But what about us? Partner and family experiences of perinatal mental health care

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Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

UCL
Declaration

I, Billie Lever Taylor confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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I would like to thank my primary supervisor, Professor Sonia Johnson, for all her support and encouragement over the years. It was you who first encouraged me to do a PhD and, although I was initially unsure about it, I am now very grateful indeed to you for having opened up this opportunity for me. I have always found your guidance and judgement calls hugely valuable and sound, keeping me grounded and making me feel well supported, knowing that you have always wanted the best for me.

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and organise my ideas and was always willing to listen and respond patiently to my anxieties and questions along the way.

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I would like to thank my whole family for supporting me, chatting things through whenever I needed, and helping me to keep going. I would especially like to thank my father for agreeing to read through an entire draft of my thesis, and my two wonderful children for all your love and patience. This thesis was in part inspired and influenced by you both and I can only hope that you will always know how much I love you and how happy I am to have you both in my life.
Lastly, I would like to thank my partner Pete for all your support throughout this process. Thank you for always believing in me and loving me. I could not have done this without you.
Abstract

Partners and wider families play a vital role in relation to women’s perinatal mental health. Clinical guidelines in the UK and internationally recommend that services treating women with perinatal mental health difficulties involve and support their families too. Yet, little is known about experiences of family inclusion in practice. I set out to address this.

This thesis was connected to a wider study exploring experiences of perinatal mental health care in England. The broader study (for which I was the main researcher) included semi-structured interviews with 52 women who received treatment for a perinatal mental health difficulty, and 32 partners/family members identified by the women as offering them some support. I included questions within these 84 interviews about how services work with partners and families and examined responses using dyadic and thematic analysis.

I found that families and family dynamics are central to understanding women’s perinatal mental health and interactions with services. Although it was the women who were diagnosed with perinatal mental health problems, their difficulties were often embedded within a complex and fraught interpersonal and wider social context. Yet instead of seeking to understand perinatal distress within this broader context – or critiquing the structures and gender norms that contributed to producing and maintaining it – services tended to focus on individual women (and babies), marginalising their families and diverting attention from the need for broader social change. The complexity of involving and supporting partners and wider families, coupled
with anxiety about this among women and their families, reinforced the tendency to exclude families.

I conclude that involving women’s families and providing the support they need is challenging but important. Services need to find ways to overcome barriers to family inclusion and to proactively challenge problematic gender norms and expectations, rather than allowing these to shape and guide practice.
Impact statement

This thesis is unique in exploring the views of women, their partners and members of their wider family about family involvement in perinatal mental health care. Although including and supporting partners and families in perinatal mental health care is a policy priority in the UK, little is known about experiences of this in practice. This thesis gives voice to previously unheard voices and has significant implications for research, policy and practice.

Dissemination of study findings

To ensure my research has a wide impact, I have been publishing outputs from it in national and international journals and books. To date, this has included:


- A book chapter drawing on my findings to critique current models of perinatal mental health care: Sweeney, A. & Lever Taylor, B.

I also presented my findings at the 2018 annual conference of The UK & Ireland Marcé Society for Perinatal Mental Health.

To reach a wider audience, including women and their families themselves, I am using social media. For example, I published a blog about my findings for International Fathers’ Mental Health Day, 2019:

https://blogs.ucl.ac.uk/psychiatry/2019/06/17/blog-for-international-fathers-mental-health-day/

**Feeding into policy and practice**

To ensure that the findings feed into policy and practice, I accepted an invitation to join an Expert Reference Group (ERG), formed in 2019, made up of clinicians, researchers, commissioners, activists and policy makers for work commissioned by NHS England. The ERG’s remit is to contribute to developing national best practice guidelines for involving and supporting partners and families of women who access specialist perinatal mental health services in the UK. This has included participating in an all-day event to share expertise and contributing to early drafts of the guidelines.

**Developing novel qualitative approaches**

Finally, in my thesis I use dyadic analysis, which is an original methodological approach not often used in qualitative health research. To ensure my learning from this innovative approach is shared widely, I
presented my reflections on dyadic analysis in a poster at the BABCP Annual Conference in 2019 and at the British Psychological Society’s 2019 annual conference:


as well as in an oral presentation at UCL’s 2019 Qualitative Health Research Network conference:

https://bmjopen.bmj.com/content/9/Suppl_1/A7.2.

I plan now to write a journal article on the methodology of dyadic analysis.
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Chapter 1. Introduction and background

1.1 Research outline and thesis structure

Mental health difficulties in the perinatal period (usually defined as pregnancy and the first year post-birth) are prevalent, affecting women as well as their partners and wider families as families adjust to caring for a new baby. There is also increasing recognition that a woman’s partner and wider family can play a vital role in relation to her perinatal mental health and should be supported and involved in decisions about her treatment. Yet it is unclear how the families of women with perinatal mental health difficulties experience mental health services or how involved they are able to be in women’s treatment. I sought to explore this qualitatively, via semi-structured interviews with women and their family members and through a combination of thematic and dyadic analysis.

In chapter 1 I provide a brief overview of perinatal mental health difficulties among women and the structure of perinatal mental health services in England. I discuss the impact that perinatal mental health difficulties can have on women’s partners and wider families and, in turn, the influence women’s partners and families can have on women’s perinatal mental health. Finally, I present a social-historical critique, examining the contextually dependent nature of terms such as ‘motherhood’, ‘fatherhood’ and ‘the family’, and the ways in which the roles of women’s partners and relatives in the perinatal period have evolved over time. This is designed to help inform our understanding of how women’s partners and families experience perinatal mental health care and possible reasons behind this.
In **chapter 2** I explore what is known so far about partners’ and families’ experiences of perinatal care. I begin by examining experiences of family inclusion in wider maternity care. I then present the findings of a systematic review and meta-synthesis I carried out, examining in detail what is currently known about partners’ and other family members’ views of perinatal mental health care. I include a discussion of the limitations of existing research in this area and explain how this informed my decision to carry out my own research to address these limitations.

In **chapter 3** I set out my primary research question, namely to explore - from the perspectives of women, their partners and wider family members - experiences of how services supporting women diagnosed with perinatal mental health difficulties work with their families. I provide a comprehensive outline of my study design - including its relationship to the wider study of which it formed a part. I describe how I approached data analysis and the rationale for using a combination of dyadic and thematic analysis. I also give consideration to some of the ethical issues I encountered and reflect on my own ‘positioning’ in relation to my research.

In **chapters 4 and 5** I set out the findings of my analysis of qualitative interview data. In chapter 4, I present the findings of the dyadic analysis I carried out. For this, I focus up close on seven interview pairs (each including a woman and her partner or other family member). I explore patterns, commonalities and contrasts within each pair of narratives, with an emphasis on understanding experiences of family involvement and support. I present each dyad in the form of a case study, in which I examine the unique and shared experiences described in the individual accounts and combine these
into an overall narrative at the ‘couple’ or ‘family’ level. I follow these case studies with a summary of the overarching findings across all the dyads. In chapter 5, I then ‘widen the lens’ or ‘twist the analytic kaleidoscope’, moving to focus on the findings of my thematic analysis of interview data across the whole dataset. In this way, I accompany the dyadic analysis with a broader perspective on the data - exploring whether the themes identified in the dyadic analysis are reflected across other interviews and seeking to compare and contrast findings across different types of service and participant.

Finally, in chapter 6, I bring together the results of the meta-synthesis, dyadic analysis and thematic analysis, presenting a discussion of the key findings from these different threads of research. I situate the findings within their wider context – revisiting the arguments made in chapter 1 about how concepts like ‘motherhood’, ‘fatherhood’ and ‘infant development’ are constructed within society and influence clinical practice. I discuss and critique the implications of my findings as they relate to policy, practice and research, and reflect on the key strengths and limitations of my study.

1.2 A brief note on who I am: knowing me, knowing you

Before I turn attention to the main substance of my introductory chapter, it feels important to say a little about myself and my interest in this research area. For, in qualitative research, reflexivity is considered vital, with researchers encouraged to acknowledge that they are not ‘outside of’ or ‘external to’ their subject matter, and that their own presence and positioning - in one way or another - will always produce an effect on the data (Steedman, 1991).
In my case, I approach this research as a qualified clinical psychologist and researcher specialising in perinatal mental health and the early years. I have experience of working as a clinical psychologist in a specialist community perinatal mental health service. It was partly through this role that my interest in families and perinatal mental health developed. In particular, I saw first-hand how mental health and maternity services at times marginalise women’s partners and families, but also how challenging it can be to involve and support them.

I also approach this research as a white British woman and mother-of-two, living with a mixed-race male partner and children. I experienced a miscarriage while I was carrying out my PhD, then became pregnant again and gave birth (to my second child) part-way through my study. Therefore, I found myself in the perinatal period during part of my research, and I paused my research while I took maternity leave. I have never been diagnosed with a perinatal mental health difficulty, but nonetheless my own experience of having a baby - particularly the first time around - was one of intense and conflicting emotions. I found my first child’s birth traumatic. I ended up on the hospital’s high dependency unit, with my daughter by my side, but without anyone else with us and without really feeling able to control what was happening to us. I was not permitted any visitors and there was no provision for partners to stay overnight. Once I was discharged back home, I struggled to live up to my image of the ‘perfect mother’, feeling afraid of being judged as a failure and of harming my daughter or my relationship with her through my own inadequacy. I loved my daughter enormously yet found motherhood relentless - an experience of giving and doing what I often felt it was beyond
my resources to give and do, day in, day out, even when I was worn out, exasperated or desperately in need of rest. I began to struggle to sleep and, at times, to leave my home.

I had taken on the primary parenting role - pausing my training as a clinical psychologist to do so - while my partner took just a short period of paternity leave before having to return to work full-time. In some ways, I liked this division because it allowed me to immerse myself in motherhood and to develop a very close bond with my daughter. But, in the end, my experience was also one of clinging frantically to my daughter for fear that I could ‘lose’ her at any moment, without feeling able to reach out to anyone around me for help. This experience contributed to my decision to focus the ensuing stage of my career on perinatal mental health.

Throughout the process of carrying out my research on family inclusion in perinatal mental health care, I reflected on how my personal and professional experiences - along with my own background - may have resulted in certain expectations or assumptions on my part and may have affected my research and interactions with participants. I revisit this in chapters 2, 3 and 4, discussing in detail some of the key ways in which I felt my own positioning may have influenced the study.
1.3 Perinatal mental health difficulties among women

“I’ve never done anything as hard as this in my life. I feel de-skilled. I’m isolated and I’m lonely, and I keep feeling I’m doing the wrong things. It’s hard – and it’s hard for me to say that it’s hard.”

(Stadlen, 2005; p.35)

Pregnancy and the period following childbirth are times of major emotional, physical and social transition for women and their families. While some women may find these changes largely positive, others become vulnerable to mental health difficulties. The most extensively researched mental health difficulty in the perinatal period - typically defined as the time from the onset of pregnancy up to the end of an infant’s first year - is depression. Period prevalence estimates suggest that nearly a fifth of women experience depression during pregnancy and a similar proportion do so in the first three months after giving birth (Gavin et al., 2005). Around a third of women who experience depression remain depressed beyond the first postnatal year (Goodman, 2004b) and around two fifths will experience a relapse either in relation to a future pregnancy or outside of the perinatal context (Wisner, Perel, Peindl, & Hanusa, 2004).

Anxiety in the perinatal period has received less attention than depression, but a review of perinatal anxiety found that up to two fifths of women experience anxiety during the perinatal period (Leach, Poyser, &
Fairweather-Schmidt, 2017) and difficulties such as obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) related to pregnancy or childbirth are increasingly recognised. ‘True’ prevalence rates may be significantly higher than these figures suggest, as many women find it hard to recognise or disclose their difficulties (Russell, Lang, Clinton, Adams, & Lamb, 2013). Acute perinatal difficulties such as bipolar disorder, affective psychosis and schizophrenia are rarer but tend to be associated with a particularly sudden onset, rapid deterioration and dramatic presentation. Prevalence rates for psychotic difficulties remain unclear although admission rates to psychiatric hospitals for women with acute difficulties have been estimated to be around 1-2 per 1000 births (Jones, Chandra, Dazzan, & Howard, 2014).

Some studies have suggested that the incidence of mental health difficulties in the perinatal period is not significantly greater than at other times in a woman’s life (Oates, 2003; O’Hara, Zekoski, Philipps, & Wright, 1990). However, other researchers have identified an increased risk of psychiatric difficulties among perinatal women once they controlled for unequal distribution of risk factors between perinatal and non-perinatal populations - e.g. by taking into account the fact that perinatal women are more likely than non-perinatal women to be in stable relationships, which can be protective against mental health problems (Eberhard-Gran, Eskild, Tambs, Samuelsen, & Opjordsmoen, 2002). Rates of hospital admission for severe mental health difficulties are also higher among perinatal than non-perinatal women (Munk-Olsen, Laursen, Pedersen, Mors, & Mortensen, 2006). For women with a pre-existing diagnosis of bipolar disorder, in particular, there is a one in five
chance of a severe relapse following delivery and almost a one in two chance of experiencing some kind of mood difficulty postnatally (Jones et al., 2014). More broadly, women are at an increased risk of experiencing a perinatal mental health difficulty if they have a personal or family history of mental health difficulties, limited social support, low socio-economic status, a history of abuse or trauma, or if they experience pregnancy complications (Howard et al., 2014).

Perinatal mental health difficulties have been found to be associated with a range of serious adverse consequences. Suicide was the leading cause of maternal deaths (from direct causes) occurring within a year after pregnancy recorded by the Confidential Enquiries into Maternal Deaths and Morbidity 2014–16 report (Knight et al., 2018). There is also evidence that perinatal mental health difficulties are associated with poorer pregnancy outcomes (Grote et al., 2010) and longstanding emotional, social and cognitive difficulties in children (Stein et al., 2014). There are significant cost implications too: in the US, women with postpartum depression have been shown to incur 90% higher health services expenditure compared to non-depressed postpartum women (Dagher, McGovern, Dowd, & Gjerdingen, 2012), while in the UK, it has been estimated that perinatal depression, anxiety and psychosis together carry with them a total long-term cost to society of around £8.1 billion for each year of births (Bauer, Parsonage, Knapp, Lemmi, & Bayo, 2014). It is clear therefore that effective support for mental health problems during pregnancy and postnatally is vital.
1.4 Services for women with perinatal mental health difficulties in England

Table 1 provides an overview of key NHS services in England that support women with perinatal mental health difficulties. For clarity, I have divided these into specialist perinatal mental health services and general mental health services not specialising in the perinatal period.

1.4.1 Primary care services (for mild to moderate difficulties)

Women who experience common mental health difficulties in the perinatal period - such as depression or anxiety - will often be cared for in England by general National Health Service (NHS) primary care services. This could include, for example, receiving pharmacological treatment from family doctors (known as General Practitioners or GPs) or accessing psychological therapy from primary care Improving Access to Psychological Therapy (IAPT) services in the community.

The IAPT programme was introduced within the NHS in England in 2007 to increase access to evidence-based psychological therapies for mild to moderate depression and anxiety (Clark, 2011). IAPT services offer brief manualised therapies, predominantly based on cognitive behavioural therapy (CBT) principles, to a range of people with common mental health problems. Although best practice guidelines recommend that IAPT therapists should adapt treatment to the needs of pregnant women and new mothers (Department of Health, 2013), in practice care is often generic with little in the way of tailoring to the perinatal period (Millett et al., 2018). Data on the number of women who access IAPT for perinatal mental health difficulties
are not routinely collected, but it has been estimated that they account for 5-11% of all IAPT service users (Department of Health, 2013).

There is relatively little in the way of specialist perinatal support for women with mild to moderate perinatal mental health difficulties in the UK. However, some women may receive support from extended primary care services, for example from specialist midwives with extra training in mental health, or via listening visits or support groups run by community public health nurses known as health visitors. Women with difficulties bonding with their babies - often in the context of perinatal mental health difficulties - may also receive specialist support from parent-infant teams.

1.2.2 Secondary care and inpatient services (for moderate or severe difficulties)

At the more severe end of the spectrum, care from specialist perinatal mental health services is usually seen as best practice in England. For example, national clinical guidelines for perinatal mental health (National Institute for Health and Clinical Excellence (NICE) 2014) emphasise the need for specialist integrated secondary care perinatal community mental health teams covering all areas of the country. These are intended to be multidisciplinary teams comprised of perinatal psychiatrists, perinatal mental health nurses and other specialists (e.g. psychologists and social workers) who assess and treat women with moderate to severe mental health difficulties in pregnancy or postnatally. It is recommended that they offer: assessment of the mother-infant relationship, psychological interventions and medication (via home visits and outpatient appointments), pre-conception
advice to women with severe pre-existing mental health difficulties (e.g. bipolar disorder), support for women before or after a psychiatric hospital admission, and close liaison with social care, maternity and other psychiatric services (The Royal College of Psychiatrists, 2018).

For women who require inpatient treatment for an acute perinatal mental health difficulty, national guidelines recommend that they “should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so” (NICE, 2014; p.40). Mother and baby units (MBUs) are dedicated facilities which admit women full-time with their infants. They are run by multidisciplinary teams with expertise in treating severe perinatal mental health problems as well as in childcare and child development. MBUs predominantly admit women with psychotic disorders, mania, and severe depression but can also support those with severe forms of other conditions, such as obsessive-compulsive disorder or anxiety.

There is considerable international interest in UK models of community and inpatient specialist perinatal mental health care, as in other countries women with moderate to severe perinatal mental health difficulties are often only able to access care from generic, non-perinatal psychiatric services (Brockington, Butterworth, & Glangeaud-Freudenthal, 2017). Nevertheless, it is also recognised that in reality: “The provision of specialised perinatal psychiatric care in England is patchy and inequitable” (Oates et al., 2012; p.10). The UK government has committed to increasing access to specialist perinatal mental health support through a five-year transformation programme, with the aim that by 2020/21 four additional MBUs will be in operation (bringing the total to twenty-one units across the UK) and specialist
perinatal community mental health teams will be available in all regions, enabling at least an additional 30,000 women each year to receive specialist support closer to home (National Collaborating Centre for Mental Health, 2018). However, prior to completion of the national roll-out of new services, in nearly half of the UK pregnant and postnatal women have not had access to local specialist services (Bauer et al., 2014).

Even with the addition of new services, access to MBUs and other specialist secondary care perinatal mental health services is likely to remain stretched. This variability in provision is reflected internationally too, with marked variations both within and between countries in the availability and distribution of specialist perinatal psychiatric services such as MBUs (Glangeaud-Freudenthal, Howard, & Sutter-Dallay, 2014). While it has been argued that Australia has the best provision of specialist perinatal mental health services of any country (Brockington et al., 2017), overall the UK has historically had greater provision than most countries (Kumar, Marks, Platz, & Yoshida, 1995) and was a pioneer for joint mother and baby admissions (Cazas & Glangeaud-Freudenthal, 2004). Specialist secondary care community perinatal mental health services are also unique to the UK, with only embryonic services in existence elsewhere.

In England, in those areas with no specialised perinatal services, women with moderate or severe difficulties are either required to travel out of area (e.g. for an admission to an MBU) or are cared for by general mental health services which do not specialise in the perinatal period. For those with the most severe difficulties, general mental health services may include admission to a local psychiatric ward - which typically involves a mother
being separated from her baby - and/or a brief but intensive programme of home care from a local crisis resolution team (CRT). CRTs - also known as home treatment teams or crisis resolution and home treatment teams - are multidisciplinary general mental health teams made up of psychiatrists, mental health nurses and other professionals and support staff. They offer rapid assessment and intensive (normally at least daily) home treatment to a range of individuals experiencing an acute mental health crisis. Support, typically offered for a period of around four weeks, can include symptom management, medication monitoring, practical help, psychoeducation, emotional support and relapse prevention (Johnson, 2013).

Women who require less intensive support are often seen by secondary care services such as community mental health teams (CMHTs). These are also multidisciplinary teams which include psychiatrists, psychologists, nurses, social workers and occupational therapists, and offer support to adults with a range of relatively severe psychiatric problems. Perinatal women with specific diagnoses may also be seen by other non-perinatal secondary care services, such as personality disorder services, or early intervention in psychosis services, which offer longer-term, continuing care.
<table>
<thead>
<tr>
<th>Specialist perinatal or non-perinatal service</th>
<th>Level of service</th>
<th>Type of service</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialist perinatal</strong></td>
<td>Inpatient</td>
<td>Mother and baby unit (MBU)</td>
<td>Specialist hospitals where women with acute mental health difficulties are admitted together with their babies</td>
</tr>
<tr>
<td></td>
<td>Secondary care</td>
<td>Specialist perinatal community mental health team</td>
<td>Multidisciplinary teams treating women in the community with moderate to severe perinatal mental health difficulties</td>
</tr>
<tr>
<td></td>
<td>Primary care</td>
<td>Specialist health visitor/midwife</td>
<td>Health visitors and midwives with additional training to offer support to women with mental health difficulties</td>
</tr>
<tr>
<td></td>
<td>Primary care</td>
<td>Parent-infant team</td>
<td>Teams which may include psychologists, psychotherapists, nurses and health visitors who provide support for parents experiencing difficulties with their relationship with their baby, often in the context of parental mental health difficulties</td>
</tr>
<tr>
<td><strong>Non-perinatal</strong></td>
<td>Inpatient</td>
<td>General acute psychiatric ward</td>
<td>General psychiatric hospitals for adults with mental health difficulties where women can be admitted (without their babies)</td>
</tr>
<tr>
<td></td>
<td>Secondary care</td>
<td>Crisis resolution team (CRT)</td>
<td>Generic multidisciplinary teams offering short-term intensive home treatment to people experiencing an acute mental health crisis</td>
</tr>
<tr>
<td></td>
<td>Secondary care</td>
<td>Early intervention in psychosis service</td>
<td>Multidisciplinary teams offering long-term, intensive support to people experiencing a first episode of psychosis</td>
</tr>
<tr>
<td></td>
<td>Secondary care</td>
<td>Community mental health team (CMHT)</td>
<td>Generic multidisciplinary teams treating adults with moderate to severe mental health difficulties</td>
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<tr>
<td></td>
<td>Primary care</td>
<td>Improving Access to Psychological Therapy (IAPT) service (i.e. talking therapy service)</td>
<td>General community services offering brief psychological therapy for anxiety and depression</td>
</tr>
<tr>
<td></td>
<td>Primary care</td>
<td>General practitioner (GP)</td>
<td>Family doctors who can prescribe medication for perinatal mental health difficulties and help with referrals to other services</td>
</tr>
</tbody>
</table>

1 In some cases, where a full specialist perinatal mental health team is not available, practitioners with additional training or a special interest in perinatal mental health may also be available to support women.
1.4.3 Women’s views of support for perinatal mental health difficulties

While it has been asserted that many adverse outcomes, such as maternal deaths associated with psychiatric illness, could be prevented by more and prompter referrals to specialist perinatal mental health services (Hogg, 2013), in fact there is a lack of robust evidence exploring the effectiveness and cost-effectiveness of specialised services like MBUs (Trevillion et al., 2019). However, qualitative research suggests that women prefer being treated on specialist MBUs than on general psychiatric wards (Griffiths et al., 2019; Heron et al., 2012; Robertson & Lyons, 2003). Women report that MBUs offer them a therapeutic environment for recovery, with practical support on hand with infant care, and high-quality advice from a team of perinatal experts. By contrast, those admitted to general psychiatric wards report distress at being separated from their babies and difficulties resulting from a lack of access to specialist treatment. In the community, perinatal women report generally positive experiences of care from general, non-perinatal services like IAPT and community mental health teams, but prefer support to be tailored to the perinatal context and delivered by clinicians with specialist expertise (Lever Taylor, Kandiah, Johnson, Howard, & Morant, 2020; Millett et al., 2018).

A meta-synthesis of qualitative research (from the twenty-first century) reviewing women’s experiences of perinatal mental health care in the UK (Megnin-Viggars, Symington, Howard, & Pilling, 2015), found that women report that fragmented care during the perinatal period (for example, having to see multiple different midwives) makes it difficult for them to disclose
mental health difficulties, particularly as they often harbour considerable fears about the implications of disclosure (e.g. possible loss of custody). Strong relationships between women and healthcare professionals (both maternity and mental health professionals) are vital, with flexible boundaries, consistency (e.g. seeing the same professional throughout pregnancy and postnatally), availability, willingness to listen, empathy and being non-judgemental cited as particularly crucial. Yet women reported that clinicians at times were too busy or seemed unwilling to listen to them, could be dismissive of their concerns, and could appear excessively wedded to procedure, allowing little space to talk about feelings. Some women also observed that midwives, health visitors and GPs in particular seemed to lack relevant experience in recognising the symptoms of their difficulties, resulting in delays receiving treatment. Others felt there was a tendency to focus on the needs of the baby to the exclusion of the mother’s own needs. Women also reported gaps in information provision and said they felt unclear about available treatment options, the benefits and risks of pharmacological treatment, and where to turn if they deteriorated.

This meta-synthesis had important limitations – not least that it imposed a priori themes on the data, rather than allowing themes to be identified inductively, which may have constrained the themes found. Nevertheless, its findings are reinforced by other research into perinatal mental health care in both the UK and abroad, which has similarly found a need for better consistency of care and better information provision, and has identified difficulties arising where healthcare professionals appear rushed or do not
ask women about their wellbeing (Dolman, Jones, & Howard, 2013; Russell et al., 2013).

A systematic review of experiences of perinatal mental health care among women from ethnic minority backgrounds found that women from Black Caribbean and South Asian backgrounds face particular challenges disclosing their difficulties to professionals because it can be considered unacceptable within these cultures for women to say they cannot cope with motherhood or to discuss personal issues outside their families (Watson, Harrop, Walton, Young, & Soltani, 2019). But the review found that healthcare professionals were not always sensitive to women’s religious or cultural beliefs and needs. With similarities to Megnin-Viggars et al.’s (2015) findings, the reviewers also noted that professionals did not consistently ask women about their perinatal mental health or recognise their symptoms.

While national guidelines in the UK recommend that professionals working with pregnant and postpartum women should have specific training and supervision in perinatal mental health (NICE, 2014), healthcare professionals such as midwives and health visitors report that they do not always feel confident working with women with perinatal mental health difficulties. They struggle with the responsibility of keeping both a mother and her baby safe, feel unsure how to respond if a woman discloses difficulties, and say they would benefit from more specialised training and greater knowledge of available support for women (Dolman et al., 2013; Jomeen, Glover, Jones, Garg, & Marshall, 2013; Russell et al., 2013).
1.5 Impact of perinatal mental health difficulties on women’s partners and wider families

While most research to date has focused on the impact of perinatal mental health difficulties on women and their babies, more recently there has also been increasing recognition that, when a woman experiences a perinatal mental health difficulty, this can affect her partner and wider family too. Qualitative research has shown that partners report fear, confusion, concern, helplessness, frustration, isolation and stigma when a woman experiences postnatal depression (Davey, Dziurawiec, & O’Brien-Malone, 2006; Engqvist & Nilsson, 2011; Meighan, Davis, Thomas, & Droppleman, 1999). They describe a sense that their co-parent is ‘absent’, resulting in loneliness and feelings of responsibility for ‘filling the void’ (Beestin, Hugh-Jones, & Gough, 2014). Where women are admitted to hospital with severe perinatal psychiatric difficulties, partners report shock and disbelief, trauma, stress, financial and work-related difficulties, relationship problems and sleep deprivation (Muchena, 2007).

It has been estimated that almost one in five marriages ends following an episode of postpartum psychosis in a mother (Blackmore et al., 2013), while the findings of a survey of over 1,500 women who had experienced a perinatal mental health difficulty found that seven in ten believed their relationship with their partner had been affected by their problems and two fifths thought their partner had also experienced anxiety or depression (Russell et al., 2013). The term postnatal depression is not commonly used in relation to fathers - or at least has not typically been applied to fathers until
recently. However, it has been estimated that 10.4% of fathers experience depression during the perinatal period (Paulson & Bazemore, 2010), and this too may be an under-estimate as many men remain silent about their difficulties (Letourneau, Duffett-Leger, Dennis, Stewart, & Tryphonopoulos, 2011; Mahalik, Good, & Englar-Carlson, 2003). New fathers’ depression rates have been found to be double the national average for men in the same age group in Denmark (Madsen & Burgess, 2010) and the US (Paulson, Dauber, & Leiferman, 2006). Maternal postpartum depression is a strong predictor of paternal postpartum depression, with a 25-50% incidence of postnatal depression among men whose partners experience postnatal depression (Goodman, 2004a), although the direction of causality is not always clear.

As with mothers, research suggests that postnatal mental health difficulties among fathers are associated with negative outcomes. For example, fathers with postnatal depression incur significantly higher healthcare costs than those without depression (Edoka, Petrou, & Ramchandani, 2011). Depression in fathers in the postnatal period has also been found to be associated with multiple indicators of adverse child outcomes (Barker, Iles, & Ramchandani, 2017) including an increased risk of later behavioural and emotional difficulties in children, independently of maternal postnatal depression (Ramchandani et al., 2008; Ramchandani et al., 2005). Infants whose parents both experience perinatal mental health difficulties are at greater risk of poor developmental outcomes than those where only one parent experiences a difficulty (Paulson et al., 2006), and there is also an
increased risk for infants whose parents experience relationship conflict (Pauli-Pott & Beckmann, 2007).

While very little research has focused on women’s extended families, one study found that along with partners - siblings, parents and grandparents of women with postnatal depression reported that the difficulties placed a considerable burden on the whole family, resulting in “a lot of worry within the family”, affecting family members’ social activities, and having a detrimental impact on family finances (Boath, Pryce, & Cox, 1998; p.200). Certainly, outside of the perinatal period it has been well-documented that the families of individuals with mental health difficulties themselves experience high levels of distress and burden (Crowe & Lyness, 2014; Grover et al., 2012).

1.6 Influence of partners and families on women’s perinatal mental health

There is also increasing awareness that partners and other family members can play a vital role in relation to a woman’s perinatal mental health. For example, strong social support from wider family and friends, help with childcare by family members, having an infant’s grandmother living with the family, and living in an extended family, have been found to be protective against perinatal depression among women (Gjerdingen, McGovern, Attanasio, Johnson, & Kozhimannil, 2014; Rahman, Iqbal, & Harrington, 2003). Infants’ maternal grandmothers have been found to help reduce stress in single mothers by playing the role of ‘replacement’ parent and partner and offering their daughters both emotional and practical support (Harper & Ruicheva, 2010). While some commentators have argued that the
growing disintegration and geographical dispersion of extended families in modern society may have contributed to an increase in perinatal mental health difficulties (Hanley, 2009), research has also demonstrated the important role that infants’ grandparents and other relatives continue to play during the perinatal period (Gray, 2005; Holley-Moore, 2018). Improved life expectancy may also have increased the likelihood of grandparents being available to help (King, 2015), although this may be offset to some extent by women having babies later.

As regards women’s partners, perceived support by an infant’s father or maternal grandmother in the postpartum period has been shown to be significantly correlated with lower rates of depression among young and first time mothers (Barnet, Joffe, Duggan, Wilson, & Repke, 1996; Leahy-Warren, McCarthy, & Corcoran, 2012), while having a supportive partner has also been found to be strongly associated with shorter hospital stays among women admitted to hospital with a perinatal mental health difficulty (Grube, 2005). In Canada, a randomised controlled trial of psychoeducation visits for women with postnatal depression found that their symptoms decreased significantly more when their partners were at the majority of visits with them (Misri, Kostaras, Fox, & Kostaras, 2000).

In addition, it has been argued that partners may act as a ‘buffer’ against the negative effects of a mother’s depression on their children. For example, in one study sensitive fathering was found to protect the babies of chronically depressed mothers from negative outcomes (Vakrat, Apter-Levy, & Feldman, 2018). In another study, a father’s self-reported positive parenting, together with spending substantial time caring for his baby, moderated the long-term
negative effects of a mother’s depression on the child’s depressed or anxious mood, although no effect was found on aggression or other ‘externalising’ behaviours (Mezulis, Hyde, & Clark, 2004). Conversely, conflict with an infant’s father, or domestic violence towards a mother by her partner negatively affects pregnancy, maternal and child outcomes (Barnet et al., 1996; Ghazanfarpour et al., 2018).

New mothers are also more likely to turn to their partners for support than to anyone else, including medical professionals (Holopainen, 2002). This is supported by Russell et al.’s (2013) survey of women with perinatal mental health difficulties which showed that nearly half of mothers speak to their partner about their difficulties first, and partners often pick up on signs of difficulties before anyone else, including the mother herself. The importance of partners is further reinforced by the finding that some women with perinatal mental health difficulties admit that they were reluctant to seek help because their partners were dismissive of their symptoms (Letourneau et al., 2007). A study among British South Asian women with postnatal depression similarly found that their partners were highly influential both in facilitating women’s access to support (e.g. by helping them speak to professionals) and restricting it (e.g. where they were resistant to women speaking to professionals) (Masood et al., 2015). These studies show that a woman’s partner and family can be instrumental in supporting her and either encouraging or discouraging her from seeking professional help.
1.7 Involving partners and wider family members in perinatal mental health care

Taken as a whole, these findings suggest that women’s partners and family members play a vital role in relation to perinatal mental health and should be included in discussions about women’s support. In recognition of this, Russell et al (2013) conclude that: “It is important that the partner is encouraged, where appropriate, to have a significant role and should routinely be involved and so well informed and prepared” (p.3). Similarly, a report published as part of the UK’s National Society for the Protection of Cruelty to Children ‘All Babies Count’ campaign argues that “perinatal mental illnesses can have a significant impact on the families of women who are affected. Family members are also important sources of support for the mother, and can mitigate the effect of her illness on the baby. Therefore it is important that mental health services ‘think family’” (Hogg, 2013, p.37).

In England, national clinical guidelines for perinatal mental health allude to the importance of partners and other family members. For example, national quality standards state that “Quality standards recognise the important role families and carers have in supporting women with a mental health problem in pregnancy and the postnatal period. If appropriate, healthcare professionals, public health professionals and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care” (NICE, 2016; p.14). Similarly, national guidelines recommend that services should “take into account and, if appropriate, assess and address the needs of partners,
families and carers that might affect a woman with a mental health problem in pregnancy and the postnatal period" (NICE, 2014; p16). Best practice guidelines for perinatal mental health internationally recommend including women’s families in their care and supporting family members as well. For example, in Australia best practice guidelines for perinatal mental health emphasise the need for collaborative decision making with women and their partners and clear referral pathways for partners who themselves experience distress (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), 2015). Likewise, researchers in low and middle income countries have argued that involving the entire family and community when supporting women with perinatal mental health difficulties is more beneficial than taking an individualistic approach (Rahman et al., 2013). Nevertheless, partners and families get conspicuously little mention overall within national and international clinical guidelines. In the UK, the recently released NHS Long Term Plan (NHS England, 2019) recognises that greater emphasis on women’s families is now needed. For example, it recommends that specialist perinatal mental health services should offer women’s partners assessments for their own mental health, signpost them to support where needed, and offer family interventions – acknowledging that partner and family support appears to be overlooked within current provision. Furthermore, in 2013 a report into perinatal mental health noted that only one MBU in the UK had space for fathers to stay with their partners (Hogg, 2013). As I discuss further below, the focus on treating mothers and babies in units away from their homes - though this clearly has benefits - may also result in excluding partners and relatives. It arguably also conforms to the dominant
medical model in psychiatry, whereby mental health difficulties are at times seen as brain disorders within individuals rather than experiences produced in the context of a person’s family and social network, which need to be treated within the milieu of those networks. More generally it has been argued that: “on the whole, stretched maternity and mental health services do not provide fathers with information and support, despite the wider benefits that this would have for families” (Hogg, 2013, p.38).

Reinforcing this argument, a UK qualitative study of women who had experienced postpartum psychosis, found that women expressed a belief that their partners would have benefitted from more information about what to expect in terms of their prognosis (Heron et al., 2012). They also felt their partners should have been offered psychological support and that psychotherapy should additionally have been made available to the whole family. Likewise, in a qualitative Canadian study of women treated for puerperal psychosis, women noted that there was a lack of support for their partners (Robertson & Lyons, 2003). According to women’s accounts, their partners often struggled to care for older children while mothers were hospitalised, at the same time as coming to terms with the woman’s difficulties and dealing with the separation from their wife and baby. In their meta-synthesis of women’s experiences of perinatal mental health care, Megnin-Viggars et al. (2015) also note, in relation to postpartum psychosis, that “information and support for partners and wider family was often insufficient” (p.754), suggesting that fathers and relatives feel uninformed. It is conspicuous though that this is the only mention of women’s partners or family members in the entire review, which may be a limitation of the meta-
synthesis itself or could more broadly reflect a lack of focus on families and partners within the literature reviewed.

It is also striking that the findings of the studies outlined above are based on women’s accounts of their partners’ and relatives’ needs, rather than on the views of partners and relatives themselves. The great majority of studies exploring perinatal mental health care have focused exclusively on the experiences of women, while the voices of partners and wider family members have largely been neglected. Even Russell et al.’s (2013) survey of perinatal mental health difficulties, which did include a more significant focus on the importance of partners and relatives, only sought out the views of women and healthcare professionals; partners and relatives were not included. Thus, these studies provide little understanding of what partners and other family members of women with perinatal mental health difficulties themselves think about perinatal mental health care. I would conjecture though that the omission of their voices from the literature may reflect an underlying tendency to overlook them. Given we know that women’s partners and wider families play a vital role in relation to their perinatal mental health, a focus on families and the interpersonal context seems vital - with the interpersonal context defined as the characteristics of a woman’s family system, family dynamics, and the assumptions and beliefs held by different family members. Beyond this, consideration of the wider social context is also essential, as it is critical to recognise that families are not dislocated, self-contained entities. Instead, family life and experiences are themselves shaped by the cultures in which families are situated, the choices available to
them, and the dominant cultural discourses, expectations and structures within which they are immersed (Dallos & Urry, 1999).

1.8 The wider involvement of partners and families in the perinatal period: a social-historical perspective

“How many days, how many months, all put together, have I spent with babies in my arms! My time, when at home, and when babies were going on, was chiefly divided between the pen and the baby. I have fed and put them to sleep hundreds of times.”

(Cobbett, 1829, p.79)

In order to help inform our understanding of why, despite calls to include women’s partners and families in perinatal mental health care, there are indications that they may be overlooked, it is helpful to consider the wider roles of partners and relatives in the perinatal period and to situate these in their social-historical context. This helps to expose the ways in which the meanings of terms such as ‘motherhood’, ‘fatherhood’ and ‘the family’ are not fixed, objective categories - though they are often presented as such - but rather are concepts which are contextually embedded and socially constructed and can shift according to broader socio-economic, historical, ethnic and religious trends. This in turn provides valuable context to enable us to develop an understanding of how women’s partners and families may experience perinatal mental health services and some of the possible reasons behind this.
1.8.1 The ascendancy of the mother as primary caregiver

With regards to the involvement of women’s partners in the perinatal period, it has been argued that fathers traditionally have been “relegated to the position of providing support for the mother, rather than having their own role to play” (Barrows, 1999; p.334). Cross-cultural studies have shown that fathers have seldom had an active role in childbirth (Lamb, 1987) and - while there are some exceptions - historically and across a wide range of cultures fathers have typically played a relatively minor role in the physical care of infants and young children, instead being primarily responsible for securing resources for the family (Engle & Breaux, 1998; Lynn, 1974). Studies of Western artwork over the past four hundred years also appear to reinforce such findings, identifying few examples of paintings depicting fathers being involved with or holding their infants (see Burgess, 1998).

Nonetheless, it has been documented that in the UK, during the eighteenth and nineteenth centuries, there was a discernible shift in responsibilities for raising infants away from fathers and towards mothers, with evidence from analyses of historical records suggesting that fathers had hitherto enjoyed greater involvement (Tosh, 1999). Previously, although men generally had a lesser role than women in childrearing, they nonetheless typically set the ‘ground rules’ for how infants should be cared for (Tosh, 1999). In working-class families in particular, significant paternal involvement was often required because of cramped living environments, high mortality rates among childbearing women, and an inability to afford childcare (Alexander, 2008). But over the course of the Victorian era, the once familiar image of the
'nursing father’ - who fed and cared for his infants and toddlers - began to wane, particularly among affluent and middle class fathers, and instead the Victorian ‘paterfamilias’ came to be categorised as harsh and remote (Tosh, 1999). While this stereotyping of Victorian fathers has been shown in reality to be crude and simplistic, as has the image of the absent, drunk working class Victorian father (Strange, 2015), it appears that fathers during this era in some respects did become physically and emotionally more distant from their infants.

Historical analyses suggest that this was partly driven by the industrial revolution during the eighteenth century and the first half of the nineteenth century, which resulted in a growing tendency for men to work away from the home. Previously, the majority of men had worked in or near their homes, making them more readily accessible to their young children. Moreover, many women also had a trade, meaning that fathers sometimes cared for infants while women worked, and both women and men contributed directly to the household finances (Burgess, 1998). But with industrialisation came an emphasis on the father’s role as the breadwinner and a reduction in fathers’ involvement with childcare, while women withdrew from the business activities of the household and into the role of homemaker (Seccombe, 1986). Similar patterns have been reported in other Western cultures too around the time of industrialisation (Lamb, 1987). For example, in the US, it has been documented how, in the second half of the nineteenth century, fathers increasingly left their homes to seek employment in an emerging industrial economy, thereby adopting the role of breadwinner, while childrearing shifted largely to mothers (Cabrera, Tamis-LeMonda, Bradley,
It is important to emphasise though that not all fathers became more absent from their families during this period (Johansen, 2001), and the shift to a ‘male breadwinner’ family set-up was not universal or always clear-cut (Horrell & Humphries, 1997).

Overall, however, women began to take on greater childrearing responsibilities. In this context, there was an accompanying trend towards an increase in the perceived influence and prestige of mothers in relation to child development: the ‘wise father’ was displaced by an idealised image of the ‘loving mother’ who supposedly had a pure, innate nurturing capacity (Tosh, 1999). Tosh connects such changes partly to increased value being given to breastfeeding, and also to secular scientific enquiry from the late eighteenth century onwards placing greater emphasis on the importance of the mother’s body in relation to pregnancy and reproduction, rather than seeing seminal fluids and male heritage as the key (a notion that had hitherto been reinforced by the Christian concept of the father as the originator of the family). Where legally a father had previously enjoyed sole rights to the custody and guardianship of his children, this shifted to the mother with the introduction of the Infant Custody Act in 1873 and the ‘tender years doctrine’, which presumed maternal custody of children until the age of 16.

In keeping with this shifting perspective, fathers’ role in childbirth also changed in a way that increasingly excluded them from the late eighteenth century on. Until the mid-eighteenth century in the UK, while childbirth was primarily a women-only event in the home (presided over by a female midwife), fathers nonetheless remained in the vicinity of the birth, were physically and emotionally involved, and were often seen as central figures...
within the social milieu of childbirth, fetching the midwife or doctor, escorting people to see the mother and baby, rejoicing with family and friends, and arranging the baptism (Blackshaw, 2003; Johansen, 2001; Tosh, 1999). The term ‘couvade’, first coined by the anthropologist Edward Tylor in 1865 (Tylor, 1865), refers to a custom observed among some cultures from ancient times where the father of a newborn - in order to publicly acknowledge his paternity - lies in bed and goes through rituals, such as eating prescribed foods and nursing the infant, as if he were physically affected by the birth. However, during the late eighteenth century, although men paradoxically began to attend childbirth more frequently, it has been contended that “instead of being the master of ceremonies and focus of public attention, the father was on the way to becoming the nervous bystander of recent times” (Tosh, 1999; p.81).

While placing women more definitively at the centre of childbirth can be viewed in some respects as representing a welcome shift, the picture is complex as, in other respects childbirth increasingly came to be looked upon as the fulfilment of a woman’s femininity and her centrality to the domestic sphere. Similarly, the increased ‘status’ of motherhood arguably did not represent a true increase in women’s standing, power or influence in comparison with men, but rather in many ways served to help ensure women were confined to the home (Burgess, 1998). Some analyses have emphasised how the transition from more egalitarian family arrangements to a dominant model in which men financially supported their dependent housewives was also associated with the erosion of women’s independence during this period, with increasing constraints and limitations placed on
women’s opportunities and involvement in employment (Horrell & Humphries, 1997).

Nevertheless, the perceived growing prestige of motherhood appears to have resulted in considerable uncertainty about the role a father was expected to play in relation to birth and the rearing of infants and young children. Attitudes towards gender and masculinity were changing: for example, over the course of industrialisation there was increasingly less tolerance for paternal tenderness, which began to be perceived as ‘effeminate’, while sensibility and responsiveness, which had once been highly valued paternal characteristics, started to be frowned upon as the dominant ideals of masculinity were increasingly seen as breadwinning, autonomy and independence (Bailey, 2011). It has been argued that such attitudinal changes were partly driven by a need to condition men to accept strenuous, often degrading physical work (Burgess, 1998), and partly were a defence against anxieties engendered by the enhanced status of the mother’s role and the resulting side-lining of fathers (Tosh, 1999). With striking similarity to contemporary debates about fatherhood, these authors have shown how concerns emerged during the industrial revolution around whether a father’s role in the perinatal period should essentially be to provide back-up support to mothers and/or to copy and emulate mothers as far as possible, or whether they should offer something different and unique.

Much less has been written about the impact on childrearing of changes to wider family networks over time. However, while individual household size remained remarkably stable over the course of industrialisation in the UK (Laslett, 1969), urbanisation and the increasing mobilisation of the population
contributed to a decrease in large extended families living in close proximity. This resulted in a shift in childrearing responsibilities away from extended families and the wider community and towards the nuclear family (Burgess, 1998). At the same time, Burgess notes how older siblings began to remain at home longer and life expectancy increased, meaning grandparents lived longer. Although offset to an extent by women having children later, this resulted sometimes in the availability of (female) family members able to help with infant care - and also in a further reduction in the reliance on fathers contributing to childcare.

The growing perception of the mother as an infant’s primary caregiver, with the father as subordinate, proved to be highly enduring over the course of the nineteenth and twentieth centuries. Ongoing imperialism and frequent military conflict, including the two world wars during the first half of the twentieth century, played a part in reinforcing this, as men had to be ready to leave their families for long durations at any moment, and many children ultimately lost their fathers (Burgess, 1998).

In relation to childbirth too, the shift away from involving women’s partners intensified further in the early twentieth century with the ‘hospitalisation’ of labour (in the UK and other Western countries), when technical advances resulted in a belief that hospital births were safer, and the increasing dispersion of the population meant that extended families too became less involved in childbirth, making it harder for couples to find support for home births (Walzer Leavitt, 2009). As rates of hospital births rose dramatically (between 1963 and 1974, the percentage of deliveries taking place at home in the UK fell from 30.0 per cent to 4.2 per cent (Nove, Berrington, &
Matthews, 2008), women’s wider families were called on to help with childbirth less and less, while women’s partners were in some cases actually barred from delivery rooms and consigned to hospital waiting rooms (King, 2017; Walzer Leavitt, 2009). As one mid-twentieth century analysis of a hospital maternity floor concluded, the waiting room for fathers was: “unattended and suggestive that the father is regarded as the least important person in the process. By its sparseness of furnishing, its physical isolation, and its small size, this room seemed to communicate symbolically the idea that the fathers are unnecessary and functionally peripheral” (Rosengren & Devault, 1963; p.278). Mid-twentieth-century artwork also depicts fathers as excluded and isolated from women giving birth, for example in the Norman Rockwell illustration shown below of a maternity waiting room.

![‘Maternity Waiting Room’ Norman Rockwell illustration (1946)](image)

Meanwhile, in the sphere of child development research, renowned twentieth century theorists such as Sigmund Freud and John Bowlby, reinforced the assumption that the mother-infant bond was of principal importance - at least during a child’s early years - with any bond with a father subsidiary. For example, Freud argued that the mother was “unique, without parallel...the
prototype of all later love relations – for both sexes” while the father was of minimal importance during infancy (Freud, 1949; p.45). Similarly, Bowlby proposed that the mother-infant bond was “by far the most important” while the father provided “value as the economic and emotional support of the mother” (Bowlby, 1953, p.16). Thus, in this realm too, the father was essentially seen to represent the ‘external world’ while the mother was required to build the ‘emotional nest’ of the home (Baradon, 2019).

Other researchers examining pregnancy, birth and early child development largely ignored fathers in clinical studies and theoretical debate too (Cabrera et al., 2000; Le Gresley, 2001). Instead studies focused predominantly on the female experience, taking a ‘matricentric’ perspective (Nash, 1965), while men remained consistently on the periphery, described as the ‘forgotten contributors’ to child development (Lamb, 1975). As recently as 2005, a review of studies of child developmental psychopathology from a range of countries found that, of 514 articles published over the preceding eight years, 45% focused only on mothers, compared with just 2% on fathers (Phares, Fields, Kamboukos, & Lopez, 2005). Furthermore, while typically an infant’s biological mother came to be seen automatically as the primary carer, the partner’s role became less distinct and could include the biological father, step-father, another father-figure, or a female partner, each of whom might or might not live with their infant (Abelsohn, Epstein, & Ross, 2013; Phares, Lopez, Fields, Kamboukos, & Duhig, 2005).

The increased emphasis on the importance of the mother-infant bond also appears to have influenced the historical development of perinatal mental health services in the UK, arguably with the - perhaps inadvertent - outcome
of excluding women’s partners and families within this arena too. In the first half of the twentieth century in the UK, as in other Western countries, women with perinatal mental health difficulties were routinely separated from their infants, whether they were cared for at home or in hospital. Working class mothers in particular were frequently sent to asylums (Howard, 2000) and there was a prevailing belief that an infant of a woman with a perinatal mental health difficulty would be “better with its granny” (Main, 1958, p.845). However, during the second half of the twentieth century, units began to be established that allowed joint mother and baby admissions. It has been argued that this was partly because help with childcare from women’s extended families had become less available and also because of the new importance attached to the mother-infant bond (Howard, 2000; Main, 1958). While very little has been written about the impact of this on partners and relatives, I would speculate that, despite its benefits (e.g. in terms of keeping mothers and babies together), the increased separation of mothers and babies from fathers and other family members may, at the same time, have further contributed to their marginalisation. Certainly, the widespread perception of the father as breadwinner and mother as primary caregiver can be seen to have influenced early MBU admissions. For example, Thomas Main, a pioneer of joint mother-baby admissions, explained his view that: “Just as it seemed important to keep a man patient in touch with his job and to treat him for the difficulties he might meet there, so it seemed important that a mother should be kept in touch with her job, and the children who were part of it” (Main, 1958, p.845).
1.8.2 The shift from ‘distant breadwinner’ to ‘involved father’

Taken as a whole, the accounts outlined suggest that, during the eighteenth and nineteenth centuries, women’s partners, and in some respects their extended families too, became increasingly less involved in the perinatal period in the UK, within the home, hospital and wider society. In relation to wider families, it has been argued that this trend has, overall, continued. For example, Hanley (2009) contends that there has been a continuing “disintegration of the supportive mothering role of the extended family, as grandmothers, as well as mothers seek gainful employment” (p.1975). Hanley notes that: “Sometimes the female family members are so removed geographically that the support network of families becomes even more fragmented than ever” (p.1975). Demographic modelling has also shown that, although young children are increasingly likely to have a living maternal grandparent, grandparents are less likely to live nearby to them (Gray, 2005). Similarly, research shows that, although grandparents continue to provide considerable amounts of caregiving to their grandchildren (especially in the context of rises in lone parenting and greater numbers of working mothers), families in the UK also increasingly opt for formal childcare, as this has become more accessible (Holley-Moore, 2018).

Other commentators have noted how, in this context - and also connected to immigration to the UK of people from varied cultural and religious backgrounds - the roles played by extended family members like grandparents have become more diverse and heterogenous over time (Bengtson & Lowenstein, 2003; Robson & Berthoud, 2006). Mothers in the
UK tend to receive less support with infant-care from their extended families than those living in more collectivist cultures (Gardner, Bunton, Edge, & Wittkowski, 2014), but studies among women from South Asian and West African backgrounds have also shown how moving to the UK can leave migrant women particularly isolated from their family networks (Gardner et al., 2014; Wittkowski, Zumla, Glendenning, & Fox, 2011).

In relation to fathers, on the other hand, it has been argued that, in both Western and non-Western societies, there has been a move away from the ideal of the father as a distant breadwinner, with a subordinate role in childrearing, and towards a modern focus on the ‘involved dad’ or ‘new nurturant father’, who spends time with his children and values active, responsive fathering and equal co-parenting (Dermott & Miller, 2015; Engle & Breaux, 1998; Machin, 2015). These changes have been attributed in part to social changes, including advances in women’s rights and greater numbers of women entering the workplace or re-entering it after childbirth (Gillies, 2009). Such changes have seen the reorganisation of the household economy and division of labour within the home (Fagan, 2001). Gillies (2009) also views the increased emphasis on the importance of being an ‘involved father’ as a defensive reaction to increased divorce rates and rises in lone parenting. It is important to note that the dynamics of social transformations such as ‘industrialisation’ and ‘modernisation’ are invariably complex and multifaceted, and historically the concept of the ‘new’ or ‘involved’ father has in fact surfaced repeatedly over time, each time posited against a stereotype of the ‘old father’ who is depicted as somehow uninvolved and retrograde.
(Strange, 2015). Nonetheless, there does appear to be evidence of a recent shift in conceptions of fatherhood.

For example, with regards to childbirth, since the 1970s the consignment of women’s partners to maternity waiting rooms has become a thing of the past (Greenhalgh, Slade, & Spiby, 2000; Kowlessar, 2012; Walzer Leavitt, 2009). This has been attributed to changing social roles and gender identities, greater acknowledgement of the importance of partners, and also to changes to the set-up of perinatal care which have required partners to ‘fill the gaps’, for example as a result of reduced hospital care and cuts to services for women (King, 2017; Machin, 2015). In the UK, a 2010 national survey found that almost ninety percent of fathers attend the birth of their child and the majority also attend their partner’s scans and regular antenatal appointments (Redshaw & Heikkila, 2010). Postnatally too, there has been an increase in fathers’ involvement with caring for their infants (Cabrera et al., 2000). On top of this, there has been a surge of interest in research focusing on fathers. Arguably reflecting underlying anxieties provoked by the social changes described, research has tended to emphasise the beneficial social and developmental influence that fathers can have on their children when physically and emotionally present for them, the negative impact of family breakdown and the absence of a father, and the role of ‘non-traditional’ fathers - such as non-resident fathers, single fathers, divorced fathers, and homosexual fathers or partners (Burgess, 2011; Gillies, 2009; Le Gresley, 2001).

Yet despite these changes, shifts in partners’ involvement in the perinatal period, in other respects, seem to have been less extensive than might be
expected. For example, there are much higher rates of part-time working among mothers than fathers, there has been a low uptake of extended paternity leave in the UK, and evidence suggests that, although fathers decrease their working hours shortly after the birth of their first child, this is usually only short-lived (Gillies, 2009; Kaufman, 2018). Burgess (1998) also argues that modern-day men have surprisingly little input into decisions such as whether to conceive and whether to terminate a pregnancy, although she neglects to fully acknowledge how this also raises complex questions around the appropriate limits of fathers’ involvement and women’s rights over their own bodies. More broadly, while paternal involvement in caregiving does appear to have increased over the past few decades (O’Brien, 2005), fathers - even in intact two-parent families - have still been found to spend less time with their offspring than mothers. For example, one study from the US found that mothers not only spent more time than fathers doing basic infant care, but also allocated more than twice as much of their total available parenting time to routine childcare than fathers (at 3, 6 and 9 months postpartum), even after accounting for breastfeeding (Kotila, Schoppe-Sullivan, & Dush, 2013). Expectations of fathers’ involvement in the perinatal period arguably remain relatively low, unless something stops the mother from coping. And while women continue to be seen as having a natural capacity for motherhood, fathers are at times depicted (e.g. in cultural imagery) as hapless, bumbling and needing direction with childcare from mothers (Saunders, 2016). Norms across many cultures continue to demand that mothers are unconditionally loving and self-sacrificing, while participatory fathers are seen as ‘exceptional’ (Åström, 2018).
In seeking to understand such findings, a qualitative study of modern-day men’s experiences of the transition into fatherhood identified that, although men were motivated to be equal parents and regarded ‘involved fatherhood’ as something of an ideal, they nevertheless felt that the reality of social norms, structures and policies (such as the need to return to work) kept them in traditional roles, resulting in their continued exclusion and marginalisation (Machin, 2016). Other research has highlighted similar tensions, with the perceived importance of being an involved father set against a backdrop of continuing societal constraints, coupled with strong continuities in traditional perceptions of masculinity. For example, an Australian study of men’s experiences of new fatherhood found that being an ‘absent’ father was no longer perceived to be acceptable to fathers, but that they nevertheless often found themselves caught in this role, remaining conspicuously on the fringes of parenthood for the first six months (Barclay & Lupton, 1999). The researchers observed that, although fathers expressed a desire to ‘be there’ for their children, they often defined what this might mean using ‘masculine’ imagery (e.g. playing outdoors). Some men in this study also cited breastfeeding as a barrier to their involvement, viewing it almost as a symbol of the unique bond they felt only a mother could provide, at the exclusion of the father. In a more recent study, in the United States, fathers were similarly found to hold multiple identities: on the one hand, they expressed the view that being a good father meant providing financially for their families but, on the other hand, they strived to be nurturing and involved with their children (Humberd, Ladge, & Harrington, 2015). Partly connected to such tensions, it
has been reported that many fathers ultimately find the transition to fatherhood distressing and frustrating (Goodman, 2005).

Similar tensions have been reported by fathers from a range of different cultural backgrounds. Rates of lone parenting are conspicuously high among women from African and Caribbean backgrounds in Britain compared to those from White or South Asian backgrounds (Robson & Berthoud, 2006). But African and Caribbean fathers in the UK have described shifts from distant and disciplinarian to more involved and communicative fathering styles within their communities too (Williams, Hewison, Wildman, & Roskell, 2013). Like other fathers, they too described this conflicting with persisting, deep-rooted ideals within their cultures of the man as the economic provider and the wife as the main carer. Of note, these fathers also observed that, in the UK, women’s extended families and wider social networks were less involved in childcare than in African societies, resulting in greater reliance and pressure on the immediate nuclear family.

In a study of Asian fathers in the UK, they too described an increasing ideal of intimacy with their children, in contrast to the ‘typical Asian father’ who was viewed as remote and authoritarian (Salway, Chowbey, & Clarke, 2009). But the researchers found that conventional perceptions of fatherhood remained strong among these fathers, with personal care-giving for young children typically seen as a mother’s responsibility (and with stigma from the wider religious community against fathers who partook in care-giving), along with a perception that there are ‘natural’ or ‘biological’ differences between men and women in their parenting capacities.
Yet, it is not only men who voice such tensions: it has been argued that some women themselves are reluctant to relinquish their control over childbirth and infant care to their partners, desiring to remain at the heart of childrearing, acting as gatekeepers to their babies, and resisting greater father entitlement or intrusion into the mothering role (Gatrell, 2007; Shorey, Ang, & Goh, 2018). This raises complex questions about the possible impact on gender equality of encouraging fathers to participate more in the perinatal period, since increased paternal involvement can be seen at once to have the potential both to enhance and risk undermining women’s status, power and control. Some researchers have argued that - although the increasing representation of men as nurturing and caring can be viewed as a welcome development - this may also serve to marginalise mothers, encouraging involved fatherhood at the expense of mothers’ own roles (Åström, 2018).

Additionally, I found it notable when reviewing relevant studies that, even though research has increasingly emphasised the importance of fathers' involvement in the perinatal period, many studies nevertheless essentially focus on simply enhancing a father’s ability to support and understand a mother (e.g. May & Fletcher, 2013), therefore arguably reinforcing their subordinate role. In other cases, studies seem to uncritically promote the benefits of fathers engaging in ‘male’ forms of nurturing, such as physical or active play (particularly for boys), or activities aimed at fostering independence, risk-taking and exploration, while the importance of a mother’s calming and comforting influence is emphasised (Grossman, Grossman, Kindler, & Zimmermann, 2008; Paquette, 2004). In this way
research too can be seen to mirror and strengthen the existing male-female divide in relation to childrearing and the tensions inherent within this.

1.9 Chapter summary

To summarise, it is clear that perinatal mental health difficulties both affect and are affected by women’s families, who thus play an important role in relation to them. Yet it is not clear how well included partners and families are in women’s support and treatment and whether or not their own needs are met. Certainly, the role of women’s partners and wider families in the perinatal period as a whole appears complex. I have shown how the meanings of terms such as ‘motherhood’, ‘fatherhood’, ‘femininity’, ‘masculinity’ and ‘the family’ are not static but have shifted over time in the context of broader social changes. In the UK, it seems that women’s partners and to some extent their wider families became increasingly less involved in the perinatal period from the eighteenth century onwards, driven by factors such as industrialisation, changing ideologies of gender, and the hospitalisation of childbirth. Although more recently there has been much greater emphasis again placed on the importance of involving partners and the wider family both antenatally and postnatally, families nevertheless continue to experience considerable barriers to achieving greater inclusion. In particular, present-day fathers face struggles where they are encouraged to aspire to an emerging ideal of the ‘new father’ who is nurturing, caring and involved, but at the same time are confined by traditional masculine discourses and by social structures and practices that continue to exclude them. Appreciating this wider social historical context can help inform our
understanding of partners' and families' experiences of perinatal services, and this is the focus of the next chapter.
Chapter 2. Partner and wider family views of perinatal services: What do we know so far?

As I outlined in chapter 1, it is increasingly acknowledged that women’s partners and wider families can play a vital role in relation to women’s perinatal mental health. It is now generally recommended that they should be supported and involved in women’s support and treatment. Yet relatively little is known about how they view their involvement by services. In this chapter I therefore explore how services are experienced by women’s families. Firstly, I provide a brief overview of their experiences of perinatal services in general (i.e. maternity care). I then follow this with a systematic review and meta-synthesis examining, more specifically and in greater detail, their experiences of services offering women support for perinatal mental health difficulties.

2.1 Family involvement in maternity care

Research into maternity care suggests that the tensions I described in the previous chapter around the involvement or exclusion of women’s partners and wider families in the perinatal period as a whole are reflected in their experiences of antenatal and postnatal care and services too. Although there have been attempts over the past few decades to make maternity care more ‘family-centred’ (Tomlinson, Bryan, & Esau, 1996), it has been argued that such changes have not yet been sufficient. For instance, in relation to hospital maternity care, it has been noted that professionals and services sometimes promote the view that simply ensuring that family and friends are allowed to visit mothers at any time and in any number offers sufficient family
inclusion, when in fact much wider-ranging information sharing and collaboration is needed between families and staff (Zwelling & Phillips, 2001).

With regards to women's partners although, as described, fathers’ participation in pregnancy and childbirth has increased, hospital practices in the UK and abroad in reality continue to marginalise them (Ellberg, Högberg, & Lindh, 2010; Steen, Downe, Bamford, & Edozien, 2012). For example, a study of Quebec’s perinatal health care system found that fathers feel ignored and side-lined by professionals (Gervais, de Montigny, Lacharité, & St-Arneault, 2016). While this study comprised only a small sample of 17 couples, the fathers included noted that there were no beds for them to enable them to stay in hospital with the mother after childbirth, meals were provided only for mothers, and their interactions with care providers were limited, often directed by the mother and focused exclusively on the mother and baby. Little provision was made for any consideration of fathers' needs and services and activities often conflicted with fathers' working hours, making them feel their presence was nothing more than auxiliary. The authors argue that such factors made it difficult for fathers to express their needs as they were forced to operate within a context that served to inhibit expressions of their own feelings and more fundamentally contributed to shaping their perception of their own needs as insignificant.

Similarly, a study of Australian perinatal services concluded that fathers may be “unintentionally marginalised by perinatal health services and by the maternal focus of social practices surrounding new babies” (Fletcher, Matthey, & Marley, 2006; p.461). Research from the UK has likewise shown
that fathers feel they are seen simply as their partner’s supporter and perceive there to be a lack of support, acknowledgement or father-focused care from healthcare professionals both antenatally and postnatally (Machin, 2015; 2016). In a recent qualitative study, first-time fathers in the UK described a lack of facilities for fathers on hospital labour wards, said they struggled to get sufficient information in antenatal classes, which they experienced as being tailored towards women, and felt uncomfortable in female-dominated groups like postnatal support and mother and baby groups (Baldwin, Malone, Sandall, & Bick, 2019). Fathers in this study also reported that midwives and health visitors occasionally treated them as incompetent, inept or “a bit of a tool” (p.8).

A meta-synthesis of 23 qualitative studies of fathers’ experiences of maternity care from a range of different countries suggested fathers feel left out, like ‘bystanders’ or ‘invisible parents’, occupying an uncertain and undefined space where they are ‘not-patient’ and ‘not-visitor’ (Steen et al., 2012). Fathers from other cultural backgrounds have expressed similar views as well. For example, a study of young black fathers from the UK found that they viewed maternity services as ‘feminised’ and ‘mother centred’ and experienced a sense of being an ‘onlooker’ who did not belong (Pollock, Trew, & Jones, 2005). These fathers also described how, within their communities, it was common for there to be a high degree of involvement in childbirth and perinatal care by the mother’s wider family and friends, which could reinforce their own feelings of being side-lined.

While there has been very little research into the views of lesbian and bisexual non-birth parents, the limited research that does exist suggests they
too voice experiences of being treated as ‘lesser’ parents, finding themselves constrained by rules and regulations that deny them full involvement and struggling to access support for their own health and wellbeing, in part due to narrow perceptions of what it means to be a ‘real’ parent (Abelsohn et al., 2013).

From the perspective of healthcare professionals too, while midwives increasingly see engaging women’s partners as an essential part of their role (Rominov, Pilkington, Giallo, & Whelan, 2016), research has shown that they can also experience frustration if they feel women’s partners or other family members take time away from their interactions with the woman, given their limited time to care for women (Ellberg et al., 2010). I recently read an article in the UK national print media which reported a midwife castigating a father who said he “felt invisible” on the labour ward saying to him, “I would suggest you perhaps see that there are other things happening on busy units other than to be looking after you and your needs” (Malvern, 2019). These points raise a complex issue, as midwives have - to some extent - had to stand up to a male-dominated medical establishment, largely monopolised by male obstetricians (Cahill, 2001). In this context, their determination to retain a primary focus on women should arguably be applauded. Yet at the same time, maternity care may at times contribute to the side-lining of fathers. One UK study of midwives’ views of fathers’ involvement in antenatal screening identified tensions wherein midwives valued father inclusion but also wanted to protect women’s reproductive autonomy and need for privacy, particularly if there were concerns around domestic violence (Reed, 2009).
Even where maternity healthcare professionals have attempted to include women’s partners and relatives or offer them support, such as antenatal or postnatal classes, or depression-related treatments, they report difficulties with attendance and uptake, particularly among fathers (Matthey, Reay, & Fletcher, 2009). Men outside of the perinatal period appear similarly reluctant to access health services (Lindinger-Sternt, 2014), partly as a result of broader social norms, whereby help seeking and acceptance of support conflict with dominant ideals of masculinity, which emphasise the importance of men being self-reliant, stoic and in control of their emotions (Addis & Mahalik, 2003). Given the particular tensions outlined around new fathers and gender roles, I would speculate that such barriers to engagement might be even stronger in the perinatal period. It has been argued, for example, that the underlying maternal focus of maternity care heightens fathers’ reluctance to engage with support services during this period, which paradoxically then serves to reinforce their feelings of exclusion (Matthey et al., 2009). Other potential barriers to engagement highlighted include work constraints, increased demands on fathers’ time due to the care needs of young infants, and fear of attracting blame for not being a ‘good’ father (Matthey et al., 2009).

These findings suggest that the wider tensions faced by women’s partners and families during the perinatal period play out in their perceptions of and interactions with maternity services, where they also feel excluded and struggle to engage. But what is less well understood is how women’s partners and families experience perinatal mental health care in cases where a woman experiences a mental health difficulty during this period. What
follows therefore is an analysis of what is known so far about their experiences.

2.2 Partner and family views of perinatal mental health care:

A systematic review and meta-synthesis

In order to comprehensively explore partners’ and families’ views of services offering support for perinatal mental health difficulties, I carried out a systematic review and meta-synthesis. My aim was to explore how involved women’s partners and relatives feel in women’s care; how well they believe their own needs are, or are not, met; and what support they believe is helpful for women’s families.

A version of the meta-synthesis presented in this chapter has been published (see Appendix 1):


Given that the emphasis of the review was on exploring and understanding key themes and meanings within the context of people’s own accounts of their experiences, I considered it most appropriate to carry out a synthesis of relevant qualitative literature. Qualitative research has become more commonplace within health services research, and there is a growing recognition of the value of synthesising qualitative research to facilitate effective and appropriate care (Atkins et al., 2008). Whereas quantitative
meta-analysis typically attempts to integrate statistical findings into a standardised metric, qualitative meta-synthesis enables researchers to identify similarities, contrasts, and patterns across data in order to deepen our knowledge of a particular topic and to document a range of experiences and perspectives (Erwin, Brotherson, & Summers, 2011).

### 2.2.1 Data sources

I identified studies through searches of electronic databases from inception up to June 2017, including PsycINFO, CINAHL, Embase, HMIC, and Medline. Keywords for the search included terms characterising the relevant time period (perinatal, postnatal, pregnancy/pregnant, antenatal, postpartum, puerperal, childbirth, baby/babies, infant), population (father, partner, husband, family, parent, paternal), mental health context (mental health, depression, anxiety, psychosis, psychotic, obsessive/OCD, posttraumatic/PTSD), service use (service, care, support, intervention, unit, team, visits, help), and study design (qualitative, (in-)depth, (semi-)structured, interpretive, phenomenological, narrative, experiential, grounded, narrative, discourse). I combined these terms into a single search string. Although the indexing of qualitative research has improved, it is acknowledged that systematically identifying qualitative health research remains a challenge (Atkins et al., 2008). Therefore, to reduce the chance of important studies being missed, I supplemented database and website searches by citation tracking and expert recommendations.
2.2.2 Selection criteria

I reviewed study titles and abstracts to check for eligibility. The inclusion criteria were that studies had to (a) use a qualitative research design, (b) consist of a sample of partners and/or relatives of women who experienced a perinatal mental health difficulty, (c) report on partners’/relatives’ views of professional care received by the woman and/or her family relating to the woman’s mental health, and (d) be published in journal articles, theses, dissertations, or reports (studies reported in book chapters, conference papers, editorials, letters, or general comment papers were excluded). Studies were excluded if they (a) did not focus on the use of services for perinatal mental health, (b) did not include the views of women’s partners or relatives, or (c) were not published in English.

Only study findings relating specifically to views of services or care were included (rather than, for example, findings related to experiences of living with a woman with a perinatal mental health difficulty more broadly).

Following screening of titles and abstracts, I reviewed full texts of potentially eligible studies and included them if eligible.

2.2.3 Data extraction and analysis

Meta-synthesis aims to integrate qualitative research findings to help make sense of what a collection of studies is saying, as well as allowing new insights to be generated (Barroso & Powell-Cope, 2000; Noblit & Hare, 1988). There are currently no standardised methods for synthesising qualitative research (Centre for Reviews and Dissemination, 2009). The analytical method I used in this review was based on meta-ethnography.
(Noblit & Hare, 1988), one of the most widely used techniques of meta-synthesis (Bondas & Hall, 2007; R. Campbell et al., 2011). This method has seven key steps: (1) getting started (i.e., identifying the area of interest), (2) deciding what is relevant to the initial interest (i.e., which studies to include), (3) reading the studies, (4) determining how the studies are related, (5) translating the studies into one another, (6) synthesising translations, and (7) expressing the synthesis. I followed each step in turn, informed by the work of Britten et al. (2002) and Atkins et al. (2008) on how to carry out meta-ethnography in practice. A key part of this approach involves listing key phrases, ideas, and concepts within each study, juxtaposing them, and ‘translating’ them into one another, considering each study’s themes uniquely and holistically but also ‘in relation to’ the key metaphors and concepts in the other studies.

Having identified the area of interest and relevant studies to include (steps 1 and 2), I read and reread the selected studies (step 3) and extracted the main themes and key pieces of data from each study, along with a description of the study setting and participants, into a tabulated grid. I initially labelled data extracted as first-order constructs (i.e., the views of participants such as direct quotations) or second-order constructs (i.e., the interpretations of study authors). The aim is that third-order constructs (i.e., the interpretations of the reviewer(s)) can then be developed for the final synthesis (Schutz, 1971). However, meta-syntheses ultimately always offer interpretations of interpretations, and although some researchers do attempt to differentiate first-, second-, and third-order constructs, dividing and delineating data in this way has been critiqued (Atkins et al., 2008). This is in
part because it can be difficult to identify such distinctions in practice, but also because it arguably masks the intricate and inextricable overlaps that exist between different ‘orders’ of data, such as the influence of researchers’ own expectations, assumptions, and interpretations on first-order data, given their role in framing and posing questions and selecting and editing participants’ responses. Therefore, I decided not to separate these constructs out in the final write-up.

Following the process of reading individual studies and extracting key data and themes, I compared and contrasted the data extracted from each study (step 4) and translated them into one another, using ‘reciprocal translation’ (step 5) whereby attempts are made to link or match themes from one paper with those from another (as per Atkins et al., 2008). I then used this to build an overarching model, including key themes or categories, which could be arranged into a coherent synthesis (step 6). A second researcher (my second supervisor; JB) cross-checked a sample of the data I extracted. Any discrepancies were discussed, until we reached consensus.

**2.2.4 Process of analysis and reflexivity**

The process of analysis was inevitably complex, subjective and to an extent messy. I had to take care to retain and re-examine data that did not initially appear to ‘fit’ within the developing synthesis and to scrutinise apparent contradictions so that I didn’t lose sight of nuance or discordance between and within studies. Meta-ethnographers emphasise that this method is not about simply aggregating data but rather is about constructing a ‘whole,’ with greater explanatory power, out of separate parts (Dixon-Woods et al., 2006).
For this review though, as my purpose was to provide a preliminary outline of what has been found to date in this area, although I sought to generate new insights and to critique study findings, I approached data from a predominantly critical realist position (Isaac, 1990). In other words, I took comments from participants and authors to some extent at face value as reflective of an underlying reality, albeit one that was seen as mediated and influenced by perceptions and beliefs. I also included some aggregation of data to show the spread of themes across the included studies.

As outlined in chapter 1, qualitative researchers encourage reflexivity, acknowledging the ways in which researchers inescapably influence how data are collected and interpreted through their own personal experiences, expectations, and biases. In my case, as already noted, I am a qualified clinical psychologist and researcher specialising in perinatal mental health, with experience of working in a specialist community perinatal mental health service. Through this role, I came to feel that women's families often seem disregarded and excluded by mental health and maternity services but that, at the same time, they express ambivalence about engaging more with services. Although these experiences were arguably valuable, as I had been immersed first-hand in the relevant context, I also acknowledge that my experiences may have influenced my expectations and assumptions when approaching the meta-synthesis. For example, it could be argued that there was a risk of 'confirmation bias' whereby - while carrying out the meta-synthesis - I could have, consciously or otherwise, ended up searching for, favouring or remembering information in a way that confirmed my pre-existing beliefs. The systematic process of analysis that I went through
should have helped to guard against this to some extent. As I also outlined in chapter 1, I am a mother but have never been diagnosed with a perinatal mental health difficulty (and am not the partner of somebody who has been). It is possible that this could have resulted in me missing nuances or not fully grasping partners’ perspectives when analysing data for the meta-synthesis. I attempted to minimise the likelihood of this by interrogating the data as comprehensively as possible, and approaching it from a curious, enquiring position.

**2.2.5 Quality evaluation**

In the absence of a gold-standard appraisal tool for qualitative research (Dixon-Woods et al., 2006), I assessed the methodological quality of studies using the criteria developed by Atkins et al. (2008), themselves adapted from the Critical Appraisal Skills Programme quality assessment tool (http://www.phru.nhs.uk). I chose to use these adapted criteria because they were developed specifically for the purposes of assessing the quality of studies in a qualitative meta-synthesis. I evaluated studies on a 13-item scale, which covered issues such as whether studies included appropriate description and justification of their methods of data collection, sampling and methodological approaches, and whether there was sufficient awareness of the role of researcher in qualitative research. Total scores were out of 13. In line with Atkins et al. (2008), I did not exclude any papers on the basis of their quality scores.
2.2.6 Results

Figure 1 shows a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) diagram of the results of the search strategy. In total, I screened 1,268 articles after removing duplicates and accessed 40 full-text articles (the remainder were excluded as screening of titles and/or abstracts revealed they did not meet the eligibility criteria outlined, whereas in two cases full-text articles could not be obtained). Out of these 40 papers, I excluded 20 studies because they did not report on views of services or care for mental health (n=7), did not include the views of women’s partners or relatives (n=6), did not relate to perinatal mental health (n=4), were conference presentations (n=2), or were not published in English (n=1).
The final meta-synthesis therefore consisted of twenty eligible studies. Table 2 shows the characteristics of the included studies.

I was only able to identify two papers which included any family members other than partners in their samples. In one of these two studies (Shaikh, 2011), although family members were included along with partners, no findings were reported relating to family members’ views of services. Thus only findings relating to women’s partners could be included from this study. The other study (Boath et al., 1998) also included partners and other close family members. However, whereas the authors at times explicitly linked their findings to women’s partners, it was not clear when or if they were also
reporting the views of wider family members. Therefore family members’
views of services (as opposed to those of partners) could not reliably be
ascertained from this study either. I made further checks to ensure that I had
not missed any other studies which included the views of women’s wider
families. Thus, the meta-synthesis ultimately focused exclusively on partners’
experiences of perinatal mental health care.

The total number of participants across the studies was 233 (sample sizes for
individual studies ranged from 4 to 40). All studies focused on postnatal
rather than antenatal mental health difficulties, with most (n=12) focusing
specifically on postnatal depression. Of the remainder, one study focused on
anxiety and depression, four on partners of women admitted with an acute
perinatal mental health difficulty to a specialist MBU, two specifically on
partners of women admitted with postpartum psychosis to a general
psychiatric ward or MBU, and one on partners of women with any kind of
postnatal psychiatric difficulty. Nineteen of the 20 studies exclusively focused
on male partners, with the majority (n=15) explicitly stating that the partner
was also the infant’s father (although precise definitions of father or partner
were frequently vague or variable). The remaining study included one same-
sex partner, along with three male partners. The studies covered a wide
range of services supporting women with perinatal mental health difficulties,
and originated from seven different countries. Most studies relied on
individual interviews with participants (n=17), whereas one study used online
narratives, one used focus groups, and one used a questionnaire. Where
analytic strategies were reported, these included thematic analysis, grounded
theory, phenomenological analysis, and frame analysis. In terms of quality, study ratings ranged from 2 to 13 (median score=10 out of 13).

2.2.6.1 Key themes

Through the synthesis, I organised the data into six overarching themes: (1) the marginalisation and neglect of partners; (2) an unmet need for information; (3) partners’ ambivalence about support and involvement; (4) practical barriers to involvement; (5) mixed views on appropriate support for partners; and (6) partners’ relief when women accessed support. Coverage of the six themes identified across the included studies is outlined in table 3.

Taken as a whole, the studies painted a picture of women’s partners feeling excluded and under-informed by services and healthcare professionals. At the same time, they struggled to identify or meet their own needs, within a context in which attitudes towards masculinity and fatherhood, coupled with a predominantly mother-baby-orientated environment, served to reinforce the perception that their own needs were insignificant. Although the included studies varied in location and to some extent time, coverage of the themes identified appeared consistent across year and location.

Marginalisation and neglect of women’s partners

A key theme generated through the synthesis related to the exclusion, marginalisation, or neglect of women’s partners by healthcare professionals supporting women’s perinatal mental health. The great majority of studies reviewed (n=18) alluded to this in some respect, and interpretation of the studies overall gave the impression of women’s partners being required to navigate a largely mother-baby-oriented environment. In one study, the
authors reported that the partners they interviewed did not appear to feel marginalised (Murphy, 2014). But even here, when I inspected the data more closely, I found examples of participants reporting that they had been unclear what support was available from professionals to meet their own needs. Most studies, however, included clear, explicit examples of partners saying they felt side-lined and disregarded.

You know, I was never included. I mean, it was like, like I wasn’t part of it. She told me that her OB/GYN said it was that [postnatal depression], but I didn’t know what that meant for her. Well, for us really. That didn’t feel good at all. (Allen, 2010; p.57)

Even when partners attended appointments with women, they commented that professionals did not always ask their opinion, listen to what they had to say, or include them.

The issue is about how the doctor spoke to [my wife] and really didn’t include me in the conversation. (Letourneau et al., 2011; p.45)

When I just went there [to the public health nurse supporting my wife with postnatal depression], they looked a bit like, what’s he doing here, but I just went even though they didn’t talk to me but just to the wife. (Tammentie, Paavilainen, Tarkka, & Åstedt-Kurki, 2009; p.720)

This perceived exclusion left partners feeling unappreciated and that their own needs were overlooked or dismissed. There was a sense that “all treatments are geared towards mothers - fathers are affected too” (Boath et
al., 1998; p.201). Partners argued that perinatal mental health difficulties should be seen as “a family affair” (Kemp, 2011; p.175), but they felt that professionals failed to ask about the impact on them of having a baby or of the woman’s difficulties, and said support was rarely extended to them.

It is mother-child, not mother-father or family. All the emphasis is on the woman. If the spouse doesn’t know what to do to encourage her, to help her, it will be much more difficult. The father, he’s an important person because he is the one accompanying, he is the one encouraging, he sees the tears, and he does everything...

There is nothing for men. (Feeley, Bell, Hayton, Zelkowitz, & Carrier, 2016; p.124)

Partners would have valued being asked by healthcare professionals about their own difficulties but said that this rarely happened. Although many partners reported struggling themselves after the birth of their baby and/or because of the woman’s difficulties, they found it difficult to ask for help.

When my wife first met the doctor they should have set up a separate appointment for me to say this could be affecting you. We would like to see you for half an hour. I am sure someone could have asked me questions and figured out that I was struggling and needed support. I guess I could have gone on my own, but I was too proud to ask. (Doucet et al., 2012; p.242)

Where women were admitted to MBUs, their partners also reported feeling left out of the process or unsupported and wanted to be better included. Although some partners did comment that visiting times were flexible and
that they had been offered emotional support or counselling, all five of the studies which referred to experiences of MBUs revealed difficulties with the inclusion and support of partners.

It kind of feels like, you know [my partner] is the patient so we don’t really care about you sort of thing. But in as much as she is the patient they should realise she has got a partner, that’s her husband, he is father of the baby, and whatever it is you are doing, you need to get him involved basically. (Marrs, Cossar, & Wroblewska, 2014; p.350)

In these studies, it was notable that partners also described unique problems with feeling excluded, related specifically to the MBU or inpatient setting. In particular, they feared they might be perceived to have abandoned their family (Boddy, Gordon, MacCallum, & McGinness, 2017) and said that the woman’s admission left them feeling somewhat relegated from their role as father - like a “temporary father” (Reid, Wieck, Matrunola, & Wittkowski, 2017; p.923) or a “fleeting figure” (Marrs et al., 2014; p.345) - as they no longer felt as central to looking after the mother or baby. They also found they struggled to “fit in” on the MBU.

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. (Kemp, 2011; p.68)

An unmet need for information

A second, related theme centred on a lack of relevant information for partners. References to this were also apparent in the great majority of
studies reviewed (n=18). Partners said they wanted to help and offer support to women but did not know how and “had no idea how to get help” (Engqvist & Nilsson, 2011; p.141). They described a lack of awareness and understanding about perinatal mental health on their part, with some saying they had found it difficult to identify the mental health difficulties. They wanted more information about perinatal mental health problems (e.g. the signs, symptoms and prognosis), the woman’s treatment plan, medication, how to cope with her difficulties, how best to support her, and where they could turn for help themselves.

I needed advice on how to handle the illness and what to say. Also, information on the early signs of relapse to watch for and if it was to the point that I needed to get help. (Doucet et al., 2012; p.241)

Partners also wanted more information about topics such as women’s physical recovery after childbirth, life with a newborn, infant development, and parenting. Many commented that antenatal classes had left them feeling unprepared for what happened and did not cover perinatal mental health or available support in any detail.

Fathers emphasised that they wanted information from a male perspective, designed specifically for fathers. They requested that this information should focus on fathers’ needs and emotions, common concerns fathers may have, acknowledgement of the father’s role, and where to find resources for fathers to access help.
Women may get those brochures and whatnot but not for the dads. Maybe if some of that says, for the dad. I think if you want to reach the dad, then it has to be for the dads. (Allen, 2010; p.61)

The importance of providing information not only to partners but also to extended family members was also noted in one study.

Extended family should be afforded some educational sessions on what’s going on...they would like to help but if they don't understand what is going on, what's the point? (Letourneau et al., 2012; p.77)

Whereas some partners had sought out information from leaflets or online, many relied on healthcare professionals to provide them with information. Issues around confidentiality could sometimes make this difficult (Boddy et al., 2017), but partners also wanted healthcare professionals to be better informed about perinatal mental health, to be more proactive about communicating relevant information, and to make greater efforts to help women and their families negotiate access to suitable resources and support.

I cannot overstress the importance of the family physician knowing what the hell he’s doing. If you don’t have that, unfortunately they are the gatekeepers of the healthcare system. If they don’t understand we’re not getting anywhere. (Letourneau et al., 2012; p.76)

I called five psychiatrists in the community before we found one. It was hard finding the appropriate support. We could have been given contact information when leaving the [psychiatric] hospital.
And even then, have them set it up. Take some pressure off us.

(Doucet et al., 2012; p.243)

**Partners’ ambivalence about more involvement and support**

Although partners reported feeling under-informed and neglected, there was at the same time a somewhat competing theme related to their own ambivalence about being better included and attended to.

For example, a majority of the studies reviewed (n=14) also depicted partners themselves as struggling to identify their own needs, minimising their own desires, prioritising the woman, or expressing a reluctance to ask for or accept help or involvement themselves. Study authors commented that, when asked to identify issues related to their own support needs, partners “often required a great deal of probing from the interviewer to access this information” (Doucet et al., 2012; p.241) and “had difficulty expressing or capturing their needs when probed” (Murphy, 2014; p.101).

I think the main priority, I think, is to take care of the mother first because she’s the one home with the kids and they are the main priority too. As far as the fathers, well you know, it’s just as long as they are given at least acknowledgment. (Allen, 2010; p.63)

The mother-baby-oriented context of care reinforced this. It was notable that, at times, study authors also appeared unquestioningly to conform to and support the view that women were the priority, stating for example, “the [mother and baby] unit is designed as a service for the mother and baby; they are therefore the priority” (Marrs et al., 2014; p.350).
Some partners also attributed their reluctance to reach out for support to pride, shame, not wanting to take attention away from women, and a belief that they “had to be strong” (Doucet et al., 2012; p.241). Such issues appeared to be connected to underlying notions of fatherhood and masculinity.

I guess looking back now I think I could have used some support, somebody to talk to. Perhaps, like it’s a kind of a guy thing - I’m not going to really seek it out. (Letourneau et al., 2011; p.45)

One study was unique in including a significant focus on culture, noting how perceived cultural differences could lead partners to experience anxiety about having greater involvement themselves with professionals (Kemp, 2011). In this study, a father from a Black African background, for example, believed that his reluctance to help feed his baby (which was regarded as an ‘abomination’ in his culture) was judged negatively by professionals. This had made him reluctant to be involved with them. In other studies, partners from mainstream cultural backgrounds also expressed reservations about seeking help or agreeing to have greater involvement with services for fear that professionals would criticise them or their approach to parenting.

I would be worried I would be going into it with some really radical feminist or someone who is like assuming that, that I am just like a chauvinistic, uninvolved father. (Allen, 2010; p.64)

**Practical barriers to greater involvement**

In 10 of the studies reviewed, it was also highlighted that practical difficulties could present a barrier to partners being involved or accessing support,
particularly where the woman’s care was not local. Partners frequently found themselves juggling new responsibilities when a woman encountered difficulties (e.g. extra parenting responsibilities or a need to help more round the house), and they struggled to fit these around their existing commitments. They reported that it could be difficult to travel or fit appointments around work and said they lacked the time or energy to become more involved in the woman’s care, seek out support themselves, or explore available resources.

I had a lot of responsibility but I think because so much was going on I didn’t have the energy to seek out one person to find out more about this. (Letourneau et al., 2011; p.45)

**Mixed views on appropriate support for partners**

Mirroring partners’ ambivalence around wanting more involvement or support, there was also considerable divergence and discrepancy apparent between and even within studies about what support partners felt would be helpful for them. For example, the authors of several studies concluded from their findings that support groups and/or mentoring by peers would be valuable for partners, to provide them with social and emotional support as well as the opportunity to share practical tips with others. However, in other cases, authors described how partners expressed considerable anxiety about the idea of meeting similar others and, in particular, about attending support groups.

I don’t think [a support group] would work because, I think, I wouldn’t feel comfortable in a group situation where I didn’t know the other people intimately, not intimately but enough to be able to
cry and talk in front of them. (Everingham, Heading, & Connor, 2006; p.1754)

Some partners had attended support groups and found the experience uncomfortable.

I did attend a couple times, but the group was so big that I found it wasn’t really intimate. It wasn’t a place where I felt super comfortable opening up. (Letourneau et al., 2012; p.75)

But, in other cases, male partners had engaged successfully with (peer) support groups and spoke highly of them, even if initially they had been reluctant to participate.

Remember when you first mentioned the idea of a men's group, and I said, you know, “What are we going to do? All sit down and talk about our feelings and **** like that?”…the actual coming and acknowledging it with the other guys…it seemed to me that we, in this group, had an understanding anyway. (Davey et al., 2006; p.215)

In a few cases, partners reported wanting ‘a listening ear’ or ‘someone to talk to’. But in other cases, they said that really they just wanted greater acknowledgement and understanding from healthcare professionals of their own role and struggles – as well as more practical support, such as help with childcare to provide them with respite.

I guess just take the father into consideration and make it seem like you can see, I mean everything falls on top of him. (Allen, 2010; p.63)
Rest. Just rest. Breaks. Breaks would have been ideal. Counselling is great. Medication is great. But nothing actually beats relaxing, resting, and not like an hour. That’s enough time to do your laundry that you haven’t done in six months. Rest. That would have been very helpful. (Murphy, 2014; p.85)

Where emotional support or counselling had been offered and taken up, this was generally positively received. However, one study reported that professional interventions had at times increased partners’ distress and feelings of failure (Everingham et al., 2006), although it was unclear what exactly such interventions involved.

Partners also varied with regards to the format in which they preferred emotional support to be offered to them. For example, in some cases, the idea of support for partners offered separately to women was preferred over accessing support jointly (Everingham et al., 2006; Letourneau et al., 2012) – but in another study the potential benefits of couple’s counselling were emphasised (Muchena, 2007). Some partners said they wanted professional support for partners to be face-to-face (in a local setting or in their home), while others appreciated the greater anonymity afforded by telephone or online support (Letourneau et al., 2012). Online support was seen as particularly useful for providing information about symptoms of perinatal mental health difficulties, tips on coping, and links to local and national resources or even chat rooms or forums.

Overall, it was notable that many partners said they primarily relied on - or preferred - emotional and practical support to come from close friends and family rather than from professionals. The involvement of friends and family,
although at times overwhelming, was described as a “godsend,” a “blessing,” and a “turning point” (Murphy, 2014; p.83), with one partner even going as far as to say “I probably wouldn't be sitting here today if it wasn't for my mother in law” (Marrs et al., 2014; p.346). Nevertheless, some partners did feel that one-to-one professional support was preferable, as they said professionals could be more objective than friends or family members and could provide greater expertise and reassurance.

The psychologist eased my mind, because it gave me a place to go, a place to talk. It's different when you are talking to someone like that, rather than to your family. They give you the confidence to believe that things are going to get better. (Doucet et al., 2012; p.242)

**Relief when women access support**

Few of the studies focused in any detail on partners’ views of women’s support itself. Three studies reported that partners could be reluctant for women to seek support, preferring to keep the difficulties within the family, as a result of stigma around mental health within their cultures or communities or because of previous negative experiences with professionals. However, in most studies partners emphasised that, above all, they wanted professionals to help the woman get better (e.g. Letourneau et al., 2012). In 10 studies, partners described experiencing considerable relief themselves once they felt the woman was receiving appropriate treatment, for example, where she had been admitted to hospital or where she had been given a clear diagnosis.
When she and the baby were admitted, I was able to relax a bit. (Reid et al., 2017; p.926)

I was scared that the baby would be disabled by the effect of medication, but I felt relieved when I heard that the doctor agreed to have her take medicine for symptoms. (Mizukoshi, Ikeda, & Kamibeppu, 2016; p.45)

Partners of women admitted to MBUs in particular described the positive effects on them of being able to ‘recharge’ while the mother and baby were looked after by the MBU (Boddy et al., 2017). They also valued having time alone with their partner while MBU staff cared for their baby (Marrs et al., 2014).

Partners would have liked professionals to be more proactive in helping women access support sooner, for example, following up with them after childbirth and responding to signs of potential difficulties (Murphy, 2014). They described experiencing stress when they felt healthcare professionals were incompetent or disorganised, provided inconsistent advice, and failed to respond appropriately and flexibly to women’s needs or where there were delayed responses from services.

2.2.7 Summary of findings

In this meta-synthesis, I explored what is known so far about views of perinatal mental health care among the partners of women who experience a perinatal mental health difficulty. I was not able to include family members other than partners in the meta-synthesis owing to an absence of research
studies including their views of care. I organised the data across the twenty qualitative studies that I reviewed into six key themes.

Overall, the findings showed that women’s partners struggle when a woman experiences a perinatal mental health difficulty and experience relief when women access support. At the same time, they feel marginalised by services and professionals. Partners said that professionals did not always listen to what they had to say or include them in appointments and did not provide them with adequate information (e.g. about perinatal mental health, available support, how best to support women, or where to turn for help themselves). Partners described being confronted by a largely mother-baby-oriented environment in which their own needs were neglected. These findings reinforce the results of previous research, outlined in chapter 1, in which women with perinatal mental health difficulties reported that information for their partners was inadequate (Hogg, 2013; Megnin-Viggars et al., 2015).

The findings suggest that partners’ feelings of being excluded from maternity care (Abelsohn et al., 2013; Baldwin et al., 2019; Fletcher et al., 2006; Gervais et al., 2016; Steen et al., 2012) extend to perinatal mental health care too.

Nevertheless, it was also apparent from the findings that women’s partners had difficulty identifying their own needs and accepting more involvement or support themselves. Although practical challenges with fitting appointments around other commitments (e.g. work and childcare responsibilities) and a lack of time and energy were influential barriers to increasing partners’ engagement, their reluctance to reach out for support for their own struggles also appeared to relate to attitudes towards masculinity and fatherhood. Male
partners believed that they had to 'stay strong' and should not deflect attention from women. They also had concerns that they might be judged by professionals to be inadequate if they accessed support themselves. The mother-baby-oriented context in which they found themselves appeared to reinforce their views of their own needs as insignificant.

Connected to this, partners also struggled to articulate their needs and expressed mixed views about the type of support they believed they might find helpful. For example, some studies found that partners were reluctant to attend peer support groups, while other studies recommended peer support based on their findings. Where partners had taken part in peer support groups, they sometimes spoke well of them even if they had initially been wary of participating. But this was not always the case, as other partners found the experience uncomfortable. Study authors did not always acknowledge that partners who accessed such groups may have differed in important ways from others who may not have been willing to do so. Mixed views were also expressed about whether partners wanted support separately from women or jointly, and whether they preferred support to be face-to-face, via telephone or online.

It seems plausible that the exclusion of partners identified in this meta-synthesis may be connected to the pervasive social attitudes towards fatherhood and child development that I described in chapter 1, which I argued contribute to fathers being relegated to a position of secondary importance in the perinatal period. The meta-synthesis findings suggest that services supporting women with perinatal mental health difficulties may reflect and reinforce these wider attitudes - for example, where MBUs,
through their focus on the mother and baby, reinforce the secondary status of
the father, or where professionals treat partners as peripheral by not
including them in appointments or enquiring about their own needs. The
finding that women’s partners struggle to identify their own needs and seek
help for themselves also appears to correspond with the research described
in chapter 1 showing how traditional masculine role models and norms
emphasise male self-reliance and emotional control (Addis & Mahalik, 2003),
making it more difficult for fathers - and men more broadly - to ask for help
(Lindinger-Sternart, 2014; Machin, 2015). I revisit these points and explore
them in more detail in chapter 6.

2.2.8 Limitations

While this meta-synthesis is the first of its kind to comprehensively review
partners’ views of perinatal mental health care, it is important to note that it -
and the studies it included - had a number of limitations.

**Conceptual limitations of the included studies**

Firstly, the great majority of the included studies focused on partners of
women who experienced postnatal depression. Examples where women
experienced other difficulties, such as anxiety or psychosis, were rarely
considered, and no studies at all focused on antenatal mental health
difficulties. It may be that women’s partners’ experiences vary depending on
the type of difficulty, especially given that recognition of difficulties and
treatment efficacy may vary depending on the condition and its presentation.
Yet this has not been explored from the perspective of women’s partners or
family members. Future research should therefore include a wider range of difficulties along with postnatal depression.

Secondly, in many cases, it was unclear in the studies included to which professionals or services partners were referring. This made it difficult at times to determine whether particular services involved or supported partners more or less effectively than others (e.g. specialist perinatal mental health services versus general non-perinatal mental health services). This difficulty was further exacerbated by the fact that the great majority of the included studies focused principally on the impact of a woman’s difficulties on her partner’s own well-being, rather than focusing on partners’ views of services and support. Therefore, in some cases, partners’ views of perinatal mental health services formed only a very minor part of the overall study and were not discussed at length. Given the importance of women’s families in encouraging and supporting women to seek and engage with help, it would be valuable for future research to focus more extensively on their experiences of services, and in doing so to explicitly consider and define which services women and their families accessed.

**Methodological limitations of the included studies**

As outlined, most studies received moderate- to high-quality scores. However, authors of published meta-syntheses are split as to whether meta-synthesis should include quality assessment at all, with some criticising it for imposing an essentially ‘positivist’ model on qualitative data (Atkins et al., 2008). Furthermore, as Atkins et al. (2008) also observed, I found that the quality appraisals chiefly reflected the quality of the written reports, rather
than the quality of the research procedures themselves, and thus were arguably of somewhat limited value. For example, studies with lower quality ratings often failed to justify their use of a qualitative approach or did not reflect on the role of the researcher.

On top of this, I judged a number of studies to have sampling limitations because they included partners of women who had experienced perinatal mental health difficulties at least ten years previously. This not only raises questions about the accuracy of recall in such instances but also means that some participants may have been referring to services long outdated or that had since been significantly altered or transformed. Further research is therefore needed to consider views of current service provision.

It was also notable that sample sizes were often very small, with few attempts made to achieve diverse spreads of participants from a range of socio-demographic or cultural backgrounds. Although qualitative research does not necessarily aim to be representative, these small samples make it difficult to generalise the findings to the wider population of partners or to examine how findings may vary for more marginalised or socially excluded groups. Consequently, future research should include larger samples of partners and should make efforts to include greater demographic diversity.

**Limitations of the meta-synthesis**

This meta-synthesis was ultimately constrained to the views of women’s partners (primarily male partners) as no research studies were found that included views of care among women’s wider family members. Even so, it was clear from the findings as well as from the wider literature, that extended
family members are often vital players within women’s support networks too. So far, however, the views of extended family members remain unheard. These should be explored. Furthermore, little attention has been given to the complexities of women’s social networks, the influence of ‘non-traditional’ family set-ups - such as non-resident fathers, non-biological fathers, or same-gender partners - and the variations in roles that different family members may play. Future research should therefore focus on their voices too.

Finally, in seeking to offer a broad but concise overview of relevant findings, this meta-synthesis adhered to a predominantly critical realist position, taking participants’ and authors’ accounts in some respects at face value. Studies were also aggregated to report the number referencing particular themes and arguably thus focused on emphasising commonalities across studies. Although efforts were also made to highlight discrepancies, contrasts, and nuances and to interpret and critique study findings, such an approach, with its emphasis on providing a broad overview of data, has been met with suspicion by some researchers, who argue that it risks undermining the integrity of individual studies, can “thin out the desired thickness of particulars” and may offer a kind of averaging process, rather than adding interpretive understanding (Sandelowski, Docherty, & Emden, 1997; p.336). The process of analysis inevitably resulted in subjective choices being made about how best to present the findings in a coherent analysis. As a result, it is recommended that readers not only consider the findings of this synthesis but also interrogate the original research papers themselves to ensure original subtleties are not lost.
2.2.9 Conclusion

To conclude, while this systematic review and meta-synthesis revealed some key themes around partners’ experiences of perinatal mental health care - in particular, relating to their feelings of exclusion - the studies included had important limitations. In particular, many only touched briefly on partners’ experiences of services, as part of a wider remit, and it was not always clear to which services or professionals the findings referred. Additionally, no studies were found that investigated views of services among family members other than partners. Given the increasing recognition that services treating perinatal mental health difficulties need to “think family” (Hogg, 2013; p.37), further research into partner and family experiences is merited.

In the study that I subsequently carried out, which I describe in the ensuing chapters of this thesis, I sought to build and expand on the research studies analysed for the meta-synthesis and also to address some of the key limitations identified. My principal aim was to explore experiences of how services supporting women diagnosed with perinatal mental health problems work with their families - and family members’ impact on women’s interactions with services.
### Table 2. Characteristics of studies included in meta-synthesis (n=20)

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Sample size</th>
<th>Population studied</th>
<th>Study country</th>
<th>Primary aims</th>
<th>Data collection</th>
<th>Analysis</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen, 2010</td>
<td>8</td>
<td>Fathers who were partners of women diagnosed with PND*</td>
<td>United States</td>
<td>To explore fathers’ views where their partner experienced PND, exploring their needs and what was helpful in getting them through that period</td>
<td>Unstructured interviews (face-to-face; some questions given to participants prior to interview to reflect on)</td>
<td>Phenomenological analysis</td>
<td>12</td>
</tr>
<tr>
<td>Boath et al., 1998</td>
<td>23</td>
<td>Partners of women participating in a study on PND. <em>Close family members also participated in this study but their views of care were not made explicit, so they were excluded from my analysis</em></td>
<td>UK</td>
<td>To explore the impact of PND on partners and other family members</td>
<td>Questionnaire</td>
<td>Not stated</td>
<td>2</td>
</tr>
<tr>
<td>Boddy et al., 2017</td>
<td>7</td>
<td>Fathers who were partners of women admitted to one of two MBUs</td>
<td>UK</td>
<td>To explore the experiences of men during their partner’s admission to an MBU for first episode postpartum psychosis</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Interpretative Phenomenological Analysis</td>
<td>11</td>
</tr>
<tr>
<td>Davey et al., 2006</td>
<td>13</td>
<td>Male partners of women diagnosed with PND. All men had completed a psychoeducation/CBT treatment intervention for partners</td>
<td>Western Australia</td>
<td>To explore partners’ experiences of PND and of participation in a 6-week group treatment program designed for male partners</td>
<td>Focus groups and written feedback</td>
<td>Phenomenological analysis</td>
<td>6</td>
</tr>
<tr>
<td>Doucet et al., 2012</td>
<td>8</td>
<td>Fathers who were male partners of mothers diagnosed with postpartum psychosis and admitted to general psychiatric units</td>
<td>United States/Canada</td>
<td>To explore the perceived support needs and preferences of women with postpartum psychosis and their partners</td>
<td>Semi-structured interviews (telephone or face-to-face)</td>
<td>Inductive thematic analysis</td>
<td>10</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Sample size</td>
<td>Population studied</td>
<td>Study country</td>
<td>Primary aims</td>
<td>Data collection</td>
<td>Analysis</td>
<td>Quality rating</td>
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<tr>
<td>Engqvist &amp; Nilsson, 2011</td>
<td>11</td>
<td>Male partners of a woman with a postnatal psychiatric illness</td>
<td>Sweden</td>
<td>To explore men’s experiences of their partners’ postpartum psychiatric disorders</td>
<td>Online narratives</td>
<td>Not stated</td>
<td>8</td>
</tr>
<tr>
<td>Everingham et al., 2006</td>
<td>6</td>
<td>Fathers whose partner had signs of mild-moderate PND</td>
<td>Australia</td>
<td>To explore how couples talk about mothers’ experiences of mild to moderate PND</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Frame analysis</td>
<td>9</td>
</tr>
<tr>
<td>Feeley et al., 2016</td>
<td>30</td>
<td>Male partners of women with PND</td>
<td>Canada</td>
<td>To compare the preferences of couples who accept a mental health assessment and those who do not.</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Thematic analysis**</td>
<td>9</td>
</tr>
<tr>
<td>Kemp, 2011</td>
<td>6</td>
<td>Fathers whose partner had an admission to an MBU</td>
<td>UK</td>
<td>To explore fathers’ experiences of a mother's admission to an MBU</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Interpretative Phenomenological Analysis</td>
<td>13</td>
</tr>
<tr>
<td>Letourneau et al., 2011</td>
<td>11</td>
<td>Fathers who were partners of women who experienced PND</td>
<td>Canada</td>
<td>To describe the experiences, support needs, resources, and barriers to support for fathers whose partners had experienced PND</td>
<td>Semi-structured interviews (telephone)</td>
<td>Thematic analysis</td>
<td>10</td>
</tr>
<tr>
<td>Letourneau et al., 2012</td>
<td>40</td>
<td>Fathers who were partners of women who experienced PND</td>
<td>Canada</td>
<td>To describe the support needs and preferences for fathers whose partners have had PND</td>
<td>Semi-structured interviews (telephone)</td>
<td>Thematic analysis</td>
<td>10</td>
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<td>Marrs et al., 2014</td>
<td>8</td>
<td>Fathers whose partners were admitted to one of two MBUs</td>
<td>UK (Scotland)</td>
<td>To investigate what impact a mother and baby’s admission to an MBU had on the father’s role and relationship with his family</td>
<td>Semi-structured interviews (not stated if face-to-face)</td>
<td>Grounded theory</td>
<td>12</td>
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<td>Author(s)</td>
<td>Sample size</td>
<td>Population studied</td>
<td>Study country</td>
<td>Primary aims</td>
<td>Data collection</td>
<td>Analysis</td>
<td>Quality rating</td>
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<td>Meighan et al., 1999</td>
<td>8</td>
<td>Fathers who were partners of women with PND</td>
<td>United States</td>
<td>To help understand PND and its impact on the family through the experiences of fathers whose spouses suffered from it</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Existential phenomenology</td>
<td>10</td>
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<tr>
<td>Mizukoshi et al., 2016</td>
<td>7</td>
<td>Fathers whose partners had anxiety or depression diagnosed in their medical records</td>
<td>Japan</td>
<td>To explore the experiences of husbands of women with depressive or anxiety disorders</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Constant comparative method</td>
<td>11</td>
</tr>
<tr>
<td>Muchena, 2007</td>
<td>8</td>
<td>Fathers whose partners were admitted to an MBU with puerperal psychosis or PND</td>
<td>UK</td>
<td>To investigate men’s subjective experiences when their partners are admitted to hospital with postnatal mental illness and offer insight into men’s needs</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Thematic analysis</td>
<td>10</td>
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<tr>
<td>Murphy, 2014</td>
<td>6</td>
<td>First-time fathers with a female partner who experienced PND</td>
<td>United States</td>
<td>To explore the experience of fathers whose partners experienced PND to inform father-inclusive prevention/intervention</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Interpretative Phenomenological Analysis</td>
<td>12</td>
</tr>
<tr>
<td>Reid et al., 2016</td>
<td>17</td>
<td>Fathers whose partners were admitted to an MBU</td>
<td>UK</td>
<td>To understand how a woman’s mental illness affects her family, and to explore how fathers view MBUs and children and family services</td>
<td>Semi-structured interviews (face-to-face or telephone)</td>
<td>Inductive thematic analysis</td>
<td>12</td>
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<tr>
<td>Roehrich, 2007</td>
<td>7</td>
<td>First time fathers whose partners experienced PND</td>
<td>United States</td>
<td>To identify the perspectives of men whose spouses or partners were diagnosed with PND</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Open coding and thematic analysis</td>
<td>12</td>
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<tr>
<td>Author(s)</td>
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<tr>
<td>Shaikh, 2011</td>
<td>4</td>
<td>Partners of women with PND (the study included 3 male partners, 1 same sex partner). This study also included 4 grandmothers, but their views of care were not explored so I excluded them from my analysis.</td>
<td>Canada</td>
<td>To explore resilience among women who experienced PND and their partners.</td>
<td>Semi-structured interviews (face-to-face)</td>
<td>Thematic analysis within hermeneutic phenomenological approach</td>
<td>13</td>
</tr>
<tr>
<td>Tammentie et al., 2009</td>
<td>5</td>
<td>Fathers whose partner had displayed symptoms of PND</td>
<td>Finland</td>
<td>To explore families’ experiences of interaction with the public health nurse at the child health clinic in connection with a mother’s PND</td>
<td>Unstructured interviews (no predetermined interview themes). Men were interviewed together with their partner.</td>
<td>Grounded theory</td>
<td>7</td>
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</table>

*PND=postnatal depression

**This study describes itself as using ‘content analysis’ but in fact appears to have used thematic analysis.
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Theme 1: marginalisation and neglect of women’s partners</th>
<th>Theme 2: unmet need for information</th>
<th>Theme 3: partners’ ambivalence about more involvement or support</th>
<th>Theme 4: mixed views on appropriate support for partners</th>
<th>Theme 5: practical barriers to involvement</th>
<th>Theme 6: partners’ relief when women accessed support</th>
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</thead>
<tbody>
<tr>
<td>Allen, 2010</td>
<td>Partners reported feeling left out of the process and wanted to be included. They also did not feel services were extended to them.</td>
<td>Partners requested information from a male perspective better explaining PND as well as how, as the partner, they could help and where they could go for help.</td>
<td>Partners talked about difficulties for men opening up, and feared professionals judging them negatively. Some saw the mother as the priority. Some partners also felt anxious about the woman accessing support feeling that problems should remain ‘within the family’.</td>
<td>Partners wanted professionals to understand their struggles as a partner, acknowledge them, and not judge them.</td>
<td>Partners said they had difficulty finding time to seek help or resources.</td>
<td>Once the mother had a diagnosis partners said this helped them cope better with her symptoms.</td>
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<tr>
<td>Boath et al, 1998</td>
<td>Partners felt all help was geared to mothers, with no acknowledgement that partners are affected and need help too.</td>
<td>There were comments from partners that they wanted to help the mother but did not know how.</td>
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<tr>
<td>Boddy et al, 2017</td>
<td>Partners commonly reported not feeling heard/valued by professionals and anger at a lack of involvement in decisions. Partners feared the woman’s admission might mean they were seen as abandoning their family and found it hard to establish family identity during admission.</td>
<td>Partners felt they were denied information due to patient confidentiality and sometimes as a result of oversight by staff. They felt healthcare professionals had limited knowledge of postpartum psychosis.</td>
<td>The authors noted that partners were sometimes uncomfortable about questioning professionals.</td>
<td>Partners were grateful for help from family and friends. They also found it beneficial when they could develop their own understanding of mental health.</td>
<td>There were difficulties due to large distances to the hospital.</td>
<td>MBU admission was described as a welcome relief with expertise from staff. Partners reported feeling they had reached their personal coping limits and it gave them a chance to ‘recharge’.</td>
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<td>Davey et al, 2006</td>
<td>Partners noted lack of organised support for men and limited avenues for them to seek help.</td>
<td>Partners reported that improved awareness of PND and its impact on families was needed. They wanted more factual information about PND. They wanted antenatal care to include a focus on PND.</td>
<td>Men reported wanting to keep up the appearance that 'everything is fine' and talked about embarrassment about seeking help.</td>
<td>Partners engaged well in a peer support group and reported valuing it highly, although they needed ‘coaxing’ initially to attend.</td>
<td>Authors note after-hours support is necessary to help include men.</td>
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<tr>
<td>Doucet et al, 2012</td>
<td>Partners felt professionals excluded them, did not listen to what they had to say and did not take their opinions seriously. Partners weren’t offered any professional support and some wanted professionals to be more proactive about inquiring about their needs.</td>
<td>Partners wanted information on the woman’s health status, treatment plan and long-term prognosis, as well as how best to handle her difficulties. They also wanted information about available community support after discharge from a psychiatric unit and help accessing it.</td>
<td>Partners struggled to identify their own needs, and also felt they had to keep their feelings to themselves and hold the family together. They wanted support but pride and privacy were barriers to asking.</td>
<td>Partners struggled with not knowing anyone in a similar position. They wanted a ‘listening ear’ and ‘emotional outlet’. Wanted reassurance they were doing the right things and their partner would recover. Wanted group peer support to provide practical pointers, and one-to-one support from a professional to talk about their feelings. Partners also wanted practical help with e.g. childcare, but preferred this to be from someone they knew. Some partners felt family support was all they needed.</td>
<td>Partners felt healthcare professionals were inflexible to individual support needs.</td>
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<td>Engqvist &amp; Nilsson, 2011</td>
<td>Authors conclude that healthcare professionals need to pay more attention to partners’ postnatal mental health and support them to support women.</td>
<td>Partners felt they got little information about postpartum mental health or where to get help. They said they received no information during antenatal care.</td>
<td>Partners reported feeling that they should be able to sort out their difficulties privately with their partners, rather than via professional support.</td>
<td>Partners’ families provided most support to them, and they said this was good enough.</td>
<td>One partner expressed relief once he knew his wife had scored highly for PND as her difficulties now had a name.</td>
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<tr>
<td>Everingham et al, 2006</td>
<td>Some partners talked about not feeling comfortable opening up in front of others.</td>
<td>One partner valued a video about PND professionals had lent him as he could watch it in privacy of his own home. The authors recommended supporting partners separately to mothers. Some fathers were uncomfortable with the idea of partner support groups. For some partners, intervention by professionals increased their distress and feelings of inadequacy.</td>
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<tr>
<td>Feeley et al, 2016 (Kemp, 2011)</td>
<td>Partners felt their needs were neglected, and the importance of their role overlooked. They wanted to be included in postpartum care.</td>
<td>Partners wanted a conversation with a professional about PND and information about how to provide support to their partners and seek help. They also wanted</td>
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<td>Kemp, 2011</td>
<td>Partners felt out of place on the MBU, marginalised and unsupported. They wanted to be ‘thought about’ by professionals and for them to treat difficulties as ‘a family affair’</td>
<td>Partners talked about not knowing who to ask to help them understand their partners’ difficulties.</td>
<td>Male social stereotypes of needing to be ‘strong’ and to ‘cope’ were seen as a barrier to taking up support. One partner felt cultural differences in childrearing left him feeling negatively judged by professionals, and said he struggled with having to take on aspects of his partners’ role (e.g. feeding the baby) as this was seen as an ‘abomination’ in his culture.</td>
<td></td>
<td></td>
<td>Relief at admission to MBU, a place to recover and restart.</td>
</tr>
<tr>
<td>Letourneau et al 2011</td>
<td>Partners spoke about being ignored by professionals, All the partners reported an information</td>
<td>Partners talked about stigma of seeking help,</td>
<td>Partners wanted someone who would listen. Friends’</td>
<td>Partners said they had a</td>
<td>Partners spoke about their relief</td>
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<td>even when they attended appointments with the mother. Nobody asked partners how they were finding the transition to parenthood.</td>
<td>gap regarding PND that contributed to lack of recognition and early detection. They reported not knowing where to look for resources.</td>
<td>they wanted support but found it hard to seek it out or share their feelings (a ‘guy thing’). They had trouble understanding their feelings.</td>
<td>insight where they had experienced something similar. Support from friends and family cited as important.</td>
<td>lack of time and energy to seek help.</td>
<td>when trained professionals took over their partners’ care (e.g. they were admitted).</td>
</tr>
<tr>
<td>Letourneau et al 2012</td>
<td>Partners felt their own mental health was minimised. They felt professionals should be better at identifying difficulties in partners, not dismissing their difficulties. Partners felt the PND literature minimised their role, and wanted more focus on how PND affects the whole family. They wanted to be involved in the diagnosis. They also wanted support for extended family.</td>
<td>Partners wanted additional information, e.g. warning signs that you might need help. They felt antenatal care did not include a focus on PND. They felt available information should feature partners more centrally.</td>
<td>Partners were sometimes uncomfortable with the idea of accessing support.</td>
<td>Partners wanted someone to talk to. Peers were valued for their first-hand knowledge of PND and new parenthood. They also wanted professionals to ‘bring their partners back’ from PND. They generally preferred to receive help separately to their partners to allow them to be open. Partners were sometimes reluctant to take part in group support - one who did felt uncomfortable opening up due to group size.</td>
<td>Partners spoke of stress when they had to travel long distances to visit their partners.</td>
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<tr>
<td>Marrs et al. 2014</td>
<td>Partners did not feel included in the woman’s care when she was admitted to an MBU. They felt ‘relegated’ and sometimes disempowered.</td>
<td>Partners felt they had to convince professionals they really did want information about what was going on. The authors also suggest specific leaflets for</td>
<td>Partners were found to sometimes restrict their own desires in a bid to help preserve the bond between the mother and baby. Some partners found it hard to approach and communicate with staff.</td>
<td>Partners valued MBU staff providing childcare to help them have time alone with their partner. Partners reported receiving most of their care from their families.</td>
<td>Partners experienced stress when they had to travel long distances to the MBU.</td>
<td>Partners felt relieved when their partner was admitted and contained by the knowledge the mother was receiving support</td>
</tr>
<tr>
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<td>Meighan et al, 1999</td>
<td>The authors recommend that partners should be included in screening, education and treatment of PND.</td>
<td>The authors conclude that written information should be provided on PND during antenatal care or at discharge from hospital including steps to take if needed and telephone numbers.</td>
<td>Partners expressed a willingness to share their experiences and offer support to others. The authors recommended a support group for partners.</td>
<td>Partners felt professionals tended to minimise the mothers’ difficulties.</td>
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<td>Mizukoshi et al, 2016</td>
<td>Partners reported that the research interview was the first opportunity they had been offered to talk to someone about their partners’ difficulties.</td>
<td>Partners reported wanting to know how to deal with the woman’s difficulties.</td>
<td>Men in the study were reluctant to seek support (6 of the 8 participants reported struggling but only 2 sought support).</td>
<td>Men also reported difficulties attending the MBU and needed services to take account of their working hours.</td>
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<tr>
<td>Muchena, 2007</td>
<td>The authors commented on a lack of resources/support for postnatal men.</td>
<td>Partners reported not knowing where to turn or how to deal with their partner’s difficulties.</td>
<td>Partners tended to use informal sources of support, such as friends or chat rooms but found these only provided temporary relief. The authors suggested couples’ counselling could also be beneficial. The authors also suggest partners wanted help with access to childcare support, support</td>
<td>Partners experienced stress as a result of delayed responses from services. They felt was relief on admission of the woman to an MBU were usually happy with the support provided, although they remained</td>
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<td>Murphy, 2014</td>
<td>In contrast to other studies, partners did not feel their needs had been minimised by professionals. Even so, participants in this study still reported that they had been unclear what support was available from professionals to meet their needs. Partners reported not knowing what information to look for or who to ask. They wanted partner-specific information, reflecting their role in the process. Partners felt there was no emphasis on PND in antenatal classes. Though they were open to help-seeking, partners struggled to identify their own needs, or what would have been helpful for them. Partners emphasised the importance of familial support. Partners would also have valued help with childcare or the offer of respite. Two partners found a postnatal parenting group helpful, as sharing their difficulties with peers normalised their experiences, provided them with information, and helped them identify their partners’ PND. Childcare issues made it hard for partners to be more involved. Partners experienced frustration when professionals were not proactive in helping women access support (e.g. not following up with them after childbirth or responding to signs of potential difficulties)</td>
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<td>Reid et al., 2017</td>
<td>The mother’s admission could make their partners feel like a ‘temporary partner’. Some partners felt visiting times were good and emotional support/counselling were offered. However, others felt disengaged from the MBU and said they were not offered support. Partners wanted more information about the woman’s mental health difficulties, medication and the MBU and wanted professionals to keep them informed. Where it was taken up, emotional support/counselling offered by the MBU were received positively. Emotional and practical support from family and friends was highly valued, though continual requests from other family members for information could be stressful. Many partners said balancing work and visiting their partner and baby was difficult. This was particularly problematic for partners with more than one child. Partners described feeling relieved when their partners were admitted and valued the MBU support. However, there were some reports of inconsistency in childcare advice between different members of staff.</td>
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<td>Roehrich, 2007</td>
<td>Partners felt professionals did not communicate with them effectively about Antenatal information was considered inadequate. Partners Shame and guilt prevented men from initially seeking support. Partners appeared receptive to the idea of mentoring or peer support Some partners felt relief once their partner had a</td>
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<td>Shaikh, 2011</td>
<td>Partners felt there was a lack of informal and formal support and resources for men.</td>
<td>Partners reported a lack of resources for how to deal with a woman’s PND.</td>
<td>While some partners encouraged women to seek help, others did not and avoided involvement themselves due to previous negative experiences with healthcare professionals.</td>
<td>to gain information and allow them to vent frustrations. Most partners received help primarily from their families.</td>
<td>Practical barriers to involvement</td>
<td>Partners spoke about reaching out primarily to their personal support networks.</td>
</tr>
<tr>
<td>Tammentie et al, 2009</td>
<td>Partners commented on an absence of ‘family-centeredness’. They said they were encouraged to attend the woman’s appointments, but when they did felt professionals spoke only the woman.</td>
<td>Being at work at times prevented partners being more involved.</td>
<td>Being at work at times prevented partners being more involved.</td>
<td>Being at work at times prevented partners being more involved.</td>
<td>Practical barriers to involvement</td>
<td>Partners spoke about reaching out primarily to their personal support networks.</td>
</tr>
</tbody>
</table>

Partners felt there was a lack of informal and formal support and resources for men. They felt ‘undeserved’ and ‘dismissed’, and believed better connection with professionals could have helped them seek help sooner. Partners felt that what was happening was ‘undeserved’ and ‘dismissed’, and believed better connection with professionals could have helped them seek help sooner.

Partners reported a lack of resources for how to deal with a woman’s PND. Leaflets were discarded through lack of time to read them.

Partners spoke about reaching out primarily to their personal support networks. However, partners reported anger and frustration when they felt professionals lacked accountability in helping families with the transition into parenthood, dismissed their concerns, and did not support women properly.
Chapter 3. Methods

3.1 Current study and research questions

As outlined in chapter 2, the systematic review and meta-synthesis I carried out had important limitations. In the present study, I therefore aimed to add to the evidence base identified through the systematic review, addressing some of the key limitations identified. The following aspects of my study ensured it expanded and improved on previous research, tackling several of the limitations highlighted. Specifically:

- The study included members of women’s wider families as well as their partners (depending on who women considered to be best-placed to give a second perspective on their support). To my knowledge this makes it the first study to include wider family members’ views of support for perinatal mental health difficulties.

- The study included women’s views along with the views of their partners or relatives. For the meta-synthesis I focused on exploring partners’ experiences in order to fill a gap in the research literature. However, for the present study, I decided to include the views of women as well. This allowed for triangulation of findings, so that the views of women and their family members could be compared and data could be analysed from different viewpoints.

- The study focused specifically on views of services and support for perinatal mental health difficulties, rather than this being only briefly covered within a wider study (e.g. about partners’ broader experiences of living with a woman with a perinatal mental health difficulty). Although the
current study did in fact also have a wider remit (see section 3.2), the topic of family inclusion by mental health services formed a key part of interviews and therefore was covered in greater detail than in many previous studies.

- Service use was recent (women were interviewed 6-9 months postnatally) helping to ensure more accurate recall than in many previous studies.
- Type of service accessed was recorded and a range of mental health services (both specialist perinatal and general non-perinatal) were included.
- The sample size was larger and more diverse than most previous studies.
- The study was set in England adding to our specific knowledge of experiences of NHS support.
- The women in the study had received support for a range of difficulties (both postnatally and antenatally), broadening the focus away from only postnatal depression.

My key research questions were:

- What are women’s experiences of the way in which services treating their perinatal mental health work with, include and support, their families?
- What are partners’ and wider family members’ experiences of the way in which services treating women for perinatal mental health difficulties work with, include and support, families?

In examining these research questions, I also sought to explore and understand the role of partners and families in relation to women’s interactions with services and perinatal mental health needs.
3.2 Study design

This study was nested within a larger project run by UCL called *Stakeholders’ views and experiences of perinatal mental health services: a qualitative study* (STACEY). The STACEY study was, in turn, part of a wider mixed-methods research programme – ESMI (Effectiveness of Services for Mothers with Mental Illness) – led by the Section for Women’s Mental Health at King’s College London. The ESMI programme was funded by the National Institute for Health Research (NIHR).

The STACEY study consisted of semi-structured interviews with women and their partners and wider family members and explored participants’ experiences of the services women had accessed for their perinatal mental health difficulties. The STACEY study also included focus groups and interviews with commissioners and with a range of clinicians to elicit their views of services supporting women with perinatal mental health difficulties too, but these were not the focus of my PhD research (in part because they did not include very much focus on women’s families).

The STACEY study used a qualitative methodology in order to allow for in-depth exploration of an area in which research evidence is limited, and where the research questions were explorative. The use of the qualitative methodology allows participants to voice their experiences and give detailed accounts of their behaviours and beliefs in context (Rubin & Rubin, 2005). It also provides the opportunity for researchers to consider the ways in which participants construct meaning from their experiences. Although qualitative studies can be difficult to generalise because of their intrinsic subjectivity, it
has been argued that qualitative research should be judged as ‘credible’ and ‘confirmable’ rather than ‘valid’ and ‘reliable’ (Merriam, 1985).

Face-to-face, semi-structured interviews were chosen as the methodology for the wider STACEY study to ensure that a nuanced understanding of participants’ experiences could be obtained (see Appendix 3 for interview schedules). What participants say in interviews will invariably be shaped by many things, including the questions asked, conventions, and what they think the interviewer wants to hear. But, at the same time, interviewing does enable participants to “speak in their own voice and express their own thoughts and feelings” (Berg, 2009; p.96), and it has particular value for “exploring the construction and negotiation of meanings in a natural setting” (Cohen, Manion, & Morrison, 2007; p.29). Whereas structured interviews are typically organised around tightly defined questions with pre-set response categories, a semi-structured format encourages interviewees to answer questions without being constrained by the pre-formulated ideas of the researcher. This provides greater opportunity for new insights to be gleaned which may not have been anticipated in advance (Berg, 2009). The researcher also has the chance to rephrase or clarify questions if needed and to probe beyond the answers provided to enhance clarity, completeness or detail (Dörnyei, 2007). At the same time, having a ‘guide’ or ‘schedule’ including broad questions and possible probes helps to ensure researchers cover all relevant topics and keep within the parameters of the key research questions (Berg, 2009).

For my PhD study, I developed and included questions in the wider STACEY study interview schedules asking women and their family members about
their experiences of how services worked with their partners and families. I then analysed responses to these questions.

3.3 My role on the STACEY study

I was employed as the main researcher for the STACEY study, supported by a wider study team of senior researchers and clinicians with whom I met regularly. In this role, I was responsible for organising and holding meetings with the wider study team, developing research materials, ensuring NHS ethical requirements were adhered to, liaising with NHS services and clinicians, recruiting women and family members to the study, interviewing women and their family members, and analysing the findings. In essence, I was responsible for running the study day-to-day. I recruited all 84 women and family members for the STACEY study and carried out 70 of the interviews myself (for details of who conducted the remaining 14 interviews, see section 3.6).

Even though I was the main researcher on the STACEY study and, as such, had considerable input into its design and setup, it is important to acknowledge that I was not involved right at the start of the project. When I joined the team - taking over from the previous researcher who left to take up a new post - the core design of the study (e.g. the decision to interview women and their family members qualitatively via semi-structured interviews) had already been agreed and ethical approval had been obtained. Therefore, the ‘seeds’ of my research idea had, in a sense, already been sown before my arrival. Even so, the main purpose of interviews with partners and family members as far as the STACEY study was concerned was to ascertain their
views of women’s care (e.g. how easily they felt women were able to access support and how helpful they perceived women’s treatment to be). It was my decision to suggest including a greater focus in interviews on their experiences of their own needs and inclusion in women’s care, as well as on exploring women’s own perspectives of family inclusion in depth.

Nonetheless, all aspects of the STACEY study did have to be agreed with the wider study team. As my PhD was nested within the STACEY study, this meant that there were inevitably some constraints around what it could include; in other words, it was necessary to balance my own research interests with those of the wider study team and - beyond that - the study funders. Most notably, interview questions about partner and family involvement in care formed just one part of a wider-ranging interview about participants’ experiences of services for perinatal mental health difficulties, limiting the time that could be spent on this topic and the questions that could be included. Interviewing a smaller sample of women and their family members in greater depth on this topic may have had benefits for my PhD. But the wider study required breadth as well as depth; it needed a wide range of topics to be covered across a large, diverse group of participants with experience of many different types of service. Therefore, my PhD ultimately drew on segments of a very large corpus of interviews. Despite these compromises, being part of a wider study team also presented me with a wealth of expertise and experience on which to draw, as well as access to an advisory panel of women and family members with lived experience of perinatal mental health care. I also found that the set-up of the study allowed me to ‘position’ myself assertively as a critical psychologist (i.e. as a
psychologist ready and willing to critique and challenge dominant assumptions and beliefs). This felt important because, while I do not consider myself to be purely a qualitative researcher - having previously carried out a range of both qualitative and quantitative research - I do believe it is vital to be able to adopt an analytical, questioning approach to mental health research and practice. A full discussion of the strengths and limitations of my study are outlined in chapter 6.

3.4 Study setting

I recruited women from services across eleven NHS healthcare providers in England. These covered a broad range of regions from inner city to more rural locations, including both deprived and more affluent areas. In order to make it as easy as possible for people to take part and to help ensure they felt comfortable and safe doing so - interviews took place in participants’ homes at a time of their choosing, or in alternative locations (e.g. cafes or workplaces) if they preferred.

The mental health services which women had accessed, and therefore on which women and their families based their experiences, were diverse. They covered all of the key services described in chapter 1, Table 1. Some women were admitted with their babies to specialist MBUs, while others were separated from their babies, as they were admitted to general psychiatric wards with no provision for infant care. In the community, some women were treated by specialist secondary care perinatal mental health services (for moderate to severe difficulties), or by specially trained mental health midwives or health visitors (e.g. for milder difficulties). Others received
support from general non-perinatal mental health services such as crisis teams (for acute difficulties), community mental health teams (CMHTs; for moderate to severe difficulties) or improving access to psychological therapy (IAPT) services (for milder difficulties). Some women also received support from non-perinatal services specialising in particular diagnoses (e.g. early intervention in psychosis services). Many women accessed more than one service. While some women also spoke about their mental health with other professionals such as general health visitors and midwives, these professionals were not included in the analysis, which focused on mental health services and professionals treating mental health difficulties.

3.5 Sampling

Whereas in quantitative research, sampling is probabilistic and aims to select a representative sample so that results can be generalised, in qualitative research, this is not always the case. Nevertheless, there are still important issues to consider around participant selection. Purposive sampling, where participants are selected because of their particular characteristics, is a popular option (Patton, 1990). For the STACEY study, a purposive sampling strategy was used in order to obtain a demographically varied and diverse sample of women who had received support for a perinatal mental health difficulty. This included women with a range of diagnoses and difficulties, from mild to severe, some of whom had been treated by specialist in-patient or community perinatal mental health services, and others who had been seen by general adult mental health services. Sampling aimed to include representation of a good range of age groups, ethnic and socio-demographic backgrounds, mental health problems, and history of previous service use. It
also aimed to include women who had experienced child protection proceedings and were no longer their child’s primary carer, as well as those who had retained a principle parenting role.

The inclusion criteria required that women:

- were aged 16 or over;
- were English language speakers (because of a lack of resources for interpreters);
- had accessed support from the NHS for a perinatal mental health difficulty during or after their most recent pregnancy (this could be for a new difficulty or for a relapse or exacerbation of a pre-existing difficulty);
- had a baby aged 6-9 months at the time of interview.

For each woman interviewed, I also interviewed either a partner or other family member wherever possible. Women nominated people who had been their main supporters and were best placed to offer another perspective on their care. Women could still take part even if no partner or relative could be interviewed. Inclusion criteria required that family members were:

- aged 16 or over;
- English language speakers;
- the partner or other family member of one of the women interviewed for the study (the definition of partner or family member was left open to interpretation by the participating women) with some knowledge of

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2 It should be noted that the original study protocol stated that a supportive friend could also be included instead of a family member, if the woman preferred. However, in practice only one friend was nominated for interview by a woman – and in this case, the woman ultimately requested that her husband be interviewed instead - which he agreed to.
or involvement in supporting the woman or her recovery (as determined by the participating woman).

Individuals lacking the capacity to consent were excluded.

My PhD study included the full sample of women and family members from the wider STACEY study (n=84). Women whose partners or relatives were interviewed were included along with those where nobody else could be interviewed, in case views differed between the two groups.

As outlined, the STACEY study also included focus groups and interviews with clinicians and commissioners, but I did not analyse these for my study.

3.6 Recruitment

Recruitment of women took place at 6-9 months post-partum. There were two recruitment routes:

1) I contacted a wide range of NHS services supporting women with perinatal mental health difficulties to seek help identifying participants. Eligible women were initially identified and approached by a member of their mental health team to ask if they might be interested in participating. Staff passed me the contact details of women who were interested and agreed to their contact details being shared with me. I then contacted these women (usually by telephone) to provide them with more information about the study, and then sent them a participant information sheet, usually by email (see Appendix 4).

Women were given at least 72 hours to consider whether or not they wished to take part. I arranged to interview women who wished to participate. All participants provided written consent when I (or
another researcher) met them face-to-face prior to their interview (see Appendix 5 for consent form).

2) Women who had taken part in the wider ESMI study and had agreed to be contacted about future studies could also be recruited. I contacted these women (usually by telephone) if they were eligible for the STACEY study and met a purposive sampling need. Upon contact, they were provided with more information about the study, and sent a participant information sheet (usually by email). As with other women, I subsequently obtained written consent from, and interviewed, those who were willing to participate.

Staff members were asked only to pass on details of women who had capacity to consent to an interview. However, I was also trained in assessing mental capacity in case any questions arose upon speaking to or meeting an individual. All women received £15 in cash in appreciation of their time.

I informed women while they were considering whether or not to participate that, if feasible, I would also like to interview their partner or another family member involved with their care. If willing, women asked a partner or relative whether they may be prepared to participate. As noted, women were still permitted to participate if they did not wish to ask a partner or relative to take part, or if no family member was willing or able to do so. Where a partner or relative was willing, the woman passed me their details and I contacted the partner or relative (by email or telephone) to provide them with more information about the study, including an information sheet (see Appendix 4). As with women, they were given at least 72 hours to consider whether or not they wished to participate. If they were willing to participate, I arranged to
interview them as well (separately wherever possible), and obtained written consent prior to interviews (see Appendix 5 for consent form). All partners and relatives received £15 in cash in appreciation of their time.

In total, 52 women were interviewed along with 32 family members. Of the 52 women who took part, 41 were referred by NHS staff (route 1) while 11 had taken part in ESMI (route 2). It is not possible to determine how many women were asked to participate but declined, because NHS professionals only informed me of interested participants. In total, I attempted to contact 64 women and 52 of these ultimately took part (81%). Reasons for not taking part were: did not wish to (n=3); ‘timed out’ – i.e. baby became too old for the study (n=3); repeatedly cancelled the interview or stopped replying (n=3); no response/phone number did not work (n=3).

As outlined, 32 family members took part, each linked to a participating woman. Reasons why no partner or relative could be interviewed were: difficult family relationships (n=5); woman had no partner/close relatives involved (n=5); partner/relatives too busy (n=4); partner/relative refused (n=2); woman did not wish to ask anyone (n=2); woman said she would ask but did not reply (n=2).

3.7 Data collection

I collected data between June 2015 and March 2017. I used interview guides (see Appendix 3) with options to probe and explore answers. I also constructed a timeline collaboratively with each participant (i.e. with women and, separately, their family members) at the beginning of each interview to chart women’s contact with services throughout the perinatal period. This
helped to clarify which mental health services and professionals women had seen.

The final interview schedule for the wider STACEY study included questions about women’s and their family members’ views and experiences of: the woman’s mental health during pregnancy and after giving birth; access to services; service delivery; interactions with healthcare professionals; any separations from the baby; contact with social services (if applicable); and both women’s and their families’ involvement in care.

As outlined, my study focused on those sections of the interviews (both for women and their family members) relating specifically to views about how services and professionals supporting women with perinatal mental health difficulties are perceived to work with their families, and the role of families in this context. Therefore, parts of interviews relating to views of women’s care more generally, rather than specifically to views about how services work with families were excluded (except where these were considered to provide relevant wider context). Specifically, I included and analysed the following questions for my PhD. Women were asked: Can you describe how services and professionals worked with other people who were supporting you and your baby (e.g. your partner, baby’s father, family members, or friends)?

Probes included: What support was there for your family? How do you feel about this? How involved were they able to be? How do you feel about this? What was your experience of having contact with family and friends while in hospital (If relevant)?

Partners/family members were asked: What has been your role supporting [mother] through this period? Can you describe how involved you have felt in [mother’s] support and treatment? Can you describe
how you’ve felt about the different professionals you’ve had contact with about her mental health? Can you describe any support you’ve received from services or professionals as someone supporting a mother who is having difficulties? How do you feel about the information that was available to you?

Family members were also asked about any separations from the mother and/or baby, as well as whether they had cared for the baby alone (e.g. while the mother was hospitalised) and, if so, what support, if any, they were offered with this. A range of probes were included and used as needed.

Given the qualitative nature of the interviews, women and their family members at times also touched on related issues elsewhere in their interviews (e.g. many women also referred to family involvement early on in their interviews when describing what happened to them during and after their pregnancies, and how they came to access professional support).

Where this happened, I analysed all relevant data.

I developed the questions for the interview guides in collaboration with the wider STACEY study team of clinicians and senior researchers. Given the qualitative, exploratory nature of the study, questions were purposely broad and open with the aim of encouraging participants to describe their experiences in their own words. Early drafts of the topic guides were reviewed by a perinatal service user and carer advisory panel (all of whom had lived experience of perinatal mental health care). I amended the guides based on their feedback to help ensure the questions were clear, sensitive and meaningful for women and their families.

Following this process, I carried out pilot interviews with two members of this advisory panel (one woman who had experienced a perinatal mental health
difficulty, and one partner whose wife had experienced a perinatal mental health difficulty). This resulted in further (more minor) amendments to aspects of question wording. The interview guide was then piloted with four other women who had accessed support for a perinatal mental health problem from one of the participating NHS healthcare providers, along with one partner and one relative. At this point, very few changes were needed so these interviews were ultimately included in the final sample, as these participants also met the study eligibility criteria.

As outlined, I conducted most of the semi-structured interviews for the study myself (n=70). The remaining fourteen were conducted, under my supervision, by: a researcher with lived experience of perinatal mental health difficulties who was a member of the perinatal service user and carer advisory panel (n=5); a professor of social care (n=5); and MSc students of clinical mental health sciences who I was supervising for their research theses (n=4). All interviewers were female and some (including me) were mothers ourselves (see section 3.10 and chapter 6 for further reflections on the possible impact of this).

Demographic data on women and their family members were also recorded (Appendix 3). No field notes were taken during the interview, but researchers wrote a brief summary of the interview afterwards outlining initial thoughts about the key points and themes from the interview. The interviews were audio-recorded and transcribed verbatim, with any identifying information removed during the transcription process to preserve privacy. Demographic data were separately noted along with details of women’s (self-reported) diagnosis.
Transcripts were not returned to women or their family members for comment or correction in part because of a lack of resourcing capacity to do so for such a large body of interviews. Owing to the very large body of interviews carried out, a professional transcribing service was used to transcribe the interviews, with audio files sent - and transcripts subsequently received - in a secure, password protected format. It has been argued that the process of transcription itself is a vital part of qualitative research since: “It is in the process of transcribing that you truly ‘hear’ what the person has said and, as such, this is a period in which analytic insights are most likely to occur” (Lofland et al., 2006; p.107). The use of a professional transcribing service thus had important downsides: not only did it have a potential impact on data quality (as transcribers were often unfamiliar with the topic area), it also arguably ‘distanced’ me from the original audio recordings. This could have reduced my ability to pick up on the nuance of interviews, although it helped that I had at least conducted the great majority of interviews myself.

To help mitigate against these potential issues with using an external transcribing service, I took the following steps: it was agreed that only the most experienced transcribers would be selected by the transcription service; I provided transcribers with a list of key words (e.g. perinatal, health visitor) to assist them in transcribing interviews; I reviewed and, where necessary, amended transcripts myself to enhance their quality. This was a time-consuming process: for approximately one quarter of all interviews, I listened to the full original audio recording alongside reviewing transcripts. For the remainder, I listened to audio recordings as necessary, in order to verify or
correct any unclear parts of transcripts, where transcribers had noted that they had struggled.

Present at the interview were the participant, the researcher and often (especially in the case of interviews with women) the baby. Where it was possible to interview a woman and her partner or relative, the pair were sometimes interviewed on the same day and sometimes on different days, depending on what was most convenient for them. Wherever possible, interviews were carried out separately with each participant. Although some researchers have argued that joint interviews allow people to expand on each other’s points and explain discrepancies (Bennett, Wolin, & McAvity, 1988), it has also been pointed out that “As much as married couples like the illusion that they are of one mind, they are not. The presence of one often inhibits the performance of another or at least slants it” (Perks & Thomson, 2015; p.155). Given the context of this study, separate interviews were seen as preferable in order to allow each individual to narrate their story from their own perspective without being restricted, constrained, or guided by the other, and to allow some aspects of the content of the two interviews to be considered together while other aspects remained separate (Eisikovits & Koren, 2010). However, in practice, in a few cases women or their family members chose to sit in on (parts of) each other’s interviews: in three cases a partner or friend sat in on all or part of a mother’s interview, while in eight cases the mother sat in on all or part of the interview with her partner or relative. In any case, it has been pointed out how, even when interviews are conducted separately, participants are still affected by each other as “individual versions are fluid, influenced by the anticipation of others’
accounts and by the interaction with the researcher” (Harden, Backett-Milburn, Hill, & MacLean, 2010; p.450).

In total, interviews lasted for approximately one hour. It is difficult to calculate exactly how long was spent discussing family involvement, other than to say that women and their family members generally gave rich, wide-ranging accounts of this within their broader interviews.

3.8 Analysis

I performed two types of analysis on the data: dyadic analysis (Eisikovits & Koren, 2010) and thematic analysis (Braun & Clarke, 2006). However, these were not entirely distinct and nor did analysis follow a simple linear process from one type of analysis to the next; rather they overlapped, alternated and interlinked.

- I conducted dyadic analysis on a sub-sample of seven ‘dyads’, consisting of a woman and her partner or other family member. I sampled these dyads purposively from the full sample to ensure that they covered a range of different types of service use, diagnosis, family set-up and socio-demographic make-up.
- I carried out wider thematic analysis on the full dataset, including interviews with women, their partners and other family members.

I felt that, by analysing the data from these two perspectives, it would help bring different issues into focus, through what has been described as a “twisting of the analytic kaleidoscope” (Ribbens Mccarthy, Holland, & Gillies, 2003; p.19). As this study included such a large sample for qualitative research, the combination of dyadic analysis and wider thematic analysis
also ensured that I was able both to ‘focus in’ on data and to ‘widen the lens’
to see the broader picture.

3.8.1 Dyadic analysis

Dyadic analysis essentially refers to the analysis of individual interviews with
two members of a dyad (Van Parys, Provoost, Sutter, Pennings, & Buysse,
2017). Firstly the individual interviews are analysed, but following this a
second analysis is performed in which overlaps, patterns and contrasts
between the individual accounts are sought, on both a descriptive and
interpretative level (Eisikovits & Koren, 2010; Van Parys et al., 2017). Thus,
the individual perspectives of two people are combined such that the first
participant’s narrative is informed by the second’s and the second’s is
informed by the first’s, with an additional ‘dyadic’ perspective at the ‘couple’
or ‘family’ level also taking shape. I felt that analysing the interviews in this
way would help to ensure that any more ‘relational’ or ‘interpersonal’
perspective on the data would be captured and that it would provide a richer,
more nuanced understanding of the (similar or discrepant) ways in which
women and their family members make sense of their unique and shared
experiences.

Dyadic analysis has the advantage that it encourages the researcher to
adopt a critical approach to the data by exposing the ways in which there are
always multiple perspectives on any one event rather than a single ‘true’
account. In other words, by confronting researchers with two (at times
competing) accounts, it helps to discourage them from taking any one
participant’s data at face value without recognising the ways in which
participants’ interpretations, attitudes and beliefs may be influencing their portrayal of events. I considered that selecting seven dyads (i.e. fourteen interviews in total) would offer a reasonable balance between allowing a detailed, sophisticated analysis to be carried out, and also including enough different interviews to cover a range of services, diagnoses, family set-ups and scenarios.

Despite the potential value of a dyadic approach, very little has been written about how to perform dyadic analysis in practice. In one of the few papers to touch on this at all, Eisikovits & Koren (2010) describe their dyadic analysis as a process of “trial and error, because no reference to individual interviewing coupled with dyadic analysis was found in the methodological literature” (p.1645). These authors describe how they initially focused on analysing the individual interviews within a dyad, each in turn, using thematic analysis. This involved highlighting significant statements, sentences and quotes in order to gradually develop clusters of meaning or themes. They then looked for contrasts and overlaps between the two interviews within each pair, which led them to reconstruct existing themes and create new ones. This paper offers helpful insights into how to approach dyadic analysis. Nevertheless, the author’s write-up was largely focused on describing the process of analysis, rather than being structured around the themes identified, making it difficult to ascertain from it how a more comprehensive write-up might look. I also felt that their write-up left the data appearing rather compartmentalised, making it difficult to get a sense of any one dyad’s broader narrative over the course of their full interviews.
In another paper, where interviews were also analysed dyadically, Van Parys et al (2017) similarly focused first on analysing individual interviews and then moved to analyse each dyad as a whole, bringing together the individual narratives and codes into new thematic categories at a family level. Finally, the authors compared the data across different families to allow them to explore convergences and discrepancies at this broader level too. In contrast to Eisikovits & Koren (2010) these authors stated that they used Interpretative Phenomenological Analysis (IPA) rather than thematic analysis, although it is unclear in what way this differed from thematic analysis in practice. These authors did not write up their findings because they were focusing on methodological issues, making it difficult to ascertain from their paper how the write-up of dyadic analysis might best be approached. More generally little appears to have been written about how best to write up dyadic analysis. For example, in their paper outlining their experiences across a range of dyadic projects with children and their parents, Harden et al. (2010) simply note that they presented findings at times as ‘case studies’ and at times as ‘thematic overviews’.

For the current study, drawing on the approaches above, I followed the following steps:

- Initial analysis of individual interviews within a dyad or pair and construction of individual-level themes. While this involved reading and analysing each interview separately, in practice there was also ‘back-and-forth’ between the individual interviews, even at this stage, so that each interview to an extent inevitably informed analysis of the other;
Analysis of contrasts and overlaps (convergence and divergence) at the dyadic level with codes developed into dyadic-level themes;

Analysis across dyads to examine the broader picture.

Like Eisikovits & Koren (2010), during the initial individual-level analysis I used thematic analysis, as I felt this would be at once a systematic yet flexible option which I could readily apply to this novel analytic framework (Braun & Clarke, 2006). This involved me firstly reading and re-reading transcripts, timelines and interview summaries to become familiar with the data. I noted down thoughts, suggestions, memos and ideas and gradually developed these into initial codes. From these codes, I then constructed themes. In the next stage of the analysis, I developed and adapted themes at the dyadic level, comparing and contrasting interviews within a dyad to “weave together threads of individual accounts” (Harden et al., 2010; p.448). While doing this, I also wrote up my own ‘researcher reflections’ for each dyad, focusing on my experiences of interviewing each pair and interpreting their data. Finally, I explored how themes compared across the seven dyads.

In some respects, analysis therefore progressed from the individual to the dyadic level, and from being more descriptive to becoming more interpretive. However, in practice, there was always back and forth between individual and dyadic, and descriptive and interpretative analysis throughout. Overall, I aimed to retain the integrity of individual and shared accounts while also generating a third, etic perspective following analysis of convergence and divergence between accounts.

In the absence of relevant literature around how best to write up dyadic analysis, I decided to present the dyadic analysis as a series of case studies.
I felt that this would help to provide a rich picture of the key themes identified in the data, while at the same time preserving participants’ unique ways of describing their narratives. I also felt that it would help avoid the problem at times inherent in thematic analysis, where data can become fragmented and disjointed. I explicitly included my own researcher reflections for each case study. Following the presentation of case studies, I wrote an overarching analysis to draw together themes across the different dyads, in order to provide a broader perspective and overview.

I presented my reflections on the methodology of dyadic analysis in a poster presentation at the BABCP Annual Conference in 2019 and at the British Psychological Society’s annual conference in May 2019: https://www.bps.org.uk/sites/bps.org.uk/files/Events%20-%20Files/AC2019%20Abstracts%20v2.pdf, as well as in an oral presentation at UCL’s Qualitative Health Research Network conference in March 2019: https://bmjopen.bmj.com/content/9/Suppl_1/A7.2

3.8.2 Thematic analysis

The second stage of analysis (which - as outlined - did not in reality take place after the dyadic analysis and was not entirely distinct from it) involved creating two larger datasets, one containing women's interviews and one containing those of their partners and other family members. I also categorised participants in each dataset according to the type(s) of service the woman accessed. I used thematic analysis to develop themes, again
following the approach described by Braun and Clarke (2006) and informed by Maguire & Delahunt (2017) guidelines.

Thematic analysis is a versatile qualitative research method that can be used across a variety of epistemologies and research questions, but also provides a rich, complex account of the data (Braun & Clarke, 2006; Nowell, Norris, White, & Moules, 2017). I considered it particularly useful for my study, because it lends itself well to summarising key themes in large datasets, as it provides a well-structured framework for managing data in a clear and organised way (King, 2004).

In line with Braun and Clarke (2006), I followed six steps: 1) becoming familiar with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes; 6) producing the report according to the main themes identified. Analysis was facilitated by the use of QSR International’s NVivo qualitative data analysis software (version 11, released 2015; Richards, 1999). This is a software package that supports qualitative research by providing a platform for researchers to collect, organise, store and analyse data like semi-structured interviews.

The wider thematic analysis was designed to enable a broader perspective on the data to be provided, helping to contextualise the findings from the dyadic case studies and allowing exploration of how these findings corresponded to the wider themes across the dataset as a whole.

To enhance validity - or rather, credibility and confirmability - I adopted a collaborative approach to coding in the early stages of the analysis. I initially selected six rich interviews with women (these were not the same six as
those selected for the dyadic analysis, but there was some overlap). The six were designed to span a range of diagnoses, types of service used, and demographics. I and a second researcher (who was part of the wider study team and was a former perinatal mental health service user) read through the transcripts from these six interviews independently in detail. I devised an initial coding frame, but the second researcher initially approached the analysis afresh without reference to this. Rather, she produced an account of the data from her own perspective and devised a coding frame herself. We then shared our coding frames and made notes on them, including where there was overlap or divergence, where we had additional themes or sub-themes and, to a lesser extent, where themes might be collapsed or expanded. A third researcher – one of my supervisors (NM) who was also a member of the wider STACEY research team – also read through two of the six transcripts in depth and reviewed my initial coding frame. The three of us then met and discussed our thoughts on the transcripts and developed and adapted my original coding frame collaboratively.

Following this meeting, I selected three additional transcripts which both I and the second researcher read in detail. These were designed to enhance the original six interviews in terms of demographics, services used and diagnoses. The two of us met twice more to discuss further thoughts and reflections, and to collaboratively adapt the coding frame.

In addition to these nine interviews with women, I also selected seven partner or relative interviews, including some linked to the interviews of the women that had been selected and some not linked (to avoid us becoming too ‘caught up’ in a single sub-set of interviews). Both I and the second
researcher read these transcripts in detail as well. As with the women’s transcripts, I devised a coding frame, and the second researcher did the same, with us then sharing our coding frames for comparison and review. We arranged a further meeting to discuss our thoughts and reflections and, following this meeting, adapted the coding frame collaboratively.

It should be noted that this collaborative coding exercise covered a wider remit than the current study, as it focused on the full text of each transcript for the wider study (i.e. on a woman’s entire care pathway and experiences of all the services she used), with partner and relative involvement and support forming a part of it.

Following the collaborative coding exercise, for both women’s interviews and those of their family members, I gradually coded more transcripts. I continually reviewed and adapted the coding frames as I went.

Despite initially organising the data in two separate databases - one for women and one for their partners or other family members, for the write-up of the thematic analysis I ultimately decided to combine the data and report the findings from interviews with women alongside those of their partners and wider families, rather than in separate chapters. Presenting such a large amount of qualitative data all together at once inevitably presented considerable challenges, especially as there were clearly a large number of possible ways to ‘split’ the data (e.g. by service type, participant type, family set-up, the mother’s diagnosis, or the mother’s socio-demographic or cultural background). In particular, I was aware of the possibility that presenting the thematic analysis in one chapter could risk me producing a very ‘high-level’ analysis that missed or only skirted over more subtle or nuanced differences.
or divergences between distinct ‘segments’ or ‘types’ of data or participant. I wondered whether presenting all the data together would allow me adequately to capture differences in the accounts of women, their partners, and their wider family members. Would it enable me to illuminate findings unique to particular services types, such as mother and baby units, or crisis resolution teams? I also wondered if it might seem muddled and confusing, making readers see the findings as jumbled and incomprehensible.

At the same time, there seemed to be enough overlap, likeness and similarity between data in the different datasets and subgroups that dividing the analysis into separate, discrete chapters felt as though it may be repetitive and limiting. I was concerned that it might restrict the extent to which data relating to different participant types or service types could be directly compared and contrasted or woven together into a thread. I also felt that it might enforce divisions on the data, breaking it up or prising it apart in ways that felt uncomfortable and awkward.

In light of these considerations, I determined that, on balance, presenting the thematic analysis in one cohesive chapter would be most compelling. Nevertheless, I complemented this with diagrams showing similarities and differences between the accounts of women, their partners and other family members; and similarities and differences between different types of service. In the text, I also attempted to highlight convergences and divergences between different parts of the data or types of participant. In this way I sought to provide a comprehensive yet nuanced account of the data, allowing it to be ‘cut’ across different dimensions and viewed from different perspectives.
3.9 Summary of service user and carer input into the study

As outlined, my study benefited from advice and input from a perinatal service user and carer advisory group made up of people with lived experience of treatment for perinatal mental health difficulties. I sought to draw on this advisory group at every stage of the study. I have noted their involvement in earlier sections of this chapter, but also provide a brief summary below:

- Interview guides were reviewed and amended by the advisory group (e.g. to simplify the wording and to ensure questions were phrased as sensitively as possible);
- Pilot interviews were carried out with one woman and one partner from this group, and then also with four other women who had accessed perinatal mental health support, and two of their partners/relatives. Small amendments to wording and to the introductory text were made following this;
- Five of the main study interviews were carried out by a woman from the advisory group;
- A researcher who was not a member of the advisory group but who had previous experience of perinatal mental health care assisted with coding the data (see section 3.7.2);
- When I wrote up my thematic analysis (i.e. chapter 5) for publication, a mother from the advisory group and two male partners, reviewed the manuscript and I then edited it based on their feedback.
3.10 Epistemological position

I adopted an essentially post-positivist or critical realist epistemological position for my study, but also drew on social constructionist (Berger & Luckmann, 1966), feminist (Hesse-Biber & Yaiser, 2003; Wright & Owen, 2001), and Foucauldian theory (Foucault, 1977, 1988). Like positivist positions, post-positivist or critical realist positions seek to unearth an underlying ‘reality’ from the data, based on the belief that there is an authenticity to be discovered (in this case reflecting a family’s experiences of care) that exists independently of the researcher’s presence. However, post-positivist researchers accept that this reality is always mediated by participants’ and researchers’ own perceptions and interpretations and therefore can never be fully apprehended. Social constructionist approaches in a sense go further than this, holding that there is in fact no ‘truth’ or ‘one true story’ to unearth, but rather that the aim of analysis is to explore how participants construct their own experiences or subjective reality. Thus a post-positivist or critical realist position in effect sits in the middle between positivism - in which research is seen as aiming to portray a knowable objective empirical reality - and relativism - which contends that there is no knowable reality, only a range of equally valid socially constructed accounts. Ribbens Mccarthy et al. (2003) argue that, from this middle standpoint, the aim of a critical realist stance is to produce a coherent ‘story’ of a family by making use of the researcher’s ‘bird’s eye view’ (i.e. their privileged position of being able to look across multiple perspectives), while also acknowledging that this story cannot claim to be the ‘truth’.
In the case of this study, where my analysis explored experiences of family involvement with perinatal mental health care, in line with a critical realist stance, I took the views of women and their family members to an extent as reflective of an underlying reality of care. This was seen in some ways to exist independently of myself as the researcher (albeit always obscured by assumptions and interpretations), with the narratives of women and their family members combined and compared in a bid to help better approximate this reality by drawing on multiple perspectives. However, drawing on social constructionist or critical thinking, I also acknowledged that there was no single valid perspective or narrative on care, but rather that the perspectives of different family members would all have some validity, with each representing a particular interpretation, reproduction or construction of that person’s social reality, within the context of shared family realities. Social constructionist influences were arguably particularly evident in the dyadic analysis, where I explicitly included my own researcher reflections to provide an additional level of interpretation of the data and to highlight possible ways in which competing meanings and accounts were socially produced and reproduced by participants according to their own agendas and interpretations. Social constructionist influences are also apparent in chapter 6, where I draw on postmodern feminism and Foucauldian theory. I use Foucauldian thinking (Foucault, 1977, 1988) to emphasise the role of psychiatry in coercing individuals to behave in certain ways and to challenge the dominant medical model of psychiatry, by critiquing the notion that mental health difficulties are essentially located within individuals. And I draw on feminist thinking (e.g. Hesse-Biber & Yaiser, 2003; Wright & Owen, 2001)
as well as Foucauldian thinking to help unpick the ways in which concepts like ‘motherhood’, ‘fatherhood’, ‘masculinity’ and ‘femininity’ are, at least in part, discursive constructions, which can also be used to control and regulate behaviour, ensuring individuals adhere to gender norms.

3.11 Ethical considerations

Ethical approval was obtained for the study from the Camberwell St Giles London Research Ethics Committee (REC reference: 13/LO/1955 – see Appendix 6).

As outlined, following my initial contact with women and their family members to discuss the study, I gave them an information sheet, usually via email (Appendix 4). Potential participants were given time to consider whether or not they wished to participate. I only arranged to interview those who were willing and, upon meeting women and their family members, prior to commencing the interview, I obtained written consent from all participants (Appendix 5). I made it clear to potential participants that they did not have to participate and could refuse to answer any questions or could stop or pause the interview at any time. I also made participants aware that participating or withdrawing at any stage in the study would not have any impact on their treatment or support and that their contributions would be kept confidential with identifying details removed. However, all researchers stated explicitly that they would pass on information if they had major concerns about a participant’s safety or that of others. Ultimately I passed concerns to social services in relation to information provided by one woman (with her agreement). Staff who helped identify and approach potential women did not
approach service users whom they judged lacked capacity to consent or were too unwell to participate. Researchers also assessed mental capacity prior to conducting interviews. During interviews, I sought to adopt a respectful, open, sensitive and non-judgemental style to encourage women and their family members to feel comfortable sharing what could be difficult, distressing personal experiences with me.

All involved researchers, including me, received training in: assessing capacity and obtaining consent; qualitative interviewing; managing interviewees’ distress; study-specific safeguarding issues and procedures; Good Clinical Practice and standard NHS Safeguarding Training to Level 3.

I allocated participants a study ID at the time of the interview and electronic records referred to participants’ study IDs, rather than their names or other identifying information. A list of the study IDs allocated to each named participant was stored separately from study data in a locked filing cabinet in a locked office at UCL.

Interview transcripts used study ID numbers and identifying data (e.g. names of participants or others mentioned in their interview) were redacted. As far as possible, quotes used did not include information that would allow a participant to be identified and either ID numbers or pseudonyms were used to label quotes.

Nevertheless, despite these precautions ethical challenges around ensuring the anonymity of participants remained - in particular related to writing up
and publishing dyadic analysis. This is because dyadic analysis involves displaying accounts from two members of a dyad alongside each other. Crucially, concerns around recognisability of participants increase when their perspectives are linked because if each member of a dyad is able to recognise their own words they will then know what the other member of the dyad said as well, even though neither may have anticipated this at the time of the interview. Thus a delicate balance has to be found between anonymising data sufficiently to avoid recognition while nonetheless maintaining authenticity (Harden et al., 2010). This is difficult to achieve in practice because it is hard to retain the authenticity and integrity of the data if one has to anonymise a person’s account and words to such an extent that they themselves cannot recognise themselves from it. In a paper on how best to anonymise research findings more broadly, Saunders, Kitzinger, & Kitzinger (2015) admit that, even after they took great care to fully anonymise participants’ data in one study, one participant contacted them to say he had worked out his pseudonym and now knew what they had written about him. Had his account been linked to that of another participant he would have known what they said too.

Even in the wider thematic analysis for this study, where interviews were not paired, it could be hard to fully anonymise data – for example, when numbers of family members like grandfathers or same-sex partners interviewed were small. Ultimately, Saunders et al. (2015) describe anonymity as inevitably always lying on a “continuum (from fully anonymous to very nearly

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3 I describe these ethical challenges here - rather than in my Discussion in chapter 6 - because I felt it would be helpful to make readers aware of these issues and their implications prior to reading the dyadic analysis in chapter 4.
identifiable)” (p.617) and point to a number of scenarios across different types of research where full anonymity is almost impossible to achieve in practice.

Other researchers too, when conducting dyadic analysis more specifically, have described how they have found themselves caught between a responsibility to protect the ‘internal confidentiality’ of dyad members (i.e. their confidentiality from one another) and a desire to illustrate their findings with enough detail to convey a dyadic perspective including two sides of a shared experience (Ummel & Achille, 2016). While some researchers have attempted to solve this challenge by discussing confidentiality issues in detail with participants at the outset (e.g. informing participants that their accounts will later be presented together in a way that means they may each be able to see what the other said about them) this can undermine the honesty of participants’ accounts and may be inadequate as it will not be known at the start exactly what the research might throw up or how its findings may be interpreted or conveyed (Saunders et al., 2015). In other cases, researchers have published dyadic analysis without giving much thought to how presentation of their findings could compromise their participants’ confidentiality. It has been argued that in the end it simply may not be possible to publish analysis of linked individual interviews at a dyadic level without compromising confidentiality to some extent, but equally that publishing data only at a very general level may mean that the findings will appear ‘white-washed’ and that the main strength of this type of analysis (i.e. that it can offer an understanding of a dyadic perspective) will be lost (Saunders et al., 2015; Ummel & Achille, 2016).
The set-up of the current study was such that confidentiality was protected between family members during interviews (i.e. data were not shared between women and their family members, except where they sat in on each other’s interviews), and there was an expectation that confidentiality would continue to be protected in any write-up. In light of this, I attempted to remove or change identifiable details as far as possible (especially where this did not affect the sentiment conveyed) in a bid to make participants less identifiable, but without losing data integrity to too great an extent. However, I also decided that the dyadic case studies presented in chapter 4 would ultimately need to be redacted prior to this thesis becoming publicly accessible or published. This felt appropriate to guard against the possibility (albeit remote) that members of a dyad might read the research, and manage to recognise their own words and thus those of another person in the study.

3.12 Reflections and reflexivity

As outlined in chapters 1 and 2, reflexivity involves the researcher being aware of his or her own influence on the research process, recognising that “knowledge cannot be separated from the knower” (Steedman, 1991; p.53) and that “there is only interpretation. Nothing speaks for itself” (Denzin, 1994; p.500). As such, researchers need to consider the ways in which their own beliefs, feelings, positions and assumptions may affect each stage of the research and must reflect on the research process itself and their experiences of carrying out the study. In this study, there were a number of ways in which I felt that my own positioning and my own role in the research
may have influenced the data and findings, and I also encountered challenges while carrying out the research, which prompted me to think more explicitly about my role.

It has been pointed out that collecting data via qualitative interviews involves a developing social relationship between the researcher and participant, with both parties exerting some control over the narrative and the authoring of the emerging story (Warin, Solomon, & Lewis, 2007). In research involving multiple perspectives (in this case, dyads) these developing relationships and the role of the researcher within them can become particularly complex. In particular, when carrying out interviews with women and their family members I noticed that I sometimes found myself almost ‘caught’ between the two members of the dyad – even though the interviews were mostly carried out separately. Something similar has been described by other researchers, who have termed it being ‘stuck in the middle’ (Forbat & Henderson, 2003).

This could happen, for example, where one member of a dyad asked me whether their partner or relative had already told me about a particular aspect of their care, or where they wanted to know what had already been disclosed to me. In such cases, I felt that it would breach confidentiality to share information between members of a dyad, especially as it was clear that participants in the study did not always share everything with each other. By not doing so, however, I was anxious that I might then come across as secretive, evasive or duplicitous, negatively affecting the developing rapport. At these times, it seemed that there were not always robust established ethical protocols to facilitate the process appropriately. What is more, in
order to avoid inadvertently sharing information between members of a dyad, I sometimes found myself having to ask one member of a dyad about something the other had already told me, as if I knew nothing about it (e.g. “Did your partner/relative have a past history of mental health problems?” or “Was there any social services involvement?”). I wondered whether this could make me seem uninformed or incompetent, with participants wondering why on earth I hadn’t already spoken to their partner or relative about it. Such issues were not restricted to me as the researcher though; I noticed that members of a dyad could similarly display uncertainty about what the other member of the dyad would want them to reveal and at times showed a desire to protect each other’s privacy. The upshot of all this seemed to be that various complex social relationships developed and played out throughout the research process, with each influencing the other and with the resultant interactions inevitably affecting the evolving narrative.

By way of example, the extract below shows an encounter between me and a participant (a woman’s mother, called ‘grandmother’ below) in which we seemed to become engaged in a kind of ‘approach-withdraw’ pattern, each testing the limits of confidentiality with each other, and ultimately making on-the-spot decisions about how much information to share or withhold, thus influencing the final account.

**Researcher:** Was there any social services involvement at all?

**Grandmother:** Yes, there was a bit of social service involvement.

**Researcher:** And can you say anything about your experience of how that was?
Grandmother: No, I think it’s been handled well.

Researcher: It has been handled well, okay. And can you say more about how it was handled well? What makes you say it was handled well?

Grandmother: I don’t know how much Lucy⁴ said to you.

Researcher: Yes, I think she touched on it, but yes - I mean you only have to say what you’re comfortable with. Because I don’t share things obviously between people’s interviews, but...

Grandmother: I really didn’t know that it went that far. Lucy really doesn’t say everything. You know, tell me everything. And I only found out the day of the meeting or the night before that I needed to go to the meeting. I was shocked... [Social services] mentally tortured her to be honest with you, you know...And they tortured her so much that she became even more depressed. You know, they made Lucy sick. The system made Lucy sick.

In this example, I already knew from Lucy that there had been social services involvement (although Lucy had in fact not talked about it very extensively). But I felt I had to ask her mother about it as if I did not know, in case Lucy hadn’t shared this information with her mother. Lucy’s mother was then initially reticent and attempted to test out what I knew already, perhaps in a bid to protect her daughter. This then resulted in me being somewhat

⁴ This is a pseudonym.
guarded about what I knew until finally Lucy’s mother ‘took the plunge’, revealing how difficult social services involvement had been for the family, and contradicting her earlier statement that it had been handled “well”. These kind of encounters felt complex yet I could see that my approach to them could affect participants’ willingness to share information. Arguably I became better at managing such interactions over time. In particular, I learnt to make explicit reference - prior to commencing an interview - to matters of confidentiality that may arise and to briefly highlight some of the potential issues with interviewing two family members separately.

A second challenge I found myself confronted with was how my own background and positioning might affect my research. As I noted in chapter 1, not only am I a clinical psychologist and researcher, with experience of working in perinatal mental health services, but also I am a White British woman and mother, living with a mixed-race male partner and children. Although I have never been diagnosed with a perinatal mental health difficulty, as outlined I struggled with the transition to motherhood. I wondered how factors like these might also influence my interviews with both women and men. For example, I felt it was possible that some participants might be reluctant to share their stories about professionals with me knowing that I was myself trained as a clinical psychologist. I found that it helped to emphasise that anything they shared about professionals would be kept confidential, and that I now worked primarily as a researcher. While I did not routinely disclose that I was a mother during interviews unless asked, I was visibly pregnant with my second child during some interviews and also wondered about the possible impact of this.
In particular, I wondered whether my status as a woman and mother might mean I empathised more with the mothers I interviewed than with the fathers, or at least that I might be perceived by fathers to be likely to ‘align’ myself with mothers. It has been noted by previous researchers that in qualitative interviews inevitably “partiality becomes part of the dynamic” (Forbat & Henderson, 2003; p.1457) and we will always to an extent ‘hear’ the stories that resonate most closely with our own stories, experiences, and beliefs (Mauthner & Doucet, 1998). Nevertheless, it did not seem as straightforward as this. In some cases, for example, I felt that my ‘proximity’ to the mothers - through my shared status with them and sometimes shared experiences - meant that I reacted quite strongly to certain participants (both male and female) perhaps because I may have seen in them aspects of myself or my own relationships and struggles, with which I was not entirely comfortable. My background as a White British woman may also have meant that I was more likely to be seen as a cultural ‘insider’ by participants who were ethnically white British, and an ‘outsider’ to those participants from other cultural backgrounds – though it has been noted that ethnically matching interviewers and participants does not necessarily produce better quality data, since other markers of identity, such as age, sex and social class may also be influential (Hillier, Hillier, & Kelleher, 1996).

These points also link to the ‘stuck in the middle’ position described previously, as they made me wonder whether I might ‘accidentally’ prioritise one participant’s perspective over another because I had formed different connections with different participants. This meant that I found I had to spend considerable time reflecting on my own feelings about the different
participants and the possible influence of these, both during interviews and when analysing the data. I also made a real effort to try to ensure that, as far as possible, I made participants feel comfortable offering their perspective, whatever this may be, and then ‘heard’ and sought to understand all their differing perspectives.

Given this context, a final reflection is that I was encouraged that, despite my initial concerns that fathers - or other family members - might see me as too ‘removed’ from their experiences - or too ‘different’ to them - to open up to me, they were surprisingly forthcoming and engaged. It seemed to help that the focus of the interview was initially on the woman, rather than on her partner or family member, with them only gradually being encouraged to discuss and reflect on their own experiences too. In other words, it seemed to facilitate their willingness to open up if a more indirect or ‘incidental’ approach was taken with them. Yet, at the same time this made me wonder whether the study itself arguably then served to deprioritise partners and relatives (in the same way that previous research shows they often report feeling deprioritised in the perinatal period more generally). In other words, did the study in some respects reinforce the secondary status of partners and wider families? For example, interviews focused first on women and only later asked about family members’ own needs; partners and family members were essentially seen in relation to women (i.e. as a supportive other) rather than in their own right; all interviewers were women and no partners or family members were involved in carrying out interviews; women were mostly interviewed before their family members; and women were relied on in the first place to ask their partners or relatives to take part. As the research
progressed, this seemed to me to present something of a conundrum in that fathers and other relatives seemed to want greater focus on them, but at the same time did not want to be too explicitly or directly focused on. This dynamic seemed ultimately also to play out in their experiences of support and this is discussed further in chapter 6.
Chapter 4. Findings of the dyadic analysis of seven interview pairs

This chapter presents the findings of the dyadic analysis, described in chapter 3, which included in-depth analysis of seven interview pairs. As outlined in chapter 3, the dyadic analysis focused on exploring patterns, connections, overlaps and contrasts between pairs of narratives, with an emphasis on understanding and illuminating participants’ experiences of family involvement with services. The aim was to articulate each dyad’s ‘story’, examining family members’ unique and shared experiences, and capturing any more relational or interpersonal aspects of the data. I sought to combine the individual accounts from each member of the dyad into an overall narrative at the ‘couple’ or ‘family’ level. I present each dyad below in the form of a case study, with the key themes described, along with my own reflections. These case studies are then followed by a summary of the overarching findings across all the dyads.

Five of the seven dyads analysed consisted of a mother and her partner, while the remaining two consisted of a mother and her own mother. As outlined in chapter 3, I sought to ensure that these seven dyads (i.e. fourteen interviews in total) covered a range of services, diagnoses, demographics and family set-ups. The pairs were all interviewed individually, with the exception of one small section of dyad 6 where both the woman and her partner were present during the partner’s interview. All names have been changed, and only limited demographic information is shared, to help preserve participants’ confidentiality as far as possible. Participants’ ethnicity
is not shared, except in one case where I felt this was central to the
narrative. However, overall five of the seven partners or family members
were White British, one was Asian (Pakistani), and one was Black African.
Six of the women were White British, and one was Asian (Pakistani). Four of
the partners/family members were working full-time, two described
themselves as unemployed and one was studying full-time. As outlined,
these case studies will be redacted from the publicly available version of this
thesis – but the overarching analysis and summary of them included in
sections 4.8 and 4.9 will be retained.

As outlined in chapter 3, I presented my reflections on the
methodology of dyadic analysis in a poster presentation at the
BABCP’s annual conference in September 2019 and at the British
Psychological Society’s annual conference in May 2019:
https://www.bps.org.uk/sites/bps.org.uk/files/Events%20-%20Files/AC2019%20Abstracts%20v2.pdf, as well as in an oral
presentation at UCL’s Qualitative Health Research Network
conference in March 2019:
https://bmjopen.bmj.com/content/9/Suppl_1/A7.2
4.1 Dyad 1: Sarah and Tim

[CASE STUDY REDACTED]

Reflections

When analysing this dyad, it felt important to consider the differing ways the couple understood Sarah’s illness and the impact of this on their experiences of services. While this is just one possible interpretation, I wondered whether Sarah’s sudden angry assertion of her views about how best to care for their baby - and her decision to prioritise the baby over Tim - had threatened the existing dynamic of the couple’s relationship, almost like an ‘act of revolt’ against what she perceived as a coercive relationship. By seeing this instead as a sign of Sarah being unwell, was Tim on some level trying to halt this potential change to their relationship? In other words, was he seeking to ‘re-stabilise’ the couple’s relationship and, in a sense, reinstate the status quo by seeing Sarah’s illness - rather than the wider interpersonal context - as the source of the family’s difficulties?

If so, by initially treating Sarah’s difficulties as a possible sign of a ‘relationship breakdown’ and therefore interpersonal in nature, the CRT arguably also threatened to disrupt the status quo, and professionals found they struggled to bring Tim ‘on board’ with this analysis. But by later sectioning Sarah I wondered whether it could be argued that, in the end, clinicians instead reinforced the alternative narrative, viewing Sarah as ill and in need of treatment - in a sense almost seeking to bring her back into submission - while failing to engage meaningfully with the wider interpersonal context.
For my part, I noticed that when interviewing Sarah and Tim, I experienced Tim as forceful, dominant and overbearing, whereas Sarah seemed submissive and compliant. This seemed to reinforce the idea that Sarah’s assertiveness with Tim after the birth of their baby may have been uncharacteristic and alarming in its possible meaning for the couple’s relationship. I wondered whether treating Sarah’s sudden ‘deviation’ from her usual, acquiescent way of being as a psychiatric disorder, ended up coercing her back into what she experienced as an oppressive relationship. But equally I was left wondering whether, just as Tim felt was the case with the CRT, my analysis might be biased because I was a woman and mother myself.

Taken as a whole it appeared that professionals had not managed to support Sarah and Tim ‘systemically’ as a family. Faced with conflicting views and complex relationship dynamics, services had struggled to help the couple develop a shared understanding of the difficulties. Neither partner seemed to feel fully heard or validated themselves and thus neither was able to really start to engage with the other’s perspective.
4.2 Dyad 2: Alice and Bob

[CASE STUDY REDACTED]

Reflections

While interviewing this pair, one thought I entertained was whether it could be argued that Alice’s mental health difficulties were on some level helping to keep the couple together through their transition to parenthood. In other words, they united the couple around a need to support Alice – support that she felt she otherwise struggled to get as a mother automatically expected to take on the primary parenting role. As Bob struggled to support Alice adequately and always fell short of expectations, Alice continued to ‘need’ him and he needed to keep trying harder, yet both were ultimately left struggling and dissatisfied. It seemed this dynamic may have served to protect each partner from a feared rejection by the other, yet at the same time maintained their difficulties in a self-reinforcing loop.

During her interview, Alice was very expressive and emotive and needed to pause at times. I noticed that she also asked Bob to look after their baby as she found her distracting, but then became anxious that he might forget to feed her. By contrast, during his interview, Bob seemed somewhat uneasy with social interaction. He broke off once to check on Alice and also looked after their baby during his interview when Alice went out. This seemed in some ways to further illustrate their dynamic, with Alice appealing for support but finding it inadequate, and Bob trying to support her, but struggling to do so or to articulate his own needs.
Both partners received professional support, but this was focused on Alice’s mental health or on her bond with their baby when, in reality, they both intimated that it was their own relationship that they most needed help with. Individual professional support - in the absence of a focus on the couple’s interpersonal dynamics - seemed destined to be inadequate, especially given that there may have been perceived downsides to any ‘recovery’.
4.3 Dyad 3: Amy and Tom

[CASE STUDY REDACTED]

Reflections

With this dyad, I noticed that the transition to fatherhood seemed to have left Tom feeling devalued by Amy, while she herself battled with the overwhelming responsibility of being a mother expected to care for their children. However, Tom seemed to try to deny or rebuff his feelings of neediness and also felt threatened by displays of neediness by Amy. They seemed to leave him feeling inadequate as a man, father and partner. But Amy arguably responded to his consequent attempts to prevent her from accessing support by withdrawing (into secrecy) from Tom, while seeking to draw more and more external support towards herself as her distress became ever higher in the face of Tom’s dismissals of her struggles. This further increased Tom’s feelings of inadequacy and thus his resistance to her seeking help, creating a vicious cycle.

Once Tom softened his stance and Amy gradually shared more with him and let go of some external support, the couple had felt closer again and more able to cope. It was also notable that despite his resistance to support, Tom had made an attempt to reach out. Similarly, while Amy had thought Tom would refuse to take part in an interview with me, he was in fact willing and forthcoming about his feelings. Yet despite this willingness to engage on Tom’s part, his underlying feelings did not appear to have been adequately attended to by professionals. Likewise there seemed to have been little
attempt to consider how the couple’s relationship dynamics might be related to the presenting difficulties. Thus they were left with unresolved issues.
4.4 Dyad 4: Jill and Susan

[CASE STUDY REDACTED]

Reflections

In this dyad, it was conspicuous that Jill’s ex-partner was central to the narrative around family involvement, yet his voice was absent (as Jill had not felt comfortable asking him to take part). Nevertheless, I was left wondering about the point Jill and her mother made about mothers being more intensely scrutinised by professionals than fathers. Although their account was, of course, partial - especially given Jill and her partner were experiencing considerable conflict - Jill’s perception that mothers faced higher expectations was reflected across other interviews too. And even though women like Jill were parenting in very challenging wider contexts, often with little support and in relationships that they experienced as controlling and exasperating, there was a sense that a ‘good mother’ was required to be mild and restrained. I reflected on how experiencing strong, intense emotions, or engaging in behaviours like self-harm, arguably did not fit into the narrative of the ‘good mother’ and could lead to being judged ‘unfit’ to parent, even if such feelings seemed at times understandable given the significant pressures mothers were placed under. This made me wonder about whether fathers faced the same judgements: would strong, angry emotions result in a father being judged negatively to the same degree? And did fathers, more broadly, face the same pressures as mothers in the first place?

It was also conspicuous within this dyad that Jill relied heavily on her mother for support, but both she and her mother also wanted privacy from each
other. It seemed that professionals had struggled to manage this in a way that was satisfactory to them both. In particular, Susan ended up feeling that she was excluded from Jill’s care, and that her own desire for confidentiality was not respected.
4.5 Dyad 5: Laila and Halima

[CASE STUDY REDACTED]

Reflections

With this dyad, it was striking that Laila considered her husband, wider family and community to be very central in her day to day life, but wanted her difficulties to be kept largely secret from them because she perceived there to be stigma around mental health within Pakistani culture. Perhaps as a result, Laila and Halima at times seemed to misjudge each other’s perspective. Professionals had to navigate these complex and sensitive dynamics and a failure to do so risked creating wider difficulties for Laila. But given that Laila’s family were clearly highly influential both in supporting Laila’s recovery and potentially increasing her difficulties, by not attending to or engaging with her family at all, services were left with Laila’s difficulties persisting and with Laila and her mother feeling options for family involvement had not been sufficiently explored.
4.6 Dyad 6: Lauren and Steve

[CASE STUDY REDACTED]

Reflections

With this dyad, I noticed that Steve and Lauren seemed rather ‘enmeshed’ with one another. Steve had given up his job to care for Lauren, they had no close family or friends nearby, and they had little time or space apart. Indeed, when interviewing the couple, they seemed to find it difficult to leave the room and let each other speak to me in privacy. Furthermore, Lauren in particular seemed to want to exert some control over Steve’s contribution, which made me wonder more broadly how comfortable she would feel with him connecting more himself with professionals involved in her care.

Lauren’s difficulties seemed to generate a dynamic between them in which Steve was continually trying to come to her ‘rescue’, while she both pulled him towards her and pushed him away (e.g. by relying on him for support while also keeping him in some respects peripheral and by her absconding and suicide threats). This perhaps helped them feel connected, while also helping Lauren maintain some control.

However, in their focus on helping Lauren, professionals in some respects seemed to reinforce this dynamic: on the one hand they depended on Steve to support Lauren and report crises to them; on the other hand they kept him on the side-lines. As a result, Steve felt responsible yet overlooked and disregarded, while the couple’s interpersonal dynamics were left unaddressed yet seemed to contribute to maintaining Lauren’s difficulties. Not only this, but also it was clear that the couple’s interpersonal dynamics
themselves were playing out within a challenging wider context, characterised among other things by deprivation, conflict and isolation. Lauren had been diagnosed with postpartum psychosis and offered support individually for this, but as long as there was no emphasis on addressing her distress within its wider context, it was difficult to see how it could be fully resolved.
4.7 Dyad 7: Nicola and James

[CASE STUDY REDACTED]

Reflections

When interviewing this couple I noticed that they seemed cohesive and supportive of one another, and often framed their experiences as a shared endeavour – for example, when discussing breastfeeding James explained: “We wanted to breastfeed [our baby] up to at least six months. We wanted to go to six months.”

However, becoming a parent seemed to have provoked in Nicola a need to be parented herself. This had shifted the dynamic of their relationship, with James having stepped into this role where normally Nicola had been the one in charge. With Nicola relying on James to put across her views to professionals, James clearly had a high level of involvement in her care. But while the MBU had engaged well with him, it was notable that the couple still felt he was overlooked in some respects. Even in this case where the couple’s relationship appeared to have been able to accommodate a shift in their dynamic, it was clear that family dynamics nevertheless needed attending to. But the wider interpersonal context did not appear to have been fully considered.

More broadly, I also reflected on how positive this couple’s experience of support appeared to be compared to the other dyadic pairs. In part, this seemed to be because Nicola had a well-resourced, proactive husband supporting and advocating for her and, connected to this, managed to access a specialist MBU quickly. It was interesting to contrast this with Jill in
dyad 4, who was a single mother parenting alone, amidst turbulent family relationships, and who had also wanted an MBU admission. She was refused admission, in her view, because she was not felt to be “ill enough” and her baby was removed from her care after she self-harmed. Although there were of course many differences between these two cases, I reflected on how some mothers were seen as essentially ‘good mothers’ - who were temporarily unwell - while others were seen as ‘bad mothers’ - whose mothering needed to be policed. I wondered to what extent having a supportive, well-resourced family set-up, compared to a more precarious one affected the way mothers were viewed and treated by professionals.
4.8 Analysis of themes across dyads

The dyads analysed were multifaceted and wide-ranging, spanning different types of family set-up, diagnoses and service use. While this made understanding and summarising the findings across dyads challenging, below are some of the key points that the analysis seemed to reveal.

**Significance of interpersonal relationships to perinatal mental health**

Firstly, it was conspicuous how integral family and interpersonal relationships were to understanding women’s difficulties. This is perhaps unsurprising given that life transitions, such as having a baby, often bring about the reorganisation of existing relationships and attachment strategies, which can lead to distress and conflict as well as revision and growth.

With regards to these dyads, although it was the women who had the diagnosis of a perinatal mental health problem, their difficulties often seemed to arise within a complex and sometimes fraught interpersonal and wider social context. In some cases, a woman’s difficulties seemed to represent something of an expression or manifestation of interpersonal conflict. At times, women’s difficulties arguably acted almost as if to serve a wider ‘function’ for the couple, such as to stabilise their relationship or hold them together during a period of transition, even if this had other undesirable consequences. In other cases, attitudes towards professional support were influenced by its perceived meaning or consequences for the couple’s or family’s relationships.
In all the dyads analysed, partners and wider families were reported to play a central role in relation to women’s perinatal mental health, whether they were perceived as supportive or not. This meant that engaging with the wider interpersonal context seemed vital when dealing with perinatal mental health problems. Many of the interviewees intimated on some level that they needed help with their relationships and that the woman’s presenting problem was not in fact the only - or even the main - issue at hand. There were references to possible aggression between couples and, even when couples were not experiencing conflict, family dynamics were still perceived to be central.

Not only this, but also a woman’s family context influenced her access to care and interactions with services. Some women had partners or relatives who pushed strongly for them to get psychiatric treatment (occasionally even when the woman did not want this), while in other cases women’s families were absent or resistant to them accessing help, at times leading them to keep their treatment secret. Though only speculative, I noticed how one woman in a traditional family-set-up, with a well-resourced, proactive partner, had been offered rapid admission to an MBU (in the context of self-harm), while another who was mothering alone in a more precarious context, was refused an MBU admission and ultimately judged to be an unfit mother (also in the context of self-harm).

**Emphasis on the individual mother not the family**

Despite the evident importance of family relationships, support often appeared to be focused on the individual mother rather than on her wider
family or interpersonal context - let alone on the broader social context within which each family was situated.

In some cases, professionals had seemingly overlooked the relevance of the family setting or it was only given a fleeting consideration. In other cases, although it is hard to know for sure, it seemed possible that, faced with complex interpersonal dynamics, professionals may sometimes have shied away from, or perhaps lacked the resources or training to engage fully with the intricacies of women’s wider contexts.

The focus on the individual rather than the interpersonal seemed to make families’ experiences of support ultimately inadequate or partial, with difficulties often persisting following treatment and with calls for couple’s therapy, particularly from women. Sometimes a lack of focus on the interpersonal context even risked exacerbating the difficulties, as when women and their partners or family members did not feel heard or validated themselves, they struggled to empathise with each other’s perspectives.

In a few cases, professionals had considered the role of interpersonal dynamics in relation to women’s presenting difficulties - for example by offering Sarah and Tim couple’s counselling (albeit unsuccessfully as the couple could not access it), or by being sensitive of Laila’s need for privacy from her family. Likewise, there were examples of partners being included or offered support – for example, in James’ positive interactions with MBU staff, or Bob’s attendance at a support group for partners. Yet such support and involvement appeared patchy and insufficient and rarely resulted in couples or wider families feeling fully supported.
Meanwhile, the emphasis on individual mothers could also make women feel they were scrutinised more than their partners or families and treated more punitively or harshly. One woman, for example, felt that she had to continually prove she was a ‘good mother’, while less was expected from her partner. What she experienced as his controlling behaviour towards her was, in her view, also overlooked.

**Marginalisation of partners and families**

Connected to the focus on individual mothers, the analysis revealed that women’s partners and wider family members reported feeling neglected and marginalised by services. Without exception in these dyads, partners and relatives had struggled themselves when a mother was experiencing a perinatal mental health difficulty, but felt their needs were frequently overlooked.

There were examples where women’s partners and relatives said they had felt disregarded by professionals even when present during appointments. They wanted to be better informed (e.g. about women’s medication), better included in women’s support, and better supported themselves, both to help them support the mother and to help them with their own difficulties. Suggestions for support included counselling, phoneline support, care coordinators for family members, online forums for partners, support groups for fathers, childminders to offer respite and, more broadly, a desire to feel ‘held in mind’.

There were also some indications that services could be perceived by fathers to be matricentric, with largely female staff, making male partners feel
excluded. Additionally, while mothers already had links with professionals like midwives, their families had fewer channels through which to access support.

**Latent ambivalence about inclusion and support**

Nevertheless, the analysis also suggested that women and their families in reality experienced some ambivalence about partner or family inclusion and support, even though ostensibly they were calling for it. For example, it was clear that women’s partners and relatives typically downplayed or dismissed their own needs (although professionals arguably also reinforced this through the low profile they gave to them, while women at times similarly appeared to treat their family members’ needs as secondary to their own). Partners and relatives often reported a belief that they had to hold things together, ‘crack on’, not expect much in the way of support, and not burden women with their own problems (although ironically it was their denial of their underlying feelings and needs that at times created additional issues). While there always appeared to be at least some desire from partners and relatives for better inclusion and support, traditional norms of masculinity acted as a barrier in some cases, with men in particular appearing to interpret it as unacceptable to require help themselves.

On top of this, women themselves also seemed to communicate some underlying ambivalence about including their families in their support. This could occur, for example, where a mother wanted her partner or relative to be more involved, yet also seemed on some level to want to keep them at arm’s length; where she accepted that her partner or relative was not
included enough, but at the same time perceived their involvement to potentially undermine her autonomy; or where she wanted her partner or relative to contribute to her care and be supported themselves, but there was also secrecy or a desire for confidentiality from them.

Taken together, these factors seemed to act as a further incentive for professionals to focus on the mother rather than her family, as they found themselves ill-equipped to respond to such ambivalence.

4.9 Summary of dyadic analysis

Overall, the dyadic analysis in this chapter demonstrates the extent to which a woman’s perinatal mental health is entwined with her interpersonal relationships. Contact with services takes place within the context of complex relationship dynamics. These are inevitably in a state of flux or disruption with the birth of a new baby, a time when particular societal expectations are also placed on mothers and their partners and wider families. The dyadic analysis found that couples and families frequently described women’s perinatal mental health with reference to the interpersonal, even if this was not always done intentionally or knowingly.

Despite this, services were reported to have taken a predominantly individualistic view. They often treated perinatal mental health issues simply as difficulties within individual mothers rather than as difficulties between or around people, and they did not often engage in a meaningful way with the wider context. This could risk pathologising individual women, or even labelling them as ‘unfit mothers’, turning attention away from the need to address their interpersonal and social contexts.
Meanwhile, women’s partners and relatives were left feeling marginalised, while couples and wider families reported unresolved issues following treatment. There was little in the way of support for women’s families, either to help them support women or to address their own distress. This left them feeling their own needs were overlooked. Nevertheless, despite their apparent calls for better inclusion and support for families, women and their families also communicated considerable ambivalence about the possible consequences of greater family involvement for their relationships and sense of self-worth. As professionals seemed inadequately prepared to overcome such ambivalence, the pattern of focusing on individual women rather than families persisted.
Chapter 5. Findings of the thematic analysis of interviews with women and their partners and family members

In this chapter I provide another perspective on the data in addition to the dyadic analysis in chapter 4. I present findings from the wider thematic analysis of the full study dataset (as described in chapter 3). In many respects, the findings of the thematic analysis complement those of the dyadic analysis (and vice-versa) with similar themes identified across both analyses. But, while the dyadic analysis focused ‘up close’ on a small number of interviews - with a particular emphasis on how systemic factors, family dynamics, and family members’ competing perspectives could influence experiences with services - the thematic analysis can be seen as ‘widening the lens’, offering a somewhat more broad-brush perspective on the data, but also one that facilitates comparison and contrast of the findings across different types of service and participant.

Like the dyadic analysis, the focus of the thematic analysis was on the role of families in relation to perinatal mental health difficulties and women’s access to support, and experiences of how services supporting women with perinatal mental health difficulties work with their families. As I outlined in chapter 3, I decided to present findings from interviews with women alongside those of their partners and family members, to allow universal findings across different participant groups to be clearly shown, and findings unique to particular types of participant also to be drawn out. This chapter includes analysis of findings across the full range of mental health services that
women accessed. Findings from participants included in the dyadic analysis are occasionally also included below, though overall I made to represent a wide spread of interviews beyond these fourteen participants (quotations from the ‘dyadic’ participants are also not explicitly labelled as such, in order to protect their confidentiality).

A version of this thematic analysis has been published (see Appendix 2):

Experiences of how services supporting women with perinatal mental health difficulties work with their partners and families, BMJ Open, 9(7), http://dx.doi.org/10.1136/bmjopen-2019-030208

I also presented the findings of the thematic analysis at the annual conference of The UK & Ireland Marcé Society in December 2018.

5.1 Characteristics of participants

Tables 4 and 5 show participants’ characteristics. Women had been given a range of diagnoses including depression, bipolar disorder, psychotic disorders, personality disorder, and anxiety disorders. Their mean age was 32 years (range: 19-43) and around two thirds (67%) were living with a husband or partner.

Although, as outlined in chapter 3, qualitative research is not typically designed to be representative or generalisable, and the numbers involved are small, a few comparisons between sub-groups of participants were
conspicuous and therefore seem useful to note, albeit cautiously. In particular, while twenty-seven of the thirty-four women in the sample from a White background were living with a husband or partner (79%), along with three of the four Asian women (75%), this was true of only two of the eleven women from a Black background (18%). Likewise, only four of eleven women diagnosed with a personality disorder were living with a husband or partner (36%), which was considerably lower than for all other diagnoses. Also, only five of the eleven women aged 25 or under were living with a husband or partner (45%), compared with thirty of forty-one women aged over 25 (73%). Overall, thirty-six women (69%) in the sample said their partners had some involvement with caring for their baby. This was the case for twenty-seven of thirty-four White women (79%) and for three of the four Asian women (75%), but for only four of the eleven Black women in the sample (36%). Twenty women (37%) said that wider family members (most commonly maternal grandparents) helped look after their babies. This was the case for three of the Asian women (75%) and fifteen women from a White background (44%), but for only two of the women from a Black background (18%).

These factors may also help to explain why I was successfully able to interview a partner or other family member for twenty-six women from a White background (76%), and for two of the four Asian women (50%), but for only three of the eleven women from a Black background (27%)⁵.

Five women in the sample did not have custody of their babies at the time of their interview. Four of these women were young mothers (25 or under), four

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⁵ The remaining interview was with the partner of one of the two women from a mixed background.
had been diagnosed with a personality disorder, and two were from a Black background (with the remaining three from a White background). None of these women were living with a husband or partner.

Just over two thirds of participating family members were women’s partners (n=22; one female – i.e. same sex partner, the others male). Around a fifth (n=7) were parents of participating women (who I refer to as ‘grandparents’). The mean age of women’s partners was 34 years (range: 23-48), while for grandparents it was 54 years (range: 39-67). The young age of grandparents may reflect the fact that they were often the chosen family member for the young (and single) mothers included.

**Table 4.** Key characteristics of participating women (N=52)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Category</th>
<th>Respondents (n; %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>19 (37%)</td>
</tr>
<tr>
<td></td>
<td>Psychosis/bipolar/schizophrenia</td>
<td>13 (25%)</td>
</tr>
<tr>
<td></td>
<td>Personality disorder</td>
<td>11 (21%)</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>9 (17%)</td>
</tr>
<tr>
<td>Key service(s) used</td>
<td>Perinatal</td>
<td></td>
</tr>
<tr>
<td>(women could use more than one service)</td>
<td>MBU</td>
<td>10 (19%)</td>
</tr>
<tr>
<td></td>
<td>Specialist perinatal community team</td>
<td>18 (35%)</td>
</tr>
<tr>
<td></td>
<td>Specialist health visitors/midwives</td>
<td>12 (23%)</td>
</tr>
<tr>
<td></td>
<td>Parent infant team</td>
<td>10 (19%)</td>
</tr>
<tr>
<td></td>
<td>Non-perinatal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General acute ward/crisis house</td>
<td>11 (21%)</td>
</tr>
<tr>
<td></td>
<td>Crisis resolution team</td>
<td>17 (33%)</td>
</tr>
<tr>
<td></td>
<td>Community mental health team</td>
<td>15 (29%)</td>
</tr>
<tr>
<td></td>
<td>Talking therapy service</td>
<td>10 (19%)</td>
</tr>
<tr>
<td></td>
<td>Early intervention in psychosis</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Previous service use for mental health</td>
<td>Yes</td>
<td>42 (81%)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>10 (19%)</td>
</tr>
<tr>
<td>Age</td>
<td>Mean age</td>
<td>32 yrs (range: 19-43 yrs)</td>
</tr>
<tr>
<td></td>
<td>≤ 25 years</td>
<td>11 (21%)</td>
</tr>
<tr>
<td></td>
<td>25 - 29 years</td>
<td>7 (13%)</td>
</tr>
<tr>
<td></td>
<td>30 – 39 years</td>
<td>29 (56%)</td>
</tr>
<tr>
<td></td>
<td>≥40 years</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British</td>
<td>28 (54%)</td>
</tr>
<tr>
<td></td>
<td>White Other</td>
<td>6 (12%)</td>
</tr>
<tr>
<td></td>
<td>Black (Caribbean)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td></td>
<td>Black (African)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td></td>
<td>Black (Other)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td></td>
<td>Asian (Pakistani)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td></td>
<td>Asian (Indian)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Category</td>
<td>Value</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Arab</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>Mixed Race</td>
<td>2 (4%)</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>20 (38%)</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>7 (13%)</td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>No religion</td>
<td>24 (46%)</td>
<td></td>
</tr>
<tr>
<td>Work status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed full-time</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>Self-employed part-time</td>
<td>2 (4%)</td>
<td></td>
</tr>
<tr>
<td>Maternity leave</td>
<td>22 (42%)</td>
<td></td>
</tr>
<tr>
<td>Unemployed/homemaker</td>
<td>23 (44%)</td>
<td></td>
</tr>
<tr>
<td>Unable to work due to illness</td>
<td>4 (8%)</td>
<td></td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal qualifications</td>
<td>8 (15%)</td>
<td></td>
</tr>
<tr>
<td>Secondary leaving qualifications</td>
<td>22 (42%)</td>
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</tr>
<tr>
<td>Undergraduate degree</td>
<td>10 (19%)</td>
<td></td>
</tr>
<tr>
<td>Postgraduate degree</td>
<td>12 (23%)</td>
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<tr>
<td>Housing status</td>
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<td></td>
</tr>
<tr>
<td>Owner occupied</td>
<td>15 (29%)</td>
<td></td>
</tr>
<tr>
<td>Private rental</td>
<td>13 (25%)</td>
<td></td>
</tr>
<tr>
<td>Local authority/housing association</td>
<td>15 (29%)</td>
<td></td>
</tr>
<tr>
<td>Living with family/friends</td>
<td>3 (6%)</td>
<td></td>
</tr>
<tr>
<td>Temporary accommodation</td>
<td>3 (6%)</td>
<td></td>
</tr>
<tr>
<td>Shared/supported housing</td>
<td>2 (4%)</td>
<td></td>
</tr>
<tr>
<td>Shared ownership</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or cohabiting with partner</td>
<td>35 (67%)</td>
<td></td>
</tr>
<tr>
<td>Single/separated/divorced/not cohabiting</td>
<td>17 (33%)</td>
<td></td>
</tr>
<tr>
<td>Mother’s key significant other</td>
<td>35 (67%)</td>
<td></td>
</tr>
<tr>
<td>Partner/baby’s father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s mother/father</td>
<td>7 (13%)</td>
<td></td>
</tr>
<tr>
<td>Other maternal relative</td>
<td>5 (10%)</td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td>2 (4%)</td>
<td></td>
</tr>
<tr>
<td>Mother has no key significant other</td>
<td>3 (6%)</td>
<td></td>
</tr>
<tr>
<td>Who cares for the baby?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother &amp; partner</td>
<td>18 (35%)</td>
<td></td>
</tr>
<tr>
<td>Mother, partner &amp; wider family</td>
<td>12 (23%)</td>
<td></td>
</tr>
<tr>
<td>Mother, partner &amp; nursery/nanny</td>
<td>4 (8%)</td>
<td></td>
</tr>
<tr>
<td>Mother alone</td>
<td>8 (15%)</td>
<td></td>
</tr>
<tr>
<td>Mother &amp; wider family</td>
<td>5 (10%)</td>
<td></td>
</tr>
<tr>
<td>Baby’s father &amp; wider family</td>
<td>2 (4%)</td>
<td></td>
</tr>
<tr>
<td>Foster carer/social services</td>
<td>3 (6%)</td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>26 (50%)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>13 (25%)</td>
<td></td>
</tr>
<tr>
<td>3+</td>
<td>13 (25%)</td>
<td></td>
</tr>
<tr>
<td>Custody status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained custody of baby</td>
<td>47 (90%)</td>
<td></td>
</tr>
<tr>
<td>Not in custody of baby</td>
<td>5 (10%)</td>
<td></td>
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</table>
Table 5. Key characteristics of participating family members (N=32)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Category</th>
<th>Respondents (n; %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to mother</td>
<td>Husband/wife/partner</td>
<td>22 (69%)</td>
</tr>
<tr>
<td></td>
<td>Mother/father (‘grandparent’)</td>
<td>7 (22%)</td>
</tr>
<tr>
<td></td>
<td>Other relative (e.g. sister/child)</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Mother’s primary diagnosis</td>
<td>Depression</td>
<td>9 (28%)</td>
</tr>
<tr>
<td></td>
<td>Psychosis/bipolar/schizophrenia</td>
<td>10 (31%)</td>
</tr>
<tr>
<td></td>
<td>Personality disorder</td>
<td>6 (19%)</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>7 (22%)</td>
</tr>
<tr>
<td>Key service(s) mother used</td>
<td>Perinatal MBU</td>
<td>7 (22%)</td>
</tr>
<tr>
<td></td>
<td>Specialist perinatal community team</td>
<td>8 (25%)</td>
</tr>
<tr>
<td></td>
<td>Specialist health visitors/midwives</td>
<td>9 (28%)</td>
</tr>
<tr>
<td></td>
<td>Parent infant team</td>
<td>5 (16%)</td>
</tr>
<tr>
<td></td>
<td>Non-perinatal General acute ward/crisis house</td>
<td>8 (25%)</td>
</tr>
<tr>
<td></td>
<td>Crisis resolution team</td>
<td>8 (25%)</td>
</tr>
<tr>
<td></td>
<td>Community mental health team</td>
<td>9 (28%)</td>
</tr>
<tr>
<td></td>
<td>Talking therapy service</td>
<td>8 (25%)</td>
</tr>
<tr>
<td></td>
<td>Early intervention in psychosis</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Age</td>
<td>Mean age (partners)</td>
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<td>Mean age (grandparents)</td>
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<td></td>
<td>Mean age (other relatives)</td>
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<td></td>
<td>≤ 25 years</td>
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<tr>
<td></td>
<td>26 - 29 years</td>
<td>7 (22%)</td>
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<tr>
<td></td>
<td>30 - 39</td>
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</tr>
<tr>
<td></td>
<td>White Other</td>
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</tr>
<tr>
<td></td>
<td>Black Caribbean</td>
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</tr>
<tr>
<td></td>
<td>Black African</td>
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<tr>
<td></td>
<td>Asian (Indian)</td>
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<tr>
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<td></td>
<td>No religion</td>
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<tr>
<td></td>
<td>No</td>
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<td>Personality disorder</td>
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<tr>
<td></td>
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<td></td>
<td>Self-employed part-time</td>
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<td></td>
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5.2 Overview of themes

Three overarching themes were identified in the thematic analysis: 1) the centrality of women’s families to their perinatal mental health and access to support; 2) experiences of partners and families being excluded by services; 3) ambivalence among women and family members about increasing family involvement/support. Table 6 shows sub-themes for these, each of which is presented and elaborated on in the text that follows. Given the large and diverse samples included in this study, diagrams 1 and 2 provide an overview of how participants’ views and experiences vary in relation to different types of mental health services (diagram 1), and in relation to their status as direct service users (women with perinatal mental health difficulties), partners, or wider family members (diagram 2).

Overall, women, their partners, and wider family members considered that families were marginalised by services and should be better included and supported. But they also described some unique anxieties about this. While all types of mental health service were reported to marginalise families, MBUs were seen as the most inclusive.
Table 6. Themes and sub-themes identified in the thematic analysis

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
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<tbody>
<tr>
<td>Centrality of women’s families to their perinatal mental health and access to support</td>
<td>The role of interpersonal transition and conflict</td>
</tr>
<tr>
<td></td>
<td>Influence of the family on support and recovery</td>
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<tr>
<td>Experiences of partners and families being excluded by services</td>
<td>Overlooking families</td>
</tr>
<tr>
<td></td>
<td>Lack of support for partners and other family members</td>
</tr>
<tr>
<td></td>
<td>Difficulties balancing women’s and family members’ needs</td>
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<td></td>
<td>Services ill-equipped for complexity of family involvement</td>
</tr>
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<td></td>
<td>Structure of services and separation of families</td>
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<tr>
<td>Ambivalence about increasing family involvement and support</td>
<td>Feared consequences of family inclusion or support</td>
</tr>
<tr>
<td></td>
<td>Partners and other family members have to ‘stay strong’</td>
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</tbody>
</table>

5.2.1 The centrality of the family to perinatal mental health and access to support

With similarities to the findings of the dyadic analysis, a key finding from the thematic analysis centred on the importance of women’s families to their difficulties, interactions with services, and longer-term recovery. The dyadic analysis demonstrated on a nuanced, almost intimate level how family dynamics could contribute to women’s struggles. The thematic analysis meanwhile, showed on a broader scale how family dynamics were viewed as central by women, their partners and other family members. While, as outlined, certain groups of women were more or less likely to be living with a husband or partner, interpersonal conflict was described as influential to women’s mental health difficulties across all diagnoses and socio-demographic backgrounds. Although it is important to acknowledge that a range of other factors were also cited as influential to women’s perinatal
mental health (e.g. pregnancy complications, birth trauma, previous trauma, poverty, having to give up work, and sleep deprivation, among others), findings from the thematic analysis supported the view that a woman's mental health needs should be addressed with reference to her family and interpersonal context.

The role of interpersonal transition and conflict

It was clear from the thematic analysis that women and their family members viewed pregnancy and having a baby as a major life transition: it resulted in shifts in their roles, relationships and identities, and this could provoke distress. Though the adjustment could be particularly marked for first-time parents, the addition of further children could also disrupt the status quo. It was conspicuous how frequently women and their family members linked interpersonal conflict and tension to the woman’s difficulties.

Women, in particular, often cited discord with their partner or wider family as contributing to or exacerbating their mental health difficulties. Several described their relationships with partners, as well as with wider family members and friends as having broken down during pregnancy or after giving birth, often leaving them to cope with their babies largely alone. One woman, who had been diagnosed with depression, spoke about her difficulties coping after her partner left her during pregnancy: she described her isolation as a young, single mother, and her struggles to live up to her image of the ‘perfect mother’.

I was in a good place before I got pregnant. And then when I found out I was pregnant, it knocked me sideways. And then, with
everything that happened with his dad [leaving me], it was just a massive blow. So, within the space of a few months, I had lost his dad, fell pregnant, gave up my job, and I was just in a big hole…

…You want to be on your game for your child, you want to be on the ball, perfect mum, and sometimes you just feel so low about yourself and the situation that you’re in. When it’s raining outside, you don’t want to take your baby when you’ve got nowhere to go. You’re not heading anywhere…

…I used to work all the time, so I had a really good group of friends…And suddenly, you’ve got no one, you’re on your own, you hardly see anyone.

Mother 17

Other women felt frustrated and overburdened, saying that their partners did not help enough with the new baby, or did not really understand how difficult motherhood was.

When I first told [my husband] about my depression…he just didn’t get it. And it’s almost like anything I say is an attack on him…or ‘Oh, well, if you’re feeling depressed, imagine how I’m feeling, you know, trying to work and pay the rent’…So I always feel like I can’t tell him my problems because they’re just so irrelevant…And he’s self-employed, so if I do want to go out or something…he’s like, ‘I can’t be turning work down’…I’ve not gone out in the evenings since having the baby…He said, ‘Oh, we’ve had so many problems since the baby was born’…She’s nearly torn us apart.
I really struggled with my partner because…it was like [our baby would] cry and I’d be the one that gets up with her. He wouldn’t even move, he wouldn’t even flinch. It was always like, almost like sub-consciously it’s my job to do that. It’s something that him and I still struggle with.

Some participants, most commonly women’s partners, expressed the view that family relations had become strained as a result of the woman’s mental health difficulties, rather than vice-versa. For example, some partners of women who experienced postpartum psychosis or postnatal depression said they believed women became difficult, withdrawn, or even suspicious and hostile towards their families, because of their depression or psychotic delusions. Sometimes women shared this view too. For example, one woman who experienced postpartum psychosis explained her belief that “I’d become quite anti and quite hostile to [my husband] when I was unwell” (Mother 28). In some cases, women’s partners also felt rejected or deprioritised by them after the birth of the baby, prompting clashes and distress.

I’ve had my own challenges as well with the change in our lives…If I was on [my wife’s] list before, I’m- I was at the bottom of the list, I’m now not on the list…
You don't have an adult relationship in the same way that you did…You know, I come in from work and [my wife] wants to get to bed early if she’s tired. So you have those sort of like clashes really.

Partner 4

As noted, some groups of women - younger mothers, those diagnosed with a personality disorder, and those from a Black background - were less likely than others to be living with a husband or partner. These women tended to describe living in particularly unstable or unsupportive family contexts. The four women from a Black African background were particularly likely to say that their partners, wider families and communities were critical of their perinatal struggles and did not understand or accept their mental health difficulties, resulting in relationship conflict, breakdown and isolation. One woman from an African Muslim background, for example, said her husband left her soon after the birth of their baby, blaming her for her postnatal depression.

For my background it’s very difficult to talk about [depression]…

Because you know like, oh it’s your fault whatever. You’ve done a mistake, it’s your fault…

…I couldn’t go out because you know…I feel I shunned, because I’m Muslim…Broke my family, broke my partner, broke myself up.

Mother 42

These turbulent relationship shifts were not confined only to women and their partners. Sometimes grandparents or other relatives were also heavily involved with supporting women and helping to care for their babies during
the perinatal period. Where grandparents and/or other relatives were involved in the perinatal period, the birth of a baby often necessitated a reorganisation of wider family relations too and this could provoke conflict. For example, one young, single mother was living with her father and he associated her mental health difficulties partly with their own shifting relationship in the context of a new baby.

I know that at the moment [my daughter’s] suffering with a bit of postnatal depression…I know because she has screaming rows…

When we argue about stuff, the crux of the argument, when we’re sort of nose to nose is, ‘I’m not your bloody boyfriend and I’m not his dad. You don’t get to-, if I was his dad you could talk to me like that…But I’m not, I’m your dad.’ And from [my daughter’s] point of view it’s like, ‘I’m raising this baby on my own’…That kicks me right in the teeth because it’s like, ‘I’m here.’

Grandparent 3

Another woman, from an Asian background, described how she began to experience panic attacks after her husband’s family (who were also Asian) expected her to conform to their views about how she should care for her baby.

My in-laws, it’s different - so certain things like really upset me. I think it just got so public and it made my husband disagree with me. I think it just got so I couldn't deal with it anymore, so I just crashed.

Mother 45
As I found in the dyadic analysis, although it was the women who had been given the diagnosis of a perinatal mental health problem (with few partners or other family members reporting a mental health diagnosis themselves), the wider interpersonal context often appeared crucial to understanding women’s difficulties, and frequently the whole family was struggling.

**Influence of the family on support and recovery**

As I also emphasised in the dyadic analysis, women’s contact with mental health services took place in the context of the complex, shifting family dynamics described. It was clear that family circumstances, and the attitudes and behaviours of family members, influenced women’s access to support, interactions with services, and recovery. Women who had some of the ‘worst’ outcomes (e.g. those who had multiple hospital admissions or had lost custody of their babies) were typically living in particularly challenging family contexts, categorised by conflict, relationship breakdown, and sometimes violence and abuse from partners or other family members. For example, as outlined, none the five women whose babies had been removed from their custody were living with a partner. All of them also described wider familial conflict.

When women perceived their partners or wider families to be unsupportive of them or dismissive of their struggles, this could increase or prolong their distress.
[My husband] was like…’You’re not the woman I thought you were.’…And it just wasn’t working. And then eventually it got worse, I think I, within two weeks anyway I was like completely suicidal.

Mother 11

In a few cases, partners or other family members put pressure on women not to access support. This could be because they were anxious about women taking medication, or feared that professionals might judge the family negatively, or even take the baby away.

The [perinatal mental health nurse] had actually suggested that maybe [my wife] might want to go into a mother and baby care unit. And I was very against that. I think that’s just my, I was kind of really fearful that if we got into that situation, it’d be something that would be on some paperwork for the rest of our lives. And who knows how somebody’s going to interpret that in the future.

Partner 1

In some cases, women turned down treatment because they felt their families were resistant to it; in other cases, they kept their treatment secret. This could be especially sensitive for women from cultural or religious backgrounds where stigma around mental health difficulties was more commonly reported (particularly Arab, African, Asian and Muslim). In some cases, as with Laila in the dyadic analysis, women remained close to their families and communities but hid details of their difficulties and treatment from them; other women became increasingly isolated, which could further exacerbate their struggles.
I don’t want anybody to know about my situation, because depression in front of our people is different... You know, depression, what I’m going through... in Africa, the difference is like you are not okay, that person is not okay.

Mother 34

On the other hand, there were numerous instances where partners and other family members were supportive of women’s treatment and recovery. They were often seen (by women in particular) as instrumental in identifying women’s difficulties, encouraging them to get help, and assisting their recovery, with some family members describing their relief when women accessed support. Supporting the speculation I made in the dyadic analysis, it appeared that women with proactive family members supporting and advocating for them got access to professional support more readily than those without.

The day after I had the meltdown my mum phoned the GP and she was trying to make an appointment and they were kind of saying, ‘No we don’t have any appointments today.’ And she was like, ‘No I really need to see the GP’. And she kind of explained the situation and they said, ‘Yes, just bring her in straight away.’... I was like, ‘Mum don’t take me to the GP, they’re going to take the baby away and they’ll think I’m crazy’... And she was just like, ‘But you need help and they’re not just going to take her away. I’m here. I’m able to look after her.’

Mother 13
I couldn’t even speak to [professionals]…So my husband did it initially to sort of get the appointment.

Mother 45

When women struggled, their partners and wider families frequently took over household chores or helped more with the baby, for example doing night feeds or looking after the baby while the woman attended appointments or was hospitalised. Women from some backgrounds (e.g. Asian) sometimes reported that sharing infant care among extended family networks (at least among female family members) was considered the norm within their culture. For other families, taking on extra responsibilities could put a strain on partners and wider families as well, especially as many partners were already struggling to juggle their existing responsibilities (e.g. the need to provide financially for their families), with having a new baby. In some cases, they blamed themselves for what had happened, worrying that they had not helped enough.

As a man, or partner, husband, you feel like it's your fault your partner is the way that they are...Maybe I’ve not loved her enough. Maybe I’ve not helped enough. But really, in essence, you’re probably doing as much as you can, or doing more than what you normally do...I blamed myself a little bit, not just for, you know, the pregnancy and the baby, but just, I don’t know, everything really.

Partner 15

It made me realise that when I had my first two my mum, bless her, she used to have [my baby] every weekend, so I could get sleep
because he never slept. But it made such a difference. And not having her this time, I think that’s a big cause of postnatal depression nowadays, is that families don’t live near each other.

5.2.2 Experiences of partners and wider families being excluded by services

Despite their perceived importance, many of those interviewed believed that families were excluded by services supporting women with perinatal mental health difficulties. Expanding on the in-depth findings from the dyadic analysis, it was clear that experiences of marginalisation were reported by women, partners and wider family members across different demographics, diagnoses and service types, although MBUs appeared to be more inclusive of families than other services. By providing a wider perspective on the data, the thematic analysis showed how the exclusion of families could manifest itself in a range of different ways including: not being invited to or included in appointments; not being provided with information about, or helped to understand, the mother’s mental health problems; not being involved in treatment decisions; family members’ own distress and difficulties not being acknowledged; and not being offered any support for these difficulties. These are described in more detail below.

Overlooking families

It was common for women and their family members to say that professionals overlooked partners and wider families, focusing their attention exclusively on women and their babies. Mirroring this, some women and
family members conceded that they too had given little thought to family involvement - e.g. not thinking to ask if family members could attend appointments or access support themselves - even if, in hindsight, women and their family members alike thought this could have been valuable.

Nobody asked [about my husband being involved]. Nobody offered or asked. I think it would have been useful, but I didn’t even think of it either.

Mother 12

Within community mental health services in particular (both specialist perinatal services and generic, non-perinatal services) there were sometimes few opportunities for family members to become involved or meet clinicians (e.g. if they weren’t invited to appointments), and a sense that there was no real “place for, like, a husband” (partner 15). As a result, women’s families often felt poorly informed about their difficulties and treatment: they were unsure exactly what support a woman was receiving, what to expect, and how best to help her.

I wing it every day with supporting [my partner], so I don’t know the correct way…There’s been no support there to help me. I feel sometimes the best way for me to support [her] is just agree with her and deal with it after…But I don’t know whether that’s the right way to go about it overall. She’s got a [specialist perinatal] psychiatrist. What about support for the dad in this case?

Partner 9
A number of women and their family members wanted families to be included in at least some appointments: they felt this would both allow them to contribute their own observations, and also help them better understand and support women.

It would’ve been nice to have had a bit more involvement [with the IAPT therapy] as far as, you know, meetings or otherwise just so that I have a better grasp to understand what issues we’re dealing with…I guess I didn’t know, within the structure of how everything works, how I could get involved.

Partner 5

[My husband] wanted to speak to professionals to tell them his side...I would [have liked that too], just to see, you know, because he’s not like the easiest of men, but then he’s not responded in a way that I needed him to respond...And he’s never ever approached me in a way he needs to approach me, so it makes me worse.

Mother 50

When mental health professionals visited women at home, family members really valued being included and asked for their input. But some felt they were ignored.

I’ve never really talked to [the early intervention service care coordinator]...Like she comes here and talks to [my partner]. Doesn’t really say much to me or doesn’t ask me, ‘How do you think she is?’ , or things like that. I mean nothing...It would have been nice
for her to say, ‘Well I’ll involve you in some of the meetings.’ But you don’t get nothing.

Partner 11

When [the crisis team] came around it was literally just to talk to me, they weren’t sort of interested in anybody else.

Mother 24

Where women were admitted to MBUs or psychiatric wards (in the majority of cases for a psychotic disorder, but in a few cases also with depression or a personality disorder), their families were more likely to have at least some contact with clinicians on inpatient units. For example, they might speak to them when visiting women or arranging visits, and some were involved in treatment decisions if women were judged to lack capacity. MBUs were praised overall for working collaboratively with women’s families, regularly communicating with them, as well as inviting them to be present at ward rounds and taking their views into account. By contrast, family members often had to be proactive and persistent to get staff on general psychiatric wards to keep them updated on the woman’s condition and treatment plan. There were even cases where women said staff on acute wards treated them like “a single person” (mother 44), hardly acknowledging their families, and sometimes not even realising they had a new baby. One man, whose partner stayed on both an MBU and an acute ward, described the MBU as more inclusive of him than the acute ward.
Two or three days go and then I would call [the ward] again because they never, well they hardly ever called me. It was me trying to find out things all the time.

I was asked to attend [meetings at the MBU] if I wanted to. You know, they wanted me to attend to see…it was run like with partners in mind. They wanted the partners to be involved and to, you know, to help in the whole process.

Partner 14

Family members pointed out that they sometimes had important information to relay to professionals and that overlooking them could result in detrimental decisions about admissions.

I wasn’t told [which psychiatric unit she was being taken to] until the ambulance was on its way and then I had some frantic phone calls trying to undo it because she’d had past experiences in this very unit…which meant it wasn’t appropriate for her to go back…and the modern matron…when he heard what I had to say about it did seem genuinely troubled by it and said, ‘Gosh, what a shame we hadn’t consulted about that and found out. It sounds like she really shouldn’t be coming to us at all.’ She was literally on her way in the ambulance and they couldn’t undo it.

Partner 12

Lack of support for partners and other family members

As well as wanting information about and involvement in women's support, some partners and family members said they would have valued emotional
support from mental health professionals themselves, for their own distress; they wanted help coping with the effects of the woman’s mental health problems on them, and addressing their own difficulties adjusting to life with a new baby. Across the data corpus and regardless of community, inpatient, perinatal or non-perinatal mental health settings, few accounts were provided of support targeted at family members.

From a personal perspective, something to help with my adjustment to [having a baby]. If there were a way to be more involved with [my wife’s] situation so I can better understand it, that would’ve been helpful for understanding her situation. But also something to help understand mine.

Partner 5

In general, families wanted support to be offered face-to-face or over the telephone. In particular they described wanting professionals to acknowledge how difficult things were for them, and to check how they were doing. Several partners and other family members felt that nobody was thinking about them.

I don’t want any sort of physical help from anyone but just talking to someone and saying, ‘You know, let’s have a cup of tea, we’ll come and see you just to see how things are going.’ That itself would have been great, but I wasn’t given any of that [by the community mental health team]. No, not at all.

Grandparent 6
I felt I wasn’t being more involved, like, and no one’s coming to me, like, ‘How are you doing? How is your mental health state?’ And all this, you know. Because it’s not easy. And I get a bit, like, okay. No one’s asking me how I am. How about me? I thought, it’s not only her going through this, it’s me. I’m there and all.

Partner 7

There were a few exceptions where professionals, most commonly perinatal specialists on MBUs or in the community, had acknowledged family members’ needs and engaged with them too, and when this happened it was valued.

[I had] lots of, just informal chats…Different members of the [MBU] staff would ask me how I’m coping, am I alright? How are things at home? And sometimes I sort of took up the offer to sit and have a bit more of a chat.

Partner 12

However, even when support had been offered, it was frequently viewed as superficial, insufficient or too late.

I was offered support [after my wife’s MBU admission], but it was all sort of quite late on in the process. And kind of, ultimately, you had a meeting with someone at home. They were very nice. But none of the things that were due to be followed up on were followed up on.

Partner 17
Difficulties balancing the needs of women and their family members

In some cases, rather than simply overlooking partners and wider families, respondents’ accounts suggested that clinicians may have excluded partners or family members because of concerns that involving them could reduce the focus on the needs of the woman (and baby), or because they were mindful of the need to protect women’s potential desire for confidentiality from their families. I described issues around privacy and confidentiality in the dyadic analysis too, and the thematic analysis showed on a broader scale how complex these challenges could be: as outlined, some women kept aspects of their mental health or treatment secret from their families, while others described experiencing turbulent, unequal and sometimes coercive and abusive relationships, meaning that privacy and time alone with professionals could be vital. Prioritising the needs of women and babies, and keeping a clear focus on them, seemed important in this context. Yet it could also leave family members feeling shut out.

Several family members, across different types of service, described how they had wanted to put across their own opinions (e.g. if they felt a woman was struggling more than she admitted, or wanted to tell professionals that a woman’s hostility towards them was, in their view, really driven by paranoia, psychosis or similar). But they felt mental health professionals were unwilling to speak to them, rarely provided options for them to speak to clinicians in confidence themselves, and appeared cautious, suspicious or mistrustful of them. Occasionally family members explicitly linked this to the maternal focus of care and to having more female than male staff within both perinatal
and non-perinatal mental health services.

I wanted to say to the [specialist] health visitor, ‘Look maybe do you think that this could be postnatal depression…?’ I would have liked the chance to discuss it with her. Not that I wanted to encroach on any of [my daughter’s] time with her…But alas…If I was in the room then everything sort of stopped until I left the room, and then they recommenced…The minute I walked in it was like tumbleweed.

Grandparent 3

The issue is when it comes to doctors and things like that, they can’t talk to me because there’s confidentiality…I’ve managed to get people to talk to me with [my partner’s] consent, but it’s a battle. If I feel something’s wrong, but [my partner] won’t admit it, so if I feel she’s deteriorating but she’s blocking it out, I can’t talk to anyone.

Partner 14

For their part, some women who desired privacy from their families had still wanted them involved in some way. As with Laila and Amy in the dyadic analysis, some women saw value in involving their partners and wider families in their care, but at the same time kept details of their difficulties secret from them (e.g. due to perceived cultural stigma around mental health and/or because they feared their families would be critical of them). These women sometimes expressed a wish that professionals had helped them to negotiate this, offering more options for how their families might be included given this sensitive wider context.
[The community mental health team] haven’t told me, ‘How would you like us to involve [your husband]?’ They just told me to bring him to my appointments. But I don’t want to bring him to my appointments because they might bring up something that he doesn’t know and then that would just cause problems afterwards…[I’d like to] take him along with me [so he could get] some sort of understanding…But like I said, it’s either come to my appointments or don’t get involved.

Mother 35

In some cases, women had explicitly asked for their partners to be included in their appointments but were told that this was not possible.

I did ask if I could take my husband with me…to the [IAPT] therapy.

Yes. But they said no. So I was really nervous. My husband came with me, but he had to sit outside.

Mother 45

However, adding to the complexity, a few women said that too much emphasis on involving their partners or family members could leave women themselves marginalised. This suggested that professionals at times may have experienced difficulties determining the appropriate emphasis to place on different people’s needs or perspectives – especially where interpersonal relationships were strained.
When you’re in hospital, they hardly listen to you. Well, this is my experience, my feeling. That, it’s like they hardly listen to you at all because they know the reason you’re in hospital is because you’re unwell. So they listen to [my husband].

Mother 26

[Her ex-partner would] just have to click his fingers and people would be like, ‘Oh okay we’ll change it, we’ll change meetings, we’ll change times, we’ll give you what you want all the time’…But [the mother is] not allowed to kick up a fuss about it.

Relative 2

Nevertheless, there were a small number of examples that suggested it was possible to protect women’s needs without excluding their families, even in difficult circumstances. These were usually cases where professionals had built up a thorough picture of the family context, for example in non-perinatal mental health teams which had been involved longer-term, not only during the perinatal period. For example, the partner of one woman (who had a pre-existing diagnosis of bipolar disorder and experienced postpartum psychosis) described how, although he initially felt marginalised by community mental health team clinicians, he felt they had got to know the family situation better over time, and became more adept at meeting both his and his wife’s needs.

It’s been a very fine line to tread for them and they’ve done it very well…Not making me feel excluded…Not using confidentiality as a rather convenient way of just not having to deal with me…But
finding sensitive and appropriate you know, professionally appropriate ways around that so that they get the information they need from me…And that I still feel supported.

Partner 12

Services ill-equipped for complexity of family inclusion

As the findings above suggest, complex interpersonal dynamics between women and their families meant that family involvement was not always straightforward. There were indications that mental health professionals at times felt ill-equipped or under-resourced to deal with this complexity, marginalising family members as a result. For example, in one case, a woman believed her perinatal mental health nurse excluded her partner from appointments because she did not feel suitably trained to deal with the tensions in their relationship. Nobody else, she said, was able to support her partner or see them together either.

I’m just, basically like, surprised that there is no support system for carers, or friends, or partners, or family members, there’s no support system whatsoever…

[My perinatal mental health nurse] doesn’t want to make it worse. It’s like a very different, couples therapy, like dealing with two people in the same room who’ve got conflict with each other, it’s a very different thing, yes. And like, so I think, I don’t know how many years of training it is, but like, she doesn’t have that training, she can’t do it, yes.

Mother 8
In another case, a woman described how her therapist within the IAPT service she accessed viewed her relationship difficulties in the wake of having a new baby as beyond the remit of her therapy for PTSD.

[Involving my partner] would have been good and-, but I know that was out of the box as well. So, I know talking about my husband was kind of outside of talking about the flashbacks…It would have been helpful because there was an anger and a frustration element of the fact that I was in labour for five days and ended up bleeding on the floor and my husband like wasn’t here.

Mother 12

I noticed that some women who had separated from their partners nonetheless maintained contact with them, for example where their partners continued to share care of, or at least visit, their babies. Couples in this situation at times struggled to manage their ongoing contact or parent jointly. However, there were few accounts of services offering support to help them with their relationships or with parenting collaboratively.

There were, however, a few exceptions where women and family members described practitioners, most often specialist perinatal practitioners, as engaging confidently with the family context and this was appreciated.

[My perinatal mental health nurse] was meeting with my boyfriend as well at the same time and he was trying, you know, to help us with the, you know, relationship thing and what is happening and stuff. No, he was very, very good.

Mother 1
Yet in other cases, partners and family members believed professionals excluded them because their perspectives could be awkward or difficult.

I’m quite happy to go in there and say to them, ‘I don’t like the way you’re doing this’ or, ‘I don’t think it’s right what you’re doing’ or, ‘you shouldn’t be doing it.’ And I don’t think they liked it…And I just think it’s because, a bit of bad blood between us that they just distanced their self away.

Grandparent 5

When professionals struggled to respond to the wider interpersonal context in a way that was perceived to be helpful by women and their families, it could interfere with women’s recovery and result in an escalation of difficulties.

It escalated out of control, basically. [Professionals] thought, ‘Oh, he doesn’t want her back.’ They needed to get [my wife] out of hospital. They discharged into, I don’t know, some secret place…I thought, ‘Wow, I didn’t mean it like that’…She was very emotionally distraught from it. And she thought I dumped her, but I said, ‘I didn’t dump you. I don’t want us to step back into the same situation and get you more stressed…We’re going to come to a breakpoint again.’…If [professionals] would have listened to me…But they took me all wrong. It was always just escalated.

Partner 7

Where wider families were involved, in particular when grandparents were supporting single mothers, they sometimes also felt that professionals were
ill-equipped to consider their unique role and needs. Likewise, in unconventional family set-ups, family members could feel poorly accommodated, for example where women had new partners who weren’t the baby’s biological father.

It’s a grandad’s role…You’re looked at from the outside world, from doctors and health professionals and psychiatric healthcare professionals as a dad in that situation…Because the dynamic of families has changed, the dynamic of the help that is offered to them should be changed.

Grandparent 3

[Professionals] didn’t want to see me as ‘Dad’…It’s been slightly difficult they didn’t accept it.

Partner 22

Just because it’s [not] biological, doesn’t make him any less a father. So stop acting like he’s just a tagger-onner.

Mother 52

The structure of services and separation of families

Finally, broader structural issues were sometimes referred to in relation to how and why partners and families were marginalised from services. In particular, women and their families noted that inpatient admissions involved separating family members from each other, often meaning that partners or relatives cared for babies (or older children) single-handedly while women were hospitalised. While women and their families generally preferred specialist MBU admissions with their babies over acute ward admissions
without them, a disadvantage was that family members were separated not
only from women but also from babies. Although MBUs were perceived as
collaborating better with women’s families than other services, some family
members felt their set-up made it difficult for families to fit in, and that the
consequences for them of the separation were not fully acknowledged.

The only thing that could have been improved on from my
perspective was a bit more recognition from the, the nursery
nurses…I’m not resident [on the MBU], I haven’t got my stuff
there. It’s, it can be quite tricky to suddenly slot into your father
role…Not having had a chance to get to know your baby very
much.

Partner 12

[The MBU] I think was really good for [my daughter]. I think their
support system for the mothers was very good. For the mother’s
family it wasn’t so good…I don’t think they’ve come to the
conclusion that I’m losing a daughter and a granddaughter for four
or five weeks, you know, and I must be missing as well, you know,
missing my family.

Grandparent 2

A scarcity of MBUs nationwide, and the wide areas they served, also meant
women were regularly admitted to facilities far from home, meaning their
families often faced long journeys to visit them, with little or no financial
support for travel. Nonetheless, MBUs were seen as accommodating family
visits well. This contrasted with acute wards, where experiences of visiting were less positive.

[My family] were very welcomed [by the MBU], well looked after. You always felt that people could visit at any time. And although there were, sort of, time restrictions, you didn’t feel they were adhered to necessarily strictly, especially for your immediate family…Once I think I had umpteen family visitors, all in the same day, and they, you know, they-, same time, and they found a little private room for us to sit in, so we didn’t have to sit in the communal kitchen and stuff. So, yes, they were always really good about that.

Mother 40

By contrast:

You can hear shouting [on the acute ward], you can hear screaming…It would be nice to have had a family room away from the ward…You want to take your child for a walk in the gardens…No. You had to be stuck in that room. Like I say, it felt like a prison.

Partner 21

Women and their partners and wider families also wanted more support from both MBUs and acute wards post-discharge, to help women and their families readjust to life back at home with a new baby and to cope with any ongoing difficulties. For example, one grandparent described how a lack of support for family members, or focus on her daughter’s family context, meant
she was sent home into the same turbulent dynamics in which her difficulties first arose, resulting in her struggling again.

Everything was just put in place [by the MBU] with [my daughter].
So there was no following up for me…But if I got the support…how to help [my daughter]…you know, how to hold her little family together, I think that would’ve been so much better. If [the MBU] did something with the parents, dads, or grandparents…because she was coming right back home…so if the support is not there for her…We didn’t hope that [she] would go back in hospital again, but it happened.

Grandparent 2

Similarly, the husband of a woman who had been admitted to an acute ward felt that the family struggled again after she was discharged because there was little support to help them adapt to life back at home together.

Treating the family as a whole instead of the individual, I think is better. Yes, it’s a better, so you can keep the synergy together. So you’ve got the strength when she comes out of the hospital…Doing it together. Whereas if she comes home, and I’m home, it’s all this, it’s hard to get used to each other again.

Partner 7

In community settings, structural factors could also contribute to marginalising families. This could occur when women were seen individually in clinics rather than in their home environment, when family members were
invited to appointments but could not attend because they were during working hours, or where support for family members was offered at inconvenient times and in awkward locations.

Professionals don’t work at weekends. It’s a Monday to Friday profession…They’re telling me I have to take time off during the week to get the support we need but I’m saying, ‘Why don’t you work a weekend so we can get the support that we need?’

Partner 14

Some family members pointed out that even if the structure of services meant there were few opportunities to meet or speak with professionals, there could still be more effort made to include families, for example by providing women with ‘homework’ tasks to complete with their families.

You know, maybe rather than having to go [to appointments] with my work [making this difficult], to have maybe an activity or something that one could, that she could take home and kind of go through it in the evening would have been interesting.

Partner 6

Across all service types there were indications that women and their families wanted services to be structured in a way that was more family-oriented or holistic. In inpatient settings, some women and their family members wished family members could stay overnight on MBUs, with a few women refusing admission because they did not want their family separated. In the community, some women (and, less commonly, partners) wanted couples/family therapy, saying their difficulties had persisted after treatment,
and that they saw addressing the interpersonal context as important to resolving their struggles. There were also examples of women questioning why they were treated or medicated for what they saw as interpersonal difficulties.

It would've been nicer to have sort of a more family-, I know it doesn’t really exist, but more of a family place that you could, so your partner and mother, so father, mother, and baby could all go there. And there’d be support for everybody…I think a lot of people would benefit from it.

Partner 21

Couples therapy would be incredibly valuable…It’s not available …Our problem was basically between the parents.

Mother 8

It’s some kind of relationship breakdown that messes up someone’s head to the extent that it affects the way they do their everyday things. So, for the system to think that just giving people medicine, especially for me…giving them a pill is not going to take that away…It just didn’t make any sense to me.

Mother 46

While it is important to acknowledge that a number of women valued the treatment they were offered, professionals’ reliance on medication and individual support, in the absence of a wider focus, could be perceived to be inadequate.

They tried giving me different medications at the doctors, and they
just didn’t help. If anything, they just made me feel sick... A couple of the doctors’ appointments were terrible. I’d sit there and I’ll explain to them what’s been going on, and they said, ‘So what do you want us to do?’…And it was just a case of, take some drugs. ‘Take these, see how you feel, then come back to us and let us know’…You give up after a while.

Mother 17

5.2.3 Ambivalence about family involvement and support

Mirroring the dyadic analysis, despite ostensibly wanting more family inclusion and support, many women and family members simultaneously seemed unsure about this, suggesting underlying ambivalence. This was not indifference on their part, but rather appeared to relate to anxieties about what greater family involvement or support would mean, whether it might make unmanageable demands on them, or have other undesirable consequences. Women’s and their partners’ and relatives’ mixed feelings about family involvement sometimes seemed to reinforce the tendency for services to marginalise families creating a vicious cycle.

Feared consequences of family inclusion or support

Women’s partners and other family members often described struggling with the burden on them. Many were trying to hold down a job, as well as support the mothers and cope with the challenges of a new baby. Although they felt neglected by services, the idea of greater involvement, let alone taking up support themselves, could also feel unmanageable: “Even the thought of
going to see a counsellor for an hour was just like, well I just don’t have time for it.” (Partner 2).

Not only this, as identified in the dyadic analysis, some women and family members appeared resistant to a greater focus on families for fear this might further disrupt their relationships or the ‘status quo’. For example, one woman, who had been diagnosed with a personality disorder and was being treated by a specialist perinatal mental health team and parent-infant team, believed that her partner was reluctant to be more involved in her support or accept support himself for fear it might require him to face up to problems in their relationship, and change his behaviour and attitude towards her and their baby. Faced with his resistance, she said professionals seemed to back off, rather than persisting in exploring ways to engage with him.

I don’t think [professionals] tried to help him enough to some degree. But then…he wasn’t willing to work with me and [our baby]…He didn’t want to work with them in any way, shape or form. And too much of self-centred and selfish person. He doesn’t want to change…They haven’t really tried to guide him in more taking it. They’ve left it more for him to do.

Mother 33

It was common as well for women themselves to express anxiety about the idea of family members being involved in their support. Some were very isolated, making family involvement difficult in any case, but a number of women also said their partners or families would not ‘understand’.

I just keep it with the professionals, and keep it private, you know.
Because not everyone understands or is willing to hear. That’s why we have the professionals there to do that.

Mother 32

This too appeared to relate in part to underlying concerns about what family involvement might mean for interpersonal relationships and whether family members might judge women negatively. Anxiety about greater family involvement was also evident among women from cultural backgrounds where, as outlined, perceived stigma around mental health was more often reported. For some women it also seemed to be connected to underlying anxieties about how family inclusion might affect their protected time with clinicians and autonomy over their treatment, especially for those living in fraught family contexts. As outlined already, privacy was important for some women and, when family members were very involved, this could occasionally leave women themselves feeling deprioritised.

**Partners and other family members have to ‘stay strong’**

Even though they struggled when women were distressed, and with the demands of a new baby, partners and other family members were often uncertain about accepting support themselves. Although they spoke of loss of sleep, anxiety, depression, stress, increased alcohol use and work-related difficulties, some were adamant that they did not need or want support themselves. Others expressed the view that they had to ‘stay strong’ and not ‘indulge’ their own needs. A few felt more comfortable staying “in the
background” (partner 1) and many seemed only really to find it acceptable for the mother (and baby) to get help.

I was looking after [our baby]. I still hadn’t recovered from the sleep…So I kind of just, I don’t need anyone’s help, I’m just going to do this…And then, you know, after I’d go and see her at the MBU, and then I would have my cry…because I was in it and it was happening I just thought I don’t really need any help, because it was [my wife] that needed the help.

Partner 2

Several women also subscribed to the view that their partners and wider families were ‘strong’ and not in need of support. This reduced their inclination to focus on their needs or push for support for them.

“[My mum] doesn’t need it, like she’s one of those characters that doesn’t need emotional support, she’s very capable and she would never fall to pieces emotionally.”

Mother 11

[My partner] was carrying on like things were normal, that it was okay and that I was going to battle through this and get better. He was always being positive, he wasn’t-, he was just helping me carry on basically…So I don’t think he really needed any support because I think he’s quite strong.

Mother 10

A number of male partners meanwhile explicitly or implicitly connected their hesitation accessing support (including peer support) to beliefs that it was
shameful and unmanly for men to voice needs. Male partners appeared to place a high value on not being ‘over-dramatic’: they wanted to wait to see if things would resolve of their own accord, and to work things out by themselves. At times this seemed to be partly connected to uncertainty about what it was ‘normal’ to feel in the perinatal period. However, there was also a sense that feelings of neediness challenged men’s sense of self-worth.

As a man, you don’t really need support. You think you can do it on your own, you’ll be fine. I don’t know how to ask people for help…I wouldn’t like to count on other people to tell me something that I maybe already know, who feel I don’t know. I like to try and figure out the problem and solve it myself.

Partner 15

A reluctance to access support was reported in relation to male partners from a wide variety of socio-demographic and cultural backgrounds, both White and non-White. However, in some cases, women believed their partners’ resistance to being more involved in their care or seeking support themselves was exacerbated by religious or cultural beliefs. For example, one woman described her belief that the couple’s Muslim background meant her husband did not really value mental health support, even though she herself would have liked them to have couples counselling.

I’ve been having major problems with my partner as well since she was born, which, you know, we’d probably benefit from couples counselling. But I don’t think he’d go for that...
…Like culturally they don’t do that. Like [my husband] wasn’t born here so I don’t think he’d [ask for professional help]…That’s how they were brought up…I know people who still think therapy and depression is all, you know, hocus-pocus or whatever, never mind, like in [Muslim cultures].”

Mother 37

Similarly, a woman from a Christian African background, who had separated from her husband after the birth of their second child, believed cultural and religious beliefs may have influenced his reluctance to be more involved in her care or access support himself.

He’s Christian and he doesn’t believe in things like that…He doesn’t want people to analyse him…He’s not good like, talking, like that…I wish he had, he would have done it because it would have helped.

Mother 4

It was conspicuous that, even when partners and other family members did want help, they often found it difficult to pinpoint exactly what it was they wanted. Some implied that they were willing to accept support to help them support women, but were not comfortable with support focused more directly on themselves. Several women and family members implied that men, in particular, were more likely to take up support that addressed their own needs if it was offered in an ‘informal’ or ‘incidental’ way.

I kind of enjoy socialising but I don’t like being pushed to meet other people, so yes. That’s just guys though, more like you know, just
they like to do it if it’s natural but if it’s organised you almost like sniff something, is that a trap?

Partner 8

The thing is blokes won't talk, we bottle it up. We won't talk in a group in a room. If we talk it's going to be down at the pub or whatever…We won't do it in a group in a room in front of professionals. That’s not us.

Partner 21

This desire for support to be casual, informal, or understated also reinforced the earlier points, where some family members said they did not so much want formal support, as greater recognition of the challenges they faced. They wanted to be noticed: for a professional to ask how they were, or to suggest having a “cup of tea” or an “informal chat”.

One partner also described how his wariness about involvement or support, coupled with a tendency on his part to view perinatal struggles and parenting as the mother's domain, was exacerbated by professionals not pushing for his involvement. He argued that this cycle might be broken if practitioners made explicit their expectation that family members should attend appointments.

I could have been involved but, I don’t know, I feel that…by putting the onus on the father more, actually people like me kind of forget it’s my job as well…I mean my default position is kind of abscond probably…And if that changed...’No wait a minute here’, you know, ‘No you are going to attend the session.’ And then at that
session they say, ‘Right blah, blah, blah, right now on to 
you’…That would be interesting actually and I think it would
certainly be beneficial for me and a lot of the other men I know are
not that responsible or lazy or fearful.

Partner 3

5.3 Summary of thematic analysis

Overall, like the dyadic analysis in chapter 4, the thematic analysis
suggested that women’s perinatal mental health difficulties need to be
considered with reference to their family and interpersonal contexts. This is
particularly true since, as already outlined, their wider contexts undergo a
process of transition with the arrival of a new baby – with women typically
taking on the bulk of parenting. Reinforcing the findings of the dyadic
analysis, women’s struggles often seemed to signify difficulties between and
around women and their families, not only within individual mothers. Women
in particular often connected their perinatal mental health difficulties to
familial struggles, with families also playing a major role in relation to access
to support and recovery. Women from some cultural backgrounds also
described stigma around mental health difficulties in the perinatal period,
which could lead to them turning down or hiding their treatment from their
families, and could leave them increasingly isolated.

However, despite the importance of partners and wider families, services
were perceived to focus on individual women (and babies), with little regard
for their wider family contexts. Although there were exceptions - for example,
MBUs were generally felt to be better at engaging with families than other
services - partners and wider family members were typically left feeling marginalised and unsupported.

At the same time, responses also suggested that it could be challenging for professionals to balance family inclusion with the need to protect and prioritise women and their babies. This was especially true given women’s complex and sometimes even abusive family contexts and, in some cases, their expressed desire for privacy from their families. Not only this, although women’s families ostensibly wanted to be better included and supported, as I picked up in the dyadic analysis as well, they also expressed ambivalence about this. Perceived norms of masculinity could mean male partners/fathers found it hard to acknowledge their own needs. Likewise, other family members often believed they had to ‘stay strong’. Greater involvement and support could also feel unmanageable, given how much families already had to cope with, and there were signs too that women and their families were fearful about the possible disruption to their relationships and the ‘status quo’ that a greater focus on families could entail. This appeared to reinforce the tendency for services to overlook and exclude families, which, in turn, arguably contributed to increasing their perception of their own needs as insignificant in a vicious cycle.
Diagram 1. Key themes expressed regarding different types of mental health service

**Inpatient mental health services**

- Good collaboration with families, some support offered (though not enough)
- Families want e.g. more support with reuniting post-discharge
- Good at facilitating family visits
- But often far away for families
- Fragmentation of family unit, partners can’t stay overnight etc.
- Mother/baby focus > hard for partners to ‘fit in’

**Community mental health services**

- Families must be proactive & persistent to be kept informed
- Not well set up for family visits
- Little in way of support offered for families
- Support not usually offered when partner or family member is left to look after baby single-handedly during woman’s admission

**Specialist Mother and Baby Units (MBUs)**

- Signs they may be better equipped than generic services at working with families; a few examples of supporting families/relationships well
- But families not very involved/supported, feel overlooked
- Emphasis on mother/baby

**Specialist perinatal**

- Families overlooked, often no ‘space’ for them – at appointments/home visits
- Marginalised, often not offered support themselves
- Focus on individual not family
- Small number of examples (e.g. in community teams offering longer-term support) of including families well in difficult circumstances, where service knows family well

**General psychiatric wards**

**General non-perinatal**
**Diagram 2. Key themes expressed by type of participant**

**Women**
- Women had often taken on the primary parenting role. Many said interpersonal conflict contributed to their distress.
- Women from some cultural backgrounds described stigma & isolation from families and communities.
- Women said their families influenced their access to and interactions with services.
- Women believed partners & families are marginalised by mental health services; want families to be helped to support them better & offered support themselves.
- Women more likely than partners/other family members to mention wanting couple/family therapy.
- However, women also harbour anxiety about family involvement & support. Fear its potential to disrupt their relationships further, marginalise their own needs, reduce their autonomy, & deny them privacy from their families.

**Partners and wider families**
- Partners and wider families struggle themselves with adjustment to having a new baby, & with impact of woman’s struggles.
- Feel overlooked, marginalised by services.
- Want to be better informed about how to support women, & want their own needs to be acknowledged – someone to think about them, ask them how they are doing.
- But also they fear greater involvement might be unmanageable – they won’t have the time or energy.

**Partners**
- Anxious also about possible destabilising effect of greater focus on them, possibility they might be required to change
- Feel they should ‘be strong’, not need help, norms of masculinity make it harder for men to accept support
- Say they prefer ‘informal’ or ‘incidental’ support

**Wider family**
- Face difficulties relating to their unique role not being recognised. For example, grandparents being treated by professionals as a ‘substitute partner’ where mother is single
- Feel as ‘carer’ they should ‘be strong’, not need help, not take attention away from woman
Chapter 6: Discussion

As outlined in the introduction in chapter 1, it has been argued that services treating women with perinatal mental health difficulties need to “think family” (Hogg, 2013; p.37). The basic contention is that perinatal mental health difficulties among women both affect and are affected by their partners and wider families: families therefore need to be involved in women’s care and supported themselves. Despite this, relatively little is known about experiences of family involvement and support in practice. The research in this thesis aimed to fill this gap, exploring experiences of family inclusion in perinatal mental health care and the role of families in this context. I included the perspectives of women, their partners, and wider families.

In this chapter, I draw together the findings of the main threads of the thesis, including the meta-synthesis in chapter 2, the dyadic analysis in chapter 4, and the wider thematic analysis in chapter 5. I begin by discussing and summarising the key findings. I suggest that the results overall show that: partners and wider family contexts are integral to understanding women’s perinatal mental health and interactions with services; partners and wider families appear to be marginalised by services; women and their families want greater family inclusion and support but also experience anxiety about this; this reinforces the tendency for professionals to exclude families. I then seek to situate and understand these findings within their wider context – building on the arguments made in chapter 1 about the way concepts like motherhood, fatherhood, infant development and the family are constructed within society and influence clinical practice. I consider the implications of the
findings for policy, clinical practice and research, while also critically reflecting on these. Finally, I reflect on the key strengths and limitations of the study and suggest possible areas for future research.

6.1 Summary of key findings

A key finding - from both the dyadic and wider thematic analyses - is how integral women’s families and interpersonal contexts are to their perinatal mental health and encounters with services. While, as outlined, clinical guidelines and wider discourses around perinatal mental health tend to portray families as affecting and/or affected by difficulties in women, my research suggests that families are in fact even more central than this conceptualisation might imply – at least from the perspectives of women with perinatal mental health difficulties and their families. As I have emphasised, although it is women who are most often diagnosed with perinatal mental health difficulties, their struggles frequently appear to signify difficulties between family members, not only within individual mothers, with all members of a family struggling. Families undergo a process of transition with the arrival of a new baby and my research shows how these changes can contribute to provoking distress as well as growth and development. While a range of other factors - including, among others, traumatic birth experiences, giving up work, sleep deprivation and pregnancy complications - were also cited as influencing women’s perinatal mental health, both the dyadic and thematic analyses demonstrated how the birth of a baby could unsettle family dynamics. Family members respond to this change in differing ways, influenced also by their wider social and cultural backgrounds. Women’s
mental health needs and contact with services play out within this wider context.

The dyadic analysis demonstrated how women’s difficulties could appear at times almost as if they represented an articulation of interpersonal conflict. It is known that the perinatal period is a critical risk time for relationship strain and even domestic violence (Rosan & Grimas, 2016). The findings of both the dyadic and thematic analyses showed that women in particular often connected their perinatal mental health difficulties to familial struggles, and that family dynamics also played a major role in relation to their access to services, interactions with professionals, and perceptions of support. For example, in some cases women’s partners and relatives strongly advocated that they should get access to psychiatric treatment (on occasion even against the woman’s wishes); in other cases, women’s families could be resistant to them accessing professional support or seemed to feel threatened or frustrated when professionals suggested particular types of support (e.g. family therapy).

In common with previous research (e.g. Watson et al., 2019), women from some cultural or religious backgrounds (e.g. African, Arab, Muslim, Asian) described facing stigma around their mental health from their families and communities. This affected women’s access to treatment, with some declining certain types of support as a result, and others keeping their difficulties and interactions with services secret. Women from a Black background were also less likely than others to be living with a husband or partner or to receive help looking after their babies from wider family members. This is in line with wider research which shows high rates of lone
parenting among Black African and Black Caribbean women in the UK compared with women from White or South Asian backgrounds (Robson & Berthoud, 2006).

Meanwhile, I pointed out how, in one dyadic case study a woman in a traditional ‘nuclear’ family set-up, with a well-resourced, proactive partner, had been offered rapid admission to an MBU. By contrast a young mother, who had been parenting alone in a more challenging familial and social context, was refused an MBU admission and ultimately judged to be an unfit mother, with her baby removed from her care. From the thematic analysis of the whole sample, it was clear on a wider scale how women who were living in more challenging contexts, and who did not have partners or relatives able and willing to support them, or advocate on their behalf, seemed to have the worst outcomes – for example experiencing repeat hospitalisation or custody loss. While directions of causality cannot be ascertained - and clearly many factors were at play - I noted how none of the women who lost custody of their babies were living with a partner; they also tended to be young and to have a personality disorder diagnosis.

Nevertheless, despite the evident importance of families, professionals were experienced on the whole as focusing on individual women (and babies). They did not often engage in a meaningful way with their families or interpersonal contexts. In line with wider societal narratives, they too appeared to view perinatal mental health difficulties essentially as being located within individual mothers, with partners and families perceived and treated as peripheral. This is not intended as a criticism of individual healthcare professionals, who undoubtedly are hardworking and dedicated –
but rather reflects the way that services more broadly were described by women and their families as being set up in ways that excluded family members, with professionals reported to lack the confidence, experience and resources to work with families.

Reinforcing and expanding on the findings of the meta-synthesis in chapter 2, the dyadic analysis and thematic analysis both showed that family members were not routinely invited to or included in appointments, or kept informed about women’s treatment. Often, they were not given support to help them support women, or asked for their own perspectives. There was also a lack of acknowledgement of their needs or support for them. Although there were exceptions, this meant that partners and families were typically left feeling marginalised, unheard and unsupported, while women and their families said difficulties sometimes persisted after treatment because of a lack of wider focus. The thematic analysis also showed, however, that although families felt neglected across all types of service - MBUs were generally seen as being better equipped to engage with families than other services. They tended to accommodate family visits well, made efforts to invite women’s families to appointments, and more often included them in the decision-making process. At the same time, inpatient care had the important downside that it fragmented families, separating women from their partners, families and interpersonal contexts and, in turn, separating fathers and grandparents from their children and grandchildren, without fully considering the impact of this.

Further expanding on the findings of the meta-synthesis - which focussed only on women’s partners - the dyadic and thematic analyses suggested that
the marginalisation of women’s families extended to members of their wider family network too. In some cultures (e.g. Asian), support with infant care from extended (female) family members was at times described as the norm. Within other cultures, although many women did not have support from their wider families, there were equally a number of examples where grandparents, in particular, could be central players in the perinatal period. They too underwent transition in their identities and relationships with the birth of a new baby, and in some cases stepped in to support women, as well as their partners and babies – whether this was perceived as helpful or not. Like women’s partners, they wanted to be included and supported by services, but felt that their needs were largely unrecognised and were usually left unaddressed. In particular, the unique impact of a woman’s treatment on wider family members, particularly grandparents, was not always fully recognised – for instance, where grandparents were separated from their children and grandchildren during an MBU admission, or where they felt they were treated by professionals as substitute partners without acknowledgement that their role was in fact different and distinct. Where women were living in non-traditional family set-ups (e.g. with new partners who were not their baby’s father), their partners and family members could also feel undervalued and marginalised.

The findings of both the dyadic and thematic analyses also suggested that clinicians may have excluded partners or family members because of anxiety that including them could reduce their focus on the needs of the woman (and baby). They appeared to be mindful of a need to protect women’s potential desire for confidentiality from their families, particularly in light of women’s
fraught and sometimes even coercive family contexts, and/or because of possible stigma attached to mental health by family members, particularly within some cultures. Male partners sometimes felt that professionals were mistrustful of them, viewing them as potential perpetrators of abuse, and there appeared to be difficulties balancing the needs of women and their babies with those of their families. Baradon (2019) alludes to the complexity of working with families in the perinatal period in her blog exploring why perinatal services do not engage with fathers, explaining how attending to a mother, baby and father – or indeed to a whole family system – can feel psychologically overwhelming even for experienced perinatal practitioners. In my study, there were indications that professionals were anxious about their capacity to handle complex family dynamics and interpersonal conflict, which acted as a further disincentive to involve families. Some researchers have also raised questions about whether societal trends towards more involved fatherhood risk privileging fathers over mothers and, in doing so, marginalising mothers (Åström, 2018) - and it may be that, on some level, women, family members and professionals alike shared such anxieties.

It was evident from both the dyadic and thematic analyses that, although women and their families called for better family inclusion and support, they also expressed significant ambivalence about this. Women at times seemed fearful of the impact of family involvement on their autonomy. Reinforcing the findings of the meta-synthesis, traditional norms of masculinity also contributed to making it hard for male partners/fathers to acknowledge their own needs. Similarly, wider family members often felt they had to ‘stay strong’ and avoid asking for support for themselves. Given how much
families already had to cope with and juggle, greater involvement and support could also feel unfeasible. There were indications as well that women and their families were anxious that, by involving families, professionals might (further) disrupt relationships and the ‘status quo’. As outlined in the thematic analysis, this too seemed to contribute to the tendency for services to overlook and exclude families. This, in turn, then arguably played a part in encouraging family members to perceive their own needs as insignificant in a vicious cycle.

6.2 Setting the findings in context

How then might we understand these findings and make sense of them in the context of the wider theory and literature? I will argue that the findings of my study seem in part to be connected to broader socio-cultural issues around conceptions of motherhood (and femininity), fatherhood (and masculinity), child development, and the family - some of which I raised in chapter 1. I will also argue that they are connected to wider issues, not unique to the perinatal period, such as the medicalisation of distress within psychiatry, which has resulted in a tendency to divorce individuals from their interpersonal and social contexts. In setting out my arguments, I will draw on the influences of Foucauldian thinking, feminism and social constructionist theory. Overall, I will contend that mental health services supporting perinatal women tend to reflect and reinforce pervasive social norms and practices around motherhood, fatherhood and infant development. Services allow these dominant discourses to shape and guide their practice, rather than confronting or challenging them to any significant degree. This, in the end,
does women and their families a disservice: it contributes to perpetuating perinatal distress, and can even act as a means of exerting social control over women and their families - endorsing idealised versions of motherhood, fatherhood and the family that uphold the gender inequalities inherent in conventional parenting roles.

6.2.1 Pathological mothers and peripheral fathers/families

“When the mother is fully functioning in her role, the infant supposedly attains optimal physical, emotional, and cognitive development; the spousal relationship thrives; and the whole family is healthy, each member nurtured and loved by the mother. When the mother is not fully functioning, the infant is dependent, fussy, neglected or abused, with physical, emotional and cognitive impairment that affects future potential. The couple’s relationship is threatened, filled with tension due to lack of communication, lack of sexual expression, and the mother’s unattractive appearance. The family is disorganized, chaotic, stressed, and in crisis.”

(Regus, 2007; p.55-56)

In chapter 1, I described how, in the UK and beyond, across different cultures, raising children has been seen primarily as a woman’s responsibility, with fathers, and often wider families too, viewed as essentially peripheral. Mothers are perceived as natural nurturers, who are innately gentle, loving, tender and caring (Reich, Silbert-Mazzarella, Spence, & Siegel, 2005). Mother-infant bonds, and the quality of mothering, are viewed
as crucial above all else, and mothers are
seen as holding primary responsibility for
the emotional health of the developing
infant. It can be argued that such
depictions of women help ‘keep them in
their place’ by construing certain types of
behaviour as ‘feminine’, proper and
natural. Feminist mythologists have
argued, for example, that images of the
Virgin Mary, over the centuries, were used
by the religious establishment to constrain
mothers by emphasising the need for ‘Godly’, womanly, maternal behaviours
(e.g. Warner, 1976). Other commentators have shown how mothers tend to
be vilified and disparaged in cases where fathers are the primary parent
(Åström, 2018). Also in chapter 1, I outlined how there has been a reduced
emphasis on the contribution of extended family members in the perinatal
period, partly owing to the increased geographical dispersal of families. I
described how, across a range of cultures, fathers too continue to be
relegated to a position of secondary importance, instead being seen as
bearing most responsibility for securing external resources for the family.
Western cultures increasingly recognise more diverse family set-ups and
definitions of the family, shifting away from the notion that heterosexual
couples are the only acceptable foundation of a family unit. But despite this
and also despite recent drives towards greater gender equality, the
fundamental perception - or construction - of mothers as primary in relation
to child development remains largely intact. For example, women’s twentieth century move into the workplace has not fully equalised the balance of labour within families; rather, working mothers continue to undertake the greater part of both domestic and emotional labour and, especially when they have more than one child, are amongst the most stressed in the workplace (Chandola, Booker, Kumari, & Benzeval, 2019). Many mothers face high levels of deprivation, with single parent families as well as those with three or more children the most likely to use food banks, often driven by in-work poverty and welfare sanctions (Loopstra, Fledderjohann, Reeves, & Stuckler, 2018). Yet the construction and promotion of motherhood as natural, innate and inevitable, carries with it the expectation that women will be able to handle it easily, and that being a mother will bring joy and fulfilment (Regus, 2007). At the same time, as I also outlined in chapter 1, fathers are increasingly expected to become more equal partners and to contribute more substantially to their infants’ care, wellbeing and development. Yet social structures and attitudes, along with continuing gender inequalities (e.g. disparities in pay between men and women), put pressure on them too (e.g. requiring them typically to continue to bear the greatest responsibility for providing external resources for their families), and as such present barriers to them achieving greater involvement with their children in practice (Machin, 2015).

Thus, the arrival of a new baby is accompanied by idealised expectations of the roles and capacities of mothers, fathers and families, along with significant obstacles to meeting these. Together with other challenges in the
transition to parenthood, this can play a role in bringing families into conflict and can go some way towards explaining the high levels of interpersonal conflict and perinatal distress seen in this study. For example, women in both the dyadic and thematic analyses at times explicitly linked their perinatal mental health difficulties to their frustration that they, rather than their partners, were expected to take on the larger share of parenting. There were also examples of women perceiving themselves to be under greater scrutiny than fathers, and there were several cases of mothers struggling to parent singlehandedly after relationship breakdown. In addition, women spoke about feeling under pressure to be ‘perfect mothers’ and experiencing distress when the pressures they faced meant they felt unable to live up to their image of this. Regus (2007) argues that this dissonance between socially constructed high expectations and reality can create a sense of failure for mothers.

Wider family members meanwhile, particularly partners, spoke about their difficulties juggling their own competing responsibilities; their struggles with feeling deprioritised in their relationships with women, who were now more focused on their babies; and their belief that it was unacceptable for anyone other than mothers to voice needs because the mother was the main focus. In short, in both the dyadic and thematic analyses, there were indications

“If a mother is too preoccupied with her own needs, her career, her ambitions, even with her married life, the infant will feel neglected, rejected, and respond with emotional upsets… In return for these excessive claims on their time, strength, tolerance, devotion, and self-sacrifice, mothers used to hold a position of supreme and unquestioned authority over their children.”

(Anna Freud, 1969; p.528-529)
that societal expectations, norms and practices around parenting contributed to provoking family conflict and perinatal anguish.

However, instead of seeking to understand perinatal distress within this wider context - or more fundamentally to recognise or critique the structures, beliefs and attitudes that appear to play a role in producing and maintaining it - the study findings suggest that services are mainly focused on diagnosing and treating individual women (and their babies). Unwittingly or not, they may even compel women to adjust to their expected role as primary nurturers. They leave interpersonal or social contexts largely unaddressed and are experienced by women and their families as keeping partners as well as other family members in their position of ancillary importance. Rather than exposing or confronting the dominant cultural discourses described, or exploring the ways in which these may help to shape families’ experiences of the perinatal period, my research findings suggest that services allow these norms to mould and guide their practice, treating perinatal distress essentially as a problem of the mother’s mind and offering predominantly individually-focused or mother-baby treatments. This strong emphasis on the mother then both exacerbates and is exacerbated by partners’ and family members’ own ambivalence about greater involvement with services – which itself appears to be based in part on their own assimilation of cultural norms.

In relation to fathers, Baradon (2019) writes in her blog that: “fathers seem forgotten - ‘out of mind’ - within the culture and provisions of services that work with infants and their families. Rarely is the presence of fathers specifically sought at perinatal appointments with midwives, health visitors, developmental checks etc. It is not common practice to enquire after the
father’s mental health or relationship with the baby. A central contributor to the bias against fathers must surely be the dominant mother-centric theories of child development which focus on the mother-infant relationship, and in which the father’s role in infant development is subordinate to the mother’s.” Expanding on this, I would argue that my findings suggest that mother-centric theories of child development can contribute both to provoking perinatal distress in the first place and to services then, whether knowingly or unknowingly, responding to this distress in a way that can perpetuate the problem.

6.2.2 Policing parents

As alluded to above, it can even be argued that mental health services treating perinatal distress may contribute to compelling women to align with their expected feminine role as primary nurturers - while simultaneously encouraging fathers to be stoical, unemotional and marginal. This tends to ensure that each parent ‘knows their place’ and remains within the boundaries of what is expected of them. Foucault (1977, 1988) emphasises the coercive power of psychiatry and argues that disciplinary power through surveillance – e.g. by medical authorities, family and social policy – compels individuals to conduct themselves and manage their bodies according to particular discourses or ‘regimes of truth’. Feminist critiques of psychiatry similarly emphasise the ways in which psychiatry can be used to exert social control over people - especially over women’s bodies - unpicking how social processes and interactions construct the social world in hierarchical, gendered ways (Hesse-Biber & Yaiser, 2003; Wright & Owen, 2001). Applying such thinking to my research, I would argue that the way in which
mental health services diagnose and treat perinatal women - while marginalising partners and wider families - contributes to legitimising and defining what is considered acceptable or ‘abnormal’ for individuals to feel or do. In relation to mothers and fathers, in particular, it puts pressure on them not to step outside of accepted gender norms or to deviate from expected ‘feminine’ or ‘masculine’ behaviours. Thus, services play a part not only in reinforcing gender norms, but also in ‘policing’ parents’ behaviour during and after pregnancy. Through ideological representations and medical categorisation, individuals become ‘docile bodies’ (Foucault, 1977) who are encouraged to conform to societal expectations of motherhood, fatherhood and the family.

So, on the one hand, fathers are encouraged to be ‘masculine’, while other family members are expected to ‘be strong’, and both groups are discouraged, or even constrained, from ‘intruding’ on the mother’s realm or diverting attention away from her. As in wider research (Addis & Mahalik, 2003), fathers in my research, in particular, described feeling that, as men, they were expected to be emotionally undemanding – and services did little to counter this perception. Also in line with other studies, men from some backgrounds (e.g. Muslim) faced additional cultural pressures to appear stoical (Ciftci, 2012).

Women, meanwhile, are seen as innately more prone to ‘hysteria’ (a word itself derived from the Greek for ‘uterus’). But, if they deviate from appropriate ‘female’ or ‘motherly’ behaviours, when confronted with obstacles and stresses - for instance by expressing strong negative, ambivalent or angry feelings towards their partners, babies or wider families -
mental health services step in to return them from this state of ‘abnormality’ to their expected ‘natural’ mothering state (i.e. gentle, self-sacrificing and nurturing). They are in a sense helped to become ‘good mothers’ and to adapt better to their mothering role. The implication - sometimes stated explicitly and sometimes implied - is that if they do not seek help, their partners, wider families and – perhaps most importantly of all – their babies will be harmed because of their untreated mental illness. It has been argued that mothers are held to different standards than fathers – for example, that fathers can leave their infants without being seen to have abandoned them, whereas mothers are judged harshly for the same behaviour, and that fathers may be considered ‘heroic’ for even relatively small amounts of paternal involvement (Strega et al., 2008). It has also been observed that the set-up of midwifery, nursing, health visiting, and social care is such that professionals are encouraged, and indeed at times obligated, to value babies' wellbeing over that of mothers (Lever Taylor, Mosse, & Stanley, 2019; Megnin-Viggars et al., 2015; Parratt & Fahy, 2011), arguably only really valuing women because of their care for their more socially valued babies, and judging mothers primarily according to how well they are perceived to ‘mother’ their babies (Parratt & Fahy, 2011).

We saw indications of this gendered, almost coercive control of women by services in relation to both Sarah and Jill in the dyadic analysis. In Sarah’s case, I described how, when she asserted herself angrily against what she perceived to be her husband’s controlling behaviour of her and their baby, she was ultimately sectioned, hospitalised and medicated – and only allowed to return home once she had ‘stabilised’. In Jill’s case, faced with what she
too described as a coercive partner, as well as relationship breakdown, and a perceived lack of support and resources to care for her baby, she felt services judged her, laid the blame for her perinatal struggles at her door, and ultimately removed her child from her care. Of course, these are not the only possible interpretations of the data, there can be alternative ways of understanding these accounts (e.g. it could be argued that Sarah was in fact severely paranoid and delusional). It is important also to remember that parents can irrevocably harm their children, who may not always be safe in their care. But nonetheless, it can be seen that services may contribute to keeping family members - parents in particular - within the boundaries of their expected roles. This helps to maintain the status quo and diverts attention away from the need to challenge the ways in which wider societal and family structures, practices, and dynamics contribute to producing and maintaining perinatal distress.

Even MBUs - which are generally well-liked by women (Antonysamy, Wieck, & Wittkowski, 2009) - emphasise the primacy of the mother-infant bond, treating mothers and babies away from fathers and wider families and, according to women and their family members in my study, often without fully acknowledging the impact of this separation. Through intervention, they seek to enhance ‘maternal’ behaviours like maternal sensitivity, attunement and responsiveness (Stephenson, Macdonald, Seneviratne, Waites, & Pawlby, 2018) and to contain mothers’ emotions through medication and psychological treatment. In this way, like other mental health services, they play a role in maintaining the status quo by not properly addressing women’s wider interpersonal and social contexts or challenging the inequalities,
structural pressures, gender norms and attitudes that contribute to their distress. As Regus (2007) argues: “Medical professionals determine what is “normal” behavior for mothers, monitor their conformity to these behavioral norms by observing and conversing with them, and diagnose and treat those who are unable to fulfil such expectations” (p.56).

However, the situation is clearly complex. The focus of MBUs on prioritising and protecting women and their babies - and on keeping them together where historically they were often separated - is undoubtedly also to be welcomed and, as already outlined, without this, mothers’ own needs may risk becoming marginalised. The increasing willingness within wider society to take perinatal mental illness seriously and to develop new treatments for women is also a positive development, in part because it helps encourage women to disclose their struggles with mothering without as much risk of social condemnation. It offers mothers access to a narrative, in which services are there to support them and take some responsibility for helping them cope. Yet, at the same time, as Regus (2007) argues, current practice also “defuses pressure to remediate the tremendous and disproportionate responsibility that mothers bear for the physical, emotional, and cognitive development of their children. It leads to the diagnosis and treatment of individual women rather than a change in the societal expectation that women be perfect mothers.” (p.58).

Like Regus (2007), Dubriwny (2010) describes how narratives that unquestioningly depict mothers who struggle as mentally ill and in need of psychiatric treatment turn attention away from the need to challenge the problematic discourse of the ‘essential/good mother’. Through an analysis of
media coverage of postpartum disorders, she also shows how access to such narratives is not equal, with white, middle- and upper-class women who experience perinatal distress more likely to be seen as ‘diverted good mothers’ (i.e. mothers who are rendered temporarily ‘unmotherly’ or ‘mad’ due to illness and will return to their ‘natural’ motherly state with appropriate treatment), while ‘out-group’ women – typically those who are non-white, single, deprived, or otherwise mothering outside of dominant cultural norms – are more likely to be rejected as ‘bad mothers’ and policed. With echoes of Dubriwny’s (2010) analysis, I observed in my dyadic analysis how there were conspicuous differences in the treatment of two mothers who had both self-harmed after having a baby: Jill (a young, lone mother, living in more deprived circumstances) was seen as a ‘bad’ mother and denied access to an MBU with her baby later removed from her care, while Nicola (a married mother in her thirties, living in more affluent circumstances and with a proactive, resourceful husband) was seen as a ‘good’ mother who was temporarily unwell and in need of rapid admission to an MBU. While there were, of course, other (potentially confounding) differences between these two women, as Dubriwny (2010) suggests in her analysis, such examples raise important questions about the extent to which factors like having a ‘normative’ family set-up, as well as a more affluent wider social set-up - compared to a more deprived, precarious one - may influence clinicians’ responses to women. In other words, it is important to consider how other identities or social factors also play a role in affecting how women are treated, along with gender.
Intersectionality theory focuses on how factors like gender interact with other social categories, like class or ethnicity, to influence the exclusion and marginalisation of particular groups or individuals in society (Lynch & Lyons, 2009). This is important to consider in relation to perinatal mental health care because, while social categories like class and ethnicity are not always spoken about as explicitly as gender in relation to parenting inequalities, the findings of my PhD point to the ways in which society’s treatment of and response to perinatal distress may not be experienced equally by all women (i.e. that it is not only gender that is at play). Though the numbers in my study were small, I noted, for example, how women who had lost custody of their babies tended to be young, single, deprived and non-white. Wider research supports the notion that there are complex inter-relations between factors such as age, poverty, lone parenting, ethnicity, perinatal mental health, and healthcare – with young, poor, lone mothers and those from some minority ethnic groups reporting high levels of perinatal distress, low levels of access to healthcare and poorer treatment outcomes (Abrams & Curran, 2009; Moffitt & E-Risk Study Team, 2002; Watson et al., 2019). There is a need to explore in more detail the ways in which multiple social categories intersect in the way women and their families are viewed in the perinatal period, and this is necessary for fathers as well as mothers. For example, it has been argued that, as with mothers, some groups of fathers (e.g. young fathers) receive less positive treatment from professionals than others, and face greater barriers to being involved with their children (e.g. as a result of housing and welfare policies) (Strega et al., 2008).
6.2.3 Widening the lens: beyond the perinatal

While the arguments above help explain and contextualise the study findings, it is also worth noting that research outside of the perinatal period has identified a similar tendency for families to feel excluded across a range of psychiatric settings. For example, a UK qualitative study of ‘carers’ of inpatient psychiatric patients - which included service users’ partners and also their parents - found that inpatients’ families reported wanting to work in partnership with healthcare professionals, but said they felt powerless, ignored, and disregarded by them, with confidentiality often given as a reason to exclude them (Wilkinson & McAndrew, 2008). With clear echoes of my own research, one service user’s mother commented that: “As soon as [my son] was admitted to the ward I became a nobody, an outsider, but I’m not an outsider, I’m his mother” (p.396), while another mother said: “no-one seemed to appreciate the impact [my son’s] hospitalisation had on me. I just wanted someone to recognise the hell that I’d gone through, to feel that someone cared about me” (p.397).

Another qualitative study, this time from the United States, likewise found that partners and other family members felt excluded by both community and inpatient psychiatric services (Rose, Mallinson, & Walton-Moss, 2004). This study included the perspectives of psychiatric healthcare professionals along with those of service users and their families, and professionals described how organisational structures impeded family involvement - for example by offering little reward or recognition for family work, providing few opportunities for skill development for such work, not having clear guidelines on patient confidentiality, and offering a lack of physical space in which to
meet families. These studies therefore point to a wider issue - not unique to the perinatal context - for mental health services to focus on individuals rather than families.

The authors of the above studies argue that the exclusion of families arises partly because the complexity of family work, with all its intricacies and sensitivities, can feel to health professionals beyond their resources, capabilities, and training. It can be perceived as outside the accepted scope of their practice and too labour-intensive. Wilkinson & McAndrew (2008) also argue that family exclusion occurs in part because sharing knowledge and information threatens professional expertise. The researchers argue that knowledge is a source of power, and that by not sharing information with family members, healthcare professionals disempower them, keeping themselves in control of decision making.

While some studies do offer more positive accounts of services engaging with families, these studies usually still highlight gaps and shortfalls. For example, a study of family members’ experiences of early intervention services found that, although these services mostly supported families well in their role caring for service users, they did not fully acknowledge or address family members’ own emotional needs (Lavis et al., 2015). With echoes of my own research, this study also noted how family members tended to deprioritise their own needs in order to prioritise the service user’s needs, and how services reinforced the family members’ perception of themselves as secondary by framing family engagement primarily around its benefit for the service user, rather than for family members themselves.
Building on the conclusions of these studies, I would suggest that the marginalisation of families and interpersonal contexts may also be partly the result of a broader tendency within psychiatry to individualise or medicalise distress. In other words, due in part to a pervasive tendency within psychiatry - beyond just the perinatal context - to interpret distress essentially as a disorder of an individual’s mind, resulting in an over-emphasis on the need for pharmacological and individual treatments that target individuals' bodies and minds, and shutting down the need to search for answers beyond the individual.

Filson (2016) writes that: “The thorough medicalisation of distress that has taken place since the 1960s, along with the emergence of pharmaceuticals, has resulted in severing people in extreme distress from the social, political and interpersonal contexts that so profoundly shape who we are – contexts that describe what happened to us rather than what is wrong with us. What is revealed in the answers we give is that we are profoundly affected by every aspect of the world we live in.” (p.21). This too arguably helps explain why psychiatric services treat individual mothers with medication, individual therapy and hospital stays - while side-lining the role of their interpersonal contexts and wider families. The primary focus is on the woman rather than on anyone else around her, and on her as an individual. This may have particularly adverse consequences in the perinatal period where, as described in chapter 1, mental health difficulties and relationship conflict can have a detrimental effect not only on parents but on infants too (Stein et al., 2014).
This potential explanation may be especially helpful for understanding my study findings relating to general non-perinatal mental health services, such as acute inpatient wards, which women occasionally said did not even fully recognise that they were (new) mothers. This argument may also help explain why wider family members – not only partners or fathers – reported feeling marginalised: in essence, they too formed part of the wider social context and therefore were largely disregarded.

While this argument can be seen as a competing explanation for the study findings, I would suggest that it is more helpful to see it in conjunction with my previous points, combining more comprehensively to explain aspects of the study findings.

In short then, social norms and practices - including mother-centric views of child development and the concomitant side-lining of fathers and families - place a burden on women and their families which, along with other challenges, can play a role in provoking perinatal distress and family conflict. Services do not tend to challenge these norms, but instead largely act in accordance with them, helping legitimise them – or even seeking to return women to what is seen as their natural caring state, and to strengthen mother-infant bonds. Fathers and wider families are meanwhile viewed - and in some respects are also driven to view themselves - as peripheral, with their own needs and roles neglected. This is intensified by broader views of women as prone to being 'hysterical' and men as 'unemotional', as well as by wider tendencies for psychiatric services to treat the individual rather than also considering the social or interpersonal context. This pattern of seeing families as peripheral and women as pathological in the perinatal period
serves to exacerbate families’ struggles, perpetuating the problem. Subsequently, fathers continue to remain peripheral, albeit less markedly so, throughout childhood (Yeung, Sandberg, Davis-Kean, & Hofferth, 2001).

6.3 Clinical and research implications

Overall, the findings of this thesis suggest that engaging with wider interpersonal networks is challenging and complex but too important to ignore. Perinatal mental health difficulties, and access to treatment, do not occur within a vacuum, but within a wider social and interpersonal context, in which the family plays an influential role. In losing interpersonal and sociocultural understandings of perinatal mental health difficulties, a focus on familial and sociocultural responses is also lost. The findings of my thesis suggest a need to approach women’s difficulties with greater focus on their social networks - challenging the way that service structures deprioritise family members’ needs, while balancing this with protecting women’s needs and confidentiality. More fundamentally, there is also a need to proactively confront the ways in which current service set-ups appear to reinforce dominant gender norms and even allow them to guide practice.

As a first step, it would be valuable to consider how best to adapt current practice when supporting women with perinatal mental health difficulties in order to make services more ‘family friendly’ and to help professionals to ‘think family’. On a basic level, this could include, for example: identifying acceptable ways to include partners/relatives more meaningfully in (at least some) appointments; routinely asking women how they would like their partners or wider families to be included; exploring with women who is in their family network and how they view their family relationships, including
consideration of the woman’s cultural context; offering separate appointments for family members or one-to-one opportunities to speak to professionals; providing childcare or crèches to enable family members to join appointments with women; offering more flexible appointment times to fit around working hours; exploring the feasibility of allowing partners to stay overnight on MBUs; ensuring partners or other family members are still able to spend time with their babies when women are hospitalised on MBUs; and seeking to ensure that staff within services are diverse and not entirely female-dominated. Encouragingly, in the UK a consortium of researchers and clinicians (commissioned by NHS England) has recently been established to develop best practice guidance on involving and supporting partners and family members of women accessing specialist perinatal mental health services. Ideally, this should seek to extend beyond specialist perinatal services to all services supporting perinatal women and their families.

Related to this, the findings suggest that efforts should be made to develop and evaluate resources and interventions aimed at women’s partners and wider families - acknowledging that some will themselves also have perinatal mental health needs. These should include resources supporting family members to help them to support women, as well as resources and interventions that seek to assess and address family members’ own needs and distress. These could include, for example: information about what the mother’s needs are and how to help her; information about perinatal mental health (e.g. signs, symptoms and prognosis); and information about what to expect from services (e.g. what is on offer). Regarding resources or
interventions targeting family members’ own needs and distress, services could focus on signposting family members to other services or support; could establish links with other services (e.g. by commissioning third sector organisations that work with families to provide family support within existing services); or could offer family members support as part of the service itself - depending on the viability of providing support or interventions to someone who is not the direct service user. Support could include interventions aimed at family members’ own mental health, support with the transition to becoming a father or grandparent, and practical support with infant-care (especially in cases where family members take on additional responsibilities while women receive treatment).

At the same time, it is important to note that ambivalence among women and family members about family inclusion and support, and the divergent needs and wishes they expressed, means there is a danger in making assumptions about what might be most helpful for them or how this might best work or be delivered. The meta-synthesis in chapter 2 showed that women’s partners express mixed views about the (limited) support currently on offer to them, as well as about what support they would like. While in my research, some family members emphasised that they wanted individual face-to-face contact with professionals, there is currently little definitive evidence about what type or format of support works best (e.g. group versus individual support, professional versus peer support, and online, telephone or face-to-face support). Reviews of treatments for paternal mental health have struggled to assess the effectiveness of interventions for fathers, because of limited, poor quality existing research (e.g. Rominov, Pilkington, Giallo, & Whelan, 2016).
Meanwhile, no research base for interventions for wider family members has been established. At this stage, more research evidence is therefore needed to evaluate the effectiveness, acceptability and potential pitfalls of a range of potential resources or approaches for partners and families, preferably based on co-production principles to ensure the views of people with relevant lived experience (including those from diverse cultural and socio-demographic backgrounds) are central. Development work will also need to take into account the finding that some family members express a preference for more ‘informal’ or ‘incidental’ forms of support - though this may be partly a result of services presently treating them as ancillary.

It is significant and potentially valuable that the recent NHS long-term plan in the UK calls for: “offering fathers/partners…evidence-based assessment of their mental health and signposting to support as required” (NHS England, 2019; p.49). However, this can only be successful if acceptable, evidence-based interventions for them actually exist to which they can be signposted. Furthermore, it would be important to avoid such initiatives simply pathologising fathers as well as mothers – rather than addressing the often interpersonal and social nature of perinatal distress.

Given the interpersonal elements of perinatal distress frequently reported, the findings also suggest a need to develop or adapt couple or family-focused interventions for perinatal populations. These could help address the high levels of interpersonal conflict seen in the context of perinatal mental health problems and could help ensure partners and families are better included in women’s care and supported themselves. A previous review - albeit limited to only a small number of studies because of a lack of available
research - suggested that therapeutic family interventions can help treat and prevent perinatal depression (Cluxton-Keller & Bruce, 2018). Another review also found that couple psychoeducation can effectively support the transition to parenthood (Petch & Halford, 2008). In the UK, clinical guidelines recommend couple or family approaches for some perinatal mental health difficulties (NICE, 2014), and the recent NHS long-term plan states that specialist perinatal mental health services should offer family interventions (NHS England, 2019). Yet it is conspicuous that such interventions are rarely available and have not been extensively tested in the perinatal period (Rosan & Grimas, 2016). An obvious research suggestion is therefore to trial and evaluate couple or family interventions for perinatal distress, with a view to then rolling these out within clinical services if effective and acceptable to families.

However, I would argue that such interventions also need to be considered critically, and their possible limitations reflected on. For, in some respects, they too may risk perpetuating, or at least failing to fundamentally address, some of the wider issues I identified in my study. In particular, the families who participated in my research were themselves operating within the constraints of their broader social contexts and the resources available to them. The focus of my thesis on women’s families and interpersonal contexts - though helpful for moving the debate away from simply locating perinatal mental health difficulties within individual mothers - has the potential shortcoming that it risks being interpreted as labelling families as ‘the problem’ instead. There is a risk that the findings could be used to argue that families should be the main focus of treatment in the perinatal period - e.g.
through couple or family interventions - so that what is really needed is a
greater focus on the interpersonal. But, such a conclusion, I believe, fails to
fully recognise or address broader social forces, factors and discourses,
which also contribute to family struggles. It risks focusing attention on the
interpersonal context, while continuing to neglect the wider social context –
and this in turn risks critiquing the individualistic treatment of women for its
tendency to dislocate them from their interpersonal contexts, while at the
very same time treating families as dislocated from the social contexts in
which they are immersed.

Dallos and Urry (1999) raise this issue in their wide-ranging review and
critique of family therapy: they stress the importance of recognising that what
can appear to be ‘pathology’ within a family is in fact: “not simply constructed
by families but shaped by the cultural context, including economic realities
and the commonly held ideas or discourses about family life.” They caution
that ignoring this risks simply “blaming families for their difficulties.” (p.184-
185). Instead of seeing distress crudely as caused by family dynamics, they
argue that we should also recognise the role of oppressive cultural forces,
which influence family dynamics and the resources and language that
families have at their disposal. They argue that “relationship problems are
therefore seen as reflecting the social materials, the dominant discourses
and patterns of power and inequality from which relationships are built”
(p.175).

In line with my findings around the importance of factors such as ethnicity
and class, as well as gender, in relation to perinatal mental health and
access to treatment, Dallos & Urry (1999) similarly emphasise how ‘pathology’
results not only from gender inequality, but also “where ethnic minorities experience racial abuse and discrimination” or “where poverty and deprivation are seen to strip people of their self-respect” (p.173). As a result, they argue that clinicians’ response to distress in families requires awareness of issues of power, structural inequalities and the potentially oppressive influence of dominant societal narratives – as well as reflection on the part of clinicians about their own assumptions, expectations and prejudices, and their positioning in terms of cultural class, ethnicity and gender.

Campbell et al. (2016) make similar arguments in their reflections on their family clinic work in New Zealand, observing that:

“Families who were coming to us for assistance with depression or ill-health were experiencing external problems such as poverty, ongoing racist experience, ongoing sexist experience, or ongoing heterosexist experience. It was these external factors that had made them vulnerable to depression which had then led to all sorts of problems of ill health. We realised that the problems these families were bringing to us were not the symptoms of family dysfunction, but instead the symptoms of broader structural issues. We, like other family therapists however, were treating their symptomatic behaviour as though it were a family problem, and then sending them back into the structures that created their problems in the first place. We were unwittingly adjusting people to poverty or other forms of injustice by addressing their symptoms, without affecting broader social and structural change” (p.198).
In reality, however, in UK policy and practice, when attention is turned to family support for perinatal mental health, more often than not the ‘problem’ is uncritically seen to be located within couple relationships and poor parenting practices, without due regard to the wider social context. Consider, for example, the current drive by the UK’s Department for Work and Pensions (DWP) and the Local Government Association (LGA) to roll out parenting programmes – targeted especially at deprived or workless families. In a document aimed at local councils entitled: *Working to support positive parenting and relationships* (LGA, 2016), it is argued that:

“A quarter of children are born into home environments that are not conducive to good parenting…One of the most common problems is postnatal depression…Relationships come under strain in these sort of circumstances…Parents embroiled in difficult relationships are typically more aggressive toward their children and less responsive to their needs…Dedicated parenting programmes for those that need extra help can make a huge difference…Mediation and counselling for couples in conflict can save relationships and help maintain a strong family unit for children to flourish” (p.4-5).

According to this argument, postnatal depression causes relationship problems, which in turn cause poor parenting, which then needs to be addressed by couple or parenting interventions. But what seems to be missing from such arguments is full recognition of the wider contexts (e.g. of austerity, inequality and deprivation) in which family difficulties arise. In other words, answering families’ struggles with calls for parents to simply be taught to parent or relate to each other better, arguably diverts attention from
tackling the wider social inequalities that families face. Williams (2018) asserts that this has been used - at least in the UK - as a way to advance the government's austerity agenda, writing (in an article in the national media) that:

“If your core business is to roll back the state, then you need to situate all success and failure within the behaviour of the individual in a nuclear family…Children really interrupt this process, since nothing that goes wrong for a four-year-old could ever be described as its fault. Building a language and set of policies around catastrophically poor parenting is quite a neat squaring of this circle, allowing you to remain sympathetic to the child – more than a crusader on its behalf – while continuing on your course of impoverishing its parents.”

All this then is to say that interpreting the study findings as demonstrating that couple or family interventions are needed is of course legitimate – and these are a valuable part of supporting families. However, there is also a need to ensure that such recommendations do not mean that families themselves are ultimately blamed or held solely responsible for problems relating to perinatal distress and/or infant development. Rather, services should seek to look beyond the family as well, recognising that families are operating within the constraints of their broader social contexts and the wider inequalities they face. In other words, it is not sufficient only to focus on the interpersonal context: the social context is key too.

What is needed then - as well as individual, father or family-focused interventions - are broader community or social responses to perinatal distress. These would address inequality and also proactively challenge the
self-reinforcing gender roles and expectations evidenced, rather than uncritically allowing them to be reflected in and even to guide practice. As well as responding to gender inequality, responses also need to address inequalities based on class and ethnicity and the intersectionality of different social categories. This is not straightforward, particularly in the context of stretched services with limited resources, but could include promoting or supporting drives to implement or strengthen policies that, for instance, lessen economic pressures on mothers, fathers and wider families; facilitate the uptake of shared parental leave; ensure fair and timely access to welfare; address discrimination; and protect rights.

The table below summarises explicit recommendations for services based on the discussion above.

**Table 7. Recommendations for services**

| Adapt current practice to be more ‘family friendly’ | Policy priorities should include consideration of how to support services to become more ‘family friendly’.
| Encourage clinicians to ‘think family’ | Examples of how practice could be made more ‘family friendly’ include:
| | - Services seeking to identify acceptable ways to include partners/relatives more meaningfully in (at least some) appointments;
| | - Routinely asking women how they would like their partners or wider families to be included;
| | - Where women express anxiety about their families being involved, exploring with women other ways to involve them that may feel more acceptable or helpful;
| | - Offering separate appointments for family members and/or one-to-one opportunities to speak to professionals;
| | - Providing childcare or crèches to enable family members to join appointments with women;
| | - Enabling services to offer more flexible appointment times to fit around working hours;
| | - Exploring the feasibility of allowing partners to stay overnight on MBUs;
| | - Ensuring partners or other family members are still able to spend time with their babies when women are hospitalised on MBUs;
| | - Seeking to ensure that staff within services are diverse in terms of ethnicity, social class and also are not entirely female-dominated;
| | - Creating ‘genograms’ with women to explore who is in their family network and how they view their family relationships, including consideration of the woman’s cultural context. |
**Reflection on ‘competing narratives’** (see Chapter 4). My research suggests that, in some cases, different family members may view women’s perinatal mental health or their family struggles in contrasting or conflicting ways and that this can affect their interactions with services. The use of resources such as genograms may offer valuable context about family dynamics, helping clinicians begin conversations with service users and family members, as well as with colleagues/other team members, about possible competing narratives. Clinicians should be open to hearing and engaging with different family members’ views or beliefs, as my analysis suggests that it is only when individual family members feel they have been heard, validated and understood themselves that they can begin to hear or empathise with other perspectives.

| Develop and evaluate resources and interventions aimed at partners and wider families | There needs to be a focus on developing and evaluating resources and interventions aimed at partners and wider families. These should include interventions that support family members to support women, as well as resources and interventions that seek to assess and address family members’ own needs and distress.

Resources could include:
- Information about what the mother’s needs are and how to help her;
- Information about perinatal mental health (e.g. signs, symptoms and prognosis);
- Information about what to expect from services (e.g. what is on offer);
- Signposting family members to other services or support;
- Establishing links with other services (e.g. by commissioning third sector organisations that work with families to provide family support within existing services);
- Offering interventions aimed at supporting family members’ own mental health, supporting the transition to becoming a father or grandparent, or interventions that offer practical support with infant-care (especially in cases where family members take on additional responsibilities while women receive treatment).
- Given the centrality of the interpersonal context to perinatal mental health, there is also a need to develop and evaluate couple or family-focused interventions for perinatal mental health.

**Reflection on ‘ambivalence’ among women and their families about family inclusion and support:** As outlined, my research findings suggest that partners and wider family members may feel unsure about seeking or attending support themselves, while some women themselves also expressed uncertainty about their families being more involved. This may be driven in part by services de-prioritising the needs of fathers, partners and the wider interpersonal context, contributing to a view of family members’ needs and wider family dynamics as secondary – and some of my recommendations around making services more family friendly might help. But it is likely that ambivalence expressed by women and their families will remain as it is also related to wider social discourses (e.g. the notion that men should be ‘stoic’ and not need emotional help) as well as to concerns about family inclusion marginalising women’s own needs. Given the lack of evidence about effective, feasible or acceptable resources or interventions for partners, other family members, couples or families as a whole – it is not possible to make definitive statements about what will work for whom or how best to engage and support family members. At this stage, clinicians may need to be creative and innovative, trying out new approaches, proactively asking women and their family members what they think might help them, and collecting evidence about approaches that do or do not appear to work well. |
Bring the wider social context into clinical practice

Family-friendly practice, and interventions for partners and families, have a legitimate and valuable place in clinical practice. However, it is vital not to lose sight of how families themselves are also immersed in a wider social context. Where partner or family interventions are implemented without proper recognition of this wider context, clinicians risk unwittingly sending families back into deprivation or other forms of inequality (even encouraging them to accept or adapt to inequality), addressing their ‘symptoms’ or relationship difficulties without considering the need for broader social or structural change.

Although written some time ago, Dallos & Urry’s (1999) three principles for more socially conscious, ‘just’ clinical practice remain helpful.

1. Commitment to equality within practice (e.g. having an explicit therapy process; seeing service users as experts about their own lives);
2. Commitment to bringing the social context into clinical practice;
3. Commitment to power redistribution within society; and to political, economic and social equality between the sexes.

Overall, clinicians’ response to distress in families requires, at the least, awareness of issues of power, structural inequalities and the potentially oppressive influence of dominant societal narratives – as well as reflection on the part of clinicians about their own assumptions, expectations and prejudices, and their positioning in terms of cultural class, ethnicity and gender. Providing opportunities for clinicians to engage in reflective practice may be valuable.

Broader community or social responses to perinatal distress are also needed. This is not straightforward, particularly in the context of stretched services with limited resources, but could include:

- Promoting or supporting drives to implement or strengthen policies that, for instance, lessen economic pressures on mothers, fathers and wider families;
- Facilitating the uptake of shared parental leave;
- Ensuring fair and timely access to welfare;
- Fighting against discrimination;
- Protecting rights

6.4 Strengths and limitations of the study and directions for future research

This study addressed a gap in the research literature, by exploring in depth how services are perceived to work with the families of women diagnosed with perinatal mental health difficulties. The meta-synthesis presented in chapter 2 found only twenty qualitative studies internationally that explored family members’ views of perinatal mental health care, and these studies
were shown to have important limitations. For example, sample sizes were usually small, studies focused only on women’s partners without also considering wider family members like grandparents, the remit of studies was very narrow in some cases (e.g. focusing on a single mother and baby unit), and in several cases it was not specified at all to which services or professionals participants were referring.

My research is unique in exploring experiences of how UK NHS services supporting women with a range of perinatal mental health difficulties work with their families, and the role of families in this context - from the perspectives of women, their partners and wider families. Women in the study had accessed treatment from a wide array of services for a range of diagnoses, giving the account richness and breadth. Participants also came from a broad mixture of socio-demographic and cultural backgrounds and lived in differing family set-ups (albeit with limited representation of non-heterosexual couples, as I discuss further below). Contrary to expectations, partners and family members were not hard to recruit, suggesting they had views they wished to share (although I was somewhat less successful at recruiting family members for women from non-White backgrounds who, as outlined in chapter 5, were less likely to be living with a partner and more likely to report facing stigma around mental health from their families).

Women, their partners and other family members gave rich, qualitative accounts of their experiences. This study is the first study of its kind to include views of family inclusion by services among wider family members as well as women’s partners.
I believe that a particular strength of my study lies in the fact that it included these different perspectives. This provided a more wide-ranging and inclusive account of family inclusion, ensuring that the (sometimes competing) views and needs of women and their partners or wider family members were all taken into consideration. The combination of broader thematic analysis and in-depth dyadic case studies helped offer different perspectives on the data. The thematic analysis ensured that there was scope to compare findings across a diverse range of different services and participants. The dyadic analysis has the significant limitation, discussed in chapter 3, that it cannot easily be published because of the need to protect confidentiality between women and their family members. But at the same time, it was essential for facilitating comparisons and contrasts between the accounts of women and their families in a more direct, intimate, and narrative way. It also encouraged me to adopt a more critical interpretation of the data because it exposed the ways in which there are always competing perspectives on any one event, and how people’s beliefs, fears and wider contexts influence the ways in which they construct and represent their experiences.

I could have stated explicitly to participants at the start of interviews that their data might be published alongside that of their family member meaning there were limits to confidentiality (as they each might be able to see what the other said). However, I think this would have significantly restricted participation and would also have affected the honesty and frankness of participants’ accounts. I could also have returned transcripts to participants after their interviews to check with them what they would or would not be
willing for me to include in a dyadic analysis. However, this would also appear to be insufficient, since participants would still not be able to know at this point how their data would look once written up and juxtaposed with that of their family member. Ultimately, there is no straightforward answer to the question of how dyadic analysis can be published in a way that retains its unique richness, while also protecting internal confidentiality.

These issues aside, reflecting on my own ‘journey’ through my thesis, I noticed how including different perspectives and different types of analysis helped to develop my own thinking. For example, in chapters 1 to 3, I began by primarily emphasising the perspectives and needs of women’s partners and wider families – focusing the meta-synthesis, for example, only on partners’ views (rather than on the views of women too) and concentrating in chapter 1 primarily on shifts over time in the roles of fathers and wider families in the perinatal period. Yet, by the time I came to write chapters 4 to 6 – I had become increasingly immersed in women’s views too - and felt much more aware of how their own needs and perspectives, along with gender norms around motherhood and fatherhood, were interwoven and influential in relation to family inclusion. In some respects, this meant that the picture felt increasingly complex as I progressed. But I also felt that exploring these different perspectives gave the account depth, nuance and balance that it might otherwise have lacked.

Nevertheless, the study had other important limitations – some of which I touched on in earlier chapters. Firstly, as I outlined in chapter 3, a potential limitation arose from the fact that I am a woman and mother, and no fathers or wider family members (e.g. grandparents) were involved in conducting
interviews. Including partners/fathers and wider family members in the process of interviewing and analysis could potentially have enabled unique insights to be generated based on shared perspectives, which partners and other family members may not have been willing or able to share with a woman/mother. While, as outlined in chapter 3, such issues are not straightforward as many variables affect researcher-interviewee interactions, future research could benefit from including fathers and family members more extensively in the research process.

Secondly, as I also suggested in chapter 3, it could be argued that the wider STACEY study of which my research formed part was, in some respects, set-up in a way that reinforced that idea that women’s families are subordinate in the perinatal period: interview guides were structured to focus first on women and only later on family members’ own needs. Partners and family members were essentially seen in relation to women (i.e. as a supportive other) rather than in their own right; women were mostly interviewed before their partners; and women acted as ‘gatekeepers’, initially asking their partners or relatives to take part. Recruitment of family members went well overall, somewhat unexpectedly, with a partner or family member successfully interviewed for around three fifths of women. But even so, it is possible to argue that by subordinating family members, the study set-up itself may have played a role in discouraging them from seeing their own needs and struggles as legitimate and important – thus feeding into their tendency at times to say they did not want or need support. Future research should consider recruiting fathers and other family members via alternative methods and exploring ways of interviewing them that better ensure they see
themselves as central contributors. This could also help guard against the possibility that, by acting as ‘gatekeepers’ to their families, women may have introduced an element of bias into the study – for example, if there were differences between family members who women did or did not ‘permit’ to take part. Such points are relevant to services as well, which may need to consider not only which family members they include in women’s care but also who they may - whether rightly or wrongly - be excluding (e.g. if a service works with a woman and baby where there is both a father and a new partner who is not the birth father).

Connected to this, I noticed that I also struggled at times when writing up my thesis to decide whether to use the term ‘partners’ or ‘fathers’. On occasion, I felt I had to alternate between the two – which could appear confusing to readers. In some instances, I also wondered whether I should use terms like ‘co-parents’, ‘significant others’ or ‘carers’ instead, but these were terms that family members rarely used to describe themselves - and the term ‘significant others’, in particular, felt impersonal. Nevertheless, the term ‘partners’, in some respects, felt like it further contributed to treating fathers as subordinate – labelling them as partners there to support women, rather than as having a central role themselves, in their own right, in relation to the baby. On the other hand, not all partners interviewed were fathers - for example, in the case of same-sex female partners or male partners who were not the birth father, which meant that the term ‘father’ could also feel misleading. This complexity reinforces the point I made in chapter 1 that the role of women’s partners can appear less distinct than the mother’s role – as it can include a wider range of individuals (such as non-biological fathers or
female partners). To some extent, this complexity extended to other family members too: I tended to group women’s relatives together under the umbrella of ‘wider family members’, but in reality they comprised a range of individuals with distinct roles and needs (e.g. grandmothers or grandfathers, women’s siblings etc.).

More broadly, throughout the research process I found it difficult to find examples of previous research into the roles, experiences or views of women’s wider families in the perinatal period – i.e. beyond only partners or fathers. Not only was I unable to find studies including other relatives’ views of services for the meta-synthesis, but also I struggled to find nearly as much written on them as on fathers in research about the perinatal period in general. This meant that, at times, the inclusion of wider family members in my research could feel like an add-on or afterthought. At one point, I even contemplated whether it would be more coherent to focus only on women’s partners - but it seemed restrictive to exclude wider families, given the rare opportunity to hear their voices. In the end, although my study was unique in including the views of wider family members, and this was one of its strengths - I nevertheless do not think I was fully able to do their voices justice: only a relatively small number of wider family members were included, mostly maternal grandparents, and overall relatively little time could be afforded to asking them in detail about their specific needs as grandparents or other relatives (because of the wide range of information that interviews already had to cover). This means that I complete my thesis with the feeling that there is more to be explored around the role of women’s extended families in the perinatal period - in particular possible cultural
differences in relation to this, and the unique needs and experiences of wider family members in relation to services. Future research should dedicate itself to exploring this in greater depth.

In chapter 3, I noted how certain constraints were imposed on my research because it was nested within a wider programme of research and thus had certain requirements imposed on it. In particular, this meant that only parts of each interview focused on experiences of family inclusion, and there were constraints on how many and what questions could be included in the interview guides. Overall, this had the effect of limiting the time that could be spent in interviews discussing the issues most relevant to this thesis. In retrospect, I think more questions could usefully have been included in the interview guides on: what support women and their families would have liked to be available for families; how exactly they wanted families to be included in care; what suggestion they had for overcoming barriers to family inclusion, and the role of families in the perinatal period more broadly. This could have allowed greater emphasis to have been given to identifying ‘solutions’ or generating new ideas about family support and involvement, which were not given as much focus in my study as they might have been. I also think it would have been helpful for more time to have been dedicated to delineating differences in family involvement depending on the type of service accessed. Although I did manage to achieve this to an extent, it was difficult given that family inclusion across the whole care pathway had to be covered within a restricted timeframe. In the end, it could sometimes feel as though individual types of service (e.g. crisis teams versus talking therapy services versus specialist perinatal mental health teams) could only be explored relatively
briefly, especially given the wide array of services included. While rich data were nevertheless obtained – and greater focus was given to exploring family inclusion by services than in many of the previous studies analysed in the meta-synthesis, future research would benefit from dedicating interviews exclusively to this topic.

Not only this, but also it is important to acknowledge that, although the women and their families in my study came from diverse cultural and socio-demographic backgrounds, and had received a range of different diagnoses, the breadth of information covered in interviews, and the large number of participants, meant that the specific influence of such factors on their difficulties and care could not always be explored in as great a depth as I would have liked. The design of the research ultimately lent itself better to a focus on broad overarching themes, and I felt that it did not lend itself as well to fully exploring the possible impact of individual differences (e.g. a mother’s age, diagnosis, socio-demographic or cultural background) on the roles of family members in the perinatal period, or on family involvement with services. As outlined, there were indications, for example, that women from Black backgrounds were more isolated than others. I also noted that I was unable to interview a partner or wider family member for the majority of these women, and this made it more difficult to reflect their families’ views in the findings or include them in the dyadic analysis.

Overall, future research would benefit from placing greater emphasis on examining possible contrasts between women and family members from different socio-demographic, cultural and even diagnostic groups. This could include, for example, focusing on women from particular cultures, examining
in-depth the ways in which norms and expectations of mothers, fathers and child development may vary across cultures and how this might affect families’ experiences of perinatal distress and views of services. In doing so, it will be important to recognise that ‘minority ethnicity’ is not a homogenous group but includes diverse groups, who cannot be treated as one, and who are likely to vary in their family set-ups and experiences. Future research should also focus on including a wider range of family set-ups. It was conspicuous that my study only included one single-sex couple, greatly limiting the ability to understand the experiences of such families - especially as, with only one participating couple living in such an arrangement, I had to take care not to breach their confidentiality.

Furthermore, the sample overall - although in many ways diverse - was also above averagely educated and included more women from the south of England than then north. Future research may therefore also benefit from being more representative on such variables. More broadly, as discussed earlier in this chapter, by honing in on interpersonal dynamics and family involvement, my research in some respects also risked deflecting attention away from the broader contexts and social constraints in which families themselves operated and the influence of these – i.e. it risked implying that focusing on families and interpersonal networks should be the main focus of attention, diverting attention from the need also for wider social change. Future research would benefit from placing greater emphasis on exploring the role of wider social contexts on families’ interactions with services.

The fact that interviews were carried out at 6-9 months postnatally, when women’s treatment was often still very recent or ongoing, was also a
requirement of the wider study. This timeframe seemed somewhat arbitrary - and it may be valuable for future research to follow up families later on, allowing them to have had longer to reflect on their experiences and enabling more exploration of longer-term outcomes and impacts. On the other hand, the fact that participants’ experiences of accessing services was so recent was also a strength, increasing the likelihood of obtaining up-to-date and accurate information from them.

Being nested within a wider study also meant making careful decisions about what data to exclude from my analysis as well as include, since not all data were relevant to my thesis. However, while some data were clearly not applicable - e.g. women’s views about their own care - other data were more ambiguous or debatable in their relevance. For example, as well as asking partners and wider family members in their interviews about how services had worked with them, I also asked (as part of the wider study) about their own views of support for women. As I noted in the meta-synthesis, this is an under-researched and overlooked area – and may provide valuable information about support for women from a different perspective. However, while I occasionally touched on views of women’s care in the dyadic analysis, to provide additional context, in the main, I essentially treated this as beyond the scope of my thesis. This was necessary in order to ensure my thesis remained feasible, focused and cohesive. However, it did mean that potentially valuable data were excluded - and future research could usefully focus on partners’ and families’ views of women’s perinatal mental health care itself.
Finally, future research would benefit from exploring the perspectives of clinicians on family inclusion – and asking them about their experiences of good practice when working with families. Relatively little is known about clinicians’ own perspectives, and they may offer value in considering potential solutions to the issues identified.

6.5 Concluding remarks

To conclude, my research has shown that partners and families are vital to understanding women’s perinatal mental health and interactions with professionals. But they are marginalised by services treating perinatal mental health difficulties. Services are seen by women and their families as being structured in ways that exclude families. Professionals are experienced as lacking the skills or resources to work with families, particularly given the need to include families while still protecting the needs of mothers and babies. Inpatient mother and baby units are seen as better than other services at including and supporting families – but they have the important downside that they separate mothers and babies from their families without always recognising the impact of this or offering help with it.

At the same time, it is evident that women and their families can be anxious about the implications of more family involvement and support. Complex family dynamics mean that some women do not want their families involved, while for male partners in particular, views of masculinity make it hard for them to acknowledge their needs or ask for support. Such issues also play a role in professionals excluding families – which can then further encourage partners and wider family members to see their own needs as insignificant.
In seeking to understand these findings, I argued that it is necessary to unpack wider cultural and historical beliefs about motherhood, fatherhood and infant development. Although Western cultures recognise increasingly diverse family set-ups - and despite recent drives towards gender equality - mothers and mother-infant bonds are still generally seen as primary in relation to child development. Fathers and wider families are viewed as peripheral. Mothers are expected to be natural nurturers, who take most responsibility for the developing infant. Fathers are increasingly expected to be more involved with their infants, yet social norms and structures create obstacles to them achieving this in practice. The findings of my research suggest that these expectations, along with other challenges in the perinatal period, play a role in provoking perinatal distress.

However, instead of addressing perinatal mental health difficulties within this wider context, I have argued that the findings of my thesis suggest that services appear to let cultural norms shape their practice. They treat perinatal distress essentially as a problem of the mother’s mind, mostly offering individual treatments (or treatment for the mother-infant bond), while neglecting fathers and wider families – and thus in some ways reinforcing traditional gender roles and diverting attention from the need for wider social change. Paradoxically, this marginalisation of fathers may ultimately exacerbate families’ struggles.

Services now need to find ways to overcome barriers to family inclusion. They need to adapt practice to be more family-friendly, develop and evaluate resources and interventions for partners and families, and also begin proactively to critique self-reinforcing gender norms and expectations.
I wrote a blog briefly summarising my research (with a focus on fathers) for International Father’s Mental Health Day 2019:

https://blogs.ucl.ac.uk/psychiatry/2019/06/17/blog-for-international-fathers-mental-health-day/
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Appendix 1. Published meta-synthesis of partners’ views of perinatal mental health care

[REDACTED]
Appendix 2. Published article on experiences of how services work with families of women with perinatal mental health difficulties

**Open access**

**Research**

**BMJ Open**

Experiences of how services supporting women with perinatal mental health difficulties work with their families: a qualitative study in England

Billie Lever Taylor, Jo Billings, Nicola Morant, Debra Bick, Sonia Johnson

**ABSTRACT**

Objectives Partners and wider family members play a vital role in relation to women’s perinatal mental health. Clinical guidelines in the UK and internationally recommend that services supporting women with perinatal mental health difficulties involve and support their families, too. However, little is known about family members’ needs and experiences, or whether they feel included by mental health services. This study set out to explore these.

Methods This research formed part of a wider study exploring experiences of perinatal mental health care in England. The broader study included semi-structured interviews with 52 women across England who received treatment for a perinatal mental health difficulty, and 52 family members identified by the women as offering them some support. Data from these 84 interviews relating to hassles women’s experiences working with partners and families were extracted and analysed thematically.

Results Analysis identified three overarching themes: (1) the centrality of women’s families to their perinatal mental health care; (2) experiences of partners and families being excluded from care; and (3) ambivalence among women and their families about increasing family involvement in care. We found that partners and families appear to have a significant influence on women’s perinatal mental health, access to care and interactions with services. However, there is a need for more research to focus on the experiences of women and their families, as these can provide valuable insights into how services can support them.

Conclusion Involving women’s families and providing support they need is essential, but important. Experiences of women and their families of services treating perinatal mental health difficulties suggest greater focus is needed on overcoming barriers to family involvement and on understanding underlying gender roles and expectations, rather than allowing these to shape and guide practice.

**Strengths and limitations of this study**

- This study addressed a gap in the research literature by interviewing women, their partners and members of their wider family about their experiences of how services supporting women with perinatal mental health difficulties work with families.
- There are increasing policy emphases on the need for mental health services to include and support families of perinatal women, but relatively little is known about how this is experienced in practice.
- This study included a large, diverse group of perinatal women and their family members with experience of a wide variety of mental health services, including mother and baby units, acute psychiatric wards, special perinatal community teams and general non-perinatal community teams.
- To our knowledge, this is the first study to explore experiences of perinatal mental health care among wider family members as well as women's health.
- It would have been useful to have explored different views of family involvement as well.

families, as families adjust to caring for a new baby. Research has shown that women’s partners experiences can vary widely. For example, some partners may feel overwhelmed, lonely and frustrated when a woman experiences a perinatal mental health problem.² Partners of women admitted to hospital with severe perinatal mental health difficulties report experiencing trauma, stress, fear, work-related difficulties and relationship problems.⁴ Almost one in five marriages ends following an episode of postpartum psychosis and maternal postpartum depression is associated with *fetal* postpartum depression.⁵ While very little research has focused on women’s extended families, one study found that - along with partners - siblings, parents and grandparents of women experiencing postnatal depression and the difficulties that resulted in “a lot of worry within the family.”⁶

CORRECTION To the Editor: The author acknowledges an error in the reference list of the published article. The correct citation is: Billie Lever Taylor, Jo Billings, Nicola Morant, Debra Bick, Sonia Johnson. Experiences of how services supporting women with perinatal mental health difficulties work with their families: a qualitative study in England. BMJ Open 2019;9:e024309. doi:10.1136/bmjopen-2019-024309
Research suggests there can be adverse outcomes for children too. Partners and other family members also play a vital role in relation to women’s perinatal mental health. Greater perceived support from a woman’s partner or even mother is significantly correlated with lower rates of postnatal depression among first-time mothers, while having a supportive partner is strongly associated with shorter hospital stays among women with severe perinatal mental health difficulties. New mothers are also more likely to turn to their partners for support with their difficulties than to anyone else, while some are reluctant to access help because their partners dismiss their symptoms.

Best practice guidelines for perinatal mental health in the UK and internationally recommend including women’s families in their care and supporting family members as well. Nevertheless, our recent systematic review and meta-synthesis found that, across a range of countries, partners of women with perinatal mental health difficulties reported feeling marginalised by services and confronted by a largely mother-baby-oriented environment. Our meta-synthesis also identified ambivalence on the part of women’s partners about seeking greater support and involvement. These findings appeared to be connected to wider social trends; it has been argued that, although fathers increasingly aspire to be more ‘involved’ in the perinatal period and beyond, societal pressures and norms continue to regulate them to the periphery, while persisting beliefs about masculinity and fatherhood discourage them from seeking support for themselves.

Meanwhile, women are seen as ‘natural’ nurturers, with emphasis placed on the importance of the mother-infant relationship, and with mothers viewed as holding primary responsibility for the emotional health of the infant.

Despite these insights, the studies identified by the systematic review had important limitations. In particular, many only touched briefly on partners’ experiences of services, as part of a wider remit, and it was not always clear to which services or professionals the findings referred. Additionally, no studies were found that investigated views of services among family members other than partners. Given the increasing recognition that services treating perinatal mental health difficulties need to ‘think family’, further research into partner and family experiences is needed and may provide useful insights for clinical practice.

The present study therefore sought to expand on previous research by exploring the role of partners and wider families in relation to women’s perinatal mental health, access to services and experiences of family inclusion by services supporting women with perinatal mental health difficulties. Women’s views were included along with those of their partners and wider families to allow different perspectives to be considered.

**Methods**

This study was part of a wider research programme exploring the effectiveness of services treating perinatal mental health difficulties. As part of this research programme qualitative, semi-structured interviews were conducted with 52 women who had accessed National Health Service (NHS) treatment for a variety of perinatal mental health difficulties, and 32 of their partners/family members. These interviews explored participants’ views and experiences of a wide range of mental health service(s). The current study focused on analysing those sections of the interviews relating specifically to experiences of how services worked with partners and families.

**Recruitment**

**Women**

Women were recruited from 11 NHS healthcare providers, across different areas of England, which varied in their urbanicity. Women were purposively sampled to obtain diversity of diagnosis, service use and sociodemographic background. Inclusion criteria required that women were 16 years or over, English language speakers, had accessed NHS treatment for a perinatal mental health difficulty (during or after their most recent pregnancy) and had a baby aged 6 to 9 months old. Eligible women were identified and approached by a clinician within their mental health team. Those expressing an interest in participating were contacted by a researcher to provide them with more information about the study and obtain informed written consent if they were willing to take part. It was not possible to determine how many women refused participation as researchers were only informed of those who were interested.

**Family members**

As previously stated, for each participating woman, a partner or other family member was also interviewed wherever possible. Women were asked if they were able/willing to identify a family member, with some involvement in supporting them, and ask them if they might be willing to take part too (although women could still participate even if no one from their family could be interviewed). A researcher got in touch with family members who were potentially willing to provide them with more information about the study. Informed written consent was obtained from all participating family members. Inclusion criteria required that participating family members were: 16 years or over, English language speakers and were the partner/family member of a participating woman with some involvement in supporting her.

**Data collection**

Interviews took place between June 2015 and March 2017, usually in participants’ homes. Participants were asked, in semi-structured interviews lasting around an hour in total, about their views and experiences of all the services women had accessed for their perinatal mental health. As outlined, the current study focuses specifically on the interview sections relating to partner/family involvement. Specifically, women were asked: Can you
describe how services and professionals worked with other people who were supporting you and your baby (eg. your partner, baby's father, family members or friends). Partners/family members were asked: What was your role in supporting (mother) through this period? Can you describe how involved you have felt in (mother)'s support and treatment? Can you describe any support you've received from services or professionals as someone supporting a mother who is having difficulties? Follow-up probes to these main questions were used as appropriate to encourage participants to give full accounts of their experiences. Given the qualitative nature of the study, related issues were sometimes also touched on elsewhere in their interviews and were included in the analysis where relevant. Participants were informed that their contributions would be kept confidential with identifying details removed, but that the researcher would pass on information if he/she had major concerns about their safety or that of others; ultimately concerns were passed to social services in relation to information provided by one woman (with her agreement).

Interviews with women were conducted separately to family members, with a few exceptions. Most interviews (n=70) were conducted by the first author, who is a clinical psychologist, researcher and mother. A small number (n=14) were also carried out by a professor of social work, a member of the study's perinatal service user and carer advisory group and two Master of Science students studying clinical mental health sciences.

Analysis
Interviews were audio-recorded, transcribed and anonymised. Researcher notes were also written up after each interview. In two cases, interviews were accidentally not recorded and researcher notes were analysed instead. Thematic analysis was used with themes and subthemes identified in a cyclical process of reading, coding and exploring patterns in the data. To enhance validity, a second researcher independently coded nine interviews with women and seven with family members, with consensus reached on the coding frame through discussion.

Analysis was facilitated by using NVivo qualitative analysis software. Given the large number of interviews, two separate data sets were created: one for women and one for family members. Participants in each data set were also categorised by the type(s) of service women accessed. Contrasts were explored across participant groups and services; several key themes were universally reported across different groups but findings unique to types of participant (eg. male partners) or service (eg. mother and baby units (MBUs)) were also identified.

Patient and public involvement
Interview guides were developed by the research team and reviewed and amended by a perinatal service user and carer advisory group (with experience of perinatal mental health care). Pilot interviews were carried out with one woman and one partner from this group, and then with four other women who had accessed perinatal mental health support, and two of their partners/relatives. The latter six interviews were included in the final sample since they met study eligibility criteria and only minor changes to the interview schedules were needed (eg. to reduce the number of probes and expand the opening/introductory text). Five of the main study interviews were then carried out by a woman from the advisory group, and another woman from this group, along with two partners, also reviewed the manuscript which was edited based on their feedback.

RESULTS
Characteristics of participants and services accessed
Tables 1 and 2 show participants' characteristics. Women had a range of diagnoses including depression, psychotic disorders, personality disorder and anxiety disorders. Their mean age was 32 years (range: 19 to 45) and around two-thirds were living with a partner. Just over two-thirds of participating family members were women's partners (one female, the others male), while around a fifth were parents of participating women (referred to as 'grandparents'). The mean age of women's partners was 34 years (range: 23 to 48), while for grandparents it was 54 years (range: 30 to 67) (the youngest age of grandparents may reflect the fact that they were often the chosen source of support for the younger and single mothers included).

The mental health services which women had accessed, and on which participants thus based their experiences, were diverse. Details of the main services participants described are given in Table 3. Some women (with a range of diagnoses) were admitted with their babies to specialist MBUs, while others were separated from their babies, as they were admitted to general psychiatric wards with no provision for infant care. In the community, some women were treated by specialist secondary care perinatal mental health services (for a range of moderate-to-severe difficulties), or by specially trained mental health midwives or health visitors (for milder difficulties). Others received support from generic, non-perinatal mental health services such as crisis teams (for acute difficulties), multi-disciplinary community mental health teams (for moderate-to-severe difficulties) or services offering talking therapies, usually cognitive-behavioural based (for milder difficulties). Some women also received support from non-perinatal services specialising in particular diagnoses (eg. early intervention in psychosis services). Many women accessed more than one service.

Overview of themes
Three overarching themes were identified in the analysis: (1) the centrality of women's families to their perinatal mental health and access to support, (2) experiences of partners and families being excluded by services and (3) ambivalence among women and family members about increasing family involvement/support. Table 4 shows

---

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Category</th>
<th>Respondents (n%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td>Depression</td>
<td>13 (57%)</td>
</tr>
<tr>
<td></td>
<td>Psychosis, bipolar/affective disorder</td>
<td>13 (57%)</td>
</tr>
<tr>
<td></td>
<td>Personality disorder</td>
<td>11 (41%)</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>9 (17%)</td>
</tr>
<tr>
<td>Service used</td>
<td>Perinatal</td>
<td>10 (50%)</td>
</tr>
<tr>
<td></td>
<td>(woman could use more than one service)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist perinatal community team</td>
<td>10 (50%)</td>
</tr>
<tr>
<td></td>
<td>Specialist health visitor/midwife</td>
<td>12 (60%)</td>
</tr>
<tr>
<td></td>
<td>Non-perinatal</td>
<td>5 (25%)</td>
</tr>
<tr>
<td></td>
<td>General acute ward/crisis house</td>
<td>11 (55%)</td>
</tr>
<tr>
<td></td>
<td>Crisis resolution team</td>
<td>17 (85%)</td>
</tr>
<tr>
<td></td>
<td>Community mental health team</td>
<td>15 (75%)</td>
</tr>
<tr>
<td></td>
<td>Talking therapy service</td>
<td>10 (50%)</td>
</tr>
<tr>
<td></td>
<td>Early intervention in psychosis</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Previous service use for mental health</td>
<td>Yes</td>
<td>42 (81%)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>10 (19%)</td>
</tr>
<tr>
<td>Age</td>
<td>Mean age 32 years (range 19–43 years)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;25 years</td>
<td>9 (18%)</td>
</tr>
<tr>
<td></td>
<td>25–29 years</td>
<td>12 (24%)</td>
</tr>
<tr>
<td></td>
<td>30–39 years</td>
<td>20 (40%)</td>
</tr>
<tr>
<td></td>
<td>&gt;39 years</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British</td>
<td>28 (56%)</td>
</tr>
<tr>
<td></td>
<td>White other</td>
<td>6 (12%)</td>
</tr>
<tr>
<td></td>
<td>Black Caribbean</td>
<td>5 (10%)</td>
</tr>
<tr>
<td></td>
<td>Black African</td>
<td>4 (8%)</td>
</tr>
<tr>
<td></td>
<td>Black other</td>
<td>2 (4%)</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>4 (8%)</td>
</tr>
<tr>
<td></td>
<td>Arab</td>
<td>1 (2%)</td>
</tr>
<tr>
<td></td>
<td>Mixed race</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Work status</td>
<td>Employed full-time</td>
<td>2 (4%)</td>
</tr>
<tr>
<td></td>
<td>Self-employed part-time</td>
<td>2 (4%)</td>
</tr>
<tr>
<td></td>
<td>Maternity loan</td>
<td>22 (44%)</td>
</tr>
<tr>
<td></td>
<td>Unemployed/homemaker</td>
<td>23 (46%)</td>
</tr>
<tr>
<td></td>
<td>Unable to work due to illness</td>
<td>4 (8%)</td>
</tr>
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<td>Level of education</td>
<td>No formal qualifications</td>
<td>8 (16%)</td>
</tr>
<tr>
<td></td>
<td>Secondary leaving qualifications</td>
<td>22 (44%)</td>
</tr>
<tr>
<td></td>
<td>Undergraduate degree</td>
<td>10 (20%)</td>
</tr>
<tr>
<td></td>
<td>Postgraduate degree</td>
<td>12 (24%)</td>
</tr>
<tr>
<td>Living with partner</td>
<td>Yes</td>
<td>35 (71%)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>17 (35%)</td>
</tr>
<tr>
<td>Number of children</td>
<td>1</td>
<td>20 (50%)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>13 (25%)</td>
</tr>
<tr>
<td></td>
<td>3+</td>
<td>13 (25%)</td>
</tr>
<tr>
<td>Custody status</td>
<td>Retained custody of baby</td>
<td>47 (95%)</td>
</tr>
<tr>
<td></td>
<td>Not in custody of baby</td>
<td>5 (10%)</td>
</tr>
</tbody>
</table>

MBU, mother and baby unit.

subthemes for these, each of which is presented and elaborated on in the text below. Given the large and diverse samples included in this study, online supplementary file 1 and 2 provide an overview of how participants’ views and experiences vary in relation to different types of mental health services (online supplementary file 1), and
Table 2: Key characteristics of participating family members (n=32)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Category</th>
<th>Respondents (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to mother</td>
<td>Husband/partner</td>
<td>22 (69%)</td>
</tr>
<tr>
<td></td>
<td>Mother/father (“grandparent”)</td>
<td>7 (22%)</td>
</tr>
<tr>
<td></td>
<td>Other relative (eg. sister/child)</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Age</td>
<td>Mean age (partners)</td>
<td>34 years (range: 23–45 years)</td>
</tr>
<tr>
<td></td>
<td>Mean age (grandparents)</td>
<td>34 years (range: 39–67 years)</td>
</tr>
<tr>
<td></td>
<td>Mean age (other relatives)</td>
<td>21 years (range: 17–24 years)</td>
</tr>
<tr>
<td></td>
<td>&lt;25 years</td>
<td>4 (13%)</td>
</tr>
<tr>
<td></td>
<td>25–29 years</td>
<td>9 (26%)</td>
</tr>
<tr>
<td></td>
<td>30–39</td>
<td>10 (31%)</td>
</tr>
<tr>
<td></td>
<td>&gt;39 years</td>
<td>10 (31%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British</td>
<td>19 (59%)</td>
</tr>
<tr>
<td></td>
<td>White other</td>
<td>2 (19%)</td>
</tr>
<tr>
<td></td>
<td>Black Caribbean</td>
<td>2 (6%)</td>
</tr>
<tr>
<td></td>
<td>Black African</td>
<td>2 (6%)</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Living with mother</td>
<td>Yes</td>
<td>20 (62%)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>Work status</td>
<td>Employed full-time</td>
<td>15 (47%)</td>
</tr>
<tr>
<td></td>
<td>Employed part-time</td>
<td>1 (3%)</td>
</tr>
<tr>
<td></td>
<td>Self-employed full-time</td>
<td>4 (13%)</td>
</tr>
<tr>
<td></td>
<td>Self-employed part-time</td>
<td>1 (3%)</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td>3 (9%)</td>
</tr>
<tr>
<td></td>
<td>Unemployed, retired/carer</td>
<td>8 (25%)</td>
</tr>
<tr>
<td>Level of education</td>
<td>No formal qualifications</td>
<td>1 (3%)</td>
</tr>
<tr>
<td></td>
<td>Secondary leaving qualifications</td>
<td>19 (59%)</td>
</tr>
<tr>
<td></td>
<td>Undergraduate degree</td>
<td>5 (16%)</td>
</tr>
<tr>
<td></td>
<td>Postgraduate degree</td>
<td>5 (16%)</td>
</tr>
<tr>
<td></td>
<td>Not recorded</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

in relation to their status as direct service users (women with perinatal mental health difficulties), partners or wider family members (online supplementary file 2). Overall, women, their partners and wider family members considered that families were marginalised by services and should be better included and supported. But they also described some unique anxieties about this. While all types of mental health service were reported to marginalise families, MBUs were seen as the most inclusive.

The centrality of the family to perinatal mental health and access to support

A key finding expressed by women, partners and other family members centred on the importance of women’s families to their difficulties, interactions with services, and longer-term recovery. This view was expressed irrespective of diagnosis, with findings indicating that a woman’s mental health needs should be addressed with reference to her family and interpersonal context.

The role of interpersonal transition and conflict

Women and their family members described pregnancy and having a baby as a major life transition: it resulted in shifts in their roles, relationships and identities, and this could provoke distress. Though the adjustment could be particularly marked for first-time parents, the addition of further children could also disrupt the status quo.

It was conspicuous how frequently participants linked interpersonal conflict and tension to the woman’s difficulties. Women, in particular, often cited discord with their partner or wider family as contributing to, or exacerbating their mental health difficulties. Several described their relationships with partners, as well as with wider family members and friends, as having broken down during pregnancy or after giving birth, often leaving them struggling to live up to their image of the ‘perfect’ mother, and to cope with their babies single-handedly. Other women felt frustrated and overburdened, saying their partners did not help enough with
like, ‘I can’t be turning work down,’ ...I’ve not gone out in the evenings since having the baby... He said, ‘Oh, we’ve had so many problems since the baby was born... She’s nearly torn as apart. (Mother S7)

Some participants, most commonly women’s partners, expressed that family relations had become strained as a result of the woman's mental health difficulties, rather than vice versa - for example saying they believed women became difficult, or even suspicious and hostile towards their families, because of postnatal depression or psychotic delusions. In some cases, women’s partners also felt rejected or de-privileged by them after the birth of the baby, prompting clashes and distress.

I’ve had my own challenges as well with the change in our lives...If I was on (my wife’s) list before, I was at the bottom of the list, I’m now not on the list... You don’t have an adult relationship in the same way that you did... You know, I come in from work and (my wife) wants to get to bed early if she’s tired. So you have those sort of like clashes really. (Partner 4)

These turbulent relationship shifts were not confined only to women and their partners. Sometimes grandparents or, less frequently, other relatives were also heavily involved (eg, where women’s relationships with their parents had broken down) and, in such cases, the birth of a baby often necessitated a reorganisation of wider family relations too. For example, one single mother was living with her father and he associated her difficulties
partly with their own shifting relationship in the context of a new baby.

I know that at the moment (my daughter’s) suffering with a bit of postnatal depression... I know because she has screaming rows...

When we argue about stuff, the crux of the argument, when we’re sort of nose to nose, I’m not your boyfriend and I’m not his dad. You don’t get to, if he was his dad you could talk to me like that... But I’m not, I’m your dad.’ And from (my daughter’s) point of view it’s like, ‘I’m raising this baby or my own... That kicks me right in the teeth because it’s like, I’m here.’ (Grandparent 5)

Overall, although it was the women who had been given the diagnosis of a perinatal mental health problem, their difficulties were frequently embedded within a complex and fraught wider interpersonal context, where the whole family was struggling.

**Influence of the family on support and recovery**

Women’s contact with mental health services took place in the context of the complex, shifting family dynamics described. It was clear that family circumstances, and the attitudes and behaviours of family members, influenced women’s access to support, interactions with services, and recovery. Women who had some of the ‘worst’ outcomes (e.g., the five women who had lost custody of their babies) were typically living in particularly challenging family contexts, categorised by conflict, relationship breakdown, and sometimes violence and abuse from partners or other family members. When women perceived their families to be unsupportive or dismissive of their struggles, it could increase or prolong their distress.

(My husband) was like... You’re not the woman I thought you were. This behaviour is just awful. You’re not loving the children. And it just wasn’t working. And then eventually it got worse. I think I, within 2 weeks anyway I was like completely suicidal. (Mother 11)

In a few cases, partners or other family members put pressure on women not to access support. This could be because they were anxious about women taking medication, or feared professionals might judge the family negatively, or even take the baby away. In some cases, women turned down treatment because of perceived family resistance; in other cases they kept their treatment secret. This could be especially sensitive for women from ethnic minority backgrounds, who sometimes reported that perceived stigma around mental health within their wider family and social networks resulted in them hiding their difficulties and treatment from their families.

On the other hand, there were numerous instances where partners and other family members were supportive of women’s treatment and recovery. They were often seen (by women in particular) as instrumental in denigrating women’s difficulties, encouraging them to get help and assisting their recovery, with some family members describing their relief when women accessed support. Women with proactive family members supporting and advocating for them seemed to get access to professional support more readily than those without.

Furthermore, when women struggled, their partners and wider families frequently took over household chores or helped more with the baby, for example doing night feeds or looking after the baby while the woman attended appointments or was hospitalised. Women from some cultural backgrounds (e.g., Asian) sometimes reported that a high level of involvement with infant care from extended family networks was the norm. For other families, taking on extra responsibilities could put a strain on partners and wider families as well and, in some cases, they also blamed themselves for what had happened.

As a man, or partner, husband, you feel like it’s your fault your partner is the way that they are... Maybe I’ve not loved her enough. Maybe I’ve not helped enough. But really, in essence, you’re probably doing as much as you can, or doing more than what you normally do... I blamed myself a little bit, not just for you, know the pregnancy and the baby, but just, I don’t know, everything really. (Partner 15)

**Experiences of partners and wider families being excluded by services**

Despite their perceived importance, many of those interviewed believed families were excluded by services supporting women with perinatal mental health difficulties. Experiences of this were reported by women, partners and wider family members across different demographics, diagnoses and service types, although MBUs appeared to be more inclusive of families than other services. Analysis suggested that this exclusion of families was manifested in various ways including; not being invited to or included in appointments; not being provided with information about, or helped to understand, the woman’s mental health problems; not being involved in treatment decisions; their own distress and difficulties not being acknowledged and not being offered any support for these difficulties.

**Overlooking families**

It was common for women and their family members to say that professionals overlooked partners and wider families, focusing their attention exclusively on women and their babies. Mirroring this, some participants conceded that they too had given little thought to family involvement, for example, not thinking to ask if family members could attend appointments/access support themselves - even if, in hindsight, women and their family members alike thought this could have been valuable.

Within community mental health services in particular (both specialist perinatal services and generic, non-perinatal services) there were sometimes few opportunities for family members to become involved or meet clinicians
(eg, where they weren’t limited to appointments), and a sense that there was no real ‘place for, like, a husband’ (Partner 13). As a result, women’s families often felt poorly informed about their difficulties and treatment; they were unsure exactly what support a woman was receiving, what to expect and how best to help her.

I sing it every day with supporting (my partner), so I don’t know the correct way...There’s been no support there to help me. I feel sometimes the best way for me to support her is just agree with her and deal with it after...But I don’t know whether that’s the right way to go about it overall. She’s got a (specialist perinatal) psychiatrist. What about support for the dad in this case? (Partner 14)

A number of women and their family members wanted families to be included in at least some appointments; they felt this would both allow them to contribute their own observations, and also help them better understand and support women.

It would’ve been nice to have had a bit more involvement (with the talking therapy) as far as, you know, meetings or otherwise just so that I have a better grasp to understand what issues we’re dealing with...I guess I didn’t know, within the structure of how everything works, how I could get involved. (Partner 5)

(My husband) wanted to speak to professionals to tell them his side...I would (have liked that too), just to see, you know, because he’s not like the easiest of men, but then he’s not responded in a way that I needed him to respond...And he’s never ever approached me in a way he needs to approach me, so it makes me worse. (Mother 50)

When mental health professionals visited women at home, family members really valued being included and asked for their input. But some felt they were ignored.

I’ve never really talked to (the early intervention service care coordinator)...Like she comes here and talks to (my wife). Doesn’t really say much to me or doesn’t ask me, ‘How do you think she is?’, or things like that. I mean nothing...It would have been nice for her to say, ‘Well I’ll involve you in some of the meetings.’ But you don’t get nothing. (Partner 11)

Where women were admitted to MBUs or psychiatric wards, their families were more likely to have at least some contact with clinicians on inpatient units. For example, they might speak to them when visiting women or arranging visits, and some were involved in treatment decisions if women were judged to lack capacity. MBUs were praised overall for working collaboratively with women’s families, regularly communicating with them, as well as inviting them to be present at ward rounds and taking their views into account. By contrast, family members had to be proactive and persistent to get staff on general psychiatric wards to keep them updated on the woman’s condition and treatment plan. A few women said staff on acute wards treated them like ‘a single person’ (mother 44), hardly acknowledging their families, and sometimes not even realizing they had a new baby. One man, whose partner stayed on both an MBU and an acute ward, described the MBU as more inclusive of him than the acute ward.

Two or three days go and then I would call (the ward) again because they never, well they hardly ever called me. It was me trying to find out things all the time.

I was asked to attend (meetings at the MBU) if I wanted to. You know, they wanted me to attend to see...It was run like with partners in mind. They wanted the partners to be involved and to, you know, to help in the whole process. (Partner 20)

Lack of support for partners and other family members

As well as wanting information about and involvement in women’s support, some partners and family members said they would have valued emotional support from mental health professionals themselves, for their own distress; they wanted help coping with the effects of the woman’s mental health problems on them, and addressing their own difficulties adjusting to life with a new baby. Across our data corpus and regardless of community, inpatient, perinatal or non-perinatal mental health settings, few accounts were provided of support targeted at family members.

In general, families wanted support to be offered face-to-face or over the telephone: ‘It would have been nice if somebody was there to just call me occasionally saying, ‘How are you doing?’’ (Grandparent 6). In particular, they wanted professionals to acknowledge how difficult things were for them and check how they were doing. Several partners and other family members felt that nobody was thinking about them.

I felt I wasn’t being more involved, like, and no one’s coming to me, like, ‘How are you doing? How is your mental health state?’ And all this, you know. Because it’s not easy. And I get a bit, like, okay. No one’s asking me how I am. How about me? I thought, it’s not only her going through this, it’s me. I’m there and all. (Partner 7)

There were a few exceptions where professionals, most commonly perinatal specialists on MBUs or in the community, had acknowledged family members’ needs and engaged with them too, and when this happened it was valued.

(I had) lots of, just informal chats...Different members of the (MBU) staff would ask me how I’m coping, am I all right? How are things at home? And sometimes I sort of took up the offer to sit and have a bit more of a chat. (Partner 12)

However, even when support had been offered, it was frequently viewed as superficial, insufficient or too late.
I was offered support (after my wife’s MIU admission), but it was all sort of quite late on in the process. And kind of, ultimately, you had a meeting with someone at home. They were very nice. But none of the things that were due to be followed up on were followed up on. (Partner 17)

**Difficulties balancing the needs of women and their family members**

In some cases, rather than simply overlooking partners and wider family, respondents’ accounts suggested that clinicians may have excluded partners or family members because of concerns that involving them could reduce the focus on the needs of the woman (and baby), or because they were mindful of the need to protect women’s potential desire for confidentiality from their families. These issues were complex; as outlined, some women kept aspects of their mental health or treatment secret from their families, while others described experiencing turbulent, unequal and sometimes coercive and abusive relationships, meaning privacy and time alone with professionals could be vital. Prioritizing the needs of women and babies, and keeping a clear focus on them, seemed essential in this context. Yet it could also leave family members feeling shut out. Several family members, across different types of service, described how they had wanted to put across their own opinions (eg. if they felt a woman was struggling more than she admitted, or wanted to tell professionals that a woman’s hostility towards them was, in their view, really driven by paranoia, psychosis or similar). But they felt mental health professionals were unwilling to speak to them or appeared cautious or mistrustful of them (occasionally also linking this to the female-dominated nature of staff within both perinatal and non-perinatal mental health services).

I wanted to say to the (specialist) health visitor, ‘Look maybe do you think that this could be postnatal depression...?’ I would have liked the chance to discuss it with her. Not that I wanted to encroach on any of (my daughter’s) time with her...But alas...If I was in the room then everything sort of stopped until I left the room, and then they recommenced...The minute I walked in it was like tarnationed. (Grandparent 3)

For their part, some women also desired privacy from their families had still wanted them involved in some way. For example, one woman from an ethnic minority background saw value in involving her husband in her care, but at the same time kept some details of her difficulties secret from him due to perceived cultural stigma around mental health. She wished professionals had helped her negotiate this, offering her more options for how he might be included given this context.

(The community mental health team) haven’t told me, ‘How would you like us to involve (your husband)?’ They just told me to bring him to my appointments. But I don’t want to bring him to my appointments because they might bring up something that he doesn’t know and then that would just cause problems afterwards... (I’d like to) take him along with me (so he could get) some sort of understanding...But like I said, it’s either come to my appointments or don’t get involved. (Mother 35)

However, adding to the complexity, a few participants said that too much emphasis on involving partners or family members could leave women themselves marginalised. This suggested that professionals at times experienced difficulties determining the appropriate emphasis to place on different people’s needs or perspectives—especially where interpersonal relationships were strained.

When you’re in hospital, they hardly listen to you. Well, this is my experience, my feeling. That’s like they hardly listen to you at all because they know the reason you’re in hospital is because you’re unwell. So they listen to (my husband). (Mother 25)

Nevertheless, there were a small number of examples that suggested it was possible to protect women’s needs without excluding their families, even in difficult circumstances. These were usually cases where professionals had built up a good picture of the family context, for example in non-perinatal mental health teams which had been involved longer-term, not only during the perinatal period. For example, the partner of one woman (who had a pre-existing diagnosis of bipolar disorder and experienced postpartum psychosis) described how, although he initially felt marginalised by community mental health team clinicians, he felt they had got to know the family situation better over time, and became more adept at arranging both his and his wife’s needs.

It’s been a very fine line to tread for them and they’ve done it very well...Not making me feel excluded...Not using confidentiality as a rather convenient way of just not having to deal with me...But finding sensitive and appropriate you know, professionally appropriate ways around that so that they get the information they need from me...And that I still feel supported. (Partner 12)

**Services ill-equipped for complexity of family inclusion**

As the findings above suggest, complex interpersonal dynamics between women and their families meant family involvement was not always straightforward. There were indications that mental health professionals at times felt ill-equipped or under-resourced to deal with this complexity, marginalising family members as a result. For example, in one case, a woman believed her perinatal nurse excluded her partner from appointments because she did not feel suitably trained to deal with the tensions in their relationship. Nobody else, she said, was able to support her partner or see them together either.
I’m just, basically like, surprised that there is no support system for carers, or friends, or partners, or family members, there’s no support system whatever...

(My perinatal mental health nurse) doesn’t want to make it worse. It’s like a very different, couples therapy, like dealing with two people in the same room who’ve got conflict with each other, it’s a very different thing, yes. And like, so I think, I don’t know how many years of training it is, but like, she doesn’t have that training, she can’t do it, yes. (Mother 8)

There were a few exceptions, where participants described practitioners, most often specialist perinatal practitioners, as engaging confidently with the family context; this was appreciated. Yet in other cases, partners and family members believed professionals excluded them because their perspectives could be awkward or difficult.

I’m quite happy to go and see them, ‘I don’t like the way you’re doing this’ or, ‘I don’t think it’s right what you’re doing’ or, ‘you shouldn’t be doing it.’ And I don’t think they liked it...and I just think it’s because, a bit of bad blood between us that they just distanced their self away. (Grandparent 5)

Where wider families were involved, in particular when grandparents were helping single mothers, they sometimes also felt that professionals were ill-equipped to consider their unique role and needs. Likewise, in unconventional family setups, family members could feel poorly accommodated, for example where women had new partners who weren’t the baby’s biological father.

It’s a grandad’s role...you’re looked at from the outside world, from doctors and health professionals and psychiatric healthcare professionals as a dad in that situation...Because the dynamic of families has changed, the dynamic of the help that is offered to them should be changed. (Grandparent 3)

The structure of services and separation of families

Finally, broader structural issues were sometimes referred to in relation to how and why partners and families were marginalised from services. In particular, participants noted that inpatient admissions involved separating family members from each other, often meaning that partners or relatives cared for babies (or older children) single-handedly while women were hospitalised. While women and their families generally preferred specialist MBU admissions with their babies over acute ward admissions without them, a disadvantage was that family members were separated not only from women but also from babies. Although MBUs were perceived as collaborating better with women’s families than other services, some family members felt their set-up made it difficult for families to fit in, and that the consequences for them of the separation were not fully acknowledged.

The only thing that could have been improved on from my perspective was a bit more recognition from the, the nursery nurses...I’m not resident (on the MBU), I haven’t got my stuff there. It’s, it can be quite tricky to suddenly slot into your father role...Not having had a chance to get to know your baby very much. (Partner 12)

A scarcity of MBUs nationwide, and the wide areas they served, also meant women were regularly admitted to facilities far from home, meaning their families often faced long journeys to visit them, with little or no financial support for travel. Nonetheless, MBUs were seen as accommodating family visits well. This contrasted with acute wards, where experiences of visiting were less positive.

You can hear shouting, you can hear screaming...It would be nice to have had a family room away from the ward...You want to take your child for a walk in the gardens...No. You had to be stuck in that room. Like I say, it felt like a prison. (Partner 21)

Family members also wanted more support from both MBUs and acute wards post-discharge, to help them readjust to life back at home with a new baby and to cope with any ongoing difficulties. Some felt that a lack of focus on women’s wider family contexts meant women were sent home to the same turbulent dynamics in which their difficulties first arose, resulting in them struggling again.

Everything was just put in place with (my daughter). So there was no follow up for me...But if I got the support...to help (my daughter)...you know, how to hold her little family together, I think that would’ve been so much better. If (the MBU) did something with the parents or grandparents...because she was coming right back home...so if the support is not there for her...We didn’t hope that (she) would go back in hospital again, but it happened. (Grandparent 2)

In community settings, structural factors could also contribute to marginalising families. This could occur when women were seen individually in clinics rather than in their home environment, when family members were invited to appointments but could not attend because they were during working hours, or where support for family members was offered at inconvenient times and in awkward locations.

They’re telling me I have to take time off during the week to get the support we need but I’m saying, Why don’t you work a weekend so we can get the support that we need? (Partner 14)

Across all service types there were indications that participants wanted services to be structured in a way that was more family-oriented or holistic. In inpatient settings, some participants wished family members could stay overnight on MBUs, with a few women refusing admission.
because they did not want their family separated. In the community, some women (and, less commonly, partners) wanted couples/family therapy, saying their difficulties had persisted after treatment, and that they saw addressing the interpersonal context as important to resolving their struggles. There were also examples of women questioning why they were treated and medicated for what they saw as interpersonal difficulties.

It would’ve been nicer to have sort of a more family, I know it doesn’t really exist, but more of a family place that you could, so your partner and mother, so father, mother and baby could all go there. And there’d be support for everybody... I think a lot of people would benefit from it. (Partner 2)

Ambivalence about family involvement and support

Despite ostensibly wanting more family inclusion and support, many participants simultaneously seemed unsure about this, suggesting underlying ambivalence. This was not indifference on their part, but rather appeared to relate to anxieties about what greater family involvement or support would mean, whether it might make unmanageable demands on them, or have other undesirable consequences. Women’s and their partners’ responses mixed feelings about family involvement sometimes seemed to reinforce the tendency for services to marginalise families creating a vicious cycle.

Feared consequences of family inclusion/support

Women’s partners and other family members often described struggling with the burden on them. Many were trying to hold down a job, as well as support the mothers and cope with the challenges of a new baby. Although they felt neglected by services, the idea of greater involvement, let alone taking up support themselves, could also feel unmanageable, given the competing demands on their time. ‘Even the thought of going to see a counsellor for an hour was just like, well I just don’t have time for it.’ (Partner 2).

Not only this, some participants appeared resistant to a greater focus on families for fear this might further disrupt their relationships or the ‘status quo’. For example, in one case a woman believed her partner was reluctant to be more involved in her support or accept support himself for fear it might require him to face up to problems in their relationship, and change his behaviour and attitude towards her and their baby. Faced with his resistance, she said professionally seemed to back off, rather than persisting in exploring ways to engage with him.

I don’t think (professionals) tried to help him enough to some degree. But then... he wasn’t willing to work with me and (our baby)... He didn’t want to work with them in any way, shape or form. And too much of self-centred and selfish person. He doesn’t want to change... They haven’t really tried to guide him in more taking it. They’ve left it more for him to do. (Mother 33)

It was also common for women themselves to express anxiety about the idea of family members being involved in their support, saying they would not ‘understand’. This too appeared to relate in part to underlying concerns about what their involvement might mean for family relationships and whether family members might judge women negatively. It also seemed connected to underlying anxieties for women about how family inclusion might affect their protected time with clinicians and autonomy over their treatment, especially for those living in fraught family contexts. As outlined above, privacy was important for some women and, when family members were very involved, this could occasionally leave women themselves feeling deprioritised.

Partners and other family members have to ‘stay strong’

Even though they struggled when women were distressed, and with the demands of a new baby, partners and other family members were often uncertain about accepting support themselves. Although they spoke of loss of sleep, anxiety, depression, stress, increased alcohol use and work-related difficulties, some were adamant that they did not need or want support themselves. Others expressed the view that they had to ‘stay strong’ and not ‘indulge’ their own needs. A few felt more comfortable saying ‘in the background’ (Partner 1) and many seemed only really to find it acceptable for the mother (and baby) to get help.

I was looking after (our baby). I still hadn’t recovered from the sleep... So I kind of just, I don’t need anyone’s help, I’m just going to do this... And then, you know, after I’d go and see her at the MBU, and then I would have my cry... because I was in it and it was happening I just thought I don’t really need any help, because it was (my wife) that needed the help. (Partner 2)

Several women also subscribed to the view that their partners and wider families were ‘strong’ and not in need of support. This reduced their inclination to focus on their needs or push for support for them.

A number of male partners meanwhile explicitly or implicitly connected their hesitation accepting support (including peer support) to beliefs that it was shameful and untrue for men to voice needs. Male partners appeared to place a high value on not being ‘overdramatic’, they wanted to wait to see if things would resolve of their own accord, and to work things out by themselves. At times this seemed to be partly connected to uncertainty about what it was ‘normal’ to feel in the perinatal period. However, there was also a sense that feelings of neediness challenged men’s sense of self-worth.

As a man, you don’t really need support. You think you can do it on your own. You’ll be fine. (Partner 1b)

It was conspicuous that, even when partners and other family members did want help, they often found it
difficult to pinpoint exactly what it was they wanted. Some implied that they were willing to accept support to help them support women, but were not comfortable with support focused more directly on themselves. Several participants implied that, in particular, were more likely to take up support that addressed their own needs if it was offered in an ‘informal’ or ‘incidental’ way.

I kind of enjoy socialising but I don’t like being pushed to meet other people’s goals. That’s just guys though, more like you know, just like they do it if it’s natural but if it’s organised you almost like sniff something, is that a trap? (Partner B)

This desire for support to be ‘casual’ or ‘understated’ also reinforced the earlier points, where some family members said they did not see the need for formal support, as greater recognition of the challenges they faced. They wanted to be noticed; for a professional to ask how they were, or to suggest having an ‘informal chat’.

**DISCUSSION**

In the UK, the newly published NHS long-term plan emphasizes the importance of mental health services working with and supporting the families of perinatal women. The importance of this is also increasingly recognised internationally, both in Western and non-Western societies. Yet relatively little is known about experiences of family involvement and support in practice. This study explored views of how services supporting women with perinatal mental health difficulties work with their families, from the perspectives of women, their partners and wider families. Women in the study had accessed treatment from a wide array of UK services for a range of diagnoses. They came from a broad mixture of socio-demographic and cultural backgrounds, and lived in differing family setups. Along with their partners and family members, they gave rich, qualitative accounts of their experiences.

Overall, analysis suggested that women’s perinatal mental health difficulties need to be considered with reference to their family and interpersonal contexts. Contact with services takes place in the midst of complex relationship dynamics, which are in a state of flux with the arrival of a new baby. Although it was the women who had been diagnosed with perinatal mental health difficulties, their struggles often seemed to signify difficulties between family members, as much as within individual mothers, and with all members of a family experiencing distress. The perinatal period is a critical time for relationship strain and even domestic violence, and women in particular often connected their perinatal mental health difficulties to familial struggles (e.g., expressing frustration at having to take on the bulk of parenting), with families also playing a major role in relation to access to support and recovery.

Despite this, services were experienced as focusing on individual women (and babies), and not often engaging in a meaningful way with families or the interpersonal context. Services were seen as being structured in ways that tended to exclude family members, and professionals experienced at times as ill-equipped and unprepared to work with families. Family members were not regularly included in appointments, or kept informed about women’s needs or support for them. Though there were exceptions, this meant partners and families were often left feeling marginalised, unheard and unsupported while women and their families said difficulties sometimes persisted after treatment because of a lack of wider focus. This study builds on our previous research which similarly highlighted the marginalisation of women’s partners across a range of countries and service settings. This study suggests this marginalisation extends beyond partners to members of the wider family too. It also echoes wider research, which shows that partners and wider families can feel excluded by mental health services outside of the perinatal period too. Although families felt neglected across all types of service, MBUs were generally reported to be better at engaging with families than other services.

Nevertheless, responses also suggested that it could be complex for professionals to balance family inclusion with the need to protect and prioritise women and their babies. This was especially true in light of women’s fraught and sometimes abusive family contexts, and in some cases, their expressed desire for privacy from their families. Not only this, although women’s families ostensibly wanted to be better included and supported, they also expressed ambivalence about this. In line with previous research, perceived norms of masculinity and fatherhood meant that male partners/fathers found it hard to acknowledge their own needs. Likewise, other family members often believed they had ‘stay strong’. Greater involvement and support could also feel unmanageable, given how much families already had to cope with, and there were signs too that women and their families were fearful about the possible disruption to their relationships and the ‘status quo’ that a greater focus on families could entail. This appeared to reinforce the tendency for services to overlook and exclude families, which, in turn, arguably contributed to increasing their perception of their own needs as insignificant in a vicious cycle.

Viewed in their broader context, the findings suggest that mental health services supporting perinatal women tend to reflect and reinforce pervasive social norms and practices around motherhood, fatherhood and infant development. As described in the introduction, in wider society women are typically seen as natural nurturers who are expected to assume primary responsibility for infant development; fathers are encouraged to be ‘equal’ partners but, in reality, are relegated to the periphery. Our findings suggest that these culturally-embedded expectations place pressure on both women and their families which - along with other challenges
can contribute to provoking perinatal distress and can bring family members into conflict with each other. Yet instead of seeking to understand perinatal distress within its wider context - or indeed to challenge the structures and norms that may produce and maintain it - services appear focused on diagnosing and treating individual women, arguably even aiming to help them adjust to their expected role as primary nurturers, while marginalising fathers and wider families. In this way, rather than challenging dominant norms, services allow them to shape and guide practice. This is arguably further exacerbated by wider prevailing cultural views of women as prone to ‘hysteria’ (itself derived from the Greek for ‘uterus’), with men expected to be emotionally undemanding, and by a broader tendency within psychiatry to see distress as located within individual minds, deflecting from the need to address people’s wider social, political or interpersonal contexts.

**Strengths and limitations**

This study addressed a gap in the research literature, by interviewing a diverse group of women, as well as their partners, and wider family members about experiences of how services work with the families of women diagnosed with perinatal mental health difficulties. Nevertheless, it also had several limitations.

First, as this study was nested within a wider research programme, only parts of each interview focused on experiences of family inclusion, limiting the time that could be spent discussing this topic, particularly as such a wide array of services were included. While rich data were nevertheless obtained, future research may benefit from dedicating full interviews to this topic. Second, interviews with women and their family members were analysed separately for the purposes of this paper. However, future research may benefit from analysing ‘pairs’ of interviews together to allow closer comparison and contrast of different perspectives. Third, while in most cases interviewees were carried out separately with women and their family members, in exceptional cases both were present. This could have had implications for what participants were willing to share in these cases (eg if they were unwilling to disclose some information in front of each other).

Fourth, interviews were carried out at 6 to 9 months postnatally, when treatment was often very recent or ongoing. It may be valuable for future research to follow-up families later once they have had longer to reflect on their experiences. Fifth, it may have been valuable to have involved partners or grandparents in conducting interviews, to see if this generated unique insights based on shared perspectives. Inevitably researchers’ own experiences (eg of motherhood and perinatal mental health care) affect their interactions with participants and interpretations of the data; a male interviewer may, for example, have elicited different data from male partners, but all researchers were female. Finally, future research would benefit from exploring the perspectives of clinicians too, and placing greater emphasis on possible solutions to the challenges identified.

**Implications and conclusions**

Study findings suggest that engaging with wider interpersonal networks is challenging and complex, but too important to ignore. Perinatal mental health difficulties, and access to treatment, do not occur within a vacuum, but within a wider social and interpersonal context, in which the family plays an influential role. Our findings suggest a need for professionals to approach women’s difficulties with greater focus on their social networks and to proactively challenge the ways in which the current setup of services may reinforce dominant gender norms, and allow them to guide practice. At the same time, participants’ ambivalence about family inclusion and the divergent needs and wishes expressed means there is a danger in making assumptions about what might be most helpful for them or how this might best work. Instead, at this stage research evidence is needed evaluating the effectiveness, acceptability and potential pitfalls of different potential approaches, preferably based on co-production principles to ensure the views of people with relevant lived experience and clinicians are central.

Possible approaches that merit further exploration include: (i) considering how to adapt current practice to make it more family-friendly (eg by identifying acceptable ways to include partners/relatives more meaningfully in (at least some) appointments), (ii) challenging the way service structures currently deprioritise family members’ needs, but also balancing this with protecting women’s needs, (iii) developing or adapting couple or family-focused interventions for perinatal populations; previous reviews suggest that family therapy can help address and prevent perinatal depression, and that couple psychoeducation can support the transition to parenthood. In England, clinical guidelines recommend couple or family approaches for some perinatal mental health difficulties, but such interventions are rarely available and have not been extensively tested in the perinatal period, developing and testing resources/interventions aimed at women’s partners and wider families, acknowledging that some will themselves also have perinatal mental health needs; this will need to take into account that some family members express a preference for more ‘informal’ or ‘incidental’ forms of support (though this also may be partly a result of services treating them as ancillary), and (v) tailoring specific staff training around engaging with families in the perinatal period, including awareness of cultural diversity.

At the same time, it is important to ensure that any changes to practice do not result in simply pathologising fathers as well as mothers, or holding families solely responsible for problems relating to perinatal distress and/or infant development. Rather, there is a need to look beyond the family as well, recognising that families too are operating within the constraints of their broader social contexts and the resources available to them.
may entail advocating for broader social changes to lessen the pressures on families.

Acknowledgements The authors are greatly grateful for the advice and support received from the Perinatal Service User and Carer Advisory Group, and from the wider EMH study team. The study team would also like to thank all the women and their family members who gave up their time to take part in the study.

Contributors BJ contributed to study concept and design, data collection, data analysis, interpretation of results and drafting of the manuscript. JG, MM, DG and SJ contributed to study concept and design and drafting of the manuscript. All authors read and approved the final manuscript.

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Competing interests None declared.

Ethics approval National Health Service ethics approval was obtained (reference 13/LO/0555).

Provenance and peer review Not commissioned externally peer reviewed.

Data sharing statement The data were generated and analysed during the current study and are not publicly available due to containing information that might compromise research participant privacy/confidentiality or are available from the corresponding author on reasonable request.

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REFERENCES


Appendix 3a. Interview guide for women

Stakeholders’ views and experiences of perinatal mental health care and services

Service User Interview Schedule

[NOTE: This interview schedule includes questions and potential prompts, but is only intended as a guide and the interview will be guided by the interviewee’s responses.]

Interview opening:

Thank you for agreeing to do this interview with me. I’m going to ask you about your experiences of the services and people you’ve had contact with about your psychological wellbeing or mental health while pregnant or after having your baby – these might include people like a GP, psychologist, psychiatrist, specialist midwife, or services like a mother and baby unit, a community team or a crisis resolution team.

The questions will be quite open so as to give you a chance to tell me about things from your perspective. We are really keen to hear about what you found helpful and what could have been better. We are asking a range of mothers and those supporting them about their experiences so that we can understand what help people want and need at this time. We will use this information to make recommendations about how best to support families during this period. There are no right or wrong answers and the interviews are not designed to judge anybody. So please be as open as you feel able to be. This study is being carried out independently of any of the services you have used. Everything you say is confidential and nobody involved in your care will be told anything about what you say, so it will in no way affect the care you receive. When we write up our findings and recommendations, it won’t be possible to identify you from what we write. The only time we would have to pass on information would be if we had major concerns about your safety or the safety of others.

The interview may touch on sensitive topics. You can stop at any time or ask for a break, or say that you don’t want to answer a particular question. The interview should last about an hour, and I will be recording it. Do you have any questions before we begin?

Ensure participant has read information sheet and ask them to sign consent form if happy to do so.

I’m going to start by asking you a few background questions.
### Background information for sampling and context

**Interviewer to complete prior to interview:**

<table>
<thead>
<tr>
<th>Participant ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of interview</td>
</tr>
<tr>
<td>Trust recruited from</td>
</tr>
<tr>
<td>Service recruited from (where relevant)</td>
</tr>
</tbody>
</table>

**Collect the following information from the mother:**

<table>
<thead>
<tr>
<th>Mother’s nationality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s country of birth</td>
</tr>
<tr>
<td>Mother’s main language</td>
</tr>
<tr>
<td>Mother’s ethnic group</td>
</tr>
<tr>
<td><strong>White</strong></td>
</tr>
<tr>
<td>1 White British</td>
</tr>
<tr>
<td>2 White Irish</td>
</tr>
<tr>
<td>3 Gypsy or Irish Traveller</td>
</tr>
<tr>
<td>4 Other (describe)</td>
</tr>
<tr>
<td><strong>Mixed/multiple</strong></td>
</tr>
<tr>
<td>5 White and Black Caribbean</td>
</tr>
<tr>
<td>6 White and Black African</td>
</tr>
<tr>
<td>7 White and Asian</td>
</tr>
<tr>
<td>8 Other (describe)</td>
</tr>
<tr>
<td><strong>Asian/Asian British</strong></td>
</tr>
<tr>
<td>9 Indian</td>
</tr>
<tr>
<td>10 Pakistani</td>
</tr>
<tr>
<td>11 Chinese</td>
</tr>
<tr>
<td>12 Bangladeshi</td>
</tr>
<tr>
<td>13 Other (describe)</td>
</tr>
<tr>
<td><strong>Black/African/Caribbean/Black British</strong></td>
</tr>
<tr>
<td>14 African</td>
</tr>
<tr>
<td>15 Caribbean</td>
</tr>
<tr>
<td>16 Other (describe)</td>
</tr>
<tr>
<td><strong>Other ethnic group</strong></td>
</tr>
<tr>
<td>17 Arab</td>
</tr>
<tr>
<td>18 Other (describe)</td>
</tr>
<tr>
<td>Mother’s age</td>
</tr>
<tr>
<td>Baby’s DOB and gender</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>DOB</td>
</tr>
<tr>
<td>Any other children?</td>
</tr>
<tr>
<td>If so, what are their ages?</td>
</tr>
<tr>
<td>Who is the mother living with?</td>
</tr>
<tr>
<td>[Check if living with baby, other children, baby’s father].</td>
</tr>
<tr>
<td>If mother is not living with baby: who is the baby living with?</td>
</tr>
<tr>
<td>Who is involved with childcare? (e.g. mother, father, other family members, child minder, nursery)</td>
</tr>
<tr>
<td>Housing tenure</td>
</tr>
<tr>
<td>Owner occupied</td>
</tr>
<tr>
<td>Private rental</td>
</tr>
<tr>
<td>Local authority</td>
</tr>
<tr>
<td>Housing association</td>
</tr>
<tr>
<td>Hostel</td>
</tr>
<tr>
<td>Other (describe)</td>
</tr>
</tbody>
</table>
### Highest level of education completed
- No formal qualifications
- GCSE or equivalent
- A-level or equivalent
- NVQ level
- BTEC level
- Higher national certificate/Diploma
- Bachelors degree
- Masters degree
- Doctoral degree
- Professional training (describe)
- Other ____________________

### What is mother’s religion?
- No religion
- Jewish
- Muslim
- Sikh
- Other religion (write in)____________________
- Christian
- Buddhist
- Hindu

### Employment status
- Employed F/T (>30 hrs/wk)
- Employed P/T (<=30 hrs/wk)
- Maternity leave
- Self-employed F/T (>30 hrs/wk)
- Student
- Self-employed P/T (<=30 hrs/wk)
- Retired
- Unemployed
- Unable to work due to sickness/disability
- Looking after home or family
- Voluntary work
- Other (write in)____________________

### Any physical health problems in mother during pregnancy, at the birth, or after the birth? (describe)

### Any other disabilities or physical health problems?

### Any disabilities or physical health problems with baby?

### Mother’s mental health diagnosis (if has one/if known)

### Any previous service contact for mental health prior to this pregnancy/birth? (brief details and year) (check if in relation to another pregnancy/birth or not)

### Who is mother’s key significant other?
- Single
- Married or cohabiting
- Partner but not cohabiting
- Separated or divorced
- Widowed
- Other (describe)____________________

### Did mother have a partner when her baby was born? [if needed, check if this was the baby’s father]

### Complete after interview:

### Were difficulties antenatal or postnatal or both?
**Topic 1: Summary of difficulties and service use**

Thank you for that. Now I’m going to ask you a bit about your pregnancy and having your baby.

Can you start by telling me a bit about your pregnancy?

How were things after the birth?

When did you first notice that you were having difficulties? (If needed, explain that we are interested in difficulties with mental health or wellbeing - if possible mirror the language the mother herself uses to describe mental health difficulties).

Can you tell me when you first spoke to professionals about your difficulties, and how that came about?

Now show them the timeline and say something like: “On this timeline I’d like us to have a go at noting down the sources of support you have accessed in relation to your psychological wellbeing or mental health. This is to help me get a picture of who’s been involved in your care and at what stage. After I’ve got the basic facts, we will focus on your experiences and views of the care you’ve received. Don’t worry if you’re not always sure, we will just fill it in as best as we can.”

So, to start with, this is when you said you first noticed that you were having difficulties (mark this on chart). Is that right? And this is when you said you first spoke to professionals about your difficulties. What happened next? Which services or professionals did you see next?” [If needed clarify that we are interested in the support they have received for their latest pregnancy/birth]

Now use the timeline over page to build up a picture of mother’s contact with professionals and services about her mental health. Mark brief details on timeline (do not include personal data such as professionals’ names).

Interviewer can refer back to this timeline as needed in the interview. It can also be updated if helpful.

N.B. under ‘other events of note’ probe for any separations from their baby, any social services involvement, any missed opportunities for support, any support offered but not taken up. However, if these topics feel too sensitive to explore this early on in the interview, they can be revisited later.
<table>
<thead>
<tr>
<th>Participant ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Became pregnant</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>When did difficulties begin?</td>
</tr>
<tr>
<td>Which professionals or NHS services were seen about mental health?</td>
</tr>
<tr>
<td>What type of support was given by each service/professional? (E.g. listening visits, medication, psychology)</td>
</tr>
<tr>
<td>Any other sources of support for mental health (E.g. voluntary organisations)</td>
</tr>
<tr>
<td>Other events of note</td>
</tr>
</tbody>
</table>

**Time/Baby’s age**

- Became pregnant
- Gave birth
- Present day
**Topic 2: Experiences of service delivery**

Now I’d like to ask you about your experiences of the care you’ve received (for your mental health) (If needed, clarify that these questions relate to their latest pregnancy/birth)

**How did you find the process of accessing support or treatment?** (Refer to timeline to personalise)

Probes:
- What was helpful? What was not so helpful?
- What could have made things easier?
- Did you have any concerns about having contact with professionals about your mental health? What were they?
- Were there any times you would have liked help but didn’t feel able to ask? Can you tell me more?

**Can you describe your experiences of the services and support you’ve received?** (Refer to timeline to help personalise questions. Probe regarding each service)

Probes:
- What’s been good about each service or source of support?
- What’s not been so good about each service or source of support?
- Is there any support you would have liked but didn’t get?
- If relevant: What happened when your contact with the service ended? How did you find this?

**Can you describe how you have felt about the different professionals you’ve had contact with about your mental health?** (Refer to timeline. Probe about the different professionals mentioned)

Probes:
- How would you describe your relationship with them?
- What’s been good? What hasn’t been so good?
- Have you seen one key person regularly or different people? How has that been?
- Have you had similar advice from the different people involved in your care? Can you tell me a bit about that?

**To what extent have you felt supported by these services and professionals in your role as a mother?**

Probes:
- Can you describe your experience of any support for practical aspects of parenting (e.g. (breast)-feeding, sleep)?
- Has the support felt like it was tailored for mums in your position?
- How isolated or well-supported did you feel? Did professionals help you with this?
- Is there any support you would have liked for your role as a mum but didn’t get?

**Can you describe how services and professionals worked with other people who were supporting you and your baby (e.g. your partner, baby’s father, family members, or friends)?**

Probes:
- What support was there for your family or friends? How do you feel about this?
- How involved were they able to be? How do you feel about this?
- If relevant: what was your experience of having contact with family and friends while in hospital?

**Thinking about the support you’ve had for your mental health or wellbeing as a whole, how well supported have you felt?**

Probes:
- What makes you say that?
**Topic 3: Social services and separations**

If mother has had contact with social services/safeguarding:
- You said that you have had contact with child protection services/social services. Can you tell me a bit about what happened? What was your experience of this?
- How did you feel about the involvement of these services? How did you experience the professionals involved?

If mother has experienced a separation from her baby related to her mental health difficulties:
- You said you were separated from your baby. Can you tell me a little bit about what happened?
- What was your experience like?
- Who cared for your baby at that time?
- Does your baby live with you now?
- Did you experience any delays being reunited with your baby?
- What support do you receive now to live with your baby/stay in contact with your baby?

**Topic 4: Information, choice and decision making**

Can you describe how involved you’ve felt in the decisions made about your care?

Probes:
- How have decisions been made?
- How do you feel about this?
- Do you feel that you’ve been able to make choices about your care and treatment?
- What support have you had to help you make choices about your care and treatment?
- Can you describe any discussions you’ve had about medication (for physical or mental health)? Were these discussions helpful?

**How do you feel about the information that was available to you about mental health difficulties in mothers? And what about information about available support?**

Potential probes:
- What was helpful? What was not helpful?
- When would you have liked information to be provided?
- What information might have been helpful?

**Final thoughts**

If you went back in time, would you like to be supported in the same way again? How would you like to be supported?

Potential probes:
- Is there anything you would do differently yourself when using services/accessing support?
- What message or messages would you give professionals working with mums in your position?
- Is there anything else you would like to say about your experiences, any of the topics we’ve covered, or anything else you think is relevant?

Thank participant for their time.
Discuss possibility of interviewing significant other.
Provide incentive.
Appendix 3b. Interview guide for partners and wider family members

Stakeholders’ views and experiences of perinatal mental health care and services (ESMI)

Significant Others Interview Schedule

[NOTE: This interview schedule includes questions and potential prompts, but is only intended as a
guide and the interview will be guided by the interviewee’s responses.]

Interview opening:

Thank you for agreeing to do this interview with me. I’m going to ask you about your experience of supporting a mother who has had treatment for her mental health or wellbeing while pregnant or after having a baby.

The questions will be quite open so as to give you a chance to tell me about things from your perspective. We are really keen to hear about what you found helpful and what could have been better. We are asking a range of mothers and those supporting them about their experiences so that we can understand what help people want and need at this time. We will use this information to make recommendations about how best to support families during this period. There are no right or wrong answers and the interviews are not designed to judge anybody. So please be as open as you feel able to be. This study is being carried out independently of any of the services [mother] has used. Everything you say is confidential and neither [mother] nor anybody involved in her care will be told anything about what you say. When we write up our findings and recommendations, it won’t be possible to identify you from what we write. The only time we would have to pass on information to clinical staff would be if we had major concerns about your safety or the safety of others.

The interview may touch on sensitive topics. You can stop at any time or ask for a break, or say that you don’t want to answer a particular question. The interview should last about an hour, and I will be recording it. Do you have any questions before we begin?

Ensure participant has read information sheet and ask them to sign consent form if happy to do so.

I’m going to start by asking you a few background questions.
### Background information for sampling and context

#### Interviewer to complete prior to interview:

<table>
<thead>
<tr>
<th>Significant other ID</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Linked mother ID</td>
<td></td>
</tr>
<tr>
<td>Date of interview</td>
<td></td>
</tr>
<tr>
<td>Service mother recruited from (where relevant)</td>
<td></td>
</tr>
</tbody>
</table>

#### Collect from significant other (some responses may already be known from mother’s interview)

<table>
<thead>
<tr>
<th>Significant other’s nationality</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant other’s country of birth</td>
<td></td>
</tr>
<tr>
<td>Significant other’s main language</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significant other’s ethnic group</th>
<th>Asian/Asian British</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>White</strong></td>
<td></td>
</tr>
<tr>
<td>☐ 1 White British</td>
<td>☐ 9 Indian</td>
</tr>
<tr>
<td>☐ 2 White Irish</td>
<td>☐ 10 Pakistani</td>
</tr>
<tr>
<td>☐ 3 Gypsy or Irish Traveller</td>
<td>☐ 11 Chinese</td>
</tr>
<tr>
<td>☐ 4 Other (describe)</td>
<td>☐ 12 Bangladeshi</td>
</tr>
<tr>
<td><strong>Mixed/multiple</strong></td>
<td>☐ 13 Other (describe)</td>
</tr>
<tr>
<td>☐ 5 White and Black Caribbean</td>
<td>☐ 14 African</td>
</tr>
<tr>
<td>☐ 6 White and Black African</td>
<td>☐ 15 Caribbean</td>
</tr>
<tr>
<td>☐ 7 White and Asian</td>
<td>☐ 16 Other (describe)</td>
</tr>
<tr>
<td>☐ 8 Other (describe)</td>
<td>☐ 17 Arab</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other ethnic group</th>
<th>☐ 18 Other (describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 17 Arab</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significant other’s age</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant other’s gender</td>
<td>M / F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to mother</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the significant other live with the mother and/or baby? [If not, check where mother and/or baby are living]</td>
<td></td>
</tr>
<tr>
<td>If not, what is the frequency of contact between the significant other and the mother? And with the baby?</td>
<td></td>
</tr>
<tr>
<td>Is the significant other involved in parenting/caring for the baby?</td>
<td></td>
</tr>
<tr>
<td>Does anyone else have a major role in childcare? (This could be a professional, such as a childminder, family member, older child, friend, partner etc.)</td>
<td></td>
</tr>
<tr>
<td>Significant other’s housing tenure</td>
<td>Owner occupied</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Significant other’s highest level of education completed</td>
<td>No formal qualifications</td>
</tr>
<tr>
<td>Significant other’s religion?</td>
<td>No religion</td>
</tr>
<tr>
<td>Significant other’s employment status</td>
<td>Employed F/T (&gt;30 hrs/wk)</td>
</tr>
</tbody>
</table>

**What was employment status before birth?**

| Does the significant other have any mental or physical health difficulties? (describe) |
| Baby’s DOB and gender | Gender M / F | DOB |
| Does mother have any other children? | If so, what are their ages? |
| Any disabilities or physical health problems with baby? |
| Any physical health problems in mother during pregnancy, at the birth, or after the birth? (describe) |
| Any other disabilities or physical health problems in mother? |
| Mother’s mental health diagnosis (if has one/if known) |
| Has mother had any previous service use for mental health prior to this pregnancy/birth? (brief details) (check if in relation to another pregnancy/birth or not) |
**Topic 1: Summary of difficulties and service use**

Thank you for that. Now I’m going to ask you a bit about your experience of [mother’s] pregnancy and birth.

Can you start by telling me a bit about how her pregnancy was from your perspective? How were things after the birth?

**When did you first notice that she was having difficulties?** (If needed, explain that we are interested in difficulties with mental health or wellbeing - if possible mirror the language the significant other uses to describe mental health difficulties).

**What has been your role in supporting her through this period?** Can you remember when she first spoke to professionals about her difficulties, and how that came about?

Now show them the timeline and say something like: “On this timeline I’d like us to have a go at noting down the sources of support [mother] has accessed in relation to her psychological wellbeing or mental health. This is to help me get a picture of who’s been involved in her care, as far as you know. After I’ve got the basic facts, we can focus on your views and experiences of her care. Don’t worry if you’re not always sure, we will just fill it in as best as we can.

So, to start with, this is when you said you first noticed that [mother] was having difficulties (mark this on chart). Is that right? And this is when you said she first spoke to professionals. What happened next? Do you know which services or professionals she saw next? ” [If needed clarify that we are interested in the support the mother received for her latest pregnancy/birth]

Explore with participant which services the mother accessed and when. Mark brief details on timeline (do not include personal data such as professionals’ names).

**Interviewer can refer back to this timeline as needed in the interview. It can also be updated if helpful.**

**N.B. under ‘other events of note’ probe for any separations from the mother or baby, any social services involvement, any missed opportunities for support, any support offered but not taken up. However, if these topics feel too sensitive to explore this early on in the interview, they can be revisited later.**
Participant ID:

Time/Baby's age

Became pregnant | Gave birth | Present day

When did mother's difficulties begin?

Which professionals or NHS services were seen about mental health?

What type of support was given by each service/professional? (E.g., listening visits, medication, psychology)

Any other sources of support for mental health (e.g., voluntary organisations)

Other events of note

Became pregnant | Gave birth | Present day

Time/Baby's age
**Topic 2. Experiences of service delivery**

Now I’d like to ask you about [mother’s] care for her mental health. I’m interested in your views of the care she received, and also your thoughts about the support and involvement you’ve been able to have as someone supporting her. (If needed, clarify that these questions relate to the mother’s latest pregnancy/birth)

**From your perspective, can you tell me what the process of [mother] accessing treatment was like?**

(Refer to timeline to help personalise questions)

Probes:
- What was helpful? What was not so helpful? What could have made things easier?
- Did you have any concerns about [mother] having contact with professionals about her mental health? What were they?

**From your perspective, can you describe your views of the services or sources of support she received?** (Refer to services on timeline. Probe regarding each).

Probes:
- What’s been good about each source of support?
- What’s not been so good about each source of support?
- Is there any support you would have liked her to have that she didn’t get?
- If relevant: What happened when [mother’s] contact with the service ended? How did you feel about this?

Can you describe how you’ve felt about the different professionals you’ve had contact with about her mental health?

Probes:
- How would you describe your relationship with them? And how about [mother’s] relationship with them?
- What’s been good? What hasn’t been so good?
- Has she seen one key person regularly or different people about her mental health? How has that been?
- Has she had similar advice from the different people involved in her care? Can you tell me a bit about that?

Can you describe how involved you’ve felt in [mother’s] support and treatment?

Probes:
- In what ways have services or professionals involved you? How do you feel about this level of involvement?
- What involvement would you have liked? What could have been done differently?
- If relevant: What was your experience of having contact with [mother] while she was in hospital?
- What was your experience of visiting/attending appointments as a [father, grandparent, friend…?]

Can you describe any support you’ve received from services or professionals, as someone supporting a mother who is having difficulties?

Probes:
- What support was there for you or for other family members/friends? How do you feel about this?
- What’s been helpful? What’s not been helpful?
- Is there any support you would have liked but didn’t get?
- Have you had any support for your role as a [father, grandparent, friend…?]
**Topic 3: Social services and separations**

Have you cared for the baby without [mother’s] support at any time, for example, because she was too unwell or in hospital?

- If yes: how was this for you? What support did you get from services? Were you offered practical support with looking after a baby?

If mother has had contact with child protection services/social services:

- You said that [mother] had contact with child protection services/social services. Can you tell me a bit about what happened? What was your experience of this?
- How did you feel about the involvement of these services?
- How did you experience the professionals involved?

If either mother or significant other experienced a separation from each other or from the baby as a result of her mental health difficulties:

- You said you/mother experienced separations from each other/baby because of services. Can you tell me a little bit about what happened?
- What was your experience like?
- What support did you receive?
- Who cared for the baby at that time?
- Did [mother/you] experience any delays being reunited with the baby?
- What support do you receive now to live with your baby/stay in contact with your baby?

**Topic 4: Information, choice and decision making**

To what extent do you feel [mother and her family] have been able to make choices about her care and treatment?

Probes:
- How have decisions been made? How do you feel about this?
- What support have you and [mother] had to help you make choices about her care and treatment?
- Can you describe any discussions about medication (for physical or mental health)? Were these discussions helpful?

How do you feel about the information that was available about mental health difficulties in mothers? And what about information about available support?

Potential probes:
- How do you feel about the information that was available to you?
- What was helpful? What information might have been helpful? At what stage would you have liked this?
Topic 5. Final thoughts

If you went back in time, would you like [mother and her family] to be supported in the same way again? How would you like her to be supported?

Potential probes:
• Is there anything you would do differently yourself when supporting a mother who is using services?
• What message or messages would you give professionals working with mums with mental health difficulties and their families?
• Is there anything else you would like to say about your experiences, any of the topics we’ve covered, or anything else you think is relevant?

Thank participant for their time.
Provide incentive.
Appendix 4a. Information sheet for women

Stakeholders’ views and experiences of perinatal mental health care and services: a qualitative study

Service User Information Sheet

You are being invited to take part in a research study. Before you decide whether or not to take part it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of this research? We want to find out what women who have used mental health services whilst pregnant or after having a baby think of the services they received. We will also talk to clinicians who work in these services about their views of how to improve services, and to people who support women (e.g. fathers, involved family members or supportive friends) to find out what they think of services.

Why have I been invited to take part? We are asking you to take part in the research because you have used a mental health service whilst pregnant or after having a baby. Staff who work in the service you have attended may know that you have been approached about this study but will not be told anything you say.

Do I have to take part? No, it is completely up to you to decide whether or not to take part. If you would like further information about the study please contact us and we will be happy to provide it and answer any questions you may have. If you decide to take part you can withdraw at any time without giving a reason. Deciding to withdraw, or not to take part in the study, will not affect the care you receive.

What will happen if I decide to take part? You will be invited to meet a researcher who will ask you a series of questions. This researcher will be experienced at
interviewing people who have used mental health services and those who support them. The researcher will spend around an hour with you, although the time taken depends on how much you have to say about the topics you discuss. You can spread this time over more than one meeting if you like. You will be asked about your experiences of using mental health services whilst pregnant or after having your baby. It is likely that you will be asked about topics such as accessing services, your relationships with staff, support for parenting, information and choice. You do not have to answer every question, and you can refuse to answer any question at any time without having to give a reason.

The interview will be recorded on audio-tape and will be typed up later to help in the analysis of what was said. The interview will take place in your home at a time that is convenient for you. You can choose to attend the interview in another location if that is preferred, such as the service you attend or at the University.

**Will what I say in the interview be kept confidential?** The interview will be confidential and anything that you say will not be traceable to you. No staff members involved in your care will be told anything about what you say. However, the researcher will pass on information to clinical staff is if he or she has major concerns about your safety or the safety of others.

The information we collect about you will have your name removed so that you cannot be recognised from it. All the data we collect will be stored in locked cabinets according to the Data Protection Act. The audio-tape and typed transcripts of the interview will be stored securely at University College London and will be destroyed once the study has ended.

**What are the possible benefits of taking part?** The main benefit of taking part is having the opportunity to talk about your views and experiences in-depth, and to have these carefully listened to, recorded and used to potentially improve services.

**What are the possible disadvantages of taking part?** Some of the topics we discuss may be distressing or upsetting. If you find any topic upsetting you have the right to take a break, complete the interview at another time or stop the interview all together.
Will any support be provided? If taking part in this research causes you to feel distressed you will be offered immediate support from the researcher. If you or the researcher feels that you need additional support, the researcher will liaise with the clinical team on your behalf. For independent advice about participating in research or this study, please contact the Mental Health Research Network Patient and Public Involvement (PPI) section. This is a national organisation designed to support the involvement of service users and carers in research.

mhrnppi@kcl.ac.uk
(T) 020 7848 0644

What will happen to the results? We will write a report for our funders and for academic journals, and will present our findings at conferences. We will also write a report especially for the people who took part in the study. It will not be possible to identify you in anything we write.

Who is organising and funding the research?
The research is being organised by University College London. It is funded by the NHS National Institute for Health Research.

Who has reviewed the research?
All research that is carried out in the UK has to be reviewed by an ethics committee. This study has been reviewed by the Camberwell St Giles London Research Ethics Committee (REC reference: 13/LO/1855).

Who is carrying out the research? The study is led by Professor Sonia Johnson and the main study researcher is Dr Billie Lever Taylor. You can contact Professor Johnson via s.johnson@ucl.ac.uk and Dr Billie Lever Taylor via billie.taylor@ucl.ac.uk. You can also contact us at this address:

Division of Psychiatry
UCL
Maple House, 149
Tottenham Court Road
London
W1T 7NF

What if I am unhappy with the way the research is conducted? If you wish to complain, or have any concerns about any aspect of the way you have been
approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. Please ask your doctor if you would like more information on this. In the unlikely event that you are harmed by taking part in this study, compensation may be available to you. If you suspect that the harm is the result of the Sponsor’s (University College London) or the hospital's negligence then you may be able to claim compensation. After discussing with your doctor, please make the claim in writing to Professor Sonia Johnson who is the Chief Investigator for the research and is based at University College London. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this. NHS Indemnity does not offer no-fault compensation i.e. for non-negligent harm, and NHS bodies are unable to agree in advance to pay compensation for non-negligent harm.

Thank you for reading this information
Stakeholders’ views and experiences of perinatal mental health care and services: a qualitative study

Significant Other Information Sheet – Version 2 (March 2015)

You are being invited to take part in a research study. Before you decide whether or not to take part it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of this research? We want to find out what people who support women who have used mental health services whilst pregnant or after having a baby think of the services they, and the person they support, received. As well as talking to partners, involved family members and supportive friends, we will also be talking to women who used the services themselves to find out what they think, and to clinicians who work in these services about their views of how to improve services.

Why have I been invited to take part? We are asking you to take part in the research because you have supported a friend, partner or family member who has used a mental health service whilst pregnant or after having a baby. The person that you support has given us your contact details but will not be told anything you say.

Do I have to take part? No, it is completely up to you to decide whether or not to take part. If you would like further information about the study please contact us and
we will be happy to provide it and answer any questions you may have. If you decide to take part you can withdraw at any time without giving a reason. Deciding to withdraw, or not to take part in the study, will have no effect on the care the person you support receives.

**What will happen if I decide to take part?** You will be invited to meet a researcher who will ask you a series of questions. This researcher will be experienced at interviewing people who have used mental health services and those who support them. The researcher will spend around an hour with you, although the time taken depends on how much you have to say about the topics you discuss. You can spread this time over more than one meeting if you like. You will be asked about your experiences of supporting someone who used mental health services whilst pregnant or after having a baby. It is likely that you will be asked about topics such as accessing services, your relationships with staff, information and choice. You do not have to answer every question, and you can refuse to answer any question at any time without having to give a reason.

The interview will be recorded on audio-tape and will be typed up later to help in the analysis of what was said. The interview will take place in your home at a time that is convenient for you. You can choose to attend the interview in another location if that is preferred, such as the service you attend or at the University.

**Will what I say in the interview be kept confidential?** The interview will be confidential and anything that you say will not be traceable to you. No staff members involved in caring for the person you support will be told anything about what you say. However, the researcher will pass on information to clinical staff is if he or she has major concerns about your safety or the safety of others.

The information we collect about you will have your name removed so that you cannot be recognised from it. All the data we collect will be stored in locked cabinets according to the Data Protection Act. The audio-tape and typed transcripts of the interview will be stored securely at University College London and will be destroyed once the study has ended.

**What are the possible benefits of taking part?** The main benefit of taking part is having the opportunity to talk about your views and experiences in-depth, and to have these carefully listened to, recorded and used to potentially improve services.
What are the possible disadvantages of taking part? Some of the topics we discuss may be distressing or upsetting. If you find any topic upsetting you have the right to take a break, complete the interview at another time or stop the interview all together.

Will any support be provided? If taking part in this research causes you to feel distressed you will be offered immediate support from the researcher. For independent advice about participating in research or this study, please contact the Mental Health Research Network Patient and Public Involvement (PPI) section. This is a national organisation designed to support the involvement of service users and carers in research.

mhrnppi@kcl.ac.uk  (T) 020 7848 0644

What will happen to the results? We will write a report for our funders and for academic journals, and will present our findings at conferences. We will also write a report especially for the people who took part in the study. It will not be possible to identify you in anything we write.

Who is organising and funding the research?
The research is being organised by University College London. It is funded by the NHS National Institute for Health Research.

Who has reviewed the research?
All research that is carried out in the UK has to be reviewed by an ethics committee. This study has been reviewed by the Camberwell St Giles London Research Ethics Committee (REC reference: 13/LO/1855).

Who is carrying out the research? The study is led by Professor Sonia Johnson and the main study researcher is Dr Billie Lever Taylor. You can contact Professor Johnson via s.johnson@ucl.ac.uk and Dr Billie Lever Taylor via billie.taylor@ucl.ac.uk. You can also contact us at this address:

Division of Psychiatry
UCL
What if I am unhappy with the way the research is conducted? If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. Please ask your doctor if you would like more information on this. In the unlikely event that you are harmed by taking part in this study, compensation may be available to you. If you suspect that the harm is the result of the Sponsor’s (University College London) or the hospital’s negligence then you may be able to claim compensation. After discussing with your doctor, please make the claim in writing to Professor Sonia Johnson who is the Chief Investigator for the research and is based at University College London. The Chief Investigator will then pass the claim to the Sponsor’s Insurers, via the Sponsor’s office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this. NHS Indemnity does not offer no-fault compensation i.e. for non-negligent harm, and NHS bodies are unable to agree in advance to pay compensation for non-negligent harm.

Thank you for reading this information sheet
Appendix 5. Consent form

Study Title: Stakeholders’ views and experiences of perinatal mental health care and services: a qualitative study

Principal Investigator: Professor Sonia Johnson, UCL

Lead Researcher: Dr Billie Lever Taylor, UCL

1. I have read and understood the study information sheet dated March 2015

2. I have had the opportunity to ask questions about the study

3. I understand that my participation is voluntary and that I can withdraw at any time, without giving any reason, and without my care being affected

4. I consent to the interview with me being tape recorded

5. I consent to a written transcript and audio-recording of the interview being stored securely at University College London

6. I consent to my data being written up for publication and used for related studies or educational activities. My name and other identifying details will not be shared and it will not be possible to identify me from any publications

7. I agree to be approached about future research studies

8. I understand that I will be given a £15 gift in cash for my participation in this study once I have taken part in it

9. I agree to take part in the study

____________________  ________________  ___________________
Name of participant                Date                Signature

___________________                _____________                          ________
Name of Researcher                      Date                                            Signature

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Appendix 6. Ethical approval

Dear Professor Johnson,

Study title: Stakeholders’ views and experiences of perinatal mental health care: a qualitative study
REC reference: 13/L/01895
Protocol number: 13/0570
IRAS project ID: 139917

Thank you for your letter of 28 March 2014, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Mr Thomas Fairman, nrascommittee.london.camberwellstgiles@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites
The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.reforum.nhs.uk.

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents
The final list of documents reviewed and approved by the Committee is as follows:

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<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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<td>15 November 2013</td>
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<tr>
<td>Covering letter on headed paper</td>
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Statement of compliance

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

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/.

With the Committee’s best wishes for the success of this project.

Yours sincerely