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

Beth Ruffell¹, Dr Debbie M Smith^{1,2} & Dr Anja Wittkowski^{1,3,*}

¹ Division of Psychology and Mental Health, School of Health Sciences, Faculty of
Biology, Medicine and Health, The University of Manchester, United Kingdom

² School of Social and Health Sciences, Leeds Trinity University, Horsforth, United
Kingdom

³ Greater Manchester Mental Health Foundation NHS Trust, England, United Kingdom

* Corresponding author: Anja Wittkowski, Division of Psychology and Mental Health,
School of Health Sciences, Faculty of Biology, Medicine and Health, The University of
Manchester, Manchester Academic Health Science Centre, Zochonis Building, Brunswick
Street, Manchester M13 9PL, England, UK. Email address:
anja.wittkowski@manchester.ac.uk.

Psychosocial support for male partners of women admitted to Mother and Baby

Units: A qualitative study

Abstract

Objective: This study explored what support male partners of women admitted to Mother and Baby Units (MBUs) wanted in terms of content, delivery and timing.

Background: Although research has highlighted the need to support male partners of women admitted to specialist MBUs, little is known about the type of support men want and how they wish support to be delivered

Methods: 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 advice from professionals. They also highlighted barriers to accessing support and offered solutions to minimise those. In terms of clinical implications, we recommend a support package, which could be developed for MBUs to improve outcomes for male partners and their family.

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. 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 MBU. MBUs exist worldwide, range from 4-13 beds, are staffed by multidisciplinary teams and offer a range of interventions to improve maternal mental health and to enhance the mother-infant-bond (Connellan et al., 2017; Wittkowski & Santos, 2017; Garrett, Turner & Wittkowski, 2017; Gillham & Wittkowski, 2015; Glangeaud-Freudenthal, Howard & Sutter-Dallay, 2014).

The 2014 NICE 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. Qualitative studies have shown that male partners support women's mental health treatment and recovery and that women wish their partners to be supported by services during this difficult time (e.g., 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 systematic 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, submitted). In addition, Harvey and McGrath (1988) found that 42% of men from a MBU group (n=40) met criteria for psychiatric disorders, compared to 4% in the comparison group (n=25). This finding was later replicated by Lovestone and Kumar

(1993): 50% of the MBU group met DSM-III scores for 'caseness' on the Schedule for Affective Disorders Schizophrenia (SADS, Endicott & Spitzer, 1978), compared with 33% of the in-patient group. MBU partners also had significantly higher scores on the General Health Questionnaire (GHQ, Goldberg & Williams, 1988), indicative of more symptoms of psychiatric mental health problems.

To date, five qualitative studies underscored the emotional impact on men during their partner's admission, which was associated with psychological distress, compromised lifestyles and conflicting feelings (Boddy, Gordon, MacCallum & McGuinness, 2017; Kemp, 2011; Marrs et al. 2014; Muchena, 2007; Reid et al, 2017). Impacts of admission on their role as a father and a partner were also reported (Kemp, 2011; Marrs et al., 2014; Muchena, 2007; Reid et al., 2017). 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, the NHS England Commissioning for Quality and Innovation Scheme (CQUIN) for 2016/17 required 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). However, this support has not been defined in terms of structure or delivery. A recent UK survey identified that support in the form of welcome information or an individual support session by staff was routinely offered to partners by MBUs, but the type of support varied across units (Turner, Garrett, & Wittkowski, 2017). A systematic review (Ruffell et al, submitted) highlighted barriers to support faced by male partners of women with postnatal mental health problems, including ineffective communication from professionals and insufficient resources. Partners can feel marginalised and ignored by perinatal mental health services (Lever Taylor, Billings,

Morant & Johnson, 2017), making them reluctant to seek support (Muchena, 2017; Kemp, 2011). 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

This qualitative 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. Due to the lack of research on this topic, no limit was placed on area/country of residence, partner's mental health diagnosis and history (including time lapse since their first MBU admission) so that a varied sample was recruited with the phenomenon of being male with a partner who had spent time on a MBU being the focus. Recruitment commenced with one UK MBU sending letters to partners of past patients. However, recruitment was slow so a second recruitment path was introduced using an online advert was posted on online forums, charities and influential bodies via Facebook and Twitter. Informed consent was obtained and, prior to the interview, participants also completed an adapted version of the Family Background Questionnaire (Sanders & Morawska, 2010), providing information on: 1) demographic details, 2) family structure, 3) experience of their partner's mental health and 4) perceived social support (adapted from Webster et al., 2000). The study had full ethical approval (17/NW/0117) and adhered to research governance procedures.

An interview schedule was developed, informed by a secondary analysis (Ruffell et al, submitted) and other literature (e.g., Turner et al., 2017). A copy of the interview schedule can be found in Appendix 1. The lead author (BR) conducted all interviews which were audio-recorded using an encrypted device and transcribed verbatim.

Analysis

Interview data were analysed using inductive and deductive thematic analysis on a latent level, to identify and interpret underlying concepts (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).

Braun and Clarke's six-phase-protocol was followed (2006) (Table 1). The first author (BR) and another author (DS) read and independently coded all transcripts with all authors agreed on the final themes. Descriptive statistics were used for participant background information and context.

[Table 1 about here]

Reflexivity

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. Two were parents and one had experience of working on a MBU. They held assumptions that male partners influenced women's outcomes, had specific needs, wanted support and that there was a gap in service provision.

Results

Interviews were conducted between September 2017-January 2018, via telephone (n=2), Skype (n=7) or in person (n=1). Interviews lasted between 48 minutes and 73 minutes (Median= 62 minutes).

All ten participants who consented to take part completed the study. Recruitment was consciously stopped at this point after a team discussion and decision that no new experiences were being expressed in the interviews. Code saturation can indeed be reached between seven and 16 interviews (e.g., Guest et al., 2006; Namey et al., 2016).

Participant characteristics are outlined in Table 2. 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 time since first admission varied between seven months and eight years. 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 2 about here]

Following analysis, five broad themes were developed with 15 corresponding subthemes:

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* (see Table 3). All interviews provided data to support each theme, although opinions were diverse. In line with the aims of the study, Figure 1 presents a thematic diagram of themes and their relationship with content, delivery and timing.

[Table 3 about here]

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 MBU admission. Four subthemes were evident.

[Figure 1 about here]

Subtheme 1.1: Prevention information

A lack of antenatal information about postnatal mental health problems, meant participants reported feeling '*shell shocked*' [P7] and did not immediately recognise the 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., submitted), and the crucial role information plays in recognising symptoms and seeking help (Plunkett et al., 2016). Experiences of '*shock*' [P8], confusion and feelings of powerlessness and helplessness have been identified previously (Boddy et al., 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 on the mother (Kowlessar, Fox & Wittkowski, 2014).

Subtheme 1.2: MBU admission

Trying to get professional help was a challenge for the families, with most journeys involving uncertainty and frustration, influenced by a perceived lack of expertise around postnatal mental health in the community and of a clear referral pathway to the MBU.

Partners 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., submitted), and experienced care as inadequate, inconsistent or delayed (Lever Taylor et al., 2017; Muchena, 2007; Ruffell et al., under review). Similarly to previous research (Boddy et al., 2017, Lever Taylor et al., 2017; Marrs et al., 2014; Muchena, 2007; Reid et al., 2017; Ruffell et al., submitted), most of the participants in the current study spoke about their relief when their partner was admitted to hospital surrounded by experts, but reported that they felt excluded from the admission process.

Subtheme 1.3: Post-discharge processes

Settling back at home was a challenging time, 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 comparable to other studies (Boddy et al., 2017; Marrs et al., 2014).

Subtheme 1.4: A space for me and my family

The importance of having a space away from their partner in which to 'get it out' [P4] was reported by some. This is akin to Kemp's study (2011) in which partners spoke about the relief of having someone to 'let off steam to', and Lever Taylor et al.'s findings (2017) that participants wanted 'someone to talk to'. Other participants said that advice on how to manage their own wellbeing would have been helpful, the impact of MBU admission on the partner's emotional wellbeing is well documented (Boddy et al., 2017; Harvey & McGrath, 1988; Kemp, 2011; Marrs et al., 2014; Muchena, 2007; Lovestone & Kumar, 1993; Reid et al., 2017).

Most participants said that peer support would have been a helpful way to support them emotionally. Ruffell et al.'s review (submitted) 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. Some participants spoke positively about the ward environment, which felt 'homely' [P8], relaxed and family-oriented, and supported family time. 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. 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

Divided into two subthemes, this theme underscores the importance for men of being part of the care process.

Subtheme 2.1: Being involved in her care

The participants spoke about wanting more involvement in the care of their partner during her MBU admission. 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, 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., submitted). Participants from past studies also spoke about wanting to be included in treatment and that treatment should be family-focussed (Kemp, 2011; Marrs et al., 2014). Furthermore, partners have been recognised as integral to a woman's recovery (Plunkett et al., 2016; Kemp, 2011).

Subtheme 2.2: Considering my needs

Participants reported that it was important to them that their health and practical needs were also considered and that they were offered specific support. Male partners have already voiced 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 (e.g., 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]

Four subthemes reflect that all participants reported uncertainty around their partner's diagnosis and/or treatment, and their infant's care.

Subtheme 3.1: Uncertainty about the problem

All participants spoke about wanting support to understand their partner's diagnosis.

Participants expressed the importance of knowing about their partner's progress, especially if they were unable to visit daily. Some participants said that they received information about their partner's mental health problem in meetings, whereas some had to ask for this

information. Others spoke about the lack of resources to help them understand the diagnosis. Sometimes the updates that were given felt too generic, with individualised updates from the treating clinician suggested as being more helpful. Most participants suggested that a combination of a leaflet and a meeting to talk through the information would be helpful, and that one-to-one meetings 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, procedures, 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 anxiety. A 'beginners guide' [P7] to the ward was suggested as a way of orientating the participants to the MBU and its procedures and policies.

Most participants spoke about the need to understand the treatment their partner was receiving, and how this lack of knowledge was stressful. Some participants did their own research. 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.

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 important to their support. Some participants spoke about trusting 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 staff trained in childcare on the ward. Some participants spoke about how they appreciated having unrestricted time with their infant, which strengthened their bond. Participants in other studies 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 of 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, 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

In the fourth theme, all the participants identified specific barriers, which had prevented them from accessing MBU related support. They offered suggestions on how these barriers could be minimised and support could be delivered.

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 (submitted) 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. Some participants spoke about not being in the 'right frame of mind' to ask for support or felt '*too shell shocked*' [P7] by the experience.

Akin to findings from previous research (Kemp, 2011; Lever Taylor et al., 2017; Muchena, 2007; Reid et al., 2017; Turner et al., 2017), participants 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. This was particularly pertinent for one participant, who had recently moved to the UK and was applying for a visa to remain in the country at the time. For some participants, '*closing up*' [P4], '*pushing others away*' [P4] and '*refusing support*' [P5] was a way of protecting themselves and others. According to Ruffell et al. (submitted), physical and emotional withdrawal as a coping strategy were used by partners experiencing adverse emotions. Ambivalence and other barriers relating to partners' willingness to engage with support have been acknowledged (Turner et al, 2017; Lever Taylor et al., 2017; Muchena, 2007). Participants were worried about '*opening up*' [P7], fearing it might make them feel vulnerable or upset other patients, including their partner. In this study, participants also talked of fearing negative responses from friends and family and that asking for support could have made staff think there was a problem in their relationship

Subtheme 4.2: Barriers relating to the MBU

Some participants were aware of financial restraints within healthcare services and wanted resources to be focussed on their partner. Other participants spoke about knowing their partner was the primary patient and therefore not '*feeling entitled*' [P1] 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 (Boody et al., 2017; Kemp, 2011; Marrs et al., 2014; Muchena, 2007; Reid et al., 2017). Contrary to Kemp (2011), most of the participants from the current said that they had not experienced the '*female dominated environment*' [P1] of the ward as a barrier.

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

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. 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. Past studies found that men perceived communication with health professionals as unhelpful (Ruffell et al., submitted), 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.

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

In the final theme, participants spoke about how their relationship with MBU staff, and how the support was delivered would allow them to overcome some of the barriers to accessing support.

Subtheme 5.1: Quality of the relationship

Although some participants had negative experiences of relationships with MBU staff (see subtheme 4.3), others described developing positive relationships. 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*' [P4], which gave them confidence in the advice they were given and trust that staff would update them if required. These positive experiences gave participants reassurance about the care being provided to their partner and baby, and hope for their partner's recovery. 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 went '*above and beyond*' [P9] their role. 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*' [P8], 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 their need for support to be voiced by staff, because this may not have been obvious to the participants at the time. This proactive MBU approach could have helped participants to overcome some of the personal and situational barriers they faced and has been mentioned previously (Lever Taylor et al., 2017; Ruffell et al., submitted). 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.

Discussion

Participants provided information on the various ways that MBUs can support them, resulting in clear recommendations, outlined in Figure 1. 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 generic and applicable to most MBUs with some additional idiosyncratic information.

As male partners wanted an individual meeting as well as written resources MBUs should invite partners to attend meetings or ward rounds in order to provide information about diagnosis, treatment and prognosis specific to their spouse, allowing male partners to

share their concerns and ask questions. Such meetings should be conducted with the woman's knowledge and consent, and staff should consider the impact on the woman and the couple relationship.

As participants emphasised their emotional support needs, MBU staff could also offer male partners advice 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. However, recovery information is likely to be generic and not individualised, so learning how to manage uncertainty is crucial for partners. 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.

In England, support of partners has been set as a MBU 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. 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.

The study used a convenience sample of male partners, who were willing to share their views and they were able to articulate their experiences. Due to a lack of research and clear guidelines as to what should be offered to males partner, variety was sought in this exploratory study and thus data and findings were not restricted to UK MBUs and one healthcare provider or one time-point. As male samples are often hard to recruit, this study required a flexible approach to recruitment including introducing online recruitment. The sample size may be considered to be small but the research team were satisfied that code saturation was reached because no new experiences were being reported in the data.

In conclusion, this qualitative study emphasises how having a partner who has been admitted to a MBU for the treatment of postnatal mental health problems can be distressing and challenging 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. Following changes to service requirements for MBUs in England (NHS England, 2016) a recent survey of UK MBUs (Turner, Garrett & Wittkowski, 2017) noted some improvements in the support being offered to male partners; however, MBU staff could be more proactive and consistent in offering psychosocial support to men for the benefit of the family. Men in this study offered valued guidance on such an intervention approach.

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Table 1: Details of the thematic analysis (based on Braun and Clarke, 2006)

Phases	Analysis of interviews for main study
1	Interviews were transcribed and the transcripts were read several times and initial ideas noted .
2	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.
3	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.
4	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.
5	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.
6	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.

Table 2: Overview of participants' socio-demographic background and MBU admission history

ID	Age	Ethnicity	Education	Employment	Financial status	Relationship status	First-time father at MBU	Planned pregnancy	MBU 1st episode of MH problems	MBU admissions	Time since admission, 1st(2nd)	Social support score
1	31	White British	University	Full time	Comfortable	Married	Yes	Yes	Yes	1	8 months	High
2	46	White Australian	Trade	Full time	Somewhat comfortable	Married	No	Yes	No	1	5 years 1 month	Medium
3	32	South Asian	School	Unemployed	Limited	Married	No	No	No	1	7 months	High
4	34	White British	University	Full time	Somewhat comfortable	Married	Yes	Yes	No	2	1 year 2 months (10 months)	High
5	42	White British	University	Full time	Somewhat comfortable	Married	Yes	Yes	No	2	8 years 1 month (5 years)	High
6	33	White Australian	University	Full time	Somewhat comfortable	Married	Yes	Yes	Yes	2	2 years 11 months (2 years 6months)	High
7	38	White British	University	Full time	Somewhat comfortable	Living together	No	Yes	No	2	1 year 8 months (1 year 7 months)	High
8	29	White British	Trade	Full time	Comfortable	Married	Yes	Yes	Yes	1	2 years 2 months	High
9	31	White British	University	Full time	Comfortable	Living together	Yes	Yes	No	1	8 months	High
10	42	White British	College	Full time	Comfortable	Married	Yes	Yes	Yes	1	6 years	High

Table 3: Overview of the five main themes, 15 subthemes and exemplar quotes

Theme	Subtheme	Exemplar quotes
1. A smoother journey to and from the MBU	1.1 Prevention information	<i>'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.'</i> [P8]
	1.2 MBU admission	<i>'... 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.'</i> [P9]
	1.3 Post-discharge processes	<i>'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.'</i> [P4]
	1.4 A space for me and my family	<i>'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.'</i> [P5]
2. Feeling included	2.1 Being involved in her care	<i>'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</i>

		<i>done to them that you have to react to.’ [P7]</i>
	2.2. Considering my needs	<i>‘...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]</i>
3. Uncertainty about ‘what is going on’	3.1 Uncertainty about the problem	<i>‘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]</i>
	3.2 Uncertainty about the ward and treatment	<i>‘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]</i>
	3.3 Uncertainty about the future	<i>‘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]</i>
	3.4 Uncertainty about my infant’s care	<i>‘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]</i>
4. Barriers to support	4.1 Personal barriers	<i>‘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</i>

		<p><i>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.</i> [P5]</p> <p><i>'Because you know, this time is like, you know, my head full of pressure because lots of appointment, CAF meeting, [ward] ward meeting, you know, childrens send to the school day care, erm, every week you know, three, four appointment erm so cope yeah that's hard time. And that time is like I taking you know English language test, immigration part pass, for application, you know all things you know.'</i> [P3]</p>
	4.2 Barriers relating to the MBU	<i>'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.'</i> [P7]
	4.3 Barriers in the relationship between participants and the MBU	<i>'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.'</i> [P10]
5. Facilitators to support	5.1 Quality of the relationship	<i>'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.'</i> [P4]
	5.2 Efforts made by staff	<i>'[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.'</i> [P9]

Figure 1: Model of findings in relation to the timing, content and delivery of support



