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# FATHERS' EXPERIENCES OF A MOTHER AND BABY UNIT: A QUALITATIVE STUDY

**Section A: The issues and challenges of fathering in the postnatal period and in the context of maternal mental ill health**
**5488 (605)**

**Section B: How do fathers experience a partner's admission to a Mother and Baby Unit?**
**7886 (245)**

**Section C: Critical Appraisal**
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**Summary of the Independent Research Project**

Section A presents a literature review of the issues and challenges facing fathers in the postnatal period, in the context of an historical marginalisation of fathers in the study of child development. The review leads to a specific focus on the limited research evidencing the increased risk fathers face to their mental health, when coping with a partner's admission to a Mother and Baby Unit (MBU). Section B presents the qualitative research study undertaken to further explore how fathers experience a partner's admission to an MBU. Interpretative phenomenological analysis was used to capture the essence of this experience for the six men interviewed. Five master themes emerged, and the impact of negotiating cultural differences in child rearing practices was noteworthy. The findings support the efforts of government policy to build effective family focused perinatal services, whilst explicating where challenges might be faced in doing so. Section C sets out the journey taken from the ethnographic inception of the research idea, through dilemmas encountered in carrying out the study, to reflections on what was learnt during the process.

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The Issues and Challenges of Fathering in the Postnatal Period and in the Context of Maternal Mental Ill Health

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Abstract

This paper reviews issues and challenges of fathering in the postnatal period, leading to a specific focus on the implications of maternal mental ill health, sufficient to warrant admission to a Mother and Baby Unit (MBU). The review begins by presenting research about different aspects of the father's unique contribution to the developing child. It moves on to focus on the challenges faced by the father in the postnatal period, including the psychological demands of transition to fatherhood, the phenomenon of paternal postnatal depression, the associations between paternal and maternal mental health difficulties, and the impact of these on the child. Research is presented showing that fathers with partners in admission to MBUs are at greater risk of experiencing mental health difficulties, than those with well partners, or those with partners in admission to general psychiatric services outside of the puerperium. Government policy is shown to join with recommendations from MBU treatment outcomes research, to advocate for a family focus to perinatal services. Gaps in the literature on fathers in the postnatal period, and specifically, in the context of the Mother and Baby Unit are presented, and the paper concludes with implications for future research in this area.

**1.0 Introduction**

This literature review presents findings which underline the importance of the father's role in the postnatal phase of family life, and, in particular, in the context of maternal mental ill health. Studies of fatherhood have burgeoned since the mid-sixties, in response to a perceived historic, 'matricentric' view of understanding child development. The importance of the father to the family, lies in his being an intrinsic part of the primary mother - father - infant triad, where research attests to a complex and not yet fully understood, dynamic relationship between paternal, maternal and child mental health and well-being. To understand the experience of postnatal difficulties in a family, is to better understand the dynamics at work in this triad, and therefore, to keep hold of the father inherent to this picture where previously the eye of research has focused mainly the mother - infant dyad.

The review focuses specifically on how fathers can mediate the success of treatment outcomes for mothers struggling with postnatal mental health difficulties of a severity which necessitates admission to a psychiatric Mother and Baby Unit (MBU), and of the potential deleterious impact of her admission on the father's own mental health. Given that the parental relationship holds the potential for providing both resilience and risks in the postnatal period, studies highlight concerns about a lingering unintentional exclusion of fathers in perinatal services, suggested as mirroring the historic 'matricentric' view of child development, and the paucity of research on the father's role in the context of the MBU. Government guidelines for perinatal services also recognise the importance of keeping the father in the picture.

Gaps in research on fatherhood in the postnatal and MBU context are highlighted, as are suggestions for future research. Evidence for this review is drawn from a literature search

(fully detailed in appendix A) of PsycInfo 1806 – February week 2 2011, Medline 1948 – February week 2 2011, EMBASE, and the Cochrane Database of Systematic Reviews. Studies were included if they were peer-reviewed, in the English language, directly included fathers in the study sample, and were found in response to keywords circumscribing the areas of child development, the postnatal period and the context of inpatient admissions to an MBU.

## 2.0 The changing constructions of fatherhood in research

Before the mid-1960s, there was an emphasis on the role of father as defined by his function of providing "protection to the mother-child relationship" (Melzer, 1988, p.65) and the "context in which the mother can fulfil her maternal role" (Stern, 1995, p.174). Barrows noted that fathers were "relegated to the position of providing support for the mother, rather than having their own role to play" in child development (Barrows, 1999, p.334). Phares, Lopez, Fields, Kamboukos and Duhig, (2005) observed that there was very little inclusion of fathers in research on normative child developmental processes, or in research and treatment of child developmental psychopathology (Phares, Lopez, Fields, Kamboukos & Duhig, 2005). Men were dubbed by Lamb (1975) in his early review of studies of fathers as 'the forgotten contributors to child development'. The past forty-five years have seen an increase in research on fatherhood, in the wake of early studies observing the unique contributions of father-child, play-orientated interactions to the development of a child's mental well-being (Lamb, 1976; Lamb, 1977), and demonstrating that infants formed an attachment with fathers in their second year (Schaffer & Emerson, 1964). The latter challenged the concept that the attachment security of the child might be exclusive to the mother-infant relationship.

Since these early studies, fathers have been increasingly included in research, redressing the historic "matricentric" view of child development noted by Nash (Nash, 1965, p.262). However, Phares et al. (2005) show from two reviews of developmental research carried out in 1992 and 2005 that fathers are still included significantly less frequently in studies than mothers, and are under-represented in the literature. Re-focussing the lens to include the father, has enabled fatherhood to be examined from many angles, including: the psychosocial demands of transition to fatherhood for first time fathers (Genesconi & Tallandini, 2009); the importance of the quality and dynamics of the parental relationship in the family (Schoppe-Sullivan, Brown, Cannon, Mangelsdorf & Sokolovski, 2008; Wong, Mangelsdorf, Brown, Neff & Schoppe-Sullivan, 2009), particularly in the context of parental mental health difficulties (Abela, Zinck, Kryger, Zilber & Hankin, 2009). It has become clear through research that the father is an important figure in a child's life and has a unique contribution to make to their development (Brown, McBride, Shin & Bost, 2007).

**3.0 The developing child: The unique contribution of the father**

Barrows (1999) notes that the father impacts on a child's development through his "indirect influence as a member of the parental couple" and his "direct role as a member of the father-infant dyad" (Barrows, 1999, p.334), and sees this as unique and qualitatively different to the influence of the mother. Bogels and Phares (2008) reviewed studies on the involvement of fathers in the normal development of the child, before going on to examine the role of the father in the aetiology, prevention and treatment of child anxiety. They proposed four dimensions in which the father contributes uniquely to a child's normative emotional growth: 'paternal play'; 'father closeness and involvement'; 'father-child attachment'; and 'the indirect role of the father through his influence on the mother'.

### 3.1 Paternal play

Burlingham (1973) and Lamb (1977) found fathers' engagement with their infants to be more play-oriented and exciting, with the engagement of mothers being more care-oriented and soothing, as a result, children often prefer their fathers as playmates. Fathers have been found to promote an active, competitive, autonomous, and curious attitude in children (Paquette, Carbonneau, Dubeau, Bigras, & Tremblay, 2003), which has a beneficial effect on the child's cognitive and social development (Parke, Dennis, Flyr, Morris, Killian, McDowell, 2004; Yogman, Kindlon, & Earls, 1995) and buffers early separation, stranger, and novelty anxiety (Kotelchuck, 1976; Ladan, 1985).

### 3.2 Paternal closeness and involvement

Wagner and Phillips (1992) demonstrated a specific relationship between paternal behaviours showing warmth and encouragement, and an increase in the child's perceived competence whilst carrying out solvable and unsolvable tasks. Mattanah (2001) found that teachers independently rated child competence more highly in those children where fathers were more involved and closer to their children. Paternal involvement and closeness was found to have a stronger effect on adolescents' well-being than maternal involvement (Flouri & Buchanan, 2003), and to protect against psychological distress in young adults (Harris, Furstenberg & Marmer, 1998). Active paternal involvement has also been found to be beneficial to the well-being of fathers themselves (Genesconi & Tallandini, 2009).

### 3.3 Father-child attachment

Research into father-child attachment has highlighted the importance of viewing the dynamics of the father-child relationship as a unique contributor to child development. 'Attachment' is a term which refers to the state and quality of a person's attachments to significant others. The term derives from Bowlby's attachment theory (Bowlby 1969; Bowlby 1973; Bowlby, 1980). The theory explains how a child will seek proximity to their main attachment figure who represents a "secure base" (Ainsworth, 1982), and provides them with a place from which they can safely explore their world. Support in exploration, and sensitive response to the infant's distress as they return from feeling the threat of separation, underpins the growth of a child's secure relationship with the caregiver and their emotional security. Bowlby believed that a child's attachments were mostly 'monotropic', but could be experienced in a hierarchy, occurring with usually the mother at the top as primary caregiver, and subsequently with father, grandparents and siblings.

Attachment theory originally had "little to say directly about the different roles of the mother and father in the child's psychological life" (Holmes, 2008). Lamb (1980) found that children are often differently attached to both parents, suggesting that the way each parent interacts with the infant determines the security of their relationship with the child, although an infant's attachment classification to the mother and father has been found to be related (Fox, Kimmerly & Schafer, 1991). Lamb (1978) and Main and Weston (1981) also found that the security of an infant's attachment to father was independent of attachment security to the mother.

However, longitudinal studies of the relation between father-infant attachment and later child attachment behaviours (Main, Kaplan & Cassidy, 1985), child personality development (Oppenheim, Sagi & Lamb, 1988), and pre-school childrens' emotional regulation (Volling, 2001), showed only weak or non-significant results. In the light of extended reviews of the importance of the father-child attachment (Hewlett, 1992; Lamb 1997), Lewis (1997) concluded that further research on father-infant attachment was necessary to explain this. A longitudinal study by Grossman, Grossman, Fremmer-Bombik, Kindler, Scheurer-Englisch and Zimmerman (2002) of father-infant and father-toddler attachment behaviours at six, ten and sixteen years, sought to explore the specific characteristics of father-infant attachment. In the course of their research, they questioned whether father-infant attachment was being measured in a valid way.

Grossman et al. (2002) returned to an evolutionary and cross-cultural perspective on fathering, which pointed towards a number of essential differences in mother-infant and father-infant interactions. In most cultures, these were that mothers provided the physical care and were responsible for the child's health, and fathers secured the resources for the family (Parke, 1995). Differences were found in observations of mother-infant and father-infant interactions, where the most important interactional context for father and child was around play (Hewlett, 1992; Lamb, 1997), which was of a more vigorous type than mothers might engage with (Parke, 1995).

Considering these differences, Grossman et al. (2002) hypothesised that although either parent could provide a secure base as primary caregiver if necessary, the contribution of the mother and father to the child's attachment security was distinct, but complementary. In their view, the mother's role was to provide attachment security through care and

providing a safe base, and the father's was to complement this by providing sensitive and challenging support when the child's exploration system was aroused, as a companion in play.

A child's attachment style has often been measured using the 'Strange Situation' (Ainsworth, Blehar, Waters & Wall, 1978). This procedure measures the infant's responses to mild stress, induced by separation from the parent, which arouses their attachment system. Volling and Belsky (1992) suggested that use of the 'Strange Situation' may not be a valid measure of the father's contribution to child attachment security, as it does not capture the natural father-infant ecology of support during exploration and play. It is this play context which might be the distinctive vehicle for forging father-child attachment security, possibly explaining why studies of father-infant attachment, based on the Strange Situation, had shown only weak or non-significant results.

In response to this, Grossman et al. (2002) devised a new measure of father- infant attachment, the Sensitive and Challenging Interactive Play scale (SCIP), in which exploratory play was central to the scale, offering greater ecological validity. They found that fathers' sensitive, exploratory play with toddlers at 18 months was significant in contributing to a child's attachment security at age six, ten and sixteen years. The study had strengths in its longitudinal design, allowing for an exploration of the implications of early experience for the child's development, and in direct independent observations of father-child interaction. However, it was limited in its representativeness due to a small sample size of forty-four families, and drawing from a mono-cultural cohort of families from northern Germany.

The research by Grossman et al. (2002) showed that application of maternal attachment measures was neither sufficient nor valid, in harnessing the unique contribution of the father to their child's development. Wong, Mangelsdorf, Brown, Neff, and Schoppe-Sullivan (2009) have posited that attachment theory has "not yet provided a thorough conceptual framework for examining infant-father attachment" (p.828). Despite limitations, the Grossman et al. (2002) study shows the importance of questioning basic assumptions about the experience of fatherhood in child research, rather than borrowing from what is known about motherhood, in order to improve the validity of research on the role of fathers.

### 3.4 The indirect role of the father through his influence on the mother

Fathers have been shown to mediate the quality of mother-child interactions through the degree of support they offer to the mother. Smith and Howard (2008) have categorised the support fathers show to mothers into two types: emotional support and instrumental support. Emotional support is defined as the father providing a 'listening ear' as the mother's confidant, and instrumental support is defined as the father providing more tangible assistance (particularly in the postnatal period), such as childcare, financial support, food or transportation. The provision of emotional and instrumental support have been linked to positive outcomes for mother (Kalil, Ziol-Guest & Coley, 2005) and child (Downer & Mendez, 2005; McBride, Shoppe-Sullivan & Ho, 2005). Cummings and O'Reilly (1997) found when fathers support the mother, it enhances the quality of the mother-child relationship, and if fathers are unsupportive, the mother-child relationship is of lower quality. Similarly, Pederson, Anderson and Cain (as cited in Lamb, 1980) found that an affectionate marital relationship is associated with better maternal sensitivity.

Research has shown that fathers influence the development and well-being of the child, directly through interaction with the child and indirectly through interaction with the mother. Research into the importance of fathers shares a central idea; that fatherhood exists because of, and is shaped by, a matrix of relationships; a move from a dyadic relationship with a partner to a triadic relationship with mother and child. To understand fatherhood is to understand the man in the context of these relationships, each of which may bring difficulties and supports, and therefore the potential to strengthen or undermine a fathering role. The importance of fathers is brought into sharp focus during the demands of the postnatal period, particularly in the context of transition to fatherhood and the experience of postnatal mental health difficulties.

## 4.0 Focus on the postnatal period

### 4.1. The triadic relationship with partner and child

The postnatal period is a time of much change and adjustment in the family to the arrival of a new baby. Genesconi and Tallandini (2009) describe the development of the triadic father-mother-child relationship, and the transition to fatherhood, from a review of 32 studies published between 1989 and 2008. They found that the transition to fatherhood could be divided into three 'time-frames' for the father, where "distinctive psychological processes" (p.315) can be observed: the prenatal phase, the labour and birth phase, and the postnatal phase.

The prenatal phase is marked by psychological reorganisation, where the father begins to gradually integrate the role of partner and father (Habib & Lancaster, 2006). Good couple

attunement before pregnancy, and a female partner who helps the man construct their triadic role, is a key predictor of a fulfilling sense of fatherhood (Lee & Doherty, 2007). During the first months of pregnancy, fathers can struggle initially to imagine a relationship with a child, and acknowledge its existence in the absence of noticeable changes in the partner; both the father and mother can have difficulties forming an emotional bond with the baby at this stage (Donovan, 1995). The father's access to the more physical aspects of pregnancy after three months, is facilitated by a good couple relationship (Genesconi & Tallandini, 2009), and from this point, the couple relationship becomes dominated psychologically by the presence of a third, which transforms dyadic relationship into a triadic one. Genesconi and Tallandini (2009) found few studies of fathers in the labour and birth phase, but those that were found showed that fathers experienced high mixed emotions at this time, ranging from helplessness, to anxiety and pride (Greenhalgh, Slade & Spiby, 2000).

In the postnatal phase, fathers struggle to balance the demands of being a father, with work and personal needs, and their new self-image (Nugent, 1991; St John, Cameron & McVeigh, 2005). Strauss and Goldberg, (1999) found that after birth, fathers were tasked with putting a fantasized image of fatherhood, constructed during pregnancy, into practice. They found that fathers who had constructed a positive father self-image experienced a motivational force for greater involvement with their child, and those whose image continued to involve many conflicting elements, found it difficult to meet the demands of their new role. The quality of the couple relationship is important in the postnatal period, as, if the woman is the baby's main caregiver, she can directly influence paternal involvement and identity, by facilitating or 'gatekeeping' the father's access to the baby (Jordan, 1990; Lee & Doherty, 2007; Schoppe-Sulivan, Brown, Cannon, Mangelsdorf & Soklowski, 2008).

Genesconi and Tallandini (2009) found that the quality of the father's relationship with his partner was common to all three phases, and mediated the ease of adjustment. Another mediator of ease of transition was the extent to which the father wanted to create a caregiving model different to his own experience of being fathered, based rather on his own abilities and wishes (Barclay & Lupton, 1999; Hyssala, Hyttinen, Rautava & Sillanpaa, 1993). The review by Genesconi and Talladini (2009) is limited in its scope due to most studies being drawn from the Western societies of America and Australia, and therefore the transitional phases may not be relevant cross-culturally. In addition, they reported great variance in study design across papers, leaving it difficult to interpret findings with consistency.

It is against the background of significant adjustment in the postnatal period and the importance of the quality of the parental relationship, that the experience of paternal mental health difficulties can be better understood.

### 4.2 Paternal depression in the postnatal period

Fathers have been found to be less likely to be depressed than mothers (Matthey, Barnett, Kavanagh & Howie, 2001). If they do become depressed, their symptoms are likely to start later than in mothers and increase over the first postpartum year (Areias, Kumar, Barros & Figueiredo, 1996). Six week postpartum, the rate of diagnosed anxiety or depressive disorders has been found to range between 2%–5% (Fletcher, Vimpani, Russell & Sibbritt, 2008); during the first year, it has been found to range between 1.2% and 25.5% in community samples (Goodman, 2004). These divergent findings have reflected the different methods for assessing paternal depression, and the paucity of studies with their main focus on paternal rather than maternal depression (Condon, Boyce & Corkindale, 2004). The

Edinburgh Postnatal Depression Scale, developed for assessing maternal depression, was validated for paternal depression in 2000 (Matthey, Barnett, Kavanagh & Howie, 2001).

However, the concept of male depression has continued to be debated, raising the question of the validity of assessments used. Studies have shown that symptoms such as anger attacks, self criticism, affective rigidity, and alcohol and drug abuse occur more often in men than women (Winkler, Pjrek & Heiden, 2004; Cochran & Rabinowitz, 2000, Piccinelli & Wilkinson, 2000). Continued research into the methods of assessing paternal depression was recommended by Condon et al. (2004) due to detection of gender differences in the experience of depression. In response to this picture of difference, Madsen and Juhl (2007) developed the Gotland Male Depression Scale (GMDS) developed to focus on male depressive symptoms (Winkler, Pjrek & Kasper, 2005), and compared its validity in screening for paternal depression to the EPDS. They found that one fifth of men with depression from a non-clinical sample of 607 contacted through a maternity ward in Copenhagen, were detected only when a 'male sensitive' scale (the GMDS) was used. This exploration in research to return to the phenomenology of men's experience of depression in order to better understand and validly measure their experience of it, echo the similar developments in attachment research discussed earlier.

The father's experience of postnatal depression can be understood as a phenomenon in its own right, but has also been evidenced to be sensitive to triadic dynamics. This attests to the importance of taking a wider view in order to better understand the demands and stresses of the postnatal period.

### 4.3 A dynamic family health system: The associations between paternal and maternal postnatal mental health difficulties and the impact on the child

Research has evidenced the associations between paternal, maternal and child mental health. Goodman (2004) found that the number of men experiencing paternal depression during the first postpartum year rose from between 1.2% to 25% in a community sample as presented earlier; to between 24% and 50% among men whose partners were also experiencing postpartum depression. Maternal depression has been identified as a predictor of paternal depression during the postpartum period (Areias, Kumar, Barros & Figueiredo, 1996) and found to be moderately correlated with paternal depression (Paulson & Bazemore, 2010; Dudley, Roy, Kelk & Bernard, 2001). A father's postnatal depression may exacerbate the effects of the mother's depression on the child's development, and where children have two depressed parents, they are at elevated risk of social, psychological and cognitive deficits (Carro, Grant, Gotlieb & Compas, 1993).

Wilson and Durbin (2010) found that paternal depression has a significant and deleterious effect on the father's parenting behaviours, and subsequently on the development of the child. In a longitudinal study of 10,975 fathers and children over seven years, Ramchandani, Stein, O'Connor, Heron, Murray and Evans (2008) found that paternal depression in the postnatal period was significantly associated with psychiatric disorder in the child seven years later, adjusting for maternal depression and paternal education; particularly oppositional defiant and conduct disorders. Abela, Zinck, Kryger, Zilber and Hankin,(2009) found in their research within an attachment framework, that greater levels of negative attachment cognitions in a child was contiguous with increases in parental levels of depression, resulting in an increase of depressive symptoms within the child. Bogels and

Phares (2008) suggested in their review of literature on the role of the father in childhood anxiety, that the father and mother "form a dynamic system in the way they influence their children" (p.552) in being able to manage anxiety, through play and caring. A limitation of the Bogels and Phares (2008) review, is that the studies measure associations, so cannot speak to causal relationships between a father's role and childhood anxiety.

Where the triadic system holds the potential for difficulty, it also has the potential to foster health. Edhborg, Lundh, Seimyr and Widstrom (2003) found that well fathers can have a buffering effect against the detrimental consequences of the mother's depression on the infant's well-being. Fathers have also been shown to compensate for the mother's depressive symptoms through more positive involvement in childcare (Hossain, Field, Gonzales, Malphurs, Del Valle, 1994). Given the association between well-being in the mother-father-infant triad during the postnatal period, the father's role and involvement in perinatal services is of importance and yet research evidences issues of paternal exclusion in services.

### 4.4 Issues of father exclusion in perinatal services

Fletcher, Matthey and Marley (2006) argued that fathers may have been "unintentionally marginalised by perinatal services due to a maternal focus" in child development research (p.461). Donovan (1995) found that fathers could also feel excluded after birth, when partners and babies receive most of the attention from social surroundings. Swedish research by de Montigny and Lacharite (2004) and Greenhalgh, Slade and Spilby (2000) has shown that hospital routines in perinatal services have been found to hinder the father's interaction with, and attachment to his infant. Persson and Dykes (2002) found that fathers were ignored and marginalised by staff, and Lindberg, Christensson and Ohrling

(2005) found that some staff viewed fathers as 'intruders' who disturb the 'mothering process'. Hildigsson (2007) found that models of care which excluded the father from staying overnight on the ward, or did not involve the father in postnatal care, increased the couple's dissatisfaction. One service within perinatal services that is tasked specifically with the fostering the mental health and well-being of the parents in the postnatal period is the Mother and Baby Unit.

## 5.0 The specific challenge of a partner's admission to a Mother and Baby Unit (MBU)

### 5.1 The nature of MBUs

A particularly distressing event and interruption to family life during the perinatal period, is the admission of mother and child to a psychiatric mother and baby unit (MBU). MBU's have been developed worldwide to treat mothers with perinatal mental health difficulties (Glangenaud-Freudenthal & Barnett, 2004). The mother and child can be jointly admitted to treat the mother, whilst helping to promote the early bonding relationship with the child. The concept of joint admission was proposed by Main (1958) who believed that both mother and child would benefit. This has since been borne out by research finding that clinical outcomes are positive for most women admitted with babies and they leave hospital without significant parenting problems (Salmon, Abel, Cordingly, Friedman & Appleby, 2003). MBU's are also increasingly tasked with carrying out assessments of the parents' capacity to care for their child (Seneviratne, Conroy & Marks, 2003).

### 5.2 The importance of fathers in MBUs

The quality of the father's relationship with the mother impacts on MBU treatment outcomes. Outcomes are improved when the mother is in a stable relationship, which has particular benefits for the infant's development, and enhancing the quality of mother–child interaction (Abel, Webb, Salmon, Wan & Appleby, 2005; Wan, Warburton, Appleby & Abel, 2007). Outcomes are poorer when the father experiences mental health difficulties and in the absence of a good relationship with the partner (Fisher, Feekery & Rowe-Murray, 2002; Salmon, Abel, Cordingley, Friedman & Appleby, 2002). Mental illness in the father has also been found to be one of the predictors of social services supervision of babies after admission to an MBU (Howard, Shah, Salmon & Appleby, 2003). These findings have led to recommendations for the father to be included in any assessments and interventions considering the "strong influence" on the mother's emotional health (Fisher, Feekery & Rowe-Murray, 2002), and for treatment to be family focussed (Howard, Shah, Salmon & Appleby, 2003), taking into consideration the parental relationship and father's own mental health needs (Salmon, Abel, Cordingly, Friedman & Appleby, 2003).

Recommendations from research to better involve fathers in child and perinatal services, echo wider government legislation. Several government policies explicitly require engagement with fathers, these include: The National Service Framework for Children, Young People and Maternity Services (DH/DfES, 2004); Working Together to Safeguard Children (2006); Support for All (DCSF, 2010) the government Green Paper on families and relationships; Getting Maternity Services Right for teenage mothers and young fathers (DH, DCSF, 2009); The Childcare Strategy (DWP, HM Treasury, DCSF, Cabinet Office, 2009); Every Parent Matters (HM Treasury, 2007). A selection of quotes is shown in figure 1 from

the 'Support for All' paper (DSCF, 2010) illustrating some references to explicit engagement with fathers. However, only two studies have focussed specifically on the impact on fathers of a partner's admission to an MBU.

Figure 1: Quotes from 'Support for All' (DSCF, 2010).

"An effective family policy must also be clear that parent means fathers as well as mothers…"

"A father's involvement is important in contributing to attachment and child development. It is also good for mothers…"

"Services that have traditionally focused on child and maternal health and well-being…need to take steps to become more inclusive of fathers…"

### 5.3 The impact of MBUs on paternal mental health

To date, two quantitative studies by Harvey and McGrath (1988) and Lovestone and Kumar (1993) have been undertaken on the impact of an MBU admission on the father. Harvey and McGrath (1988) compared a group of forty MBU fathers, with recent fathers whose partners had not needed psychiatric admission (matched for age of infant). Psychiatric diagnosis was measured by the Psychiatric Assessment Scale (PAS), and possible correlates of psychiatric distress were measured by the Social Stresses and Supports Inventory (SSSI) across six domains: work, finances, marriage, housing, social life and family. The MBU fathers showed a higher incidence of psychiatric morbidity (42%, N=17) than fathers in the comparison group (4%, N=1), with diagnoses including generalised anxiety disorder (N=7), major depressive episode (N=6), atypical anxiety disorder (N=2), dysthymic disorder (N=1), simple phobia (N=1) and schizophrenia (N=1). Harvey and McGrath (1988) found that MBU

fathers also experienced significantly higher stress and less support than fathers in the comparison group, on factors of marital stress, support from social networks, support from family, and support from work. Further, it was found that marital factors distinguished fathers with and without a psychiatric diagnosis within the MBU group, such as greater stress in how affection was expressed, difficulty in agreeing rather than arguing, and difficulty sharing important thoughts with each other.

Lovestone and Kumar (1993) went on to replicate and extended the Harvey and McGrath (1988) study. They sampled an index group of twenty-four fathers with partners admitted to an MBU, and compared them to two control groups, one of recent fathers whose partners had not undergone psychiatric admission, and the other of men who had partners in admission to general psychiatric services, but outside of the perinatal stage. The men were assessed for psychiatric disorder using the General Health Questionnaire (GHQ-30; Goldberg & Williams, 1988), the Schedule for Schizophrenia and Affective disorders (SADS; Endicott & Spitzer, 1978) and the Research Diagnostic Criteria (RDC; Spitzer, Endicott & Robins, 1978). They were also assessed for variables found to be associated with psychiatric disorder (Brown & Harris, 1978; Birtchnell, 1991) including: problems with social networks using the Significant Others Scale (SOS: Power, Champion & Aris, 1988); difficulties in marital relationships using the Golombok Rust Marital Scale (GRIMS: Rust, Bennun & Crowe, 1986) and the 'Marital' scale of the Paternal Attitudes and Behaviour – Postnatal version scale (PAPA-PN: Kumar & Smith 1984); adverse life events using a twelve item list in a semi-structured interview (Brugha, Bebbington & Tennant, 1985); and chronic social difficulties using the Social Problems Questionnaire (SPQ: Corney & Claire, 1985). In addition, MBU fathers were asked to talk about memories of how supportive and caring their own parents had been, to assess for type of 'parental representation' using the Parental

Bonding Instrument (PBI: Parker, Tupling & Brown, 1979). Finally, nine month follow-up assessments (by which time all mothers had been discharged from the MBU) were completed with any MBU fathers who had experienced mental health difficulties, using the SPQ, GHQ-30 and PAPA-PN.

Results from the Lovestone and Kumar study (1993) replicated the Harvey and McGrath (1988) study, showing that MBU fathers had significantly more symptoms of psychiatric disorder than husbands of well mothers, as reflected in their mean GHQ scores (9.3 compared with 3.9; ANOVA F=7.4, P<0.01). In addition, Lovestone and Kumar (1993) found that 42% of MBU fathers reached 'caseness' for a psychiatric disorder (N=10) compared with 33% of men with partners admitted to general psychiatric services (n=3), although this result was not significant. Lovestone and Kumar (1993) took a closer look at factors which distinguished MBU fathers who did, and did not, reach 'caseness' for psychiatric disorder. They found that those who did were significantly more likely to have had a past psychiatric episode, to describe social problems in more domains in their life, and to be dissatisfied with their relationship with their father (but not mother). However, no significant differences in quality of marital relationship were found between the MBU fathers.

A possible temporal link was found between father's psychiatric well-being and the MBU event was found in both studies. In the Lovestone and Kumar (1993) study, only one of nine MBU fathers with a pre-existing lifetime psychiatric disorder remained well after the admission of his partner, and ten of the twenty-four MBU fathers experienced the onset of psychological difficulties soon after the onset of mental health difficulties in their partners. Of the ten MBU fathers who experienced psychological difficulties, measures of psychological distress for the nine available to nine-month follow-up showed that

psychological distress had decreased (as measured by a significant fall in the mean number of symptoms recorded on the GHQ-30 from 16.4 to 2.5) despite no change on measures of marital and social difficulties (as measured by the PAPA-PN and SDQ respectively). In the Harvey and McGrath (1988) study, for those fathers who struggled with mental health difficulties (N=18), the onset occurred during, or just after the partner's pregnancy.

Both the Harvey and McGrath (1988) and Lovestone and Kumar (1993) studies suffer from methodological limitations including small sample which impacts impacting on the representativeness of samples and generalisability of findings. The Harvey and McGrath (1988) study excluded fathers who were 'not born in Britain' from their study, with no further breakdown of ethnicity given, whereas the Lovestone and Kumar (1993) study was open to all fathers and the breakdown of ethnic group was reported as including White European (N=15), Afro-Carribean (N=4), African (N-4) and Asian (N=1). The impact of ethnic and cultural difference on social and interpersonal assessments was not investigated. Despite these shortcomings, the results of both studies supported a link between an increased risk for postnatal paternal mental health difficulties, in particular for those with a history of mental illness, contiguous with maternal mental health difficulties and an MBU admission. These findings are of importance to clinical psychology, and to MBU services not currently set up to provide formal and systematic support to fathers.

**6.0 Gaps in research literature**

Despite an increase in research on fatherhood over the last 45 years, the father continues to be under-represented in research on child development (Phares, Lopez, Fields, Kamboukos & Duhig, 2005). This, and evidence of a dynamic association between the mental health and well-being of the mother, father and child, attest to the importance of

keeping fathers in the picture. A note of caution has been sounded about ensuring that research with fathers is undertaken with awareness of potential assumptions based on research on maternal experience. Studies have shown how a return to the ecology and phenomenology of father-infant interactions has helped to increase the validity of measures to understand their experience (Grossman et al., 2002; Madsen and Juhl, 2007; Winkler, Pjrek, Kasper, 2005).

### 6.1 Further research on fathers in the postnatal period

Studies have shown that the father and mother can contribute in distinctive ways to a child's development. In the case of child attachment, future investigation could help to conceptualise attachment security within a broader family framework, helping to determine how each parent's contributions to child attachment might be integrated to explain the development of a child's internal working model of attachment. Similarly, Bogels and Phares (2008) found that the interactions of mothers and fathers form a dynamic system of shared and distinct rearing behaviours impacting on the aetiology of childhood anxiety. They cited a lack of experimental, multilevel designs and genetic research, to move beyond associations, to ascertain causal relationships of the contributions of each parent to childhood anxiety.

Further research into the disentangling the influence of psychological, social and cultural variables on each of the phases of transition to fatherhood, could help clarify such a complex process, as the research review by Genesconi and Tallandini (2009) was based on studies with a variety of designs, making drawing consistent conclusions difficult.

### 6.2 Further research on fathers in the specific context of the MBU

Only two studies have focused on the father in the context of the MBU (Harvey & McGrath,1988; Lovestone and Kumar, 1993). Both found that a higher number of fathers experienced mental health difficulties contiguous with their partner's illness and the MBU event. Given the importance of fathers to the mental health and well-being of the mother and child, further research is indicated to replicate these findings. It would be interesting to find out to what extent the MBU admission contributed to the father's mental health difficulties, over and above the influence of maternal mental illness. In each sample, 40% of MBU fathers experienced mental health difficulties, but little is known about the resources fathers might have drawn upon to help them cope. Research into the impact of cultural differences on the fathers' experience of the partner's admission to an MBU could also be taken up, as this was not explored in these two studies.

These two studies were quantitative in nature, and measures were chosen by the researchers aiming to harness potential correlates of psychiatric distress for fathers (quality of marital relations, support from social networks, family and work). Although these measures were carefully chosen based on what was known to contribute to mental health difficulties, such a study design precluded understanding from the fathers themselves what may or may not be validly important to negotiating such a difficult interruption to family life, already rife with challenges for those transitioning to fatherhood. A qualitative study grounded in grasping the phenomenology of the MBU experience for the father would be useful, as it would ensure that it the experience was understood from the perspective of the father (heeding the caution against matricentric assumptions), and that a relatively uninvestigated area was opened up based on what fathers felt was important. Attending to the father's

perspective would help address an area deemed to be historically biased in its ‘gendrification’ towards the maternal experience, and move towards an integration of knowledge based on the triad. This could help underpin a family focus to MBU treatment, supporting the recommended family perspective in perinatal services.

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# How Do Fathers Experience A Partner's Admission To A Mother And Baby Unit?

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Abstract

Fathers' experience of the joint admission of a partner and child to a Mother and Baby Unit (MBU) has been the subject of limited research, despite initial findings suggesting fathers are at increased risk of postnatal paternal mental health difficulties. This qualitative study aimed to explore the lived experience of fathers in this context, to inform the validity of future research in the area. Interpretative phenomenological analysis was carried out following semi-structured interviews with six fathers in south east England. Five master themes showed that these fathers experienced the onset of their partners' postnatal mental health difficulties as unexpected and traumatic. Fathers needed to acknowledge limits in their ability to help, and the necessity of calling on specialist services. During admission, fathers felt pulled physically and emotionally between managing their own needs, and the needs of their partner and new baby. Themes showing the MBU admission challenged their fathering role and identity were contrasted with the importance fathers placed in treatment needing to be a 'family affair', inclusive and supportive of the father, and mindful of the impacts on the couple relationship. The impact of culture on fathers' adjustment to involvement at the MBU was noteworthy. In conclusion, this research helps understand the importance of including the father where appropriate in a mother's recovery programme, and helping the father define a role alongside the clinical team. The findings of the study validate the efforts of government policy to build effective family focused perinatal services.

Keywords: Mother and Baby Unit, fathers, interpretative phenomenological analysis, paternal postnatal depression

The joint admission of a mother and child to a psychiatric Mother and Baby Unit (MBU) is a distressing interruption to the postnatal phase of family life, particularly for those men who are already challenged by transition to fatherhood for the first time (Genesconi & Tallandini, 2009). MBU's have been developed worldwide to treat mothers with perinatal mental health difficulties (Glangenaud-Freudenthal & Barnett, 2004). The mother and child are jointly admitted to treat the mother's mental illness, whilst helping to promote the early bonding relationship with the child.

Research indicates that fathers are important to the mother's recovery at the MBU. Abel, Webb, Salmon, Wan and Appleby (2005) found that outcomes are improved when the mother is in a stable relationship, which in turn has been found by Wan, Warburton, Appleby and Abel (2007) to benefit the infant's development, and the quality of mother–child interactions. Fisher, Feekery and Rowe-Murray (2002) found that outcomes are poorer when the father experiences mental health difficulties, and the quality of the couple relationship is poor. Howard, Shah, Salmon and Appleby (2003) found that mental illness in the father, as well as the mother, has also been found to be one of the predictors of social services supervision of babies after admission to an MBU.

These findings led to recommendations for the father to be included in MBU assessments and interventions (Fisher, Feekery & Rowe-Murray, 2002), and for treatment to be family focused and consider the father's mental health needs (Howard, Shah, Salmon & Appleby, 2003). These recommendations stand alongside government guidelines explicitly encouraging engagement with fathers, including The National Service Framework for Children, Young People and Maternity Services (DH/DfES, 2004).

An MBU admission has been found to impact on the mental health of fathers (Harvey & McGrath, 1988; Lovestone & Kumar, 1993). Despite limitations in representativeness due to small samples (N= 40 and N=24), two studies reported a higher incidence of paternal postnatal mental health difficulties for fathers with partners in admission to an MBU, than fathers whose partners had not had a mental illness (Harvey & McGrath, 1988; Lovestone & Kumar, 1993), and men who had partners in admission to general psychiatric services outside of the puerperium (Lovestone & Kumar, 1993).

Correlates of paternal mental illness were found to include significantly higher stress and less support in the couple relationship, social networks, family and at work (Harvey & McGrath, 1988; Lovestone & Kumar, 1993). In both studies, fathers were significantly more likely to struggle with mental illness if they had experienced previous mental health problems.

The studies suggested a temporal link between paternal mental health difficulties, and maternal mental illness and the MBU event itself. Fathers experienced the onset of mental health difficulties during their partner's pregnancy, or shortly after their partner became unwell (Harvey & McGrath, 1988; Lovestone & Kumar, 1993). In the Lovestone and Kumar (1993) study at nine month follow-up, results showed that psychological distress had significantly decreased in nine of the ten men who had become unwell, despite no change in marital or social difficulties.

Research has evidenced the associations between paternal, maternal and child mental health. Maternal depression has been identified as a predictor of paternal depression during the postpartum period (Areias, Kumar, Barros & Figueiredo, 1996) and found to be moderately correlated with paternal depression (Paulson & Bazemore, 2010; Dudley, Roy, Kelk & Bernard, 2001). A father's postnatal depression may exacerbate the effects of the mother's depression on

the child's development, and where children have two depressed parents, they are at elevated risk of social, psychological and cognitive deficits (Carro, Grant, Gotlieb & Compas, 1993).

Ramchandani, Stein, O'Connor, Heron, Murray and Evans (2008) found that paternal depression in the postnatal period was significantly associated with psychiatric disorder in the child seven years later, adjusting for maternal depression and paternal education.

Where the triadic father-mother-infant system holds the potential for difficulty, it also has the potential to foster health. Edhborg, Lundh, Seimyr and Widstrom (2003) found that well fathers can have a buffering effect against detrimental consequences of the mother's depression on the infant's well-being. Fathers have also been shown to compensate for the mother's depressive symptoms through more positive involvement in childcare (Hossain, Field, Gonzales, Malphurs & Del Valle, 1994).

Attempts have been made over the past forty-five years to address what has been seen as an historic 'matricentric' view of child development (Nash, 1965, p.262). Re-focussing the lens to include the father, has enabled fatherhood to be examined from different angles: the psychosocial demands of transition to fatherhood for first time fathers (Genesconi & Tallandini, 2009); the unique developmental contributions of the father to his child (Bogels & Phares, 2008), and the importance of the quality and dynamics of the parental relationship in the family (Schoppe-Sullivan, Brown, Cannon, Mangelsdorf & Sokolovski, 2008; Wong, Mangelsdorf, Brown, Neff & Schoppe-Sullivan, 2009).

Fletcher, Matthey and Marley (2006) argued that fathers may have been "unintentionally marginalised by perinatal services due to a maternal focus" (p.461). De Montigny and Lacharite (2004) and Greenhalgh, Slade and Spilby (2000) found that hospital routines in perinatal services

hindered the father's interaction with, and attachment to his infant. Persson and Dykes (2002) found that fathers were ignored and marginalised by staff, and Lindberg, Christensson and Ohrling (2005) found that some staff viewed fathers as 'intruders' who disturb the 'mothering process'. Hildigsson (2007) found that models of care which excluded the father from staying overnight on the ward, or did not involve the father in postnatal care, increased couple dissatisfaction.

Redressing a 'matricentric' focus in child research, has required challenging gendered assumptions about how the paternal experience is measured. A return to the ecological study of father-infant interactions (Volling & Belsky, 1992) and the phenomenology of the male experience of depression (Winkler, Pjrek & Heiden, 2004; Cochran & Rabinowitz, 2000, Piccinelli & Wilkinson, 2000), improved the validity of father-infant attachment measures (Grossman, Grossman, Fremmer-Bombik, Kindler, Scheurer-Englisch & Zimmerman, 2002 and paternal depression (Madsen & Juhl, 2007).

The current evidence base regarding the impact on fathers of a partner's admission to a Mother and Baby Unit is limited, but suggests further research is warranted and of interest to the field of clinical psychology, considering that fathers have been found to be at increased risk for experiencing mental health difficulties during an MBU admission. This is against a background of the associations found between the postnatal mental health of the mother, father and child, recommendations from government policy to engage fathers in perinatal and child services, and the importance of the father in MBU treatment outcomes for the mother.

Previous studies of fathers in the MBU (Harvey & McGrath, 1988; Lovestone & Kumar, 1993) were quantitative in nature, and measures of the correlates of psychiatric distress were chosen based on top-down knowledge of what is known to contribute to mental health difficulties.

However, such a study design precludes understanding from fathers themselves what may, or may not, be validly important to negotiating this experience. Concerns about attending to the phenomenology of the father's experience, due to an historical 'matricentric' bias in the perinatal field, could be assuaged by the use of a bottom-up qualitative methodology; such a methodology would also be well placed to open up a relatively under-researched area.

This study aimed to understand how fathers experience a partner's postnatal mental illness and subsequent joint admission with child, to a psychiatric Mother and Baby Unit. The aims of the research were to find out (a) How does this event impact on the father's role? (b) What are the supports and stresses of the event on the father? And (c) What is it like to be a man in a perinatal mental health service?

## Method

### Study Design

Interpretative Phenomenological Analysis (IPA) was chosen as the qualitative methodology guiding data collection and analysis, as outlined by Smith, Flowers and Larkin (2009). This methodology was identified for the following reasons:

1. It is a qualitative methodology which allows for the exploration of an area where research evidence is limited, and the research questions are explorative.
2. It provides a framework for a bottom-up analysis of the perceptions and meanings that participants give to their experience.
3. It aims to understand and describe subjective, personal experience rather than explain social processes, which are more the domain of grounded theory methodology (Charmaz, 1995; Glaser & Strauss, 1967).

4. It provides a method for ensuring rigour during the dynamic process of analysis, where the researcher's active interpretation of the participants' experience is formally acknowledged.

**Participants**

Participants were selected through purposive sampling, approaching those relevant to the research question from a single NHS Foundation Trust in the South East of England. Inclusion criteria stipulated that fathers had a partner in admission to an MBU at the time of interview, and were visiting them on the ward where they would be recruited. Criteria for exclusion from the study were: fathers undergoing residential assessment with their partner at the MBU; fathers needing an interpreter due to insufficient command of the English language to understand what was entailed by the study, and to talk about their experience in an interview; fathers deemed unable to give informed consent by the clinical team and fathers under the age of 18 years.

Over a recruitment period of twelve months, twelve fathers meeting the inclusion criteria were approached and six consented to take part in the study. This sample size was deemed sufficient to meet the requirements of an in-depth, postgraduate level IPA study by Smith (2003) who recommends five to six participants. Smith (2009, p.51) states that the "primary concern of IPA is with a detailed account of individual experience. The issue is quality not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases".

**Procedure**

A potential NHS service was visited by the researcher, and an initial meeting held with the consultant clinical psychologist. The clinical team discussed the research, and a further meeting was held between the clinical team and the researcher to discuss the study. Potential participants were approached directly by the clinical team and handed study information sheets (appendix B),

an invitation to take part (appendix C), and the researcher's contact details. Written consent was obtained at interview (appendix D) which took place at the MBU. Interviews lasted between 50 and 90 minutes, guided by how long the participant needed to talk about what was important about their experience. All interviews were digitally recorded and transcribed verbatim.

**Data analysis**

IPA is the study of a particular phenomenon, through the double hermeneutic process of interpretation, i.e. the researcher making sense of how the participants make sense of their experience, by moving between interpretation and raw data in an iterative cycle of analysis. This results in an attempt to grasp the essence of the meaning of this particular phenomenon for this particular group of participants.

A semi-structured questionnaire (appendix E) was developed by the researcher. It was initially piloted with two colleagues to ensure the questions were relevant to the research question. The ethos of the interview was to move with the flow of the conversation, the ordering of the questions was therefore flexible. The questionnaire was divided into eight broad questions to meet the three aims of the study: the first three questions encouraged the participants to think about the impact of the MBU admission; the fourth and fifth questions sought to glean more about how the father perceived his role; the sixth aimed to explore more about potential supports and stresses from external influences such as family and work; the seventh question asked specifically about being a male in an MBU, and the final question, about the father's position to seeking support, should the admission have presented difficulties for him. The data from the first interview with a father was rich and detailed, and no subsequent changes were made to the questions, this interview was therefore retained as a part of the sample analysed and not treated as a pilot.

The process of analysis was guided by the recommendations of Smith, Flowers and Larkin (2009). Four phases of analysis were undertaken, three based on individual transcript analysis, and the fourth to identify 'master' themes across the group. The first phase of analysis consisted of writing initial textual notes attending to content, style of narrative and initial tentative interpretations (Appendix F). The second phase of analysis consisted of forming emerging themes from the initial textual notes. In the third phase of individual analysis, emerging themes were collected together within interviews to form super-ordinate themes for that participant, using the processes of abstraction, subsumption, polarisation, contextualisation, numeration and function as suggested by Smith, Flowers and Larkin (2009). In the fourth phase of analysis, super-ordinate themes from each participant were gathered together, and master themes formed according to the same interpretative processes used for super-ordinate theming. Some of the super-ordinate themes within participant, did not reveal themselves to be connected until group theming stage. At each phase, the iterative process was adhered to, ensuring that interpretations were grounded in the meaning participants made of their experience.

The validity of emerging, super-ordinate and master themes was checked at each stage by research supervisors, reflected upon and adjusted where agreed. Analysing the transcripts occurred as a discrete phase of the research and entered into in full immersion. Teaching on IPA methodology was received through lectures and attendance at a two day IPA workshop. A reflexive diary (Appendix G) was kept during the study noting personal responses to the transcripts, connections and patterns during the theming process, and changes in the researcher's 'fore-structures' when moving from one transcript to the next. This helped 'bracket' these as potential bias to interpretation, to stay close to the participants' sense-making of the experience.

**Ethical considerations**

The research gained ethical approval from the NHS National Research Ethics Committee (Appendix H), and the BPS code of conduct (2006) was adhered to throughout the study. After much discussion in supervision, the confidentiality of the fathers' participation and right to consent was honoured, and fathers were given the choice whether they wanted to inform their partner about their participation. Participants were informed that their choice whether or not to take part in the study would not affect the current or future treatment options of themselves, their partner or child. At interview, the researcher talked through the study information with participants to ensure they were properly informed, any questions were answered, and they understood they could withdraw at any time. Participants were informed that the interviews were confidential unless they disclosed intent to harm themselves or others, when the interview would be stopped and a member of the clinical team notified. Participants were given the choice of having a standard letter sent to their GP (appendix I) about their participation in the study, and written consent was obtained. Participants were debriefed following each interview and given the opportunity to discuss any concerns raised. Participants were offered follow-up consultation with the consultant clinical psychologist if they wished to speak further about their experiences. All identifying information was removed from transcripts.

# Results

## Participant characteristics

Participant characteristics are described in table 1. Pseudonyms have been used for the father, mother and child. Child details were known only if disclosed by the father, the researcher did not have access to the partner's medical notes.

Table 1. Participant characteristics

| Participant No. | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Father[1] | Dev | Carl | Kaleb | Jack | Filippo | Alek |
| Mother[1] | Lisa | Lydia | Nadia | Julie | Tricia | Melanie |
| Baby[1] | Sarah | David | Jamie | Sam | Stephen | Ana |
| Married | Yes | Yes | Yes | No | Yes | Yes |
| Ethnic group of father | Other Asian Background | Black African | Black British | White British | White European | White European |
| Born in UK? | No | No | Yes | Yes | No | No |
| Age of father (years) | 31 | 33 | 41 | 25 | 35 | 34 |
| Father employed | Yes | Yes | Yes mental health work | Yes | Yes | Yes including mental health work |
| Working at time of interview | No | No | Yes | No | Yes | No |
| First child / gender[2] | Yes / girl | Yes/boy | No/not disclosed | Yes / boy | Yes / boy | No /girl |

[1] Pseudonyms have been used

[2] Identifiable from interview with father

**Characteristics of partner in admission**

MBUs have been developed worldwide to treat mothers with perinatal mental health difficulties. The MBU provides a service for women who have developed postnatal depression, post partum psychosis or have had a relapse of serious mental illness following the birth of their baby. The mother is supported to develop a relationship with her infant in order to reduce the impact of the mother's illness on the child. The stage of the partner's treatment at the time of interview was approximated from interview details .One partner was two weeks into her admission, three were in the midst of their admission, and two partners were at the end of admission, with discharge plans arranged.

**Themes**

The analysis of the six interview transcripts resulted in capturing five group master themes.

- Striving to make sense of what has happened to the partner helps adjust to, and cope with, this unexpected trauma.
- Feeling limited in being able to help and needing professional support.
- Pulled physically and emotionally between the needs of partner, child and self.
- The MBU as a challenge to fathers' role and identity.
- Treatment as a "family affair": supporting the mother, father and their relationship, as key to recovery.

Each master theme and its contributing super-ordinate themes are presented in turn, in tables below. The themes are described and illustrated with key quotes from fathers.

**Striving to make sense of what has happened to the partner helps adjust to, and cope with, this unexpected trauma.**

*Table 2. Master theme ' Striving to make sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and co*ntributing super-ordinate themes

| Master theme<br>(No. of participants supporting theme) | Super-ordinate themes<br>(Participant no.) |
|---|---|
| Striving to make sense of what has happened to the partner, helps adjust to and cope with, this unexpected trauma (6) | Understanding the partner's illness from experts helps to cope with it (1) |
| | Birth and admission to the Mother and Baby Unit (MBU) as events signalling a venture into the unknown (1) |
| | Having courage to face the unknown and "handle it" (1) |
| | Juggling different beliefs of relational, biological and supernatural factors as causes of perinatal illness (2) |
| | Adjusting from the happy expectations of child birth to the unexpected trauma of his wife's postnatal illness (3) |
| | From biology and environment to witchcraft and destiny: Juggling different views on why this has happened (3) |
| | Scared at the changes in the mother after childbirth and worry about the impact on the baby (4) |
| | Having expectations of family happiness and being unprepared for this nightmare (5) |
| | Looking to the wife's past to try to understand postnatal depression (6) |

This master theme (table 2) is centred on how the fathers experienced the onset of their partner's mental health difficulties, and admission to the MBU. It encapsulates three elements: the partner's illness and admission as unexpected and traumatic; the father's need to make sense of it, and the sense-making itself as something that helped fathers adjust to the situation and cope with it.

Dev: "I think the major thing that helps me cope with this situation is probably understanding or trying to understand Lisa's illness."

Dev also once described visiting the MBU as returning to "ground zero", a term associated with great trauma. Carl and Filippo spoke about the shock, confusion and nightmarish quality of the event.

> Carl: "when I saw her unwell, really I cried because, er, I haven't seen something like that before…I became sort of er confused and shocked."
>
> Filippo: "it was supposed to be the happiest time…it has actually been the opposite, it has been a nightmare."

The fathers' struggle to understand what was happening to their partner, saw them juggling different conceptions of mental illness; their own beliefs, and beliefs of family and friends. Possible causes of their partners' illness included biological, supernatural, environmental, philosophical and relational explanations; the impact of the father's culture on these explanations was noteworthy.

> Carl: "…my parents are very Christian, so really believe in Christianity, but my friends, they told me that I should look elsewhere of what is happening to my wife… they really believe that there is some negative power…maybe someone want to ruin my family…want to make my wife mad…But really, I really believe in, I don't think someone can harm me, I say no….she is in the best hands. I think they really find out what is the problem."

Each father was drawn to speak of how difficult the events were leading up to the admission, in particular, trying to cope with understanding the development of the partner's mental illness.

**Feeling limited in being able to help and needing professional support.**

*Table 3 Master theme: 'Feeling limited in being able to help and needing professional support' and contributing super-*ordinate themes

| Master theme (No. of participants supporting theme) | Super-ordinate themes (Participant no.) |
|---|---|
| Feeling limited in being able to help and needing professional support (6) | Preferring partner and child to be at home but accepting the need for the admission (1) |
| | Feeling limited in skills to help compared to professionals (1) |
| | Being distressed at the changes in his wife and needing to ask for professional help (2) |
| | Becoming a service user and doubting his ability to help his wife despite knowledge of mental health (3) |
| | The MBU provided the specialist help needed for the mother and child (4) |
| | Feeling helpless to fix the problem and needing family and professional support (5) |
| | Regretting his confusion and the lack of information to help recognise and respond differently to the early signs of illness (5) |
| | Coming up against limits and needing support (6) |

This master theme (table 3) also centred on events leading up to the partner's admission to the MBU. It captures how all six fathers experienced reaching a point, at which they no longer knew what to do to help their partner.

Filippo: "she had a problem, I had no clue what it was and how to fix it…I had no clue what's happening. I just saw her everyday getting worse and worse and worse, and I didn't know what to do."

Fathers seemed to convey a wish that they had the skills and knowledge to help, and a sense of powerlessness that they couldn't provide this.

Dev: "She was progressively getting ill, and based on that, umm, she needed medical help which, um, I obviously couldn't provide."

Alek: "She was getting more worse, ummm, I didn't went to the doctors… because I was thinking maybe I could do something myself for her, to help her…she said I can't explain what is happening to me…and then we decided to speak to the doctor"

This master theme harnesses how fathers experienced limits in being able to help, and attendant powerlessness in the face of the severity of their partner's mental ill health, which required asking for support from specialist services.

**Pulled physically and emotionally between the needs of partner, child and self.**

*Table 4 Master theme: 'Pulled physically and emotionally between the needs of partner, child and self' and contributing super-*ordinate themes

| Master theme (No. of participants supporting theme) | Super-ordinate themes (Participant no.) |
|---|---|
| Pulled physically and emotionally between the needs of partner, child and self (5) | Pulled physically and emotionally between looking after the needs of his partner, child and himself (1) |
| | The physical and emotional difficulties of splitting time between looking after mother, child, yourself and work (3) |
| | "Catch 22" being torn between spending time with mother and time with baby (4) |
| | Subjugating his needs to prioritise Julie's recovery (4) |
| | Pulled physically and emotionally between work, partner and child (5) |
| | Feeling "slowed down" with the demands of wife and children and uncertainty of recovery in the first months of admission (6) |
| | Subjugating his own needs by focussing on keeping his children happy (6) |

This theme (table 4) captures how split five fathers felt; pragmatically coping with the separation from wife and child after admission to the MBU, and balancing conflicting emotions in response to a partner's illness and the birth of a new baby.

Kaleb: "you have to work, take care of your wife, take care of the baby…it's kind of a test in time for you to just pull yourself together".

All fathers described themselves as working, during interview it became clear that three of the fathers had taken time off work to cope with their partner's admission, two were working, and one had left work.

Fathers experienced coping with a mix of conflicting feelings, happiness at the birth of their baby, and worry about the partner's mental health difficulties. Kaleb explained this in a particularly moving way.

Kaleb: "Something has changed, and that kind of sets different parameters …to how you celebrate, how do you?...You cannot grieve because you have a baby! Mum is well physically, but mentally is a bit… So how do you celebrate that? That is the confusion about the whole thing that it brings out. Are you going to smile or are you gonna cry? And who, if you are crying, are you crying for? If you are smiling, who are you smiling with? So you don't know how to be."

Fathers described how their own needs were subjugated to those of the partner or child.

Jack: "What keeps me ticking is what I was going through was nothing compared to what Julie was going through…in my mind I'm not a selfish person and not a 'me me'. I always knew…it's always about Julie."

Alek spoke about how his wife's lengthy admission required him to find a way to manage his sexual needs that was consonant with his Christian beliefs. He found he could "forget" about his needs if he focused on his children's well-being and having faith in his wife's eventual recovery.

Alek: "I didn't know how a man could live without a woman for so long time...what I mean, is just like the private life of a man and woman...but when I look to my kids this gives me more strength, and I forgot about myself, my feelings…stopped to watch the

movies to make more problem for myself, because I believe that my wife she will come back, and…because I am religious, so I couldn't let this happen."

Admission saw these fathers struggling with a range of conflicting emotions, balancing their worry about their partner's illness with the joy of a new child; whilst meeting the practical demands of working (for two fathers), visiting, and providing childcare.

**The MBU as a challenge to fathers' role and identity.**

*Table 5 Master theme: 'The Mother and Baby Unit as a challenge to fathers' role and identity' and contributing super*-ordinate themes

| Master theme (No. of participants supporting theme) | Super-ordinate themes (Participant no.) |
|---|---|
| The MBU as a challenge to fathers' role and identity (5) | Shame at breaking male cultural traditions and adapting to shared child care (2) |
| | Feeling conspicuous as a man in the MBU and not belonging (3) |
| | The MBU excludes the father and usurps his role (4) |
| | Needing to see himself as "one of the mum's" to cope with getting "hands on" in an environment unnatural and daunting to men (4) |
| | Identifying with the social stereotype of being "macho" and "strong" which are a barrier to taking up support (4) |
| | Feeling able to ask for help because of less of a "macho" culture in his family and trusting an excellent infrastructure (5) |
| | Feeling "lost as a man" (6) |

This master theme (table 5) was supported by five of the six fathers interviewed, who seemed to experience the MBU as a challenge to their identity and fatherhood role. Carl helped his wife care for their baby in the MBU (alongside staff) because she was too unwell. This directly challenged the traditions of his culture, where it was frowned upon for males to be actively involved in child care.

Carl: "It was very extremely difficult…feeding the baby with feeding bottle, making the baby food, it looks like a…abomination…yeh, it looks like that seeing the man feed the baby…no, no, you don't do it…we believe that taking care of the baby is for the women…its part of our culture."

Kaleb and Jack described not belonging as a man in the MBU environment. Jack described feeling it required a change of gender to fit in, as if being a man in the MBU was in transgression of a natural law. He refered to men unwittingly as 'they' underlining the distance he felt from being male in this situation.

Kaleb: "it's like…being a man amongst women isn't it? That somehow you get the sense of do I belong here? How long can I stay here? I feel a bit strange…you are here because your wife is here….because maybe your son or daughter is here. How extent do you feel comfortable? I don't know."

Jack: "It's quite uncomfortable as a man…you've gotta be one of the mums!...It's not really a male environment, or an environment where they thrive."

Jack's description gave a sense that the MBU had usurped his fathering role.

Jack: "the Mother and Baby Unit is like…it says on the tin, it's about mother and baby, its not about father, but at the same time there's a father in the background there…the father's role is to look after the mother and baby. That's taken out of your hands really, you know? Someone else is looking after them."

Filippo and Jack highlighted respectively how distance from male 'macho' stereotypes helped being able to ask for support, and identification with them hindered it. This underlined how relying on help from the MBU in itself may have challenged the fathers.

Jack: "as much as I'm in touch with my feminine-side, or being a modern man…I still got that macho prowess. I think that you feel like you've got to…cope you know?"

Filippo felt he had been more able to seek help, because the influence of 'macho' stereotype in his own culture had been eased by being less prevalent in his own family.

> Filippo: "I come from a macho country, a machista country, where a man is very proud, yeah, I look after my family well, yeah, this mentality is a little faded away, I know that I very much understand that if I'm not capable with something, the best thing to do is to call for help…I come from a family where there is not such a machista, macho culture…society is changing."

A single phrase from Alek's transcript seemed to sum up the fathers' experience of being challenged in role and identity; "as a man, I felt lost".

This theme highlighted how the influence of male stereotypes in society, and gender defined, cultural traditions around child care, impacted on their ability to adjust to the demands of help seeking and childcare tasks consonant with an MBU admission, and affected their identity and role as fathers.

**Treatment as a "family affair": supporting the mother, father and their relationship, as key to recovery.**

*Table 6 Master theme: 'Treatment as a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super-*ordinate themes

| Master theme (No. of participants supporting theme) | Super-ordinate themes (Participant no.) |
|---|---|
| Treatment as a "family affair": supporting the mother, father and their relationship, as key to recovery (6) | Importance of retaining partner's trust (1) |
| | The importance of being able to provide support and guidance to help the partner recover (1) |
| | Not knowing who to ask at the MBU for support means his needs are 'pushed away'(1) |
| | Treatment should be a "family affair" supporting the couple as the relationship is key to recovery (2) |
| | Being in the role of expert on his wife's illness (3) |
| | Services don't understand family–centric child rearing practices from other cultures (3) |
| | Needing to be a "tower of strength" in the face of feeling persecuted, marginalised and unsupported at the MBU |
| | The family system is a resource for health and recovery (4) |
| | Believing there is a lack of support for fathers and that it should be offered equally alongside support for the mother (4) |
| | Couple conflict over sectioning as a specific trauma to the marital relationship (5) |
| | The MBU as a place to recover, restart and "get our life back" (5) |
| | Believing fathers in his situation have a tough time and would be relieved to be "thought about" by services (5) |
| | Wife's depression makes him question the quality of their family relationships (6) |

This master theme (table 6) was named for a super-ordinate theme drawn out from Carl's account, and echoed by all the fathers. In experiencing their partner's postnatal illness and admission to the MBU, fathers came to believe that treatment should be inclusive of the father and therefore family focused. Fathers illustrated that MBU treatment should keep the family in mind.

Carl: "The man needs to be involved. It should not only be Mother and Baby Unit…it should be a sort of 'family affair unit', yeh, it would really encourage…it would make the matter solved very quickly…she need to be getting love and care every moment, every time so she will be ok. So let them try to make it 'family affair'."

Filippo: "with the help of the team here, they are really great, very, very, very good, so yeah, with their help, one day we will get our life back."

The importance of including the father in the partner's treatment was outlined clearly by Kaleb, who had been angry at feeling ignored during the process of admission.

Kaleb: "I'm saying, "excuse me I'm the husband!"… [staff member]"yes I know you're the husband, but I'm not talking to you I'm talking to your wife" …I feel very angry, it felt, it felt very dehumanising when people kind of push you down, make you feel as if you are nothing."

The super-ordinate themes which make up the master theme, are subdivided into three areas: support for fathers; support for the couple relationship; the father as a unique resource for recovery.

**Support for fathers.**

Father's felt that support should be available equally to them and their partner at the MBU. Dev described how the need for support was hampered by not knowing who to ask, which meant the need was then 'pushed away'.

Dev: "You don't really know who to actually ask, and say sit down, and say you know what, actually I need some of your time to actually understand this. You kind of just push it away and ok, I'm dealing with this, the situation."

Carl alluded to his wife's lack of insight into what was happening due to her mental health difficulties, and compared this with his awareness of what was going on. He seemed to experience

his well-being as a burden for which he needed support, as it meant that he had to cope with the stress of the event.

Carl: "There was a day I come here, they say I was a visitor, I say I can't be a visitor! The say I'm not a patient. I say I am a patient! They say are you sick? Are you unwell? I say look! I'm more sick! I'm more unwell than my wife who you see here, yeh, because all the pressure, all the troubles come to me…My wife doesn't know that she is sick... I know that I am troubled, so it's me that is sick! I'm really a patient in here! So I have to be here!"

Kaleb, Jack and Filippo believed that there was a lack of support for fathers in the MBU, which suggested it left them holding the stresses of the event alone. Support to them would mean the relief of having someone to "lean on" or "let the steam off to".

Kaleb: "You become your own pow…tow…power of strength…you don't have anyone to lean on…they don't actually think about the dad."

Jack: "I think there should be more help for fathers. Even maybe just someone to talk to, just someone to let out, to let a bit of their steam off to. I don't think that's been there, well since I've been coming here there's not been nothing like that I've seen offered. This is the first time I've had to talk to anyone about how I feel about it all to be honest."

Filippo: "…my family, friends from all over the world were calling, 'What's happening to Tricia?', 'What's going on?', 'How is the baby?'. Then one day someone says 'How are you coping with that?'…I say 'I find it hard'. Ahh there is someone that actually is thinking also that they are not the only one going through a tough time…it was a little question but a big relief, because it got me for the first time to speak a little about this."

**The father as a unique resource for recovery.**

Fathers felt they held valuable knowledge about their partner, and that their presence was a unique resource in aiding the partners' recovery.

Dev: "if you can see a slight improvement…and reemphasising it…it probably gives her courage as well that, you know, I am actually improving…so it's reassuring for me, it's reassuring for her, it helps her recovery."

Jack: "when I first started coming… it was like things changed for Julie instantly, she started to get better…so it's been a big turnaround for Julie to have a father about."

Carl believed that his absence during the birth, and not understanding that some of the "troubles" that came with pregnancy, meant that he had not given his wife enough "love and care". He therefore believed that the remedy for his wife's illness was to be present, and to love and care for her. His presence and attending to their relationship was, to him, the unique resource that would aid her recovery.

Carl:"They need to be told that love and caring can create more impact than even the drug because…if you think from the starting of the whole issue…something might have made her unwell, and it wouldn't be the drug, so the something that make her unwell, if it changes, she can be well again."

Jack believed that supporting the father would in turn help support the mother's recovery.

Jack: "it all goes round in roundabouts, we're here to help the mother and baby, so maybe if we need the help, maybe it should be there, you know? It isn't there."

**Impact on the couple relationship.**

Despite the father and the couple relationship being a resource for recovery, fathers described how the partner's illness and MBU admission impacted negatively on the couple relationship. This included threatening the trust between the couple due to the trauma of involuntary admission, and the partner's mental illness making the father question the quality of their relationship.

> Filippo: "…my wife has completely discredited everything I've done for her, or tried to do. She says '…the police were pulling me out of the house and you were doing nothing' and I was! I tried to explain to her 'listen, I've done it for you', but she's not well…she hasn't got to the stage of recovery where she fully understands that she had a very serious illness that had to be treated urgently, so I hope she will get to this stage as some point soon, so she can understand that it hasn't been easy for me."

> Alek: "I was worried, and this what is happening with her, it has made me feel that all my life I tried to be a good husband, I tried to help her, I tried to …I am a soft person, and maybe sometimes I shouldn't be like…more staying with my word or something…I don't know…anyway, I tried to make her happy for all these years."

Kaleb's experience of the MBU was difficult, as he felt his parenting skills were under heightened scrutiny (although not under formal parenting assessment), due to a lack of understanding about cultural differences in child rearing. In Kaleb's non-Western culture, and in his family, the shared care of children amongst wider family was the norm and he himself was brought up this way.

> Kaleb: "It's different for us [our culture] because when a baby is brought into the world, it belongs to the family. It's not like you are the mother. Everybody takes part."

He believed Western culture was overly focused on the mother, to the detriment of taking a more family focused perspective.

> Kaleb: "if someone brings a baby [to the MBU], the mother has to be strong enough to look after baby, even if the mother is crashing down, the mother has to be strong. No, I remember my mother, some of us were…we grew up with different family members. It doesn't make a bad person. It doesn't make a person incapable of looking after their daughter."

This master theme elucidates how fathers felt that their involvement was important to their partner's recovery, but that support might be needed for fathers in order to fully facilitate this during the various demands of the MBU admission. The MBU is presented as a place that should include and offer support for father, but at the same time, as a place which challenged men seeking support due to male cultural stereotypes and traditions around help-seeking and child care. It was also a place where the quality of the couple relationship was being reflected upon by fathers, whether due to concerns about maternal postnatal depression being caused by relational difficulties, or, in Filippo's case, due to his wife's belief that his motives were malign in having her admitted.

## Discussion

This study aimed to capture how the admission of a partner to an MBU impacts on the father and his role in the family, the supports and stresses of this event on the father and what is it like to be a man in a perinatal mental health service. Five master themes, and contributing super-ordinate themes, showed that these fathers experienced the onset of their partners' postnatal mental health difficulties as unexpected and traumatic, and found them striving to make sense of it. They reached a point at which they needed to acknowledge the limits in their ability to help their partner themselves which was seen as an important part of their role as father, and instead need to call on professional services. During admission, fathers felt pulled physically and emotionally between managing their own needs, and the needs of their partner and new baby. Fathers felt that treatment should be a 'family affair', inclusive and supportive of the man who is the father, and mindful of the impacts on the couple relationship. However, being involved with the MBU admission also meant experiencing challenges to their fathering role and male identity. This was linked with feelings of not belonging in the MBU environment, and being uncomfortable with asking for support in the face of social stereotypes that men should not show vulnerability.

The Lovestone and Kumar (1993) and Harvey and McGrath (1988) studies found that MBU fathers were at higher risk of paternal postnatal mental illness than fathers with well partners, and men with partners in admission to general psychiatric services. The emergence of the theme 'striving to make sense of what has happened to the partner helps adjust to, and cope with, this unexpected trauma' suggested that fathers found the onset of their partners' mental illness traumatic, shocking and confusing. This IPA study asked fathers to speak in their own terms about the impact of this experience, and therefore cannot comment on whether this disturbance to the fathers meant that they might have been struggling to an extent that would warrant a formal mental health diagnosis.

This study sampled fathers who were present and involved in their partner and child's care. Research suggests that their partners could expect better treatment outcomes, as involved fathers have been shown to have a buffering and compensating effect for the mother's postnatal depression on the child (Edhborg, Lundh, Seimyr & Widstrom, 2003; Hossain, Field, Gonzales, Malphurs & Del valle, 1994), and predict better treatment outcomes for mother, when her difficulties are of a severity that requires admission to an MBU (Abel, Webb, Salmon, Wan & Appleby, 2005).

The theme 'Treatment as a 'family affair': supporting the mother, father and their relationship, as key to recovery', highlighted that these fathers felt that including and supporting them would help maximise their ability to aid their partners' recovery. However, fathers felt a sense of not belonging and a lack of formal support at the MBU, perhaps echoing Fletcher, Matthey and Marley's (2006) hypothesis that "fathers may have been unintentionally marginalised by perinatal services due to a maternal focus" (p.461).

Despite fathers feeling that the provision of support was important, male social stereotypes of needing to be 'strong' and 'cope' were cited as a barrier to taking up that support. This suggests that research on men's help-seeking behaviours, could be relevant in informing services on how to make support for MBU fathers more acceptable and accessible.

Fathers also felt that going through this experience had had a significant impact on their couple relationship. A good quality relationship was found to be important to the father's mental health in the MBU (Harvey & McGrath, 1988), and to the development of fathering identity for new fathers (four of the six men in this study) (Genesconi & Tallandini, 2009). These findings support the widening of the MBU treatment perspective beyond primarily the care of the mother and child, in line with research and government recommendations (Abel, Webb, Salmon, Wan & Appleby, 2005), and also reveal the social, organisational and historical barriers which may inhibit doing so effectively.

**Study limitations and future research**

The findings of this study represent the experiences of these six fathers, going through this phenomenon, at this time; although it harnessed rich descriptions, in line with much qualitative research, it is not possible to generalise the findings to other fathers with partners in admission to a Mother and Baby Unit. However, Willig (2001) posited that once an experience has been identified through qualitative research, it is known that it exists within society.

The researcher's preconceptions are potentially a bias to the interpretation of participants' accounts. However, the IPA methodology acknowledges this threat to validity, and analytic tools are incorporated to limit the impact of researcher bias. These include validity checks on emerging themes, active researcher reflexivity and the use of external supervision.

Replication of the Lovestone and Kumar (1993) study is recommended to build up the evidence base surrounding the prevalence of paternal mental health difficulties in the context of the MBU. Findings from this study could help improve the validity of questionnaires investigating the father's experience. The impact of culture differences in child rearing practices merits further study in its own right, as relevant to providing services acceptable and accessible to fathers in multicultural society.

**Clinical implications**

Findings suggest that these fathers came to the MBU feeling confused, and grappling to understand the changes in their partner's mental health, psychoeducation could be offered to fathers early on in admission. The MBU represented a challenge to these fathers' sense of role and identity, fathers could be offered an opportunity to identify an active role in their partner's recovery, in collaboration with the clinical team, and in a way that is mindful of cultural beliefs around child rearing. Individual sessions could be offered to the father to provide space to talk about his experiences, and couple sessions could be offered as a matter of course to address any impact on the relationship. Fathers who are juggling many tasks, could be offered flexible visiting times, and the possibility of overnight stays.

In conclusion, this study has added a richness of detail to how fathers experience the admission of their partner and child to an MBU. It extends knowledge by documenting the challenges and struggles they encountered as involved fathers coping with the MBU admission. The experience evoked conflicting emotions in response to a partner's illness contemporaneous with the birth of a new child, and a sense of powerlessness about not being able to help their partner themselves. Father's placed great value in being involved in treatment to aid their partners' recovery, but this had to be balanced with the MBU itself representing a challenge to the

fathers’ sense of role and identity. This in turn had implications for how MBU services might meet the recommendations for government policy to provide an effective family focused service. The impact of culture on childrearing practices was noteworthy, and seemed to mediate how fathers adjusted to involvement at the MBU. Further research into this area would be useful to inform how fathers can be helped to find a role consonant with their cultural beliefs, and supportive of their partner’s recovery at the MBU.

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**Critical appraisal**

Word count: 4072 (299)

## The genesis of the research

This research was borne out of an interest in attachment theory, and threats to attachment security in the early stages of bonding. This led me to visit the Mother and Baby Unit where this study eventually took place. I arranged to meet with the clinical psychologist and the developmental psychologist to talk about their work. During the visits to the unit, I saw that fathers were present and I noticed how that surprised me. In a later phone conversation with the psychologist, we spoke about the fathers, and the sentence "they're often left holding the baby whilst mum is so unwell" stayed lodged in my mind. I reflected on my 'surprise', I had learnt to attend to surprises in the context of clinical sessions with clients, as a marker of where a priori 'understandings' of a phenomenon differ from what is present. My view had been bounded by the gaze of my original research focus, the mother and child, but this surprise led me to re-examine my research idea, to what extent are fathers thought about in the context of the MBU? My interest in carrying out research in the MBU from a father's point of view was ignited.

During my background literature search, I found only two studies of fathers in the MBU context (Harvey & McGrath, 1988, Lovestone & Kumar, 1993). The studies showed that researching fathers in this context was relevant to the field of clinical psychology because fathers were found to be at increased risk of postnatal paternal mental health difficulties. Further conversations with the clinical psychologist confirmed that, although fathers were encouraged to approach clinical staff should they have any concerns, no formal support system was in place for them at the MBU. The literature search widened and I learnt about the phenomenon of paternal postnatal depression, the demands of transition to fatherhood, and the unique contributions of the father to child development. Four of the six fathers in this study disclosed in interview that they were first time fathers. The literature review by Genesconi and Tallandini (2009) was helpful in presenting the struggles that first time fathers might experience in adapting to their new role. This

contextualised the demands the new fathers in my study might have been coping with (born out in the master theme 'Pulled physically and emotionally between the needs of partner, child and self') as well as a partner's postnatal mental health difficulties.

The literature review pointed to an historical dearth of research of the father in child development, due to the different construction of fatherhood over time. In the opinion of Barrows (1999) fathers had been "relegated to the position of providing support for the mother, rather than having their own role to play" (p.334). This sense of marginalisation in research resonated with my own experience of surprise at seeing fathers present and involved in the unit. Research showed that fathers had an important role to play in the well-being of the mother-father-infant triad, and that there were significant associations between maternal and paternal postnatal mental health difficulties, yet no formal system was in place to support them. The father seemed conspicuous by his absence in the MBU literature, and conspicuous by his presence on the unit. I felt there was a gap in the literature in understanding more about the father's experience of the MBU. I began a research presentation to peers and service users about the idea for my research with: "Mother and Baby Unit" – can anyone tell me what is missing from this slide? Peer and service user feedback from this presentation helped me think about how flexible I would need to be in my schedule, to recruit fathers who may be difficult to get hold of depending on visiting hours and time they could spend away from partner and child.

The experience of completing a literature review required moving from the specific to the general. My journey began from an ethnographic, bottom-up position of noticing a specific phenomenon occurring in an particular environment, and moved to delving into the literature to find out what was known about fathers in the MBU context, onto fathering in child development, and further to the construction of fatherhood in history. The literature review highlighted how

research had returned to the ecology of father-infant interactions and the phenomenology of the male experience of depression, in order to ensure the father's experience was validly measured. I felt that the aim of my study mirrored the endeavour to return to the essence of a father's experience in the MBU in order to validly inform further research in a little researched area. It was anxiety provoking to handle such a large amount of data from the review, make sense of it, and be certain enough of which parts were relevant to the justification and rationale for my research question. Deciding what to leave in and boldly leave out, was a challenge I met again in the analytic work of my research.

**Choosing a methodology to fit the research question**

Considering the paucity of studies on fathers in the MBU and the aim of my research question to return to the phenomenology of the father's experience, I chose interpretative phenomenological analysis as my research methodology. This would allow the knowledge gained from this study to be grounded in the voice of the fathers themselves. I chose this in preference to grounded theory, as I wished to examine the lived experience of these fathers, to generate a rich description of the essence of it, in order to inform the validity of future research; as opposed to seeking to describe a social process, and generating a model and theory which is often used to help design an intervention (Starks & Trinidad, 2007).

Interpretative phenomenological analysis is phenomenological, in that it is concerned with how a person perceived an event, it allows the examination of experience "in the way it occurs and in its own terms" (Smith, Flowers & Larkin, 2009, p.12). IPA is concerned with hermeneutics, the study of interpretation and acknowledges the active role of the researcher in interpreting, and the need for awareness of assumption brought to the task. These assumptions can be bracketed off, and the father's sense making can be focused on clearly. I found it helpful to

think of the process as discerning the father's 'signal' from the 'noise' of my own biases. The 'essence' of the fathers experience could then be discoverable through the double hermeneutic cycle of interpretation - the researcher making sense of the participant, who is making sense of their experience (Smith, Flowers & Larkin, 2009). This requires a move from the specific or ideographic (the father's accounts), to the contextual, interpretative and shared (the essence of a phenomenon shared by the group of fathers).

Smith, Flowers and Larkin (2009) discuss how Husserl believed that the identification of the essential qualities of an experience could "transcend the particular circumstances of their appearance, and might then illustrate a given experience for others" (p.12). This meant that, as long as the IPA principle of finding an homogenous group of people (homogeneity defined as experiencing the same phenomenon), analysis of the fathers accounts allows the discovery of the essence of that experience.

## Ethical dilemmas

The recruitment of fathers, confidentiality of information about the mother, and how fathers might be supported during the study were ethical issues that needed to be carefully considered from all angles in supervision. In terms of recruitment, the fathers were not themselves the index patient at the MBU, but were present on the unit because of the mothers. Discussion arose in supervision about whether the mothers should be informed about the father's participation in the research, and the impact of an approach to the father on the mother, particularly should the mother's mental health difficulties mean that she might be more likely to interpret such an approach as threatening. In terms of protecting the confidentiality of the mother, it was decided that I wouldn't have access to the mother's notes, however, I needed to be sensitive about any information disclosed by the father about the mother's situation during the interviews. Lastly,

there was no formal support system in place on the unit for the fathers, but previous studies had evidence that they might be struggling with mental health difficulties themselves.

These were certainly dilemmas, and each was discussed in turn. Regarding recruitment, it was felt that the father was a consenting adult who had the right to accept or refuse participation in the study. His participation in the study, as for any participant, should be confidential to him, unless he himself chose to discuss it with another (the partner). It was important to be sensitive to the mother who was vulnerable, and approaches to fathers were discussed by the clinical team, and would be made by staff not directly involved in the care of the mother. We would also exclude those fathers who were under the additional pressure of being subject to a parenting assessment at the MBU with their partners, as it was felt that these couples might already be under a significant amount of stress coping with this. During the course of the interviews, I discovered that all fathers had made the mother aware of their participation. In terms of disclosing details of the mother's admission, the interview transcripts would be anonymised to protect the identities of the father, mother and child.

These recruitment methods meant that the results of the study would reflect the experiences of fathers who were visiting their partner and child and actively involved in their care. This study cannot speak to the experience of fathers who had a partner admitted to the MBU, but who had decided not to be involved in the admission. Six fathers took part in the study which took place at a single MBU. Multi-site ethical clearance had been gained in the hope of approaching other MBU sites in the South East, this did not occur as one of the sites then closed their MBU, and despite efforts, another did not respond to my requests to carry out the study at their unit.

It was agreed that fathers involved in the study would have access to individual time with the clinical psychologist at the MBU, should difficult feelings be evoked and they request more time to think about their experiences than could be met in a 15 minute debrief. This was also important in the light of findings by Lovestone and Kumar (1993) and Harvey and McGrath (1988) that a proportion of these fathers might be struggling with mental health difficulties, and potentially not receiving formal support. Only one father was initially interested in taking this up, but did not follow up on his request. Some fathers spoke directly in interview about how they had valued the opportunity to speak for the first time about their experience, and some hoped that their views might help fathers in similar situations to themselves.

Our resolutions to these ethical issues were discussed and agreed by the National Ethics Research Committee. On reflection, I feel an improvement to the study might have been to have met fathers in a space outside of the ward that was in keeping with Trust 'lone worker' policies.

## The experience of interviewing

I had not undertaken semi-structured interviewing for qualitative research before, and it was important to find a way to open up and explore an area further prompted by what was important to the father, whilst needing to ensure my questions and prompts were relevant, but not leading. Listening back to the interviews whilst transcribing and analysing them, showed it wasn't until the second or third interview that I started to feel more relaxed and able to let the father lead the interview, weaving my questions around his narrative. Sometimes the father naturally covered some of the questions I had written down in front of me, and I didn't need to ask more about them. I found that my supervisor's advice to have an initial situating question about what it was like to experience a partner and child in admission was helpful in drawing the fathers' attention immediately to the focus of the interview. The interview questions had been discussed and run

through with both supervisors, and we thought that the first interview may need to be treated as a pilot to see whether the questions were relevant or needed changing. Further questions at a two day IPA workshop about this, confirmed that first interviews could be included in the study, if it was felt that the questions elicited enough rich material. This was certainly the case for the first participant, who spoke at length and thoughtfully about his experience.

During interviewing I was mindful of my position as a researcher who was also training as a clinical psychologist. My closest experience up to this point of one to one work, was based on seeing a client for therapeutic intervention. Fathers in this study were talking about the stresses of a very difficult interruption to their family life, and the impact of the mental ill health of their partner on them. I noticed I had to stay constantly aware the difference between engaging someone in a way that helped them feel comfortable to open up about their experience, and exploring someone's perceptions and interpretations in order to formulate their difficulties, and intervene therapeutically. A visual analogy helped me to stay on track as a researcher. I saw my questions as pebbles which caused an impact on the surface of the father's thoughts, the responding ripples were the experiences that the questions elicited and that he felt comfortable to share with me. I was interested in harnessing the purity of the father's sense making, which meant stopping short of helping to reformulate any thoughts about things he might have found difficult, confusing or puzzling.

There was one occasion during the interview where I did feel pulled towards taking a more therapeutic stance. One father felt his parenting skills were under unfair scrutiny due to cultural differences in child rearing practices. He expressed his anger in the interview and it was important to debrief, and for me to acknowledge his anger and empathise with it, in order that it didn't overwhelm him. On reflection, I drew on therapeutic skills in order to help the father contain the

anger and anxiety that he was experiencing, given the ethical necessity of being sensitive to a participant's distress during the study. I felt that the interview had provided him an opportunity to reflect on his experience, and for him this meant reflecting on an experience that was difficult. He agreed to meet with the psychologist to discuss his experience further, but I understand he did not follow up on this. On reflection, I feel that an improvement to this study might have been to ask a psychologist not affiliated to the MBU, to offer the additional support to fathers who might need it. This father felt persecuted by staff at the unit, and may have declined further opportunity to speak of his experiences due to the psychologist being a part of the same service. During analysis, I wondered how his experience would fit with the others, who were not angry, but as I trusted in the process, I came to realise that he often highlighted the same themes that arose for others, but as a counterfoil to their experience.

The impact of culture on the father's adjustment to the MBU admission was also felt by a second father, who came from a country where tradition dictated that child care was strictly the mother's task. This father had to directly challenge these traditions during admission, as he wanted to be involved in helping his partner and child. Being told about the impact of cultural differences by these fathers was fascinating; I learnt something of the history of gendered child rearing practices in other countries first hand, and the psychological adjustment that the fathers were making in order to cope with finding a helpful role in a family that was struggling with separation and distress.

**The process of interpretation**

Smith, Flowers and Larkin (2009) discuss how IPA takes a centre-ground position between the hermeneutics of empathy and the hermeneutics of suspicion. They explain that the task of analysis using the former approach is to "reconstruct the original in its own terms" (p. 36)

and the task in the latter, espoused by Ricoeur (1970), is to use "theoretical perspectives from outside to shed light on the phenomenon" (p.36). In taking a centre-ground position, Smith (2004) and Larkin, Watts and Clifton (2006) felt that interpretative work was appropriate as long as its aim was to 'draw out' the meaning of the participant's experience.

I was aware that as a trainee psychologist I was used to interpreting the experiences of others based on formal psychological theory. In particular, I have an interest in psychodynamic theories, and drawing out themes and working with fathers' metaphors felt closely allied to the interpretations one might make in psychodynamic work. However, it was important to remember the cautions of Smith (2004), that IPA and psychodynamic interpretations look in different directions for authority of interpretation, IPA looks inside the reading for meaning, and psychodynamic interpretations look outside to theory. As I analysed scripts, I would note down psychodynamic interpretations as they came to mind, in order to 'bracket' them off and refocus back to the text, to find meaning from within it from the participant's own words.

The process of moving from the ideographic, detailed study of each singular account, to the examination of themes across cases was challenging. Smith, Flowers and Larkin (2009) suggest that in a good IPA study, shared themes and distinctive voices should be apparent. My method was to treat each transcript as if it were a new analysis as far as possible, following guidance by Smith, Flowers and Larkin (2009) to "treat the next case on its own terms, to do justice to its individuality" (p.100). I did this with the acknowledgment that my "fore-structures", or understandings about the new case would be influenced by the previous ones. It was not until all cases were individually analysed to super-ordinate theme level, that I moved to forming group master themes. I found that I had pulled through many super-ordinate themes to group theme level, but it wasn't until this level of analysis that the connections between some super-ordinate

themes became apparent to me. This highlighted the IPA principle that interpretation continues to occur right up into the final stages, even until the final write up, with the analysis moving in the double hermeneutic circle from the specific (individual case data) to the general (the group).

Initially the richness of the transcripts made me wonder how I would find common factors between participants. On reflection I felt that the initial breadth of super-ordinate themes was also a function of being a novice to IPA analysis, and struggling with the brevity of letting go of the detail and moving to the interpretive. Reflection during the process of analysis did help me become aware of this, and try to remedy this as analysis progressed. The analysis of the first participant initially generated themes that were more descriptive than interpretative, I typed up the emerging themes, cut out each individual one, and then arranged them spatially to form super-ordinate themes. Several devices advised by Smith, Flowers and Larkin (2009) were used to form themes during the analytic process including: abstraction, putting like with like; polarisation, clustering oppositional themes; numeration, the recurrence of an idea several times in the text, and contextualisation, noting certain narrative moments which seemed salient to the father. Super-ordinate themes and master themes were developed using the same devices, and during each cycle of analysis, interpretations were checked back against the text an accordance with Smith Larkin and Flowers (2009) description of IPA as a dynamic, nonlinear style of interpretation, which moves in a hermeneutic circle from the whole to the part and back again.

Fathers were asked during the consenting process whether they were interested in receiving a brief document on the findings of the study, none of the fathers asked for this, although all said they hoped that the study might help other fathers going through their situation. The findings will be fed back to the clinical team through formal presentation. This will be done sensitively concerning themes of father exclusion and challenges that the MBU presents to the

fathers sense of role and identity, with feedback focusing initially on raising awareness of the importance of fathers in the mental health and well-being of the mother-father-infant triad.

## Methodological limitations

The IPA methodology gives a rich description of the experience of these fathers at the time of the study. The process of forming master themes requires that emerging themes not supported by the majority of the group are sometimes lost as less salient. Some of the less salient emerging themes may have been of importance to another group of MBU fathers, but would not be represented here in this research. This attests to the specificity of the findings of this study, but these findings can be understood to add depth to ongoing research, as Warnock (1987) suggested that the insightful case study contributes to the understanding of the universal, as it touches on what it is to be human, which is shared and communal.

The majority of fathers in this study were experiencing having their first child, this may have impacted on themes such as ‘Pulled physically and emotionally between the needs of partner, child and self’ due to the challenges normally encountered by men in transition to fatherhood, as described in Genesconi and Tallandini (2009). This might have impacted on the prevalence of this theme in the fathers’ narrative and therefore on the findings of this research.

## Theoretical implications

This study highlighted how fathers felt ‘macho’ social stereotypes could be a barrier to fathers in taking up support offered by MBU services. This supports findings by other studies of the difficulties men have in help seeking behaviour. A literature review of men and health help-seeking behaviour by Galdas, Cheater and Marshall (2005), found that gender-specific studies evidenced a trend of delayed help seeking when men became ill. These included problems as

diverse as depression, substance abuse, physical disabilities and stressful life events. A prominent theme implicated 'traditional masculine behaviour' as an explanation for delays in seeking help. However, the reasons and processes behind the issue received limited attention. In background to this finding, they cited a growing body of research in the United States suggesting that men are less likely than women to seek help from health professionals, and that the principle health related issue facing men in the UK was their reluctance to seek access to health services. Brownhill, Wilhelm, Barclay and Schmied (2005) also found that men in the age group 20–35 years rarely seek medical advice unless they have acute symptoms, and are reluctant to seek advice regarding emotional health issues.

### Clinical implications

Fathers' ambivalence about support could be tackled in the MBU by offering a tiered support system, where fathers could engage at a level that they felt comfortable with. A tiered support system could be structured to provide a range of support including low level psychoeducation on admission to help understand a partner's difficulties and orientate fathers to the unit; then a space where fathers could work collaboratively with the team to identify an active role for the father in his partner's recovery where appropriate and mindful of cultural difference in child rearing practices; and finally, a higher level of support which may include one to one sessions with a psychologist for the father to speak about his experience and help normalise conflicting emotions, particularly in the context of becoming a father for the first time. At this level, couple sessions could be offered to address any impact on the relationship of the partner's illness and admission.

Fletcher, Matthey and Marley (2006) found in their study addressing anxiety and depression amongst new fathers, that interventions to help support fathers could be best placed

during the perinatal period, when the mother is in regular contact with antenatal clinics and general practitioners. This would provide an opportunity to supply information to fathers and mothers, distinguishing between postnatal mental health difficulties and the normal stresses associated with the birth of a new baby.

Fathers who are juggling many tasks, could be offered flexible visiting times, and the possibility of overnight stays. Interestingly, during the study, the facility for fathers to stay overnight on the ward was withdrawn, due to NHS policies favouring single sex wards due to concerns about protecting patients' privacy. This could exacerbate feelings of exclusion for fathers, and couple dissatisfaction, as evidenced by Hildigsson (2007), who found that couples were less satisfied when overnight stays for the father were not part of the treatment model in perinatal services.

**Future research**

An extension to this study could be to further investigate the findings of the Lovestone and Kumar (1993) study, that fathers' distress decreased significantly at nine month follow-up after the partner had been discharged from the MBU. A qualitative study could elaborate further on these findings, and a narrative methodology would be best placed to capture changes in the father's experience over the admission and follow-up time points.

The fathers who consented to take part in this study described themselves as being from five different ethnic groups, and four were not born in the UK. The impact of cultural difference in child rearing practices was particularly prevalent for two of the fathers, and this was noteworthy as an aspect of the master themes, although it did not reach master theme status in itself. This study highlighted that some fathers needed to adjust to child rearing practices that

challenged those of their own culture. Findings seemed to suggest that increased dissonance between cultural child rearing practices, may make adjusting to the demands of involvement in an MBU admission more difficult for fathers. Further investigation of the impact of culture on the fathers' experience of the MBU could help to further explicate this tentative finding.

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**Appendix A: Literature search for this research**

The literature cited to support the rationale for this study was found through searches of PsycInfo 1806 – February week 2 2011, Medline 1948 – February week 2 2011, EMBASE, and the Cochrane Database of Systematic Reviews 2011. Searches were time unlimited and stipulated the return of all peer reviewed journals that were in the English language. Search terms were a combination of the keywords and search terms: *'mother and baby unit' and 'fathers'; 'perinatal unit'; 'father'; 'role of father'; 'fathering'; 'paternal'; 'husband'; 'family relations'; 'triadic'; attachment behaviour'; 'parenting'; 'parent child relations'; 'postpartum'; 'postnatal'; 'postnatal depression'; 'puerperal disorders'; 'depression'; 'psychiatric hospitalization'*. Further papers were followed up from the reference lists of those returned by the searches. Searches returned 90 literature reviews and 190 discrete journal articles mentioning fathers. Of these studies, those which did not include fathers directly in the research measures were excluded, resulting in a final 104 papers relevant to the review.

**Appendix B: Study information sheet**

**Experiencing a partner's admission to a Mother and Baby Unit**

## Introduction

You are invited to take part in a research study. I am a Trainee Clinical Psychologist and this research is part of the work I need to do for my Doctoral training in Clinical Psychology at x.The study has been ethically approved by a national research committee. Before you decide to take part it is important that you understand why it is being conducted and what it involves.

### What is the title of the study?

Experiencing a partner's admission to a Mother and Baby Unit

### What is the purpose of the study?

This study hopes to get a better understanding of what it is like for men to experience their partner and child's admission to a Mother and Baby Unit, to help services develop to support men's needs at this time.

### Why am I being asked to take part?

You are being asked to take part because I am interested in your experience of your partner and child being admitted to a Mother and Baby Unit. There has been lots of research about the mother's experience of being admitted to a Mother and Baby Unit. I would like to understand more about what it is like for the partner involved.

### What does the study involve?

I will interview you for one hour about what it is like for you to experience your partner and child having been admitted to a Mother and Baby Unit. The interview and any discussion with the researcher will be confidential. It is your decision whether you want to discuss your participation in the research with anyone else. All

information you share will be made anonymous for the study, so no one will be able to identify you. There will be time allocated directly after the interview to talk about any issues that have been raised for you if you wish. Should you want to speak further about these, you can contact x Clinical Psychologist at the Mother and Baby Unit and your discussions will be kept confidential.

**Do I have to take part?**

No you do not have to take part, it is entirely you decision. Whether you do or do not take part will in no way affect your partner's treatment. If you do decide to take part, you can pull out at any time without needing to give a reason.

**What will happen if I agree to take part?**

If you agree to take part, this is what will happen:

1. Please leave your contact details with a member of the team at the Mother and Baby Unit (tel: x) or the Unit's psychologist x.
2. I will contact you to arrange a time to meet for the interview.
3. The interview will be an hour long and will be based at the Mother and Baby Unit.
4. At the end of the interview there will be time for you to ask any questions you might have.
5. I expect to complete the research by July 2010. I will send you a summary of the research findings, if you would like me to do this.

**Will my taking part be kept confidential?**

Information collected in this study is kept confidential. All identifiable data (names and addresses) is made anonymous so no one other than myself, the lead researcher, can identify you. I will also anonymise any identifiable information in quotations used for the research. You can choose whether or not a standard letter is sent to your GP to let them know you have taken part in the study.

**Why does the interview have to be audio recorded? Will this be confidential?**

The way I need to analyse the information from this study means that I have to have an accurate record of what is said in the interviews. The best way of doing this is by audio taping them. I will transcribe the tapes into written form within two weeks of interviewing. The tapes will them be erased. Any information in the written transcripts which can identify you will be made anonymous to protect you. The anonymised transcripts will be stored on a file on my computer, which is protected with a password.

**Are there circumstances where you would pass on information about me?**

The only time I would ever need to pass on any information would be if during the interview you revealed information suggesting you or someone else might be at risk of serious harm. I would then need pass this information on to an appropriate person.

**What happens with the results of the study?**

In x you will receive a summary of the findings of this study unless you say you do not want this. The study will then be examined in x. At a later stage, I am hoping that the findings will be published in a professional psychology journal.

**Who do I contact for more information?**

Please contact a member of the Mother and Baby Unit team or the Unit's psychologist, or leave a message for me on x and I will return your call. You can also email me on x.

Thank you for taking the time to read this information sheet. If you have decided to take part in this study, I would like to thank you in advance for your contribution.

Yours sincerely,

Trainee Clinical Psychologist

## Appendix C: Invitation to participants to take part in the study

**Research project: Experiencing a partner's admission to a Mother and Baby Unit**

Dear Participant,

My name is x and I am a Clinical Psychology Doctorate trainee. A part of my Doctorate studies I have to carry out a piece of research for x I would be really grateful if you could take part.

The main aim of this study is to get a better understanding of what it is like for men who are experiencing their partner being in a Mother and Baby Unit. I am interested in understanding what it is like for you and your views. This research has not been done before and will help services to understand your needs.

The study will be supervised by x, Clinical Psychologist for x, and x Clinical Psychologist and Clinical Tutor at x. This study has been approved by a National Ethics Committee.

The study will involve being interviewed for up to an hour and will be audio taped. The interview will be written up with all identifying information anonymised (e.g. names, addresses etc.) so no one other than myself will be able to identify you. The tape will then be destroyed. Any information recorded in the study will be kept strictly confidential.

Further information about the study and what you can expect can be found in the enclosed study information sheet. It is entirely your decision whether you choose to take part in this research.

If you feel you would like to take part in this study or find out more details about it, please contact any member of staff or x, clinical psychologist, at the Mother and

Baby Unit (tel: x) or leave me, x, a message on tel: x and I will return your call as soon as possible. You can also email me at x

Many thanks for your time and I look forward to hearing from you.

Yours sincerely,

Trainee Clinical Psychologist

**Appendix D: Consent form**

**Consent Form**

Title of project: **Experiencing a partner's admission to a Mother and Baby Unit**

Name of researcher: **xx**

Please tick the boxes below:

☐ I understand that I don't have to take part in this research and I can pull out from the study at any time without giving my reason and without affecting my partner's treatment.

☐ I agree to have my interview audiotaped.

☐ I agree that quotations taken from my interview may be used in the study and if it gets published. I understand that all quotations will be anonymous and I and others will not be identifiable from them.

☐ I agree to take part in the above study.

☐ I am happy to be contacted on the telephone number given to arrange a time to be interviewed.

**I do / do not** ✶ wish a standard letter about me taking part in this research to be sent to my GP. ✶*(please delete as you wish)*

**Please leave me a message on tel:**xx **or email me at** xx **if you have any further questions or concerns.**

Name: ______________________________________________________

Date: _______________________________________________________

Signature: ___________________________________________________

**Appendix E: Semi-structured questionnaire**

## Interview schedule

Hello, my name is X and I am a trainee clinical psychologist. I will be interviewing you today if you decide you would like to take part.

Thank you for showing an interest in this study. I will be going through some details with you first to check that you are ok to take part in the study and then I will ask you to sign a consent form to confirm this.

This study is to help find out what it is like for men to experience their partner and child being admitted to a mother and baby unit. Research on your experience has not been done before. It is important for us to understand more about what it is like for you to help services to support men as well as possible at this time. I will ask you some questions relating to you and your experience which should last for no more than an hour, but might finish earlier. I will be recording this interview to help me remember clearly what you have said.

This interview is voluntary. If you want to end it at any stage you can, we will finish and your data won't be included in the study. All your details will be made anonymous when I write up this interview, so no one will be able to identify you. The anonymised information will be kept on a password protected computer file that only I will know the password for.

Do you have any questions before we begin?

Are you happy to sign the consent form? [*signing of form if agrees*]

Before we start the interview, would you mind firstly completing this form which asks for some basic information about you [*complete demographic data form*]

**____________________START TAPE RECORDING____________________**

[*The following broad questions will be used, but further more specific questions will be asked, some noted as prompts below, guided by the interviewee's responses*.]

First of all…thinking about your partner's admission to this mother and baby unit…

1. What is it like for you to have a partner who is experiencing difficulties at this time?

2. What did you expect things might be like before your partner was admitted to the Mother and Baby Unit?
    - [prompt] Have your expectations changed?

3. How do you feel you have responded to your partner and child being admitted to the unit?
   - [prompt] Has anything been particularly difficult for you?
   - [prompt] What helps you cope with this situation?
   - [prompt] Has this situation made you think about anything differently?
   - [prompt] How does this situation impact on what you do in your daily life?

4. What do you feel your role is towards your partner and child?
   - [prompt] Are there particular things that you feel influence you to take this role?
   - [prompt] Does anything from your own upbringing influence your role?
   - [prompt] Is your role different from what you thought it might be before the admission?

5. What is it like to have a child here?

6. How have people in your life responded to your situation?
   - [prompt] friends?
   - [prompt] family?
   - [prompt] if you are working (quick check if yes or no), the people at work?

7. What is it like to be a man here in a mother and baby unit?

8. Do you feel you could ask for support if you needed it?
   - [prompt] What might you ask for support with?
   - [prompt] Who might you ask for support?
   - [prompt] What might make asking for support difficult?
   - [prompt] What might help you to ask for support?

**___________________ STOP TAPE RECORDING_______________________**

**De-brief**

Do you have any further comments or questions you would like to ask me?

[*Check for participant distress*]

Thank you for participating in this study today.

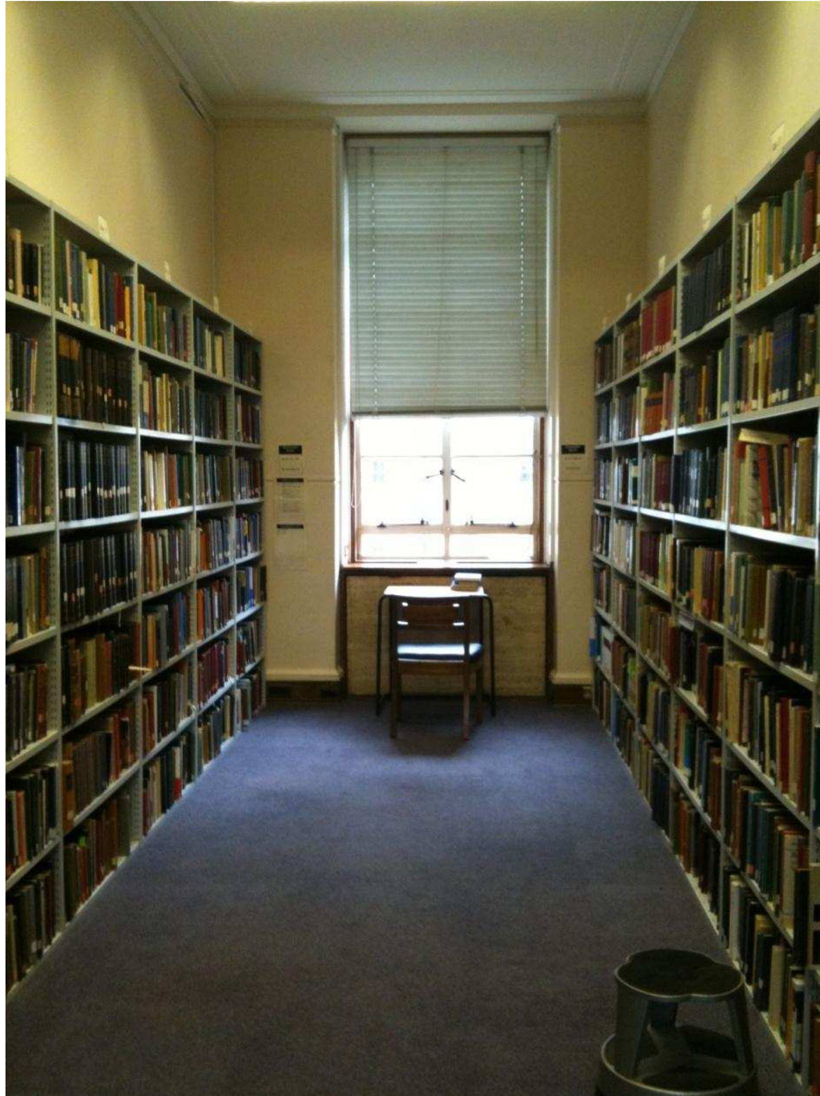
[*End interview*].

## Appendix F: Transcript extract showing initial textual notes for analysis

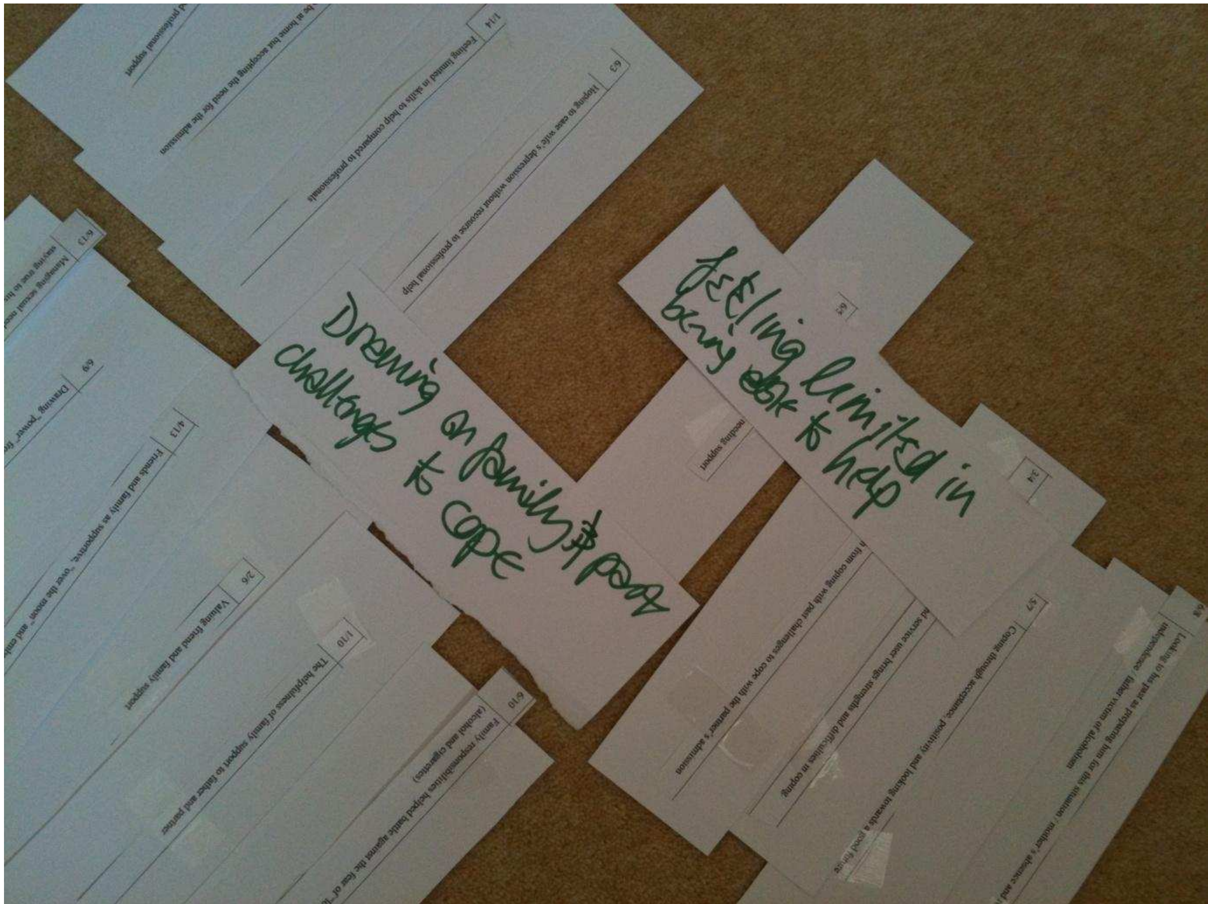
*"This has been removed from the electronic copy".*

**Appendix G: Extracts from research diary**

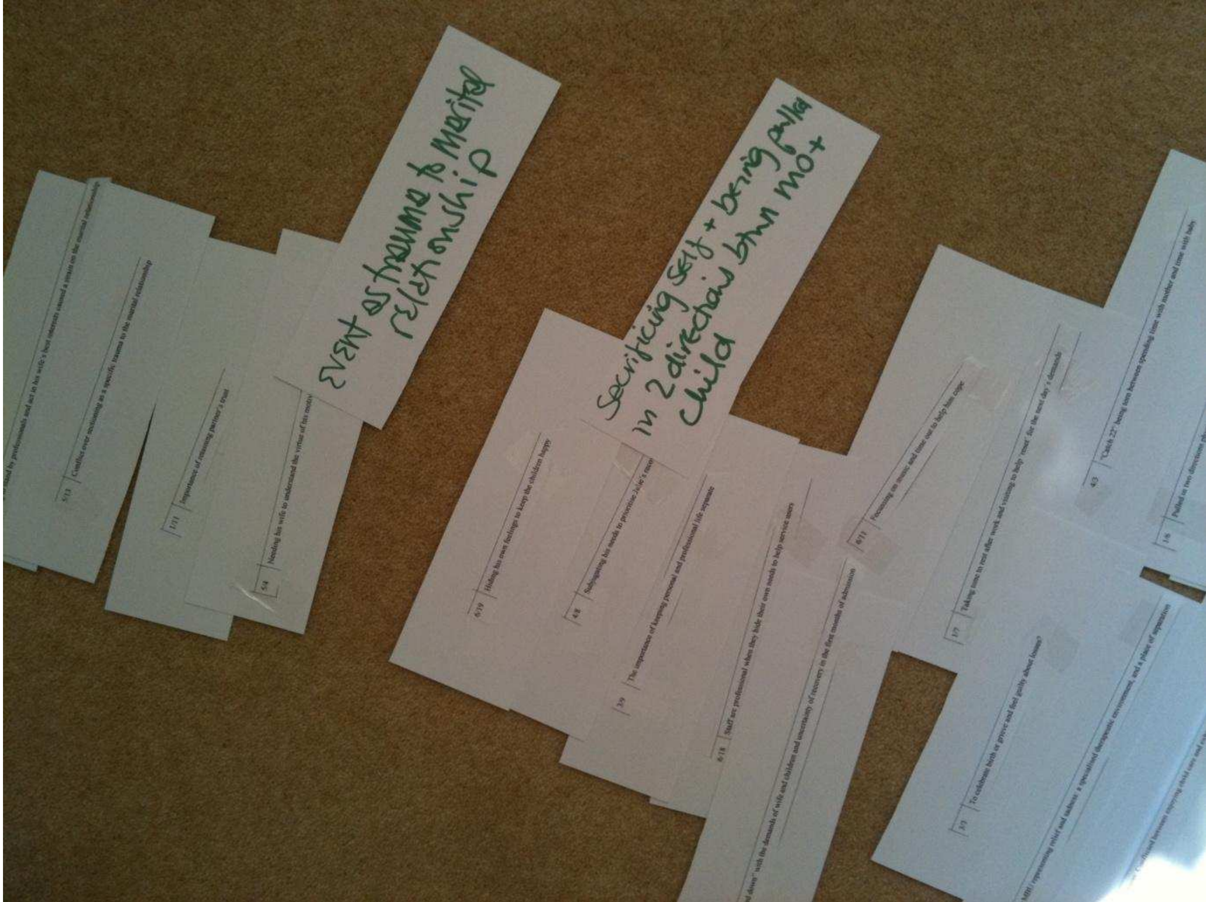
Bringing together the literature for Section A



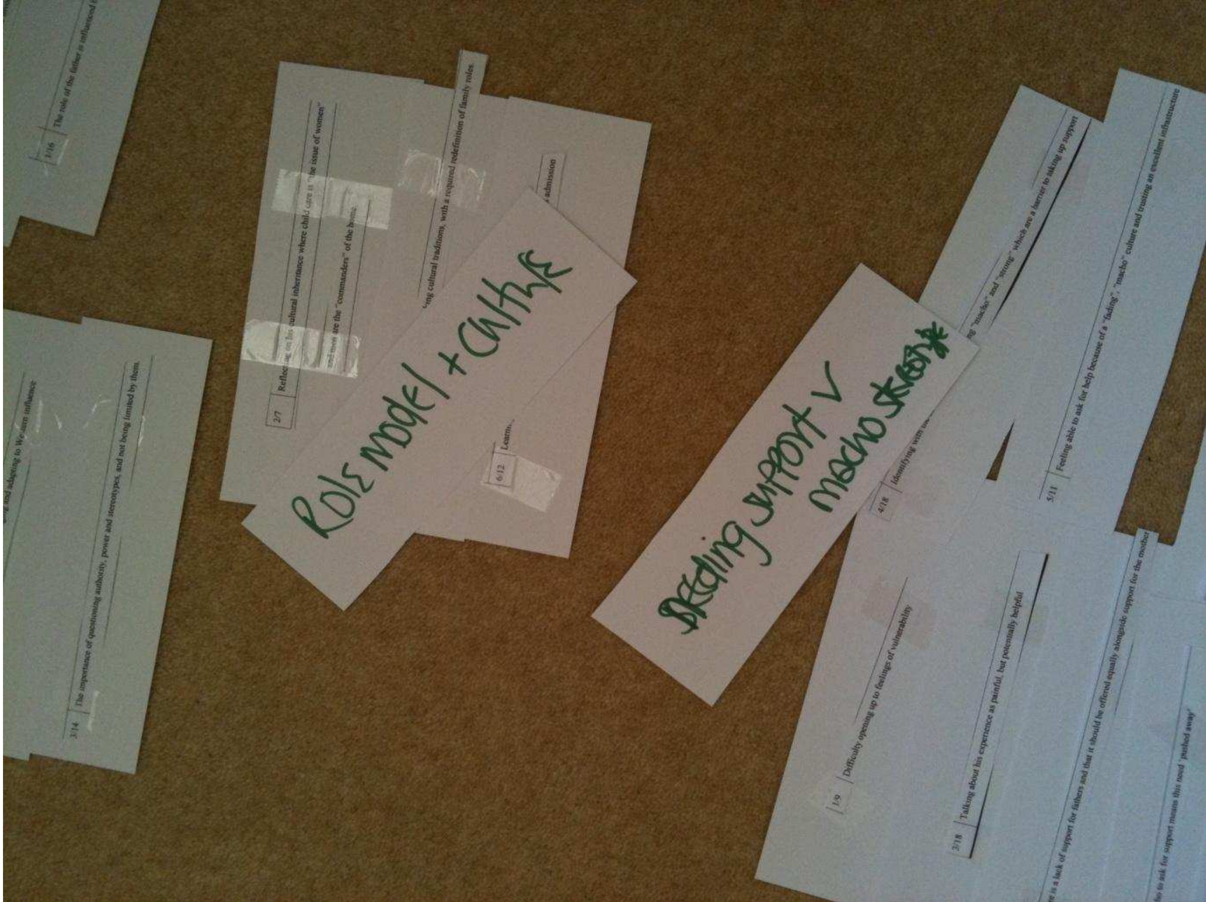
**Feeling limited in the ability to help and calling on support from family, friends and professionals**



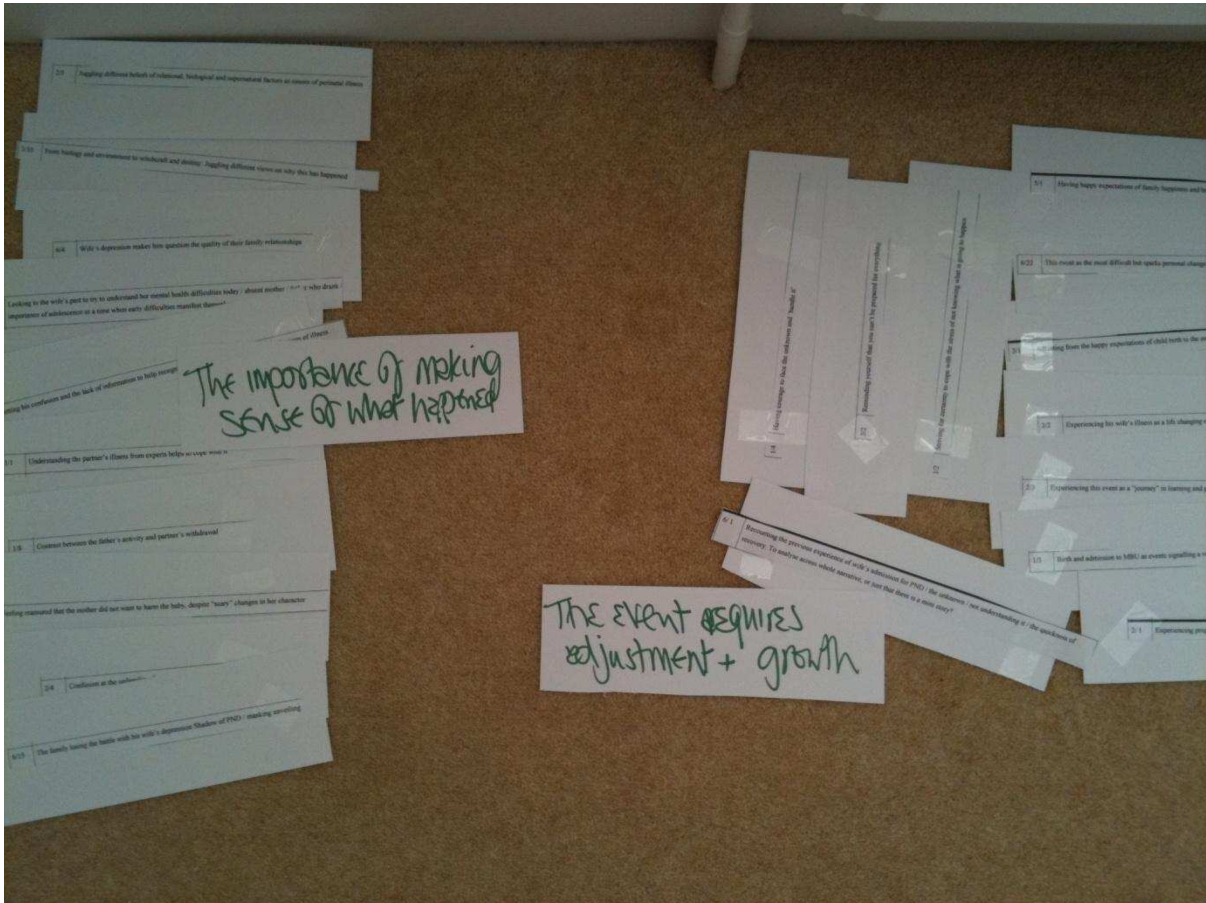
**Sacrificing yourself and being pulled in two directions between looking after mother and child**



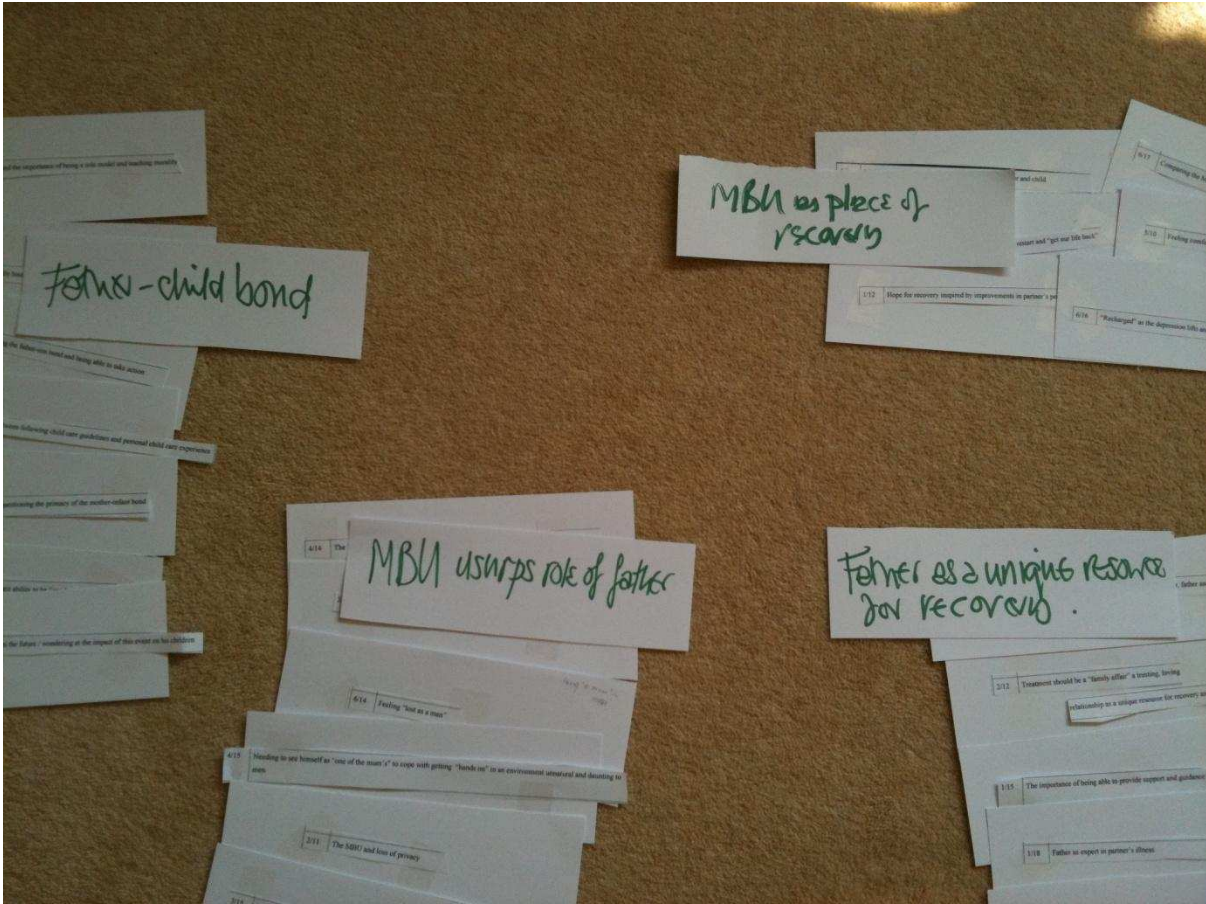
**Culture as a mediator of how the father copes at the MBU and capacity to seek support**



**Adjusting to the situation by striving to make sense of what is happening, leading to growth**



**Conflict between the MBU as a place of recovery and bonding, versus usurping the father's role and missing out on harnessing him as a unique resource for recovery (there is so much here I'm not sure et how to put it!)**



Forming master themes from super-ordinate themes

Forming super-ordinate themes from emerging themes

## Excerpts from notes during interviewing

### Reflections: Participant 2

A father spoke of the different possible causes of mental illness as including 'fetishes'. ?unusual sexual interest? It wasn't clear from the father's explanation what he meant. I checked a dictionary to find out all the possible meanings of this word and realised that it was another term for a supernatural power, which I had only previously heard referred to as voodoo or black magic.

Mobile interruption when talking of privacy

### Reflections: Participant 3

Referencing me / teaching me / deflecting from talking about himself / fostering empathy?
Mobile interruption when talking about all the tasks busy to complete
Bringing me into the narrative, too close for comfort (as fellow MH practitioner)
Many of the themes were of powerlessness or needing help, or feeling emasculated, none of these things would have featured in this narrative, as he was very defended against them
Referring to how I, as working in mental health, might experience it
Doll analogy: positioning me as the doll or the child – unclear? Subverting my perceived authority over him?
Phone interruption: not being prepared for it, being unexpected, you can't think of everything, sense of criticising me for not having that as a check on the forms – difficulty showing me empathy despite his experience of not being able to prepare everything. Issues of competency?

### Reflections: Participant 6

Me formulating: His identification with his mother in child care, learning this from her, keeping her alive through replicating her life?
Wanting to help me by giving me advice about how to relax my eyes as they seemed red to him. Wanting to give back. Does what he gives ever feel good enough?

Is he worrying that I also understand him correctly? Is this a chance for him to 'set the record straight'? Highlights the impact of language, anxiety and length of interview on getting incorrectly understood at the meeting with professionals. Concerns about this interview? Being properly represented?

**Reflections: Participant 5**

I'm turning therapist, needing to contain the anxiety of remembering the crisis before admission. Tells me about how difficult this was for him.

## The process of interpretation

**(date)**

I've decided I'm going to theme a little differently. You see, I initially wrote notes on the script in one margin, then wrote emerging themes on the script in the other margin, based on what I thought was going on at that point in the script. That's ok, because they can be done chronologically. I then wrote up the themes. The thing is, that left me with a written up table only of emerging themes and key quotes to put into super ordinate themes through chopping up the emerging themes and synthesising them where it felt right according to different ways of doing so (in the book).

However, this time, I will write up the notes I've done first in a line by line table, and then chop those up and use that to work out and write up the emerging themes in their table, less chronological, but it gives me a more robust table to show how I did the emerging themes (for validity and transparency) later before I chop those up and do super ordinate themes. I think the notes table will make it easier to step away from the text sooner (which for me is important as I think I need more brevity to do so, as theming was a little bogged by too much checking back before), and it'll be a quicker and more systematic way to explain and check the emerging themes.

(date)

I've checked my themes process against reading threads on the subject on the IPA forum, and I think my process is right, but I would like a double check on my final data,. I also put my own question about it on the forum so I'll see what comes back.

(date)

Theme title revisions: I need to collapse them more, but I don't think I can without losing richness? I think that I have gone back to my first position that my notes were emerging themes, and my themes were superordinate already!

(date)

I did this one according to the book, with the table like box 5.5. It’s a learning curve in using the methodology. Neither are wrong in terms of theming, just the second improves the first in terms of transparency.

(date)

A question is coming up about analysis in case 3. This man is someone who I think would be prone to feeling persecuted and angry at authority in any situation where he felt powerless (as he seems to here). I think this situation in the MBU pressed all his buttons, and his interview is colourful. He is the man I passed on for a potential support meeting, but I understand he didn't take it up. Its making me think how much of the difficulty of his experience in the MBU is down to problems there, and how much is how he would interpret / hear / receive things. I'm going to go through and analyse it 'as is' staying close to the data, but I think it highlights how some are more vulnerable to finding this situation difficult than others, dependent on their history. I think in IPA they call it a negative case study - everything for this man was wrong and difficult and he was very angry. Perhaps it highlights some themes bought up by others, but from the other side of the coin. I'll trust in the process and see what comes out at the end.

(date)

I had an email last night and she felt the themes for 1 and 2 fitted with how she would interpret them and said that the data were rich, which is good because its difficult to know if I'm doing the 'synthesising not simplifying' well enough to theme, but do justice to the nuances of the interview. She suggested a super-super -ordinate theme of conflict in general. It sounds like she is suggesting a possible group theme here, I'll see if that feels right depending on how the others go.

(date)

I found this interview particularly hard to analyse as the dynamics in the room were testing to manage at times (projections of incompetence and worthlessness) and also anger, which once named was easier to manage. It was a classic case of needing to balance being an interviewer allowing someone their space to explore their experience, and intervening on a low level with containing empathic statements so as to de-escalate anger and normalise some of what he was experiencing. I will be noting this in section C.

(date)

This narrative was thoughtful and coherent (he was coping very well) his themes were more cogently linked and I didn't know when to stop collapsing them! I could have revised them down again, but was already worried that I had collapsed so much into each one!! I think I prefer to have more themes rather than less at this stage, as I feel that if I merge too many

before the final cut for group themes, I fear I'll loose a fine grain somewhere. I also know however, that I find it hard to let go and simplify.

(date)

For the meeting I would like to discuss how I simplify themes as I think that's needed and cutting for group themes (I don't know how much of the group theming I'll get done but will try my best). Also some pointers about writing the results section of section B, in particular the style, how to present interpretations and balance those with the data (in turn the I and the P of IPA)

(date)

Here it is ...the final participant. This was tough to do and harder to mine for themes than the others, as they spoke more naturally in the moment, and themes seemingly unlinked in time were easier to grab and pull together. However, I feel that some important things have come forward from an IPA look at it. I have left some of the superordinate themes a little woolly, as I would appreciate some help to think about this one in the meeting.

The next part its to spend time thinking about how the superordinate themes link with each other to give master themes representing the commonalities of the participants' experience - and worrying about what to "lose". I hope that they are there as I have stayed focussed and open to each individual account, trusting in the process, however if they are few, then that tells us something too and I guess would be the qualitative version of a non significant finding - with this methodology at least!.

I've downloaded example IPA studies to help think then about the journal write up which is section B

Fathers fathers fathers!

(date - email)

Thanks for the helpful meeting and then wind down with a nice cup of tea yesterday.I forgot to say, but it was particularly interesting to hear what you had taken from the theming tables I've sent your way over these weeks. Its as if I can only concentrate on one micro bit of the research at a time at the moment to plough through it, but it reminds me that soon I'll have to come back to the whole again. I just don't feel quite at that stage yet, as I need to get the analysis finished and more digestible for myself and others first!

I'm off to buy index cards to build my theming mountain range - quite looking forward to it. I'd like to send them to you when I do, and check your take on them if thats ok?

(date)

I've hit a real worry today about theming and I need guidance as I dont know what would be right to do. Basically I have many super ordinate themes from each participant, so bringing

these through to group analysis means a lot of work at 'group' level to finalise master themes. My worries are these:

Should I return to individual analysis level and try to condense more and therefore pull through fewer themes to analyse at group level?

Or

Should I, continue to work with these using the suggested cut out and pile technique (!). The difficulty is how would I present the data? As I could have up to 10 sub themes in each master theme. Is that too many/wrong?! I've stuck by the process of honouring their experience, it's just my way of working and interpreting? I know Smith is quite flexible.

(date)

I pressed on and I think I might have cracked it! (photos taken with standby headings) I pooled the super-ordinate themes together into about 13 master themes on the floor to start with. I went through them this morning, and organised them into a first cut of about 5 master themes. I do have quite a few sub themes. The thing is, I think pressing on as I was seems to have worked, I think these master themes, with a little more thought today, capture the common experiences.

(date)

I have included the remaining super-ordinate themes underneath the five main tables. These are still rich in detail, I need to focus on for IPA - the common group experiences. So, the master themes I have are supported by 5 or more participants.

(date )

The fathers' quotes are really lighting up all the research and theory this section B has looked like until now! I feel really entranced by it! I hope my write up isn't too skew of what it needs to be, because, for the first time today, I actually believed I might have a shot at getting something in that's good enough!

**Appendix H: NHS National Research Ethics Committee approval**

*“This has been removed from the electronic copy”.*

## Appendix I: Research and Development approval from the host Trust

*"This has been removed from the electronic copy".*

## Appendix J: Demographic information sheet

**Participant no: __________**

**Demographic Information**

**ETHNIC GROUP (please circle)**

**White**
White British
White Irish
White Scottish
White Welsh
White European
White Other

**Mixed race**
White and Black Caribbean
White and Black African
White and Asian
Other mixed race background

**Asian**
Asian British
Indian
Pakistani
Bangladeshi
Other Asian background

**Black**
Black British
Black Caribbean
Black African
Other Black background

**Chinese**

**Other** ethnic group (please specify):

____________________________________________

**Not Stated**

**Cont…**

**Cont…**

**Age:** ______________________________________________

**Country of birth:** ______________________________________

**First language:** ________________________________________

**Occupation:**_________________________________________

**Currently employed?: Yes / No**

**Highest educational qualification:**

_______________________________________________________

_______________________________________________________

## Appendix K: Tables of master themes and contributing super-ordinate themes, emerging themes, notes and key quotes for cross check to the original transcript

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Note | Page |
|---|---|---|---|
| Understanding the partner's illness from experts helps to cope with it (participant 1)<br><br>Key quote: *"I think the major* thing that helps me cope with this situation is probably understanding or trying to understa*nd Lisa's illness."* | Understanding reduces father's stress | Understanding reduces stress | 43 |
| | Learning from the partner's first episode | Partner had previous episodes of illness, informing the next | 6 |
| | Being prepared because of partner's history of psychiatric problems | The first time partner was ill he was stressed, he is not as stressed this time. | 4 |
| | Efforts to get into the experience of the ill partner, striving to understand her symptoms and what it must be like | Not knowing what she goes through, but them speaking about what it might be like – using 'I'. | 5 |
| | Efforts to see what the admission must be like from partner's view | Trying to understand the admission from the partners point of view. | 36 |
| | Understanding the illness on reflection as helpful | Trying to understand the illness to the best of his ability. | 15 |
| | Understanding the illness helps cope with it | "I think the major thing that helps me cope with this situation is probably understanding or trying to understand Lisa's illness." | 15 |
| | Driven to personal research on the internet, but seeing this as inferior to professional advice | Using Google but interpreting the worst, not finding it helpful. Clinicians can speak about your particular case with expertise. | 44 |
| | Work understanding that the partner has an illness | Importance of work understanding the his wife had an illness. | 27 |
| | The family understanding the illness | Partner has a supportive family who understand the illness | 26 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super-*ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Note | Page |
|---|---|---|---|
| *Cont…* | Planning helps ward off the stress of the unknown | Knowing what you're getting into helps | |
| Understanding the partner's illness from experts helps to cope with it (participant 1) | Not knowing is stressful | Not having seen his wife like this before increases the stress, it was still a shock | 43 |
| | Preparation helps a bit | Planning and discussing helps a bit | 4 |
| | The importance of knowing the goals which define improvement | Knowing what to expect and how partner might progress helps. | 20/ 15 |
| | Asking the professionals about prognosis | He reiterates the questions he asked clinicians | 32 |
| | Asking for prognosis in the face of the unknown | Wanting to hear about chances of recovery in certain terms from clinicians | 49 |
| | Having a discussion with professionals before birth cannot fully pre-empt the outcome | Discussions before the birth still didn't help him understand how extreme his partners illness would be. | 3 |
| | Hypothetical planning | Looking at statistics and worst case scenarios | 3 |
| | Preparing for all outcomes relieves stress. | Knowing what you're getting into would help | 3 |
| | Wanting to clear away doubt through preparation | Coming to the unit beforehand would have helped clear away doubts about facing a new challenge and what to do. | 37 |
| | Being able to measure recovery | Wanting time frames and measurements in place to help predict recovery | 49 |
| | Is asking for certainty asking too much. | Asking if its too much to have a progress map | 50 |
| | Discharge date left to deduction | Guessing at a discharge date. | 47 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Note | Page |
|---|---|---|---|
| Birth and admission to MBU as events signalling a venture into the unknown (participant 1) | Birth heralds psychiatric difficulties | Getting progressively ill after she gave birth | 1 |
| | Complete difference in partner's behaviour after birth | Partner's behvaiour totally different to her usual character | 8 |
| Key quote: *"...its something that I haven't seen before, so it was kind of a different ball game."* | Pending birth meaning not enough time to prepare | Finding out about the pregnancy late did not give them time to prepare | 7 |
| | Having a baby is unreal, unbelievable | Having a child is unbelievable | 25 |
| | No idea how to make sense of new presentation | It was a "different ball game" | 8 |
| | Coping is hard when its an unfamiliar experience | Being stressed because he hadn't seen this before | 8 |
| | MBU admission as a strange, disorienting environment | Not knowing where he was going – a strange and confusing environment. | 37 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Note | Page |
|---|---|---|---|
| Having courage to face the unknown and 'handle it' (participant 1) | Having the courage to venture into an unfamiliar environment | Feeling uncomfortable in the MBU, but "taking the bull by the horns" and doing what he can do. | 29 |
| | Being able to cope | Feeling that it is important to handle the situation | 15 |
| Key quote: *"I would say it's important to actually handle it."* | | | |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| Juggling different beliefs of relational, biological and supernatural factors as causes of perinatal illness (participant 2)<br><br>Key quote: *"...my parents are* very Christian, so really believe in Christianity, but my friends, they told me that I should look elsewhere of what is happening to *my wife...* they really believe that there is some negative *power...maybe someone want to ruin my family...want to make my wife mad...But really, I really believe in, I don't think someone can harm me, I say no....she is in* the best hands. I think they really find out what i*s the problem."* | Taking responsibility leading to maturity | Feeling that his wife's illness was his fault, and this leading him to take things seriously. | 17 |
| | Being absent during childbirth | Having no contact with mother and child during childbirth | 2 |
| | Blaming his absence as a cause of wife's illness | Regretting not being in the country | 9 |
| | Reflecting and blaming his absence as a cause of wife's illness | The event made him ask himself if he should have been here whilst she was pregnant. | 9 |
| | Blaming his absence for causing her post natal depression | Believes he shares the greater part of the blame for being absent | 20 |
| | Absent fathers causes post natal depression | Blaming her illness on his absence | 6 |
| | Being absent during child birth | He was absent abroad during childbirth and just after | 6 |
| | Absent fathers causes post natal depression | Seeing other women in the MBU without partners | 6 |
| | Absent fathers and a lack of love cause post natal depression | Believing a maternal depression is due to the absence of a father and not having love and only having disappointment in that period: an explanation for depression centred around the couple relationship. | 6 |
| | Family problems cause post natal depression | He believes that family problems can make the woman unwell in child birth if they start around that time. | 40 |
| | Lack of care and love as a cause of wife's illness | Repeating that he believes that these things happen with lack of care and love. | 9 |
| | Reflecting and the importance of the wife's mother during child birth | Considering whether he should have brought her mother over from Nigeria whilst she was pregnant, as this may have "averted trouble" | 9 |
| | The separation of mother and infant as a trigger for post natal depression | When one wants to "go out" anything can happen…one can "take much" from this person (the mother) | 8 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super-*ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| *Cont…* | The separation of mother and infant as a critical moment for their well being | Realising mother and child are "connected" (umbilical cord?). Thinking "anything can happen" when mother and child become separated. | 8 |
| Juggling different beliefs of relational, biological and supernatural factors as causes of perinatal illness (participant 2) | Pregnancy changes women | Pregnancy changes a woman | 42 |
| | Changing hormones during pregnancy can cause a women to act in troublesome ways | Learning about hormone changes during pregnancy, believing that women can "cause trouble" during pregnancy because of hormones. | 41 |
| | Pregnancy can cause a women to act in troublesome ways | Her role is that she will have no control over her actions and her hormones will change her as she has "become double" | 42 |
| | The consequences for men not understanding the changes that can happen with pregnancy are high (divorce and difficulties in child birth) | Men need to know this comes with pregnancy, otherwise it can jeopardise their relationship and there will be "no love". This could escalate into arguments and divorce and she could go into labour without love and in fear. | 41 |
| | The consequences for men not understanding the changes that can happen with pregnancy are high (divorce and difficulties in child birth) | Everyone should tell the man that these things come with pregnancy, and to keep calm, otherwise they will pay for it later when the woman becomes depressed | 41 |
| | Friends believe wife's illness is caused by supernatural fetish powers. | Friends have responded by believing there may be some "fetish" that has affected him and his wife. | 24 |
| | Friends believe wife's illness is caused by supernatural fetish powers. | Wife's Illness as a result of voodoo | 25 |
| | Friends believe wife's illness is caused by supernatural fetish powers. | Friends concerned that the problem is not medical, it is some negative power than can be solved by sending money home to Nigeria. | 25 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| *Cont…* | Friends believe wife's illness is caused by supernatural fetish powers. | Friends believe that the negative power has the power to harm his wife, ruin his family, make his wife mad. | 26 |
| Juggling different beliefs of relational, biological and supernatural factors as causes of perinatal illness (participant 2) | Friends believe those envying his status may use supernatural fetish powers to harm him by harming his wife. | The friends believing he should be careful as he is considered a "big guy" with some small scale companies which people might want to harm. | 26 |
| | Parents do not believe in fetishistic explanations | Parents hold Christian beliefs and do not believe in Fetish | 25 |
| | He believes his wife is in the "best hands" in the MBU | He does not believe in fetishes, but believes that his wife is in the best hands in the MBU | 26 |
| | He believes his wife is in the "best hands" in the MBU | The MBU as the "best hands", they must know what it is all about. | 26 |
| | The MBU as a place where his wife can be "in the best hands" | He doesn't believe in fetishes | 27 |
| | The MBU as a place where his wife can be "in the best hands" | Medics will be able to make her better | 27 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| Adjusting from the happy expectations of child birth to the unexpected trauma of his wife's postnatal illness (participant 3) | The event as unexpected | You never expect it to happen to you | 2 |
| | The event as unexpected | You don't expect it to happen to you | 3 |
| | The event as unexpected | Searching to understand the reason for what has happened | 7 |
| | The event as unexpected | How did it come to this point? | 2 |
| | The event as unexpected | Wondering how he got to feeling this way | 28 |
| Key quote: *"Seeing the person go* through that kind of trauma is a bit kind of nightmare in that sense, you never expect it to *happen to you… you wake up in* the morning just feel like you are *in a different world…"* | Expectations of happiness | Expectations of happiness | 8 |
| | Expectations of happiness | Expectations of happiness and joy before child birth | 8 |
| | Expectations of happiness | Expectations of good and happy things | 8 |
| | Adjusting to a different world | You wake up in the morning and feel like you're in a different world | 3 |
| | Adjusting to a different world | Having plans and having to abandon them | 8 |
| | Adjusting to a different world | Feeling that everything is distorted now socially | 10 |
| | A nightmare | Nightmare | 1 |
| | A traumatic nightmare | Trauma, nightmare | 2 |
| | A nightmare | It was my nightmare | 2 |
| | A nightmare | Nightmare | 7 |
| | A shock | Shock at wife's illness | 8 |
| | Reminding himself that you can't be prepared for everything | Stating that you cannot be prepared for everything | 10 |
| | Reminding himself that you can't be prepared for everything | Car insurance analogy about not being able to be prepared for everything despite trying | 10 |
| | Reminding himself that you can't be prepared for everything | You can't know everything | 10 |
| | Reminding himself that you can't be prepared for everything | Phone interruption: not being prepared for it, being unexpected, you can't think of everything. | 12 |
| | Reminding himself that you can't be prepared for everything | You can't prepare for everything | 12 |
| | Reminding himself that you can't be prepared for everything | Our conversation: Something about agreeing that there is only so much you can prepare for and being comfortable with uncertainty. This as a 'beautiful example' of what he was talking about. | 12 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| From biology and environment to witchcraft and destiny: Juggling different views on why this has happened (participant 3)<br><br>Key quote: *"we have the religious* side of it, and it becomes sometimes good to go onto the transpersonal aspect of it. Some people think it was *witchcraft….and the family background."* | Juggling different views on the causes of mental illness | Juggling different views on causes of perinatal illness: problems in family background, witchcraft, transpersonal factors, religious views | 3 |
| | Juggling different views on the causes of mental illness | The wife's mother blames herself | 4 |
| | Juggling different views on the causes of mental illness | Believing in a biological cause of postnatal depression: the role of hormones, extreme neurochemical imbalances | 4 |
| | Juggling different views on the causes of mental illness | Wondering whether pregnancy or labour itself is the cause of illness | 8 |
| | Believing this has happened because of destiny | Not a major event, it's a crisis that happens now and then in people's lives, its my turn | 19 |
| | Believing this has happened because of destiny | Asking himself why this has happened to him | 30 |
| | Believing this has happened because of destiny | Believing that everyone faces difficult journeys at some point, and that its his turn this time | 30 |
| | Believing this has happened because of destiny | Believing that destiny makes the decisions about who has to journey through a difficult time | 30 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and cont*ributing super-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| Scared at the changes in the mother after childbirth and worry about the impact on the baby (participant 4)<br><br>Key quote: *Interviewer:"What* was that like for you, all that going on?<br><br>*Jack : "Scary really, I've not seen* that side to Julie to know like, you really *know she's sick cos she's* so out of character, the things she was doing, the things she was *saying, yeah, really scary."* | Scared at the change in Julie after childbirth | Scared at the change in Julie after child birth | 2 |
| | Julie as acting out of character after childbirth | Julie was acting out of character, showing a side not seen before | 2 |
| | Scared at the change in Julie's character after childbirth | Julie was doing and saying things out of character and it was scary | 3 |
| | Julie acting out of character after childbirth | Julie saying "far out" things, being paranoid | 3 |
| | Finding Julie's illness scary | It was really scary when she was at her most ill | 3 |
| | Julie's illness not interfering with the mother – baby bond | Julie always knew in the back of her mind she needed to look after the baby | 3 |
| | Julie's illness not leading to her harming the baby | Knowledge of other mum's not bonding with the baby or wanting to harm the baby – this wasn't Julie's problem though | 3 |
| | Julie's illness not leading to her harming the baby | No question of her wanting to harm the baby | 3 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Having expectations of family happiness and being unprepared for this nightmare (participant 5) | This experience as "the opposite" of being the happiest time he expected | Expectations of it being the happiest time in his life, but its actually been the opposite | 1 |
| | Having expectations of sharing the happiness of childbirth with family | Expected to share happy times with parents, family and friends | 1 |
| Key quote: "it was supposed to be *the happiest time…it has actually* been the opposite, it has been a *nightmare."* | This experience as "the opposite" of being the happiest time he expected | Expecting to be home, happy, enjoying walks (marker of recovery) but its been the opposite | 2 |
| | Imagining family life before the baby's birth / the event as unforeseen / los? | This is not how I imagined it would be | 12 |
| | Imagining harmonious family life before the baby's birth / loss? | Imagined a "happy mummy" doing domestic chores and baby care, and he would help her so she could attend classes | 12 |
| | The contrast between imagining harmonious family life and the crisis of reality / loss | Reality is different, unplanned, the involvement of police, his wife contacting a lawyer from the ward against her detention | 12 |
| | The event as a nightmare | It has been a nightmare | 1 |
| | The event was unforeseen | Didn't see it coming | 2 |
| | The event as unforeseen | Nothing in pregnancy books prepares you for this | 20 |
| | Experience of wife's previous depression did not prepare him for this | Wife had a previous episode of depression which compared very mildly to this illness | 2 |
| | The event was unforeseen | Didn't see it coming | 2 |
| | The event as unforeseen | I didn't see this coming | 12 |
| | The event as unforeseen | Never thinking this could happen to him | 20 |
| | The event as unforeseen | Never thought this could happen to me | 21 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| Looking to the wife's past to try to understand postnatal depression (participant 6)<br><br>Key quote: *"I started to study what's happened in the past…you* know, because if from the beginning there is some, anything, then umm when the girl becomes a woman, I understand she is *starting to show what's happened in the past…she felt left by her parents…this is one of the stamps on her past."* | Seeking to understand his wife's illness | Recounting his wife's previous admission for postnatal depression and seeking to understand why it had happened. | 2/3 |
| | Discussing his wife's past with her and believing that feeling "left" by her parents had left to her "nervous" character | Describes his search for understanding his wife's difficulties. Describes her as an only child who was separated from her mother who went to work abroad, and her father who worked long hours and started to drink because he worried about the length of time his wife was away. Wife had to stay with neighbours. She was almost a teenager an worried what was happening with her family | 8 |
| | Discussing his wife's past with her and believing that feeling "left" by her parents had left to her "nervous" character | His wife explained that feeling left by her parents had made her a nervous child, until her mother returned, and then they met as a couple and moved in together. | 9 |
| | Communicating to me the conversations between them to me, to understand her difficulties | I'm hearing him formulate her difficulties to understand and I'm hearing their conversations as a couple, intimate, trusting communication | 9 |
| | Looking to the past to understand her difficulties today | His story begins before the MBU | 2 |
| | Looking to the past to understand her difficulties today | He tried to understand her nervousness | 9 |
| | Looking to the past to understand her difficulties today | Not finding an explanation in the present for her outbursts, so looking to the past for answers | 9 |
| | Believing childhood experience leaves a stamp on life which manifests at adolescence | Believes that childhood experience impacts on adult behaviour, with adolescence as a turning point "when a girl becomes a woman…she is starting to show whats happened in the past" | 10 |
| | Discussing his wife's past with her and believing that feeling "left" by her parents had left to her "nervous" character | Believing that being an only child meant she felt "left" by her parents | 10 |

*Master theme: 'Striving to makes sense of what has happened to the partner, helps adjust to, and cope with, this unexpected trauma' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| *Cont…*<br><br>Looking to the wife's past to try to understand postnatal depression (participant 6) | Believing childhood experience leaves a stamp on life which manifests at adolescence | He sees her feeling '"left" by her parents as leaving a "stamp" or indelible mark on her past | 10 |
| | Looking to the past to understand difficulties today | The importance of telling me their histories to explain part of their story at the MBU | 10 |

*Master Theme: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Preferring partner and child to be at home but accepting the need for the admission participant 1)<br><br>Key quote: *"I felt yeh it was the* best place for her to actually be in, although in an ideal world, uh it would be good to have mum and *baby at home."* | Preferring to have partner and baby at home, but accepting the need for admission | Felt it would have been good for partner and baby to be at home, but that the MBU was the best place for them | 2 |
| | To have a new baby and partner mentally well would be too good to be true | You can't have your "bread buttered on both sides" | 2 |
| | Accepting the need of admission | He felt accepting of the need for admission | 2 |
| | Preferring partner and baby to come home, admission as worst case scenario | Them being at home would have been the best outcome, being at the MBU is the worst outcome | 3 |
| | Accepting the need for the admission but wishing to have partner and baby back home | The MBU as the best place to be in, although preferring them to be at home. | 2 |
| | Looking forward to being a family unit at home | Looking forward to discharge and being home as a family. | 35 |

*Master Theme: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Feeling limited in skills to help compared to professionals (participant 1) | Remaining positive by focussing on what you can do and what the professionals can do | Doing what he can do in his power, and leaving the rest to the "experts" | 18 |
| | Focussing on what you can't do is stressful | Focusing on the things you can't do is stressful | 44 |
| Key quote: *"She was* progressively getting ill, and based on that, umm, she needed medical help which, um, I *obviously couldn't provide."* | Being able to rely on professional support enables him to focus on what he can do | Partner had trained people to help her, he will focus on what he can do. | 19 |
| | Focussing on what you can do can change things, whereas feeling sorry for yourself doesn't change anything | He believes feeling sorry for himself won't help, he focuses on what he can do. | 18 |
| | The stress of experiencing the limits of what you can do | Not knowing what to do when his partner becaome really withdrawn. | 9 |
| | Not being able to provide help | "She was progressively getting ill, and based on that umm she needed medical help which um I obviously couldn't provide." | 2 |
| | A sense of inadequacy and being unskilled in researching help | N: "You mentioned self research, where were you looking?"<br>P: (laughs) "ah just Google" | 7 |
| | Accepting the limits of what you can do | Accepting that there are trained people who can help his partner, so just letting that happen. | 16 |

*Master Theme: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Being distressed at the changes in his wife and needing to ask for professional help (participant 2) | Distress at the change in his wife | Crying because he hadn't seen his wife like this before | 3 |
| | Confusion, shock | Feeling confused and shocked | 3 |
| | Things became mystifying / unfamiliar/remarkable /extraordinary | It was a strange thing | 3 |
| Key quote: "It's a simple language 'depression', but I don't really know what it is about, childbearing and women" | Confused at the change in his wife | Confused because known wife for a long time and no problems like this before | 5 |
| | Wife unaware / absent | Wife unaware | 5 |
| | Wife unaware / absent | Experiences his wife as having gone away | 36 |
| | The wife as unaware | He returns to the beginning and describes how his wife didn't know him due to her illness when he first arrived. She wouldn't go anywhere or leave the hospital. | 38 |
| | Distress experienced when he first saw his ill wife | At first crying everyday | 27 |
| | Not knowing about post natal depression | Not knowing about depression or the word depression | 3 |
| | Not knowing about post natal depression | Not knowing about serious situations in child birth | 7 |
| | Not knowing about post natal depression | Not knowing about depression, child bearing and women's issues. | 26 |
| | Wanting to know about prognosis | Asking many questions of staff about the possibility of recovery | 4 |
| | Looking for normalisation | Asking if what has happened to his wife is familiar to anyone else | 5 |
| | Seeking to makes sense of these "strange" events | Asking staff questions to try to understand the changes in his wife's condition. | 9 |

*Master Theme: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Becoming a service user and doubting his ability to help his wife despite knowledge of mental health (participant 3)<br><br>Key quote: *" just like a doctor* whose wife is not well, he knows, maybe somehow the diagnosis, he might even have treated somebody with a similar illness, the fact that the wife is not recovering kind of puts some doubt inside him – what am I *doing that is not right?"* | The difference of facing mental health issues as a service user, than as a professional | Unexpected change from mental health nurse to service user and carer | 1 |
| | The difference of facing mental health issues as a service user, than as a professional | Changing from giver of help to receiver of help | 2 |
| | The difference of facing mental health issues as a service user, than as a professional | Going through this experience helps to understand what others in the same situation go through | 2 |
| | The difference of facing mental health issues as a service user, than as a professional | Compares going through this with someone close to you as a trauma, compared to being able to cope with going through it as a professional with a client | 2 |
| | The difference of facing mental health issues as a service user, than as a professional | Being a service user | 28 |
| | The difference of facing mental health issues as a service user, than as a professional | Being a carer of a service user | 28 |
| | Doubting his ability to help himself as a service user despite his knowledge of mental health | Feeling like a doctor who has to heal himself, but how do you heal yourself? | 3 |
| | Doubting his ability to help his wife despite his knowledge of mental health | Compares himself to a doctor experiencing doubts over his ability to help someone with a physical illness in his own family | 10 |
| | Doubting his ability to help his wife despite his knowledge of mental health | Doubts about whether he can help his wife, despite his experience in mental health | 10 |

*Master Theme: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| The MBU provided the specialist help needed for the mother and child (participant 4) | MBU as a the right place to help Julie | MBU is the place to come to get better | 1 |
| | MBU as the right place to help Julie | MBU treatment was for the best | 2 |
| | Needing to seek professional help for Julie | Needing professional help | 2 |
| Key quote: "Julie is sick and we *needed her to get better…so we* knew this was the place to *come…I didn't think she was gonna get better. She weren't gonna get better at home."* | Needing to seek professional help for Julie | The admission was a necessity | 2 |
| | MBU meeting Julie's need to recover and have the baby with her | Julie wanted her baby with her and MBU provided an opportunity for recovery and having the baby | 2 |
| | MBU as solving two problems, helping both mother and child | Killing two birds with one stone: The MBU allows you to solve two problems as the same time: Get mother better and look after child | 2 |
| | MBU as the first step to getting better | MBU was the first step to getting better | 3 |
| | MBU as the first step to getting better | MBU was the first step to getting better | 4 |
| | Julie's recovery included learning to look after the baby | Julie learning to look after her baby was a big part of the treatment | 6 |
| | Importance of the child's needs if a parent with mental health difficulties | You have to think about the children when you've got mental health issues | 6 |
| | Julie needing help to learn to care for their child | Julie progressed with help in being "hands on" with her child | 8 |
| | The MBU as an excellent service | Not being able to fault the service | 9 |
| | The MBU as effective in treatment | Julie and Sam were helped and Julie gained knowledge about child care | 9 |

Master Them*e: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Note | Emerging themes | Page |
|---|---|---|---|
| Feeling helpless to fix the problem and needing family and professional support (participant 5)<br><br>Key quote: *"she had a problem, I* had no clue what it was and how *to fix it…I had no clue what's* happening. I just saw her everyday getting worse and worse *and worse and I didn't know what to do."* | MBU admission as a relief, as it was the best place to be looked after and wife could have the baby with her | MBU admission as a relief as the best place for mother and baby | 4 |
| | A relief for him when his wife was moved to the MBU for the right treatment | A relief that his wife could receive specialist treatment at the MBU | 5 |
| | Coming to the MBU was good because the previous ward was "horrible", "double locked", "people screaming and talking nonsense", and they weren't experts on puerperal psychosis | The MBU as more therapeutic and offering specialised treatment than the first ward. | 4 |
| | His main concern is that his wife and baby are well | The wife and baby's health as the main focus | 24 |
| | The usefulness of being referred to a place that can offer the right treatment | The importance of referral to specialist treatment | 23 |
| | Knowing the MBU is the best place for wife, and the best place for the baby is with his mother | MBU as the best place for mother and baby | 1 |
| | Conflict of wanting them home, but knowing the best place for wife is the MBU, and the baby should be with her | Conflicting feelings of wanting them home but the MBU being the best place for mother and baby | 1 |
| | I've no idea how to sort this out | Feeling helpless | 12 |
| | Wife's condition got worse despite trying mother-in-law's idea of getting sleeping tablets from the GP so she could sleep | Trying to fix the problem at home | 12 |

*Master Theme: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Note | Emerging themes | Page |
|---|---|---|---|
| *Cont…* | Needing professional help | Needing professional help | 12 |
| | Professionals realised she was sick | Professionals recognising that his wife was unwell | 4 |
| Feeling helpless to fix the problem and needing family and professional support (participant 5) | Needing help | Needing help | 6 |
| | Calling his own parents to help him by looking after the baby so he could be more involved with his wife and try to speed up the admission to the MBU | Needing his parents to support him so he could attend to his wife's needs | 6 |
| | Parents caring for the baby also meant he could go back to work | Needing his parents to support him so he could provide for the family | 6 |
| | All the family going through the stress of this event | The whole family is effected | 1 |
| | His parents left once the baby could be with the mother | The mothers improvement meant his no longer needed parental support | 6 |
| | Relying on doctors help 100% | Relying on professionals | 12 |
| | Traumatic experience of not understanding and feeling helpless | Traumatic experience of not understanding and feeling helpless | 22 |
| | Father not "having a clue" | Not understanding | 22 |
| | "Apparently she had a problem, I had no clue what it was and I couldn't fix it" | Not recognising or understanding the illness and feeling helpless | 22 |
| | Wife's symptoms getting worse and not having a clue what to do | Leading to the crisis: helplessness increasing with severity of wife's symptoms | 22 |
| | Feeling powerless to force her, days passing and not having a clue what to do | Leading to the crisis: helplessness increasing with severity of wife's symptoms | 22 |
| | Feeling helpless | Feeling helpless | 23 |
| | Work being supportive with time off | Work being supportive with time off | 15 |

*Master Theme: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| Regretting his confusion and the lack of information to help recognise and respond differently to the early signs of illness (participant 5)<br><br>Key quote: *"There is not much* advice for fathers, for husbands, where to search for help, where to look, what, how to behave at *home"* | The importance of advice for fathers to recognise the early signs of illness | Help is also needed before the crisis happens, at the stage where things are just not quite "right" | 23 |
| | The importance of advice for fathers to recognise the early signs of illness | More awareness might help pre-empt the crisis | 23 |
| | The importance of raising awareness | Importance of raising awareness | 21 |
| | The importance of making knowledge available and raising awareness | Frustration that few studies are available on post natal psychosis on the internet | 21 |
| | The importance of making knowledge on perinatal illness available | The internet as being the only resource he has | 21 |
| | The importance of advice for fathers to recognise and respond to the early signs of illness | There is no advice for fathers as to where to get help or how to behave at home when this starts happening | 21 |
| | The importance of advice for fathers to recognise and respond to the early signs of illness | Seeing something going on that "wasn't normal" and not knowing if it might be temporary | 21 |
| | The importance of advice for fathers to recognise and respond to the early signs of illness | Thinks there should be more advice out there about how to behave early on when you see changes. | 21 |
| | The importance of advice for fathers to recognise and respond to the early signs of illness | Advice on whether to call for help, or to support and reassure partner that things will be alright | 21 |
| | The importance of advice for fathers to recognise and respond to the early signs of illness | Hoping her behaviours were temporary | 22 |

Master Theme*: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging theme | Notes | Page |
|---|---|---|---|
| *Cont…* | The importance of advice for fathers to recognise and respond to the early signs of illness | Recognising that she had an illness and the seriousness of it would have helped him behave differently | 22 |
| Regretting his confusion and the lack of information to help recognise and respond differently to the early signs of illness (participant 5) | The importance of advice for fathers to recognise and respond to the early signs of illness | Believing its helpful to be aware of the signs | 22 |
| | Regretting not knowing more about the early signs of illness | Wished he had known more beforehand about how serious the problem could get, then he would have acted differently | 23 |
| | Regretting not knowing more about the early signs of illness | Loosing his temper with her when things started to become difficult to deal with and regretting it | 21 |
| | Noticing unusual behaviour in his wife | She was talking all night | 12 |
| | Regretting not knowing more about the early signs of illness | Story of her incessant whispering in his ear all night and ignored pleas for her to leave him alone, resulting in him loosing his temper and pouring the nightstand water all over her | 21 |
| | Regretting not knowing more about the early signs of illness | Mother-in-law being "scandalised" at his behaviour | 22 |
| | Feeling confused | Living with a psychotic person affected his thinking too | 12 |
| | Feeling a loss of control | Feeling like he was loosing control of himself | 22 |

*Master Theme: 'Feeling limited in being able to help and needing professional support' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Coming up against limits and needing support (participant 6)<br><br>Key quote: *"She was getting more worse, ummm, I didn't went to the doctors… because I was thinking* maybe I could do something *myself for her, to help her…she said I can't explain what is happening to me…and then we decided to speak to the doctor…"* | Involving professionals when all other ways had failed to help | They then spoke to health professionals at the scan about her difficulties | 8 |
| | Support of his parents with his first child | His parents arrived to support him during that time | 11 |
| | Support from his church community | Accepting help from his church community so he could visit | 13 |
| | Grateful for the sacrifices of the church community when they have their own families | Grateful for the help of the church group over a long period of 6 months despite having their own families (sacrifice?) | 21 |

*Master Theme: ‘Pulled physically and emotionally between the needs of partner, child and self’ and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Pulled physically and emotionally between looking after the needs of his partner, child and himself (participant 1)<br><br>Key quote: “You go through all the emotions when you have a new born baby, and its your first *child as well, so it’s like you* wanna be there, and you want to hold her, and you want to do the feeds and changing, and see her do things; at the same time you have Lisa on the other end who its *totally not well…and uh, so you’re on one hand expecting the* worst and also trying to remain *positive.”* | Father splitting himself to share time with the partner and child | Feeling he has to split himself into two places | 9 |
| | Pulled in two directions between the partner and child | Spending time playing with the baby and spending time trying to help Lisa. | 10 |
| | Experiencing a “constant flavour of mixed emotions” | Feeling happiness about the baby and sadness about the person he loves being in pain. “a constant flavour of mixed emotions.” | 11 |
| | Experiencing contrasting emotions with partner and with child | Going through emotions from having your first child, and wanting to be there for her, help with her care, and then having an ill partner, who is withdrawn and you are expecting the worst, whilst trying to remain positive. “ | 10 |
| | Sensitivity to partner’s pain | “Well its hard actually you know, to see your partner in any pain that’s as well from a paper cut, to being quite ill.” | 8 |
| | Wanting to be with the baby as much as possible | Feeling love for his baby from the first moment, and wanting to be with her. | 25 |
| | Taking time to rest and reset is refreshing | Having 20 minutes to rest, refreshes you and enables you to carry on again. | 14 |
| | Taking time to rest helps the father keep balanced amidst the demands | Taking ten minutes to rest keeps him balanced. | 12 |

*Master Theme: ‘Pulled physically and emotionally between the needs of partner, child and self’ and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| The physical and emotional difficulties of splitting time between looking after mother, child, yourself and work (participant 3)<br><br>Key quote: “you have to work, take care of your wife, take care *of the baby…its kind of a test in* time for you to just pull yourself *together”* | The importance of keeping personal and professional life separate | No one at work knows whats going on | 18 |
| | The importance of keeping personal and professional life separate | Separates his “life” from work, hides his situation so not to make others sad | 18 |
| | The importance of keeping personal and professional life separate | My life is none of their business at work | 19 |
| | The importance of keeping personal and professional life separate | Work / life split | 19 |
| | The importance of keeping personal and professional life separate | Its none of their business | 19 |
| | To celebrate birth or grieve and feel guilty about losses? | Confusion about knowing ‘how to be’ | 9 |
| | To celebrate birth or grieve and feel guilty about losses? | Cannot grieve because you have a baby, cannot celebrate because his wife is ill | 9 |
| | To celebrate birth or grieve and feel guilty about losses? | Wondering whether to smile or cry | 9 |
| | To celebrate birth or grieve and feel guilty about losses? | Not knowing who he can smile with – being alone | 9 |
| | To celebrate birth or grieve and feel guilty about losses? | Not knowing who he would cry for, himself, his wife or his child? | 9 |
| | To celebrate birth or grieve and feel guilty about losses? | Its like going through a bereavement for the man | 8 |
| | To celebrate birth or grieve and feel guilty about losses? | The man feels guilt instead of happiness | 8 |

*Master Theme: 'Pulled physically and emotionally between the needs of partner, child and self' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | To celebrate birth or grieve and feel guilty about losses? | I don't know how I feel | 25 |
| The physical and emotional difficulties of splitting time between looking after mother, child, yourself and work (participant 3) | Juggling the demands of taking care of wife, baby and work | Difficulties of juggling the demands of taking care of wife, baby and work | 4 |
| | Juggling the demands of taking care of wife, baby and work | Having to portion your time | 10 |
| | Juggling the demands of taking care of wife, baby and work | Having to be careful with time | 11 |
| | Juggling the demands of taking care of wife, baby and work | Each day is prescribed and you know what you have to do | 11 |
| | Juggling the demands of taking care of wife, baby, himself and work | Before having a carefree life | 11 |
| | Juggling the demands of taking care of wife, baby and work | Now spending much of each day travelling and visiting the MBU whilst trying to have time to rest | 11 |
| | Juggling the demands of taking care of wife, baby and work | Trying to live as normally as possible helps to cope with the fact that anything can happen the rest of the time | 11 |
| | Juggling the demands of taking care of wife, baby and work | Questioning how to manage being a husband and being a dad | 13 |
| | Having to divide attention between helping mother and child | Finding your attention divided between giving to mum to help her recover and giving to child to help them grow up | 8 |
| | Having to divide attention between helping mother and child | Juggling two balls | 8 |

*Master Theme: 'Pulled physically and emotionally between the needs of partner, child and self' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| "Catch 22" being torn between spending time with mother and time with baby (participant 4)<br><br>Key quote: "It was *like a "catch 22", cos you've got my son there* who I wanna spend all the time *with, then you've got Julie sick, so you want her to get better…really hard it was"* | Being torn between spending time with mother and baby | Being torn between spending time with the child and time with Julie | 2 |
| | "Catch 22" being torn between spending time with mother and time with baby | Catch 22: Being in a no win situation between wanting to spend time helping Julie recover, and spend time with your son | 2 |

*Master Theme: 'Pulled physically and emotionally between the needs of partner, child and self' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Subjugating his needs to prioritise Julie's recovery (participant 4)<br><br>Key quote: "What keeps me ticking is what I was going through was nothing compared to *what Julie was going through…in my mind I'm not a selfish person and not a 'me me'. I always knew…it's always about Julie."* | Prioritising getting Julie better | Focussing on getting Julie better after the birth was the priority | 1 |
| | Prioritising getting Julie better | A priority to get Julie better first | 5 |
| | Its all about Julie getting better | It's all about Julie getting better | 6 |
| | Its about Julie getting better | Its about Julie getting better | 6 |
| | All about Julie getting better | It was all about her getting better | 7 |
| | Recovery allowing a focus on Sam | Now Julie's better its all about Sam | 11 |
| | Prioritising Julies getting better | Being there for Julie first | 17 |
| | Giving up his needs to prioritise Julie's needs | Not being a selfish person, its all about Julie | 17 |
| | Comparing his experience favourably with Julie's | Severity of Julie's illness helped put his difficulties into perspective | 17 |
| | Dedicated to helping Julie recover | Doing anything to help her get better | 24 |

*Master Theme: 'Pulled physically and emotionally between the needs of partner, child and self' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Pulled physically and emotionally between work, partner and child (participant 5)<br><br>Key quote: *"…you try to do your* best for the baby, feed him and *change him…on the other hand, I* had my wife, whose mind had completely gone somewhere, and *it broke my heart…on one hand* you have to look after the baby, and on one hand you have to try to help your wife and that was the *toughest one."* | Finding juggling the demands of baby care at home and visiting his wife very stressful | The most difficult part was when the wife and child were separated and he had to juggle meeting the 24 hour needs of the baby and helping his wife | 8 |
| | Balancing contrasting feelings about wife and baby's admission with being separated from them | Balancing "contrasting" feelings of happiness at his wife's improvement and sadness at not being able to see his own son often due to living far away and working | 2 |
| | His life is filled by juggling the needs of his family | Dividing his life between long shifts at work and long hours at the MBU | 9 |

*Master Theme: 'Pulled physically and emotionally between the needs of partner, child and self' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Feeling "slowed down" with the demands of wife and children and uncertainty of recovery in the first months of admission (participant 6)<br><br>Key quote: "there was a few weeks from the beginning, especially after when she was thinking about to kill herself, I was so worried, it was too much pressure, too much stress for me and especially with the *children…to sort everything out."* | The first weeks of wife's admission coping with her suicidality and the children's needs was overwhelmingly stressful | Describes the first few weeks of admission as when he was the most "worried" and under "too much pressure, too much stress" with a suicidal wife and needing to look after the young children. | 13 |
| | The demands of wife's depression and caring for the children during the first months of admission left him feeling "slowed down" | Up to the third month of admission, he felt like "when a battery is slowed down" | 18 |
| | The demands of wife's depression and caring for the children during the first months of admission left him feeling "slowed down" | Worrying about how long his wife's recovery would take as well as looking after teething twins at night, made him loose his strength | 19 |
| | Juggling the enjoyment of spending time alone with the twins with being worried about his wife at the MBU | Juggling the enjoyment of spending time alone with the twins with being worried about his wife at the MBU | 12 |

*Master Theme: ‘Pulled physically and emotionally between the needs of partner, child and self’ and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Subjugating his own needs by focussing on keeping his children happy (participant 6)<br><br>Key quote: *“I didn’t know how a* man could live without a woman for so long time...what I mean is just like the private life of a man and woman...but when I look to my kids this gives me more strength and I forgot about *myself, my feelings…stopped to* watch the movies to make more problem for myself, because I believe that my wife she will come *back, and…because I am religious, so I couldn’t let this happen.”* | Being unsure how to manage his sexual needs over the 6 months of his wife’s absence | The importance of the “private life” of a couple and sex for men. | 16 |
| | Being unsure how to manage his sexual needs over the 6 months of his wife’s absence | Not being sure how to manage his sexual needs when his wife is absent for so long (6 months) | 17 |
| | Focussing on looking after his children helps to distract him from his sexual needs | Coping with his needs for sex by distracting himself and focussing instead on his children’s needs. | 17 |
| | Choosing not to seek a sexual relationship outside of his marriage at this time | Choosing not to seek a sexual relationship outside of his marriage during this time. | 17 |
| | Needing to cope despite feeling unable to | Feeling like he couldn’t manage but he had to | 14 |
| | Trying to make up for their mother’s absence (like his mother and her mother) | Understanding he can’t give them mum and dad, but only dad | 14 |
| | Hiding his own needs for the children’s happiness | Keeping the children happy despite how he might be feeling | 15 |
| | The importance of keeping his children happy | The importance of keeping his children happy | 14 |
| | Keeping the children happy | Taking the children on trips and to the caravans | 15 |
| | Hiding his own needs for the children’s happiness | Making his children happy “doesn’t matter what I feel” sacrifice? | 16 |
| | Hiding his own needs for the children’s happiness | Focussing on his children makes him “forget about myself, my feelings”. The children are more important | 17 |
| | Hiding his own needs for the children’s happiness | Things that have helped him not “cry” but cope are focussing on making his children happy and making fun games for them | 18 |
| | Sacrificing his needs for the children’s needs | “I have to give them [the kids] what I can”, sacrifice | 20 |

*Master Theme: ‘The MBU as a challenge to fathers’ role and identity’ and contributing super-*ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Shame at breaking male cultural traditions and adapting to shared child care (participant 2) | Breaking natural laws / second language issues / difficulty explaining something outside our experience (language / childbirth) | “transgression” to break a moral code or law | 8 |
| Key quote: “It was very extremely *difficult…feeding the baby with* feeding bottle, making the baby food, it looks like *a…abomination…yeh, it looks* like that seeing the man feed the *baby…no, no, you don’t do it…we* believe that taking care of the *baby is for the women…its part of our culture.”* | Child care as difficult for him | The idea of taking care of the baby is hard | 10 |
| | Fearing the judgement of other males in his culture regarding his child care role | His Nigerian friends would be shocked and finding this very extremely difficult. | 12 |
| | Feeding the baby as shameful, abomination, transgressing | A male feeding the baby is an “abomination”. Shameful, detestable. Would prefer to pay someone to do it. | 12 |
| | Strict cultural rules exist around child care | It is simply not done in Nigeria | 13 |
| | Difficulty adjusting to breaking with cultural traditions | Being asked to do things differently from his cultural traditions and expectations is difficult | 14 |
| | Contravening traditional male role as defined by his culture, by participating in child care | It is difficult for him to take care of the child against this cultural heritage | 11 |
| | Fearing the judgement of other males in his culture regarding his child care role | It was difficult to tell his friends in Nigeria how he had to take care of the baby | 11 |
| | Contravening traditional male role as defined by his culture, by participating in child care | Considers himself a “real true African male” and therefore finds it difficult to nurse a baby | 11 |
| | Wanting to be in the traditional male role | Liking the traditional male role | 11 |
| | Impact of culture on father’s role | Being Nigerian | 2 |
| | Breaking with tradition, transgressing | Acting in ways that transgress cultural traditions | 12 |
| | Child care as the wife’s work | Sees child care as his wife’s “area of work” | 12 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Carrying out child care tasks to help his wife in the MBU | Describes the difficulty of looking after the baby at night. | 12 |
| Shame at breaking male cultural traditions and adapting to shared child care (participant 2) | Experiencing life from a woman's perspective and finding it hard | Looking after baby at night makes him see into a different world "what kind of life is this!" | 12 |
| | Having no choice in breaking cultural traditions | His wife's illness gives him no choice in participating in child care. | 14 |
| | Preparation could have allowed for a culturally consonant solution | Not knowing things could be this way did not give him time to prepare and ask the mother to come. | 14 |
| | The necessity of breaking with some cultural traditions. | This event has taught him that it is important to break with some cultural traditions in his life. | 17 |
| | Breaking free of gender roles as prescribed by his culture | Not believing any one person should have any particular role. | 18 |
| | Breaking free of gender roles as prescribed by his culture | Not living to prescribed roles | 18 |
| | Redefining roles in the family from cultural expectations; the importance of doing things together | Doing things together – sharing roles | 18 |
| | Redefining roles in the family from cultural expectations; the importance of doing things together | No defined roles as man and woman, they will do things together | 18 |
| | The importance of doing thing together now | A focus on doing things together "let us do this" | 19 |
| | Redefining roles in the family from cultural expectations; the importance of doing things together. | Describes the changes in his role from what he expected. He has gone from expecting to look after just money and work for the family, to now wanting to be involved in helping his wife with domestic tasks and with the children. | 20 |
| | The importance of doing things together and seeing his wife as his equal. | Feeling now that his wife is part of him, he will discuss with her and take ideas from her. | 23 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Standing by his wife despite traditional cultural perceptions of her as "failing" in child bearing. | He would not marry another wife because his wife has been admitted to the MBU | 23 |
| Shame at breaking male cultural traditions and adapting to shared child care (participant 2) | Child care as the women's role in his culture | His view is that in Africa "we believe that the taking care of the baby is for the women" | 10 |
| | The influence of culture on child care practises | Introducing the importance of cultural expectations | 10 |
| | Explaining his cultural inheritance | Referring to African cultural beliefs in the "ancient days" | 10 |
| | Explaining his cultural inheritance around polygamous family traditions | Talks about past polygamous family traditions: The man has his own house and builds smaller ones for each of his wives and their children | 10 |
| | Child birth as an event where men and women are separated in his culture | It is normal in his culture for men to be separated from wife and child during childbirth | 11 |
| | Cultural traditions divide the genders on status: men have higher status | Difference in status between men and women | 11 |
| | Explaining his cultural inheritance around the separation of men from women and children | Men live separately from the women and children | 11 |
| | Cultural traditions divide the genders on status: men have higher status | Seeing the traditional roles as good for men and bad for women | 11 |
| | Explains male role as the worker in African culture | In his culture, men do the 'dirty' work | 11 |
| | Explains male role as provider in African culture | Male responsibility to work and pay bills, to provide for wife and child | 12 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…*<br><br>Shame at breaking male cultural traditions and adapting to shared child care (participant 2) | Cultural differences around child birth require explanation in order to appreciate the impact of this event on him. | Describes traditions around having a new baby in his culture. | 13 |
| | The important role of the wife's mother in child birth | The wife's mother comes to help her daughter after the birth, to give her strength | 13 |
| | Strict traditions govern hierarchical roles for women in the family during child birth | Wife's mother and sisters help with the baby, and traditional rules about the order that they are called on to help according to their seniority and availability. Power structures within women's society. | 13 |
| | Father's role towards his child is to acknowledge and play with it. | The man would not have any work to do, he would only visit the child and acknowledge it as his and play with it. | 13 |
| | Cultural norm for the parents to live separately | Normal for the mother and father to be in different countries | 19 |
| | Child care as the women's role in his culture | Restating that in Nigeria childbearing is "the issue of women" | 19 |
| | Authority: Women have authority over men during child birth rituals | Men excluded from childbearing by women. Women have power to take over in this area and to make demands of the man. | 19 |
| | Women as accepting of traditional gendered role distinctions | Reporting women as comfortable with this division of roles around child birth | 19 |
| | Referencing the 'olden days' | Drawing on the "olden days", forming a rationale, explaining to me as a western woman? | 19 |
| | Child birth as a gender separating event | Childbirth as separating genders | 19 |
| | Traditionally women cope between them with child birth | Women deliver the baby – no mention of trained staff. Is this why he thought it was easy? | 19 |
| | Child care as alien to the man's role | Nurturing the baby as never being the role of men. | 20 |
| | The father oversees the child's upbringing / importance of child's education | The fathers role is to check that the mother brings up the baby to study well | 19 |

Master Theme*: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Reflecting on his parental roles and authority: father holds the authority | His father was the commander of the house. | 22 |
| Shame at breaking male cultural traditions and adapting to shared child care (participant 2) | Reflecting on parents roles and authority: father holds the authority | Father's role as decision maker, mother has no say in family decision, even of the marriage of daughters | 22 |
| | Reflecting on parental roles and authority: father holds the authority | Parental authority as with the man, | 22 |
| | Reflecting on parental roles and authority: The mother has no authority | Mother does not have much impact | 22 |
| | Reflecting on parental roles and authority: father holds the authority | Everything belongs to the father | 22 |
| | Reflecting on parents roles: women as excluded from men's business | Women excluded from men's business, women as compliant with this | 22 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Feeling conspicuous as a man in the MBU and not belonging (participant 3) | Feeling conspicuous as a man in the MBU | Feeling like a man amongst women in the MBU | 21 |
| | Not feeling like he belongs as a man in the MBU | Feeling like he doesn't belong as a man in the MBU | 21 |
| Key quote: *"its like…being a man amongst women isn't it? That* somehow you get the sense of do I belong here? How long can I stay here? I feel a bit *strange…you are here b*ecause *your wife is here….because* maybe your son or daughter is here. How extent do you feel *comfortable? I don't know."* | Not feeling welcome in the MBU | Feeling like there is a time limit to his welcome in the MBU | 21 |
| | Not feeling like he belongs as a man in the MBU | Feeling strange as a man in the MBU | 21 |
| | Not feeling like he belongs as a man in the MBU | Feeling that the MBU is not a home | 21 |
| | Not feeling like he belongs as a man in the MBU | Unsure if anything could change what he feels like as being a man in the MBU | 22 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Note | Emerging themes | Page |
|---|---|---|---|
| The MBU excludes the father and usurps his role (participant 4) | The father's role is to look after the mother and baby, but that role is taken out of your hands | The MBU as usurping the role of the father | 20 |
| Key quote: *"the Mo*ther and Baby *Unit is like…it says on the tin, its* about mother and baby, its not about father, but at the same time *there's a father in the background there…the father's role is to look after the mother and baby. That's* taken out of your hands really, you know? Someone else is *looking after them."* | It's the father's job to look after the mother and baby | The role of the father as looking after mother and child | 20 |
| | Fathers role is giving mum support | Fathers role as supporting mother | 26 |
| | The main thing is for the father to focus on mother and child | The father's role as supporting the mother and child | 26 |
| | There should be more of a role for fathers in the MBU | The MBU as usurping the father's role | 21 |
| | Feeling like things are out of your hands when you have to leave | The MBU as usurping the father's role | 7 |
| | Its hard to leave his son in the hands of the MBU but he has to | Not wanting to leave his son in other hands | 8 |
| | People don't think about what the father is thinking or how the father is getting on | Feeling excluded in the MBU | 19 |
| | MBU "does what it says on the tin" its not about the father, but the father is in the background | The name "Mother and Baby Unit" represents the exclusion of involved fathers | 20 |
| | The MBU "says what it is on the tin", mother and baby. | The name "mother and baby unit" signals a focus on helping mother and baby. | 29 |
| | There are no father and baby units! | The name "Mother and Baby Unit" represents the exclusion of involved fathers | 22 |
| | The doctors are Julie's and their conversations are confidential | Feeling excluded from support from doctors despite being the father | 23 |
| | If there is food left over you are offered it | Father's as peripheral in the MBU | 28 |
| | Staff are here to help Julie and Sam | Feeling excluded in the MBU | 28 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Note | Emerging themes | Page |
|---|---|---|---|
| *Cont…* | Feeling "like a gooseberry" | Feeling peripheral | 28 |
| The MBU excludes the father and usurps his role (participant 4) | Not feeling entitled to ask for help unless the issue is about Julie or the baby | Feeling excluded from help | 28 |
| | Not expecting any help as it's a mother and baby unit | The name "mother and baby unit" signals that fathers aren't helped | 28 |
| | Staff aren't here for you as the father | Feeling excluded from help | 29 |
| | MBU is not really there for the father to get better. | The MBU is not a place where fathers are supported | 26 |
| | Feels it's important that the fathers' "angle" should be studied as its not looked at often | Fathers as peripheral to studies of the MBU experience | 29 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Needing to see himself as "one of the mum's" to cope with getting "hands on" in an environment unnatural and daunting to men (participant 4) | The MBU as an uncomfortable place for a man | Being a man in the MBU is about getting comfortable in a place that feels uncomfortable to be in | 25 |
| | The MBU as a daunting place | The MBU as a daunting place for men | 25 |
| | The MBU as an unnatural environment for men | The MBU is not a place where men "thrive", not a "male environment" | 26 |
| Key quote: *"Its quite uncomfortable as a man…you've gotta be one of the mums!...It's* not really a male environment, or an environment where they *thrive."* | The mother perceived as the primary parent | To cope you just "have to be one of the mums!" | 25 |
| | An unnatural environment for men as MBU focussed on needs of mothers and babies | Not a male environment and nothing could change this as the unit is for mothers to get better with their babies | 26 |
| | Being daunted by seeing unwell mothers | Finding the other unwell mothers daunting | 25 |
| | The MBU as an uncomfortable place for a man surrounded by mothers and babies | Being uncomfortable with being surrounded by mothers and babies | 25 |
| | Needing to change behaviours to meet different needs of mother and child | Feeling like you need to "tread on egg shells" around the mums, but not "pussyfoot" around the babies needs | 25 |
| | Having the drive to get involved in the MBU despite feeling uncomfortable | Throwing yourself in, no time to be uncomfortable | 26 |
| | Having the drive to get involved in the MBU despite feeling uncomfortable | You've got to "get in there and get hands on" | 25 |
| | Throwing himself into being involved with supporting mother and baby | Throwing himself into it | 7 |
| | Needing to be careful of behaviours around women on the ward, to be allowed to stay | Being polite and getting on with the "girls" in the MBU as you're there for a while | 26 |
| | Feeling confident to get involved at the MBU | Feeling comfortable in own skin and being able to get on at the MBU | 26 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributin*g super-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Identifying with the social stereotype of being "macho" and "strong" which are a barrier to taking up support (participant 4) | Aware of individual differences in fathers taking up support | Feels that not all fathers would take up support if offered | 29 |
| | Awareness of men having different experiences | Different men will feel differently | 26 |
| | Finding it difficult to need support | Not wanting to think about needing a "rock" for support , but needing it | 20 |
| Key quote: "*as much as I'm in* touch with my feminine side, or *being a modern man…I still got* that macho prowess. I think that *you feel like you've got to…cope you know? You don't wanna be asking for help, because if you're* asking for help then you feel like *you're* maybe letting them down *in a way."* | Finding it embarrassing to need support | Believing his mother has been "a rock" of support, but would be embarrassed to tell her that | 20 |
| | Hidden support needs | Needing support even though he doesn't feel he is one to show his emotions | 13 |
| | Feeling the male stereotype of "needing to be strong" is a barrier to his taking up support | Feeling that he has "macho prowess" which makes it hard to take up support | 30 |
| | Believing fathers must cope | Believing you've got to show yourself as coping | 30 |
| | Believing mother and child are "let down" if the father doesn't cope | If you ask for help you're letting the mother and baby down | 30 |
| | Believing fathers must cope | I should be helping them not getting help | 30 |
| | Finding it difficult to need support | Feeling he wouldn't want support but would deal with things in his "own way" | 21 |
| | Not feeling like he would take up support | Hasn't seen any option of support, but wouldn't have taken it anyway | 23 |
| | Individual differences in fathers taking up support | Feels he wouldn't use support | 29 |
| | Individual differences in fathers taking up support | Feels he wouldn't use support | 29 |
| | Believing he would not take up support | Feeling he wouldn't use a "port of call" to "let off steam" | 30 |
| | Believing he would not take up support | Feeling he wouldn't take up help | 31 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Men suffer under societal stereotype of needing to "be strong" and deny needing help | Society prescribes a role for men which says they should be strong and not need help. | 22 |
| Identifying with the social stereotype of being "macho" and "strong" which are a barrier to taking up support (participant 4) | The role of the father is defined by society | Society defines the father's role | 20 |
| | A father's role is not only defined by male family role models | You take this role even if you've grown up around women | 30 |
| | Male stereotype of "needing to be strong" as a barrier to taking up support | Thinks men don't take up support because of wanting to maintain a "macho" image | 30 |
| | A father should be capable of looking after mother and child unsupported | Your job as a man is to look after mother and provide for your children, they aren't there to look after me. | 30 |
| | Believing it will be easier to seek help when the male stereotype of "being strong" is outdated | Things could be different for more modern men | 30 |
| | Believing it will be easier to seek help when the male stereotype of "being strong" is outdated | The modern man is more in touch with his "feminine side" | 30 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Feeling able to ask for help because of less of a "macho" culture in his family and trusting an excellent infrastructure (participant 5)<br><br>Key quote: "I come from a macho country, a machista country, where a man is very proud, yeah, I look after my family well, yeah, this mentality is a little faded away, I know that I very much *understand that if I'm not capable* with something, the best thing to *do is to call for help…I come from* a family where there is not such a *machista, macho culture…society is changing."* | Being comfortable with asking for support many times | Being happy to ask for support many times regarding health and legal decisions | 18 |
| | Asking for help when things are beyond your reach | Understanding that if he is not capable, he needs to ask for help | 19 |
| | Asking for help when things are beyond your reach | Life experience has told him that you can't do everything perfectly, you must ask for help when things are beyond your reach | 19 |
| | Macho mentality is fading away | He comes from a "macho" culture where men are "proud" and "look after their family", but "macho" mentality has begun to fade away now | 19 |
| | Coming from a family less bound by "macho" culture | There is not such a "macho" culture in his own family | 19 |
| | Macho mentality is fading away | Being relieved that society is changing and the need to "be macho" is fading away | 19 |
| | The importance of trying before asking for help | Believing it's important to try your hardest before asking for help | 20 |
| | Feeling comfortable asking for help | Feels able to ask for help as he knows that there are people who are skilled and trustworthy to ask | 19 |
| | Valuing the good health service infrastructure in this country | Feeling lucky to live in a country with a good infrastructure | 20 |
| | Valuing the good health service infrastructure in this country | Valuing the help that is available | 20 |
| | Praising skill of the ambulance service | The ambulance crew were excellent and wanting to thank them | 18 |
| | Valuing the good health service infrastructure in this country | Thinking there is an excellent infrastructure for providing help | 20 |

*Master Theme: 'The MBU as a challenge to fathers' role and identity' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Feeling "lost as a man" (participant 6)<br><br>Key quote:<br>"as a man, I felt lost". | A challenge to male identity | Feeling "lost" as a man in the context of not knowing how to manage his sexual needs whilst separated from his wife at the MBU. | 17 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Importance of retaining partner's trust (participant 1) | Encouraging trust between the couple | Seeing progression in his partner's ability to trust him | 4 |
| | Trust between partner and her family | Noting that his parent only has two people she feels she can trust, and they are in her family | 26 |
| Key quote: She needs to basically put her trust to me and whatever does happen you know is based *on what's in her best interest."* | Trust between couple and family | Trust as important to their relationship | 5 |
| | Trust between the couple, when trusting is difficult due to illness | Father provides a close relationship which can help spark trust in the partner who may feel threatened due to her illness. | 5 |
| | Encouraging trust between the couple | "She needs to basically put her trust to me and whatever does happen you know is based on what's in her best interest." | 3 |
| | Importance of retaining partner's trust | Trying to give information to the partner about her discharge, but not being sure of when this might be is a threat to trust in their relationship | 49 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| The importance of being able to provide support and guidance to help the partner recover (participant 1)<br><br>Key quote: *"if you can see a slight improvement…and reemphasising it…it probably* gives her courage as well that, you know, I am actually *improving…so it's reassuring for me, it's r*eassuring for her, it *helps her recovery."* | The father's role as provider, leader and supporter to the wife | The father as steering ahead like a typical man, being the provider and supporter, fulfilling his role. | 22 |
| | Helping partner to adjust to the unfamiliar environment | Thinking it must be difficult for the woman to adjust to a new environment if she is alone, especially when ill. It could be daunting. | 5 |
| | The partner being able to lean on the father for support | Being someone to lean on, until his partner gets back on her feet. | 5 |
| | Emphasising the partner's improvements helps her recovery and reassures them both. | "…if you can see a slight improvement on one day… reemphasising it… its reassuring for me, its reassuring for her, it helps her recovery." | 15 |
| | Knowledge of the triggers for the partner's relapse | He talks at length and in detail about sleep being one of his wife's triggers, and how the medication, feeds and blood tests whilst she was on the maternity ward, all interfered with her ability to sleep. Speaking to the midwife to try and get help with this, but there was little help. Thinking that if this hadn't have happened, it might have made her symptoms now less severe. | 38 |
| | Knowledge of the triggers for the partner's relapse | Talking about Lisa's triggers including sleep, and that she got no sleep in a shared maternity ward with screaming babies. | 40 |
| | Recommending that other mothers are made more aware of services to help with mental health difficulties around childbirth | Thinking that maternity staff could do more to put procedures in place for women at risk for postnatal mental health difficulties. | 36 |
| | Recommending raising awareness about how to deal with mental health issues | Believes that other women could benefit from having more knowledge of postnatal mental health difficulties and treatment options. | 41 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Not knowing who to ask at the MBU for support means his needs are 'pushed away' (participant 1) | Not knowing who to ask for support means its easier not asking anybody | Feeling that its easier not to ask anyone, if you're not sure who to ask on the clinical team for help. | 34 |
| | Having lots of questions but worried about 'badgering' staff | Feeling like he might badger staff if he asks for help | 34 |
| Key quote: "*You don't really* know who to actually ask and say sit down and say you know what, | Not knowing who to ask for support means this needs is "pushed away" | Not being sure that nursing staff could help answer his questions as opposed to a doctor, but he rarely sees the doctor. | 34 |
| actually I need some of your time to actually understand this. You kind of just push it away and ok, *I'm dealing with this, the situation."* | Not thinking about or speaking to anyone about having his own support | " You don't really know who to actually ask and say sit down and say you know what, actually I need some of your time to actually understand this. You kind of just push it away and ok, I'm dealing with this, the situation." | 32 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Treatment should be a "family affair" supporting the couple as the relationship is key to recovery (participant 2)<br><br>Key quote: *"The man needs to be* involved. It should not only be *Mother and Baby Unit…it should* be a sort of family affair unit, yeh, *it would really encourage…it* would make the matter solved *very quickly…she need to be* getting love and care every moment, every time so she will be ok. So let them try to make it *family affair."* | 'MBU' representing the exclusion of the father | The name 'mother and baby unit' means "the family is not complete", "the man is not there" | 35 |
| | The MBU should be a 'Family Unit' | The name should involve all the family | 35 |
| | The MBU should be a 'Family Unit' | The husband wife and child should be together | 36 |
| | The MBU should be a 'Family Unit' | This has to be a family affair | 39 |
| | The MBU should be a 'Family Unit' | The man needs to be involved, it shouldn't be called just mother and baby unit: a family affair unit | 42 |
| | Importance of a homely atmosphere for recovery | If the person feels at home, they will recover quickly | 37 |
| | Seeing the MBU as a family home | "living here" ..."just like one family", finding the patient friendly, "wanting to make a family house" | 29 |
| | Excluding the father ignores him as a resource for recovery and integration into normal life | The father gives an example of why it is good to involve the man: he was invited to a dancing lesson by a patient, but the staff said it was only for his wife. He believed that his wife might not attend on her own. He also believed that "its a thing of the psyche" if he went for the patients, as "they would think, we are not in prison" (like a women's prison?). | 35 |
| | Excluding the father ignores him as a resource for recovery and integration into normal life | The man as representing the outside world, bringing the outside world into the hospital, or that this hospital is part of the outside world, not segregated like a prison? | 36 |
| | Excluding the father ignores him as a resource for recovery and integration into normal life | He believes that the presence of the father in classes like these would make the women feel "still a part of life". | 36 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…*<br><br>Treatment should be a "family affair" supporting the couple as the relationship is key to recovery (participant 2) | Excluding the father ignores him as a resource for recovery and integration into normal life (because his absence brought about illness in his mind – so widens this out to the unit in general S-O theme) | Taking the men away means that the women would focus only on their situation at the moment | 36 |
| | Excluding the father ignores him as a resource for recovery and integration into normal life | For men to be included (whether sitting watching or dancing with a couple together) "it can change something" | 36 |
| | The MBU and feeling part of the team regarding his wife's recovery | He feels the team work together with him and take his advice, they don't hide anything from him, they are open. | 33 |
| | The MBU and feeling part of the team regarding his wife's recovery | The team "move together with you", help by lending a car seat. | 34 |
| | Importance of being supportive and loving from the beginning to prevent post natal depression | Believing that being involved and loving and caring prevents the illness from happening | 20 |
| | Helping his wife is important to her recovery | He believes that not helping could lead to a decrease in her improvement. | 14 |
| | Importance of being supportive and loving from the beginning to prevent post natal depression | He feels that it is important now to be there at the beginning, to be involved in every step, being loving, being caring | 20 |
| | The unique role of the father in helping a wife's recovery | The importance of taking time off work | 40 |
| | Loving relationships help recovery | Love creates an impact on recovery | 36 |
| | Improvement in her symptoms brings him happiness | Feeling happy at the swiftness of her recovery | 5 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Improvement in her symptoms brings him happiness | If his wife is ok, he is ok | 5 |
| Treatment should be a "family affair" supporting the couple as the relationship is key to recovery (participant 2) | Loving relationships help recovery | If the husband is not around, they should think about other men most important to the woman – brother. A loving brother can change things and bring a woman back | 36 |
| | The power of a loving relationship to help recovery | From the first moment they arrived at the MBU he focused on speaking to her about his love for her. Rebuilding his relationship. | 38 |
| | The power of the mother-baby bond to subvert the illness | The baby is the first person she will become aware of. Describes the unique recognition between mother and child, despite illness. She would recognise if it wasn't her child. | 37 |
| | The power of a loving relationship to help recovery | The next person who can help her recovery (bringing her back) is a person she loves. That person should be near her. | 37/38 |
| | The unique role of the father in helping a wife's recovery | He supported her in wanting to go home, they agreed to take her main symptom of hearing voices from the television, and would check her improvement by waiting until she could recount the television news and not the voices as a sign of being well. An experiment devised together. Success led to hugging and laughing. Believing that no nurse or midwife would be able to do that job. | 38/39 |
| | The unique role of the father in helping a wife's recovery | Husband's play an important role in staying with the wife, talking to the wife, helping the wife, as this is one of the first voices she will start hearing (from where she has gone away?) | 37 |
| | The unique role of the father in helping a wife's recovery | Professionals called on him for help as "they didn't know what to do". And the father responded by asking them all to leave so he could talk with her alone. It was speaking to her about his love for her, that helped her to engage with him, trust him and agree to go to the MBU | 38 |
| | The power of a loving relationship to help recovery | Getting love and care every moment solves the matter more quickly, being involved gives the wife less time to think about her situation (get more depressed?). | 42 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Acceptance of wife's distress | Family can help a woman can express any "harshness" she feels. | 36 |
| Treatment should be a "family affair" supporting the couple as the relationship is key to recovery (participant 2) | The power of a loving relationship to negotiate difficulties | They quarrelled and laughed together | 38 |
| | The unique role of the father in helping a wife's recovery | Love means being there for the wife | 40 |
| | The treatment is in addressing the relationship, which is not cured by medication. | Drugs didn't make the women ill, so they can't make her well. Love and caring can create more impact than even the drugs. | 40 |
| | Importance of trust in relationship when wife lacks insight into illness | Importance of trust between him and his wife | 6 |
| | Importance of trust in relationship when wife lacks insight into illness | He was the only person she would believe | 6 |
| | In a trusting relationship, the father spurs wife's recovery | Believing her recovery was facilitated by his presence and her trusting him | 6 |
| | Importance of parental trust when wife lacks insight into illness | Wife valuing his opinion. She has to try to trust people. | 39 |
| | The power of the family to subvert the illness | The first person she will trust is the child, the second is the husband. | 39 |
| | Advises the MBU to encourage fathers to stay involved | The team: Encourage men to stay with their wives | 34 |
| | Advises the MBU to encourage fathers to stay involved | The MBU should advise that the man stops work and stays with the wife. | 39 |
| | Advises the MBU to support the father early | The team: The earlier the team can help the man and give him advice the better | 34 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Advises the MBU to support the father | The team: Important for the team to reassure the man | 34 |
| Treatment should be a "family affair" supporting the couple as the relationship is key to recovery (participant 2) | Advises the MBU to help the father remain positive | The team: Important to create a laughing atmosphere to take his mind from the trouble | 34 |
| | The MBU as an institution with authority to stop men working | The MBU should have the authority to write to the man's workplace – even if they worked in a bank, and the banks would have to honour it. | 40 |
| | Advises the MBU to encourage fathers to stay involved | Getting men to understand they can have an impact | 40 |
| | Advises the MBU to encourage fathers to stay involved | Some men don't know and they need to be told how they can do it. | 40 |
| | The father as service user in need of support | Believing "I am not a visitor! I am a patient!" "more sick and unwell" than his wife because he is aware of "all the pressure and the troubles", | 43 |
| | The burden of carrying the insight of illness for his wife | His wife doesn't know she is sick, "I do!" | 43 |
| | The father as service user in need of support | "I am sick because I can't do anything, I am troubled. I'm really a patient in here! That's what the man needs to be." | 43 |
| | Advises education for fathers about pregnancy | Advising that lectures are given to men to make them aware of the changes that can happen to women in pregnancy | 41 |
| | Advises education for fathers about pregnancy | Advising classes for men to know more about childbirth, what they can do and the outcomes of it. | 41 |
| | Pregnancy can cause a women to act in troublesome ways | Advising men that the woman can be physically aggressive towards him in the last period of pregnancy. She can be harsh | 42 |
| | Reflection: Focus on love and care during labour | Reflects that he would advise other men with a wife about to go into labour to forget their problems and show love and care | 7 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Being in the role of expert on his wife's illness (participant 3)<br><br>Key quote: "*They [family] don't* understand, they need to be *educated and I'm educating them, somehow. I don't know how far or* best they understand what I do, or what is happening, but I try to *educate them…explaining in kind of lay terms."* | Knowledge of mental health leads to role as expert in his family | The family don't understand | 19 |
| | Knowledge of mental health leads to role as expert in his family | Family need education and I'm educating them about the illness | 19 |
| | Knowledge of mental health leads to role as expert in his family | How his job gives him knowledge to educate his family | 19 |
| | Knowledge of mental health leads to role as expert in his family | Helping family to understand how not understanding his wife's illness can make her more anxious | 19 |
| | Knowledge of mental health leads to role as expert in his family | Explaining to his family in lay terms | 19 |
| | Knowledge of mental health leads to role as expert in his family | Using a wound analogy with his family to illustrate the damage caused to recovery when someone is made anxious. | 19 |
| | Knowledge of mental health leads to role as expert in his family | His knowledge confers authority in this field in his family | 19 |
| | Knowledge of mental health | Importance of using lay terms | 20 |
| | Knowledge of mental health leads to role as expert in his family | His experience in mental health confers knowledge and authority in this area in his family, they ask him for explanations | 20 |

*Master Theme: ‘Treatment should be a “family affair”: supporting the mother, father and their relationship, as key to recovery’ and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Services don’t understand family–centric child rearing practices from other cultures (participant 3)<br><br>Key quote: “if someone brings a baby [to the MBU], the mother has to be strong enough to look after baby, even if the mother is crashing down, the mother has to be strong. No, I remember my *mother, some of us were…we* grew up with different family *members. It doesn’t make a bad person. It doesn’t make a person* incapable of looking after their *daughter.”*<br><br>*“It’s differen*t for us [our culture] because when a baby is brought into the world, it belongs *to the family. It’s not like you are* the mother. Everybody takes *part.”* | Social services as not understanding cultural difference in family traditions | Believing that social services think Africans are not able to support their families (feeling persecuted) | 5 |
| | Social services as not understanding cultural difference in child rearing practices | Describing cultural differences: believing the baby belongs to the family not just the mother, if the mother is ill, family support is available, so there is no risk to the baby | 5 |
| | Social services as not understanding cultural difference in family traditions | Having many supporters, but a limit to number of visitors allowed | 5 |
| | Nt understanding cultural difference in child rearing practices | MBU as holding a Western perspective and not understanding cultural differences in raising a family | 5 |
| | Not understanding cultural difference in family traditions | Irritation at a lack of consideration for cultural contexts | 5 |
| | Not understanding cultural difference in family traditions | Irritated that people don’t think of culture | 6 |
| | Not understanding cultural difference in family traditions | Different cultures would handle this situation differently | 7 |
| | Social services as not understanding cultural difference in family traditions | An expectation of this culture is that even if a mother is crashing down, she has to be strong | 7 |
| | The child is reared by the family | The baby belongs to the family | 7 |
| | The child is reared by the family | The whole family are involved in the care and upbringing of the child to initiate the child into the culture | 7 |
| | The child is reared by the family | Every wants to be part of the baby’s life | 7 |
| | Ignorance in services of culturally diverse child rearing practices | Here they don’t understand that all the family help to bring up the baby, they focus only on the ability of the mother | 7 |
| | Challenging the stigma of postnatal illness, and believing in the importance of family | Mental health difficulties doesn’t make a woman ‘bad ‘ or ‘incapable’ of looking after a child in his culture, as they have family support | 7 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery'* and contributing super-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | A different cultural upbringing does not limit his ability to be a father | Defending his upbringing by his whole family as not meaning he is a poor parent | 8 |
| Services don't understand family–centric child rearing practices from other cultures (participant 3) | A different cultural upbringing does not limit his ability to be a father | Feeling nothing from his upbringing limits his being a father | 15 |
| | Culture "carried with you" | Explaining how culture is carried with you | 6 |
| | Culture "carried with you" | Moving from your culture doesn't take it from you | 6 |
| | Culture "carried with you" | Believing people carry their culture with them | 8 |
| | Culture "carried with you" | Believing you cannot take the culture out of the person | 8 |
| | The importance of environment in development | The environment impacts on who we are and how we respond in life | 16 |
| | The importance of family in growing up | Drawing on his own experience of being raised by different family members | 7 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Needing to be a "tower of strength" in the face of feeling persecuted, marginalised and unsupported at the MBU (participant 3) | Focus on child protection issues | MBU focus only on child protection | 5 |
| | Focus on child protection issues | A focus on risk | 5 |
| | Focus on child protection issues | Child protection label affects everyone | 5 |
| | Fighting battles to keep family together whilst coping with child protection issues | Fighting battles between maintaining harmony in the family and making sure no one takes your child away | 5 |
| Key quote: *"You become your own pow…tow…power of strength…you don't have anyone to lean on…they don't actually think about the dad."* | Focus on child protection issues | Having to deal with social services | 5 |
| | Focus on child protection issues | Understanding the need for social services to be concerned about vulnerable women and children | 5 |
| | Social services / society as persecutory | Social services assessments of living space are not to help you they are to criticise you | 6 |
| | Social services / society as persecutory | Social services suggesting there are not enough bedrooms for the child to come home | 6 |
| | Social services / society as persecutory | Social services using the child as a pawn | 6 |
| | Social services / society as persecutory | Society as a magnifying glass on you constantly | 8 |
| | Social services / society as persecutory | Society plays God | 8 |
| | Social services / society as persecutory | Being looked at "under a different glass": through a different lens? Under a microscope? | 5 |
| | Believing that authority and empathy are mutually exclusive | They cannot be in your shoes | 6 |
| | Believing that authority and empathy are mutually exclusive | Authority and empathy are mutually exclusive | 7 |
| | A test of strength | This event as a test | 4 |
| | Needing to cope | Believing in needing to "pull yourself together" | 4 |
| | Standing alone as a tower of strength in the face of no support | Needing to be a power / tower of strength as there is nobody to lean on | 4 |

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| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Standing alone as a tower of strength in the face of no support | Being your own tower / power of strength | 5 |
| Needing to be a "tower of strength" in the face of feeling persecuted, marginalised and unsupported at the MBU (participant 3) | Standing alone builds resilience | Standing alone helps you become more resilient | 6 |
| | Feeling unsupported | MBU not providing support for carers | 4 |
| | Feeling unsupported as a father | MBU not thinking about dads | 4 |
| | Feeling unsupported | No support from social services | 6 |
| | Standing alone as a tower of strength | Feeling as if he is holding the fort for everyone | 18 |
| | Feeling unsupported | Angry at feeling unsupported, not knowing where to get support, not being offered support | 26 |
| | Not being helped to get support | Not knowing who the psychologist is | 26 |
| | Not being helped to get support | Angry at not being aware of who is here to provide him support on the ward | 26 |
| | Not being helped to get support | Angry at not being clear who is in the staff team and who he could go to for support | 27 |
| | Not being helped to get support | Feeling there is a lack of sharing information | 27 |
| | Not being helped to get support | Thinking how bad it is that he doesn't know the direct number for the ward | 28 |
| | Not being helped to get support | Not knowing who to go to for information | 28 |
| | Feeling unsupported | Feeling staff are not helpful | 28 |
| | Feeling vulnerable | Feeling particularly vulnerable at admission as his wife was unwell, to the extent of requiring admission and they had just had their child two days before. They had only been home for a day. | 29 |
| | Feeling vulnerable and ignored and | Feeling wounded before he came to the MBU, then his experience of staff at admission making him feel pushed around and like he didn't matter | 29 |
| | Anger at the MBU staff | Finding the staff attitude in the MBU irritating | 22 |
| | Anger at Social Service | Irritated with social services | 6 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and co*ntributing super-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Anger at feeling ignored and demeaned as a father when vulnerable | Being annoyed | 7 |
| Needing to be a "tower of strength" in the face of feeling persecuted, marginalised and unsupported at the MBU (participant 3) | Anger | Wondering if others also feel annoyed | 7 |
| | Anger | Feeling angry now | 29 |
| | Anger | Feeling very angry | 31 |
| | Anger at feeling ignored on admission | Feeling angry as he felt ignored as the husband on his wife's admission | 22 |
| | Anger at feeling ignored and demeaned on admission | Felt his knowledge of his wife's initial 'catatonic' presentation was not sought or valued | 22 |
| | Anger at feeling demeaned | Questioning whether staff could know more about his wife's situation than he could | 22 |
| | Anger at feeling ignored and demeaned as a father | "I am the husband!" as a statement of his importance at admission | 22 |
| | Anger at feeling ignored | Staff only trying to communicate with his wife | 22 |
| | Anger | Feeling "angry" | 22 |
| | Feeling demeaned | Feeling "dehumanised" | 22 |
| | Feeling demeaned | Feeling "pushed down" | 22 |
| | Feeling demeaned | Being made to feel "as if you are nothing" | 23 |
| | Anger at feeling ignored and demeaned | Being made to feel that he doesn't matter | 23 |
| | Anger | Not wanting to help with their assessment after being made to feel as if he doesn't matter | 23 |
| | Anger at feeling ignored | Story of anger at not being recognised and allowed into the ward | 24 |
| | Anger at feeling ignored and demeaned | Feeling like he doesn't matter | 24 |
| | Feeling demeaned | Feeling "dehumanised" | 29 |
| | Feeling ignored and demeaned | Being treated as if he didn't matter | 30 |
| | Feeling ignored | Analogy of being ignored, feeling like he had been "thrown from a 19 story building" to be left on the ground. | 22 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| The family system is a resource for health and recovery (participant 4) | The baby's presence as spurring mother's recovery | Julie wouldn't have got better without the baby | 4 |
| | The baby's absence as a strain | It made her worse not to see the baby after giving birth, she bore the strain of separation for 2 weeks | 4 |
| Key quote: *"it all goes round in roundabouts, we're here to help* the mother and baby, so maybe if we need the help, maybe it should be the*re"* | The baby's presence as spurring recovery | Important for the baby to be with Julie, would never have got better without the baby | 4 |
| | The baby's absence as detrimental to mother's recovery | She would have "cracked up" without the baby | 4 |
| | Love for his baby helps him cope | His love for Sam helps him cope | 9 |
| | Being really happy about his son | Being really happy about his son | 5 |
| | Love for his baby helps him cope | Sam is what helps him go to work and what he comes home for "Sam is my everything" | 9 |
| | Love for his baby helps him cope | Sam as a light for him | 9 |
| | The duty of the MBU to support fathers, to harness a circularity of well being between service, father, mother and child | Help is circular it "goes in roundabouts" father here to help mother and baby, so if father needs help it should be there | 30 |
| | The duty of the MBU to support fathers, to harness a circularity of well being between service, father , mother and child | The MBU is there to help mother and baby, but helping fathers also helps the mothers, so fathers should be supported | 29 |
| | A connection between the fathers and mother's distress | Its just as traumatic for the father as the mother | 19 |
| | A connection between the fathers and mother's distress | The father tries to be strong but goes through everything the mother does | 19 |
| | His situation impacting on everyone around him / the family experience trauma | It affects everyone | 19 |
| | The father also experiences trauma in this situation | The father goes through "stress and turmoil" at the same time even though he isn't sick | 21 |

Master Theme: *'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery'* and contributing super-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | The fathers needs should be obvious to services | It's obvious that the mother's torment will affect fathers who are involved | 29 |
| The family system is a resource for health and recovery (participant 4) | Circularity of support and wellbeing | He will always support Sam, which will support Julie | 10 |
| | Circularity of support and wellbeing | Importance of family support for him, so he can support Julie and Sam | 13 |
| | Being involved helped Julie's recovery | Saving Julie | 7 |
| | Being involved helped Julie's recovery | Julie instantly got better when he got involved | 7 |
| | Fathers as a unique resource aiding mothers recovery | Believing that mothers need the father around them | 21 |
| | Fathers as a unique resource aiding mothers recovery | The presence of the father can make the mother better in a short period of time | 21 |
| | Fathers as a unique resource aiding mothers recovery | Julie recovered quickly since he was involved | 21 |
| | Fathers as pivotal in aiding mothers recovery | Its been a "turnaround" for Julie to have the father around | 21 |
| | Fathers as a unique resource aiding mothers recovery | Believing his involvement helped Julie's recovery speed up. If he knew what it was that helped he would bottle it and sell it! | 23 |
| | Fathers as a unique resource aiding mothers recovery | Being there helps | 23 |
| | Fathers as a unique resource aiding mothers recovery | Being supportive was part of helping Julie to get better | 24 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super-*ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Believing there is a lack of support for fathers and that it should be offered equally alongside support for the mother (participant 4)<br><br>Key quote: *"I think there should* be more help for fathers. Even maybe just someone to talk to, just someone to let out, to let a bit of *their steam off to. I don't think that's been there, well since I've been coming here there's not* been *nothing like that I've seen offered. This is the first time I've had to* talk to anyone about how I feel *about it all to be honest."* | The duty of society to see beyond old stereotypes of men not needing support | Modern society should provide support for men | 29 |
| | The human rights of the father to be treated equally | "I thought we were all equal?" | 29 |
| | Support for fathers should be offered on an individual case basis | There should be support for fathers, but not all will need it | 21 |
| | Individual differences between father is seeking support | Being sure that some fathers might need help | 21 |
| | The MBU should provide fathers someone to talk to, to get things "off their chest" | There should be more help for fathers in the MBU. Someone to talk to "let off stream", "get it off their chest", "let it out" | 21 |
| | Lack of official support in the MBU | There should be more help for fathers that need it | 32 |
| | The fathers needs should be obvious to services | Being able to see if a father needed help and providing it if they needed it | 31 |
| | The importance of providing support for fathers who need it | There should be more help for fathers that need it | 22 |
| | Support for fathers described as "having a chat", low key, minimised | Referring to support as "having a chat", low key, informal | 23 |
| | Lack of support for fathers | The only lack is not having someone to talk to | 28 |
| | The lack of support tailored for fathers at the at the MBU | Not seeing any support for fathers | 21 |
| | Usefulness of regular opportunities to talk to a professional | Suggests a counsellor for fathers once a week | 28 |

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| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Requirement / duty / obligation of MBU to provide opportunities for fathers to "let out" feelings (not hide them) | Fathers should have somewhere where they can let off steam, and let out feelings | 28 |
| Believing there is a lack of support for fathers and that it should be offered equally alongside support for the mother (participant 4) | Lack of support for fathers | Not having seen any help advertised | 28 |
| | Suggesting that fathers could be best supported through informal spaces to talk | Suggests a "calling point" for fathers where they can have a "chat and a coffee" | 29 |
| | The lack of support tailored for fathers at the at the MBU | No support for the father | 23 |
| | Lack of official support in the MBU | Official notices are looked at on the board, and not seeing anything there. | 31 |
| | The usefulness of a separate space for fathers to talk about their experiences | Feeling it would be useful for fathers to talk about things you can't talk to family and friends about | 22 |
| | The usefulness of "in depth" conversation | Having an "in depth" conversation as a good thing that can't cause harm | 22 |

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| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Couple conflict over sectioning as a specific trauma to the marital relationship (participant 5) | Wife resisting help from services | Wife resisting help from ambulance crews advising her to go to hospital | 2 |
| | Wife resisting help from services | The ambulance crew being unable to persuade his wife to go to hospital despite their skill and knowledge | 18 |
| | Wife resisting his help | Trying everything to get his wife admitted voluntarily to hospital | 18 |
| Key quote: | Wife resisting help from services | Wife lacking insight and resisting seeking help | 22 |
| *“m*y wife has completely *discredited everything I’ve done* for her, or tried to do. She says *“…the police were pulling me out* of the house and you were doing *nothing” and I was, I tried to explain to her, listen, I’ve done it for you, but she’s not well…she* ha*sn’t got to the stage of recovery* where she fully understands that she had a very serious illness that had to be treated urgently, so I hope she will get to this stage as some point soon, so she can *understand that it hasn’t been easy for me.”* | Wife resisting help from services | Wife refusing to attend meetings with the mental health team or the GP | 22 |
| | Increasing stress juggling the needs of his wife and the baby | Stress increasing as time passed, wife’s symptoms became worse, and having the 24 hour needs of the baby to cope with | 22 |
| | His collaboration with services | Help with the decision making process during the crisis | 21 |
| | The involvement of services | Ambulance and police were involved | 2 |
| | The distress of involuntary admission | Wife was out of control | 18 |
| | The distress of involuntary admission | Recounting the distressing memory of his wife being “taken by force” by the police. It was “very tough” | 4 |
| | Talks again about his wife’s involuntary admission as a distressing event | Re-tells the distressing story of his wife’s admission under the MHA | 18 |
| | The distress of being blamed for involuntary admission | Wife and mother-in-law screaming when she was taken and said it was “his fault” it was a “nightmare” | 4 |
| | The distress of involuntary admission | Wife was assessed as being too ill to look after her baby or herself and sectioned against her will | 4 |
| | The involvement of services | By the time things got really bad, many people were involved | 23 |
| | This crisis occurred rapidly | Feeling that things changed “in the blink of an eye” | 23 |
| | This crisis occurred rapidly | It feels like it happens “in the blink of an eye”, that there is a sudden change | 24 |
| | Needing his wife to understand the virtue of his motives | Importance of needing his wife to understand that he won’t discharge her because he wants the best for her, and her difficulty in understanding that | 11 |
| | Needing his wife to understand the virtue of his motives | Trying in vain to get his wife to understand that he was doing his best | 6 |

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| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | The dependence of his role in the family on his wife's recovery | Being unsure about his role in his family as his wife "has discredited everything" he did for her | 9 |
| Couple conflict over sectioning as a specific trauma to the marital relationship (participant 5) | Needing his wife to understand the impact of her illness on him | Needing her to understand how difficult it has been for him | 9 |
| | Heartache at the severity of his wife's difficulties and her detention | It broke his heart that his wife's "mind had gone" and she had been locked up | 8 |
| | The distress of supporting involuntary admission as being in his wife's best interests whilst facing denunciation by his wife and mother-in-law | It was very hard to stand by his decision to keep his wife admitted in the face of her and her mother's hateful comments towards him, blaming him, criticisms that he wasn't helping, and the strain therefore on their relationship | 5 |
| | The distress of supporting involuntary admission as being in his wife's best interests whilst facing denunciation by his wife and mother-in-law | Needing to listen to doctors and himself, not to his wife and wife's mother | 6 |
| | The importance of advice for fathers to recognise and respond to the early signs of illness | Realising that "something was wrong" and not knowing whether to listen to his wife who was denying this, or to professionals | 21 |
| | Not knowing who to trust | Who do I trust? | 21 |
| | Mother-in-law advising against hospital | Wife's mother was "stubborn" and advised against hospital | 2 |
| | Mother-in-law as not recognising his wife was unwell | Wife's mother believed she just needed to sleep more | 2 |
| | Mother-in-law as not recognising his wife as unwell | Wife's mother did not recognise her as being ill | 2 |

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| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Relying on professional knowledge to support his decision not to challenge involuntary admission | Relying on the doctor's knowledge to ensure that he is doing the right thing, rather than his wife who had no insight into her illness | 11 |
| Couple conflict over sectioning as a specific trauma to the marital relationship (participant 5) | Relying on professional knowledge to support his decision not to challenge involuntary admission | Relying on the doctors and standing by his decision to listen to them. | 11 |
| | A transfer to specialist treatment as the MBU as the reason to support involuntary admission | Standing firm in his decision to keep wife admitted in the hope of a transfer to the MBU which had the expertise in his wife's illness | 5 |
| | The distress of supporting involuntary admission as in his wife's best interests whilst facing denunciation by his wife and mother-in-law | It was "tough" to stand by his decision not to discharge his wife and to wait until the transfer to the MBU | 6 |
| | Holding the responsibility for decision making in the face of his wife's lack of insight | Needing to "think straight" for them both | 6 |
| | Psychosis has stolen his wife's ability to cope | His wife has experience of child care from her family, but psychosis took this capability from her | 11 |
| | Psychosis has stolen his wife's ability to cope | Wife's psychosis means she can't think straight and couldn't do anything at home | 12 |
| | Wife as having no insight | Wife had no insight into her illness | 2 |
| | Strain on the marital relationship | Wife phoned fire and police services as she said she felt threatened by him | 2 |
| | The dependence of their relationship on his wife's recovery | Hoping his relationship with his wife will rebuild with her recovery | 9 |
| | Strain on the marital relationship | Hoping this event will not have an irreparable effect on their relationship and new family | 12 |

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| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| *Cont…* | Strain on the marital relationship | Being both grateful and irritated that is wife accepts advice from friends but not from him | 16 |
| Couple conflict over sectioning as a specific trauma to the marital relationship (participant 5) | His wife's friends supporting the decision to listen to the doctors | Wife's friends have supported him by encouraging her to listen to the doctors' advice as being in her best interests | 16 |
| | Strain on the marital relationship | The situation between him and his wife feeling "tense" | 16 |
| | Questioning the helpfulness of his presence for his wife | Questioning whether his presence is helpful for his wife | 17 |
| | Trying to nurture the family whist feeling it was being pulled apart | Worrying about his wife's mother visiting his wife before MBU admission and criticising him, whilst he had to stay home and take care of the baby | 6 |

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| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| The MBU as a place to recover, restart and "get our life back" (participant 5) | The MBU team can give them their lives back | The MBU team will help "get our life back" | 8 |
| | Feeling his wife's recovery began at the MBU | At the MBU his wife's condition improved and she began attending classes | 5 |
| Key quote: "with the help of the team here, they are really great, very, very, very good, so yeah, with their help, one day we will *get our life back."* | Feeling his wife's recovery began at the MBU | In time they were able to go out for a walk together (marker of recovery) | 5 |
| | The MBU team can give them their lives back | All he wants now is his life, happiness and wife and baby back | 6 |
| | The importance of his wife's recovery | It is important to him to see his wife progress | 9 |
| | Wanting to begin his own family as it should have begun | Hoping they can have what they missed out on. | 7 |
| | Wanting to begin his own family as it should have begun | Wanting to restart from the beginning without any interference from his family | 7 |
| | Longing to return to being a happy family with a normal routine | Sad that the ideal situation of coming home with his wife and baby didn't happen | 7 |

*Master Theme: ‘Treatment should be a “family affair”: supporting the mother, father and their relationship, as key to recovery’ and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Believing fathers in his situation have a tough time and would be relieved to be “thought about” by services (participant 5)<br><br>Key quote: *“…my family, friends* from all over the world were *calling, ‘Whats happening to Tricia? What’s going on? How is* the baby? Then one day someone *says ‘How ar*e you coping with *that?’…I say ‘I find it hard’. Ahh* there is someone that actually is thinking also that they are not the only one going through a tough *time…it was a little question but a* big relief, because it got me for the first time to speak a little *about this.”* | Wondering how other fathers feel in this experience | Thinking of other fathers in this situation | 20 |
| | Fathers also suffer and this should be studied | Thinking studying fathers is helpful and being supportive of this study as fathers don’t have it easy | 20 |
| | Wishing to communicate to other fathers that support is available | Important to “send out the message” that help is available if your wife has these problems | 20 |
| | Useful to talk about his experiences | Feeling it is good to talk about it | 24 |
| | The father’s wellbeing is not thought about / a relief to talk | Recalls receiving calls from family all over the world about how his wife is , then one day, and a question about how he is coping from his sister-in-law. That “little question was a big relief” | 25 |
| | The father’s wellbeing is not thought about | He doesn’t feel that what the father goes through is thought about | 25 |
| | The father having a tough time | Having a tough time | 25 |
| | The father’s wellbeing is not thought about | Understanding the concern for mother and baby, but it was nice to be thought about | 25 |
| | A relief to talk | A relief to talk | 25 |
| | Needing to enable conversations with fathers about their experience | The question enabled him to talk about his experience, otherwise he would not have do so | 25 |

*Master Theme: 'Treatment should be a "family affair": supporting the mother, father and their relationship, as key to recovery' and contributing super*-ordinate, emerging themes and transcript notes for cross-check

| Super-ordinate theme | Emerging themes | Note | Page |
|---|---|---|---|
| Wife's depression makes him question the quality of their family relationships (participant 6)<br><br>Key quote: "I was worried, and this what is happening with her, it has made me feel that all my life I tried to be a good husband, I tried to help *her, I tried to …I am a soft* person, and maybe sometimes I *shouldn't be like…more staying with my word or something…I don't know…anyway, I tried to* make her happy for all these *years."* | Wife's depression makes him question how good he is as a husband | Wife's illness makes him question whether he has been a good husband despite trying | 12 |
| | The importance of seeing his wife improve in being able to cope himself | Finding it hard to cope with seeing his wife looking like a person who has "lost everything in life and she doesn't want to live". | 17 |
| | Trying to help his wife by spending a holiday alone together, but his wife becoming more unwell | Wanting to make his wife happy, wanting to find something to help, but his solution didn't work | 6 |
| | The children couldn't make her happy | The children couldn't make her happy | 7 |
| | Questioning whether his "soft" nature has lead to problems with his wife | Questioning whether his nature is too "soft" which is not good when you are a man, and he should stand by "his word" more often, stand firm | 13 |
| | Questioning whether his "soft" nature has lead to problems with his wife | Finding it hard to say no to his wife, giving in to his wife, | 13 |
| | Questioning whether his "soft" nature has lead to problems with his wife | Questioning whether he needs to more firm with her in a loving way | 13 |
| | Reflecting on the quality of his marital relationship | Feeling he has tried to make her happy and that she has made him happy by giving him so many children | 13 |

**Appendix L: Journal of Family Psychology Guidance for Authors**

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