, which had meant that they had felt “shell shocked” [P7] and did not immediately recognise their need for professional support. Previous research has similarly highlighted partners’ difficulties in identifying mental health problems (Lever Taylor et al., 2017; Marrs et al., 2014; Muchena, 2007; Ruffell et al., under review), and the crucial role information plays in recognising symptoms and seeking help (Plunkett, et al., 2016). Experiences of ‘shock’, confusion and feelings of powerlessness and helplessness have also been previously identified (Boddy et al.’s study, 2017; Marrs et al., 2014; Muchena, 2007; Kemp, 2011; Reid et al., 2017). Participants suggested that they would have been better prepared if such information was given in antenatal classes. Research into transition to fatherhood highlights how antenatal classes can inadvertently exclude men by focussing primarily on the mother and can lead to greater feeling of separation (Kowlessar, Fox & Wittkowski, 2014). According to Lever Taylor et al. (2017), participants felt unprepared by antenatal classes, which did not include information on perinatal mental health.

Subtheme 1.2: MBU admission

Trying to get professional help was challenging for the families, with most journeys involving uncertainty and frustration. This was influenced by the perceived lack of expertise around postnatal mental health in the community, and the lack of a clear referral pathway to the MBU. Partners from other
studies also perceived healthcare professionals as having limited awareness of postnatal mental health, or as not taking their concerns seriously (Boddy et al., 2017; Ruffell et al., under review), and experienced care as inadequate, inconsistent or delayed (Lever Taylor et al., 2017; Muchena, 2007; Ruffell et al., under review). Most of the participants spoke about their relief when their partner was admitted to the MBU, and feeling as though she was in the right place surrounded by experts, which has been echoed in the literature (Boddy et al., 2017, Lever Taylor et al., 2017; Marrs et al., 2014; Muchena, 2007; Reid et al., 2017; Ruffell et al., under review). Comparable to Boddy et al.’s findings (2017), participants from the current study reported that they did not feel involved in the admission process and felt excluded.

**Subtheme 1.3: Post-discharge processes**

Participants spoke about wanting the discharge from the MBU to be more individualised, formalised and to feel more involved in this process. Settling back at home was a challenging time for the couple, and adjusting to their partner’s needs was difficult. The participants felt they needed more support post-discharge, particularly advice about how to support their partner, which was not always available from their partner’s community mental health teams. The anxiety around discharge felt by participants, and concerns about being responsible once again for their partner, was similar to that reported by previous studies (Boddy et al., 2017; Marrs et al., 2014).
Subtheme 1.4: A space for me and my family

Some participants spoke about the importance of having a space away from their partner in which to “get it out” [P4]. This is akin to Kemp’s study (2011) in which partners spoke about the relief of having someone to “lean on” or “let off steam to”, and Lever Taylor et al.’s findings (2017) that participants wanted “a listening ear” or “someone to talk to”. Some participants felt they needed support around their experiences, which may have been traumatising, which was also described in Kemp’s study (2011). Other participants said that advice on how to manage their own wellbeing would have been helpful. Previous studies have also highlighted the impact of MBU admission on the male partner’s emotional wellbeing (Boddy et al., 2017; Harvey & McGrath, 1988; Kemp, 2011; Marrs et al., 2014; Muchena, 2007; Lovestone & Kumar, 1993; Reid et al., 2017). In the current study, one participant was given professional one-to-one support, whilst another was offered couple’s therapy. Ruffell et al.’s review (under review) also demonstrated that partners wanted professional emotional support. Some participants in Reid et al.’s study (2017) had been offered emotional support and counselling, and had found this helpful. Furthermore, women have also shared concerns for their partners, and wished for them to have professional help, believing it would aid their recovery (Plunkett et al., 2016).

Although some participants perceived the advice they were given was too generic, most of the participants said that peer support would have been a helpful way to support them emotionally. Ruffell et al.’s review (under review) underscored the benefits of peer support to reduce isolation and stigma; however, Lever Taylor et al. (2017) reported on a ‘divergence or
discrepancy’ in partners’ opinions on whether they would welcome or find peer support helpful. Participants spoke about wanting to have ‘normal’ family time during their visits on the ward, which was comparable to Marrs et al.’s study (2014) in which participants spoke about wanting to ‘keep the family together’. Some participants spoke positively about the ward environment, which felt ‘homely’ [P8], relaxed and family-oriented, and supported family time. One participant spoke about how the ward had organised a Christmas Day on the ward for his family, which had felt very supportive. Other participants spoke about the ward feeling too clinical or not having a space to be alone with their partner and infant and to talk without restrictions. Participants in Marrs et al.’s study (2014) valued staff supporting alone time with their partner. Some participants reported that the staff observations (implemented to manage risk in line with the Mental Health Act, 1983) were experienced as a barrier to private family time.

Theme 2: Feeling included

It was important to the participants that they felt included during their partner’s stay on the ward. The majority of participants spoke about how the MBU could involve them in their partner’s care and the ways in which the ward could meet their needs as a partner of the admitted patient. Theme 2 was divided into two subthemes: 2.1 Being involved in her care, and 1.2 Considering my needs.

Subtheme 2.1: Being involved in her care

The participants spoke about wanting more involvement in the care of their partner during her admission to the MBU. These are similar to findings in the
review by Ruffell et al. (under review) in which research highlighted partners’ preference to be involved in their partner’s care. They expressed the desire to be updated in their partner’s progress and consulted about care decisions. Participants also spoke about how “working together” [P5] with MBU staff would be beneficial, with men sharing lived experience of their partner, and mediating the relationship between their partner and the MBU to increase her trust of the staff. Similarly, participants in past studies have felt excluded by services, feeling ‘relegated from next-of-kin status’ (Marrs et al., 2014) and as though their role was considered unimportant (Boddy et al., 2017; Ruffell et al., under review). Participants also spoke about wanting to be included in treatment and that treatment should be family focussed (Kemp, 2011; Marrs et al., 2014). Furthermore, participants in Kemp’s (2011) study argued their presence and knowledge of their partner were unique resources to help their partner recover. Previous research has recognised partners as integral to a woman’s recovery (e.g., Plunkett et al., 2016).

**Subtheme 2.2: Considering my needs**

Participants reported that it was important to them that their needs were also considered and that they were offered specific support. Although their presence on the ward was “tolerated” [P1], they did not feel included by MBU staff. Male partners have already voiced feelings of exclusion and that their own needs were marginalised and neglected by perinatal mental health professionals (e.g., Lever Taylor et al., 2017); however, men have also highlighted times when they felt supported by staff; for example, around flexible visiting times (Lever Taylor et al., 2017; Reid et al., 2017). Indeed, participants in this study
reported that practical gestures from the ward, such as being offered food, flexibility around visiting times, and being encouraged to stay over on the unit made them feel as though their needs were being considered.

**Theme 3: Uncertainty about “what is going on” [P6]**

All participants reported that they did not fully understand their partner’s diagnosis and/or treatment. They also spoke about their concerns about their infant’s care, and needing reassurance that their infant was being looked after. They said they wanted to be kept up-to-date throughout their partner’s admission and to be given information about her future recovery. Uncertainty and male partners’ desire for information on diagnoses, treatment, recovery, and how to support their spouse, has been identified in reviews (e.g., Lever Taylor et al., 2017; Ruffell et al., under review). Theme 3 was made up of four subthemes: 3.1 Uncertainty about the problem, 3.2 Uncertainty about the ward and treatment, 3.3 Uncertainty about the future, and 3.4 Uncertainty about my infant’s care.

**Subtheme 3.1: Uncertainty about the problem**

All participants spoke about wanting support to understand their partner’s diagnosis better and shared their ‘shock’ at their partner’s deteriorating mental health. Participants expressed the importance of knowing about their partner’s progress. Participants in Reid et al.’s study (2017) also expressed a need for regular updates from the ward about their partner’s progress. This felt particularly pertinent for participants who lived far from the unit and were unable to visit daily. Some participants said that they received information
about their partner’s mental health problem in meetings. Others spoke about the lack of resources to help them understand the diagnosis and having to ask for information. Sometimes the updates that were given felt too generic, with one participant suggesting that individualised updates from the treating clinician would have felt more helpful. Another participant suggested that it would have been helpful to receive automatic daily updates over the telephone or via text, instead of having to ring the ward himself. Most participants suggested that a combination of a leaflet and a meeting to talk through the information would be helpful, and that a one-to-one meeting in the absence of their partner could allow them to ask questions without the risk of upsetting their partner. Male partners have voiced their request for information about their spouse’s mental health diagnoses (Muchena, 2007 Reid et al., 2017) and such information could increase male partners’ sense of empowerment and aid their adjustment to the situation (Kemp, 2011; Ruffell et al., under review).

**Subtheme 3.2: Uncertainty about the MBU and treatment**

Participants talked about the need to understand the structure of the MBU, its policies, procures, and therapeutic goals, and the rules they were expected to follow. Orientation to these details could help participants feel familiar with the MBU, and thus reduce their anxiety. One participant spoke about being given information in the admission meeting, which he found helpful, but others spoke about the lack of information given about the ward. A “beginners guide” [P7] to the ward was suggested as a way of orientating the participants to the MBU and its procedures and policies. A similar suggestion had been made in a previous study (Reid et al., 2017). Most participants spoke about the
need to understand the treatment their partner was receiving, and how this lack of knowledge was experienced as stressful. Some participants did their own research, and one participant was given information in a meeting with MBU staff. Searching the Internet for information is a strategy highlighted by previous studies (Boddy et al., 2017; Lever Taylor et al., 2017). Participants also spoke about the lack of information on treatment and having to ask for information. As with the diagnosis, some participants suggested that the most helpful method would be a leaflet and a meeting to talk through the information. Past studies have suggested that information about the MBU and interventions available helped to reduce partners’ uncertainty (Boddy et al., 2017; Reid et al., 2017). Participants spoke about wanting more information on how they could support their partner. For example, how to respond to her questions, understand her behaviours and the triggers for these, and to be reassured that they were not to be blamed for their partner’s distress.

Participants in Kemp’s study (2011) described how the MBU admission had created tension in the couple relationship, impacting their partner’s trust of them. Two participants said they would have liked for this support to be given in a one-to-one session, whereas another suggested that talking to another man with lived experience would have been helpful.

Subtheme 3.3: Uncertainty about the future

Comparable to findings reported by Reid et al. (2017), participants wanted reassurance that their partner would recover from this episode of mental ill health. Most participants said they wanted to be given professional information about their partner’s prognosis and recovery, managing at home post-discharge
and future family planning. Others suggested that hearing from people with lived experience of postnatal mental health problems could be helpful.

**Subtheme 3.4: Uncertainty about my infant’s care**

Participants talked about the anxiety caused by being separated from their infant, knowing that their partners were unwell and not always able to look after their infant. Therefore, believing that their infant was being cared for by experienced staff was vital to their support. Some participants spoke about trusting the staff to care for their infant and receiving regular updates on their progress, whilst others had concerns about the care of their infant; they wanted updates and having staff trained in childcare on the ward was important. Some participants spoke about how they appreciated having unrestricted time with their infant, which strengthened their bond. This is comparable to other studies: participants felt like a “temporary father” (Reid et al., 2017) or a “fleeting figure” (Marrs et al., 2014), with fathers worrying that they might be perceived as abandoning their baby (Boddy et al., 2017). Fathers have also reported detachment and reduced enjoyment towards their baby (Muchena, 2007; Reid et al., 2017). Most participants in this study said they would have liked to be included more in childcare activities on the ward, but some reported that they had been given helpful parenting support and advice by staff. These findings mirror recommendations that MBUs should offer fathers consistent parenting support and guidance (Marrs et al., 2014; Reid et al., 2017). However, some fathers may not want such support; for example, participants in Kemp’s study (2011) felt the expectation to be involved challenged their cultural traditions, and fathers also felt their parenting skills were under scrutiny by MBU staff.
Theme 4: Barriers to support

All the participants identified specific barriers, which had prevented them from accessing MBU related support, including their own emotions and perceptions as well as situation-specific factors. They offered suggestions on how these barriers could be minimised and support could be delivered. Theme 4 consisted of three subthemes: 4.1 Personal barriers, 4.2 Barriers relating to the MBU, and 4.3 Barriers in the relationship between participants and the MBU.

Subtheme 4.1: Personal barriers

Most of the participants talked about hiding their distress from staff, feeling embarrassed because they were struggling, and wanting to preserve an image of ‘being strong’, which have been previously cited in the literature (Lever Taylor et al., 2017; Ruffell et al., under review). Participants in Kemp’s study (2011) described feeling “lost” as a man and that ‘macho’ stereotypes hindered them asking for support. Conversely, findings from Ruffell et al.’s review (under review) also highlighted that participants’ need to ‘be strong’ for their family was also experienced as empowering for them. Most participants spoke about how the nature of the experience meant they were focussed more on the needs of their partner and infant than their own, with some not realising they need support until later on, which prevented them from accessing support. Lever Taylor et al.’s review (2017) also reported that partner’s struggle to identify their own needs, minimise their needs and prioritise the needs of their partner and infant. Some participants spoke about not being in the ‘right frame of mind’ to ask for support, that they had no ‘head space’ or felt ‘too shell shocked’ by the experience. They spoke about not having any time to organise
support for themselves, because they were too busy arranging visits to the MBU around work, childcare and other appointments. Previous studies have also cited the practical demands for partners of working, visiting the MBU and providing childcare (Kemp, 2011; Lever Taylor et al., 2017; Muchena, 2007; Reid et al., 2017). Similarly, participants of the national survey of MBUs (Turner et al., 2017) stated that partners’ ability to travel to the MBU and availability due to other commitments were barriers to support. For some participants, ‘closing up’, ‘pushing others away’ and ‘refusing support’ was a way of protecting themselves and others. According to Ruffell et al. (under review), physical and emotional withdrawal as a coping strategy were used by partners experiencing adverse emotions. Similarly, participants in past research have spoken about how they “pushed away” their needs (Kemp, 2011), “putting them on hold” (Marrs et al., 2014) and restricting their communication with staff in response to feeling excluded (Marrs et al., 2014). Staff in the national MBU survey (Turner et al., 2017) also highlighted barriers relating to partners’ willingness to engage with support. Partners’ ambivalence about involvement in support and reluctance to seek help has also been highlighted in other studies (Lever Taylor et al., 2017; Muchena, 2007). Participants were worried about ‘opening up’, fearing it might make them feel vulnerable or upset other patients, including their partner. In this study, participants also talked of fearing stigma from friends and family and that asking for support could have made staff think there was a problem in their relationship. Previous research also highlights partners’ fears of stigma relating to mental health problems, their desire to protect their family and concerns about criticism from
professionals (Boddy et al., 2017; Lever Taylor et al., 2017; Muchena, 2007; Ruffell et al., under review).

**Subtheme 4.2: Barriers relating to the MBU**

Some participants were aware of financial restraints within healthcare services and wanted resources to be focused on their partner. Other participants spoke about knowing their partner was the primary patient and therefore not ‘feeling entitled’ to ask for support, or not knowing how to ask, or what to say.

Partners’ feelings of exclusion within the female-oriented MBU environment have been highlighted in past research (Boody et al., 2017; Kemp, 2011; Marrs et al., 2014; Muchena, 2007; Reid et al., 2017). Some participants spoke about how as the MBU staff worked shifts, ‘faces changed’ meaning they were not always familiar with staff and did not know whom to approach. When asked about the female-dominated environment of the ward, most of the participants said they had not experienced this as a barrier. However, participants in Kemp’s (2011) study had described feelings of ‘not belonging’ in the MBU environment due to their gender, one of whom said “It’s quite uncomfortable as a man…you’ve gotta be one of the mums”.

**Subtheme 4.3: Barriers in the relationship between participants and the MBU**

The participants spoke about how their relationship with MBU staff was influenced by the behaviour of staff, trust and the communication between them. Some participants perceived the offers of support from staff as insincere and that staff did not make time for them, meaning they had to ‘fight’ to get
more support. Others felt staff were not collaborative in their approach and experienced rules as rigid and restrictive, leading to feelings of tension and distrust towards staff. These findings are similar to past research, in which participants found communication with health professionals unhelpful (Ruffell et al., under review), increasing their uncertainty (Marrs et al., 2014) and leading to disengagement in their relationship with staff (Reid et al., 2017). Furthermore, they mirror the findings from the national MBU survey (Turner et al., 2017) in which staff spoke about barriers relating to staff training and inflexible shift patterns, which restrict their ability to flexibly meet partners’ needs.

Participants also explained that they often felt unable to talk honestly and openly when their partner was present, because they were concerned about upsetting her. They also spoke about not feeling able to talk to other partners on the unit, and that no space was created for this. Most spoke about how a male presence on the ward might have adversely affected the female patients and that this was a priority over their own needs. However, some participants said that having a male staff member could have provided a different type of conversation or support to them. In our MBU survey (Turner et al., 2017), MBU staff also suggested that having support interventions led by male staff could facilitate partners’ engagement.

**Theme 5: Facilitators to support**

As with subtheme 4.3, participants spoke about the importance of having a good relationship with MBU staff, and how this influenced their access to support and the burden they felt. They also spoke about how the support was
delivered would allow them to overcome some of the barriers to accessing support. Theme 5 was divided into two subthemes: 5.1 *Quality of the relationship*, and 5.2 *Efforts made by staff*.

**Subtheme 5.1: Quality of the relationship**

Although some participants had negative experiences of the relationship they had with MBU staff (see subtheme 4.3), others described developing positive and trusting relationships with staff. For example, participants spoke about how MBU staff had been approachable, accessible to answer questions and responsive to their concerns. Other participants had experienced effective communication with the MBU and were clear on how they could contact the ward, who they should talk to and trusted MBU staff to keep them updated. Participants also shared how MBU staff had made an effort to get to know them, made efforts to build a relationship, and asked them how they were doing. These participants described feeling supported and cared for by the staff, and trusting staff as ‘experts’, which gave them confidence in the advice they were given and trust that staff would update them if required. Participants in Boddy et al.’s study (2017) also viewed MBU staff as experts and valued their expertise. These positive experiences gave participants reassurance about the care being provided to their partner and baby, and hope for their partner’s recovery.

**Subtheme 5.2: Efforts made by staff**

Although some participants spoke about how they experienced staff as insincere or unavailable in their efforts to support them (see subtheme 4.3),
other participants spoke about times they believed that MBU staff exceeded their role expectations. These gestures, which came out of a flexible and ‘bigger picture’ approach to care, made the participants feel as though the support was being extended to the whole family. The participants said that if staff had ‘reached out’, encouraged, and made it as easy for them to access support, they would have been more likely to take up the offer. Some participants spoke about the need for staff to highlight their need for support, because this may not have been obvious to the participants at the time. This proactive approach could have helped participants to overcome some of the personal and situational barriers they faced. This wish for a proactive approach was also highlighted by previous research (Lever Taylor et al., 2017; Ruffell et al., under review). Staff that participated in the national MBU survey (Turner et al., 2017) also suggested that staff should be aware of the male partners’ needs and that a willingness to offer support would facilitate engagement, but they also believed that an informal approach to support would be best.
Table 7: Overview of the five main themes, 15 subthemes and exemplar quotes

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<th>Theme</th>
<th>Subtheme</th>
<th>Exemplar quotes</th>
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| 1. A smoother journey to and from the MBU | 1.1 Prevention information            | “I think what would be really good. I mean we even did the [antenatal] classes. Which was a complete waste of time. Genuinely it was. Y’know you pay money to do it and there was a few useful tips, but ultimately there was not one word of, and yeah it is rare but y’know there’s not one word of this. Y’know, you’re never told what this postpartum psychosis is. Erm, and I suppose its education and y’know, something to be aware of. Is depression, and y’know postpartum depression, postpartum psychosis, y’know, there’s some education around it, so you could, in the early days, spot signs.” [P4]  
“I did feel that there was enough information made (on the MBU), but before, before that, we, I knew absolutely nothing about it, I’d never heard of it, never, never had any sort of, what I guess, when all the antenatal classes and things that we went to and stuff, nothing was really told that this could happen, erm, so we were totally in the blue, and it took us by shock, erm, when it happened.” [P8]  |
|                                        | 1.2 MBU admission                      | “…it was other medical professionals, like the A&E and things like this, having to wait, it took, it must have took, six or seven trips to A&E going in and out, every single other day, erm, before anything sort of got put in place, so sort of the help, erm, and it was nobody down [city] was, er, helpful, medical staff wise, it wasn’t until my wife went up to [region] to stay with her mum that she, they ended up in, er, in [city] it wasn’t until then that somebody noticed and made a, they give us the number for the crisis team and said if things progress, they saw that she was poorly, and things progressed to ring this number, and that’s how it all come about, I guess.” [P8]  |
### 1.3 Post-discharge processes

“... when you get to the mother and baby unit everybody knows what’s going on and “we seen all this before and this is how we’re gonna treat it”, and in the hospital it was, you were very much in the dark, and the expertise definitely lies in the MBU.” [P9]

“So we got information about that kind of bi-proxy but there was both discharges it was basically “we think she’s fine, she’s coming your way, time for your time, good luck”. Nothing, there was no real formal discharge process. Which I find very odd.” [P7]

“The healthcare in [hometown] is atrocious. The mental health care. They were completely out of their depth. There was no support. There was no advice. You were left alone. I was crying out for help. Erm, absolutely crying out for help. At times, just a bit confused where to go. Erm, and it got to the point where it was just like we need [ward] back, we need to get her back in a unit.” [P4]

### 1.4 A space for me and my family

“I think I’d have probably just wanted someone to whinge at really ((laughs)). And to kind of, someone who would make it ok, it sounds a silly childish thing to want, but I think it is what I would’ve wanted, would be someone for whom I didn’t have to be erm (sighs) understanding or strong about it. That I could moan that it was a crap state of affairs ((laughs)) and y’know that I was lumbered with looking at, doing all the work and it was horrible. Which wasn’t y’know necessarily how I felt all the time, I think I probably did have a part of me that wanted, that would’ve wanted to get that out, so... That would’ve wanted to express something like that.” [P5]

“Erm but you never got a chance, and I mean this is the most platonic way, to sit down and have a cuddle, and to say hi. You could, there was a room that were there with other people, which was fine, I’m not talking about conjugal visits given...”
that, you know two months out of C-section, that’s not what you’re talking about! But it’s just time for a bitch and just a “come here and have a hug” kinda way where you’re not perched on a hospital bed or you’re not sitting in an overlooked public space.” [P7]

| 2. Feeling included | 2.1 Being involved in her care | “I did I felt like it was that definite sense of ‘we’re doing this as a partnership’, me and the paid staff were kind of working together towards a common goal.” [P5] |
| | | “What would have been helpful, if you’re doing normative and best case scenario is to be actively involved and informed in the decisions about care, rather than feeling like your partner has been taken away from you and now things are being done to them that you have to react to.” [P7] |
| | 2.2. Considering my needs | “…it was very much about [wife] and [son] and how they interact and it wasn’t a family supporting unit, therefore support for the father wasn’t really considered I don’t think. Now that was a big thing for me. Knowing that the support for the father and the family was a thing that ensures on-going success as a family, erm it seems odd that that’s not just core to what they do.” [P7] |
| | | “They would regularly go and steal food from the erm, from the, so in the main ward they had a kitchen area, and a dining area and a hatchway and stuff so they would go and do raids on there for me if I’d been there a lot of the day... They just kind of, they had some consideration that I needed food and sleep and stuff as well as everyone else.”[P5] |
| 3. Uncertainty about “what is going on” | 3.1 Uncertainty about the problem | “It was it was a relief, it was a relief to know, look we know what we are dealing with, [if] you know what you’re dealing with you can work to a solution, erm and I suppose that was something you can then start to get your head round, and maybe do some research, because we were both very very uneducated about it, absolutely
| 3.2 Uncertainty about the ward and treatment | “It was just uh and some of the drugs weren’t working and things like that so it was just kind of like what’s happening basically? What is going on? And no one really would tell me that. And that was what was useless for me, and stressed me out a lot.” [P6] “Yes because you, you could say something to her and she could take it the wrong way and then that’d be it, you get the silent treatment, they wouldn’t want to speak to yer, or they wouldn’t open up to how they were feeling, so if you sort of knew what sort of things would set her off, then it, it would, it would help to avoid or maybe better ways of getting your point across without ... just upsettin’ ‘er.” [P8] |
| 3.3 Uncertainty about the future | “And maybe, it was just cause I could see just how much distress [wife] was in, being psychotic probably two weeks and it was, I just wanted to know that it was going to get better basically. For both of them, y’know. It was horrible, yeah.” [P6] “Yeah ... I mean if you’ve got someone, erm, I suppose if someone goes into the mother and baby unit who’s been through it, who’s strong enough to go back there, you know someone who’s positive and outgoing and goes in, it’d be like a breath of fresh air ... er, “I was, I was the same as you, look, look at me now.” [P10] |

“Just the lack of information and especially about, about how she was travelling, because she um yeah she wasn’t getting any better for a while, and I was like “what is going on?” and no one really answered ((emotional tone)).” [P6]
| 3.4 Uncertainty about my infant’s care | “I found it very hard to relinquish the care of him and concerned, as I say that she was still very poorly (sighs) erm, and a bit unsure about what that would mean (breaths deeply) and, y’know, what her care of him would be. Erm, so yeah, the having (sighs) having the nursery nurse on site, erm most of the time having one of them at any one time, yeah that meant quite a lot for me personally.” [P5]  
“I could do anything I wanted to with [infant] ... if I wan’ed to sit with her, pick her up, hold her, feed her, change her nappy, y’know anything like I feel like, yeah I wasn’t watched over, y’know, all the, how they do it is very clever, y’know, you don’t feel like you’re getting, y’know, the eye over your shoulder all the time.” [P4] |
| 4. Barriers to support | 4.1 Personal barriers | “… it was hard to talk about without getting upset .. still can be sometimes, but, erm ... at the time it was very raw, and just, it’s not so bad, it’s when, you know when you’ve injured yourself and someone says, “are you alright?”, it’s, it’s that’s when, you don’t want someone to be nice to you.” [P10]  
“I think it was, just as I’ve said I just think it wasn’t my focus at all. Erm, y’know I’m not saying I’m in any way kind of heroic or selfless. I think you just kind of get consumed by the situation. Y’know you’ve got one, in the next case two small children depending on you. Erm and you’ve got er, y’know I’ve got a wife who was not able to function at all in those times really. And, I think that was enough in my head. I don’t think I had the space to kind of really even consider erm looking after anyone else, including myself in amidst that.” [P5] |
| 4.2 Barriers relating to the MBU | “[I felt] ‘my wife’s the ill one, concentrate on her ... don’t worry about me, if she’s better, I’ll be better’, in fact that’s what I used to say, ‘as soon as she’s better, I’ll be better’”. [P10] |
“Erm, so there’s a lot of shifts change, the time you can go can change and vary massively erm so seeing constancy of relationship I think is often a huge issue with any provision of care. So if I knew it was ‘X’ nurse who knew what was going on with me, not in any great detail but just who I would speak to to advocate myself then I think that above all else would be helpful.” [P7]

4.3 Barriers in the relationship between participants and the MBU

“Erm, possibly, just, just because, I don’t know ...(sighs) I know you shouldn’t, but sometimes you might have talked to a male, like you might not feel to talk to a, a woman about things. Erm ... not, not to be sexist or anything like that, it’s just what you feel comfortable with.” [P8]

“Er, no, no it weren’t particularly needing it would have just felt more but it just seemed to be a sincere question, the fact that they were asking me just in the corridor as I arrived .. er .. it was just in passing, if you know what I mean.” [P10]

5. Facilitators to support

5.1 Quality of the relationship

“...there was a sense of time I guess on there that people, that the staff did have a bit of time to spend with you and sit with you and talk to you and they were, they y’know, just on a human level they kind of wanted to have turn cuddling the babies and chatting to my son when he was in and, and stuff, so it did, it all felt more, a much more kind of supportive environment.” [P5]

“Erm, they were the experts, we, we you know, I had every confidence in in their advice. Again, something that, you know, is alien to yer, erm. You have to basically go off what they were saying but erm, erm, I felt, yeah I had every confidence in in what they were advising.” [P4]
### 5.2 Efforts made by staff

“[wife] needed a breast pump, and, erm, I hadn’t got there yet in the morning and one of the staff drove to ‘Mothercare’ and bought her one, erm, you know, that’s above and beyond, they didn’t have to do that, but that’s what [wife] wanted so, or needed so they offered to go do it .... so .. yeah, they were really looking after us with that.” [P9]

“...beyond the poster [advertising support for fathers], actually somebody be it the doctor or psychologist or social worker reaching out and saying “as a partner we recommend that you consider talking to our social worker or counsellor or whoever, cause this is stressful for you”. So that being acknowledged and erm the link being made in a face-to-face way, saying “this is the person you can talk to if you want to, and we want to make time to talk with you, to make sure you’re ok”. [P7]
Figure 3: Model of findings in relation to the timing, content and delivery of support

<table>
<thead>
<tr>
<th>TIMING</th>
<th>CONTENT</th>
<th>DELIVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-admission</td>
<td>Mental health information and warning signs</td>
<td>Antenatal classes</td>
</tr>
<tr>
<td>MBU admission</td>
<td>Clear MBU pathway and partner’s/couple’s involvement in admission</td>
<td>Trained professionals and good links with MBUs</td>
</tr>
<tr>
<td>MBU stay</td>
<td>Involvement in care/progress updates/consultation on care</td>
<td>Working together with staff- collaborative approach</td>
</tr>
<tr>
<td></td>
<td>Information given regarding the ward, the diagnosis, treatment plan and updates on progress</td>
<td>1:1 meeting away from wife to explain/clarify Individualised information Treating clinician- up-to-date and knows wife well Updates to be given automatically</td>
</tr>
<tr>
<td></td>
<td>Information on how to support wife (e.g. triggers, coping strategies, ways of responding)</td>
<td>1:1 meeting away from wife Man with lived experience</td>
</tr>
<tr>
<td></td>
<td>Information about recovery</td>
<td>Professional, woman with lived experience</td>
</tr>
<tr>
<td></td>
<td>Specific support for partners, inclusion in activities, consideration of needs (e.g. food, visiting, staying) Support with trauma, wellbeing advice</td>
<td>Private space, professional 1:1, peer support, individualised support Staff being approachable/accessible/ building relationships and reaching out proactively</td>
</tr>
<tr>
<td></td>
<td>Updates about infant/Parenting support/advice Space alone/privacy/’Homely’ ward environment Inclusion in parenting activities</td>
<td>Trained childcare professionals Whole family approach</td>
</tr>
<tr>
<td>MBU discharge</td>
<td>Individualised discharge process and involvement in discharge planning</td>
<td>Formalised and individualised discharge process</td>
</tr>
<tr>
<td>Post-discharge</td>
<td>Support post discharge e.g. advice on how to support partner</td>
<td>Support from community mental health teams, peer support, people with lived experience</td>
</tr>
</tbody>
</table>

**PERSONAL:**
- ‘Being strong’, protecting self, fear of stigma, embarrassment, lack of time and ‘headspace’

**MBU RELATED:**
- Focussed on needs of partner/infant, Female-oriented environment

**RELATIONAL:**
- Wife’s presence, relationship and communication with staff, no contact with other partners

**RELATIONSHIP:**
- Staff as approachable, accessible and taking time to get to know Partners’. Partners’ trusting staff as experts

**EFFORT:**
- Being flexible, going beyond role, whole family approach, reaching out and highlighting support

**Facilitators:**
- Role for clinical psychologists
  - Developing resources for partners
  - Providing psychological formulations and therapeutic support
  - Providing training/supervision to staff
Clinical implications

The participants from the current study provided rich data on the various ways that MBUs can support them, resulting in clear recommendations which are outlined in Figure 3. Drawing on the literature, and in collaboration with clinical psychologists, MBUs could develop an information and welcome booklet for partners which covers the following: 1) an introduction to the MBU, including policies, procedures, and an introduction to team members, 2) information about common diagnoses and usual treatments, 3) advice on how men can support their partners and be involved in their care, 4) advice and information regarding supporting their own emotional wellbeing during this time in the family’s life, 5) information on what emotional support is available to them, including information on helpful websites and charity organisations, and pathways to seek more formal support, and 6) accounts from people with lived experience and links to peer support organisations. This booklet could be specific to a particular MBU, or it could be a generic one applicable to most MBUs with some additional idiosyncratic information. Finally, the information could also be offered as a centralised resource, such as an Internet site.

An important finding is that male partners would like an individual meeting as well as written resources, and for this reason in addition to an information booklet, MBUs should invite partners to attend weekly ward round meetings in order to provide information about diagnosis, treatment and prognosis specific to their spouse, allowing male partners to share their concerns and ask questions. Partners should therefore be encouraged to attend ward round meetings, whenever possible.
However, not all partners would be able to attend ward round meetings, which occur during working hours; for example, some men may not have the support of employers to attend. Thus, a third approach would be for a MBU staff member to offer a face-to-face meeting or a telephone call. This approach should also be offered to partners who wish to discuss concerns away from their partner.

As participants emphasised their emotional support needs, a fourth approach could be for the MBU staff, in consultation with clinical psychology, to offer male partners advice on the following: 1) monitoring their own emotional wellbeing, 2) managing difficult feelings and experiences, such as shock, stress and anxiety, through the use of stress reduction exercises and self-care information and 3) managing uncertainty and anxiety related to their spouse’s diagnosis, treatment and recovery through self-help materials or staff consultation. The average admission to a MBU in the UK is six weeks, although this can vary (Turner et al., 2017), and often a lengthy assessment is required to establish exact diagnosis, which may cause delays in providing information to partners. Furthermore, recovery information is likely to be generic and not individualised, so learning how to manage uncertainty is crucial for partners. In some cases it may be appropriate to consult with the MBU clinical psychologist about how the male partner could be best supported either via MBU staff, referral to formal services or via clinical psychology input.

There are clear recommendations for MBU staff in terms of taking a proactive approach to including partners, building positive and collaborative relationships with them and communicating sensitively with them during the
woman’s admission. Clinical psychologists are well placed to provide relevant staff training and supervision, taking into consideration the barriers outlined by this study. Clinical psychologists could also advise staff on how to empower the man to become more actively involved in their partner’s care as well as their infant’s care, such as having sessions with nursery nurses.

In England, MBUs have CQUINs with targets, which they have to demonstrate they are meeting. Support of partners has been set as a CQUIN priority recently (NHS England, 2016). For MBU managers, this study identified barriers to supporting partners as relating to staff resources. Having team members who are dedicated to supporting men would help staff build positive and effective relationships with partners. However, due to low staffing levels, MBUs sometimes have to rely on agency staff that may not have this experience. Providing information on which experienced staff members are on duty each shift could help reduce partners’ uncertainty about who they can approach.

Participants spoke about wanting a smoother pathway between community and inpatient services. The ‘Five Year Forward View for Mental Health’ (NHS England, 2016), which aims to establish outpatient perinatal mental health services linked to each existing MBU in the UK, is a promising recent development. A recommendation would be for these outpatient services to incorporate the needs of the woman’s partner in their plans. It is important to note that funding agreements, as well as local and national policies restrict where MBU resources are directed, and therefore links with local and national charities could allow for additional support to be provided to partners. As participants spoke about their fear of stigma relating to seeking support, a final
recommendation is for national and international mental health awareness campaigns, and government legislation to support change at a wider societal level in order to increase public awareness and to reduce stigma of mental health problems.

**Limitations**

The study used a convenience sample of male partners, who were willing to share their views and experiences and were able to articulate those. As participants were living in the UK and Australia, the findings were not just restricted to UK MBUs and one healthcare system. The participants reflected on experiences that occurred eight years or were as recent as seven months ago. Changes to service requirements for MBUs in England have meant that practices have recently changed (NHS England, 2016). However, four of the participants who were interviewed had experienced their partner being admitted to a MBU less than 12 months ago. Due to ethical reasons, information pertaining to the women’s diagnoses, length of admission or treatment history was not obtained from clinical records. These factors could have influenced the participant’s support needs. Lastly, the sample size of ten participants may be viewed as a possible limitation to the analysis; however, data saturation for this study was assessed at the level of code saturation, and code saturation was reached by ten interviews in this study. This sample size is consistent with research showing that code saturation can be reached between seven and 16 interviews (Guest et al., 2006; Namey et al., 2016).
**Recommendations for future research**

Several recommendations for future research arose from the current study. Firstly, this study highlights the importance of involving both fathers and mothers of lived experience of perinatal mental health services in research into service improvements. Secondly, there is need to investigate the stigma that prevents men seeking-help, the impacts of this and how it can be reduced. Thirdly, it is important to explore staff attitudes to involving fathers in perinatal mental health services, and what barriers exist to including them in the woman’s treatment from a healthcare perspective. Fourthly, the current study could be extended to explore the specific support needs of female partners, and other family members and supporters (such as grandparents and community neighbours). Lastly, future research could also explore whether a more structured and systematically delivered psychosocial intervention could reduce men’s concerns and reduce uncertainty and anxiety in men and lead to positive family outcomes.

**Conclusions**

This qualitative study emphasises how having a partner who has been admitted to a MBU for the treatment of postnatal mental health problems is distressing for men. The men in this study experienced high levels of uncertainty and concern for their partner and infant. Crucially, the way in which support is offered to men before, during and after their spouse and infant’s admission, is key to men adjusting and coping during this time, and builds their capacity to support their partner. Men want to be involved and included in the care of their partner and baby, and wish for advice and information to be given to them.
proactively by staff. The findings from this study were informed by reviews, secondary analysis and analysis of current data, and make clear recommendations for how MBUs could improve the support they offer to male partners. This study makes clear recommendations for a tiered support system that provides information, advice and emotional support, including: 1) a welcome booklet, 2) face-to-face support via ward rounds or individual meetings, and 3) individual tailored emotional support and wellbeing advice.

Acknowledgements

The authors wish to express their sincere gratitude to all the men who took part in our study and who shared their time and experiences; without their support, this study would not have been possible. We would also like to thank Action on Postpartum Psychosis and the MBU staff and their ward manager for helping with recruitment for this study.
References


Ruffell, B., Smith, D. M, & Wittkowski, A. (under review). The experiences of male partners of women with postnatal mental health problems: A systematic review and thematic synthesis of the qualitative literature. For submission to *Social Science and Medicine*.

Paper 3:

Critical reflection of the research process

This paper is a reflective piece and not intended for submission.

Word count: 5,022 (excluding references)
Overview

This paper presents a critical appraisal and personal reflections on the research process throughout the whole body of the work, including the systematic review, the national survey, the secondary data analysis and the empirical study. Decisions made regarding design and methodology will be discussed, including strengths and limitations of these approaches. The researcher’s reflections of the research process as a whole will be offered.

The complete body of work

The work aimed to develop research to support the development of psychosocial support interventions for male partners of women admitted to mother and baby units (MBUs). The project was structured according to the Medical Research Council (MRC) guidance on the development and evaluation of complex interventions (Craig, Dieppe, Macintyre, Michie, Nazareth, & Petticrew, 2008), which outlines three stages: Stage 1 Identifying the evidence base; Stage 2 Identifying/developing theory; Stage 3 Modelling processes and outcomes. In line with this guidance, the project was developed to consist of three phases: a systematic literature review and synthesis of relevant research alongside a national survey of MBUs in the UK were part of Stage 1; a secondary thematic analysis of qualitative interviews of male partners of MBU patients formed Stage 2, and; Stage 3 consisted of an empirical qualitative study. The empirical study was informed by Stages 1 and 2 and explored what psychosocial support male partners of MBU patients would find helpful, including a model of the findings. Figure 4 illustrates how the distinct phases of the project combine to produce the complete body of work.
Figure 4. Illustration of the distinct components of the whole body of work in relation to the MRC guidance

Stage 1.1: Systematic literature review
A synthesis of qualitative research, found that men experience a range of negative emotions in response to the challenges of having a partner with postnatal mental health problems, and that their coping can be helped or hindered by the response of their support networks (including professional support).

Stage 1.2: National survey of MBUs
A survey of ten MBUs in the UK highlighted that MBUs offer support to male partners, but that there was diversity in what support was being offered and how this support was being delivered, and that services experienced a number of barriers to delivering support.

Stage 2: Secondary data analysis
Secondary analysis of interviews with male partners of MBU patients found that men wanted support in relation to being a man, a father and a partner whilst the woman and infant were admitted to an MBU.

Stage 3- Empirical Study
1:1 semi-structured interviews conducted with male partners of MBU patients.

Interview schedule devised, informed by results from stages 1-2, including specific questions relating to content, delivery and timing of support offered to male partners by MBUs.

Findings relating to what support male partners want, how this can be delivered by MBUs, and when this is required.

Clinical outcomes
Results from Stages 1-3 point towards clear clinical recommendations for perinatal mental health services including male partners and offering them support. A key suggestion is for a tiered support package for male partners of MBU patients to be developed and trialled.
Paper 1 (Stage 1.1): Systematic literature review

Topic selection

The overall aims of the research project were considered when choosing a topic to focus on for the systematic review, including what contribution the researcher wanted to make to the literature and the clinical field of perinatal mental health. The researcher was particularly interested in systemic factors influencing mental health outcomes and the use of service user experience to guide service development. An initial scope of the literature found recent reviews on MBU research (Connellan, Bartholomeaus, Due & Riggs, 2017; Gillham & Wittkowski, 2015), and of research exploring partners’ experiences of perinatal mental health services more broadly (Lever Taylor, Billings, Morant & Johnson, 2017). However, no review had explored research specifically relating the male experience of having partner with postnatal mental health problems. As support needs are likely to be guided by responses to, and the impacts of, the experience of postnatal mental health problems, it was decided a review of research into the broad spectrum of experiences, including but not exclusively MBU admission, would be necessary. This review was timely, as research into this area is growing, and therefore a comprehensive review with a broad scope could contribute to current knowledge and understanding within this field.

Inclusion and exclusion criteria

The primary aim of the review was to explore men’s experiences of having a partner with postnatal mental health problems, which determined the inclusion and exclusion criteria. During an initial scoping exercise it became clear that
although some studies included male partners of women with postnatal mental health problems as participants, their voices were not reported as separate from others. Therefore, rather than include these studies, one of the exclusion criteria was ‘studies that did not explicitly report the voices of the male partners as separate from other people’. This ensured that the data were tied to the experiences of men exclusively so that the results remained valid and relevant to the research questions. Good agreement with an independent screener suggested that the inclusion and exclusion criteria were clear comprehensive.

Search strategy
The SPIDER search tool (Sample, Phenomenon of interest, Design, Evaluation, and Research type) was selected because it has been widely used and fitted with the research question (Cooke, Smith, & Booth, 2012). Some limits were applied to improve the utility of the search. For example, design, evaluation and research type were not used, to ensure a broad search. Additionally, since the research topic was men’s experiences, limits based on gender were applied to each database so that only papers relating to men were returned. Only peer-reviewed journal articles published in English were included. However, no limits were placed on publication date. Seven additional papers relevant to the review were identified through hand searching Google search engine, citations in included papers and recent publications from journals publishing included papers. The researcher checked the keywords of these articles and found that although they included keywords also included in the search, the combination of keywords with conjunctions meant they were not returned in the search. A
second search was trialled removing these conjunctions, which returned over 30,000 articles, and was therefore considered too broad.

**Quality appraisal**

Currently, no standardised method for appraising the quality of qualitative research exists (Tong, Flemming, McInnes, Oliver & Craig, 2012). Thus, several tools were considered for appraising the quality of the studies included in the meta-synthesis. According to Tong et al. (2012), the quality appraisal for thematic synthesis should have “criteria related to aims, context, rationale, methods and findings, reliability, validity, appropriateness of methods for ensuring findings are grounded in participant perspectives” (p.5). The CASP tool (Critical Appraisal Skills Programme, 2018) was considered to meet these aims well (See Appendix S) and it is a widely used tool for assessing the quality of qualitative research. The CASP tool includes a comprehensive list of essential criteria, with some guiding information for making the decision. In keeping with recommendation from research that tools can be adapted to suit the review (Tong et al., 2012), response items were assigned a score (i.e. ‘no’= 0, ‘can’t tell’=1, ‘yes’= 2) to derive an overall score for each article, so that comparisons between the quality of the studies could be made.

**Analysis**

As no standardised method currently exists for synthesising qualitative research (Britten et al., 2002), several factors were considered in making the decision, including the type of synthesis to be conducted, which is an important consideration given the varying aims of the distinct methods. The approach
chosen was thematic synthesis, as outlined by Thomas and Harden (2008), which seeks to find patterns within the reported results across studies. Thematic synthesis is described as a realist approach, which is often used to inform policy and practice, including health services (Barnett-Page & Thomas, 2009; Tong et al., 2012). Hence, it was appropriate to the aims of this review. In interpreting the findings from the synthesis, a formulation was produced by the researcher, to help understand the connections between the findings, illustrated by Figure 5. As can be seen in this formulation, aspects relating to being a partner and a father within the context of maternal postnatal mental health problems are associated with the emotions they experience. Participants coped with these feelings in a number of ways and reported different outcomes of coping. Participants reported several barriers to seeking support as well as suggesting ways in which these barriers could be reduced. This formulation aided the researcher’s interpretation of the findings, which were reported in themes and subthemes in the final paper.

Limitations

One clear limitation of the review was that only articles published in English were included, which limited the scope of the research and excluded countries in which English was not the native language. Thus, a language bias is possible. Research from six countries (the UK, Australia, Canada, USA, Japan and Sweden) were included in the review, and the patterns and commonalities described between them suggest a transferability of the findings. However, MBUs also exist in countries within Europe (France, Belgium, the Netherlands, Hungary, and Germany) and outside Europe (Israel, India and Sri Lanka), that
were not included in this review (Connellan et al., 2017). It is likely that the different cultural and societal structures existing between these countries impact upon healthcare provision and participants’ experiences and needs. Therefore, a review that is not restricted by English language should be undertaken in future to consider the breadth and diversity of experience.

Walsh and Downe (2006) state that research which is used to inform healthcare must be critiqued. All of the studies scored 16 or above using the CASP tool (Critical Appraisal Skills Programme, 2018). One study which was returned from the database search did not meet the two screening items on the CASP. Walsh and Downe (2006) suggest that studies scoring low in quality rating should still be included, but that this should be accounted for when synthesising the results. However, it was decided that in light of the gaps in methodological quality, this study should be excluded from the review. Only four studies clearly commented on reflexivity in relation to the relationship between the researcher and participants (CASP question six). Berger (2003) argues that reflexivity is paramount to the quality of qualitative research, because it acknowledges the influence of the researcher on the research process, which is vulnerable to bias. As published research was assessed, it is possible that some studies considered this but it was lost when the research was submitted for publication due to stringent word counts.

The kappa score for the inter-rater reliability for the quality appraisal was 0.65, indicating a good level of agreement. One possible explanation is that some criteria on the tool were more vulnerable to subjective interpretation from the rater, and thus increased discrepancies between scores. However, it is important to note that the quality rating scores are subjective interpretations.
made about the quality of the research, and are only suggested as a guide to the
reader when considering the studies included in the review.

*Dissemination*

Authors Beth Ruffell, Debbie Smith and Anja Wittkowski have written this
review up for submission for publication in the journal *Social Science and
Medicine*. 
Figure 5. Formulation of the findings from the thematic synthesis

Aspects of experience and resulting emotions

Shock/ trauma/ confusion
- Diagnosis/ change in partner’s behaviours
- Unmet expectations of parenting

Loss
- Loss of partner/intimacy/ relationship
- Loss of trust and communication

Resentment/ frustration
- Parenting alone

Depression
- Criticised/ excluded in parenting

Isolation
- Parenting alone

Worry
- Future family planning
- Separation from baby
- Partner’s treatment and recovery
- Unpredictable moods/behaviours

Helplessness
- Not knowing how to help partner

Guilt
- Harm to baby/partner

Strength/ resilience and growth
- Bonding with baby

Joy
- Stepping up

Outcomes of coping
- Increased isolation
- Increased confidence, strength and resilience
- Increased control and empowerment
- Reassurance
- Reduced burden

Ways of coping
1) Withdrawing from partner, social network and distancing from feelings
2) ‘Being strong’ for family and ‘bridging the gap’
3) Problem solving (i.e. seeking information, involvement and resources)
4) Seeking support from professionals, peers and support network

Ways to improve support
- Increasing emotional and professional support
- Improving quality of information and resources
- Proactive and flexible support from professionals
- Increased access to peer support
- Increased public awareness
- Support from employers (e.g. time of work)

Barriers to seeking support
- Feeling unable to reach out
- Not understanding partner’s needs
- Wanting to protect family
- Partner not wanting help
- Support network’s lack of understanding
- Professionals’ lack of awareness
- Insufficient information, resources, and advice
- Ineffective communication with professionals
- Being excluded by professionals
Stage 1.2: National survey of MBUs in the UK

Aims

In developing the empirical study, it was important to explore what support was currently being provided by services to male partners of MBU patients. Therefore, a survey of MBUs in the UK was conducted to identify what support was actually offered, and what support services wished to see developed in the future, as well as identifying any barriers to MBUs providing support. The results of this evaluation were used to inform the interview schedule for the empirical study, bringing in methods of support that were already being offered to explore participants’ views of these.

Designing the project and gaining ethical approval

A survey of open-ended questions was devised, which gathered specific information on support that was being offered to male partners of MBU patients, including specific questions on: 1) support methods, 2) delivery of support, and 3) any barriers or facilitators to providing support experienced by MBUs (Appendix V). Ethical approval was provided by the Manchester Mental Health and Social Care Trust, and all 17 MBUs in the UK at the time of the survey were contacted and invited to take part.

Conducting the survey

At the time of conducting the survey, a CQUIN had been issued to MBUs, which expected services to provide support to partners and family members, although no specific guidance around what this should look like was outlined (NHS England, 2016). This was an advantage for the survey, because it meant
that this topic was on the agenda for MBUs and that support interventions were being rolled out.

Limitations

One potential limitation of the survey is that it was conducted over the telephone/email and was self-reported by MBU staff, which might have made it vulnerable to bias. An alternative method would have been to visit the MBUs and establish what they were providing, using certain criteria, which may have added a level of richness to the results. However, as the project was not funded, there were time and resource restraints. The chosen method had benefits in terms of minimal burden to services, who could choose a time to complete the survey that was convenient for them.

Another limitation was that only ten MBUs participated in the survey, and it was therefore not a complete picture. One possible reason for this is that MBUs, whose staff teams are already very busy and stretched in terms of resource, prioritise the service in relation to their primary patient, namely the woman. This may have meant that as the project related to the needs of male partners, it was seen as a lower priority for MBUs. A lot of effort and time was required to generate interest and collect the data to overcome this barrier. The researcher attended the Perinatal Quality Network Annual Forum in London on 15th November 2017, and had the opportunity to talk to some MBU staff that spoke about their efforts to engage men, but that they had found this challenging for several reasons, which was in keeping with the survey results.
Dissemination

The results of the national survey were disseminated in a number of ways. Firstly, a report was completed and shared with the supporting NHS Trust and participating MBUs. In January 2018, the study was published in *Women's Health Research Journal* (Turner, Garrett & Wittkowski, 2017; open access journal). The study has also been disseminated via poster presentations at the following three conferences: 1) *37th Annual Society for Reproductive and Infant Psychology Conference* (12 and 13th September 2017, York); 2) *Perinatal Quality Network Annual Forum* (15th November 2017, London), and 16th *World Association for Infant Mental Health World Congress* (26th-30th May 2018, Rome) (Appendix T).

Stage 2: Secondary data analysis

**Aims**

The aim of this phase was to explore what male partners of women admitted to MBUs had previously said in terms of their support needs to ensure the questions contained within interview schedule for the empirical study were derived from personal accounts from members of the population from which the empirical study would be recruiting.

**Designing the project and gaining ethical approval**

The primary supervisor for the current thesis project was also supervisor of another project, which had interviewed male partners of MBU patients (Reid, Wieck, Matrunola & Wittkowski, 2017). This project had the aims of exploring fathers’ experience of their partners mental health problem and how this
impacted their relationships, their view of MBU services and their experiences of child and family services. Although some preliminary themes around MBU support were reported by this study, the current study aimed to analyse the interviews again to identify whether participants had said anything in addition to these in relation to support. The North West Research Ethics Council and the Health Research Authority granted ethical approval for this study (Ref: 12/NW/0187, Appendix N).

Data analysis
The data contained in the original transcripts from interviews were analysed using thematic analysis to identify patterns and themes (Braun & Clarke, 2006). All transcripts were read and analysed independently by two authors (BR and DS), to ensure validity and reliability of the findings, and the whole research team agreed the final themes. During analysis, the researchers were careful to ensure that the findings were relevant to aims of the empirical study, and were distinct to the findings already reported by Reid et al. (2017).

Findings
Three themes were identified in relation to what support men wanted from the MBU, namely: 1) Being a man, 2) Being a father and 3) Being a partner. Men described their awareness of being a man on a female-dominated ward, and feeling as though they were intruding, and that they were not included. In terms of their role as a father, participants emphasised the importance of having private time with their infant, support from staff around parenting, and they expressed concerns relating to their infant’s care during admission. In relation
to their partner, men requested information on how they could support their spouse during her admission, and wanted time to function as a family unit. These findings were used to inform the questions and prompts used in the interview schedule for the main study.

**Strengths and limitations**

An advantage of secondary data analysis is that it allows for data to be analysed without the need to collect new data, which reduces participant burden. As secondary analysis utilises data that would otherwise not be reported, it can also be argued that this is ethically advantageous. One limitation to conducting secondary data analysis is that as the researchers were not involved in the primary study, they may have missed vital information contained within the knowledge derived from conducting the interviews. The use of a third researcher who was involved in the original study to check the reliability and validity of findings may have gone in some way to compensating for this.

**Paper 2 (Stage 3): Empirical paper**

**Aims**

The aim of the empirical study was to explore the experiences of male partners of MBU patients and their preferences regarding the content, delivery and timing of support. This project was built on the findings from the systematic literature, the national survey, and the secondary analysis to identify male partners specific views and preferences regarding support.

**Designing the project and gaining ethical approval**
The originally proposed consent process required the woman to consent to the research before approaching potential participants, which was used in a previous study (Reid et al., 2017). However, the proposal was reviewed by the North West Research Ethics Committee (REC), who recommended the consent procedure be changed to remove the need for the woman as gatekeeper, stating that this may prevent inclusion of willing participants whose experience was valuable and separate from that of their partners. The consent process was amended and accepted by the REC (Ref: 12/NW/0187, Appendix U).

Interestingly, nine out of the ten men who participated in the interviews heard about the study through women who had previously been MBU patients (eight who were partners and one female friend). So, although women were seen as potential barriers to men participating in research, the opposite was true in this study, and women were facilitators to recruitment. This is in-keeping with past research, which has found that women with postnatal mental health problems want their partners to be supported and feel this is necessary for their own recovery (Dennis & Chung-Lee, 2006; Doucet, Letourneau & Blackmore, 2012; Plunkett, Peters & Wittkowski, 2016; Robertson & Lyons, 2003).

However, it was still possible that in the course of this study some men could have been prevented from participating in the study if the woman’s consent was required first.

Recruitment

The biggest challenge to the study was recruitment, which was perhaps not surprising with consideration to the barriers that exist for participants, namely: 1) stigma around sharing experiences and seeking support, 2) the complexity
that fatherhood and mental health problems adds to people’s lives, and 3) the marginalisation faced by men in child development research and perinatal services. Therefore, it can be argued that this study recruited men from a hard to reach population, and in doing so amplified their voices within research, which is a significant achievement. The original proposal was to recruit participants from two MBUs. These MBUs were chosen because the primary supervisor had professional and research links to them, and research studies were already being conducted within them, providing resources and opportunities for the current study. However, due to cuts to resources, staff changes, and their involvement in the development of community perinatal mental health services, the capacity for the MBUs to support recruitment was limited. After several months of perseverance a decision was made to change the recruitment process to include participants whose partner had been a historic MBU patient and to advertise the study online (on Facebook and Twitter). The ethical approval process required for this change meant delays to recruitment. Maintaining a visible presence on social media via Twitter required a significant level of dedication and time and resulted in only one more participant. However, 80% of participants were recruited via Facebook (n=8), through a charity organisation Action on Postpartum Psychosis (APP). This was a particularly helpful route for recruitment, as APP has a wide following and therefore broad reach both nationally and internationally; APP was very supportive of the project. However, the disproportionate number of participants being recruited via this group could mean that more of men whose spouse had experienced postpartum psychosis took part in this study.
Furthermore, the study may have reached only families who were active on social media, and therefore likely to be motivated and engaged.

*Experience of interviews*

Semi-structured interviews are a common method used in qualitative research (DiCicco-Bloom & Crabtree, 2006), and are ideal for exploring participants’ experiences of healthcare (Pope, Van Royen & Baker, 2002). The questions and prompts outlined in the interview schedule were guided by findings from the systematic literature review, national survey and secondary data analysis, and were devised as explorative open-ended questions about participants’ experiences which did not influence responses (Fossey, Harvey, McDermott & Davidson, 2002). Nine interviews were conducted via telephone or Skype, which is an effective and appropriate method for semi-structured interviews (Cachia & Millward, 2011). Although telephone/Skype interviews were advantageous in terms of flexibility, allowing interviews to be conducted at a preferred time for participants, and ensuring a wider geographical reach, conducting interviews in such a way meant that non-verbal cues which may have helped build rapport were lost (Fontanella et al., 2006). The researcher found that her clinical training enhanced the interview process, allowing her to notice, respond to and explore important aspects of participants experiences, however she also noted the need to maintain an awareness of the focus of the interviews, which was to collect research data and not to provide therapeutic intervention. However, during the course of the interviews, participants commented that sharing their experiences, sometimes for the first time, had felt like a therapeutic process. Two participants in particular commented that the
interview had helped them notice that they might benefit from further therapeutic input, and this insight motivated them to seek this. It can be argued that although unintended, this is an important and helpful outcome for the participants from this study.

Reflexivity

Berger (2003) argues that reflexivity is an important process in ‘meaning-making’ within qualitative research, where researchers ‘bracket out’ their experiences, formed of their beliefs, attitudes, cultural identity and experiences. The researcher kept reflective notes from the interviews to aid reflexivity. Author BR is a white British woman, who at the time of conducting the research was in her final year of a clinical psychology doctorate. She has professional mental health experience and training, and has held both research and clinical roles, including perinatal mental health and qualitative research. This research grew out of an interest in involving men within perinatal mental health services. She noted that as a female with no personal experience of motherhood, she was an ‘outsider’ within the interviews (le Gallais, 2008), which may have impacted the meaning within her interpretations. Furthermore, her gender, which was known to participants, may have influenced what the men felt safe to talk about within the interviews. Participants in the study said that although the female-dominated environment of the MBU was not experienced as a barrier for them, having a man to speak to might have provided a different type of conversation. Thus, including a male researcher, possibly with lived experience of maternal postnatal mental health problems might have aided the interview process.
Data analysis

Thematic analysis, outlined by Braun and Clark (2006), was used to identify patterns within and across the whole interview dataset. Six interviews were transcribed by the researcher, but due to delays in recruitment, the remaining four were transcribed by an independent member of staff at the University of Manchester, who had extensive experience in transcription and adhered to professional and research ethical guidelines around confidentiality. Although this may have impacted the researcher’s familiarity of the transcripts, she listened back to the interviews and read the transcripts in parallel to check for accuracy and to help guide analysis. The thematic analysis was conducted using Microsoft Word, sections of interviews were highlighted and coded, and extracts were collated under themes and represented in tables. This helped the researcher remain close to the data and ensured the accurate recording and sharing of the analysis between the two independent researchers, for reliability checking. Participants did not provide feedback on the findings; however, they were asked whether they would like the findings to be shared with them at the end of the study.

Limitations

The current study was enriched by the inclusion of partners from different UK regions (rural/urban), as well as non-UK countries, who had experienced varied experiences of services, including types, access and availability. Therefore, an important finding is about the transferability of partners’ experiences, and how they wished to be supported by MBUs. However, there are some limitations to this study, which should be considered when
interpreting the results. Firstly, the participants were mostly from English-speaking countries and from backgrounds of relative socioeconomic advantage. This may have biased the recruitment to include more motivated and ‘resourced’ participants. However, participants’ motivations for participating varied between having both positive and negative experiences. Secondly, although basic demographic data were collected, information was not collected on participant’s mental health history, which could have influenced their support needs. However, Letourneau and colleagues (2012) compared men who reported depressive symptoms associated with their partner’s postnatal mental health problems and those who reported no symptoms, and found that they were indistinguishable in terms of support needs and preferences. Furthermore, due to consent procedure changes pertaining to not seeking the women’s consent, data on the women’s diagnoses, treatment or length of admission could not be collected. These factors could have influenced the participant’s support needs, and thus future studies should collect such data. Thirdly, for some participants, their partner’s MBU admission had occurred several years ago. As perinatal mental health services have undergone a lot of changes in recent years, it is possible that some of these experiences are unlikely to be relatable to admissions to MBUs of today. However, many of the findings are similar to those conducted with participants whose partner was admitted to a MBU more recently (Lever Taylor et al., 2017; Ruffell et al., under review) as well as information from a recent survey of MBUs in the UK (Turner et al., 2017), and therefore should not be disregarded. Lastly, the study recruited participants from different geographical regions both nationally and internationally, whose experience of services was likely to be diverse, but as
the study did not collect data on service structure and provision, it is not possible to comment on how much of an influence this had on participant experiences. Future research could collect data pertaining to the structure and provision of MBUs accessed by participants to allow for these factors to be considered in the data analysis.

Implications of the results
This study identifies clear outcomes for service development in terms of supporting male partners of women admitted to MBUs. The project also highlights findings that may be relevant to community perinatal mental health services and antenatal services. The methods used to collect, analyse and present the findings have been selected and applied to be most useful to service development, with the hope that they can be easily translated into clinical practice. Clear implications have been identified for clinical psychologists in terms of service development, developing resources and supporting staff to improve the ways in which they meet the needs of this population. It can be argued that as the patient within the MBU is the woman, and research has demonstrated that once the woman’s mental health improves so does her partners (Lovestone & Kumar, 1993), there is little need to improve support for male partners. However, research has also emphasised the key role men play in outcomes for women (Burgess, 2011; Grube, 2005; Reid et al., 2017; McGrath, Peters, Wieck & Wittkowski, 2013; Plunkett et al., 2016) and their children (Di Folco & Zavattini, 2014; Mezulis, Hyde, & Clark, 2004), and the impact of maternal postnatal mental health problems on men’s mental health (Harvey & McGrath, 1988; Lovestone & Kumar, 1993; Ruffell et al., under review). The
systematic review by Ruffell et al. (under review) demonstrated that men cope in diverse ways, some of which mirror problem-focused and emotion-focused coping described in the literature (Folkman & Lazarus, 1980). This review suggested that such theories could be used to guide support packages for men. Therefore, the need to improve support for men and promote their effective coping could prevent unnecessary suffering and improve outcomes for men, women and their infants.

*Future research*

Future research should seek to include a broader spectrum of experiences, which considers specific differences in cultural and social structures, mental health presentations and service provision. Furthermore, future research should trial an intervention for psychosocial support developed from the current project, involving service users in the development and evaluation process.

*Dissemination of the project findings*

Authors Beth Ruffell, Debbie Smith and Anja Wittkowski have written this study up for submission for publication in the *Journal of Clinical Psychology and Psychotherapy*. The authors also plan to submit this project for presentation at the *Perinatal Quality Network Annual Forum 2018* and will seek out other relevant conferences to disseminate the findings. A lay summary will be developed and sent to participants, all of who requested to be informed of the study’s findings.
Overall impact of the research

The findings from this body of work advance our understanding of supporting men both in the clinical and academic arenas. The findings have several implications for clinical practice. Firstly, they could influence improvements in MBU practice and guide service developments, especially for the new MBUs in England. This research was conducted at a key point in time, when perinatal mental health outpatient and community services in the UK are being developed. Therefore this research is likely to influence how these services are set up or refined to improve outcomes for women, infants and partners. Secondly, through publication and dissemination in key journals and at conferences and relevant MBU and perinatal network events, the findings may guide future CQUIN targets. Lastly, the findings could inform the development of future NICE guidelines around perinatal mental health.
References


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https://doi.org/10.1348/147608303770584755.

Ruffell, B., Smith, D. M, & Wittkowski, A. (under review). The experiences of male partners of women with postnatal mental health problems: A systematic review and thematic synthesis of the qualitative literature. For submission to *Social Science and Medicine*.


Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC medical research methodology, 12*(1), 181.


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Appendix A. Social Science and Medicine: Submission guidelines

SOCIAL SCIENCE & MEDICINE

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DESCRIPTION
Social Science & Medicine provides an international and interdisciplinary forum for the dissemination of social science research on health. We publish original research articles (both empirical and theoretical), reviews, position papers and commentaries on health issues, to inform current research, policy and practice in all areas of common interest to social scientists, health practitioners, and policy makers. The journal publishes material relevant to any aspect of health from a wide range of social science disciplines (anthropology, economics, epidemiology, geography, policy, psychology, and sociology), and material relevant to the social sciences from any of the professions concerned with physical and mental health, health care, clinical practice, and health policy and organization. We encourage material which is of general interest to an international readership.

The journal publishes the following types of contribution:

1) Peer-reviewed original research articles and critical or analytical reviews in any area of social science research relevant to health. These papers may be up to 8,000 words including abstract, tables, and references as well as the main text. Papers below this limit are preferred.

2) Peer-reviewed short reports of research findings on topical issues or published articles of between 2000 and 4000 words.

3) Submitted or invited commentaries and responses debating, and published alongside, selected articles.

4) Special Issues bringing together collections of papers on a particular theme, and usually guest edited.

Please see our Guide for Authors for information on article submission.

AUDIENCE
Social scientists (e.g. medical anthropologists, health economists, social epidemiologists, medical geographers, health policy analysts, health psychologists, medical sociologists) interested in health, illness, and health care; and health-related policy makers and health care professionals (e.g. dentists, epidemiologists, health educators, lawyers, managers, nurses, midwives, pharmacists, physicians,
GUIDE FOR AUTHORS

Your Paper Your Way
We now differentiate between the requirements for new and revised submissions. You may choose to submit your manuscript as a single Word or PDF file to be used in the refereeing process. Only when your paper is at the revision stage, will you be requested to put your paper in to a ‘correct format’ for acceptance and provide the items required for the publication of your article.
To find out more, please visit the Preparation section below.

INTRODUCTION
Click here for guidelines on Special Issues.
Click here for guidelines on Qualitative methods.

Social Science & Medicine provides an international and interdisciplinary forum for the dissemination of social science research on health. We publish original research articles (both empirical and theoretical), reviews, position papers and commentaries on health issues, to inform current research, policy and practice in all areas of common interest to social scientists, health practitioners, and policy makers. The journal publishes material relevant to any aspect of health and healthcare from a wide range of social science disciplines (anthropology, economics, epidemiology, geography, policy, psychology, and sociology), and material relevant to the social sciences from any of the professions concerned with physical and mental health, health care, clinical practice, and health policy and the organization of healthcare. We encourage material which is of general interest to an international readership.

Journal Policies
The journal publishes the following types of contribution:

1) Peer-reviewed original research articles and critical analytical reviews in any area of social science research relevant to health and healthcare. These papers may be up to 8000 words including abstract, tables, figures, references and (printed) appendices as well as the main text. Papers below this limit are preferred.

2) Systematic reviews and literature reviews of up to 15000 words including abstract, tables, figures, references and (printed) appendices as well as the main text.

3) Peer-reviewed short communications of findings on topical issues or published articles of between 2000 and 4000 words.

4) Submitted or invited commentaries and responses debating, and published alongside, selected articles (please select the article type ‘Discussion’ when submitting a Commentary).

5) Special Issues bringing together collections of papers on a particular theme, and usually guest edited.

Due to the high number of submissions received by Social Science & Medicine, Editorial Offices are not able to respond to questions regarding the appropriateness of new papers for the journal. If you are unsure whether or not your paper is within scope, please take some time to review previous issues of the journal and the Aims and Scope at https://www.journals.elsevier.com/social-science-and-medicine/.

Submission checklist
You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:
• E-mail address
• Full postal address
**Essential cover page information**

The Cover Page should only include the following information:

- **Title.** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible and make clear the article's aim and health relevance.
- **Author names and affiliations in the correct order.** Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.
- **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address. Contact details must be kept up to date by the corresponding author.
- **Present/permanent address.** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

**Text**

In the main body of the submitted manuscript this order should be followed: abstract, main text, references, appendix, figure captions, tables and figures. Author details, keywords and acknowledgements are entered separately during the online submission process, as is the abstract, though this is to be included in the manuscript as well. During submission authors are asked to provide a word count; this is to include ALL text, including that in tables, figures, references etc.

**Title**

Please consider the title very carefully, as these are often used in information-retrieval systems. Please use a concise and informative title (avoiding abbreviations where possible). Make sure that the health or healthcare focus is clear.

**Abstract**

An abstract of up to 300 words must be included in the submitted manuscript. An abstract is often presented separately from the article, so it must be able to stand alone. It should state briefly and clearly the purpose and setting of the research, the principal findings and major conclusions, and the paper's contribution to knowledge. For empirical papers the country/countries/locations of the study should be clearly stated, as should the methods and nature of the sample, the dates, and a summary of the findings/conclusion. Please note that excessive statistical details should be avoided, abbreviations/acronyms used only if essential or firmly established, and that the abstract should not be structured into subsections. Any references cited in the abstract must be given in full at the end of the abstract.

**Research highlights**

Research highlights are a short collection of 3 to 5 bullet points that convey an article's unique contribution to knowledge and are placed online with the final article. We allow 85 characters per bullet point including spaces. They should be supplied as a separate file in the online submission system (further instructions will be provided there). You should pay very close attention to the formulation of the Research Highlights for your article. Make sure that they are clear, concise and capture the reader's attention. If your research highlights do not meet these criteria we may need to return your article to you leading to a delay in the review process.

**Keywords**

Up to 8 keywords are entered separately into the online editorial system during submission, and should accurately reflect the content of the article. Again abbreviations/acronyms should be used only if essential or firmly established. For empirical papers the country/countries/locations of the research should be included. The keywords will be used for indexing purposes.

**Methods**
Authors of empirical papers are expected to provide full details of the research methods used, including study location(s), sampling procedures, the date(s) when data were collected, research instruments, and techniques of data analysis. Specific guidance on the reporting of qualitative studies are provided here.

Systematic reviews and meta-analyses must be reported according to PRISMA guidelines.

Footnotes
There should be no footnotes or endnotes in the manuscript.

Artwork
Electronic artwork
General points
• Make sure you use uniform lettering and sizing of your original artwork.
• Preferred fonts: Arial (or Helvetica), Times New Roman (or Times), Symbol, Courier.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Indicate per figure if it is a single, 1.5 or 2-column fitting image.
• For Word submissions only, you may still provide figures and their captions, and tables within a single file at the revision stage.
• Please note that individual figure files larger than 10 MB must be provided in separate source files. A detailed guide on electronic artwork is available.

You are urged to visit this site; some excerpts from the detailed information are given here.

Formats
Regardless of the application used, when your electronic artwork is finalized, please ‘save as’ or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS (or PDF): Vector drawings. Embed the font or save the text as ‘graphics’.
TIFF (or JPEG): Color or grayscale photographs (halftones): always use a minimum of 300 dpi.
TIFF (or JPEG): Bitmapped line drawings: use a minimum of 1000 dpi.
TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale): a minimum of 500 dpi is required.

Please do not:
• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); the resolution is too low.
• Supply files that are too low in resolution.
• Submit graphics that are disproportionately large for the content.

Color artwork
Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article. Please indicate your preference for color: in print or online only. Further information on the preparation of electronic artwork.

Figure captions
Ensure that each illustration has a caption. A caption should comprise a brief title (not on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables
Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References
Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full at the end of the abstract. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal (see below) and should include a substitution of the publication date with either "Unpublished results" or "Personal communication" Citation of a reference as "in press" implies that the item has been accepted for publication.

Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references
This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

References in special issue articles, commentaries and responses to commentaries
Please ensure that the words 'this issue' are added to any references in the reference list (and any citations in the text) to other articles which are referred to in the same issue.

Reference management software
Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley and Zotero, as well as EndNote. Using the word processor plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide.

The current Social Science & Medicine EndNote file can be directly accessed by clicking here.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:
http://open.mendeley.com/use-citation-style/social-science-and-medicine
When preparing your manuscript, you will then be able to select this style using the Mendeley plug-ins for Microsoft Word or LibreOffice.

Reference formatting
There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct. If you do wish to format the references yourself they should be arranged according to the following examples:

Reference style
Text: All citations in the text should refer to:
1. Single author: the author's name (without initials, unless there is ambiguity) and the year of publication;
2. Two authors: both authors' names and the year of publication;
3. Three or more authors: first author's name followed by 'et al.' and the year of publication.
Citations may be made directly (or parenthetically). Groups of references should be listed first alphabetically, then chronologically.
Examples: 'as demonstrated (Allan, 2000a, 2000b, 1999; Allan and Jones, 1999). Kramer et al. (2010) have recently shown ....'
Appendix B. Example of coded article extract
Appendix C. Table illustrating which papers included data for each theme

<table>
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<th>Paper</th>
<th>Theme 1: Being a father</th>
<th>Theme 2: Being a partner</th>
<th>Theme 3: Experiencing negative emotions</th>
<th>Theme 4: The ways in which men cope</th>
<th>Theme 5: Where support is needed</th>
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### Appendix D. Table of additional exemplar extracts for main themes from thematic synthesis

| Theme 1: Being a father | “I completely have no break, as childcare never stops even on holidays. However, that’s okay! My baby is so cute! And recently, my colleagues looked after the baby, so I hope to talk about childcare at my company more.” (Mizukoshi et al., 2016)  
“[feeling] guilty for not giving your kids the time you know they need- they want that time and they don’t understand the situation” (Beestin et al., 2014)  
“Those were very tough days... it was so touch to see Mom hold her daughter and there be nothing. No love, no affection, no caring. It was so tough.” (Engqvist & Nilsson, 2011)  
‘Only two participants expressed a lack of joy towards the new baby. They attributed their dissatisfaction with the child to lack of interaction and engagement in meaningful activities.’ (Muchena, 2007)  
“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” (Davey et al., 2006)  
“Obviously I was sad that I missed out on so much in those early days...”(Wyatt et al., 2015)  
“I don’t want to say it’s made us grow up...but I suppose it has...It’s made is...become my parents...It’s a different life to the one we’d sort of planned, even while she was pregnant”(Boddy et al., 2016)  
“I guess there is a level of trust that kind of needs to be rebuilt...with how she is around the baby...I’m...very proactive and will sometimes, without realising it, take over.”(Boddy et al., 2016)  
“...with the first three children because there was no illness my role as a father was more provider [...] like doing their temperatures and stuff she knew all that [...] But when she’s been in hospital my role has changed now because I have gone from provider to being main carer”(Reid et al., 2017)  
“I think having a child together is massively helpful because there’s a child [...] if there wasn’t a child you might be inclined to be less supported.”(Nathan) (Reid et al., 2017)  
“I’d come home and as soon as I came home I’d let her [wife] go to bed, and it would just be me and [daughter]. And I think that’s why I’m more chilled out with her to be honest with you, ‘cos I did spend, it felt as though it was just me and her (...) in out own little world.”(Beestin et al., 2014) |
| Theme 2: Being a partner | “It was very extreme behaviour... I thought she would never fully come back. I thought she might be in that state forever.”(Reid et al., 2017) |
“It was somebody else in her body I suppose, that’s the only way of putting it... and it wasn’t a normal person either ((laughs))...It was like dealing with a malfunctioning robot.” (Boddy et al., 2016)
“The first couple of months she always needed comfort... I was there for her.” (Feeley et al., 2016)
“It’s, kind of the elephant in the room [mood changes] that we’re both just so exhausted and so tired and stressed and everything.” (Henshaw et al., 2016)
“I think that she can manage or handle situations by herself...So the only problem is that sometimes, after birth, she cried. But I think it’s not critical. It’s not like we can see that she as to go see a specialist. So it’s like I give her an option, if you think that you can handle this, it’s okay. But if not, go to see a specialist.” (Bell et al., 2016)
“When she is depressed, I give up sleeping and listen to her. I wait for her to start speaking.” (Mizukoshi et al., 2016)
“Fiona is my family, so to not have that person to bounce of... I just felt completely isolated.” (Wyatt et al., 2015)
‘Many fathers felt their partner relied on them for support. This resilience could both strengthen and strain the relationship’ (Marrs et al., 2014)
‘While some partners re-established themselves in the relationships, others had sustained arguments and a ‘blame culture’ to the extent that relationships suffered irreparable damage.’ (Muchena, 2007)
“And again, without thinking about having full sex, or whatever, but, caressing or touching you know, it’s part of normal behaviour in a couple. [My wife] didn’t really like it. I mean she was really, really bad with it... certainly there was this problem that she obviously didn’t want to be touched, at all.” (Nicholls & Ayers, 2007)
“Our communication is not good... L. said the other day that it was easier for her when I’m not there, that hurt...” (Davey et al., 2006)
“...wondering what I’ve done wrong, trying to help, but no matter how you try and help you can’t really say too much to make it better.”(Everingham et al., 2006)
“It was very extreme behaviour... I thought she would never fully come back. I thought she might be in that state forever.”(no reference) (Meighan et al., 1999)

**Theme 3:**
**Experiencing negative emotions**

‘The majority of fathers had no knowledge or experience of mental illness, and this limited understanding made the fathers feel “helpless and ignorant”’(Oliver)’ (Reid et al., 2017)

“I felt like I was out there all on my own, without anybody to guide me, or anybody to talk to.” (no reference) (Bell et al., 2016)
“My wife’s psychiatrist told me, ‘Those who don’t overdo things are safe from postpartum depression.’ So I wasn’t expecting her to become severely depressed like now. When the baby is crying, we are irritates and break down emotionally. Now I am so distressed because I raise my baby and keep house whilst my wife is depressed.” (#3) (Mizukoshi et al., 2016)

‘Partners viewed themselves as responsible for seeking and providing support. However, they felt isolated and required emotional and practical support from others to fulfil this role.’ (Wyatt et al., 2015)

‘Participants emphasised the inescapable, unexpected and profoundly isolating experience of taking on the duties of two parents.’ (Beestin et al., 2014)

‘Father’s therefore carried a burden of stress related to their partners’ deteriorating condition. Outbursts of anger as well as feelings of sadness were commonly reported by participants as they attempted to process and deal with emerging experiences’ (Muchena, 2007)

 “[I had] a massive feeling of helplessness. I mean, I could do absolutely nothing to help [my wife]” (Couple C, man) (Nicholls & Ayers, 2007)

“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-V1) (Davey et al., 2006)

‘The fact that they could not understand made it very difficult for the men to cope with their partner’s symptoms. In Matthew’s case, his inability to understand his wife’s distress led to his own feelings of depression” (Everingham et al., 2006)

“[I was afraid to leave because she said she wanted to die- to just get in the car and drive off into a tree” (no reference) (Meighan et al., 1999)

“[I didn’t know how long it would take to get over it- if we ever did get over it... I was really afraid that she was going to be a mental case forever.” (no reference) (Meighan et al., 1999)

“Nothing in my life prepared me to hear those words [suicidal thoughts] from the woman I love so much. Nothing had prepared me to deal with how quickly our wonderful life with our new baby had spiralled down into thoughts of suicide.” (Engqvist & Nilsson, 2011)

“I think with [my wife] I was a lot more careful of what I might say and what I might do. It was a bit like walking on eggshells all the time. You put one foot wrong and you’re likely to cop a serve. Yes I guess I avoided the position which could lead to an argument for a long time”’ (Couple A, man) (Nicholls & Ayers, 2007)
### Theme 4: The ways in which men cope

“I spoke to one of the nurses on the MBU as I was feeling low and they helped me. They are experienced.” (Mike) (Reid et al., 2017)

‘In response to this uncertainty, most participants sought more information. Some used resources like Internet forums, others connected with family who worked in health services. Having a name for their partner’s difficulties often provided some understanding and hope of recovery.’ (Boddy et al., 2016)

“Of course we hear about [perinatal depression]... at birth, she received a pamphlet... Maybe if it [the pamphlet’s content] had been discussed, maybe it could have helped.” (205b) (Feeley et al., 2016)

‘For professional treatment, fathers commonly sought information online, encouraged treatment, or facilitated professional consultation.’ (Henshaw et al., 2016)

“ I would come home from [hospital] and there’d be a lasagne in the oven... her best friend, she was great, she was always there for us.”(Rob) (Wyatt et al., 2015)

‘Fathers received the majority of their support from family. The intensity varied but several participants received intensive daily help, on occasions even moving in with family. Fathers received both practical and emotional support and some acknowledged they would not have been able to cope without it.’ (Marrs et al., 2014)

“The main way I worked through my frustration was sports. My mom was good about coming over to be with my wife and child while I played volleyball and blew off steam that way. Or go to a hockey game, work on the car, or play poker with friends.”(no reference) (Doucet et al., 2012)

“I had to withdraw to a huge degree my expectations of what to expect in terms of attention and affection.”(10) (Engqvist & Nilsson, 2011)

“Just to meet people who were saying, yep I was bad. And your situation was nothing like mine and mine is nothing like yours but I made it.”(DAD_04) (Letourneau et al., 2011)

‘Fathers tended to use informal services such as chat rooms or telephone helplines, or sought emotional support from friends. Three fathers attempted to gain comfort by drinking alcohol with friends in pubs. These measures provided instant but evanescent relief from their psychological problems.’ (Muchena, 2007)

‘Most of the men in this study however, were unable to offer the support required by the mother and they became frustrated and distressed themselves, leading some to withdraw into a sphere of activity they felt more confident in—their work, home renovations, sport or a hobby.’ (Everingham et al., 2006)
‘Each couple mentioned family as the first port of call for help. Six couples also mentioned health visitors and five mentioned the GP, in four interviews all three were mentioned.’ (Webster, 2002)

“It was up to me to hold things together... I had to take care of them...my needs were last.” (Meighan et al., 1999)

Theme 5: Where support is needed

‘However, often, fathers’ needs for information were not met by the MBU, and this was identified as an area for improvement: “Maybe if there was an information area for partners about different conditions”(Isaac)’ (Reid et al., 2017)

“Follow-up, it’s for the mother and baby. The hospital, it is mither-child, not mother-father or family. All the emphasis is on the woman. If the spouse doesn’t know what to do to encourage her, to help her, it will be much more difficult. The father, he’s an important person because he is the one accompanying, he is the one encouraging, he sees the tears, and he does everything...There is nothing for men.” (Feeley et al., 2016)

“The only information that I could do anything about was actually coming home and researching it myself online...everything [about PD] was dedicated to her. There was nothing for me that I could see.” (Henshaw et al., 2016)

“When her condition became worse, beyond my limit, I told her, ‘We should tell your parents about your disease.’ But, she cornered me by saying, ‘No! My parents will get worried. Why don’t you take care of this! You are responsible for me now!’” (Mizukoshi et al., 2016)

“Although [Lucy’s brother has] been told stage by stage everything...he hasn’t really took much of it in and, the relationship’s changed...” (Wyatt et al., 2015)

‘Others reported feeling responsible for protecting the family from external judgement.’ (Beestin et al., 2014)

“They discharge you, the health nurse come to check on your wife and your kid. I wasn’t home for any of that stuff. They never once asked about me... They’re trained to check moms for any of the symptoms for depression and baby stuff. They don’t even request the dad to be there so that they can ask the dad a few simple questions that could determine if things aren’t right.” (Letourneau et al., 2012)

‘The men express that they are angry and disappointed towards hospital staff and doctors, and blame them for not being interested, not caring and for lacking knowledge about this disorder. They are convinced that the women would get better treatment somewhere else but do not know where to turn’ (Engqvist & Nilsson, 2011)

“So it took awhile for her to be self aware and it also took awhile for her to get over the stigma and to realize this is serious enough that we had to do something. In terms of me personally, it would be just my own character flaws. Just really not being comfortable accepting help from anyone.” (Letourneau et al., 2011)

‘This finding suggests that fathers had no previous knowledge of detecting postnatal psychiatric illness in their partners.
They did not know to whom they could turn nor how to deal with the situation.’ (Muchena, 2007)

“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.” (Davey et al., 2006)

“I don’t think [a group] would work because, I think, I wouldn’t feel comfortable in a group situation where I didn’t know the other people intimately, not intimately enough to be able to cry and talk in front of them. Otherwise it would be too confronting… it would not enhance or encourage correct or accurate feelings, because you’d be too worried about the rest of the people in the group.” (Everingham et al., 2006)

“It is something that people tend to keep to themselves and don’t want to admit to. If they do admit, then there are no resources there to actually help you.” (Webster, 2002)

“People don’t take it seriously. It’s like having a terminal disease and… people [either do not understand] or they don’t know enough about it… and I’m talking nationwide.” (Meighan et al., 1999)
Appendix E. Clinical Psychology and Psychotherapy: Submission guidelines

AIMS AND SCOPE

Clinical Psychology & Psychotherapy aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. Clinical Psychology & Psychotherapy will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.

MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research articles: Substantial articles making a significant theoretical or empirical contribution.
Reviews: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies.
Assessments: Articles reporting useful information and data about new or existing measures.
Practitioner Reports: Shorter articles (a maximum of 1200 words) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

4. PREPARING THE SUBMISSION

Parts of the Manuscript
The manuscript should be submitted in separate files: title page; main text file; figures.

File types
Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. LaTeX files may be submitted provided that an .eps or .pdf file is provided in addition to the source files. Figures may be provided in .tiff or .eps format.

New Manuscript
Non-LaTeX users: Upload your manuscript files. At this stage, further source files do not need to be uploaded.
LaTeX users: For reviewing purposes you should upload a single .pdf that you have generated from your source files. You must use the File Designation "Main Document" from the dropdown box.

Revised Manuscript
Non-LaTeX users: Editable source files must be uploaded at this stage. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.
LaTeX users: When submitting your revision you must still upload a single .pdf that you have generated from your revised source files. You must use the File Designation "Main Document" from the dropdown box. In addition you must upload your TeX source files. For all your source files you must use the File
Designation “Supplemental Material not for review”. Previous versions of uploaded documents must be deleted. If your manuscript is accepted for publication we will use the files you upload to typeset your article within a totally digital workflow.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley’s best practice SEO tips);
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The author’s institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
5. Conflict of Interest statement;
6. Acknowledgments.
7. Abstract, Key Practitioner Message and keywords;
8. Main text;
9. References;
10. Tables (each table complete with title and footnotes);
11. Figure legends;
12. Appendices (if relevant).

Figures and supporting information should be supplied as separate files.

**Authorship**
Please refer to the journal’s Authorship policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

**Acknowledgments**
Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

**Conflict of Interest Statement**
Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the Conflict of Interest section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

**Abstract**
Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

**Key Practitioner Message**All articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

**Keywords**
Please provide five-six keywords (see Wiley’s best practice SEO tips).
Main Text

1. The journal uses US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.
2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References
References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the APA FAQ.

Reference examples follow:

Journal article

Book
Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Endnotes
Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

Tables
Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶ should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends
Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.
Appendix F. Approval letter from Greater Manchester Research Ethics Committee- Empirical study

Health Research Authority
National Research Ethics Service
North West - Greater Manchester East Research Ethics Committee
3rd Floor, Barrow House
4 Minshull Street
Manchester
M1 30Z

Please note: This is an acknowledgement letter from the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval.

21 March 2017
Ms Beth Turner
Zoonosis Building
University of Manchester
Manchester, M139GB

Dear Ms Turner,

Study title: The psychosocial support for male partners of women admitted to mother and baby units.

REC reference: 17/NW/0117
Protocol number: NHS001151
IRAS project ID: 214435

Thank you for your email of 14 March 2017. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 07 March 2017.

Documents received
The documents received were as follows:

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<td>08 March 2017</td>
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Approved documents
The final list of approved documentation for the study is therefore as follows:

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A Research Ethics Committee established by the Health Research Authority
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [The University of Manchester and Subsidiary Companies] | 1 | 15 June 2016 |
| Interview schedules or topic guides for participants [Semi-Structured Interview Topic Guide] | 3 | 13 January 2017 |
| IRAS Application Form [IRAS_Form_02022017] | 2 | 02 February 2017 |
| Letter from sponsor [Sponsor Reference: NHS001151] | 1 | 09 January 2017 |
| Non-validated questionnaire [Family Background Questionnaire (FBQ)] | 3 | 13 January 2017 |
| Other [Participant Information Sheet for Partners] | 2 | 13 January 2017 |
| Other [Part 1: Capacity form] | 3 | 13 January 2017 |
| Other [Consent to Contact Form] | 2 | 13 January 2017 |
| Other [Distress Management Protocol] | 2 | 13 January 2017 |
| Other [Debrief information] | 2 | 13 January 2017 |
| Other [CURRICULUM VITAE] | 1 | 13 January 2017 |
| Other [GANTT chart] | 2 | 13 January 2017 |
| Participant consent form [PARTICIPANT CONSENT FORM for Partners] | 3 | 13 January 2017 |
| Participant information sheet (PIS) [Participant Information Sheet for Mothers] | 1 | 13 January 2017 |
| Research protocol or project proposal [Study Protocol] | 2 | 13 January 2017 |
| Response to Additional Conditions Met | 3 | 13 January 2017 |
| Summary CV for Chief Investigator (CI) [CURRICULUM VITAE-Beth Turner] | 1 | 17 September 2016 |
| Summary CV for supervisor (student research) [CURRICULUM VITAE] | 1 | 13 January 2017 |

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor’s responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

17/NW/0117 Please quote this number on all correspondence

Yours sincerely,

Rinat Jibli
REC Manager

E-mail: nrescommittee.northwest-gmeast@nhs.net

Copy to: Ms Lynne Macrae

Ms Sue Dobson, Manchester Mental Health and Social Care Trust

A Research Ethics Committee established by the Health Research Authority
Appendix G. Approval letter from the Health Research Authority-
Empirical study

Health Research Authority

Ms Beth Turner
Zochonis Building
University of Manchester
Manchester
M130GB

21 March 2017

Dear Ms Turner

Letter of HRA Approval

Study title: The psychosocial support for male partners of women admitted to mother and baby units.
IRAS project ID: 214435
Protocol number: NHS001151
REC reference: 17/NW/0117
Sponsor: University of Manchester

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England
The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read Appendix B carefully, in particular the following sections:

- Participating NHS organisations in England – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- Confirmation of capacity and capability - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.
It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices
The HRA Approval letter contains the following appendices:
- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval
The document "After Ethical Review – guidance for sponsors and investigators", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:
- Registration of research
- Notifying amendments
- Notifying the end of the study
The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:
- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the After Ethical Review document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope
HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-reviews/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback
The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application
procedure. If you wish to make your views known please use the feedback form available on the HRA website: [http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/](http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/).

**HRA Training**

We are pleased to welcome researchers and research management staff at our training days – see details at [http://www.hra.nhs.uk/hra-training/](http://www.hra.nhs.uk/hra-training/).

Your IRAS project ID is 214435. Please quote this on all correspondence.

Yours sincerely

Miss Helen Penistone
Assessor

Email: hra.approval@nhs.net

Copy to: Ms Lynne Macrae

Ms Sue Dobson, Manchester Mental Health and Social Care Trust
Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

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<td>[The University of Manchester and Subsidiary Companies]</td>
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<td>Interview schedules or topic guides for participants [Semi-Structured]</td>
<td>3</td>
<td>13 January 2017</td>
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<td>Interview Topic Guide</td>
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<td>IRAS Application Form [IRAS_Form_02022017]</td>
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<td>Other [Distress Management Protocol]</td>
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<td>Other [Debrief information]</td>
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<tr>
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<td>13 January 2017</td>
</tr>
<tr>
<td>Other [GANNT chart]</td>
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<tr>
<td>Other [SoA - all site activities]</td>
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<td>20 March 2017</td>
</tr>
<tr>
<td>Other [SoE - all site activities]</td>
<td>1</td>
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<tr>
<td>Other [Statement of Activities - Recruiting site]</td>
<td>1</td>
<td>20 March 2017</td>
</tr>
<tr>
<td>Other [Schedule of Events - Recruiting site]</td>
<td>1</td>
<td>20 March 2017</td>
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<td>Participant consent form [PARTICIPANT CONSENT FORM for Partners]</td>
<td>3</td>
<td>13 January 2017</td>
</tr>
<tr>
<td>Participant consent form [Mothers]</td>
<td>2</td>
<td>13 January 2017</td>
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<tr>
<td>Participant information sheet [PIS] [Mothers]</td>
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<td>Participant information sheet [PIS] [Partners]</td>
<td>3</td>
<td>10 March 2017</td>
</tr>
<tr>
<td>Research protocol or project proposal [Study Protocol]</td>
<td>2</td>
<td>13 January 2017</td>
</tr>
<tr>
<td>Response to Additional Conditions Met</td>
<td></td>
<td>14 March 2017</td>
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<td>1</td>
<td>17 September 2016</td>
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<tr>
<td>Summary CV for supervisor (student research) [CURRICULUM VITAE]</td>
<td>1</td>
<td>13 January 2017</td>
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</tbody>
</table>
Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Beth Turner  
Tel: 0161 306 0400  
Email: beth.turner@postgrad.manchester.ac.uk

### HRA assessment criteria

<table>
<thead>
<tr>
<th>Section</th>
<th>HRA Assessment Criteria</th>
<th>Compliant with Standards</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>IRAS application completed correctly</td>
<td>Yes</td>
<td>No comments</td>
</tr>
<tr>
<td>2.1</td>
<td>Participant information/consent documents and consent process</td>
<td>Yes</td>
<td>Non-substantial amendments were made to the Participant Information Sheets following REC favourable opinion. This was to clarify who will have access to data. An administrative amendment was made to the Consent Form for Mothers.</td>
</tr>
<tr>
<td>3.1</td>
<td>Protocol assessment</td>
<td>Yes</td>
<td>No comments</td>
</tr>
<tr>
<td>4.1</td>
<td>Allocation of responsibilities and rights are agreed and documented</td>
<td>Yes</td>
<td>The sponsor intends that the statement of activities will act as agreement of an NHS organisation to participate. This is for sites hosting all activities and those acting as a recruiting site.</td>
</tr>
<tr>
<td>Section</td>
<td>HRA Assessment Criteria</td>
<td>Compliant with Standards</td>
<td>Comments</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------</td>
<td>--------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>4.2</td>
<td>Insurance/indemnity arrangements assessed</td>
<td>Yes</td>
<td>Where applicable, independent contractors (e.g., General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study.</td>
</tr>
<tr>
<td>4.3</td>
<td>Financial arrangements assessed</td>
<td>Yes</td>
<td>According to the Statement of Activities, no funding will be available to sites to support the study.</td>
</tr>
<tr>
<td>5.1</td>
<td>Compliance with the Data Protection Act and data security issues assessed</td>
<td>Yes</td>
<td>The Family Background Questionnaire was revised following REC favourable opinion as it was not deemed necessary to collect the date of birth the babies' siblings.</td>
</tr>
<tr>
<td>5.2</td>
<td>CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed</td>
<td>Not Applicable</td>
<td>No comments</td>
</tr>
<tr>
<td>5.3</td>
<td>Compliance with any applicable laws or regulations</td>
<td>Yes</td>
<td>No comments</td>
</tr>
<tr>
<td>6.1</td>
<td>NHS Research Ethics Committee favourable opinion received for applicable studies</td>
<td>Yes</td>
<td>No comments</td>
</tr>
<tr>
<td>6.2</td>
<td>CTIMPS – Clinical Trials Authorisation (CTA) letter received</td>
<td>Not Applicable</td>
<td>No comments</td>
</tr>
<tr>
<td>6.3</td>
<td>Devices – MHRA notice of no objection received</td>
<td>Not Applicable</td>
<td>No comments</td>
</tr>
<tr>
<td>6.4</td>
<td>Other regulatory approvals and authorisations received</td>
<td>Not Applicable</td>
<td>No comments</td>
</tr>
</tbody>
</table>
Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There will be two study site types:

- Site type 1 – potential participants will be approached and provided with information about the study.
- Site type 2 – participants will be recruited and interviewed at site.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England (site types 1 and 2) will be expected to formally confirm their capacity and capability to host this research.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

Site type 1: it is not expected that there will be a Principal Investigator or Local Collaborator at site as no research activities will be undertaken.
Site type 2: It is expected that there will be a Local Collaborator at site to facilitate the access of externally employed researchers. The researcher, rather than local staff, will be responsible for all research activities following consent.

The sponsor does not intend to provide any training to members of the research team and does not expect that any particular training is completed.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken.

Site type 1: Any activities expected to be undertaken by staff at participating NHS organisations in England for this study will involve accessing identifiable patient data without consent. This should be done only by staff who have legitimate access to that data as part of their normal responsibilities at the participating NHS organisation (i.e. a member of the direct care team for the target patient group).

Site type 2: Where arrangements are not already in place, externally employed researchers requiring access to site to undertake research activities would be expected to obtain a Letter of Access based on a standard DBS check and occupational health clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.
Appendix H. Participant information sheet

Study Title: Psychosocial support for male partners of women admitted to mother and baby units.
Chief Investigator: Beth Turner

Participant Information Sheet for Partners

Thank you for showing an interest in the above study. We would like to invite male partners of women who are currently, or have been previously, admitted to a Mother and Baby Unit to talk to a researcher about what support they would find helpful during this time.

Please read the following information carefully and discuss it with others if you wish. If anything seems unclear or if you would like more information, contact us at any time. Please take some time decide whether or not you wish to take part and if you wish to take part, please get back to us within 24 hours of reading this information.

What is the purpose of the study?
A previous study was undertaken exploring men’s experience of their partner’s admission to a mother and baby unit, which found that men seek support during this time. We are therefore carrying out this study in order to develop a deeper understanding of how men would like to be supported by staff at the Mother and Baby Unit during their partner’s admission to hospital. We would like to find out what kind of support men need and how best to offer this. The purpose of this is to improve the support for male partners during this time and make it as helpful and beneficial for partners as possible.

Why have I been invited?
We are looking for approximately 15-20 men whose partner is currently, or has been previously admitted to a Mother and Baby Unit.

Do I have to take part?
No, you do not have to participate in this study if you do not want to. Participation is completely voluntary. If you decide to take part, you will be given this information sheet to keep and then you will be asked to sign a consent form (a copy of which you will be given to keep). If you decide to participate, but you change your mind later, you are free to withdraw at any point. Your decision to withdraw from the study will not affect your legal rights and you will not be disadvantaged in any way.
What will happen if I decide to take part?

If you are from Greater Manchester we will arrange a convenient time to meet with you to tell you more about the study and to answer any questions you may have. The interview can take place at either your home address, the Mother and Baby Unit or over the telephone, whichever you prefer.

If you are from outside Greater Manchester we will arrange a convenient time to call you to tell you more about the study and to answer any questions you may have over the telephone. The interview will take place over the telephone, including completion of the questionnaire, at a time that is convenient for you.

What does this study involve?
Participation will involve meeting with a researcher, for around an hour and a half to talk about what support you would welcome and find helpful during your partner’s admission to the Mother and Baby Unit. This will take the form of a semi-structured interview, and will involve being asked a number of open-ended questions allowing you to share your thoughts. The interview will be audio-recorded and then written out in full (transcribed). You will also be asked to complete a Family History Questionnaire, to provide some brief details about yourself, such as your age, occupation and family circumstances. The information you provide may be referred to in the study. All information you provide will be anonymised, which means that your name will not be used, and an identifier code will be used instead.

What are the possible benefits of taking part?
Many people find it helpful to share their views and want to provide some feedback about their experiences. Although we anticipate that there will be no particular benefits of you taking part in this interview, the information we receive may help improve the support given to male partners of women admitted with mental health difficulties to a Mother and Baby Unit in future.

What are the possible disadvantages and risks of taking part?
For some people talking about their experience of being a partner of a person experiencing mental health difficulties and sharing their views of this can be difficult because this topic can be sensitive and personal. There is a possibility that talking about it may bring up strong emotions for some people. The researcher will be mindful of this possibility and proceed only if you wish to do so. She will also remind you that you can withdraw from the study at any time. One other possible disadvantage of participating in this study is the time commitment of taking part in an interview for an hour and a half.

Will my taking part in the study be kept confidential?
The interview will be recorded using an audio-recording device. Your interview will then be written out in full (transcribed) by either the interviewer or a person who is external to the research team. This person will not have access to any
information about you other than what is on the audio recording, which will be minimal, and they are bound by the same confidentiality agreement. The transcribed interviews will be anonymised, which means that your name will be taken out, and an identifier code will be used instead. All data including audio recordings, transcripts, questionnaires and forms will be stored securely. Data will be kept in locked filing cabinets, and on encrypted devices within the University of Manchester. If you require more information about the storage and management of the data held for the study, you can contact Dr. Anja Wittkowski at the University on the details at the bottom of this information sheet.

For monitoring and auditing purposes, study data and materials may be looked at by individuals from the University of Manchester or from the NHS Trust. All will have a duty of confidentiality to you as a participant. Personal data, such as names and addresses, will be destroyed as soon as it is no longer required for the study, in line with the requirements of the Data Protection Act (1998).

Information will remain strictly confidential and will not be shared outside the research team. There is one exception to this: If you tell us anything that makes us think that you or anyone else is at risk of harm, we will have to share this information, for example, with your GP.

When we publish the findings of this study, we may use direct quotes, but these will be used in such a way that they will not reveal your identity. Written transcripts of the interviews will be kept for a minimum of 5 years after the date of any publication which is based upon it, to follow recommended good practice guidelines for research. If you give your permission in the consent form, we will keep your anonymised data for us in future research studies.

**What will happen if I do not want to carry on with the study?**
You can withdraw from the study completely at any time without giving a reason and without any consequence to you. No further data will be collected from the moment you withdraw. You can withdraw from the study, even if you have begun your interview. If you choose to withdraw, we will destroy identifiable information about you or your partner. Any data that has already been collected and had been fully anonymised (cannot be linked back to you or your partner) will be kept by the research team.

**What will happen to the results of this study?**
Once all the information has been collected and analysed, the findings will be published in an academic journal. We will also share the results with participants and their partners, if they wish us to do so, and other health care professionals and researchers at conferences. In all cases, any information you provided will be anonymous and used in such a way so they will not identify a particular participant.
**Who is organising the study?**
This study is being conducted as part of a Clinical Psychology Doctoral Thesis project, sponsored by the University of Manchester. This study is overseen by Dr. Anja Wittkowski from the University of Manchester.

**What if there is a problem (complaint)?**
If you have a minor complaint then please contact the researcher(s) in the first instance:
**Dr. Anja Wittkowski** – anja.wittkowski@manchester.ac.uk - 0161-306 0400
or **Beth Turner**- beth.turner@postgrad.manchester.ac.uk - 0161-306 0400

If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researchers in the first instance, then please contact the Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674 or 275 2046.

In the unlikely event that something does go wrong and you are harmed during the study, you may have grounds for a legal action for compensation against the University of Manchester or NHS Trust but you may have to pay your legal costs. The normal NHS complaints mechanisms will still be available to you.

**Who has reviewed the study?**
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by Greater Manchester East Research Ethics committee and was given a favourable opinion on 21st March 2017. The REC reference number is: 17/NW/0117.

*Thank you for considering taking part in this study.*

**Contacts for further information**
**Beth Turner**
The University of Manchester, School of Health Sciences, Division of Psychology and Mental Health,
2nd Floor Zochonis Building, Brunswick Street
Manchester M13 9PL
Tel. 07544 303 972
beth.turner@postgrad.manchester.ac.uk

Dr Anja Wittkowski
Chief Investigator for this study
Senior Lecturer in Clinical Psychology,
The University of Manchester, School of Health Sciences, Division of Psychology and Mental Health,
2nd Floor Zochonis Building,
Brunswick Street
Manchester M13 9PL
Tel. 0161 306 0400 or 291 6971
Anja.wittkowski@manchester.ac.uk
Appendix I. Participant consent form

Study Title: *Psychosocial support for male partners of women admitted to mother and baby units.*
Chief Investigator: *Beth Turner*

**PARTICIPANT CONSENT FORM for Partners**

1. I confirm that I have read and understand the Participant Information Sheet (Version 3, 18.05.2017) for the above study and I have had the opportunity to ask questions.

2. I understand that my participation in this study is voluntary and that I am free to withdraw from this study at any time without giving any reason or my legal rights being affected. I understand that should I withdraw, all identifiable data will be destroyed. I understand that any data that has already been collected and has been fully anonymised (cannot be linked back to me or my partner) will be kept by the research team.

3. I agree for my interview to be audio-recorded and then written out in full (transcribed).

4. I understand that anonymised direct quotes from my interview may be used in publications, conferences and dissemination of findings.

5. I understand that data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from Manchester Mental Health and Social Care Trust, where it is relevant to my taking part in research. I give permission for these individuals to have access to my data.

6. I wish to be contacted at the end of the study and for the results to be shared with me and my partner.

7. I agree to my anonymised data to be used in future studies.

8. I agree to take part in the above study.

______________  ____________  ____________
Name of Participant  Date  Signature

______________  ____________  ____________
Name of person taking consent (if different from researcher)  Date  Signature

______________  ____________  ____________
Researcher  Date  Signature

1 copy for participant; 1 copy for researcher
Appendix J. Online study advert

Study Advertisement Poster

Did you know? That the University of Manchester is doing a study to find out how men would like to be supported during their partner's admission to a psychiatric Mother and Baby unit.

Are you?
- Over 18 years old?
- A male partner of a woman who has been admitted to a psychiatric Mother and Baby unit?
- Able to comprehend and understand English well enough to take part in a study?

Would you be interested in?
Sharing your experiences and telling us about what support you would welcome and find helpful during this time.

Participation in this study is completely voluntary. If you would like to take part, please contact Beth Turner on 07544393972 and/or beth.turner@postgrad.manchester.ac.uk for more information on what is involved in this study.
Appendix K. Recruitment letter sent from MBU

[Appendix contents]

Dear Sir,

I am writing to inform you about a research study that is being carried out at The University of Manchester, which may be of interest to you as a husband, partner, or father who has visited [Name of Ward].

This project is focusing on the experiences of men whose family have been admitted to a Mother and baby unit. The researchers are keen to hear about your experiences of the Mother and baby unit and what support or information helped or could have helped you. The ward is supporting this project as we believe it will improve things for others who use our service.

I have attached some further information about the study so you might consider participating. If you are interested, please contact the researcher directly using the contact details below:

Name: Beth Turner  
Tel: 0754 430 3972  
Email: beth.turner@postgrad.manchester.ac.uk

Yours sincerely,

[Insert Name and Job title of ward manager]
Appendix L. Family Background questionnaire

Family Background Questionnaire (FBQ)

This information collects information about your family. Please read and answer every question in this booklet. All information provided will be treated in strict confidence and will not be made available to any other source without your written approval.

Today’s date: ………../……………/……………
Researcher:……………………..
Father’s Age……………

1. **Current Relationship Status**

Married ☐ If so, how long have you been married? ...............
Living together ☐ If so, how long have you been living together? ............... 
Separated or divorced ☐ 
Other ☐ please describe ........................................

At present, does anyone else live at home with you and your partner (e.g., children, grandparents, lodger)?
Yes ☐ If so, who? …………………………………
No ☐

2. **Ethnicity: With which ethnic group do you identify?**

<table>
<thead>
<tr>
<th>White</th>
<th>Black or Black British</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details</td>
<td>Details</td>
</tr>
<tr>
<td>……………..</td>
<td>……………...</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mixed</th>
<th>Other ethnic groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details</td>
<td>Details</td>
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<tr>
<td>……………..</td>
<td>……………...</td>
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</table>

<table>
<thead>
<tr>
<th>Asian or Asian British</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details</td>
</tr>
<tr>
<td>……………..</td>
</tr>
</tbody>
</table>

3. **Religion: With which faith do you identify?**

<table>
<thead>
<tr>
<th>Islam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christianity</td>
</tr>
<tr>
<td>Hindu</td>
</tr>
<tr>
<td>No religion</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>☐ please state ………………………..</td>
</tr>
</tbody>
</table>
4. **Education**

What is your highest level of education?

- No qualifications
- GCSEs, CSEs, or O-levels
- To end of year ___
- A levels/ BTEC
- Trade/apprenticeship
- University degree
- Other (please specify)

5. **Employment Status**

- Full time
- Part time
- Home duties
- On Maternity Leave
- If so, please also indicate your employment status prior to your leave.
- Unemployed

6. **Household Income**

During the past 12 months, has there been a time when your household could not meet its essential expenses? By essential expenses, we mean things like food, the mortgage or rent payment, utility bills, child care, or important medical care.

- Yes
- No
- I don’t know

After you have paid for your essential expenses like food, housing, utilities, child care, and medical care, how much money is left over?

- enough that we can comfortably purchase most of the things we really want
- enough that we can purchase only some of the things we really want
- not enough to purchase much of anything we really want
7. **Family**

Do you and/or your partner have children other than your new baby?  
☐ Yes  ☐ No

If yes, please complete the following information:

I have ______ children  
Child’s Age…………… Gender: ……………… ☐ Live in household  
Child’s Age…………… Gender: ……………… ☐ Live in household  
Child’s Age…………… Gender: ……………… ☐ Live in household  
Child’s Age…………… Gender: ……………… ☐ Live in household  
(please complete on a separate sheet if necessary)

My partner has _____ children  ☐ As above  
Child’s Age…………… Gender: ……………… ☐ Live in household  
Child’s Age…………… Gender: ……………… ☐ Live in household  
Child’s Age…………… Gender: ……………… ☐ Live in household  
Child’s Age…………… Gender: ……………… ☐ Live in household  
(please complete on a separate sheet if necessary)

8. **Your experience of your partner’s well-being**

Is this the first time you have/had experienced your partner having emotional or psychological difficulties?  Yes ☐  No ☐

Is this the first time you have/had experienced your partner being admitted to a Mother and Baby Unit?  Yes ☐  No ☐
When was your partner admitted to a MBU?

…….(month)/……(year)

9. **Pregnancy relating to the infant admitted to the MBU with your partner**

Was this pregnancy planned?
Yes □ □ If so, did you make use of IVF to help you get pregnant?
Yes □ □ No □

No □

Were there any complications during this pregnancy?
Yes □
No □

Were there any complications during birth?
Yes □
No □
10. **Social support**

I have good friends who support me

<table>
<thead>
<tr>
<th>Always</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

My family is always there for me

<table>
<thead>
<tr>
<th>Always</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

My partner helps me a lot

<table>
<thead>
<tr>
<th>Always</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

There is a lot of conflict with my partner

<table>
<thead>
<tr>
<th>Always</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

I feel controlled by my partner

<table>
<thead>
<tr>
<th>Always</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

I feel loved by my partner

<table>
<thead>
<tr>
<th>Always</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>
Appendix M. Scoring for the family background questionnaire

Social Support

Questions: | Response options (score): | Descriptive label (score range):
---|---|---
1. I have good friends who support me | Always (5) | ‘High’ (21 to 30)
2. My family is always there for me | Most of the time (4) | ‘Medium’ (11 to 20)
3. My partner helps me a lot | Sometimes (3) | ‘Low’ (1 to 10)
4. There is a lot of conflict with my partner* | Rarely (2) |
5. I feel controlled by my partner* | Never (1) |
6. I feel loved by my partner | *reverse scored |

Total = 30

Financial status

Question:
After you have paid for your essential expenses like food, housing, utilities, childcare, and medical care, how much money is left over?

Response options: | Descriptive label:
---|---
Enough that we can comfortably purchase most of the things we really want | ‘High’
Enough that we can purchase only some of the things we really want | ‘Medium’
Not enough to purchase much of anything we really want | ‘Low’

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Appendix N. Approval letter from Greater Manchester Research Ethics Committee- Secondary data analysis

---

**North West – Preston Research Ethics Committee**

Barlow House  
3rd Floor  
4 Minshull Street  
Manchester  
M1 3DZ  
Tel: 020 71048008

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Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

---

19 June 2017

Miss Holly Reid  
Postgraduate Student  
University of Manchester

Dear Miss Reid

Study title: The experiences of fathers when their partners are admitted with their infants to a psychiatric mother and baby unit.

REC reference: 12/NW/0187  
Amendment number: 6  
Amendment date: 02 March 2017  
IRAS project ID: 87237

Change to sponsor

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The members had no issues with this amendment.
Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice of Substantial Amendment (non-CTIMP)</td>
<td>6</td>
<td>02 March 2017</td>
</tr>
<tr>
<td>Other [confirmation of indemnity]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other [REC form signed by new sponsor]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members’ training days – see details at [http://www.hra.nhs.uk/hra-training](http://www.hra.nhs.uk/hra-training).

12/NW/0187: Please quote this number on all correspondence

Yours sincerely

[Signature]

Dr Rob Monks
Chair

E-mail: nrescommittee.northwest-lancaster@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Dr Kathryn Harney
          Miss Holly Reid, University of Manchester
North West – Preston Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 30 June 2017

Committee Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Present</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Carol Haigh</td>
<td>Professor of Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Rob Monks</td>
<td>Senior Lecturer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Also in attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position (or reason for attending)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Carol Ebenezer</td>
<td>REC Manager</td>
</tr>
</tbody>
</table>
Appendix O. Distress management protocol

**Distress Management Protocol**

*If a participant appears to become distressed, the researcher will:*
- Encourage the participant to take a break from answering questions.
- Acknowledge that talking about their experiences can be distressing.
- Offer support by reassuring the participant that they do not need to answer questions if they do not wish to.
- Ask if they would like to stop the interview or would like to continue.

*If the participant would like to stop:*
- Finish the interview at that point and offer to return at another time.
- If the participant withdraws their consent to participate in the study, then another time will not be arranged, and no further data will be collected.

*If the participant would like to continue:*
- Take time at the end of the interview to talk informally, and encourage the participant to access further support depending on their level of distress (e.g. assess the level of distress as low, moderate or severe).
- Discuss with the participant if they want their GP to be made aware of their feelings in order to gain additional support from health care professionals. Discuss if the participant would like to make that professional aware of their distress themselves or if they consent for the researcher to do so.
- If the participant has any questions or requires some reassurance about the research at a future point, they should be encouraged to contact the chief investigator or the research assistant they have previously seen, using the contact details given on the participant information sheet.
- If the participant still appears to be distressed when the interview is over, then the researcher will offer to phone back within 48 hours to ensure the distress has not escalated and to reiterate the sources of support. A debrief sheet with additional information can also be left with the participant.
- If the participant’s distress is severe enough to increase the risk to their safety they will be advised to contact their GP, crisis team, The Samaritans, or their local Accident & Emergency department if necessary.
- If there is a concern about the participant’s level of distress, the researcher will complete an incident form which will be shared with the chief investigator and the project team.
Appendix P. Debrief information (UK and Australia)

Debrief information - UK participants

Thank you for participating in this research study. We hope that you have found it interesting and have not been upset by any of the topics in the questionnaires or interview.

In the event that you have found any part of this experience to be distressing, there are a number of people and organisations that you can contact for support:

- If you would like to speak to the researcher, please contact Beth Turner on 07544303972 or beth.turner@postgrad.manchester.ac.uk. Alternatively, you can contact Dr Anja Wittkowski by writing to University of Manchester, 2nd Floor Zochonis Building, Oxford Rd, Manchester M13 9PL or emailing anja.wittkowski@manchester.ac.uk.
- If you feel as though you are struggling to cope, or feeling low in mood, it is important that you contact your GP for support.

There are also a number of organisations listed below that you can contact:

<table>
<thead>
<tr>
<th>Organisations</th>
<th>Contact Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALM (Campaign Against Living Miserably)</td>
<td>0800 58 58 58 (open 5pm-midnight daily)</td>
<td>CALM is a registered charity, which exists to prevent male suicide by offering support to men in the UK, who are down or in crisis via our helpline or website. We offer accredited confidential, anonymous and free support, information and signposting to men anywhere in the UK through our helpline.</td>
</tr>
<tr>
<td>PANDAS</td>
<td>08432898401 (open from 9 am – 8 pm daily)</td>
<td>PANDAS is the leading UK charity in supporting families suffering from pre (antenatal) and postnatal illnesses. We provide our PANDAS Help Line, Support Groups, and online advice to all and much more.</td>
</tr>
<tr>
<td>Mind Infoline</td>
<td>0300 123 3393 (open from 9am-6pm Monday to Friday, except bank holidays)</td>
<td>Mind provides advice and support to empower anyone experiencing a mental health problem. We wont give up until everyone experiencing a mental health problem gets support and respect. Mind Infoline provides information on a wide range of topics including: types of mental health problem, where to get help, medication and alternative treatments, advocacy.</td>
</tr>
<tr>
<td>ManKind</td>
<td>01823 334 244 (open 10am to 4pm Monday-Friday)</td>
<td>ManKind is a charity that supports male victims of domestic abuse. For 15 years we have been at the forefront of providing services and support for male victims and campaigning to ensure that male victims receive the support they need from other organisations. Our confidential helpline is operated by trained people who can give both emotional and practical support as well as providing information.</td>
</tr>
<tr>
<td>NHS Direct</td>
<td>111 (open 24 hours a day)</td>
<td>NHS Direct provide health advice and information.</td>
</tr>
<tr>
<td>Samaritans</td>
<td>0845 7909090 Open 24 hours a day.</td>
<td>Samaritans offer confidential emotional support by telephone, email, text, letter and face to face.</td>
</tr>
</tbody>
</table>
Debrief information- Australian participants

Thank you for participating in this research study. We hope that you have found it interesting and have not been upset by any of the topics in the questionnaires or interview.

In the event that you have found any part of this experience to be distressing, there are a number of people and organisations that you can contact for support:

- If you would like to speak to the researcher, please contact Beth Turner on 07544303972 or beth.turner@postgrad.manchester.ac.uk. Alternatively, you can contact Dr Anja Wittkowski by writing to University of Manchester, 2nd Floor Zochonis Building, Oxford Rd, Manchester M13 9PL or emailing anja.wittkowski@manchester.ac.uk.
- If you feel as though you are struggling to cope, or feeling low in mood, it is important that you contact your GP for support.

There are also a number of organisations listed below that you can contact:

<table>
<thead>
<tr>
<th>Organisations</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>beyondblue</td>
<td>beyondblue provides information and support to help everyone in Australia achieve their best possible mental health, whatever their age and wherever they live. Support is offered via the telephone, email or online forums as well as providing information and links to help on their website.</td>
</tr>
<tr>
<td>MensLine Australia</td>
<td>MensLine Australia is the national telephone and online support, information and referral service for men with family and relationship concerns. The service is available from anywhere in Australia and is staffed by professional counsellors, experienced in men’s issues.</td>
</tr>
<tr>
<td>Lifeline Australia</td>
<td>Lifeline is a national charity providing all Australians experiencing a personal crisis with access to 24 hour crisis support and suicide prevention services. Lifeline offers a 24 hour telephone crisis line, online crisis support chat and other helpful resources and links on their website.</td>
</tr>
<tr>
<td>SANE Australia</td>
<td>SANE Australia is a national charity helping all Australians affected by mental illness. They offer support via their telephone helpline, online chat, email and online forums as well as providing information and links on their website.</td>
</tr>
<tr>
<td>Samaritans</td>
<td>Samaritans offer 24/7 anonymous crisis support services in Australia. You can access this support through their website, telephone line or email address. Samaritans volunteers are trained to provide emotional support and we can help you explore your options to come up with solutions.</td>
</tr>
</tbody>
</table>
Appendix Q. Example of coded extract of transcript

I: And it wasn’t something that you were offered prior to that?

P: No, that’s the point that I probably I am quite passionate about is the fact that there was never, it seems to be never considered erm nor looked for until erm I was very overt about it in the hospital. So there was no offer prior to me pushing for something.

I: And had you of got, how do you think erm it would have been if you’d have been offered that sooner?

P: Err very hard question to answer. Um, because I had to be convinced, the poor social worker had a hard job with me, I had to be convinced there was anything wrong with me erm at that time. I don’t want to make this all about me, obviously this was about [wife]’s care. Erm, so I am not sure I would have taken it up until, it’s hard to say, I don’t think I would have taken it up if it had been too early in the situation. It was more as the situation evolved then I became more affected therefore wasn’t able to support [wife], therefore they needed to support me as well.

I: Hmm. Do you think it would’ve been helpful to have been offered support sooner?

P: If yes. Um, yeah it would’ve been, whether I, again whether I would’ve accepted it or not, how it was offered I suppose would be the key and yes probably.

I: Hmm and how do you think, cause you mentioned before that they had a poster erm on the ward, and that you’d explored that but it kind of was sort of an external er misplaced thing. How, I guess ideally how, what do you think would have been helpful for you in your situation in terms of how you were offered support by the MBU?

P: What would have been helpful, if your doing normative and best case scenario is to be actively involved and informed in the decisions about care, rather than feeling like your partner has been taken away from you and now things are being done so them that you have to react to... And also clear erm, what the word I am looking for? Signposting! Uh from the ward, and beyond the poster, actually somebody be it the doctor or psychologist or social worker reaching out and saying “as a partner we recommend that you consider talking to our social worker or counsellor or whoever.
### Appendix R. Table of additional exemplar extracts for main themes and subthemes from thematic analysis

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Extract</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A smoother journey to and from the MBU</td>
<td>1.1 Prevention information</td>
<td>“Erm, so yeah there’s, I think women who do suffer from anxiety and depression prior to falling pregnant erm need special treatment, and its not just about the mother baby unit. They need to receive life and coaching skills prior to the baby coming, because y’know my wife deserved to be a mother like any other woman. It’s just she has complications when it comes to emotionally coping. And there was none of that. Y’know she, again in the five years previous to our first child, erm, y’know she went into hospital because of her anxiety and depression. Erm they just pump you full of drugs so you calm down and send you on your way. So yeah.” [P2]</td>
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<td></td>
<td></td>
<td>“Or even, even just a, because you do a lot of antenatal courses beforehand, maybe doing one for just men to sort of, where you just get everyone in and just say these are the sorts of things you could be looking for, erm, so, and just letting them know, that, you know, just because it’s, your wife who’s having, or, or partner’s going to be having the child, erm, doesn’t mean that you can’t you know have a class to tell you what you’re gonna be coming up with and what things could happen.” [P8]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Yeah. But she had erm, in terms of postpartum and getting admitted 1, y’know I believe (exhales) they don’t know how it happens or what it’s caused by. I just think there must be something in the make up of it to happen, she had suffered from a bit of anxiety and depression in the past. Erm, so that’s my personal opinion on it. I think that obviously labour’s massive, erm, so. I’m not saying that I could’ve predicted this ‘cause I, y’know, that’s just ridiculous, but y’know I feel it’s, it could be erm, y’know, looking back on her records they could’ve quite easily said, y’know, “we’ll keep an extra close eye on you”, which they would do the second time around. Because they know. But I think, they could maybe do a bit more at the start. To say, y’know, “potentially, because you’ve had an episode of erm anxiety and a bit of depression, then we’re gonna, y’know, maybe just do a few extra things after the birth”. So, y’know that in a service would be probably good.” [P4]</td>
</tr>
</tbody>
</table>
| 1.2 MBU admission | “...in terms of the admission, I wasn’t involved in that at all. [wife] was invited into the hospital to speak with somebody and then (coughs) just told “right, we think you should be admitted”...I was at work when I got that phone call.” [P7]  
“(sighs) I think the thing that would’ve made the whole experience better would’ve been more ready access, I don’t know how you’d achieve that but actually the period before getting onto the MBU was a really difficult time and she became massively unwell a lot more quickly. Um, the change in her when she got onto that unit was, was indescribably huge, uh so y’know the, the kind of value of being on that unit, having access to her child was um, was incalculable” [P5]  
“In tune, I mean the midwives were useless, if I’m honest, erm ... I remember saying to one, “I don’t think my wife’s quite right, it might be the baby blues”, and she said, “oh I think it’s past that by now”, and like, “oh, well, what then?”, but then that was it, nothing, they’re just like, oh...So they, they kind of new sommat was wrong but they didn’t tell me and they didn’t act upon it, they just thought it was just, I don’t know, “someone else’ll look after that” I suppose.” [P10]  
“And when they did come round, yeah, and when they did come round and they sat there and they, y’know you’d only have to look and talk to her, and to not act on it, y’know, I suppose it, I don’t know how much of it played like, y’know the house was always, the house is always tidy, erm, where [wife] had got dressed, you know what I mean? Erm, it wasn’t, y’know it weren’t carnage, but, so maybe they just looked at that and thought “Ah, they’re all right, they’re all right” d you know what I mean? But, it certainly wa’nt the case.” [P4] |
|---|---|
| 1.3 Post-discharge processes | “I, I felt they were just following the rules that they’ve got written down, that was just procedures, never mind that she seemed fine, it’s just, “no, that’s it” .. so in the end, it was only after the 28 days that they kind of said, ok she’s, she’s ok to go home ...” [P10]  
“I think so. Yeah, just kind of just lessens the shock. Cause it can be quite, like when you’re around six other mums and staff 24/7 that, and then going home to being by...” |
yourself can be really hard on the mother and then in turn that makes it hard on the partner, just cause they’ve got to try and help a lot more with the transit.” [P6]

“As I say, you know we were very fortunate in, in so far as it, it was the right decision, and it was all, it was all absolutely fine, but erm, but yeah, there was a definite, erm, we, we kind of stumbled through and, and, erm, you know, made some minor adjustments to how we did things at home and things like that to kind of accommodate things, but, but there wasn’t, there wasn’t much by way of support.” [P1]

“Yes. Yep, yep. So we got, which is, yeah so the month she came out, erm, with obviously sort of discharged etc, then back into the care of our community healthcare, this is in the [hometown] area. Erm, and that’s when the wheels came off. When we were discharged.” [P4]

“Erm, so there needs to be some aftercare process that allows those husbands who do want to help, to be able to help, and if they, because, my wife, her friends that have been in the Mother and Baby Unit, erm, don’t receive any additional care, er to help them, um, other than, you know, ‘take more drugs’. ” [P2]

“I think there was a poster that said “Are you a dad and you also need support- ask for it” but that was it. It was never offered and when I enquired about it I was kind of bounced between nurses until they gave me a phone line to a Christian counselling service where I could phone and get a counsellor if I wanted to pay for a counsellor. So that was the extent of the support at the start, in terms of when it wasn’t particularly helpful in any way.” [P7]

“Yeah honestly nobody you taking to that, but you know, erm, interviews like, saying ‘Mr (name) come into this room and you can share your feelings’, you know, nobody you know.” [P3]

“Erm, but obviously they had their protocols, so they have to do it, it’s just .. I think when, every individual case and if, if you feel that there’s, they’re not a threat during
the night and they like their sleep, then they should be able to just be given some privacy.” [P8]

“No, no I don’t think I did, I think that was the bit that didn’t happen really at all. There wasn’t anything specific in place in terms of erm my own mental health I think. Or even, you know I guess y’know how to deal with the trauma of the experience or how to... and I, you know I didn’t seek that, I didn’t ask for it, so I don’t and obviously I’m a bit selfish to say “I should’ve had all these things and I didn’t get them”. But at the same time I wasn’t, there wasn’t any offer or any y’know consideration that I might need those things.” [P5]

“No. No definitely not. It was kind of, sometimes I would go in and sort of pick up the baby and then [wife] would have a break while I was there. So I was there present but I wasn’t actually there with [wife]. I was there to help with care. You never had that set-aside space.” [P7]

2. Feeling included

2.1 Being involved in her care

“Erm, yeah, I suppose, with regarding medication and things, erm, my wife, my wife was a, she was a nurse, erm, herself, so when she first went in she, she rejected what was happening, and she wouldn’t take the medication, she didn’t want the medication that they were offering, so they would speak to me and obviously I just think, erm, it was important to be involved and they did speak to me, but, erm, I always seemed to do all the calls, I would, I would say that would be the only downfall.” [P8]

“Er, no, from, from my point of view everything was, I was involved in pretty much anything that I wanted to be involved in, they would let me, and I, I was always able to speak to staff about things, and ring up, so, I was never told that I wasn’t allowed to ask. I was always, I felt like I always allowed to be involved, in treatment or decision making.” [P8]

“Yeah .. if the husband doesn’t know the wife better than they do, then there’s something wrong.” [P10]

“On one occasion where she did see a psychologist erm I was asked to be involved.
Erm, I was hoping that I would get asked questions about my wife, erm, erm, so that I could be involved in caring for her. Erm, but that isn’t what happened. Erm, and it was nothing about, it was nothing about me and how I help and and they didn’t seek any questions from me they just wanted to tell me what was happening.” [P2]

“There was definitely a, a period of kind of settling down and things like that where, where it would have been useful to, erm, to be able to understand, erm, yeah, what, you know, kind of what, what she was going through and things like that, how to support her best.” [P1]

2.2. Considering my needs

“...erm, like I say, it was, it was one of those things that, that I was, I was welcome to be there, but, erm, but wasn’t actively catered for in any way.” [P1]

“So, it was really good in that respect, there was, there was not visiting times, you could visit at any time really.” [P8]

“I had to come away every night and it was really, really difficult, erm, you know, saying goodbye every night, and coming home, but, erm, yeah, so how was I supported? Erm .. I supposed by being able to stay a bit later, like I said, erm, .. … supported, I don’t know, my, erm, family was very supportive” [P9]

“It would have been really helpful would have had dinner (laughs) with everyone. Just if they, cause they bring in food for the baby and [wife] and it would have just been really helpful just to have dinner together as a family again. Just get there and have your dinner. But, it wasn’t an option and I had...Erm, yeah just something like that, just simple, just eating together would be great erm, erm (sighs). I know they allowed for people to, partners to stay some nights, like you weren’t allowed to stay every night but your were allowed to stay some nights. But it’s, it wasn’t really encouraged. It was more like if you want to, or if you have to you can. So, I guess I didn’t stay any nights, just cause I didn’t feel like the nurses really wanted it to occur. Erm, this is in the second place. In the first place there was no option to stay.” [P6]
<table>
<thead>
<tr>
<th>3. Uncertainty about what is going on</th>
<th>3.1 Uncertainty about the problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“I had quite a lot of one-to-one time with the nurse, or nurses, particularly in the early stages again. Erm, and then there was group sessions obviously with [wife] when we’d review her medications but in terms of like, there was quite a lot of look what y’know “how’s she getting on?” y’know “how was she last night?” erm, them types of questions, which we did, which I did one-on, which seemed t’happen one-on-one.” [P4]</td>
</tr>
<tr>
<td></td>
<td>“They gave me, you know, erm, three four paper sheet as well. Sheet information you know, about [wife]’s illness, what is schizophrenia, and how can you cooperate to that, you know, schizophrenic patient as well, and uh, this and that, lots of information.” [P3]</td>
</tr>
<tr>
<td></td>
<td>“I, I think, you know, so, erm, er, [wife] had postpartum psychosis, which, erm, I’d never heard of until she got it, like a lot of people, er, she’d never heard of it until she got it, so, erm, I think just anything, just, just, you know, it’s a, it’s a traumatic time, you know we had a four day old baby, erm, and, and kind of had never experienced anything like this before, so, erm, it’s just a really, it’s a stressful time anyway, and then, and then for this to happen was, was kind of really unexpected, so, from my perspective, I, I, I like to read and consume information and things like and I like to kind of know all these things and, like I say, I’d read the Wikipedia article on it.” [P1]</td>
</tr>
<tr>
<td></td>
<td>“That was variable information. So I was basically told by the doctor this is what it is and these are the potential side-effects and I had to, I remember going away and having to Google some of the medication to get a sense of what it was.” [P7]</td>
</tr>
<tr>
<td>3.2 Uncertainty about the ward and treatment</td>
<td>“...how do I, when’s the best time for me to access the ward? Should I come at lunchtime or should I not? How do I interact with other patients? Just a general ‘beginners guide’ to what is happening right now erm and what is this unit? What is the aims, etc?” [P7]</td>
</tr>
</tbody>
</table>
|                                     | “Erm, y’know being told that, y’know having the explanation about the, the drugs and the value that they have in her treatment, somebody said that and I went ‘ok, that
make sense to me. Thank you for telling me that”. I need a lot more information like that.” [P2]

“I would like to know how I am suppose to…. talk to, what I am suppose to say, erm, how I am suppose to, if you like, behave, erm, when my wife is in a state of, erm severe depression, erm how am I suppose to help in that situation, y’know ‘casue I can tell you that I’ve felt absolutely helpless. My wife wants me to say something, but if I say something then erm it’s, it’s going to be the wrong thing, but not saying something isn’t the answer either.” [P2]

“I suppose just sharing, sharing erm experiences and, y’know “how did you deal with that” I suppose, someone who’s actually experienced it, ‘cause it is quite rare I suppose. So, y’know, “how did you..” yeah just, sharing experiences, ‘cause it can just be helpful.” [P4]

3.3 Uncertainty about the future [talking about reading on a charity website] “And especially I really really enjoyed and really really ((laughing)) feel a lot better, the stories of other mothers who’d gone through similar situations and things like that. That was the best part, cause I was like as I’d never seen this condition before, I was really worried that it was going to be something that I didn’t know she’d recover from, y’know…. so it’s just to see, read stories of other people that have gotten through it. I guess was really, really helpful.” [P6]

“Yeah, absolutely, erm, I think, I think if somebody had been through it and told me that they, they’d been through it, you do get through it and like, if, if I knew sort of then, that somebody had been through a really difficult stage and then they got, they got through it and they were still with their wife or partner, they were happy, even, even knowing if anyone had tried for another baby and it didn’t happen, you know. things that like this that we’re now thinking about, erm, obviously we’re always gonna be worried now, in case it could happen again, erm, it’d be, it’d be useful to know of people that had had it, that sort of haven’t gone through it again.” [P8]

“Er, well it took a while before, postpartum psychosis was diagnosed .. erm .. from
what I remember, I wasn’t … er … the psychiatrist, psychiatrist or psychologist? I never remember which way round it is, but … it took a while before I heard those words … erm … and that was completely alien to me, and then because I didn’t have any … anyone to sit down with me and tell me what it was, on my own, and what the recovery is, or the drugs are, I was left with google … so I’ve got electric shock therapy in my head … I’ve got, “she’s never gonna get better, she’s gonna have episodes all the time”, our life is gonna be permanently taking my wife to … sounds bad but taking her to the mental hospital.” [P10]

“No. no, erm, and, and, not at all, erm, but yeah, that, that, that would have been useful, erm, and again I guess it comes back to, to kind of two, the sort of two streams in the kind of clinical support in terms of understanding, erm, or at least helping to understand, trying to understand, you know, how, how she’s likely to be and how, erm, what her recovery prognosis was, was likely to be like, and those kind of things.” [P1]

3.4 Uncertainty about my child’s care

“…you don’t know how much attention they get, especially when there’s a lot of other babies, so I was hoping that um they would take good care of him so I was a bit worried, but I knew that they would. Erm, but y’know it’s your kid and so I hope, I want the best for them, so you’re kind of just a bit worried about it. Erm, and I know that they are not as attentive because they, they want to get them into good sleeping patterns so they kind of allow them to cry a bit more than what I would’ve liked. But, they set him up on a great sleeping pattern so I can’t, y’know I can’t complain erm about that. Just, y’know, you just hope that they didn’t ignore him too much when he was a little baby (emotional tone).” [P6]

“…anything that I didn’t understand they would, they would, the staff would ask and if we couldn’t, if I couldn’t calm my little girl down or my wife couldn’t, the staff members would say, “would you like me to try?” And they were, they were very helpful, they were, and anything I needed I knew they were there, basically.” [P8]

“Some of them, some were nursery nurses and some were just nurses as I understand it. Some had professional experience and some were just nurses who got I think there
was perks of doing that particular shift for some reason.” [P7]

“Erm, and, and, I’m realistic, it’s, again difficult with time and things like that, erm, you know you can’t be there twenty four seven, and a lot of that stuff obviously isn’t, er, isn’t necessarily scheduled, but, erm, but yeah, it would have been nice to be there for kind of baths and things like that certainly.” [P1]

4. Barriers to support

4.1 Personal barriers

“I guess I’m conscious that I probably swanned onto the ward saying “it’s alright, I’ve got this” (laughs) and y’know “I know a bit about mental health. I’m fine with it, it’s all fine”.” [P5]

“Very typical er….male not really fully emotionally open to what I may be experiencing (laughs) so I needed some professionals to help me see that.” [P7]

“I suppose I felt like I pushed people, I wanted to push people away and just deal with it. Y’know even like my close friends y’know, popping round or y’know, or “we’ll come and cook dinner and stay over” and “Ah no, I’m fine. I’m fine” y’know, in looking back y’know if anything ever happened again like that I’d definitely be, y’know have people round more then I did (exhales).” [P4]

“I don’t know if it was just an admin person, or a nurse, or .. or what, but, ‘cos they
all dress the same, there’s no uniform, it’s just, erm, .. I didn’t know who was staff actually, and who was a patient, ((laughs)))” [P10]

“No, no, I don’t think there was actually, there, obviously the vast majority of the staff were female, erm, but not exclusively, there were, there were a couple of men, erm, one of whom was [wife]’s nominated, erm, you know, er, carer sounds like the wrong word, I can’t remember the term they used, but, but, erm, he was terrible, never saw him, but, but there was one of the other sort of support, erm, staff, who, who was male and he was very good, erm, so, I was kind of never the only man around, as I say was often one of the other partners was there, erm, it’s obviously a very female dominated environment, but no, it, I, I didn’t, I didn’t ever feel kind of awkward or, or was made to feel awkward or anything like that. Erm, by being a man, so, no, I don’t think that was a, a massive issue.” [P1]

“I don’t know if I’m honest if I would expect that from an NHS unit, um. You know, if I had to choose I would rather support continued to be focussed on, on my wife and other women in there and the children, y’know. But in terms of, I wasn’t being noble I just think that’s y’know if they’ve got to make choices about where there put their resource then I think that’s what I would say is sensible.” [P5]

4.3 Barriers in the relationship between participants and the MBU

“... And you didn’t really want to pry into everyone’s life, cause I didn’t know what half the women were in there for. And y’know some of them were in the hands of the state I think, some of the babies, so I was just, there wasn’t really a good social I guess environment for me, but I’m sure for [wife] it was different, like she would have talked to all the mums during the day, I mean they were in there 24/7 I guess. But not really for dads I think.” [P6]

“Well when they were saying that she wasn’t allowed off the ward, and we’re allowed in the back garden, at first I thought, “ok”, but .. I kind of felt she was ok to go out at that point, and then when it became, “you can go to Asda”, I thought “well that’s ridiculous” .. if you’re letting her out with me, then she can go anywhere, and then when they allowed that weekend, she was absolutely fine, and I almost, we almost decided, not to bother going back .. .. because you, you did feel like you were
... almost school children, and you had to do what the teacher tells you, it’s that, that feel to it .. not treated as, as adults, if you know what I mean?” [P10]

“We were at times, but it never, it was never really erm, they never really backed down. Whenever I left again they would once again try and enforce their preferred methods.” [P7]

“Again er I suppose that’s one I remembering but I asked for that and again the charge nurse and I agreed to do that once a week on a Monday at a time. It happened for a fortnight then dropped off. And I had to go and chase it up and say “what’s happened to this? Why is it not happening?” Erm so it was never constant, never a, no consistent outreach and consistent relationship between the mother and baby unit and me as a father.” [P7]

<table>
<thead>
<tr>
<th>Facilitators to support</th>
<th>5.1 Quality of the relationship</th>
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<tbody>
<tr>
<td>“I think they, they were always there to speak to, so if at any point, if I was there like every day, all day, and if at any point at all I had anything, any concerns about [wife] wellbeing, or, you know, if she, “is the psychosis coming back”, or, erm, I could, I could just talk to somebody and immediately would be kind of, you know, like I’ve like, go in a, in a private room and talk about it.” [P9]</td>
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<tr>
<td>“Yeah, the nurses were great, there were few of them um obviously they worked shifts so you don’t see them all, like each day you don’t see each one each day but you kind of, there were about three or four that were always there um that you’d see intermittently and they were great. They were really nice and friendly and just kind of, like they were sort of similar age so they kind of just bought it back to reality that you know, like we’ll get through this, and like y’know as in like they were just kind of distracting you from the fact that you’re where you were and things like that. And they were good to have around I think.” [P6]</td>
<td></td>
</tr>
<tr>
<td>“When we got there the nurses and the nursing staff they were, they did give us any information and like I say, they always made themselves available for anything, they always said, ‘anytime you want anything, we’re here’.” [P8]</td>
<td></td>
</tr>
</tbody>
</table>
“"I think they, they were just kind of motherly (laughs) I think they would just sort of ask me how I am, am I getting sleep, am I, y’know getting enough to eat.” “[P5]

5.2 Efforts made by staff

“There was a, a, there’s a back door that we could use, and when they sort of, trusted us a bit more they let us use that so we didn’t have to go through the ward with, I didn’t need to use that the first time round, but when I visited with my son erm they let us use the back door, it’s like a fire door, erm, so that he didn’t have to walk through the ward. Which was a general psychiatric ward as I say, with a fairly large, well I think sort of fifteen, sixteen bed ward off the top of my head. And, y’know I, he was only three, it’s not that I kind of would want to shield him from all those things, but I think it was, there was some element of risk potentially walking through a general psychiatric ward with a three year old. Or certainly that’s what the staff were keen to avoid. Erm, and y’know I don’t know who was on the ward at the time but they did so they must have had reason for wanting that to be avoided.” “[P5]

“(sighs) perhaps it would be helpful, but I probably need a bit more encouragement, you know, than just a letter through the door, erm .. it would have helped at the time definitely” “[P9]

“Um, I guess yes but I wouldn’t have sought them out, I would’ve wanted them to seek me out, rather than the other way. Just cause I don’t, it’s just not in my personality to kind of deal with, to go out asking for help. Um, but it would’ve, it could’ve been nice if someone just asked y’know “are you going, y’know, it’s going to be ok” or just talk you through that and that type of thing. I think it would be nice to have.” “[P6]

“Yeah, now, now that I’m looking back on it and thinking, like if someone was to reach out, once we were out and said “look we understand what you’ve been through, would you like to come..”, that was maybe something I would consider going and talking, if I could help other people, sort of my experience.” “[P8]
Appendix S. CASP quality assessment tool

CASP
Critical Appraisal
Skills Programme

CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

Are the results of the study valid? (Section A)
What are the results? (Section B)
Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA ‘Users’ guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.

©CASP this work is licensed under the Creative Commons Attribution – Non-Commercial-Share A like. To view a copy of this license, visit http://creativecommons.org/licenses/by-nc-sa/3.0/ www.casp-uk.net
### Section A: Are the results valid?

**1. Was there a clear statement of the aims of the research?**

- **Yes**
- **Can't Tell**
- **No**

**HINT:** Consider
- what was the goal of the research
- why it was thought important
- its relevance

**Comments:**

**2. Is a qualitative methodology appropriate?**

- **Yes**
- **Can't Tell**
- **No**

**HINT:** Consider
- if the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- is qualitative research the right methodology for addressing the research goal

**Comments:**

**Is it worth continuing?**

**3. Was the research design appropriate to address the aims of the research?**

- **Yes**
- **Can't Tell**
- **No**

**HINT:** Consider
- if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)

**Comments:**
4. Was the recruitment strategy appropriate to the aims of the research?

- Yes
- Can't Tell
- No

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g., why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

- Yes
- Can't Tell
- No

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g., focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g., for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g., tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:
6. Has the relationship between researcher and participants been adequately considered?

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:
8. Was the data analysis sufficiently rigorous?

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher’s arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:
Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature)
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:
Appendix T. Poster presentation of national survey of MBUs

Psychosocial support for male partners of women admitted to Mother and Baby Units in the UK

B Turner, C Garrett, A Wittkowski
1 Division of Psychology and Mental Health, The University of Manchester
2 Greater Manchester Mental Health NHS Foundation Trust

Introduction
Psychiatric Mother and Baby Units (MBUs) offer dual admission for women experiencing perinatal mental health problems and their infant in order to improve mental wellbeing and minimise disruption to the mother-baby bond. However, this also means separation from their partners, which can have a detrimental impact on the relationship between the woman and her partner and the father-infant bond, as well as impacting on the man’s wellbeing and adjustment to fatherhood.

As partners can help facilitate recovery, current UK guidelines for managing mental health problems in pregnancy and the postnatal period recommend addressing the needs of partners by offering appropriate emotional, informational and practical support.

Previous qualitative studies conducted with partners of women admitted to MBUs have highlighted that men would like support during their partners admission (1,2). Thus, the current survey sought to identify what support has been offered to male partners of MBU patients in the UK.

Method
Participants
Seventeen Mother and Baby Units in the UK were contacted.

The Survey
A questionnaire was devised requesting information on:
1. The service context and clinical population
2. Psychosocial and/or psychological support for male partners
3. Barriers to and facilitators of providing support
4. Future aspirations for supporting male partners

Procedure
The MBUs were contacted via telephone and email between September 2016 and February 2017 by two researchers and given information on the survey. The questionnaire was then completed over the telephone.

Data analysis
Survey responses were summarised using descriptive statistics and the qualitative data were grouped into themes.

Conclusions
The current survey was the first of its kind to be conducted in the UK to examine what support has been offered to male partners of women admitted to MBUs in the UK.

All of the participating MBUs (n=17) reported offering psychosocial/wellbeing support to male partners. The way in which this support was offered varied between units, which is likely to be influenced by the needs of the men and the services resources.

This survey identified good practice amongst MBUs and highlights opportunities for additional programmes that can further enhance mental health outcomes for the women and their families.

We are currently conducting a study to explore what support would find helpful and how they would like this to be offered, as well as exploring the barrier to and facilitators of accessing this support from the men’s perspective.

References

Faculty of Biology Medicine and Health

www.bmh.manchester.ac.uk
Appendix U. Approval letter from Greater Manchester Research Ethics Committee - Substantial amendment to recruitment procedure

NHS
Health Research Authority

North West - Greater Manchester East Research Ethics Committee
3rd Floor, Barlow House
4 Minshull Street
Manchester
M1 3DZ
Tel: 030 71048008

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

30 June 2017

Ms Beth Turner
Zochonis Building
University of Manchester
Manchester
M139GB

Dear Ms Turner

Study title: The psychosocial support for male partners of women admitted to mother and baby units.
REC reference: 17/NW/0117
Protocol number: NHS001151
Amendment number: 1
Amendment date: 18 May 2017
IRAS project ID: 214435

Changes to recruitment.

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The members had no ethical issues with this amendment.
Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copies of advertisement materials for research participants</td>
<td>1</td>
<td>18 May 2017</td>
</tr>
<tr>
<td>[Online advertisement]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-validated questionnaire [Family background questionnaire]</td>
<td>4</td>
<td>18 May 2017</td>
</tr>
<tr>
<td>Notice of Substantial Amendment (non-CTIMP)</td>
<td>1</td>
<td>18 May 2017</td>
</tr>
<tr>
<td>Participant consent form</td>
<td>4</td>
<td>18 May 2017</td>
</tr>
<tr>
<td>Participant information sheet (PIS)</td>
<td>3</td>
<td>18 May 2017</td>
</tr>
<tr>
<td>Research protocol or project proposal</td>
<td>3</td>
<td>18 May 2017</td>
</tr>
</tbody>
</table>

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members’ training days – see details at [http://www.hra.nhs.uk/hra-training/](http://www.hra.nhs.uk/hra-training/)

17/NW/0117: Please quote this number on all correspondence

Yours sincerely

[Signature]

Mr Simon Jones
Chair

E-mail: nrescommittee.northwest-gmeast@nhs.net

Enclosures: List of names and professions of members who took part in the review
**Questionnaire for service evaluation: psychological support offered to partners of women admitted to UK MBUs & Survey**

Date completed ____________________

**BACKGROUND INFORMATION**

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Name of Service</td>
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<tr>
<td>2.</td>
<td>Total number of beds</td>
</tr>
<tr>
<td>3.</td>
<td>Ward team staff structure/ team members/ roles (please describe):</td>
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<tr>
<td>4.</td>
<td>Name of clinical psychologist(s)</td>
</tr>
<tr>
<td>5.</td>
<td>Usual time spent on the ward by the clinical psychologist/ week (hrs):</td>
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<tr>
<td>6.</td>
<td>Primary diagnoses of ward population</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia (pre-dating pregnancy) ____%</td>
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<tr>
<td></td>
<td>Schizoaffective disorder _____%</td>
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<tr>
<td></td>
<td>Puerperal psychosis _____%</td>
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<td></td>
<td>Bipolar disorder ______</td>
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<td>Anxiety disorder ______%</td>
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<td></td>
<td>Personality disorder ______%</td>
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<td></td>
<td>Intellectual disability ______%</td>
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<td></td>
<td>Other ______%</td>
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<tr>
<td>7.</td>
<td>Average length of ward stay (days):</td>
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</table>
The CQUIN 2016/17 Standards for In-Patient Mother and Baby Units outlined a need for MBUs to ensure that appropriate emotional, informational and practical support is offered to partners to enhance their understanding and participation in the woman’s care and promote their bond with the infant (NHS England, 2016). Following this guidance we are interested in what general support partners of MBU patients are offered by the ward. This support could take many forms, some of which may be informal and others that may be more structured. Support may be offered on the ward but we are also interested in anything that partners are signposted to that is outside the ward or online. Support may be offered by the ward psychologist or by other trained members of staff. The support may follow a structure that has been developed elsewhere or ‘in-house’. If you have taken a pre-existing resource but adapted it for your setting/ client group, we would be interested to hear about this.

SECTION 1: DESCRIPTION OF PSYCHOLOGICAL SUPPORT OFFERED TO PARTNERS ON MBUS

Definition: In line with the 2016/17 CQUIN, the term ‘support’ within this questionnaire refers to psychological, emotional, informational and practical support.

How do you support partners of MBU patients? (please circle):
- Leaflet
- Face-to-face chat
- Telephone support
- Support group
- Informal support session
- Formal support session
- Other (please state):

Is this support: a.) a pre-existing resource obtained from elsewhere or b.) something that has been developed ‘in-house’ (please delete as appropriate)?

If from elsewhere, where did you hear about/ obtain the intervention and who are the authors/developers? Please give details.
**Brief description of support** (e.g. 1:1 support/chat or group support):

**Who has access to this support? All partners/ Only some partners** (please delete as appropriate)
If only some partners, please give details of criteria used to select:

**Delivery**

1. **Individual/ group/ mixture** (delete as appropriate)

2. **Structure** (number of sessions, frequency, session length, time between sessions):

3. **Who delivers the support?**

4. **Is information relating to consent and engagement recorded?** (E.g. number of partners enrolled in support, whether partner declined and whether consent was sought from patient). If so, where is this information recorded (e.g. in patient’s notes, or in patient’s care plan?)

5. **What is their professional background/ occupation?**

6. **Is this person a member of the core staff team?** Yes/ No (delete as appropriate)

7. **Was the specified person required to undergo specific training to undertake this intervention?** Yes/No (please delete as appropriate)
   If yes, please give details (info on cost would be useful if paid for by the NHS):

8. **Materials used** (e.g. manuals, worksheets- please describe):

9. **(If the support is a pre-existing resource) Do you deliver the support as originally specified or has it been adapted to suit your the setting or patient group?** Yes/No (please delete as appropriate)
Please describe any adaptations you have made:

10. **Is the programme available for general use or under copyrighted?** (please delete as appropriate)
    Please give details of availability (if appropriate):

11. Related to the answers to previous questions (ques 3-7), what are the cost implications of the support provided?

12. Related to the answers to previous questions (ques 3-7), what are the practical challenges of the support provided (e.g. mothers not consenting or father declining)?

**SECTION 2 – FUTURE DEVELOPMENT**

1. **Is there any psychosocial or psychological support aimed at partners that you feel you would like to be able to offer on your unit?**

2. **Do you have a sense of who might be best placed to deliver this?**

3. **Do you perceive any barriers to offering further structured/manualised psychological support on your ward?**

4. **Do you perceive any facilitators to offering further structured/manualised psychological support on your ward?**