The Impact of Postpartum Psychosis on Partners

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This thesis is dedicated to Margaret Joan Fish.

Abstract

Postpartum Psychosis is a severe mental health problem following childbirth, with a psychotic element and associated mood disturbance. Research to date has primarily focused on mothers' experiences, and on identifying risk factors, aetiology, and intervention efficacy. Within both research and clinical communities, there has been little acknowledgement of partners' experiences of Postpartum Psychosis, nor the important support role that partners can provide. The aim of this study was to consider the lived experiences of partners of women who have had Postpartum Psychosis, and the impact that it has had on their lives and relationships. Participants were partners recruited through the charity Action for Postpartum Psychosis. Partners were asked to complete an online questionnaire to provide basic demographic and contextual information, followed by an in-depth, semi-structured interview regarding their experiences of Postpartum Psychosis. Interpretative Phenomenological Analysis was used to analyse the interview transcripts. Partners reported a lack of support being provided to them, and typically perceived a deterioration in the quality of their couple relationship during, and following, the episode of Postpartum Psychosis. Seven superordinate themes were extracted from the interview data: powerlessness; united vs. individual coping; hypothesising and hindsight; barriers to accessing care and unmet needs; managing multiple roles; loss; and positive changes from Postpartum Psychosis. These findings provide a rich illustration of the experiences of partners, and highlight areas in which support could be provided for partners. Limitations of the study, and implications for future research and clinical practice, are discussed.

Keywords: Postpartum Psychosis, partners, experience, loss, support, relationship

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Chapter One: Introduction

1.1. Focus of the Thesis

Pregnancy and childbirth are times of considerable change, placing increased demand on a couple. The relationship that a couple have with each other, and the relationship that they build with their infant during the postnatal window, help to provide a foundation for infant development and secure attachment (Ainsworth, 1973; Bowlby, 1969; 1973). Establishing this foundation can be challenging in the best of circumstances, but may be further challenged when perinatal mental health problems are encountered. Although rates of perinatal mental health problems remain low, awareness of such difficulties is increasing, with greater recognition across research, clinical, and policy contexts. This includes a focus on the development of perinatal mental health screening tools and, most recently, the Chief Medical Officer's (CMO) annual report outlined a need for increased access to perinatal mental healthcare services (Department of Health, 2015; Kingston *et al.*, 2015). Whilst the understanding of the impact of perinatal mental health problems for the mother might be improving, the research literature provides little focus on the impact of such difficulties on partners, or on their relationships with their new infant and their spouse. This study will seek to explore the impact of one particular perinatal mental health problem, that of Postpartum Psychosis (PP), on partners, the couple relationship, and the father-infant relationship.

1.2. Definitions of Key Terminology

1.2.1. Postpartum Psychosis

Postpartum Psychosis is a severe mental health problem, with a psychotic element and associated mood disturbance following childbirth, and is often described as a 'psychiatric

emergency' (Heron *et al.*, 2012, p.155). Typically, a PP presentation includes: cognitive disorganisation; elated, manic, or dysphoric mood; bizarre behaviour, such as agitation, hyperactivity, rambling speech, insomnia or emotional distance; and suicidal ideation (Brockington, 1996; Heron *et al.*, 2008; Wisner *et al.*, 1994). Delusions and hallucinations are also common, occurring in approximately 50% of women experiencing PP, with the mother expressing delusional ideas relating to their new infant; for example, that someone might kill or harm their infant (Chandra *et al.*, 2006). The Diagnostic and Statistical Manual, Fifth Edition (DSM-V), does not recognise PP as a distinct diagnostic category from that of psychotic disorders, but allows for clinicians to specify a peripartum onset (American Psychiatric Association, 2013). According to these criteria, a woman is thought to have PP if they have experienced at least one episode of depression, mania, or mixed mood state, with accompanying psychotic features, commencing within 4 weeks of childbirth.

1.2.2. Partner

This research was open to all couples but only heterosexual partners volunteered. Therefore, in this thesis, the term 'partner' relates to the biological father of the infant who was in a relationship with the mother at the time of the infant's birth.

1.2.3. Mother or Spouse

These terms are used to indicate the mother of the infant and the wife, or girlfriend, of the partner.

1.2.4. Attachment

In this study, the term 'attachment' relates to the perceived relationship and bond formed between a parent and the infant. Based on the research articles from which the term is

referenced, the meaning of 'attachment' within this thesis varies along a continuum: from a broad informal construct signifying the relationship between a parent and the infant, to a formal construct and associated assessment of the parent-infant relationship in specific relation to attachment theory (see section 1.9. Relevant Psychological Theoretical Models).

1.3. Postpartum Psychosis

1.3.1. Aetiology and Risk Factors

Postpartum Psychosis is an emerging field of research which has primarily focused on identifying incidence rates, aetiology, risk factors, and exploring genetic susceptibility. Postpartum Psychosis occurs in 1 to 2 per 1000 births, with a peak window of onset within the first two weeks after birth (Mishra *et al.*, 2011). Although the precise cause, or causes, of PP remain unknown, risk factors have been identified; such as having a pre-existing mental health problem, primiparity, marital conflict, lack of social support, and the presence of stressful life events (Lawson *et al.*, 2015). Having a diagnosis, or familial history, of Bipolar Disorder (BD) is a risk factor (Jones & Craddock, 2001; Stewart *et al.*, 1991). Jones and Craddock (2005) noted that 25% of women with a diagnosis of BD experienced an episode of PP following childbirth. Moreover, Di Florio *et al.* (2014) identified that within a sample of women with BD, the onset of PP was significantly greater in primiparous women than multiparous women, even after controlling for a reduction in further pregnancy rates in women who had experienced PP following their first pregnancy. Comorbidity rates in PP are high, with some research demonstrating that 72% also had a diagnosis of BD, and 12% also had a diagnosis of Schizophrenia (Stewart *et al.*, 1991). In fact, Mishra *et al*.'s (2011, p.5) review of research into PP suggests that PP is an 'overt presentation of Bipolar Disorder that results from tremendous hormonal shifts during delivery'. Sleep loss, or sleep disruption, has also been identified as another possible risk factor by Lawson *et al.* (2015), who completed a

systematic review which considered 31 studies. The review reported that one study had a strong association, 13 a moderate, and 17 a weak association between postnatal mental health problems and sleep loss. However, studies included in this review encompassed PP, Postnatal Depression (PND), and Postpartum Anxiety (PA). There is also an added impediment in concluding a causal relationship between sleep loss and perinatal mental health problems, when sleep loss is typical and associated with childbirth in general; it may be a coinciding factor rather than a causal factor.

1.3.2. Treatment Efficacy

The onset of PP is typically sudden, unexpected and severe, with 4% of women with PP taking their own life (Appleby *et al.*, 1998; Heron *et al.*, 2008). Treatment of, and the course of recovery from, PP has been described as 'a long and difficult process', often involving a psychiatric admission of the mother to a general psychiatric ward, or admission of the mother and infant to a Mother and Baby Unit (MBU) (Heron *et al.*, 2012, p.155). Glangeaud-Freudenthal *et al.* (2011) reported that most women experience significant improvement once under the care of an MBU.

Pharmacological intervention is frequently adopted in the treatment of PP, due to the sudden and severe presentation of symptoms. Nevertheless, clear guidance and a standardised treatment for PP is yet to be established (Bergink *et al.*, 2015). Doucet *et al.* (2010) undertook a systematic review of the literature into the prevention and treatment of PP, noting limited evidence to support the use of Electroconvulsive Therapy (ECT), antipsychotics, lithium, or hormone therapy. Doucet *et al.* (2010) highlighted the methodological limitations of PP treatment studies conducted to date, identifying limitations such as small sample sizes, or published studies being based largely on case reports. Due to

these limitations, Doucet *et al.* (2010) concluded that the studies reviewed could not formulate clear recommendations for the treatment of PP, and called for further research to be conducted with larger sample sizes. More recently, Bergink *et al.* (2015), using a larger sample size, looked at the effectiveness of a proposed sequenced treatment for women diagnosed with a first episode of PP. Step one included administering benzodiazepines, step two involved the addition of antipsychotics, step three the addition of lithium, and step four involved ECT. Results indicated that over 98% of women achieved remission within the first three steps, with none requiring ECT. Women treated with lithium were found to have a significantly lower rate of relapse; factors indicative of relapse included the presence of non-affective psychosis and multiparity. Other non-pharmacological factors raised as important in the treatment of PP included psychological and nursing interventions, to help establish sleep hygiene and feeding routines, and develop mother-infant (M-I) and father-infant (F-I) interactions and attachment. Specific research exploring the use of psychological interventions in PP, or the benefits of interventions for the couple or the partner, has seemingly been neglected.

1.3.3. Guidelines and Policy Documentation

The National Institute for Health and Care Excellence (NICE, 2014) issued guidance on antenatal and postnatal mental healthcare, recommending that healthcare professionals be alert to any possible symptoms of PP within the first two weeks after childbirth if a woman has a first-degree relative, or own history, of severe mental health problems. Moreover, it stipulates that if a sudden onset of symptoms is noted, a referral should be made for an assessment, preferably to a perinatal mental healthcare service; noting that the assessment should occur within 4 hours of referral, thus reflecting the urgency to receive immediate and appropriate care. More general recommendations for perinatal mental healthcare providers

included: establishing a co-ordinated care plan; offering medication and cognitive behavioural therapy, or family therapy based interventions; and considering both the role of the partner, in providing support to the mother, and the potential effect of the perinatal episode on the couple relationship. The National Institute for Health and Care Excellence (2014) also provides recommendations for future research into PP: developing a clinical tool to improve identification of women at risk of PP; establishing interventions that can be adopted to prevent the onset of PP; and utilising randomised controlled trial designs to create cost-effective interventions for PP.

Within England, the CMO's annual report on the health of women recognised the financial impact of perinatal mental healthcare, noting an 8.1 billion pound total spend to cover the direct, and indirect, costs of perinatal mental health for each annual birth cohort (Department of Health, 2015). The report listed the main barriers to better health outcomes across multiple levels: personal (stigma, lack of awareness and information, and language); access (services not commissioned, capacity, and no access to funds); and service (recognition, understanding, and training). The report stated that half of women in the United Kingdom had little or no access to perinatal mental healthcare services, yet only 3% of clinical commissioning groups in England have a strategy plan for commissioning such services (Department of Health, 2015). General suggestions for future policy centred on reducing the barriers outlined in the report. This included developing anti-stigma campaigns; increasing awareness and training for primary and secondary level healthcare professionals; providing access to clinicians for women at risk of postnatal mental health problems to help them plan for their pregnancies; and implementing timely referral pathways to access care and psychological therapies.

Within Wales, the CMO's report focused on the physical health needs of new and expectant mothers and neglected to consider perinatal mental health problems (Welsh Government, 2015). However, within the Together for Mental Health Delivery Plan: 2016-2019, the Welsh Government (2016) has highlighted a need to address perinatal mental healthcare services. The Welsh Government (2016, p.8) outlined the need 'to provide better outcomes for women, their babies and families with, or at risk of, perinatal mental health problems'. The plan proposed that changes be made, by offering information and support pre-, during, and post-pregnancy; and ensuring that there are accessible community perinatal mental healthcare services in every health board.

1.3.4. Prognosis

For many, PP may occur as a single episode, and research has indicated that women report it can take over a year to feel recovered (Bergink *et al.*, 2015; Doucet *et al.*, 2010). Following an episode of PP, there is an increased risk of subsequent PP episodes, or psychotic episodes unrelated to childbirth (Robertson *et al.*, 2005; Sit *et al.*, 2006). Blackmore *et al.* (2013) highlighted the risk of subsequent episodes following PP, stating that only 58% of women went on to have a second pregnancy, and 54.4% of those went on to experience a subsequent episode of PP. The main factors found to be associated with a second episode of PP were a longer first episode of PP, and leaving a longer interval between pregnancies. This relationship was found to be partly, but not completely, explained via a function of episode severity, whereby women who had experienced more severe episodes were likely to wait longer for a second pregnancy, and were more likely to have a second episode of PP. The rate of subsequent episodes of psychosis outside of pregnancy was 69% for all, independent of severity, with all of these episodes classed as BD due to any subsequent psychosis occurring within mood states (depression or mania). These results may partially reflect the

recruitment method for Blackmore *et al.*'s (2013) research, which included gathering participants who had experienced an episode of PP from a sample of women who had already taken part in a genetic study into BD. It is not clear from the reported results whether the PP episodes occurred pre- or post- a BD diagnosis.

The impact of PP extends beyond managing the symptoms that are present within the episode. The process of experiencing the episode, and a long recovery, significantly affects the mother, the partner, the couple, and the parenting relationships (Morgan *et al.*, 1997; Robertson & Lyons, 2003). The symptoms of PP unsettle the family system and may create shifts in familial roles, and how couples relate to each other and towards their infant. Such changes may endure well beyond the time that pharmacological intervention may cease, thus clinical psychologists can have a key role to play in addressing these acute and enduring difficulties.

A theoretical understanding of the recovery process for women following PP has been presented by McGrath *et al.* (2013, see Figure 1). The theory highlighted four superordinate themes: the recovery process; evolving an understanding; recovery strategies; and sociocultural context. McGrath *et al.* (2013) postulated that the process of recovery, and achieving an understanding of their experience, run in parallel, each informing the other. In addition, McGrath *et al.* (2013) reported that most of the women interviewed in the study found that receiving a diagnosis of PP was beneficial, as this assisted with implementing some strategies for recovery. Some useful recovery strategies identified were: being able to access certain health support systems; seeking information on PP; and being provided with reassurance that they were not just 'going mad' or 'bad mothers'; and that recovery was possible (McGrath *et al.*, 2013, pp.348-349).

Figure 1. The Recovery Process Following Postpartum Psychosis

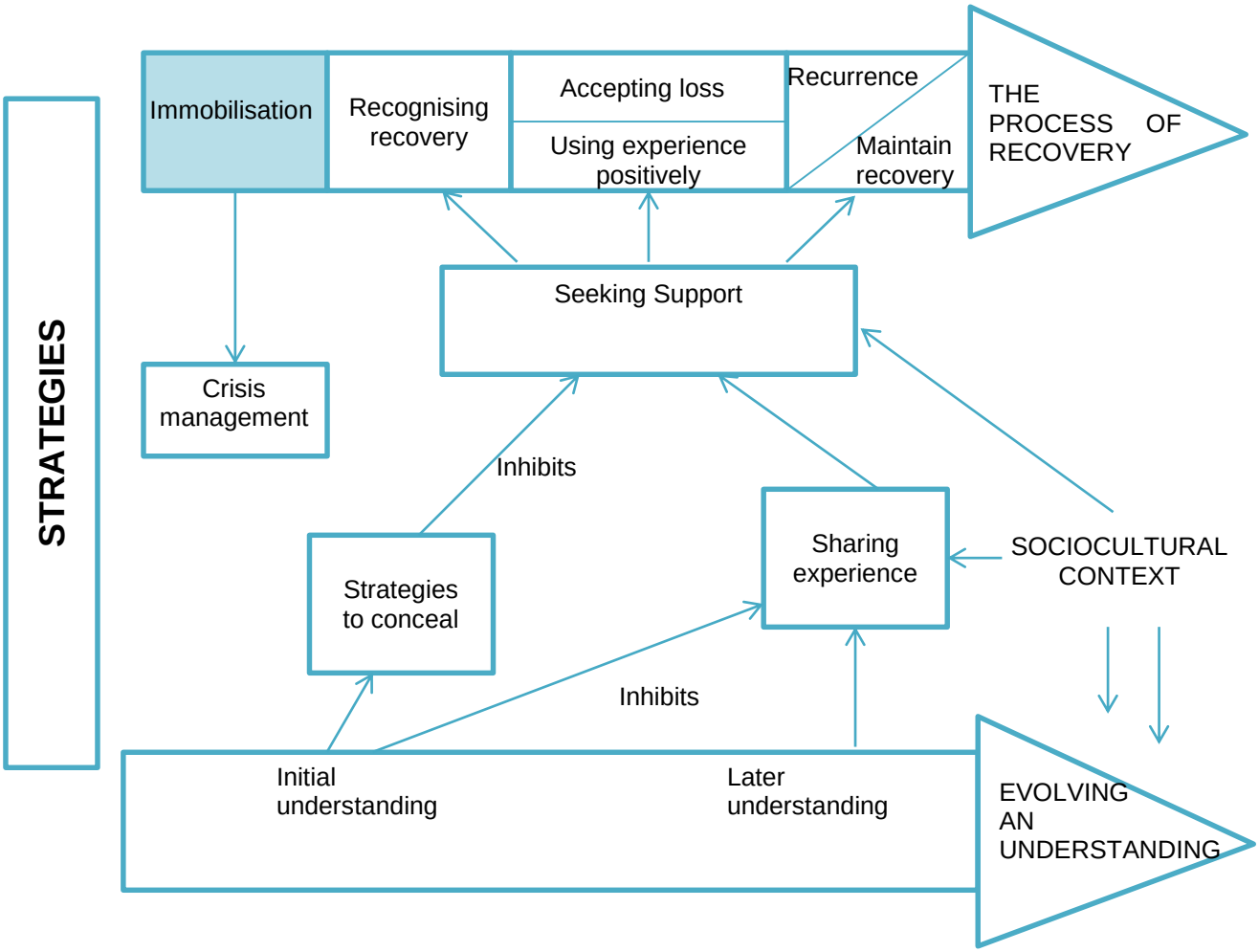


Figure 1. Visual depiction of the theoretical understanding of the recovery process following Postpartum Psychosis. Adapted from 'The process of recovery in women who experience psychosis following childbirth,' by McGrath *et al.,* 2013, *BMC Psychiatry,13,* p.345. Copyright 2013 by BioMed Central.

1.4. The Impact of Postnatal Mental Health Problems on Mothers

1.4.1. Postpartum Psychosis Literature

Qualitative research has been the main source of information in the exploration of the lived experiences of women with PP. Engqvist *et al.* (2012) analysed internet-posted narratives of women who had experienced PP. Four overarching themes were identified for the women:

unfulfilled dreams (delivery not as anticipated, unable to care for infant by feeding as planned, and feelings of guilt and paranoia); enveloped by darkness (fear, things not seeming real, being controlled, and confusion); disabling symptoms (not feeling right, lack of sleep, suicidal thoughts or behaviour, infanticide ideas, and difficulty concentrating); and abandonment (inability to trust, including healthcare staff, and feeling let down or angry by care provided). Engqvist *et al.* (2012) stressed that women expressed the importance of increased training for, and understanding of, staff to ensure earlier diagnosis and appropriate treatment.

Research by Heron *et al.* (2012) further explored the need for mothers to receive information and support during the recovery process from PP. Their study took a novel approach, by training women who had experienced PP to interview other women who had experienced PP. This collaboration, between academics and service users, generated open and in-depth discussions of womens' lived experiences and provided a holistic view of the recovery process beyond symptom reduction. Themes identified varied over the course of recovery, but included: unmet expectations of motherhood, and a sense of loss of what they expected from motherhood; ruminating and trying to rationalise their unexpected and traumatic experiences; understanding that recovery will take time and that the process may not be linear; rebuilding their social confidence; accessing health support, including provision of adequate post-admission support and information relating to PP and recovery; and valuing the importance of family support and developing a sense of family functioning, highlighting the need for partners to have access to psychological support.

A review paper exploring the impact of PP on infant development indicated that women experiencing PP demonstrated poorer infant caretaking during the PP episode, but that this

improved with recovery (Murray & Hipwell, 1995). Whilst the women were experiencing PP, the predominant mood state of the mother impacted on the type of interaction she had with her infant. Those experiencing mania appeared unpredictable and inconsistent with their care, whilst those experiencing psychosis appeared disorganised and inadequate in meeting the infant's care needs. The reviewers also highlighted the inconsistency in the literature surrounding the impact that PP has on infants; from evidence of infants displaying no impairment in attachment or cognition, to mothers struggling to respond sensitively, consistently and appropriately to their infant's needs (McNeil *et al.*, 1988).

A comparison has been made as to the impact of PP and PND on attachment. Noorlander *et al.* (2008) considered the attachment relationship between mothers and infants when admitted to an MBU, finding that mothers admitted for PND demonstrated more negative M-I interactions than those displaying PP, with interactions that were more rejecting, angry, and anxious. Similarly, Hornstein *et al.* (2006) indicated that women with PP self-reported negative bonding experiences, but those with PND self-reported more negative bonding experiences. These results may reflect an increased 'negative lens' through which an individual in a depressive state views the world, and perceives themself, rather than being an actual difference between PP and PND. Observations indicated, perhaps more worryingly, that infants whose mother had experienced PP demonstrated less eye contact, and their infants strived for independent self-regulation rather than seeking comfort and regulation from their mother. This has potential ramifications in terms of attachment formation, or the type of M-I attachment established.

Research has also explored whether there are any enduring effects from postnatal mental health problems on M-I interactions. Hipwell *et al.* (2000) noted that for women who had

experienced depression (with or without psychosis) in the postpartum period, M-I interaction disturbances were evident at 12 months postpartum, despite self-reports of maternal depressive symptoms having returned to their premorbid state. These disturbances were indicative of an insecure attachment, displaying interactions that were less sensitive, less appropriate and more negative in play. In contrast, women who had experienced mania in the postpartum period demonstrated interactions more indicative of a secure M-I attachment.

Results from the M-I interaction literature highlight the complexity and inconsistency of different mood states and symptoms in a PP presentation. It would appear that any observable impact on M-I interactions is predominantly whilst the mother is acutely unwell, rather than in recovery (Murray & Hipwell, 1995). Moreover, Murray *et al.* (2003) concluded that little evidence exists to indicate that an acute episode of PP has any enduring impact on infant development. Yet findings indicate that it would be desirable to increase the role of partners, so that they provide additional care to their infants, and more consistent interaction experiences, when their spouse is unwell.

1.4.2. Postnatal Depression Literature

The literature surrounding PND is another area of research that can inform our knowledge of the impact of psychiatric difficulties on women in the postpartum period. Although PND clinically presents very differently from PP, depression is often an element of PP, consequently, research that explores PND literature remains relevant when considering PP.

Research has established an association between maternal depression and reduced maternal responsiveness, and between perinatal depression and adverse infant development (Field, 2010, as cited in Pearson *et al.*, 2012; Hay *et al.*, 2001). Infants of mothers with depression

have been found to be more likely to demonstrate insecure attachment, and cognitive, emotional, and behavioural developmental difficulties (Goodman *et al.*, 2011). Interestingly, the impact on M-I interactions appears less in women with affective disorders than those with Schizophrenia (Riordan *et al.*, 1999). This particularly relates to the exploration of the impact of PP on infants, due to both a psychotic and affective disturbance being simultaneously present in PP. Moreover, Murray *et al.* (2003, p.71) stated that the care provided by a mother to her infant can be 'compromised if she is suffering from postnatal depression or postpartum psychosis'. Mothers were identified as being more likely to stop breast-feeding, and struggle to respond to and manage infant cues and crying (Cooper *et al.*, 1993; Seeley *et al.*, 1996). Enduring effects of PND have also been identified, whereby the majority of 5-year-old infants of mothers who had experienced PND demonstrated insecure avoidant attachments, and had increased issues with anxiety (Essex *et al.*, 2001; Martins & Gaffan, 2000; Murray *et al.*, 1999). Such research highlights a role for partners, and the support systems, to assist mothers in caring for their infants during a perinatal mental health episode.

Research has identified the importance of environment, life events, and social support for women with PND (Lane *et al.*, 1997; Paykel *et al.*, 1980). There is also evidence of a potential link between a poor quality couple relationship and PND, in particular an argumentative couple relationship (Johnstone *et al.*, 2001; Zhang *et al.*, 1999). Letourneau *et al.* (2012) pressed for PND to be re-conceptualised as an issue that impacts upon the whole family: the couple relationship; the parenting and parent-infant relationships; and the infant's health and development (cognitive and socio-emotional). Moreover, Dennis and Ross (2006) demonstrated that social support is a significant distinguishing factor for women diagnosed with PND, compared to those without depression, where the primary source of social support

for most women postnatally originates from their partner. Dennis and Ross (2006) considered Weiss' (1974) social relationship model, which illustrates that support can be provided through guidance, reliable alliance, reassurance of worth, attachment, social integration, and opportunity for nurturance. Women who scored their partners lower in all of Weiss' (1974) areas of support were more likely to have PND. The quality of the couple relationship has also long been identified as a factor in the development of PND (Johnstone *et al.*, 2001; Logsdon and Usui, 2001; Marks *et al.*, 1996; Patel *et al.*, 2002; Takeda *et al.*, 1998; Zhang *et al.*, 1999).

The risk of developing PND is higher if a couple's relationship is strained; however, PND may also impact upon, and strain, a pre-existing positive couple relationship (Lija *et al.*, 2011). Women with PND have been found to demonstrate less warmth, closeness, and confidence with both their infant and their partner (Lija *et al.*, 2011). This indicates that potentially, within the context of PND, partners may experience a sense of non-reciprocal care, feeling less supported and cared for by their spouse, at a time when they may be having to provide more warmth and care towards their spouse. The research by Lija *et al.* (2011) demonstrated the potential for women with perinatal mental health problems to struggle with engagement and relatability with their partners, and the added strain that this may place on the couple relationship at a time when the relationship provides key support and a sense of stability for the woman.

1.5. Why Study Partners?

1.5.1. Postpartum Psychosis Literature

Most research to date has focused on the woman's experience of PP, with the exception of three studies that have included partners. Firstly, Doucet *et al.* (2012) explored both maternal

and paternal views regarding support needs during a PP episode. Partners were found to typically report the support needs they felt that their spouse required, or lacked, and neglected to raise discussion of their own needs; instead, they identified that they struggled to ask for help and felt isolated and overwhelmed. Secondly, Blackwell *et al.* (2015) looked into partners' support needs and reported that partners were provided with little support or information regarding PP, and that partners felt isolated. The main change that partners proposed was to see greater support provided for themselves, and for better communication with healthcare professionals. Thirdly, Engqvist and Nilsson (2014) focused on the recovery process of PP, with both mothers and partners identifying that once a turning point was reached, whereby the mother decided to 'return to life' rather than contemplate taking their own life, then a phased recovery process could follow (Engqvist & Nilsson, 2014, p.10). This involved an individualised stepped recovery process leading towards mothers noting an increased sense of strength returning. Main sources of support were identified as being from relatives and friends, and also from professional support and medication. Support needs identified included: sleep, hope, encouragement, and help for women to recognise that they can get better. Although Engqvist and Nilsson (2014) included the partners' perspectives, only 4 of the 24 quotes within this article were from partners, and regarded their interpretation of their spouse's needs at different stages, or their needs as a couple, rather than their own individual needs. Apart from these three explorations, no other research has been conducted to explore partners' experiences of PP, or the impact they feel PP has had on themselves, their lives and relationships, and their self-perceived role.

1.6. Systematic Review

1.6.1. Introduction

The current study aimed to explore the lived experiences of partners of women who had been diagnosed with PP. This is an area of research which has been largely neglected, with PP literature primarily focusing on the mother, and looking at risk factors, aetiology, treatment, and the mother's lived experiences (Engqvist *et al.*, 2012; Heron *et al.*, 2012). The research conducted to date has highlighted the importance of support given to mothers who experience perinatal mental health problems, and the role and impact that the quality of the partner relationship can have on the risk of developing PP and PND, and on the recovery process (Dennis & Ross, 2006; Dudley *et al.*, 2001; Lane *et al.*, 1997; Murray *et al.*, 1999; Tissot *et al.*, 2014). This research has also demonstrated the extra pressure placed on partners, to provide additional support and care for both their spouse and their infant at a time of considerable change in both their family structure and their role.

The methodology and search strategies for the current study will be presented within the following systematic review, along with the inclusion and exclusion criteria utilised to identify relevant research. The procedure for assessing the quality of these studies is outlined, and a narrative thematic synthesis depicting the results of the review is provided. Finally, a discussion is presented of the results relating to wider research literature.

1.6.2. Review Methodology

An initial search was conducted to determine whether research had investigated the impact of PP in terms of a relationship alteration between partner and spouse, and partner and infant. The focus for the systemic review was partly directed by the charity Action for Postpartum Psychosis (APP), as an area that required further exploration. The following question was

asked: ‘To what extent does Postpartum Psychosis impact upon the relationship between the partner and the mother, and partner and the infant?’ On the 21 August 2015, a search was completed of the research evidence using Web of Science; Science Direct and OvidSP (Databases: Cardiff University Full Text Journals); AMED (Allied and Complementary Medicine); Embase (1947-present); Ovid Medline (1946 to August Week 2 2015); PsychINFO (1806 to August Week 3 2015); and PsycArticles Full Text. To help identify the key search terms to be used for the systematic review, the acronym SPICE (Setting, Perspective, Intervention/phenomena, Comparison, Evaluation or Exploration) was considered in relation to the research question. The following terms were used to complete this search: (Impact OR effect) AND (“postpartum psychosis” OR “puerperal psychosis” OR “postnatal psychosis” OR “perinatal psychosis”) AND (partner OR father) AND (relationship OR attachment) AND (mother OR spouse OR infant OR child* OR neonate OR newborn OR Offspring). This search resulted in 21 studies being generated (minus duplications); however, all were excluded as related either to partners’ mental health problems following a normal childbirth experience, or women’s experience or treatment of perinatal mental health problems, or heredity of mental health problems.

The systematic review search terms were then expanded to consider the impact of PP on partners (without specifying impact on relationships). The following question was asked: ‘To what extent does Postpartum Psychosis impact on partners?’ On the 21 August 2015, a search was completed of the research evidence using Web of Science; Science Direct and OvidSP (Databases: Cardiff University Full Text Journals); AMED (Allied and Complementary Medicine); Embase (1947-present); Ovid Medline (1946 to August Week 2 2015); PsychINFO (1806 to August Week 3 2015); and PsycArticles Full Text. The following terms were used to complete this search: (Impact OR effect) AND ("postpartum psychosis" OR

"puerperal psychosis" OR “postnatal psychosis” OR “perinatal psychosis”) AND (partner OR father). This expanded search resulted in 89 studies being generated but, due to the reduced specificity of the search terms, the studies generated either related to PP in general, or treatment, or the mothers’ perspective, or depression experienced by the partner in the postpartum but without the context of maternal PP. Only one published study was identified through this search as directly relating to the impact on partners and this involved couples, rather than just the partners, and explored the couples’ support needs (Doucet *et al.*, 2012).

Due to the lack of research conducted to date exploring partners’ experiences of PP, a systematic review was completed to look at the impact of another perinatal mental health problem, that of maternal PND, on the partner’s relationship with the mother and infant. Although PND is clinically distinct from PP, some similarities may be postulated in terms of the shared impact that having a spouse with a perinatal mental health problem may have on the couple, and F-I, relationship. Both PP and PND may involve: the spouse experiencing considerable difficulties in completing day-to-day tasks requiring additional support from those around them; an often unprecedented and unexpected onset of mental health difficulties during the postpartum period; partners adopting a more adaptive role to encompass becoming a carer for both their new infant and their spouse; and the experience of added stress and uncertainty during a time of considerable change.

The following question was asked: ‘To what extent does maternal Postnatal Depression impact upon the relationship between the partner and the mother, and partner and the infant?’ On the 21 August 2015, a search was completed of the research evidence using Web of Science; Science Direct and OvidSP (Databases: Cardiff University Full Text Journals); AMED (Allied and Complementary Medicine); Embase (1947-present); Ovid Medline (1946

to August Week 2 2015); PsychINFO (1806 to August Week 3 2015); and PsycArticles Full Text. The following terms were used to complete this search: (Impact OR effect) AND ("postnatal depression" OR "postpartum depression" OR "perinatal depression") AND (partner OR father) AND (relationship OR attachment) AND (mother OR spouse OR infant OR child* OR neonate OR newborn OR Offspring). These search criteria resulted in nine studies being considered after duplications and exclusions were applied (see Figures 2 and 3 for the systematic review search process and the article selection process). This search was repeated on the 1 May 2016 to identify any new research that had been published since the original search date; no new relevant studies were identified. An overview of the nine peer-reviewed studies and their key methodology, conclusions, and critiques are noted in Table 1.

1.6.3. Inclusion and Exclusion Criteria

To identify relevant studies, the following inclusion criteria were applied to the search strategy:

- Studies published between 1806 to 1 May 2016 in the English language;
- Studies focusing on the partners of women who had PND;
- Studies where the research focused on the partners' experiences, or when the partners were the sample explored in the research (with or without the mothers and/or infants also within the sample).

The aim of the search was to identify research within a neighbouring field, which is potentially relevant to the exploration of the lived experiences of partners of women having had PP. A number of exclusion criteria were applied to filter the results of the search to those most relevant to help inform the current study's design, application and analysis.

Studies generated from the research strategy were excluded if:

- Studies were duplicates, found by searching across multiple databases;
- Studies focused on maternal experiences, risk factors for PND, or prevalence rates;
- Studies were not peer-reviewed and instead were noted as miscellaneous, letters, conference proceeding publications, or dissertations;
- Studies tested interventions or treatment approaches for PND;
- Studies related to maternal PND and the direct impact of PND on infant development, with no consideration of the role of the partner in that relationship;
- Studies related to partner's own depression in the postpartum without the spouse having PND;
- Studies related to the 'normal' process of becoming a father, not in the context of maternal PND;
- Studies were review articles summarising other research found within the systematic review;
- Studies were not relevant to the context of PND, and instead considered trauma and PTSD in fatherhood.

A summary of the process of applying both the inclusion and exclusion criteria is depicted in Figure 3.

Figure 2. Systematic Review Search Process

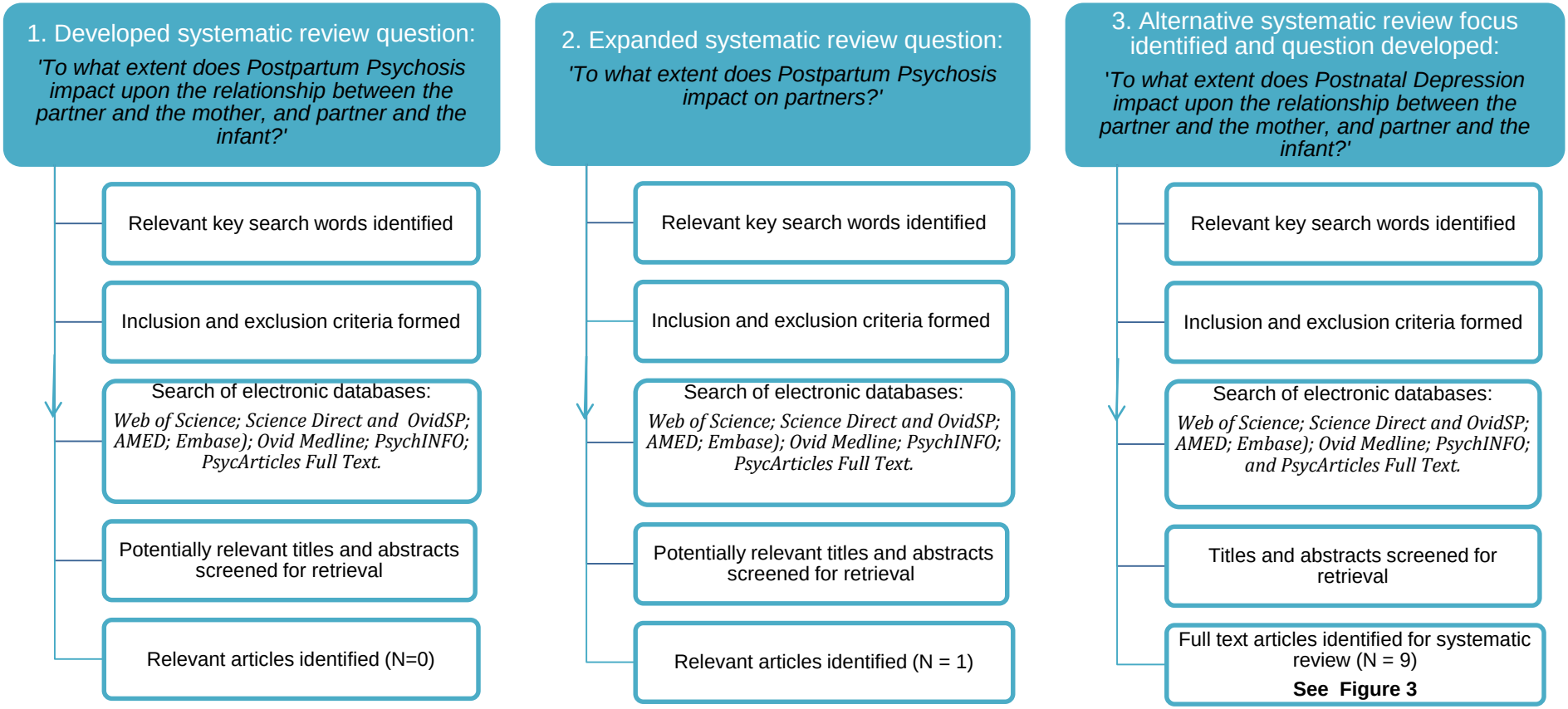


Figure 2. A flow chart depicting the systematic review search process.

Figure 3. Systematic Review Article Selection Process

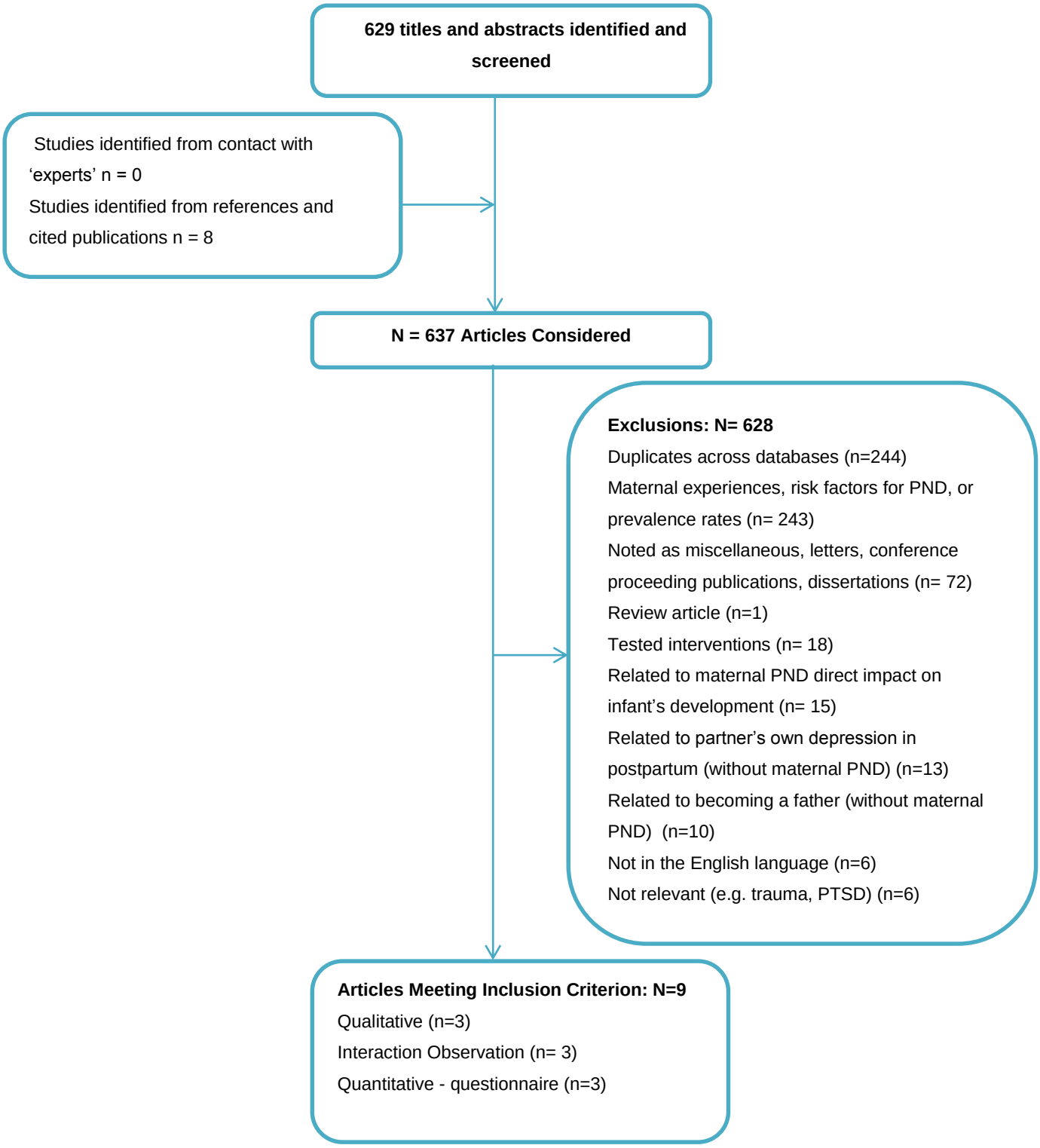


Figure 3. A flow chart depicting the selection process of studies included in the systematic review.

1.6.4. Quality Assessment

A total of nine studies were included in the systematic review. The final nine studies were assessed using a quality framework for their reliability. The Critical Appraisal Skills Programme (CASP) checklists were adopted to establish a quality rating for each study. The final nine studies included studies of different designs (e.g. qualitative, quantitative and observational), therefore, the corresponding CASP checklist was applied and results of these quality assessments are presented in the respective tables (see Appendix A and Appendix B). A benefit of choosing the CASP framework was the availability of different quality checklists for each study design. The tables provide a brief summary of each of the studies, considering each of the 10 assessed quality elements according to a 0-2 point system (whereby 0= not present or not reported, 1= partially present, and 2= present). Thus, the total maximum achievable quality score for any study would be 20. This quality score was then converted to a percentage and displayed in the overarching systematic review summary table (see Table 1). The majority of the nine studies considered demonstrated high quality ratings, ranging from 85% to 70%; however, one study by Goodman (2008) rated lower at 55%, largely due to some methodological and reporting shortfalls. Interestingly, Goodman (2008) was the one study presented within the systematic review that provided conflicting results to the other published studies, thus Goodman's (2008) results will be presented and referenced with some caution.

1.6.5. Results

The results of the systematic review are presented in four sections. The first section describes 'Partners' Expressed Concerns and Sense of Loss', and is based predominately on qualitative reports from partners. The second section explores 'Partners' Perception of Change in Relationships', and the impact that PND can have on relationships with both the

spouse and infant. The third section, 'Partners' Compensatory Role', describes changes in F-I interactions; for example, whether or not partners compensate for their spouse's reduced quality of maternal interactions. The fourth section, 'Impact of PND on Partners' Own Health', explores the potential impact of PND on partners' own mental health. A brief summary of the studies is provided below, but a detailed summary of each study is presented in Table 1.

Three qualitative studies were included in the systematic review. Meighan *et al.* (1999) considered the lived experience of partners of women experiencing PND, utilising a thematic analysis qualitative approach. The lived experiences of partners of women experiencing PND was also explored by Beestin *et al.* (2014), who completed a qualitative interview and an Interpretative Phenomenological Analysis (IPA) of the impact of PND on partners. Marrs *et al.* (2014) explored partners' concerns and experiences following their spouse's admission to an MBU utilising a Grounded Theory approach. One quantitative study also explored the impact of PND on partners. Zelkowitz and Milett (1996) looked at partners of women with PND and considered their levels of stress, the support they received, their attitudes, and perceptions.

One quantitative study within the systematic review explored the impact of PND on relationships. Milgrom and McCloud (1996) followed couples where the spouse had scored highly on the Edinburgh Postnatal Depression Scale (EPDS) at 3-, 6-, and 12-months postpartum, with partners being asked to rate their marital relationship and their relationship with their infant.

Three observational studies were included in the systematic review. Edhborg *et al.* (2003) observed mother-father-infant (M-F-I) triad interactions, and considered the impact of maternal PND on parent-infant interactions at 15- to 18-months postpartum. Albertsson-Karlgren *et al.* (2001) also observed M-F-I triad interactions at 10-months postpartum, and considered the impact of maternal mental health problems on parent-infant interactions. Goodman (2008) observed M-F-I triad interactions to explore the influences of maternal PND on partners and F-I interactions.

One quantitative study within the systematic review, by Lovestone and Kumar (1993), considered the vulnerability of 24 partners to mental health problems when their spouse was admitted to an MBU due to a postnatal mental health problem (predominantly PND, but also Schizophrenia, and BD).

1.6.5.1. Partners' Expressed Concerns and Sense of Loss

Meighan *et al.* (1999) documented very similar reported experiences across partners, with partners equating the birth of their infant with the loss of their spouse. Other experiences noted by partners included: a sense of loss of control; loss of intimacy; loss of expectation and established routine; and feelings of helplessness with regard to helping their spouse to overcome PND. For many, this helplessness resulted in partners reporting frustration, fear and confusion. Moreover, partners referenced the sacrifices they were making to hold their family and their relationship together. Many stated that even when the PND episode improved, an uncertainty remained as to what their future would look like with their spouse who seemed different. This research provides some insight into the concerns experienced by partners of women with PND; predominately it raises a theme of loss across many domains of a partner's life and their relationship with their spouse

Other research has reflected this theme of loss, with partners having commented that PND had led to a physical, or psychological, maternal absence and a 'fracturing' of their family unit (Beestin *et al.*, 2014, p.717). Partners reported unfulfilled expectation, unequal division of duty, a reduction in fathering, and loss of a close adult relationship with their spouse. For others, the partner adapted to the situation by accepting the loss of shared parenting and increasing their investment in the F-I relationship. The main themes that emerged from Beestin *et al.* (2014) included: absence; filling the void; thwarted fathering; and investing in the F-I relationship.

Another concern expressed by partners was the difficulty of creating and maintaining family bonds, particularly in the context of the mother and infant being admitted to an MBU (Marrs *et al.*, 2014). Partners expressed a desire for their role to be more recognised, be included in their spouse's care, and for healthcare professionals to consider the partner's needs. This research raised important issues relating to the impact of separation of the partner from the mother and infant on admittance to an MBU, and also the apparent lack of consideration for the partner and their needs. Partner concerns echoed a sense of being ignored, despite the reliance placed on both themselves and the extended family to continue to provide support and care to their spouse and infant following discharge.

Zelkowitz and Milett (1996) demonstrated that partners of women with PND scored higher on stress, had lower social support, and higher levels of psychological symptomology. Partners scoring higher on stress (due to work and economic stressors) were less likely to have sources of social support available to them. Moreover, partners scoring higher on stress also displayed more negative perceptions of their marriage, their paternal role, and their

infant's behaviour. This research highlights the changing role of partners in the context of PND and the pressure of taking on the role of being a carer, partner and father, all placing increased demands on top of daily life stresses.

1.6.5.2. Partners' Perception of Change in Relationships

Partners of women who scored highly on the EPDS rated their marital relationship, and their relationship with their infant, more negatively than partners of women who scored lower on the EPDS (Milgrom & McCloud, 1996). In addition, partners reported that their lifestyle had become more restrictive, their infant more demanding, and there was less satisfaction and cohesion within their couple relationship. Moreover, these difficulties were often found to increase with time. Milgrom and McCloud (1996) indicated a higher separation and divorce rate in PND couples compared with non-depressed couples, with partners noting increased fatigue, inertia, and bewilderment.

1.6.5.3. Partners' Compensatory Role

Albertsson-Karlgren *et al.* (2001) noted that mothers with perinatal mental health problems showed less sensitivity to their infant at 10-months-old, and less positive affect to their infant at 2-years-old, compared to M-I interactions within the control group. In contrast, partners within the clinical group showed more warmth compared to mothers, and were more active in parenting when mothers were mentally unwell to buffer the impact of a poorer M-I interaction (Albersson-Karlgren *et al.*, 2001). Other research exploring this question has also made the claim that partners function to compensate for the impact of poorer maternal interactions when mothers are unwell (Edhborg *et al.*, 2003). Edhborg *et al.* (2003) concluded that partners compensated for the mother's PND, although the sample size was

small for group comparisons to be made, and it would seem that a comparison across F-I interactions in PND and non-PND groups is non-significant. This questions the claim as to whether partners are compensating or just seeming to interact better with their infants, in contrast to PND M-I interactions compared to non-PND M-I interactions. Goodman (2008) further questioned this proposed compensatory role, yet indicated that maternal PND was associated with increased paternal PND and higher paternal parenting stress. Partners of women with increased PND demonstrated poorer interactions with infants, suggesting no compensatory role existed to reduce the impact of maternal PND on infant interactions. Overall, these studies demonstrate a potential for partners to take on a compensatory role in interacting with their infants in the context of the mother having PND, although the results appear mixed.

1.6.5.4. Impact of Postnatal Depression on Partners' Own Health

Not only is experiencing PND difficult for the women, but it is also a time of increased stress on the partner who is trying to support not only his spouse but also their new infant. Lovestone and Kumar (1993) proposed that 50% of partners of women experiencing postnatal mental health problems were identified as having a mental health problem when their spouse was admitted to an MBU. This study demonstrated the added stress placed on new fathers at a time of psychosocial flux (Benedek, 1959; Jarvis, 1962). Lovestone and Kumar (1993, p.214) highlighted that 'a frequent comment was the sadness that many men felt at returning home alone each day, a sadness heightened by the unused prams and toys'. This reflects a sense of loss of what was expected in the initial weeks of fatherhood. In general, there has been an increase in research which considers that partners may be vulnerable to developing PND, independent of whether or not the woman has PND (Wee *et al.*, 2011). However, the strongest predictor of paternal PND is maternal PND, the

hypothesised reason being impaired spousal support and poorer relationship satisfaction (Don & Mickelson, 2012). Previous research by Kuipers (1992) identified that people who frequently provide care for someone within the family who has a mental health problem, often have symptoms of a mental health problem themselves. Therefore, it would seem that the conclusion to be drawn is that having a spouse experiencing PND, and being admitted to an MBU, is a time of considerable stress for the partner which may result in a relapse or, in some cases, the development of mental health problems.

Table 1. Summary of Studies Considered within Systematic Review

Reference	Design	Sample				Method and Measures	Key Findings	Limitations	Q %
		N	***Gender % Female***	***Age mean years / range***	***Criterion***				
Albertsson *et al.* (2001)	Observational	36	_	<u>Psychiatric:</u> Mothers 28.7 / 21-36 Partners 31.1 / 23-51 <u>Physical:</u> Mothers 29.3 / 20-40 Partners 32 / 22-43	<u>Psychiatric:</u> 14 M-F-I triads where mothers had mental health problem (2 PND no Psychosis, 1 Dysthymia, 2 chronic Schizophrenia, 5 PND, 4 Bipolar Disorder). Partners, bar one (with Schizophrenia) healthy. Hospital admittance within 6 months postpartum. <u>Physical:</u> 22 M-F-I triads where mothers had physical health problems.	<u>Recruitment:</u> Recruitment randomly made fortnightly from psychiatric and health departments in four hospitals in Sweden. <u>Measures and Analysis:</u> M-F-I interactions videoed sessions when infant 10-months-old and at 2 years postpartum. Videos rated for sensitivity vs. insensitivity. ANOVA analysis. observation of interactions - coded using Mellow Parenting Coding System of parent interaction.	<u>10 Months:</u> Mothers with mental health difficulties showed less sensitivity in comparison to mothers in physical health problem group. <u>2 Years:</u> Mothers with mental health problems showed less positive affect and less link-infant follow. Partners in clinical group showed more warmth compared to mothers, whereas in physical health problem group partners showed higher autonomy and lower link-infant follow than mothers. Concluded partners have more active parenting role when mothers mentally unwell and is a buffer to M-I relation.	1) Data collected 1985-1988 but published 2001. 2) Grouped different mental health difficulties together. 3) No healthy control sample included. 4) Results from Parenting Coding System slightly altered from those obtained in Puckering *et al.* (1994) with same coder. 5) Small sample for group comparison.	70%
Beestin *et al.* (2014)	Qualitative	14	0	Partners 33.9 / 25-50	<u>PND:</u> British fathers whose (ex) spouse had =>1 PND episode. <u>Control:</u> No control group.	<u>Recruitment:</u> Recruited through PND support group. <u>Measures &Data Analysis:</u> IPA of narrative interviews exploring impact of PND on partners, the couple relationship, and fathering.	<u>PND:</u> PND led to physical/psychological maternal absence and 'fracturing' of family unit, unfulfilled expectation, unequal division of duty, reduction in fathering, and loss of couple relationship. Adaptation occurred through acceptance of loss of shared parenting and alternative	1) Wide age demographic – perhaps depicting different experiences for fathers at different ages. 2) Five fathers had no experience of childrearing outside of PND. 3) Outcome was split 7/7 recovered/depression ongoing. 4) Sample included 3 men noted as feeling no effect from spouse's depression. 5) Sample mixed those still in	75 %

							investment in F-I relationship. Main IPA themes: Absence (master theme), filling the void, thwarted fathering, investing in the F-I relationship.	couple relationship/separated.	
Edhborg *et al.* (2003)	Observational	25	_	Infants 15-18 months	PND: 11 M-F-I triads. Control: 14 matched triads.	Recruitment: Not described. Measures and Data Analysis: Parent Child Early Relational Assessment scale (PCERA).	PND: Infants of women with PND demonstrated less persistence in play, less joy in reunion. Most partners in PND families established joyful relationships with infant and secure attachment. Concluded partner 'compensated' for the mother's depressive symptoms.	1) Partners not screened for own depressive symptoms. 2) Parental ages not reported. 3) Sample size limited - of the 25 families, a number were unable to complete all components of the PCERA (6 incomplete data sets).	65%
Goodman (2008)	Observational (and mixed methods)	128	_	_	PND: M-F-I triads cohabiting; infant discharged within 1 week of birth; healthy newborn examination; mother >18 years old; neither parent had mental health problem other than depression; and both parents could speak and read English. Scored >= 10 on Edinburgh Postnatal Depression Scale (EPDS) identified with PND (women and partners). Control: Approximately half sample scored <10 on EPDS.	Recruitment: - Measures and Analysis: Measures completed at 2-3 months postpartum and videoed interaction. Measures included: EPDS, parenting stress index-short form, Dyadic Adjustment Scale, marital satisfaction, Parent-Child Dysfunctional Interaction, and Nursing Child Assessment Teaching Scale. Descriptive comparative design. Used Chi-square; T-test; Hierarchical multiple regression	PND: Maternal PND associated with increased paternal PND, and higher paternal parenting stress. Paternal Interaction: Partners of women with PND demonstrated less optimal interaction with infants, indicating fathers not compensating for any negative effect of mother's PND. Maternal Interaction: Maternal interaction not influenced paternal interaction, but how mother's perception of relationship with infant did.	1) Limited demographic, predominantly white middle class. No information on parental ages. 2) Results indicate if women had PND then partner more likely to also have PND. Separate result indicated that partners of women with PND demonstrated less optimal interactions. Study not stipulated if partners with less optimal interactions are the same partners who fit criterion for PND. 3) Results conflict with previously published research indicating that partners act as a buffer to maternal PND. 4) Not clear how partners consented or were recruited to research. 5) Cut off for EPDS lower than in other studies.	55%

						analysis.			
Lovestone & Kumar (1993)	Quantitative	70	0	MBU: Partners 33.1 Psychiatric: Partners 40.6 Health: Partners 32.3	MBU: 24 partners of women admitted to MBU. Psychiatric: 23 partners of women with no mental health problems after birth. Health: 23 partners of women admitted to inpatient mental health ward but not following childbirth. Screening included use of EPDS of Health control group to ensure no depression.	Recruitment: Recruitment through wards: MBU, psychiatric, and health. Measures and Analysis: General Health Questionnaire (GHQ-30); Schedules for Schizophrenia and Affective Disorder (SADS-L current and lifetime); Social Problems Questionnaire; Life events questionnaire; Golombok Rust Marital Scale; Paternal Attitudes and Behaviour – Postnatal Version, Significant Others Scale, and Parental Bonding Instrument. Data gathered at 1 week and 9 months postpartum.	Partner's health: Rates of mental health problems were higher in partners of women admitted to MBU (12/24). Partners had history of chronic social problems, and poor relationship satisfaction with their own fathers. Couple relationship: Little difference was noted in the marital relationship ratings.	1) 8/12 of MBU fathers had pre-existing past history of mental health problems, therefore, impact from maternal PND ambiguous.	85%
Marrs *et al.* (2014)	Qualitative	8	0	MBU: 37.5 / 28-51	MBU: British partners (5 first-time fathers, 3 had older children). Partners must: have visited the spouse and infant on MBU; be over 18-years-old; and be fluent in English. Exclusions: Partners experiencing high distress as judged by clinical teams.	Recruitment: Recruitment through 2 MBUs. Measures and Analysis: Depression Anxiety Stress Scale administered to partners. One-off interview lasted mean 69 minutes. Open-ended questions. Grounded Theory of	Partners concerns: Difficulties in creating and maintaining family bonds (especially with long admissions with infrequent visits). Struggling to establish F-I bonds, but focused establishing M-I bond. Strained couple relationship and anxiety at partner's illness, feelings of relief at admittance. Reliance on external family	1) Not state reason for admission of mothers to MBU. 2) None of partners noted anxiety or depression. 3) Only 16% of those approached agreed (is there something about their experience which makes it different to the other 84%). 4) Although ethically, exclusion of partners experiencing high levels of distress is understandable, their concerns may have been different and of interest to note.	85%

						interview transcripts.	support. Desire to improve communication and involvement in partners care planning. Call for increased staff awareness of partners' needs, and additional support to promote F-I attachment. <u>Model:</u> Proposed a model of how partners cope, and manage themselves and relationships during MBU admission through key themes identified: • Keeping the family together • Feeling contained • Feeling overwhelmed • Experiencing and managing uncertainty.		
Meighan *et al.* (1999)	Qualitative	8	0	-	<u>PND:</u> Partners of women with PND.	<u>Recruitment:</u> Recruited through spouse involvement in other projects or via health professionals. <u>Measures and Analysis:</u> Interviews audio transcribed. Thematic Analysis conducted: eidetic phenomenology.	<u>Partners reported:</u> • Fear • Confusion • Concern • Inability to fix = frustration • Sacrifices to maintain relationship and family unit • Uncertainty about future • Coping with change in spouse who is very different from previously. <u>Themes:</u> • Spouse becomes an alien • Loss of intimacy • Attempts to fix the problem • Making sacrifices	1) No socio-demographic information on sample. 2) No information on selection of sample or criteria to determine PND, nor which healthcare professionals enabled recruitment. 3) Women present during interviews may have impacted on what partners felt they could share/say about the impact of PND on them.	85%

							• Crisis • World collapsing • Loss of control.		
Milgrom & McCloud (1996)	Quantitative	82	50	PND: Mothers 30.4 / 19-39 Control: Mothers 31.1 / 20-38	PND: 38 couples where women has PND. Classified as depressed using EPDS (> 12). EPDS average score 18. Admitted to MBU before 3 months postpartum. Control: 46 control couples where women without PND. EPDS average score 6.3. No mental health problem (according to General Health Questionnaire).	Recruitment: Recruited from a metropolitan MBU. Measures and Analysis: Women assessed with EPDS to assign to group. Women and partners assessed at home 3, 6, 12 months postpartum on: Parenting Stress Index; Profile of Moods Scale; Dyadic Adjustment Scale; and Short Temperament Scale. PND group compared to non-depressed controls. ANOVA analysis.	Mothers: Mothers with PND rated infant as less reinforcing, less acceptable, less adaptable, more moody and more demanding. Rated self as less competent, less emotionally attached to infant, less healthy, more depressed, and more socially isolated, with a poor relationship with their partner and more restricted lifestyle. Difference persisted 3-12 months postpartum even when depression reduced. Partners: Partners of women with PND rated themselves, marital relationship, and their infant more negatively than controls, and difficulties became more pronounced with time. Partners' scores not as elevated as mothers' scores. Partners also noted more restrictive lifestyle and found infant more demanding. Profiles of Mood Scale and Dyadic Adjustment Scale showed less affection expression, satisfaction, cohesion for PND couples. Difficulties overall endure with time and often deteriorated. Noted higher separation and divorce rate in PND couples. These partners rated themselves as more fatigued, inert, bewildered, and less	1) Some missing data reported of parents not fully completing the questionnaires. Observed means estimated. 2) Sample of PND women - limited to women who sought help. 3) Recruitment through MBU and other appropriate agencies but not stipulate which other agencies. 4) No mean age provided for partners.	85%

							active than controls. These partners also maintained their mood state over time but became more confused.		
Zelkowitz & Milett (1996)	Quantitative	100	0	PND: Partners 31.9 Control: Partners 33.8	PND: 50 partners of women with PND. Identified if women scored > 10 on EPDS. Control: 50 partners of women scoring < 10 on EPDS. Exclusions: If significant complications birth or with infant (e.g. low birth weight).	Recruitment: Recruited through two community health centres. Measures and Analysis: Woman telephone interview at 6 weeks postpartum - screen depression (EPDS), and Structured Clinical Interview for DSM-III-R, and Symptom Checklist 90-R, Transition to Parenthood Scale, Neonatal Perception Inventory, stress and support scales.	PND: Partners indicated: more stress, less support, and had higher levels of psychological symptomology. Stress typically was work related or economic, and partners were less likely to report supportive in-laws, other relatives, or friends. Stress was associated with more negative perceptions of marriage, parental role, infant behaviour (not support). Work related stress had impacted on paternal attitudes.	1) Not directly assess F-I interactions. 2) Newly devised stress and support scale. 3) All recruited live in urban area – perhaps having a sample from a rural area would help generalisability of results. 4) Cut off for EPDS lower than in other studies.	85%

Table Key:

- = Unknown

IPA = Interpretative Phenomenological Analysis

F-I = Father-Infant

MBU = Mother and Baby Unit

M-I = Mother-Infant

M-F-I =Mother-Father-Infant

PND = Postnatal Depression

PP = Postpartum Psychosis

Q = Quality Rating

1.6.6. Discussion

1.6.6.1. Summary of Findings

The studies included in the systematic review provide a good basis for exploration and insight into the experiences of partners of women with PND. Predominately, a theme of loss appears across many areas of partners' lives: loss of what was expected after a new infant is born; loss of normality in life as it was; loss of their spouse, who becomes almost unrecognisable; loss of intimacy in the couple relationship; and loss of a united family unit. Loss of the family unit occurs through both physical separation of the partner from the mother and infant upon admission to an MBU, and also psychological separation as the spouse is often described as distant and, to some extent, disassociated.

In the studies reviewed, partners report feeling helpless and ignored by healthcare professionals. As a result they feel frustrated, fearful and generally confused as to the progression of their spouse's mental health problem, leading them to question whether normality will ever resume and their spouse return to the individual they recognise. There is a sense of partners feeling excluded from their spouse's treatment, yet also an expectation being placed on partners to provide the ongoing care and support to their spouse post-discharge. The role of the partner clearly involves trying to balance becoming both a carer to their infant and to their spouse. Some results have indicated that partners end up investing and compensating in the father role, in order to try and counteract any difficulties which may emerge due to their spouse's lessened involvement in their infant's care during the initial weeks. Despite partners attempting to create a more positive bond with their infants, partners have been found to rate their relationship with their infant more negatively than partners of women without PND. Similarly, partners have rated their couple relationship more

negatively during their spouse's PND, perhaps reflecting the reported distancing of the couple and the lack of intimacy. Overall, having a spouse with PND seems to result in partners experiencing greater stress (as greater demands are placed on them) and the deterioration of their own mental health.

1.6.6.2. Strengths and Limitations of Key Studies

Factors contributing to the awarded quality ratings are as follows:

1.6.6.2.1. Design

Of the nine studies that were reviewed, there was an even split as to whether the study design was qualitative, quantitative, or observational. Of the qualitative studies, all involved interviews with partners, using different analysis techniques (of either IPA, Grounded Theory, or Thematic Analysis) to fit their research question and design. Quantitative measures used across studies varied widely, and included: a maternal depression screening (EPDS); adjustment scales; marital satisfaction scales; temperament scales; and general health questionnaires. However, there appeared to be a lack of consistency according to when these measures were administered during the postpartum period, which reduced control for other factors which may have affected results; for example, tiredness levels immediately post-childbirth. Observations either involved parent-infant dyads or M-F-I triads, with interaction scoring measures being inconsistent across studies. Scoring measures used were: Early Relational Assessment Scale; Ainsworth's Sensitivity and Insensitivity Ratings; and the Mellow Parenting Coding Systems.

1.6.6.2.2. Sampling

The nine studies reviewed all involved partners of women who had experienced PND (N=9). Within this sample, some studies also considered the family triad with mothers and infants also participating (n=5). Across studies, the average age of partners were in their thirties, but partners overall ranged from 23- to 51-years-old. A study by Beestin *et al.* (2014) provided detailed analysis of the main factors partners perceived as being affected by PND. Although the diversity of the sample was a strength of the study, providing varied perspectives on partners' lived experiences, the range of ages of partners was very varied (from 25- to 50-years-old). It could be argued that such a wide age range may reflect very different experiences of partners, depending on where they were in their lives at the time of the PND episode, and thus reduce the homogeneity of the sample. Overall, sample sizes varied considerably across studies, ranging from 25 to 100 for quantitative and observational studies (including controls), and from 8 to 14 for qualitative studies.

Recruitment tended to occur indirectly through initial contact with the mothers; for example, through PND support groups, or healthcare professionals, or as a result of maternal hospital admissions. One study, by Marrs *et al.* (2014), stated a very low recruitment rate compared to couples approached, with only 16% of partners approached agreeing to take part in the study. Therefore, results may reflect a trait, or experience of certain partners, which makes them more likely to want to share their experiences than if a larger proportion of those approached had opted to take part. For instance, only partners who held a grievance or experienced a particular difficulty, or had a positive experience, or who were most recently or heavily involved in the service, may have volunteered in order to get their views heard.

Mothers were most often screened using EPDS, to generate a depression score rating which helped identify them as being within the PND group rather than the control group. However, the cut-off score set to identify PND on the EPDS varied in some studies, challenging the homogeneity and comparability across PND groups. At times, the cut-off was set at 10 (instead of 12 to 13) to increase the sensitivity of the measure within a community-based sample; this potentially resulted in its use lacking an appropriate level of specificity. Goodman (2008), and Zelkowitz and Milett (1996), applied this lower cut-off score, which resulted in women scoring 10 and over as being classed with PND yet within the subclinical or borderline range on the screening. The studies do not clarify whether women scoring the highest on the EPDS had partners who scored proportionally higher on the other measures, compared to partners of women who scored within the 10 to 12 range.

Within the quantitative studies, control groups were either matched in age and by socio-demographic variables with healthy controls, or had other mental, or physical health problems. The use of control groups added strength to the quality of the studies considered. In terms of the experimental group sample, within the research presented by Lovestone and Kumar (1993), 8 out of the 12 partners who were found to demonstrate mental health problems during their spouse's admission had pre-existing mental health problems, which following their spouse's admission had resulted in a relapse. The total sample in the study was 24, therefore, a high proportion of those within the experimental group had pre-existing mental health problems. It would be interesting to know if this percentage would change if a larger sample were sought.

1.6.6.2.3. Data Analysis and the Presentation of Findings

Most of the research presented within the review demonstrated a high quality rating, providing an indicator that the studies have a sound methodology and that their results can be considered with confidence. However, Goodman's (2008) results, indicating that partners do not play a compensatory role, are to be considered with some caution given their lower quality rating compared to the other studies within the review. Goodman (2008) demonstrated a general lack of transparency in providing the complete methodology and in the general write-up of the article. Another study within the review fell short on the data management rating; although Milgrom and McCloud (1996) generally appeared to have a strong methodology, some data collected was missing as some couples had not fully completed all questionnaires presented. There is little indication within the article as to how missing data was managed, or whether there was a pattern as to which questions were skipped, or missed, when completing the questionnaires. This may have indicated a theme, or that there were certain questions that couples struggled to answer, or did not want to provide information on, or were not relevant to their experiences.

1.6.6.2.4. Interviewing Partners of Women with Postnatal Depression

The majority of studies reported interviewing the partners separately to their spouse, and it would appear from the results provided that partners provided rich and detailed responses. However, one of the main critiques of the study by Meighan *et al.* (1999) would be that partners were interviewed in front of their spouses. It is clear from the article that partners still provided quite in-depth answers, but it would have been interesting to know if partners may have been more likely to raise, or discuss in more depth, certain topics if their spouse had not been present at the interview. It may be that a partner is sensitive to discussing the extent of their difficulties in front of their spouse for fear of upsetting them, or not wanting to

raise potentially traumatic memories, or feeling unable to 'complain' about their experiences in contrast to what their spouse may have experienced.

1.6.6.3. Integration of Review Findings with Wider Literature

The theme of loss highlighted by partners of women with PND, echoes that of maternal experiences of PP (Beestin *et al.*, 2014; Engqvist *et al*., 2012; Meighan *et al.*, 1999). Maternal reports of their own sense of loss particularly focused on loss of their expectations of motherhood and a positive perinatal experience, which was disrupted due to their experiences of PP (Heron *et al.*, 2012). In addition, the reported sense of loss of intimacy is important when considering research by Morinaga and Yamauchi (2003), who highlighted the stress-buffering effect of marital intimacy and support following childbirth. Overall, the sense of loss within the couple relationship is of particular consideration in the light of research by Marks *et al.* (1996), who noted that where partners were more positive about their wives postpartum, their wives were less likely to relapse. Finally, Takeda *et al.* (1998) highlighted an association between lower PND scores and the higher frequency with which partners listened to their spouse's concerns and anxieties, and where partners were more considerate and attentive and helped with the practical care of the infant. These results indicate that there may be associated changes linked to a sense of loss within a relationship, which may place a spouse at greater susceptibility to PND, although the direction of causality with these associations is unclear.

Partners of women with PND report feeling ignored, an area also raised within the maternal PP literature where women with PP called for the need for their partners to access care and support (Heron *et al.*, 2012; Marrs *et al.*, 2014). This can be considered a particularly

relevant point in the context of the impact that having a spouse experiencing PND can have on a partner's own mental health (Lovestone & Kumar, 1993). Research has also explored the ability of partners to care and support their spouse if their spouse has a severe mental health problem and the partner also has a mental health difficulty (Frayne *et al.*, 2014). Results indicated that although partners felt positive about becoming a father, financially 25% reported struggles to support their spouse, 60% had recreational habits which may impact on their own health (smoking, drinking or drugs), and 12.5% noted their own severe mental health problem may result in them being less able to emotionally support their spouse.

Within both the PND and PP literature, there appears evidence of a reduction in the sensitivity and quality of M-I interactions (Hay *et al.*, 2001; Hipwell *et al.*, 2000; Horstein *et al.*, 2006). The reviewed literature suggests that partners of women with PND may be aware of this and try to compensate for their spouse's interactions with their infant (Albertsson-Karlgren *et al.*, 2001; Edhborg *et al.*, 2003).

Research into partners' experiences of PND has noted negative ratings of the partner's relationship with both their spouse and infant (Milgrom & McCloud, 1996). This result is reflected in research from the spouse's perspective, whereby women with PND also reported negative ratings of the couple relationship (Dudley *et al.*, 2001). Moreover, Lija *et al.* (2011) reported that women with PND demonstrated less warmth, closeness, and confidence in their relationship with their partner, perhaps linking with Milgrom and McCloud's (1996) finding of partner's negative relationship ratings.

1.6.6.4. Implications for Research

The research that has been conducted exploring partner experiences of PND has provided an insight into the struggles and needs of partners when their spouse is unwell. The literature has highlighted four main areas that partners have communicated as being particularly difficult, these include: a sense of loss; change in their relationships; taking on a compensatory role; and the impact on their own mental health. The studies have highlighted the added pressure, and expectation, placed on partners to be a source of support at a highly emotive time, but also the vulnerability that this creates for the partner's own wellbeing, and the potential that this increased supportive role may have on their relationships with the mother and infant. Although the studies considered relate to PND, similarities may be found in the context of PP and may help inform clinical support provision to both the couple and the partner.

1.7. Synthesis of Findings

The nine studies considered within the systematic review have provided good insight into the experiences of partners during their spouse's PND episode. From the literature, key themes can be identified:

- The main theme identified across studies was that of a sense of loss. Loss may take the form of their spouse seeming different, loss within the couple relationship and of intimacy, loss of expectation of what fatherhood may look like, loss of a united family unit, and loss of 'normal' life as it was known;
- Partner's role shift within the postpartum period, to one of a carer to both infant and spouse;

- Partner's relationship with their infant may be more involved in the context of PND, potentially as an attempt to compensate for their spouse's initial difficulties interacting with their infant;
- There is little reported recognition by healthcare professionals of the role that partners take in supporting and caring for their spouse;
- Partners are not generally offered support by healthcare professionals, nor consideration given to partners' needs and the impact that PND is having on partners;
- Partners report rating their relationship with their spouse and their infant more negatively in the context of PND;
- Partners note feeling helpless and uncertain as to what the future may hold and if their spouse will again become recognisable, and whether their lives will return to a greater sense of normality.

1.8. Overview

Overall, research into partners of women with PND may help inform the design of research into partners of women with PP. Studies appearing most relevant are those of qualitative design, which explored partners' lived experiences of PND, as they appear to have generated the widest breadth, and richest description, of the partners' experiences, thoughts and concerns. However, observational and quantitative studies have also enabled consideration of the more measurable changes in partners as a result of maternal PND; for instance, changes in the partner's own mental health, stress levels, and their interactions with their infant and spouse.

1.9. Relevant Psychological Theoretical Models

To help elucidate the findings presented within the systematic review, and to provide a psychological context within which to consider the current study's results, some psychological theoretical models are presented. The models have been selected based on their representation of social relationships, loss in the context of expectation, coping, attachment, and also the researcher's clinical awareness of the selected models.

1.9.1. Social Relationship Model

Weiss (1974) provided a model outlining six different social 'provisions' that may be met through interactions and relationships with others. These provisions included: attachment; social integration; guidance; reliable alliance; reassurance of worth; and nurturance. Within the framework outlined by Weiss' (1974), these social provisions may be met by different people within an individual's support network; for example, guidance may be gained from significant friends, and a reassurance of worth gained through interactions with work colleagues and managers. Based on Weiss' (1974) model, research has demonstrated that a buffering effect, from social support through these domains, can reduce the impact of PND on mothers (Cutrona & Russell, 1987). Moreover, even within the context of a healthy perinatal experience, research by Poh *et al.* (2013) highlighted that first-time fathers reported emotional changes in their spouse and expressed a need for support, and improvement in healthcare.

1.9.2. Expectation-Loss Theory

Leading up to the birth of an infant, there are often high expectations as to what the addition of an infant will bring to a couple's life. From the moment they find out that they are going

to be parents, to the time of delivery, expectations will inevitably be present. These expectations will range from infant gender, to infant weight, to an idealisation of what the family unit will be like and to their potential future happiness. However, when a postpartum experience is not as anticipated, this can create a sense of loss for what 'might have', or 'could have', been. This expectation-loss experience is something that can be experienced by parents when, for example, their infant is born with a visible physical disability or sensory impairment (Luterman, 2008). Such research has equated an unexpected diagnosis of disability, or impairment, as being perceived by parents as similar to an infant death. Their infant is not the infant they had imagined, and instead they are presented with an infant that does not look, behave or interact with them as they expected; thus parents can find themselves mourning the loss of the expected future they had imagined. A similar experience may be noted by parents who experience perinatal mental health problems, wherein an idealised image of parenthood is very different from the reality. From a partner's perspective, they may have gone from the expectation of becoming a mutually, parentally supportive family unit, to potentially losing that initial shared experience of parenthood, as they take on the role of both a carer to their spouse and father to their infant. The partner may have to rely on others to provide support, and have others witnessing the happy early developmental events that they had hoped to share with their spouse.

1.9.3. Cognitive Relational Theory of Emotion and Coping

Lazarus and Folkman's (1987) model acknowledges that coping may be neither an entirely learned response behaviour, as evolutionary psychology may imply, nor an entirely cognitive process, as psychoanalytic psychology may posit. Lazarus and Folkman (1987) state that neither discipline proposes a complete picture of coping and emotion; moreover, links between coping and emotional response are seen by such disciplines as uni-directional.

Therefore, Lazarus and Folkman (1987) proposed a process-orientated model of cognitive relational theory. This model identifies the link between an individual's emotional response and their environment as being ever changing, and mediated through their cognitive appraisal of events and their coping response.

Stemming from both Lazarus and Folkman's (1987) model, and McCubbin and McCubbin's (1993) resiliency model of family stress, adjustment and adaptation, Marrs *et al.* (2014) proposed a theoretical model of how partners cope personally and relationally, during their spouse's admission to an MBU (see Figure 4). This model incorporated the demands placed on the partner, what support was available, and partner participation in relationships. It concluded that the partner's ability to cope, the extent to which they were emotionally impacted on, their engagement in relationships, and their ability to acquire knowledge from professionals, was mediated by the partner's own personality and attachment style. Marrs *et al.* (2014) highlighted four key areas that affected a partner's adaptation to their spouse and infant being on the unit and which should be considered by healthcare professionals, these were: practical issues, such as travel and childcare; partner's role as caregiver; demands of spouse's illness; and partner's own beliefs and understanding being taken into account

Figure 4. Marrs *et al.*'s (2014) Model of Partner Coping Following Spouse Admission to MBU

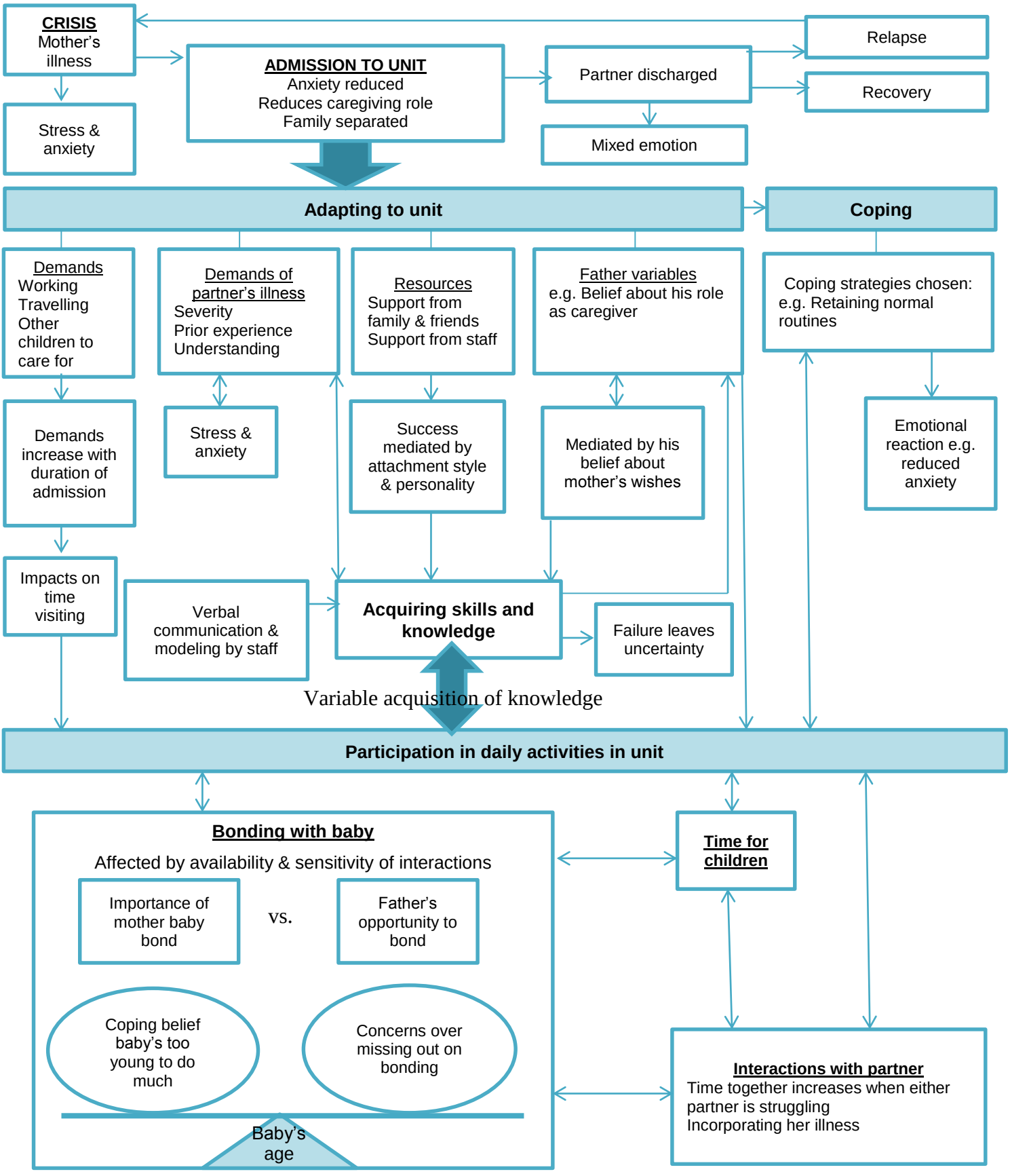


Figure 4. Theoretical understanding of how partners cope following their spouse's admission to an MBU. Adapted from 'Keeping the family together and bonding: a father's role in a perinatal mental health unit,' by Marrs *et al.*, 2014, *Journal of Reproductive and Infant Psychology, 32*, p.349. Copyright 2014 by Taylor and Francis.

1.9.4. Attachment Theory

Attachment theory was proposed and first systematically explored by Bowlby (1969, 1973). Attachment theory stemmed from psychoanalytic, developmental, and evolutionary theory, and drew from observations of infants and their responses to the presence, and absence, of their primary caregiver. Attachment theory proposes that early attachment experiences of forming, and maintaining relationships, with primary caregivers shape infant development and the ability to form responsive and secure adult relationships (see Figure 5). Research has indicated that disruption in attachment formation, or insecure attachment, can have an impact on an infant's social, cognitive and emotional development, as well as their ability to form future relationships (Bridges & Grolnick, 1995; DeMulder *et al.*, 2000; Vondra *et al.*, 2001). Infant early attachment experiences are thought to result in an internal working model of relationships that shape infant self-perception and also expectation of others (Hughes *et al.*, 2012). When an optimal attachment is formed with a primary caregiver, the caregiver consistently displays warmth and attention, functioning as a 'secure base', which enables the infant to feel safe and explore and learn from the world around them. Conversely, if an infant's primary caregiver is unresponsive, distant or inconsistent, infants struggle to utilise them as a 'secure base' and the infant's interpretation and learning of the world is filtered through anxiety and insecurity.

Attachment theory is important when exploring the impact that PP may have on partners. Some of the effects of experiencing PP is that the mother may withdraw and distance herself, and be unable to meet all of the infant's needs or respond to them consistently and warmly. A number of studies have indicated that in such situations partners can act as a buffer, or moderator, in terms of the effect that this has on an infant's attachment development (Albertsson-Karlgren *et al.*, 2001; Edhborg *et al.*, 2003). The attachment relationship that is

formed between father and infant may help the infant develop a secure internal representation of relationships, and provide a foundation on which future relationships, and exploration of the world around them, may be built; although, at times of such familial stress, this may be hard to achieve and may understandably not be a partner's prime focus.

Figure 5. Stages of Attachment

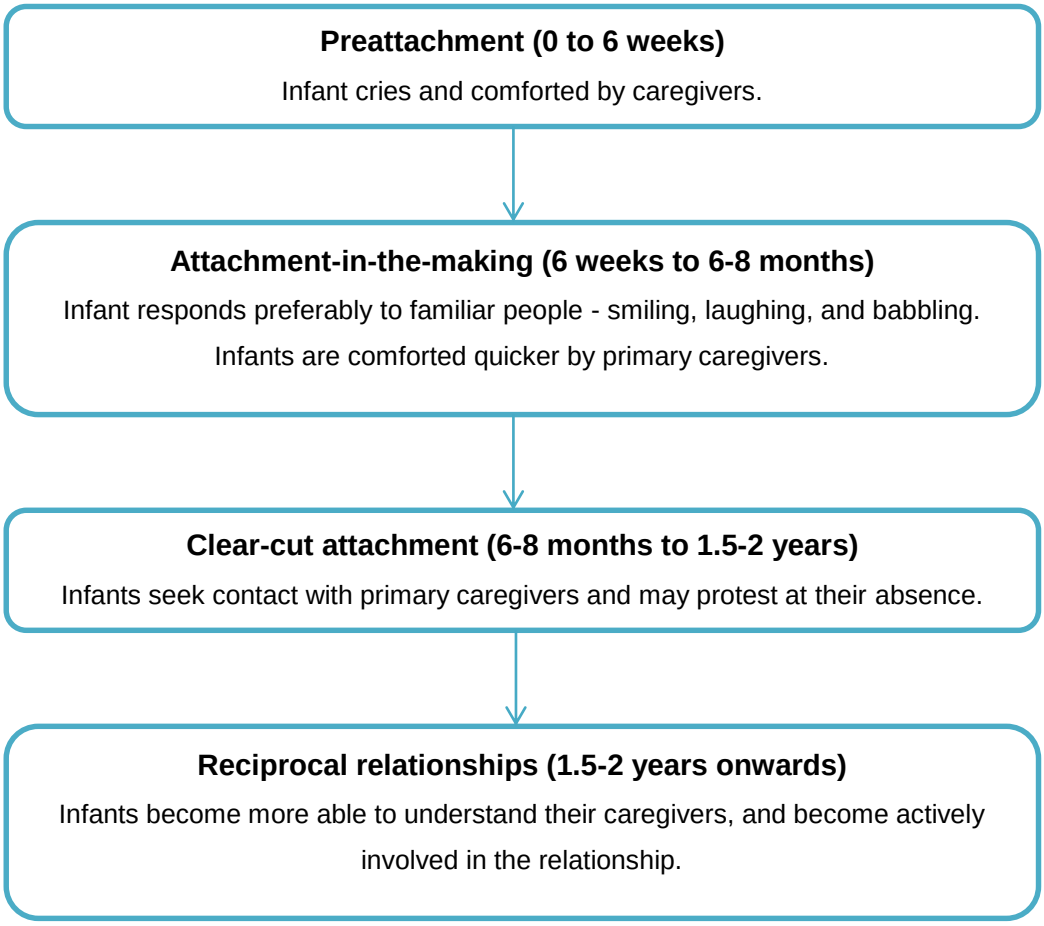


Figure 5. Visual representation of Bowlby's (1969, 1973) stages of attachment formation.

Following on from Bowlby's (1969, 1973) work, Ainsworth (1973) considered the types of attachment that may be formed between infant and caregivers through a test of relationship security named the Strange Situation. Ainsworth (1973) identified three types of attachment: secure; insecure avoidant; and insecure resistant or ambivalent (see Figure 6). At a later

stage a fourth attachment type, that of disorganised or disorientated, was added by Main and Solomon (1990). Ainsworth (1973) demonstrated that attachment type was correlated with caregiver sensitivity, whereby insensitivity to infant needs, inconsistency, and rejection correlated with insecure attachment. Ainsworth (1973) identified such parental sensitivity as fundamental when engaging and responding to infant emotions and communication.

Figure 6. Types of Attachment

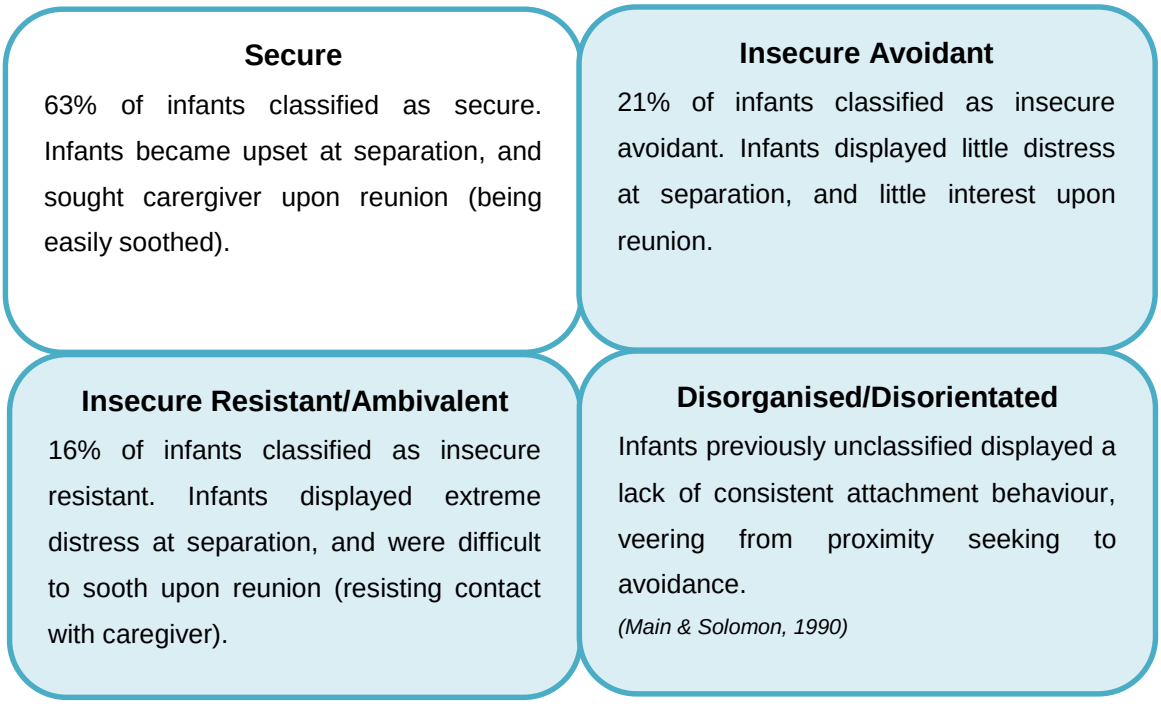


Figure 6. Attachment types as noted by Ainsworth (1973), and Main and Solomon (1990).

1.10. Thesis and Hypothesis Rationale

Postpartum Psychosis impacts heavily on the new mother, but also on the partner and infant. There is a general lack of research into the impact of PP from the partner's perspective, so exploration within this field would be largely unique at this time. Although PND research can partially help inform understanding of partners' experiences of PP, the symptoms and consequences of PP are very different; thus, caution needs to be made in extrapolating

findings across conditions. There is a need for research to focus on PP and, in particular, the impact that it has on partners.

Partners are typically the main provider of social support to mothers experiencing postnatal mental health problems, and social support has been noted as a significant factor in recovery and preventing relapse. However, it is not clear what impact the experience of PP, and being the main providers of social support, has on partners and their relationship with either the mother or the infant (Dennis & Ross, 2006; Heron *et al.*, 2012). The impact and experience of PP will be explored from the partner's perspective, by looking at: their experiences of PP; their relationship with the mother and infant; their support needs; their role alteration; and the impact of PP on different domains of their life. Adequately identifying the partner's perspective, and their perception of change in their relationship with the mother (positive and negative), may vicariously help with the provision of appropriate support for the mother and infant, and should directly inform what support could be offered to the partner, the couple, and the family triad.

Chapter Two: Methodology

2.1. Aims of the Research

The majority of research conducted within the area of Postpartum Psychosis (PP) has centred on mothers' experiences, aetiology, and intervention efficacy (Glangeaud-Freudenthal *et al.*, 2011; Jones & Craddock, 2001; Lawson *et al.*, 2015; Mishra *et al.*, 2011). No research has been completed that focuses solely on partners' experiences of PP and the impact that they feel PP has had on their lives and their relationships. Research within neighbouring fields, such as that of partners' experiences of Postnatal Depression (PND), has highlighted both the theoretical and clinical benefits of conducting such research (Beestin *et al.*, 2014; Marrs *et al.*, 2014; Meighan *et al.*, 1999).

The aims of the current study are to:

- Explore the lived experiences of partners of women who have experienced PP;
- Consider the impact of PP on partners' lives and relationships;
- Gather information which may help inform future clinical interventions to support partners and couples experiencing PP;
- Help progress research within the area of PP and develop a stronger theoretical understanding of the effects of PP.

2.2. Design

This study uses a qualitative design to explore the lived experiences of partners of women who had been diagnosed with PP. The main aims of the study were addressed through a semi-structured interview with partners, which gathered the information for Interpretative Phenomenological Analysis (IPA) to be completed. In addition, a short

online questionnaire was devised in order to identify socio-demographic details; provide a brief summary of the partner's experiences of PP; and establish ratings of the impact that partners felt PP has had on their lives and relationships.

2.3. Introduction to Qualitative Methods

Qualitative analysis focuses on the exploration of people's experiences and the meaning that they derive from them. Such analysis helps engender a wider and greater understanding of events and experiences, especially when little research has already been conducted around a particular topic. Qualitative analysis allows for flexibility in exploration, and centres on individual experiences and perspectives. Both the participant and researcher are considered within the analytic process, although the participant remains the primary focus. Summarising themes that emerge as part of a qualitative analysis occurs only after each participant's hypothesised meaning of their experiences has been considered. Qualitative analysis provides a stark contrast to quantitative approaches, which predominately confirm established hypotheses and are population, rather than individual, focused (Davidsen, 2013; Smith *et al.*, 2009).

2.4. Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis is a form of qualitative analysis that explores individuals' lived experiences; often the experiences of a specific group of individuals whose selection is based on a particular event, or process, that they have lived through. The aim of IPA is to try and capture the insider's perspective, focusing on the details of what was experienced by each individual and the meaning and importance that the individual makes of their experience (Conrad, 1987). Within a sample, each individual experience of the same

event may differ based on each individual's circumstance, history, culture and values (Larkin *et al.*, 2011). Interpretative Phenomenological Analysis attempts to capture unique, but also collective, experiences of the considered event. However, when exploring a sample of individuals who have experienced the same event, general overarching themes emerge as to what it can be like for someone to go through such an event. Data exploration within IPA requires that '… the IPA researcher is engaged in a double hermeneutic because the researcher is trying to make sense of the participant trying to make sense of what is happening to them' (Smith *et al.*, 2009, p.3).

2.4.1. History of Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis is a relatively new qualitative approach; its initial presence within health psychology literature surfaced when Smith (1996) proposed its use as an experiential qualitative analysis research approach. Interpretative Phenomenological Analysis was suggested as a new qualitative approach to unite the importance of both experimental and experiential exploration, drawing from three key areas of the philosophy of knowledge development: phenomenology, hermeneutics, and idiography (Elliott *et al.*, 1999; Smith *et al.*, 2009).

Phenomenology is the study of experience and reflecting on what it is like to experience something. Phenomenology unites '…philosophy, science and lifeworld and attaches importance to rich contextualised descriptions, based on experience' (Davidsen, 2013, p.320). Smith *et al.* (2009) considered some of the philosophical concepts important within phenomenology and their relevance to IPA:

- The importance of experience and an individual's perceptions of their experiences. This includes systematic reflections on the content of what someone is reporting, and

holding the knowledge that what is experienced and perceived by an individual does not occur in isolation but within a social and personal context of events, objections, and relations (Denzin, 1995);

- The impact of an individual's prior knowledge and awareness of the world and that an individual's knowledge of the world, and experience of being a person within the world, shapes their interpretation of new events (Anderson, 2003);
- The current and historical presence, and absence, of relationships in shaping an individual's experience of events.

Overall, these philosophical concepts have helped to develop an enriched understanding of phenomenology which '…invokes a lived process, an unfurling of perspectives and meanings, which are unique to the person's embodied and situated relationship to the world' (Smith *et al.*, 2009, p.21). Interpretative Phenomenological Analysis centres on these concepts as a qualitative approach, which is interpretative, and reflective, and considers the meanings that individuals try to make of what has happened to them.

Another area of philosophy drawn upon in IPA is that of hermeneutics, which can be defined as '…the theory of interpretation' (Smith *et al.*, 2009, p.21). Smith *et al.* (2009) considered some of the philosophical concepts important within hermeneutics and their relevance to IPA:

- The importance of objective and psychological meaning and understanding of what is being said, which is identified by the analyst. This includes both the visible and the concealed meaning of what is being said;
- The impact of personal history and preconceptions on interpretation;

- That the hermeneutic cycle focuses on the relationship between the part and the whole, whereby to understand any part you need to look at the whole, to understand the whole you need to look at the parts; thus demonstrating an iterative process.

The final area drawn upon from philosophy in IPA is that of idiography, which focuses on the 'particular', and is noted by Smith *et al.* (2009, p.29) as functioning at two levels:

- First, in the thoroughness, detail and depth of the analysis;
- Second, in the understanding of the event through the perspective of the individual and their context.

Interpretative Phenomenological Analysis' roots in idiography highlights the need to take a cautious approach to developing generalisation through in-depth analysis and understanding. It stresses the importance of a full understanding of each case, but also allows for the comparison of similarities and differences across cases; this enables recognition of shared themes and also individual distinct themes.

2.4.2. Rationale for the Use of Interpretative Phenomenological Analysis in the Current Study

The qualitative approach of IPA was selected as the main aim of the current study was to identify partners' personal experiences of PP, and the meaning that they attempt to make of their experiences (Reicher, 2000). Interpretative Phenomenological Analysis considers the cognitive and affective processes involved in an individual making sense of events, creating a person-centred approach to analysis and exploration. Interpretative Phenomenological Analysis also enables the extraction of themes to help develop a greater overarching understanding of partners' experiences of PP. Other qualitative approaches focus solely on

exploring narratives used by participants, or on considering common emotional constructs experienced by a group of participants, or on the development of an explanatory theory to try and capture a group of participants' experiences (Smith *et al.*, 2009). These alternative qualitative approaches were considered but excluded, as the aim of the analysis for the current research fitted best with an IPA approach; namely to explore the meaning that partners make of their lived experience, examining both individual themes (which may differ across partners) but also shared themes across partners. Moreover, IPA is suited to a more in-depth exploration of a few participants' experiences, rather than requiring a high number of participants from which to devise and saturate a proposed theory. In a review of IPA research published to date, the three most common uses of IPA were to explore experiences of illness, psychological distress, and the carers' perspective; with most areas of research being completed within health, clinical, and counselling psychology (Smith, 2011). In addition, studies which have considered partners' experiences of PND have adopted an IPA approach (Beestin *et al.*, 2014).

2.4.3. Researcher's Perspective

Open-mindedness is important throughout the IPA process, with researchers encouraged to reflect and be aware of their own personal interpretation and perspective on what is being studied (Lyons & Coyle, 2007). In the current study, the researcher's previous experience and understanding of PP and perinatal mental health problems is considered below. This includes personal information regarding the researcher's history and family context, as well as academic and work history experiences.

The researcher was a 31-year-old female who was approximately the same age as the majority of the participants in the study. She is from a white, middle class family and was

born in south Wales and continues to live there. She has frequently visited family in South Africa and has travelled to various locations throughout the United Kingdom (UK) and Europe. Most of the participants volunteering for this study lived within England and Wales, although one participant lived abroad in Australia.

The researcher is married and has been with her husband for ten years, and was pregnant with the couple's first child during the write-up of this research. She did not have any personal experience of PP, or any shared experience of what it is like for a couple during the postpartum period. However, within her extended family, there is a history of mental health problems following childbirth. This occurred many years ago, but talking with this family member about their experience has been a separate source of motivation in completing this research.

The researcher comes from a nuclear family and has one older sister. She has always been the youngest in her family and has little personal experience of the introduction of a new baby into the immediate family. Nevertheless, she has an awareness of the differing dynamics and relationships formed within a family, between a couple, between a parent and a child or children, and between siblings. More specifically, she has experience of how difficult events within a family's life can impact on family relationships and how the roles of family members may alter in order to adapt to and manage these difficulties.

The researcher is a third-year trainee clinical psychologist on the South Wales Doctoral Programme in Clinical Psychology. Prior to training, the researcher completed a PhD in developmental psychology, which focused on infant emotional development and emotion regulation, with some additional focus on maternal interactions. Some of the PP and PND

literature reviewed to date utilised parent-infant interactions to explore relationship changes. The researcher's PhD focused on a population sample of well mothers and infants and attempted to map developmental trajectories, rather than trying to establish any differences within participant sample groups as is explored within the PP and PND literature. Therefore, the researcher's experience is purely at a methodological level and an awareness of how maternal interactions could be assessed.

The research topic was selected due to the researcher's previous work exploring maternal experiences of PP and links to Bipolar Disorder (BD). This previous experience resulted in the researcher developing a great interest in PP, and also provided the opportunity to reflect and identify areas of research that needed further exploration within that field. Prior to the current study, the researcher's understanding of PP was limited to the mother's experiences and interpretation of events; therefore, the researcher was only able to extrapolate potential shared themes that partners may have experienced. One of the researcher's supervisors on this research project was a psychiatrist involved in a research project exploring PP in mothers, which the researcher worked on prior to clinical training. This supervisor's experience, and links with individuals working in the area of PP, helped direct the researcher in the recruitment process and enabled access to a relatively small sub-population.

2.4.4. Consideration of Quality in Interpretative Phenomenological Analysis with Reference to the Current Study

There is some debate as to how best to assess quality and validity in qualitative research, with some researchers questioning the relevance of using quantitative terminology, such as validity and reliability, within a qualitative context (Smith *et al.*, 2009). Two sets of criteria for assessing quality in qualitative research are those proposed by Elliott *et al.* (1999) and

Yardley (2000; 2008). There is some similarity in the two approaches in terms of the factors they identify as essential when assessing quality, but both have been considered with regard to the current study to try to ensure quality criteria have been adequately addressed.

2.4.4.1. Elliott et al.'s (1999) Assessment of Quality

Elliott *et al.* (1999) presented a set of seven guidelines to be considered when assessing qualitative research for publication, to try to ensure quality control, validity, and to further develop and legitimise qualitative approaches within psychological research.

2.4.4.1.1. Owning One's Perspective

Owning one's perspective involves the researcher clearly stating their own perspective, including both their theoretical and personal expectations, prior and during the research process. This could include describing their values, beliefs, and assumptions and how this may impact on understanding and interpreting any data collected. Within the current study, a statement of the researcher's own perspective has been clearly noted, from both their personal and academic perspectives.

2.4.4.1.2. Situating the Sample

In completing qualitative research, the importance of considering the context within which participants exist is stressed in order to best interpret the collected data. Within the current study, the researcher has attempted to provide information on the sample by summarising the demographic information of all participants, and their recruitment through the charity Action for Postpartum Psychosis (APP).

2.4.4.1.3. Grounding in Examples

All results should be evidenced with quotes from participants. Within the current study, the researcher has attempted to provide an even mix of quotes across participants to evidence all superordinate themes that are presented.

2.4.4.1.4. Providing Credibility Checks

Credibility may be achieved through: checking the researcher's understanding with others; using an analytic auditor to verify the analysis process; or by comparing different qualitative perspectives. Within the current study, the researcher approached a research psychologist working within APP who had extensive knowledge of PP, in order to discuss the analysis and superordinate themes. The research psychologist agreed with the analysis and themes that had emerged, and felt the superordinate themes listed had summarised the data well.

2.4.4.1.5. Coherence

Coherence relates to the analysis and presentation of data and how well the superordinate themes fit the data. Within this study, the researcher has presented a summary of the results depicting the stages of analysis, from emergent subordinate themes through to the final master superordinate theme structure, which attempts to best fit the data and provide a clear understanding of the data and experiences of partners.

2.4.4.1.6. Accomplishing General vs. Specific Research Tasks

The term general refers to an overall understanding of the experiences narrated by the partners, whereas specific allows for a more in-depth analysis of particular cases. Within the current study, the researcher has tried to present both a general and specific understanding of the research area. A general understanding of the partners' experiences, and their perceived

relationship changes, stemmed from data collected from the online questionnaire, whereas a specific understanding was developed through the analysis of the more in-depth, one-to-one interviews.

2.4.4.1.7. Resonating with Readers

The degree to which the reader of the research and results resonate with what is described is another source of quality assurance. Within the current study, the research is yet to be published to receive any reader feedback; however, results have been presented to APP, which included presenting the results to some staff members who had themselves experienced PP. All APP staff members who reviewed the results communicated that they felt the research analysis and findings were sensitive and seemed to encompass the experiences of partners.

2.4.4.2. Yardley's (2000) Assessment of Quality

According to Yardley (2000), there are four key criteria to consider when assessing quality in qualitative research.

2.4.4.2.1. Sensitivity to Context

Qualitative research should consider, and be sensitive towards, the context. This sensitivity should be achieved at multiple levels, from sensitivity to the existing literature to that of the data collected from participants. The use of IPA as a qualitative approach within the current study demonstrates a sensitivity to the participant group, by seeking the personal and individual lived experiences of each participant. The approach of IPA was particularly favoured by APP, through which recruitment occurred, as it was felt this approach would be sensitive to the voices of the partners and not solely focus on the researcher's agenda. The

topic of partners' experiences of PP is one which has required great care and sensitivity in its exploration with participants, with the researcher being very aware of the potential difficulties that partners may have faced, and with partners potentially having had very little opportunity to discuss or share these experiences with others. The researcher tried to ensure that participants felt at ease during the interview process, and participants were provided with contact numbers to access support after completion of the interview, if required; this included contact details for APP and the Samaritans.

Sensitivity has also been required from the researcher when considering what each participant has experienced and analysing the interview transcripts. Throughout the research process, it was very important to try and maintain the voices of the partners, with many verbatim quotes included within the write-up, through which themes have been extracted. Moreover, the researcher reviewed the PP literature and conducted a systematic review in a neighbouring specialty, PND, before completing the research, to try to be as sensitive as possible to the research context and difficulties that partners may report. Within the discussion of the research findings of this current study, the researcher will attempt to reflect back and relate these findings to existing research literature.

2.4.4.2.2. Commitment and Rigour

Commitment and rigour relate to the focus of the research and its completion, as well as the thoroughness of the researcher. By using IPA within the current study, the researcher has tried to be equally attentive to all participants and all interview transcripts, demonstrating the same approach to both interview and analysis. The researcher has attempted to use the same prompting across interviews, and held an awareness of cues given by participants as to whether to explore a topic further. The researcher found their clinical psychology training,

and the commitment, rigour and sensitivity that is required in a clinical interview, provided transferable skills that were useful when conducting these research interviews. For all eight interview transcripts analysed by the researcher, the same stepped procedure was adopted to ensure equal consideration and rigour (as outlined in sections 2.8.2.1.-2.8.2.8.).

2.4.4.2.3. Transparency and Coherence

Transparency refers to the clarity with which the data collection and analysis is written up, whilst coherence focuses on how well the data fits the themes that are identified by the researcher. To try and ensure transparency within the current IPA research, each stage of the research process has been written up as a step-by-step process, from how participants were selected to how analysis was completed. To achieve coherence, the data and themes have been reviewed and the fit of the themes to the data has been checked. The researcher has also sought the opinions of APP staff members regarding the fit of the data to the themes that have been extracted. Moreover, the fit of the findings to existing research within PP and PND literature is explored within the discussion, and an awareness of the inherent interpretative nature of IPA, and the personal position held by the researcher, has been considered within this chapter.

2.4.4.2.4. Impact and Importance

Impact and importance relate to the worth of the research, looking beyond how well the research has been conducted to the contribution that the research may make. The current research explores partners' experiences of PP, which to date has largely been ignored within research literature. This research aims to provide new and useful information regarding an awareness of the experiences of partners, which will hopefully result in better support and understanding within a clinical setting. This research also aims to provide a basis upon

which further research may be conducted into partners', and the couples', relationships in the context of PP, and how better support interventions could be developed and adopted to help partners when their spouse is experiencing PP.

2.4.4.3. Bracketing Interviews

Bracketing is another method by which validity can be ensured within qualitative research (Ahern, 1999). Bracketing interviews allows for a researcher to reflect upon and consider their own experiences and separate them from the data that is presented to them, in order to allow for more accurate analysis free from prejudice and assumption. Rolls and Relf (2006, p.286) describe the function of bracketing interviews to '…explore the impact of the researcher's personal and professional experiences during data collection and analysis'. Bracketing helps prevent the researcher from influencing the participant's own understanding of events. However, Crotty (1996) highlighted the limits placed on bracketing, primarily that it is impossible for someone to bracket something off unless they are aware of it being a belief, assumption, or value that they hold.

Chan *et al.* (2013) explored the use of bracketing interviews in qualitative research, proposing strategies when bracketing. One such strategy was that of keeping a reflexive diary to note any perceptions, emotions, or thoughts that are encountered throughout the research process. Chan *et al.* (2013) noted points to consider at each stage of bracketing:

- Does qualitative research suit the researcher and is bracketing possible for them?
- Is it possible to write an ethics research proposal without a complete literature review?

- Can flexibility be adopted and open-ended questions be asked within the semi-structured interview?
- Can the researcher's own preconceptions be suspended during data analysis?

Within the current study, the researcher attempted to address the points outlined by Chan *et al.* (2013). The researcher considered their own ability to bracket off any assumptions, preconceptions, beliefs, or knowledge that they held about PP, or partners' experiences of perinatal mental health problems, by presenting a researcher's perspective statement. The researcher kept a reflexive diary of their experiences at each stage of the research, and any personal or prior experiences that they felt were relevant to reflect upon and bracket during the research process. In terms of the research literature, there is no published existing literature looking at partners' experiences of PP, therefore, the researcher could not be influenced by prior findings in this specific field. Furthermore, the systematic review which considered partners experiences of another postnatal mental health problem, that of PND, was completed after the research ethics proposal had been written and after interview data had been collected. During data collection, the researcher utilised a semi-structured interview approach, ensuring that open-ended questions were asked, and allowing the participant to guide the direction of the interview based on their experiences. Finally, during data analysis, the researcher used their reflexive diary to note down any of their preconceptions or beliefs, to help remain focused on each individual participant's experience and understanding. The researcher was also aware in the initial stages of analysis to ensure that each interview was considered separately, so that each partner's unique experience and understanding could be considered without the influence of a comparison with a prior interview.

2.5. Ethical Considerations

2.5.1. Ethical Approval

A full ethical review of this current research project was conducted, with final ethical approval being provided by Cardiff University School of Psychology's Research Ethics Committee on 23 February 2015, and prior to any data collection. A copy of the ethics approval documentation is provided in Appendix C. As participants were not recruited through UK health departments or clinics, no additional National Health Service (NHS) ethical approval was required. The researcher also sought, and was provided with, permission to recruit for the research through APP, by meeting with the charity's director and other members of the APP leadership team.

2.5.2. Informed Consent

Due to the design of the study, informed consent was sought at multiple stages. Participants were provided with information sheets at each stage where consent was needed to ensure that consent provided was informed. First, information regarding the study and completion of the online questionnaire was provided, and informed consent was sought electronically prior to completion of the questionnaire. At the end of the online questionnaire, participants were provided with the option as to whether they wished to be contacted and were supplied with information about taking part in a more in-depth interview. Participants who opted for this additional contact were then provided with another information sheet regarding the interview stage of the research, and another consent form was required to be completed and returned prior to the interview being arranged. Participants were also given the opportunity to contact the researcher at any point throughout the research process should they have questions or concerns that they wished to be answered or addressed. Moreover, participants were

reminded that they could withdraw from the research project at any point until the stage that their interview was audio transcribed, at which point their data was anonymised and it would not be possible to identify their data to withdraw it from the study. Participant information sheets and consent forms can be viewed in Appendices D, E, G, and H.

2.5.3. Anonymity and Confidentiality

Data collected within the online questionnaire was anonymised at the point of analysis, whilst the interview data was anonymised at the point of audio transcription. Each participant was issued with a unique identifier code to reference their data contribution; for those that took part in both the questionnaire and interview, this identifier enabled their data to be linked should future analysis thus require. At no point after data collection was the data stored or analysed using the participant's name. Following audio transcription, the audio recordings were deleted and any identifiable information within the recording was altered; for example, if reference was made to the participant's name or any associated names or locations. If this was the case, the participant's name was replaced with 'participant (plus number)' as an identifier, and if their infant's or spouse's names were used within the recording, these were replaced with 'infant' or 'spouse'. Similarly, if a location was mentioned, this location was altered to a generic term, such as 'location A'. During the write-up, a pseudonym was given to each participant to avoid them being referenced as a number, to try and communicate a personal voice to the quotes provided within the results section whilst maintaining confidentiality and anonymity. All research information was only available for the researcher to view.

2.5.4. Participant Wellbeing

The main ethical consideration was that the majority of questions asked in the questionnaire and interview relate to an emotive time in participants' lives. Questions of this nature were unavoidable given the aims of the project, but care and sensitivity was taken throughout as to how questions were asked and phrased. In addition, staff members of the APP team who had experienced PP were consulted, to provide a different perspective on the research, and offer additional advice regarding how to limit the emotional impact on participants. It was also made clear to participants that they may leave the research at any point without giving a reason, and that they could opt not to complete or answer any question if they so chose. At the end of both the online questionnaire and the interview, the option and contact number for both APP and the Samaritans was provided in case partners required additional support, beyond that provided through discussion with the researcher. Within a clinical setting, the researcher is experienced in conducting clinical interviews with clients and discussing highly emotive topics, so these skills were transferred to the research setting to help develop rapport and an empathetic listening stance with participants. None of the participants who completed the research reported a need to seek any additional support following completion of their involvement with the research project.

2.5.5. Debriefing

Participants were made aware of the aims of the research project throughout so no formal debriefing session was provided. In addition, the participants were given contact information for the researcher and research supervisors, and were invited to ask any questions they may have regarding the research. Results from the research will be published on the APP website, and participants were informed that overall study results would be available through this means upon study completion.

2.5.6. Researcher Wellbeing

A risk assessment was completed to help identify any risk placed on the researcher in completing this research. Main areas of risk identified by the risk assessment were that of the researcher driving to and from interviews, and completing face-to-face home visits for participants who preferred this mode of interview. Strategies were outlined as to how to manage such potential risk, including establishing a lone worker policy and assigning an individual with the task of expecting the researcher to contact them immediately prior and post visits. Other risks associated with this task involved ensuring that the researcher's car was adequately filled with fuel and that breakdown cover was in place.

The content provided by the participants in the interviews can be highly emotive and distressing. However, the researcher had previous experience of working both in a clinical and research setting, discussing similarly difficult and emotive topics. Furthermore, the option of supervision with one of the supervisors on the research project was provided should the researcher feel they required such support.

2.6. Participants

2.6.1. Sample

Typically, much smaller sample sizes are required when completing qualitative compared with quantitative research. The focus within qualitative research is to consider the quality and depth of information provided through reported lived experiences, rather than establishing and reporting an effect or result of a group. Within IPA, a sample size of between 4-10 participants is deemed sufficient, although the focus within IPA is on the quality and depth of the analysis and not the quantity of participants (Smith *et al.*, 2009). The

primary focus with IPA is on the detailed lived experience of each individual participant, and then on any similarities or differences across participant experiences. Interpretative Phenomenological Analysis has been completed in the current study on a sample of eight partners whose spouses have experienced PP.

2.6.2. Inclusion and Exclusion Criteria

Inclusion criteria were set for participants to be over 18-years-old, and for the partners of the women who had experienced PP to have been in a relationship with the mother at the time of birth and during the postnatal period. Inclusion criteria also stipulated that the episode of PP had to have occurred less then 10 years ago (for accurate recollection purposes), and more than 6 months ago (to try and limit any distress caused through discussion of the episode). Similar timespans have been deemed appropriate in other qualitative retrospective research (Doucet *et al.,* 2012). It was also agreed that partners would be excluded from taking part if their spouse was currently experiencing PP. In addition, if the mother or infant had died during, or since, the episode of PP, the partner would not be interviewed due to ethical implications; however, no such participants presented. A further exclusion was if the spouse had been diagnosed with another mental health problem other than PP. The initial online questionnaire that partners completed acted in part as a screen to identify any exclusions, and to ensure that inclusion criteria were met.

2.6.3. Participant Recruitment

Participants were recruited through the UK based charity APP. The clinical supervisor on this project, Professor Ian Jones, was also the Chair of this charity at the time of the research being proposed. Permission to recruit through APP was obtained from the charity's director

and leadership team. As an organisation, APP consists of psychiatrists, research psychologists, administration staff, trustees, and some individuals who have themselves experienced PP. There are over 700 members of APP, including women who have experienced PP, their partners, and healthcare professionals with an interest in APP. The charity provides membership to people within the UK but also worldwide. Through APP, an advertisement for the current research was posted on the internet (see Appendix D). A brief description of the study and call for participants was placed on the APP forum website, Facebook page, and Twitter feed, and included a link to more information regarding the study, and to an online questionnaire for partners to complete regarding their experiences of PP.

2.6.4. Response Rate

Due to the low occurrence rates of PP, a small sample size was anticipated. Recruitment occurred between 27 February 2015 and 2 July 2015. Participants were welcomed to participate in the research until December 2015, but no further participants volunteered after July 2015. A total of 19 individuals completed the questionnaire, but only 15 were included after considering inclusion and exclusion criteria. A total of four exclusions were made based on: a participant being the spouse who had completed the questionnaire rather than the partner; the episode of PP occurring more than 10-years-ago; the partner having a spouse who was diagnosed with adjustment disorder rather than PP; and the partner not accurately completing the consent form and not providing any contact details.

All partners who completed the online questionnaire were provided with the option of agreeing to further contact for an in-depth interview about their experiences. A total of nine partners agreed to be contacted for interview, of which eight completed the interview. One

participant, despite frequent attempts by the researcher, was unable to arrange a convenient time for the interview to be completed due to commitments.

2.6.5. Participant Demographics

Of the sample that completed the initial questionnaire, all partners were male (N=15). The most common age bracket for partners was between 30- to 34-years-old (n=6), although the participant's age range varied from 25- to 50-years-old plus. Most partners classed themselves as married (n=11), and all noted they were still with their spouse at completion of the questionnaire. The partners' highest level of educational attainment varied, although the majority of partners had a master's degree qualification (n=8), with only one participant noting no qualifications. The majority of partners were in full-time work (n=11), although two partners reported they were part-time workers and two were currently unemployed. Demographic and contextual information relating specifically to the partners who went on to complete the semi-structured interview is displayed in Table 2.

Table 2. Interview Participant Information

Pseudonym	Age Range (Years)	Educational Level	Employment Status	Number of Episodes of PP	Onset of PP Post Childbirth	Duration of PP Episode	Time Since Episode of PP	Hospital Admission of Spouse	Marital Status	Duration of Couple Relationship Prior to PP Episode
Henry	45-49	Masters	FT Worker	1	2 Days	1-3 Months	3 Years, 8 Months	General Psychiatric Unit	Cohabiting	4 Years
John	30-34	No Qualifications	FT Worker	2	1 Week	4-6 Months	4 Years, 8 Months	None	Married	11 Years
Ben	45-49	A Levels	FT Worker	1	3 Weeks	1 Year +	9 Years	MBU	Married	14 Years
James	30-34	Undergraduate Degree	FT Worker	1	3 Days	1-3 Months	2 Years	General Psychiatric Unit	Married	12 Years
Mark	30-34	Undergraduate Degree	FT Worker	1	2 Weeks	1-3 Months	9 months	MBU	Married	12 Years
David	30-34	Undergraduate Degree	FT Worker	1	6 Days	< 7 Days	10 Months	MBU	Married	5 Years
Stuart	35-39	Masters	FT Worker	1	0 Days	7-12 Months	7 Years	None	Married	4 Years
Peter	40-44	Masters	FT Worker	2	3 Days	1-3 Months	8 Years, 10 months	None	Married	2 Years, 4 Months

2.7. Data collection

2.7.1. Online Questionnaire Data

Online data collection occurred between 27 February 2015 and 2 July 2015. Partners completed the questionnaire in their own time. The questionnaire was set up through Qualtrics and all questionnaire data collected was stored securely on Qualtrics software, accessed through Cardiff University's secure site. The study was password protected, with only the researcher and the academic supervisor being able to view data. Consent for completing the online questionnaire was stored securely and electronically through this software. Questions included within the online questionnaire were designed to gather demographic information, to identify whether partners met inclusion or exclusion criteria, and to develop a basic understanding of the episode of PP experienced by a partner, and the impact a partner felt this has had on their relationship with their spouse. Questions included in the online questionnaire can be viewed in Appendix F.

2.7.2. Semi-Structured Interview

Interviews were completed between 17 April 2015 and 23 June 2015. Any participants who volunteered and completed the questionnaire after 23 June 2015, either opted not to complete the interview stage of the research or noted that, although interested in taking part in the interview, they were too busy to take part at present. The partners who were interviewed were either interviewed in their homes, via Skype or Facetime, or via the telephone. All interviews were audio recorded, with participants' consent forms, and data associated with the interviews, being stored using anonymised identifiers. Audio recordings of completed interviews were destroyed once transcription was completed and all potential identifiers removed. A semi-structured interview design was adopted, with questions designed to source

open and expansive answers around partners' experiences of PP. The question schedule can be viewed in Appendix I and was used to guide the researcher in their asking of questions, although the interview was flexible in structure and was lead by the participant and the telling of their experiences (Smith *et al.*, 2009).

2.7.3. Development of the Interview

The questions covered within the interview schedule were based on the researcher's interests and ideas for exploration, along with an awareness of previous literature within the areas of mothers' experiences of PP and partners' experiences of PND. During the question development process, consultation was also sought from the researcher's academic and clinical supervisors and the recruiting charity APP. The researcher greatly valued the consultation with APP members in the development of the interview schedule. Action for Postpartum Psychosis members provided unique insight due to: their experience of working with individuals with PP; their awareness of research into PP; the fact that some of the charity workers could reflect on their own personal experiences of PP and assist with the wording of questions or identify if important questions were missing. Some questions that were added after consultation related to enquiring if partners felt that the way they communicated with their spouse had altered, and whether they felt their sexual relationship with their spouse had changed, during and since the episode of PP.

2.7.4. Interview procedure

Participants were provided with the option as to whether they wished their interview to be conducted face-to-face, via Skype or Facetime, or via the telephone. Only one of the eight partners interviewed opted for a face-to-face interview, with most noting that it was easier,

and felt more private, for them to complete an interview via a video link or on the telephone. Participants were given the option as to the best time for them to complete the interview. Participants mainly chose to be interviewed in the early evening, with participants opting to stay later in work to have some privacy from their family when completing the interview, or to be interviewed late in the evening once their family duties had ended. Throughout the interview, participants were provided with an opportunity to ask questions. Participants were also reminded that they were free to withdraw from the interview, or opt not to answer a question, at any point. The interview only commenced after participants had read the information sheet and completed an interview consent form, stipulating the nature of the study and ways in which confidentiality and anonymity were met within the study. Each interview was recorded, using an audio digital recorder and transcribed and analysed by the researcher. The interview length varied from 30 minutes to 80 minutes, with the mean length of interview lasting 43 minutes.

At the start of each interview, the participant was invited to describe their experience of PP. This part of the interview varied the most in duration, with some participants providing very in-depth accounts of their experiences and their interpretation of what had happened, and others providing very brief synopses. The interview schedule covered topics relating to partner relationships with their spouse and infant, changing roles, decision regarding future pregnancies, and coping and support. At the end of the interview, participants were invited to ask any questions regarding the research, thanked for their involvement in the project, and informed that results from the completed research would be made available through APP.

2.8. Data Analysis

2.8.1. Online Questionnaire Data

Each set of participant demographic data gathered from the questionnaires was assessed to look at the spread, range, and averages. Data relating to the PP episode was summarised, such as start date of episode, episode length, expectation of PP, time since episode ended, support offered or sought, and admission status. In addition, partner ratings of the quality of their relationship prior, during, and post the PP episode was considered, and a graph depicting each participant's ratings across the three time points was developed.

2.8.2. Semi-Structured Interview Data

Utilising the guiding chapters provided by Smith *et al.* (2009), the researcher followed a step-by-step procedure for completing IPA on the line numbered interview transcripts. Respecting the ethos of IPA, analysis of the interview data focused primarily on developing an understanding of the meaning that each participant made of their experience of PP. Due to the subjective nature of interpretation, the researcher held an awareness of the different hermeneutic levels involved which are depicted in Figure 7.

Figure 7. The Hermeneutic Levels of Meaning Making

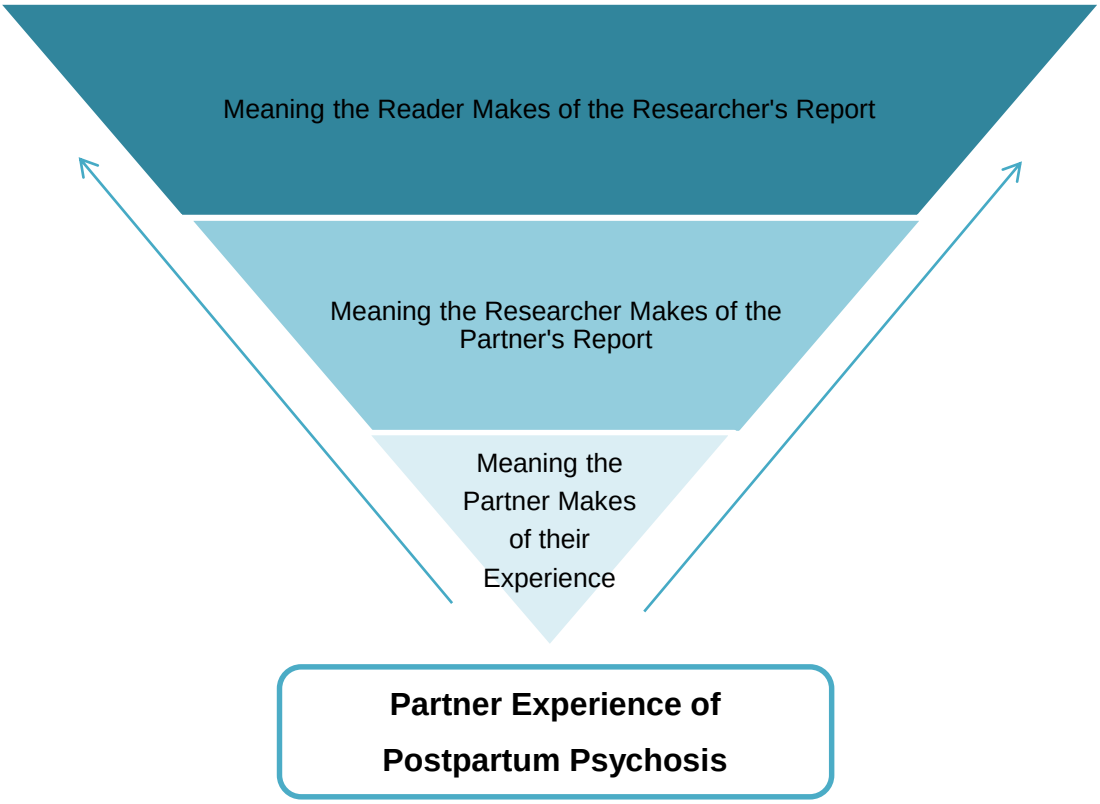


Figure 7. The hermeneutic levels involved in developing an understanding of postpartum psychosis.

The process of completing IPA involves a repeated cycle of analysis, focusing initially on the individual participant transcript and then consideration of all participant transcripts. The researcher followed a stepped analytic process.

2.8.2.1 Step 1: Reading

The researcher started the analytic process by reading and re-reading the first interview transcript. The researcher focused on the meaning and understanding that the participant was trying to convey about their experiences of PP. During this process, if any personal thoughts, or the researcher's own understanding, was triggered, the researcher noted and bracketed these within a separate notebook so that the researcher could concentrate on the participant's own interpretation.

2.8.2.2. Step 2: Initial Notation

The researcher progressed to making comments in the left margin of the transcript regarding the semantic or descriptive content (such as the content raised by participants, the use of key words or phrases, and the participant's emotional response); the language used by the participant (such as use of pronouns, repetition, metaphors); and the conceptual content (such as how points are raised or questioned). Analysis strategies that the researcher adopted involved underling key points, and reading sentences backwards to help highlight key words.

2.8.2.3. Step 3: Development of Emergent Subordinate Themes

The researcher focused on the initial comments that they made in the transcript, from which they attempted to develop and note emergent subordinate themes in the right margin of the transcript. Identifying emergent subordinate themes involved highlighting and summarising what was important about the comments that had been made. An example of an annotated transcript can be viewed in Appendix J.

2.8.2.4. Step 4: Connections Across Emergent Subordinate Themes

A summary of the chronology of the emergent subordinate themes was made by the researcher. Following this, a theme map was developed to try and identify the frequency with which themes were raised, and to provide a structure in which to present emergent subordinate themes. From this the researcher tried to identify clusters of similar themes, with clusters of the emergent subordinate themes named to identify superordinate themes. The researcher used qualitative analysis strategies to develop these superordinate themes, including: abstraction, subsumption, contextualisation, and numeration. A table was created

to summarise the subordinate and superordinate themes identified for the participant. Moreover, quotes demonstrating each theme were collected within a Word document.

2.8.2.5. Step 5: Moving to the Next Transcript

The researcher repeated steps 1 to 4 for each of the remaining transcripts. Each participant's transcript was considered separately, with the researcher ensuring that notes were made to bracket off any assumptions or thoughts relating to previous participants' experiences and descriptions. This process was to try and ensure that each participant's experience was considered and valued in its own right.

2.8.2.6. Step 6: Looking Across Transcripts

The researcher printed out the charts for each participant, depicting their subordinate and superordinate themes. This enabled the researcher to consider if there were any similarities or differences in themes communicated by participants. Some themes were merged to form a different and more inclusive superordinate category, whilst for others, notes were taken as to how a similar theme may have been expressed differently by different participants. The researcher formed a summary table depicting a list of master superordinate themes, and whether the theme had been expressed by each participant (see Table 7). The master superordinate theme structure can be viewed in Figure 11.

2.8.2.7. Step 7: Testing Coherence and Plausibility of Theme Structure

The researcher arranged separate meetings with their research supervisor, clinical supervisor, and the charity APP, to discuss the identified superordinate themes. The researcher presented

their interpretation of a theme structure, and the supervisors and APP were invited to question and challenge the themes presented in terms of their understandability and cohesiveness.

2.8.2.8. Step 8: Developing a Narrative of Results and a Personal Reflection

Within the results chapter, the researcher goes on to provide a narrative summarising the results of their IPA analysis, including quotes from which themes were identified. Moreover, the researcher notes a personal reflection on the results obtained from the current study.

Chapter Three: Results

3.1. Questionnaire Results

The online questionnaire had three functions. Firstly, to ascertain the demographics of partners, and identify whether the partners and the episodes of Postpartum Psychosis (PP) met the inclusion, or exclusion, criteria of the study. The demographics, and any exclusions, were reported within the methodology chapter. Secondly, the questionnaire captured a basic understanding of the PP episode experienced by each partner, what support was offered to the individual and to the couple, and asked partners to rate the impact that PP had on the couple relationship. Thirdly, it provided an opportunity for partners to consent to further contact in relation to the interview. A total of 15 questionnaires were completed, with 8 partners going on to complete the more in-depth interview.

3.1.1. Onset and Duration of Postpartum Psychosis Episode

The majority of partners who completed the online questionnaire (80%) reported that their spouse's episode of PP started within the first week after childbirth, and all spouses' PP episodes had started by the end of the third week (see Table 3). Rates of onset decreased after the first week of childbirth, with only one partner noting an onset in the second week and two partners reporting an onset in the third week post-childbirth.

Table 3. Onset of Postpartum Psychosis Episodes, as Reported by Partners

Onset After Childbirth	<1 Week	2nd Week	3rd Week
PP Episodes	80% (n=12)	6.67% (n=1)	13.33% (n=2)

The duration of each episode of PP varied considerably across partners' reports (see Table 4). Most partners (40%) stated that the episode of PP lasted between 1 to 3 months; however, the range of PP episode duration varied from less than 7 days to over 1 year.

Table 4. Duration of Postpartum Psychosis Episodes, as Reported by Partners

Length of PP Episode	< 7 Days	1-4 Weeks	1-3 Months	4-6 Months	7-12 Months	> 1 Year
PP Episodes	6.67% (n=1)	20% (n=3)	40% (n=6)	13.33% (n=2)	6.67% (n=1)	13.33% (n=2)

Partners reported in the online questionnaire whether their spouse had been admitted to hospital due to the PP episode (see Table 5). The majority of spouses required a hospital admission (66.67%), although the type of admission was evenly split between a general psychiatric ward, or a specialised perinatal mental health ward or a Mother and Baby Unit (MBU).

Table 5. Frequency and Type of Hospital Admission for Spouse, as Reported by Partners

Admission Required for PP	None	General Psychiatric Ward	MBU or Perinatal Psychiatric Ward
PP Episodes	33.33% (n=5)	33.33% (n=5)	33.33% (n=5)

3.1.2. Support Offered During Postpartum Psychosis Episodes

Results obtained from the questionnaire clearly demonstrate that it was rare for partners to be offered any individual form of support during their spouse's episode of PP (see Figure 8). Only four of the fifteen partners noted that support was offered to them, and this support only took the form of information on general caring for their infant or on explaining PP. No support was provided regarding partners' own needs or mental health. All partners reported

that individual support was offered to their spouse, with two partners commenting that additional support was provided either by Home Start or by a private healthcare provider. However, most support provided to the spouse related to their mental health, and involved: ongoing psychiatric reviews, Community Mental Health Team (CMHT) engagement, and talking therapies. As a couple, most support was given either by health visitors or by the perinatal mental health team at the MBU, and the support provided predominately related to information regarding how to care for their infant. Partners' needs were not considered, as the support offered to the couple typically involved the partner co-attending psychiatric reviews and helping implement changes suggested by ongoing community support.

The only individual support given to partners was provided by a social worker and only occurred in one instance; no other healthcare providers were identified by partners as having offered, or provided, them with support (see Figure 9). In contrast, there was considerable variability in who provided individual support to the spouses, although partners stated that most individual support to spouses was by Community Psychiatric Nurses (CPNs) and the CMHT.

Figure 8. Support Offered During Episode of Postpartum Psychosis, as Reported by Partners

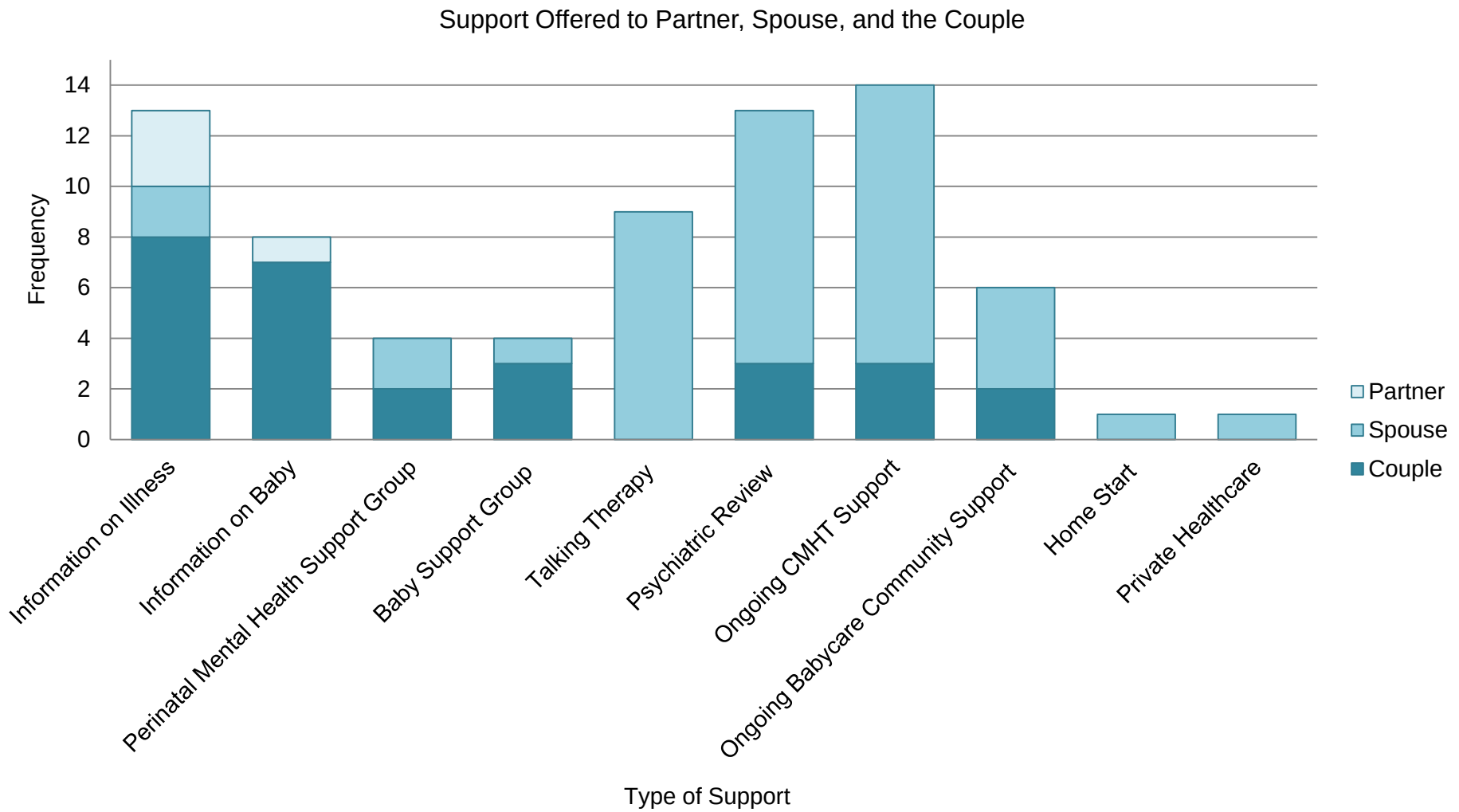
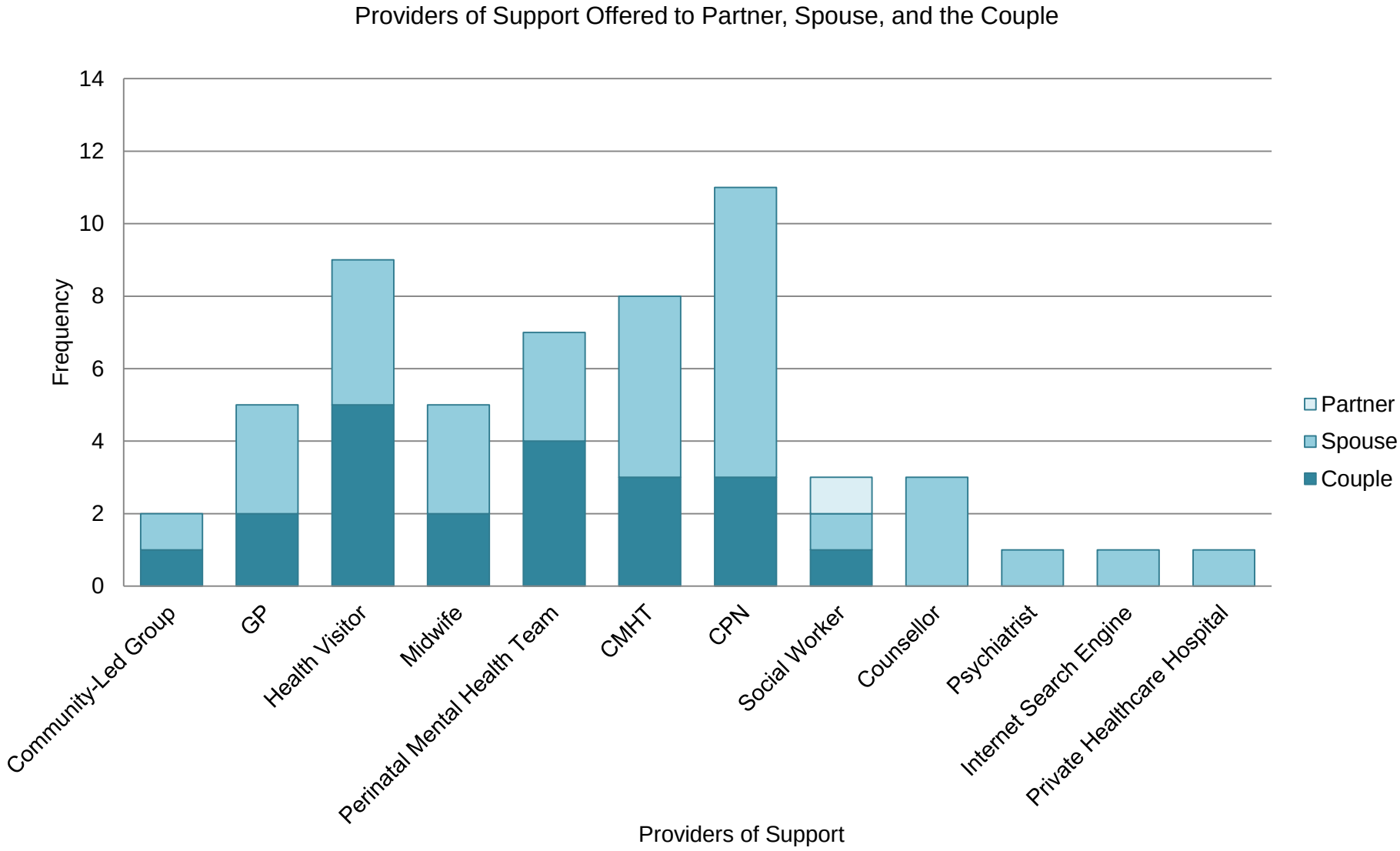


Figure 9. Providers of Support Offered During Episode of Postpartum Psychosis, as Reported by Partners



3.1.3. Partners' Reports of the Impact of Postpartum Psychosis on the Quality of the Couple Relationship

Partners retrospectively rated the quality of their relationship with their spouse prior, during, and post the PP episode. A line chart depicting the ratings given by partners is presented in Figure 10. An Analysis of Variance (ANOVA) was considered to identify if there was a collective impact of PP on the couple relationship; instead, a line chart was chosen to best represent this information and enable the clear presentation of the differences across partners, which would have been lost had an ANOVA been completed. To further preserve the individual patterns regarding the impact of PP on partners' perception of their couple relationship, the occurrence of different patterns of change is depicted in Table 6. The majority of partners noted that the quality of their relationship deteriorated, when comparing ratings for the period prior to the episode of PP to those during the episode; although one partner noted the quality of their relationship improved. The majority of partners stated that their relationship quality improved, when comparing ratings from during the episode of PP to after the episode, although some noted further deterioration. Overall, 40% of partners commented that their relationship had deteriorated in quality as a result of the episode of PP, and did not return to its pre-episode level even after the episode had passed. Two partners noted that their relationship quality improved as a result of having experienced an episode of PP (13.33%), whilst most reported that it returned to pre-episode levels (46.67%).

Figure 10. Impact of Postpartum Psychosis on the Perceived Quality of the Couple Relationship

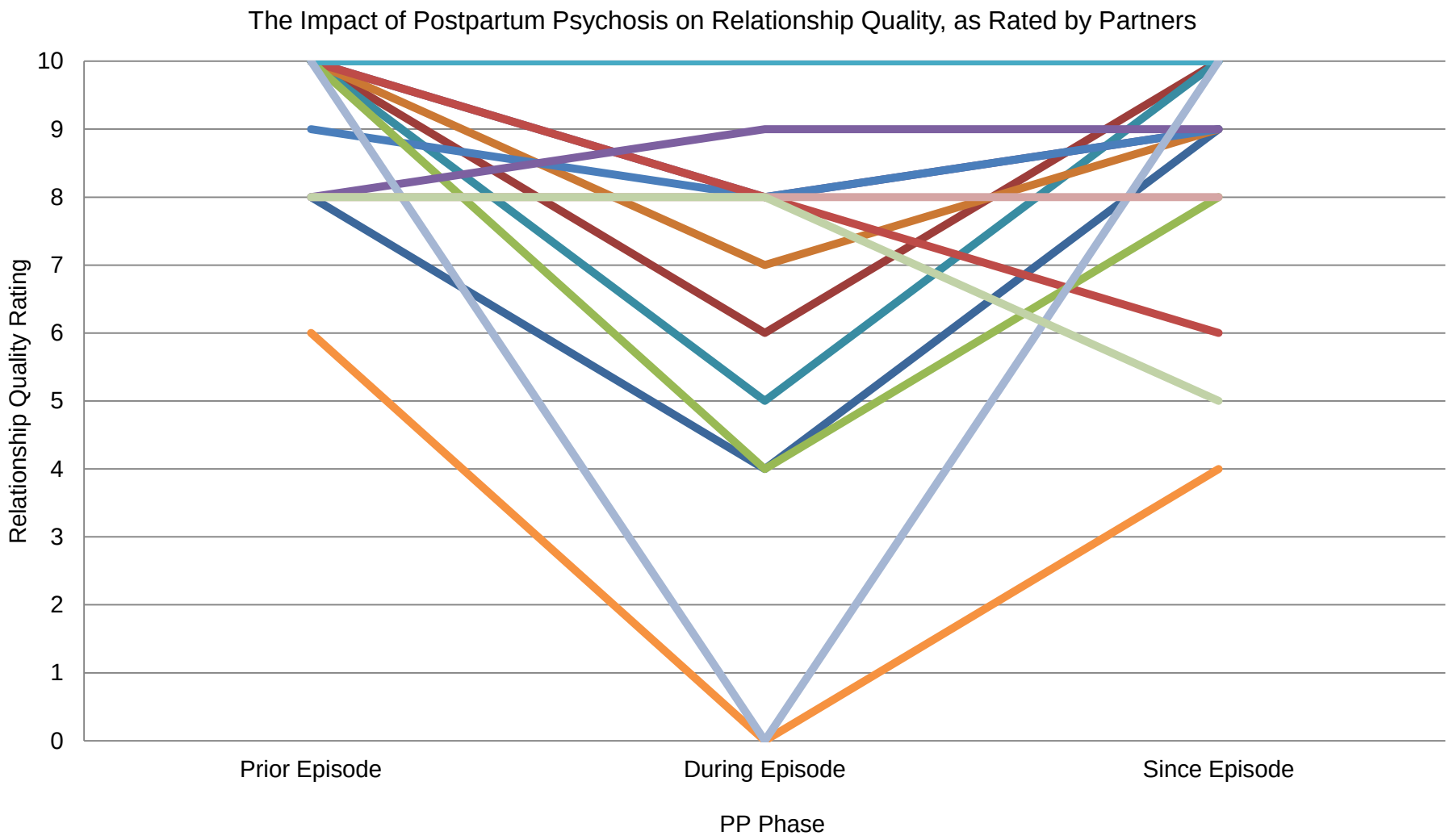


Table 6. Relationship Quality Changes Prior, During, and Post Episode of Postpartum Psychosis, as Reported by Partners

Relationship Rating	Prior-During Episode	During-Post Episode	Prior-Post Episode
Deteriorated	66.67% (n=10)	13.33% (n=2)	40% (n=6)
Same	26.67% (n=4)	26.67% (n=4)	46.67% (n=7)
Improved	6.67% (n=1)	60% (n=9)	13.33% (n=2)

3.2. Interview Results

Utilising Interpretative Phenomenological Analysis (IPA), seven superordinate themes were identified from the eight participant transcripts (see Figure 11 for Theme Structure). Each superordinate theme, and their subordinate themes, are discussed along with some of the quotes through which the themes were identified. Both shared and unique themes are commented upon and the prevalence of themes across participants are noted in Table 7. To clarify the context of quotes, or for establishing anonymity, some words have been added within brackets '[ ]'. To aid readability of the text and exclude any hovering utterances, such as 'hmmm', the use of an ellipsis '…' has been adopted. Participants have been assigned pseudonyms.

Figure 10. Theme Structure

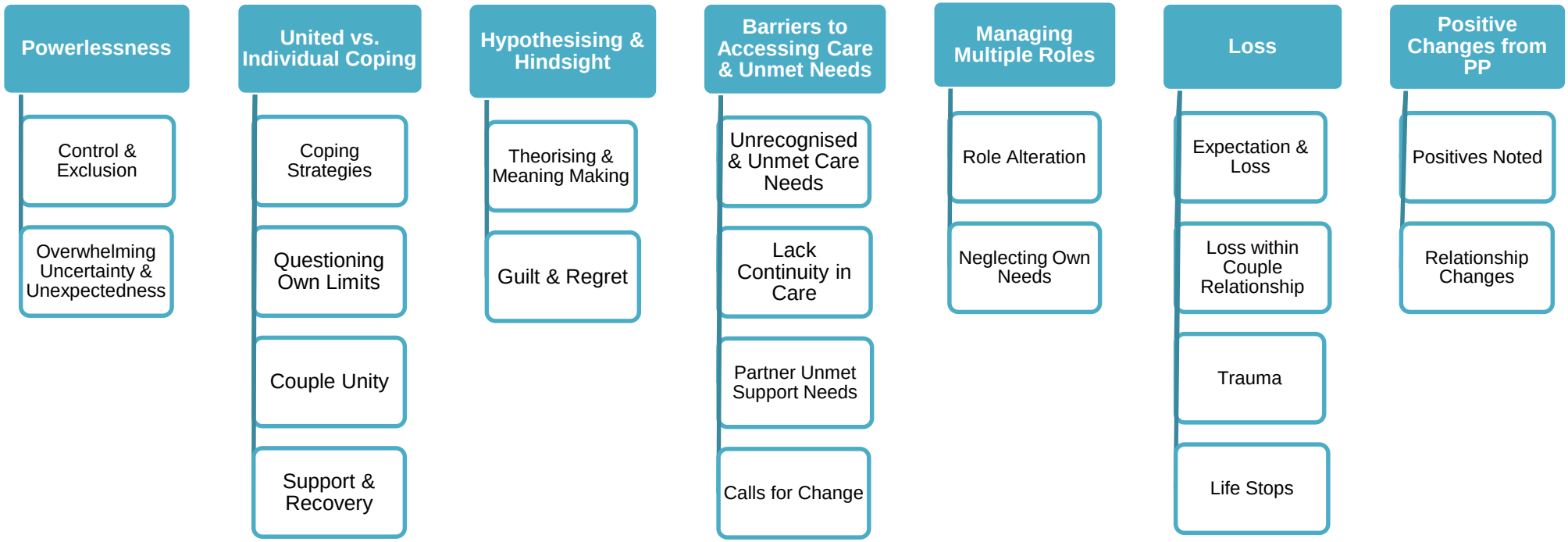


Table 7. Theme Prevalence

Superordinate Theme	Henry	John	Ben	James	Mark	David	Stuart	Peter	No.
Powerlessness	Y	Y	Y	Y	Y	Y	Y	Y	8/8
United vs. Individual Coping	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Hypothesising & Hindsight	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Barriers to Accessing Care & Unmet Needs	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Managing Multiple Roles	Y	Y	Y	Y	Y	Y	Y	Y	8/8
Loss	Y	Y	Y	Y	Y	Y	N	Y	7/8
Positive Changes from PP	N	Y	Y	Y	Y	Y	Y	Y	7/8

Table Key:

Y = Theme present

N = Theme absent

No. = Total number of partners for which theme is present

3.2.1. Superordinate Theme 1: Powerlessness

3.2.1.1. Control and Exclusion

A subordinate theme within the superordinate category of powerlessness is that of control. The theme of control focuses around the loss of control of the situation felt by the partner, for both themselves and their spouse, but also the regaining of control as a sign of recovery. For some, the loss of control started during the birthing process, and was subsequently exacerbated as their spouse became unwell with PP. There was a sense of escalation of the PP episode, with partners not knowing what was wrong, or how to help their spouse, or whether their spouse would get better. A quote from Henry, and his use of the word 'just', denotes the sense of futility and powerlessness felt by partners in how they may be of help to their spouse.

> *But I had no control on the situation, no input into it. I was just holding the sick bowl.* (Henry, p.4, line 105)

Some partners commented that they felt that the loss of control was an initial trigger for their spouse to become unwell. Conversely, some partners reported that a sign of recovery was when their spouse would gradually start to regain control and a greater equality in control would emerge within the couple.

> *She got to the extent when that was too much for her and I'd take control… taking over stuff like that…I had to start giving her the bits back to do.* (James, p.3, line 84)

All partners noted the frustration and powerlessness of feeling excluded, either by their spouse or by healthcare professionals, which made them feel even more out of control of the situation.

> *…as a partner, I wasn't allowed to know what was happening…* (Henry, p.3, line 89)

The phrase 'I wasn't allowed' in the above quote indicates that partners perceived that others dictated their involvement, with any control derived from being able to set their own boundaries as to their level of participation and role removed.

3.2.1.2. Overwhelming Uncertainty and Unexpectedness

Partners noted a sense of uncertainty, typically around the PP experience, with them simply not knowing what was wrong or what was PP. This feeling of uncertainty was often reported to apply to the extended family, and even at times to healthcare professionals who were unable to identify PP.

> *I didn't quite know what was going to happen next really.* (Ben, p.3, line 97)

> *I think even with my mum and dad, because we just didn't know what was going on. We didn't know how to treat it.* (Ben, p.8, line 244)

> *[healthcare professionals]…were starting to raise concerns to me, "Is this how she normally is?".* (Henry, p.1, line 25)

Many partners noted feeling on edge, and being overwhelmed by the situation and not knowing what to do. Words used by partners to describe the events during the episode of PP typically involved descriptors such as 'big thing' or 'huge', highlighting the perceived gravity and enormity of their experiences. Ben noted a relentless struggle to try and cope and support his spouse.

> *I don't think I could have coped much longer… I honestly don't think I could have survived much longer [without MBU]*. (Ben, p.8, line 240)

Most partners described the unexpected and sudden onset of PP, with their spouse having had positive pregnancy experiences up until that point. Moreover, the language used by partners stressed the severity and swift escalation of PP.

> *…very rapidly. I mean, thinking back at it, it happened within an hour, or hour and half, of [son] being born.* (Stuart, p.1, line 28)

> *So, it was all a bit… exploding all of a sudden.* (John, p.1, line 30)

A sense of powerlessness also emerged, with unambiguous emotional descriptors being used by partners to elucidate their feelings about what might happen next.

> *And that quite scared her and scared me too.* (John, p.2, line 51)

> *Well it was pretty terrifying really.* (David, p.4, line 116)

3.2.2. Superordinate Theme 2: United vs. Individual Coping

3.2.2.1. Coping Strategies

Partners listed the variety of methods they used to try and cope during the episode of PP; these were varied within, and across, partners and included the following strategies:

- Focusing on practicalities, such as care routines for their infant;
- Using strategies they were already familiar with, for example, utilising business terminology to manage stress;
- Using dry humour;
- Learning to talk about their emotions;
- Speaking as a couple;
- Seeking normality;
- Needing their own space, so taking the dog for a walk;
- Venting to friends;
- Taking one day at a time;
- Seeking out other people who had experienced PP;
- Seeking information, for example, using internet search engines to try and find out about PP;
- Blaming, for example, that the spouse's birth plan choices resulted in the episode.

> *…I would walk the dog and avoid the house, and call some of my best mates and just have a beer with them… relaxing away from home.* (John, p.3, line 95)

I was trying to get sleep. I would go to…our next door neighbours at the time, they were away on holiday and I used their sofa I think one night just to be out the house. But it didn't work, you know you just lie there thinking everything is going on. You really don't think about anything else. (Ben, p.8, line 247)

…I think my only coping mechanism was that I thought about everything by the day. (Ben, p.7, line 224)

I did try and go back to work. I tried to work some mornings. Trying to get a bit of reality. Trying to get normality. But that was really tough. (Mark, p.3, line 94)

I'm now a specialist in postpartum psychosis medication involved, because I am one of those people who will research in terms of [internet search engine] and APP networks and what not. I guess that had been my idea of finding out what is actually going on. (Mark, p.9, line 272)

The word 'specialist' used in the above quote demonstrated the need to self-educate about the nature and development of PP, in order for partners to better cope and understand the experience. Furthermore, it implied a lack of communication and information from healthcare professionals, which motivated partners to commence a process of information seeking and assimilation, in order to generate answers to partners' outstanding queries regarding PP.

3.2.2.2. Questioning Own Limits

Partners questioned their own limits as to what they felt they could cope with and the impact that a possible long-term prognosis had on their perceived coping limits.

> *I didn't have the resources in me to cope, to help both [spouse] and [son].* (Henry, p.4, line 110)

> *I work well under stress, I like it. But just when it gets to a certain level, I think look I can only do what I can do.* (Ben, p.19, line 617)

> *The thought of being a father was going to be tough and then you have that on top of it. Your world comes crashing down all around you. Looking back now you kind of think I don't know how I got through that.* (Mark, p.3, line 77)

The use of the phase 'your world comes crashing down all around you' further explicates the all-encompassing scale and impact that PP had on their lives and perspectives.

3.2.2.3. Couple Unity

Some partners communicated a sense of unity in coping during the episode of PP, and used the term 'we', rather than 'I', in descriptions of how they coped. However, this sense of unity seemed to shift depending on the stage of PP and on the individual partner, with some partners referring to their own, rather than the couple, experience.

…we thought something was wrong but we didn't know what. (John, p.1, line 17)

[To spouse] "Look, you have to snap out of things, and if you don't I'm out of here because I can't cope with this". (Henry, p.2, line 35)

In order to cope, partners reported that they and their spouse had to compromise on some of their values. For example, both John and Ben noted that the decision not to breastfeed was made by them and their respective spouse to enable their spouse to receive medication, despite as a couple having held strong beliefs that they wanted their infant to be breastfed.

My wife is very much anti-medication. I mean she will have medication but she doesn't like medication, so she was like look let's see what happens…It was like two days after and she said, "Look I need to be on medication". (John, p.2, line 41)

She had to stop breastfeeding which she didn't want to do… (Ben, p.3, line 93)

3.2.2.4. Support and Recovery

Predominately, partners reported the invaluable support provided by their own, or their spouse's, parents during the PP episode. The support provided to partners from other family members was considered indispensible in order to help them cope during the episode of PP.

The lack of a substantial support network during this time was indeed 'impossible' for partners to comprehend.

> *We were really lucky with our immediate family being so supportive…. I mean it would have just been impossible really to manage at the time.* (David, p.8, line 249)

> *I think it was at our last meeting at our house that my dad sat down with me and the psychiatrist and said, "This has got to stop, you've got to do something".* (Ben, p.5, line 162)

Other sources of support were identified, included work, friends, and anonymous support provided through online forums, which at times were noted as the easiest format in which to discuss their difficulties.

> *My work were amazing. They would give me as much time as I needed. There's no pressure to go back or anything.* (Mark, p.3, line 96)

> *The anonymity is a huge support [online forum].* (John, p.7, line 225)

Family and friends often helped by providing support, but some lacked an understanding of PP, which resulted in difficulties whereby the partner would have to filter contact with those people to limit the upset caused to their spouse.

…they still don't understand it even though her mum, who was there at the time, doesn't quite understand it…what postpartum psychosis is, what it entailed for [spouse]. Her sister was kind of "snap out of it, stop being silly, just go to sleep", and she didn't understand her…. It's just that they are not willing to try and understand it either… (James, p.6, line 203)

Beneficial support provided by healthcare professionals was limited, and partners remarked that on only one occasion was it provided to them as a couple. When support occurred, it was informally given, with the partner noting the importance of rapport and that he could approach a particular healthcare professional if needed. In general, partners were not offered any support nor any enquiry made as to their own needs or feelings.

…I needed that [healthcare] professional to go that it will subside and it will go away and it will get back to a normal life. (Mark, p.8, line 260)

Although family support was highly praised by partners, partners also described the difficulties in establishing boundaries when receiving support, and the potential for over-involvement of family members. This was further compounded by the fact that some spouses were less inhibited during their episode of PP, and thus disagreements emerged between the spouse and extended family members that the partner had to then try and resolve.

I think it strained… because the in-laws came and lived over at the house for a bit and helped out quite a bit. Which was good but hard to tell them to back off. (John, p.6, line 188)

At the time, I was a bit more standing my ground saying, "Guys… back off a bit. Thank you very much for your support but…", which was an extremely hard thing to say. (John, p.6, line 192)

Henry commented that the limited support provided by healthcare professionals was not clarified or useful, and it felt as though his competence as a father was being questioned.

Even when [spouse] came out [of MBU], we got some more social workers who would come as a pair… and even then I never really understood what that was about… what benefit it was to anyone… (Henry, p.5, line 138)

I didn't know what sort of support I needed. In fact I would say they didn't help… I was completely lost as to what a social worker does and what benefit it was to me. (Henry, p.5, line 129)

Moreover, David stated that he struggled to believe in any reassurance provided by health professionals that things would improve. This partly stemmed from healthcare professionals not accurately identifying what was wrong with his spouse, and thus providing reassurance that his spouse would be fine after a rest; it was then difficult to believe subsequent reassurance by healthcare professionals who did understand PP.

…I thought she [nurse] was trying to comfort me rather than it actually being true…it was pretty hard, impossible to believe really at the time. (David, p.4, line 126)

Although no partners stated that they sought specific therapeutic support as a result of having experienced PP, some partners did note that since the episode they had sought general therapeutic support, either via work or privately. Part of that support resulted in them discussing the PP episode and its impact on them.

> *I kind of never really discussed it with anyone, you know what I mean, until it really surfaced and even then, you know, I still didn't really talk to anyone.* (Stuart, p.5, line 146)

> *I went to the counselling for just trying to get over what the feelings were…* (James, p.8, line 250)

Moreover, partners said that even after they considered their spouse to have recovered, they continued to monitor and analyse what their spouse was saying in case it was a sign that they might become unwell again. Peter's habitual 'second guessing' suggested the ongoing and unrelenting self-questioning partners experience and their concerns as to any indication of a relapse.

> *I think I am far more aware of how [spouse], or how I perceive [spouse] to be feeling, so even without her saying anything I will find myself second guessing how I think she is feeling, and I will then probably change the way I am interacting with her when I am sensing, although she might be displaying, but when I am sensing she is having a down day… I will probably be second guessing what I think she wants me to do.* (Peter, p.6, line 189)

…I analyse our conversations more than I should really. (James, p.4, line 133)

3.2.3. Superordinate Theme 3: Hypothesising and Hindsight

3.2.3.1. Theorising and Meaning Making

Partners typically developed one specific theory that they felt may have triggered their spouse's episode of PP. Each partner tended to focus on one main trigger, but these triggers differed across partners and included: poor sleep; pressure or problems breastfeeding; exhaustion; experiencing a difficult labour; unexpected changes to the birth plan; hormonal changes; anaemia; failing to follow a childrearing book; delayed access to appropriate perinatal mental health services; antidepressants; and the spouse's choice to relinquish control in the birthing process.

…with the anaemia, I think, for me, was part of that trigger. (Ben, p.7, line 210)

It has got to be largely due to sleep deprivation really. (David, p.3, line 95)

…as I said one hour after taking the first dose of anti-depressants she completely nose-dived… (Peter, p.3, line 89)

Partners noted the benefit of being able to look back and reflect on their experiences in order to identify potential triggers, and even notice when symptoms may have first started. Some partners particularly stressed the benefit of this to them as a couple, to reflect on their

experiences to help make sense of what had happened. Moreover, James referred to their infant as 'this little person', highlighting the sense of reality, responsibility and vulnerability faced by partners in trying to adequately meet their infants' care needs in the context of also trying to care for their spouse.

> *...we feel that the sleeplessness was very much a big thing... we have actually got this little person to look after....* (James, p.1, line 32)

> *Looking back at it now, I think it probably started straight away.* (Mark, p.1, line 5)

Partners also commented that at the time it was difficult to know what was a normal part of having a new baby, but reflecting back helped them identify what was, and was not, normal.

> *Is this normal for childbirth? Is this what happens to every mother afterwards? Is it temporary? Is it not temporary?* (John, p.3, line 98)

3.2.3.2. Guilt and Regret

Partners communicated feelings of guilt surrounding the strain placed on the extended family by having to rely on them for extra support.

> *...I could see that my mum was really getting tired... I mean they are older parents, they were getting really tired of it all.* (Ben, p.9, line 296)

Ben described feelings of guilt from encouraging his spouse to follow their doctor's advice, which in hindsight was not felt to be beneficial.

> *...there is a huge amount of guilt I felt that I had pushed her into going out and things like that... because I'd been told to. But actually that didn't help her at all and I felt masses amount of guilt.* (Ben, p.8, line 236)

Moreover, partners demonstrated considerable self-questioning as to whether they contributed to, or caused PP, or if they simply missed doing something that might have prevented it.

> *...there was a part of me that was... did you cause this to [spouse]? Did you cause this to happen?* (James, p.5, line 150)

Some partners used a lot of 'should have' statements, with references to 'guilt' in their descriptions of what they felt they 'should have' done, seemingly having apportioned considerable time to think and reflect upon their experiences. After reflecting, partners felt they had not been supportive enough, or had not been present enough of the time, and they communicated a general sense of having let their spouse down.

> *I suppose just feeling negative... that I let [spouse] down, when I should have been...[partner paused].* (Stuart, p.5, line 151)

> *...I probably felt if anything guilty that I wasn't there in the unit.* (David, p.6, line 200)

Regrets that were identified seemed very specific to each individual partner's experience. One partner noted a sense of regret at focusing their attention on their infant and relying instead on healthcare professionals to care for their spouse. Whereas John reported feeling regret for thinking that their spouse was managing to care for their infant, when the infant then ended up being hospitalised due to malnourishment because of the spouse's difficulties with breastfeeding.

> *[Referring to healthcare professional's comment] "… you need to get him to hospital or he's going to die because he was so undernourished…"* (John, p.1, line 25)

Another regret by partners centred around the way in which partners communicated with some friends at the time, and the impact that this has subsequently had on those friendships.

> *My emotions at the time had been quite closed and not accepting of people coming around… being quite blunt with people…* (James, p.7, line 218)

A final regret reported by partners was that of not being provided with information to make an informed decision as to whether to have a second child, and thus opting not to. There was also a feeling that the choice to pursue future pregnancies had been taken out of their control, either as a result of the lack of information as to the risk of a future PP episode, or due to their spouse's age once adequately recovered from PP.

…it would have changed my mind, having read other stories, evidence and stuff, I think we would have been in a better position to do that [decision to have second child]. (Ben, p.16, line 506)

She saying it's too late now [relating to choice to have another child]. (Henry, p.5, line 201)

3.2.4. Superordinate Theme 4: Barriers to Accessing Care and Unmet Needs

3.2.4.1. Unrecognised and Unmet Care Needs

Partners stated that their spouse's physical health needs were prioritised over her mental health needs, due to poor understanding and a lack of empathy from primary care services – predominately General Practitioners (GP) and Accident and Emergency (A and E) departments. The following quotes signified that partners often felt that their spouses were initially treated inappropriately by healthcare professionals. Typically, uniform, blanket care approaches inadequately assessed the spouse and their needs, and led to a failure in instigating timely and appropriate care and treatment within an MBU.

…[GP] just told [spouse] to go and have a bath, try and chill out for a bit, and take some natural sleeping remedies and you'll be fine…that's another day or two down the line and we tried that and she just got worse and worse and worse. (James, p.9, line 282)

We had the crisis team involved…they basically didn't look at her as a new mum really. They were just trying to put her in a box, that's how I felt. (Mark, p.7, line 226)

We just felt like a square peg in a round hole…[in A & E]. (David, p.9, line 282)

…psychiatric team is basically no good, they are just pumping her full of more drugs…we took her to [private healthcare provider]. (Peter, p.2, line 56)

Many partners commented that they felt that a delay in receiving suitable care could have resulted in their spouse's condition escalating further, rather than if they had received more appropriate care sooner.

…people in the healthcare profession, they could have helped more, and got to get us support sooner, that is at the centre of everything. (Stuart, p.6, line 182)

I think [spouse] could have been treated and diagnosed if handled properly four or five days earlier. (Henry, p.9, line 298)

3.2.4.2. Lack Continuity in Care

Partners identified a problem when there were frequent changes in the healthcare professionals involved in their spouse's care, resulting in people caring for their spouse who failed to understand what 'normality' was for the spouse.

> *…all the people that knew us, all the health visitors and doctors, they were completely different – they were all away on holiday.* (Ben, p.1, line 20)

When many healthcare professionals were involved in caring for the spouse, there was a general lack of communication between health professionals regarding the spouse's care. In one case, this resulted in an antidepressant medication being prescribed that a previous psychiatrist had stated should not be prescribed, as it may cause the spouse's condition to worsen. Partners noted a struggle when trying to find the right people to provide care for their spouse, and in knowing how to access appropriate care. The anger and frustration experienced by partners at some healthcare providers' unhelpful responses is clearly evident in the following quote.

> *…the locum at the end was "you'll have to try harder than that to kill yourself", and I could have disappeared I was so angry.* (Ben, p.3, line 87)

3.2.4.3. Partner Unmet Support Needs

Partners described not being heard, either individually or as a couple, by healthcare professionals, and if they were listened to then it was only after their spouse had reached crisis point.

I was never listened to – at all! (Peter, p.3, line 80)

…when the medical teams would be coming around and I would be talking to them, and thinking back, ignoring every single word I said. (Peter, p.10, line 310)

For most partners, no enquiry was made by healthcare professionals to the partner's own needs and no support offered.

At the time I wasn't offered anything, there was no counselling or anything from that point of view… (Ben, p.19, line 608)

…there was nothing in place, there was no counselling, no provision of any telephone helplines for any advice… there was no support network for me as a dad. It just didn't exist. (Peter, p.10, line 317)

Some partners felt that there was an assumption made by others that as a man they would be fine and did not need help or support.

From the typical bloke perspective it was just kind of assumed by everyone that everything would be okay. There was never much discussion, even from family, but certainly not from any of the medical services, as to how I was, what concerns did I have. I was very much left to feel that you have got to cope… (Peter, p.4, line 103)

Peter mentioned that the first time any enquiry had been made as to how he had found the episode of PP was when taking part in this research interview.

> *[this interview] …is probably the first time I actually had the opportunity to express it because going right back to day one no one ever really asks.* (Peter, p.10, line 323)

3.2.4.4. Calls for Change

Partners who accessed an MBU heavily praised them but requested that more MBUs should be established, so that some of the strain on families could be lessened. Due to the small number of MBUs that have been established, many spouses and infants were placed at some considerable distance from their partners, which partners reported was difficult to manage. The difficulties expressed by partners included: the physical strain of a long daily commute to see their family, especially if they were trying to work or had other children to look after; the psychological strain; and the potential impact that distance had on the couple's relationship, and ease of access to their infant in order to be able to build a bond.

> *The whole MBU staff was fantastic because they know it, and I think, at that point that was the first thing I'd heard of postpartum psychosis.* (Ben, p.6, line 178)

> *…those places [MBU] are a lifesaver, because if you are not in that specialism no one else can really understand.* (Mark, p.11, line 334)

Mark's description of an MBU as a 'lifesaver' clearly identified the perceived worth and value of MBUs by partners. Wherein the MBUs have provided partners with the only place where they and their spouse have been understood and listened to.

Another change called for by partners was that of educating healthcare professionals, especially GPs and midwives, as to what is PP and what is appropriate treatment.

> *[With second PP episode] …the GP gave a prescription for antidepressants, which she bought home… I instantly then went straight back to the GP and insisted on seeing the GP immediately, who called up her notes on the computer to see that the specialist…had put notes on her record when they wrote to the GP practice to say in their opinion she should never be given that sort of medication ever again.* (Peter, p.8, line 258)

> *Having health professionals on the maternity ward that were aware of it… to me as a lay man that is a pretty fundamental thing if you are a midwife… they should be able to spot it.* (Stuart, p.5, line 157)

> *The nurses in the hospital were super concerned but just didn't know what it was.* (Henry, p.9, line 297)

> *No one knew exactly what was going on.* (Peter, p.9, line 296)

Some partners also proposed that a service be set up, whereby a healthcare professional could telephone on a few occasions after childbirth and speak separately to both spouse and partner, to check on how they were coping and their mental health.

> *Even someone who just gave a phone call and said, "Hey, how are you feeling", and had a talk not only with the mother but also with the father*. (John, p.8, line 262)

Educating partners about PP may also help in their sense of preparedness and reduce their feelings of uncertainty. Partners described feeling it was difficult research their spouses' behaviour, when they didn't actually know what to look for or where to get the information. Other partners noted that even when their spouse had been diagnosed with PP and was in recovery, they were not provided with any information as a couple as to the likelihood of the episode of PP happening again. Partners also stressed the benefit of being provided with a diagnosis in order to understand what was happening and to seek further knowledge.

> *...I didn't really know what was happening...* (Stuart, p.2, line 44)

> *I didn't really know anything about depression and essentially at that time I thought that this must be depression. So you don't know quite what to say or do.* (Ben, p.2, line 64)

> *My experience was I was just thrown in the deep end…* (Henry, p.9, line 267)

Henry's description of his spouse's admission to hospital demonstrated his lack of understanding or awareness of his spouse's experience of PP and the value of her treatment.

> *[spouse] was committed to an asylum…* (Henry, p.2, line 38)

Educating as to the likelihood of future episodes of PP, in couples who have elected to have subsequent pregnancies, has also been identified by partners as being beneficial by increasing their sense of preparedness.

> *I think if we have just got to plan it and if it does happen again then we know what we are dealing with this time, rather than last time it was completely in the dark.* (David, p.7, line 222)

3.2.5. Superordinate Theme 5: Managing Multiple Roles

3.2.5.1. Role Alteration

Predominantly, partners noted a shift in their roles, going from partner and worker to father, carer for infant and spouse, advocate for spouse, and reassurer and filterer of unhelpful contacts for spouse from people lacking an understanding of PP. Information provided in interviews clearly stressed that there was no respite for partners, juggling their new roles day and night to support and monitor their spouse; this was especially the case in the context of partners trying to work.

> *I finally get her up to have a bath and the door would lock and I would think, no, now I don't know what's going on. You sort of sit outside…[listening]* (Ben, p.9, line 270)

I think things were really, really stressful, really stressful at work, then when I took my new job I was worried that I would keep my job sort of thing. Then having to take time off it was stressful. (Stuart, p.5, line 141)

...I still had to work, there was no one who could cover my job, and look after a newborn, not getting much sleep, my wife is potentially on suicide watch, and being watched 24/7. (Peter, p.4, line 112)

...I was very fearful about people… I might have taken three or four hours to calm, to talk [spouse] down from where she was, or talk her up slightly… and then you get somebody coming into the house and say the wrong thing…within five minutes of talking to that person, you were back four or five hours to where you were previously. It was so demoralising you felt like screaming at them… (Ben, p.13, line 411)

Partners communicated feeling a great sense of responsibility in all of their roles. Some partners also adopted practical support roles, for example: completing housework; driving to appointments when their spouse's driving license had been revoked due to PP; and delegating roles to extended family members, by asking them to inform other family members as to what was happening to the couple and infant.

...I'm going to be deemed primary carer to look after her. (John, p.7, line 208)

...we had to agree to have her sectioned. Which obviously wasn't very nice... it is obviously not the kind of decision you want to have to make. (David, p.2, line 49)

...our parents kind of told, or let people know slowly, what had happened... (David, p.8, line 247)

A marked change was also noted by partners in their sense of self, shifting from feeling they were a 'man's man', to a man talking about their emotions. All partners stated the difficulty in managing and prioritising roles, with Henry remarking that he focused almost solely on caring for his infant and left the caring role for the spouse to healthcare professionals.

...so I concentrated on [son] and I just left the doctors to deal with the psychosis. (Henry, p.4, line 111)

Partners also described needing to be calmers and negotiators with their spouse, often needing to modify and simplify their communication style.

She needed some tablets to rein it in but she wouldn't take it. She got a little bit out of hand really. (Mark, p.1, line 22)

...it was almost like speaking to a child I guess in a way... (David, p.6, line 182)

David's quote signified a shift in the partner's role within the couple relationship from one of mutual supporter, to that of protector and carer. The perceived vulnerability of the spouses

by partners altered the relationship dynamic and resulted in adopting a modified, non-egalitarian and patriarchal communication style.

3.2.5.2. Neglecting Own Needs

When recounting events, many of the partners refocused what they were saying regarding the impact that PP had, talking instead about the impact on their spouse or infant, rather than about themselves. Based on the content of descriptions, partners clearly prioritised their spouse and infant needs before their own on a daily basis.

> *I would take on everything. I would just want [spouse] to sit in the corner and chill out and watch TV if she wants to, if she likes, and I would try and do everything else.* (James, p.3, line 82)

This often resulted in partners not getting enough sleep, as they focused on monitoring their spouse, or tending to their infant, and neglecting their own self-care.

> *...I felt I struggled to sleep, because I wanted to make sure that she was sleeping and that put me on edge and I felt very agitated myself.* (James, p.3, line 100)

Partners often described hiding their emotions from their spouse in order to limit the stress on their spouse. This resulted in many partners bottling up their emotions and having no opportunity to consider or vent how they were feeling.

…There wasn't really time to stop and think how am I feeling because there was no choice but to deal with everything. (Peter, p.4, line 120)

In fact, some partners' descriptions of PP lacked emotional content, and instead focused on the factual content of what happened. Some partners demonstrated a personal disconnection from their own emotional experience, and also communicated a disconnection with their spouse's emotional experience of PP. This was typically coupled with a general lack of shared experience between the couple.

Obviously [it was] my partner who had it [PP], not me. (Henry, p.1, line 2)

3.2.6. Superordinate Theme 6: Loss

3.2.6.1. Expectation and Loss

Partners described a feeling of loss in terms of their expectations regarding the experience of having a new child. For example, James discussed his expectation of being able, as a couple, to go around and 'show off' their new infant to family members, but in reality missing out on this experience entirely.

You would think that the first time after having a baby you go round obviously showing her off to everybody, and we couldn't do that purely because [spouse] wasn't there. (James, p.3, line 73)

This loss of expectation of a shared couple experience was further compounded by the physical loss communicated by partners as a result of their spouse and infant's admission to

an MBU, often at a considerable distance away from their home. Partners expressed concern over this physical absence in terms of not being able to have time to bond with their infant.

> *…she was in there [MBU] for a month…* (James, p.1, line 22)

> *You can't get a cuddle, that sort of closeness is ripped apart…I felt I had lost not only my wife but my little one, he was in the MBU.* (Ben, p.11, line 359)

Ben's visceral description of being 'ripped apart' signified the physical and emotional pain he felt by being separated by his spouse and infant.

3.2.6.2. Loss within Couple Relationship

The main loss reported by partners was a sense of loss of their spouse, with their spouse becoming unrecognisable or as though lost in a trance. Partners often questioned whether their spouse would ever return to a recognisable state.

> *Essentially, I had gained a child on one day and lost my partner on the next day.* (Henry, p.2, line 41)

> *…she just slumped down on her knees, not crying, just slumped down on her knees, holding her arms around her knees against the door basically. And just so inward. Completely lost, I would say.* (Ben, p.4, line 107)

> *At a lot of times, we would go up to [MBU] in the car and I'd go "who is she", and I suppose those were the most difficult times.* (Mark, p.3, line 71)

Some partners then noted a change in communication style with their spouse during the episode, and subsequently. Wherein, the impact of the PP episode resulted in them feeling more like a carer than being in a mutually caring couple relationship. Henry said that he took on a more forceful role to try and manage the relationship.

> *I was very much going in as a visitor to a friend to go in and say hello, sort of thing [visiting spouse in hospital].* (Henry, p.6, line 175)

> *...trying to drive my point home, not violent and not shouting, but getting more and more forceful with her.* (Henry, p.6, line 185)

Partners noted the impact that PP had on their intimate relationship, stating that intimacy was lost in the couple relationship during PP, with Henry noting that his relationship with his spouse became one of a distant friendship that he considered leaving. However, some partners commented that a loss in their physical relationship was to some extent replaced by seeking comfort and affection from each other.

> *It wasn't a partnership at that point, so why should I stay around?* (Henry, p.6, line 173)

…during it all there was no husband and wife relationship, which we had been having you know a week or so before [infant] was born. (Peter, p.6, line 183)

I don't think we had sex for a few, for probably maybe a couple of months probably after [episode ended]. (David, p.6, line 194)

3.2.6.3. Trauma

Partners described PP as a traumatic experience, stressing their feelings of loss for their spouse and infant. The grief and sense of abandonment experienced by partners is manifest by the frequent use of the word 'lost' within the following quotes.

I didn't recognise her at all… it just wasn't her, but it was almost like she was kind of possessed. I was just terrified really that she... that I had lost her really. (David, p.3, line 118)

There were times there where we felt, I felt, that we had lost all of our family, that I wasn't going to have [spouse]. (Ben, p.12, line 392)

The thought of being a father was going to be tough and then you have that on top of it. Your world comes crashing down all around you. Looking back now, you kind of think I don't know how I got through that. (Mark, p.3, line 77)

For some partners, they remarked on the need to seek their own counselling after the PP episode had ended in order to talk through their experiences.

> *I've actually gone through a series of…counselling sessions myself as a result of it, because I can no longer settle so much like I used to.* (James, p.3, line 102)

3.2.6.4. Life Stops

Another area of loss surrounds the impact that the episode of PP had on their daily life, with partners noting that their 'normal' life, from friendships to work, seemed to stop.

> *I blanked friends and family and said just leave us alone sort of thing… I didn't even accept phone calls.* (James, p.2, line 47)

> *…it did strain my work… I said to her [partner's boss], "Then when I come back you probably might want to send me my P45 or have my resignation on your desk because I can't help this".* (James, p.7, line 224)

Peter felt as though they as a couple were just 'surviving' and not living.

> *Our social life vanished. We did retain nothing but surviving really.* (Peter, p.9, line 272)

The impact, and loss of the life that partners knew, appeared to be enduring and a long-term effect of PP, and was often surrounded by a sense of stigma attached to mental health problems.

> *I kind of kept it very vague and people sometimes, you know, get a bit discriminative about mental illness…* (David, p.7, line 231)

3.2.7. Superordinate Theme 7: Positive Changes from PP

3.2.7.1. Positives Noted

Partners commented on a number of personal positives which emerged as a result of their experiences of PP, these included: having more empathy regarding mental health problems; wanting to give something back; gaining confidence in coping as a couple; establishing greater equality in chore division between the couple; having better awareness of their spouse's feelings; and placing a greater focus on building a bond with their infant.

> *…it gave us an empathy, not even with PP… people going through depression… I was probably being a bloke's bloke beforehand in terms of thinking about people with depression. "Just snap out of it" type, sort of thing.* (Ben, p.10, line 327)

> *I think I am far more aware of how [spouse], or how I perceive [spouse] to be feeling, so even without her saying anything I will find myself second-guessing how I think she is feeling…* (Peter, p.6, line 189)

Partners also highlighted as a positive the benefit of the MBU's involvement in assisting them to quickly establish a routine with their infant.

> *...If there was any silver lining to be had out of this whole story, it was that the Mother and Baby Unit taught you how to look after a little one.* (Ben, p.11, line 333)

3.2.7.2. Relationship Changes

Long-term changes were noted in the couple relationship, with some reporting that their relationship had strengthened and become more supportive as a result of going through PP.

> *I've always said that it has got better. It's got stronger, that sounds really odd… I always say that we are actually stronger for it. These things make you feel stronger, I guess.* (Mark, p.4, line 121)

> *...we are both very supportive of each other in life… when one seems exhausted and drained then we give each other a break, but then we kind of more sympathetic than before.* (David, p.5, line 159)

> *...she knows through thick and thin I am there by her side.* (Peter, p.6, line 181)

Many partners identified a refocus in their lives, prioritising their familial relationships, and a showing a renewed commitment to spending valuable time with their families above their occupational commitments and goals.

...it definitely affected my outlook on life, and work-life balance and stuff. (Ben, p.12, line 378)

My focus used to be very different. I used to be quite career driven… whereas now I'm like it's just get through the day, get home. I use to work 90% of this time. Whereas now I'm out the door at one minute past five. (Mark, p.6, line 179)

Mark also noted the positive impact that PP had on the relationship with their in-laws, and the closeness that has emerged with the couple's extended family.

Even now we [in-laws] are certainly close. I don't know if that happened just because of them having grandchildren, they came closer as well, or the fact of what we've been through has definitely brought us closer. (Mark, p.6, line 193)

3.3. Summary

The questionnaire data identified that the onset of PP occurred for most spouses within the first week after childbirth. The episode of PP typically lasted 1 to 3 months in duration, with hospital admission of the spouse being common. However, admissions were evenly split across MBUs and general psychiatric wards. In terms of support needs, partners were largely ignored, with any support that was offered being provided in the form of information on either PP or caring for their infant. Any couple support that was provided was typically

directed at the partner supporting the spouse or infant care needs; and no opportunity was offered for partners to report, or identify, their own needs. Results indicate that support to spouses was provided through CPNs and CMHTs, whereas a variety of healthcare professionals could be involved in providing the couple or partner with support. Only one partner noted that an enquiry was made as to their needs; this enquiry was made by a social worker, despite a limited involvement with social workers. In terms of the couple relationship, most partners reported a deterioration in the quality of their relationship during the episode of PP, with many reporting a failure to return to pre-episode levels after the PP episode had ended, although some improvement post-episode was typically noted. A few partners reported an overall improvement in the quality of their relationship due to experiencing PP.

From the interview data, a total of seven superordinate themes were identified across all interviews (with each consisting of subordinate themes):

- Powerlessness;
- United vs. Individual Coping;
- Hypothesising and Hindsight;
- Barriers to Accessing Care and Unmet Needs;
- Managing Multiple Roles;
- Loss;
- Positive Changes from PP.

Partners noted a sense of powerlessness, encompassing a general lack of control and uncertainty stemming from the birth and throughout their spouse's PP episode. The language partners used in describing their experiences highlighted their feelings of being

overwhelmed, exclusion, terror, and the perceived gravity and enormity of their experience. Moreover, partners stressed their sense of exclusion and not being heard by healthcare professionals.

A variety of individualised coping strategies were identified by partners, but all partners questioned their ability to cope and sought support, even if that was anonymised support. Partners noted it was 'impossible' to comprehend how they would have coped without familial support. Some partners clearly communicated a unified approach to coping as a couple, whereas for others, coping occurred as a separate process for partner and their spouse. Coping often involved partners having to become a 'specialist' in PP in order to understand what was happening to their spouse, and answer questions that healthcare professionals had failed to address. Issues that were encountered when trying to cope included: having to compromise their values; having no opportunity to vent their emotions; and continuing to question their spouse's behaviour after recovery for fear their spouse was becoming unwell. Partners also reported the difficulties in setting boundaries for extended family involvement in providing care, understanding what support was offered, and believing any reassurances from healthcare professionals. The benefit of reflection was remarked upon, especially as a couple, in making sense of their experiences. However, partners also communicated feelings of guilt and regret, often commenting on things they felt they 'should have' done.

Partners identified barriers to accessing care for their spouse, which included healthcare professionals failing to accurately identify what was wrong with their spouse, and the lack of consistency in care and communication between healthcare professionals. Partners advocated that some changes need to happen, for instance: increasing the number of local MBUs, having noted them to be a 'lifesaver'; raising awareness of PP among primary care staff;

educating partners about PP and increasing the support offered to them; and helping couples to be aware of PP and feel prepared for it, as this had helped some partners following later pregnancies.

Partners commented on the conflict between their many new roles and meeting the care needs of their family, particularly in the context of trying to maintain a job. In order to manage, partners would typically prioritise their spouse's, or infant's, needs above their own, and would often then have to prioritise whether to care for their spouse or their infant. Partners noted a shift in their couple relationship whereby they likened communicating with their spouse as if 'speaking to a child'. This shift from a mutually supportive relationship often led partners to bottle up their emotions and hide their own difficulties from their spouse.

A general sense of loss was strongly communicated, from a loss of what was expected to loss of the couple relationship; physical loss or separation due to admissions; and a feeling that life stops. Partners used quite visceral language, such as, 'being ripped apart' from their spouse to refer to their experience of loss. A subordinate theme of trauma emerged due to the perceived threatened loss of their spouse through PP.

Finally, the majority of partners nevertheless detailed positive changes that had occurred due to PP. This included increasing partners' own empathy and understanding towards mental health issues in general. Furthermore, there was recognition for MBUs assistance and role in establishing a care routine for their infant. Positive changes to the couple relationship were also noted by some partners. Wherein, following the episode of PP, the couple relationship had strengthened and became more supportive. Moreover, partners had experienced more time to bond with their infant, and had concentrated on redressing their work-life priorities.

Chapter Four: Discussion

4.1. Results Considered within the Context of Existing Literature

The main aim of the current study was to develop an understanding of the lived experience of partners of women with Postpartum Psychosis (PP), and the impact that it has on their lives and relationships. Partners reported a lack of support being provided to them, and typically perceived a deterioration in the quality of their couple relationship during, and following, the episode of PP. Seven superordinate themes were extracted from the interview data: powerlessness; united vs. individual coping; hypothesising and hindsight; barriers to accessing care and unmet needs; managing multiple roles; loss; and positive changes from PP.

The researcher was not able to identify any existing research that had considered partners' experiences of PP, beyond that of recent investigations into partners' support needs, and a joint examination of couples' perceptions of recovery (Blackwell *et al*., 2015; Doucet *et al.*, 2012; Engqvist & Nilsson, 2014). Exploration of partners' own experiences of PP is largely unique at this time, therefore, the researcher considered all existing literature surrounding PP, which primarily consisted of literature that explores aetiology, intervention efficacy, and maternal experiences of PP. As a neighbouring, although clinically distinct area of research, partners' experiences of Postnatal Depression (PND) were considered within the systematic review: specifically the impact that PND had on the couple and infant relationships. This is an area of research that depicts experiences which may overlap with those of partners of women with PP, as both involve a shared experience of having a spouse with a postnatal mental health problem. In an attempt to more fully conceptualise the experiences of partners

reported in this current study, each of the findings will be considered in relation to existing research literature and psychological theory.

4.1.1. Postpartum Psychosis: Onset, Duration, and Admissions

Results of the current study demonstrated that, for most, the onset of PP was noted by partners to have occurred within the first week after childbirth. This finding fits with the diagnostic criterion stipulating that the onset of PP occurs within four weeks of childbirth, and with existing literature which illustrates that onset typically occurs within two weeks of childbirth (APA, 2013; Mishra *et al.*, 2011).

The duration of the PP episode, as reported by partners, ranged from 1 to 3 months. Although there is no specified length of duration of PP, existing literature has noted that recovery from PP is described as a 'long and difficult process' (Heron *et al.*, 2012, p.155). Women often report that it can take over one year before they feel they have recovered (Bergink *et al.*, 2015; Doucet *et al.*, 2010). This indicates that the duration of PP stated by partners within the current study is less than would be anticipated; however, some consideration needs to be made as to the interpretation of the duration of PP. Some partners may have responded to this question by providing an answer based on the acute phase of the PP episode, rather than considering the length of PP from start to recovery.

In terms of hospital admissions for PP, findings indicated that admissions were area dependent: namely, admissions varied based on the presence or absence of a mother and baby unit (MBU) in the vicinity. Partners reported that most mothers required an admission, although the type of admission was evenly split between an MBU and an adult acute mental health ward. This is an important finding as it depicts the continued lack of specialist

provision available for perinatal mental healthcare, and the ongoing separation of mothers from their infants in order to receive treatment when an MBU is not available. In addition, some MBU admissions were out of area, further highlighting the sparsity in their availability and accessibility. This is particularly concerning when considered in relation to existing literature, which has noted that most women start to improve once under the care of an MBU (Glangeaud-Freudenthal *et al.*, 2011).

4.1.2. Support Provision

Partners in the current study reported that their needs were ignored and the only support provided was information on how to care for their infant, or information following a psychiatric review of their spouse. Partners stated that they had no opportunity to discuss their own needs, or any concerns relating to their spouse; and that any healthcare professionals who visited their spouse failed to identify their role or function. Based on the number of healthcare professionals who were identified by partners as being involved with the spouse, it appeared a missed opportunity for those healthcare professionals to enquire as to the partner's concerns or seek their perspective. This neglect is also evident within the research literature. Blackwell *et al.* (2015) reported that partners were provided with little support or information about PP, felt isolated, and requested more support be offered to them. The lack of support provided to partners is particularly concerning, when considered in relation to research which has highlighted the benefit of the support that partners themselves provide to their spouse, and the protective function that this can offer in the context of postnatal mental health problems (Dennis & Ross, 2006). Partners provide ongoing support to their spouse and are best placed to give feedback to healthcare professionals about their spouse's presentation. However, support is neither offered at an individual level to consider partners' own needs, nor at the family unit level to consider the system of care partners

provide to their spouse and their infant. The valuable support provided by partners needs in itself to be supported or scaffolded, due to the vital role it plays, and the insight it can provide, in order to successfully assess and treat their spouse.

4.1.3. Partners' Perception of the Impact of Postpartum Psychosis on the Couple Relationship

The majority of partners in the current study reported a deterioration in the quality of the couple relationship during the episode of PP. Following the episode, partners typically noted an improvement in the quality of their relationship, yet for most this did not return to the pre-episode level. This result helps to further illustrate the impact that PP can have on the whole family system and relationships (Morgan *et al.* 1997; Robertson & Lyons, 2003). The impact of PP on the couple relationship appears to share similarities with the impact resulting from PND. Zelkowitz and Milett (1996) highlighted that mothers with PND reported more negative perceptions of the couple relationship. Furthermore, Milgrom and McCloud (1996) identified higher rates of separation and divorce following PND, and that the severity of the episode of PND seemed proportional to the impact that it had on the quality of the couple relationship. As PP is known for its severity, it may thus be expected that the impact that PP has on the couple relationship is also proportionally severe. One reason postulated as to the change in the couple relationship, beyond the direct impact of PP, is due to some of the indirect effects: Lija *et al.* (2011) commented that women with PND demonstrated less warmth, closeness, and confidence with both their infant and their partner.

In the current study, a minority of partners stated that the couple relationship improved in quality as a result of the episode of PP. This is a result which has not been reported within the PND literature. Partners reflected on this improvement during the interview, explaining

that the shared experience of going through the PP episode resulted in them feeling closer, and that they were now more supportive and had a better understanding of each other.

4.1.4. Superordinate Theme One: Powerlessness

All partners described a sense of powerlessness during the episode of PP, which encompassed feeling a lack of control, as well as being overwhelmed by much uncertainty, and unexpectedness. Sources of uncertainty included not knowing what support was available for their spouse or how to access it, nor knowing whether their spouse would get better. Partners utilised descriptors such as 'big thing' and 'huge' to denote their experiences of PP. Such reports by partners fit with the general clinical description of PP as being sudden, severe, and unexpected (Appleby *et al.*, 1998; Heron *et al.*, 2008). Similarities can be drawn with PND literature, which noted that partners experienced higher stress, lower social support, more negative perceptions of their relationship, and more psychological symptomology during their spouse's PND episode when there was greater demand on them to support their spouse (Zelkowitz & Milett, 1996).

Partners felt that their concerns were unheard and that they were excluded from all aspects of their spouses' care and treatment, further adding to their sense of powerlessness. Similarly, within the PND literature, Engqvist *et al.* (2012) noted partners' inability to trust healthcare professionals due to perceived misgivings over the care that was provided to their spouses, contributing to a wider sense of abandonment. It is clear from the current study's results that partners often experience a plethora of emotions ranging from feeling 'scared' to finding PP 'terrifying', escalating their general powerlessness and unknowing during the PP episode. Considerable expectation is placed on partners, from both family members and healthcare professionals, to provide support for their spouse. This occurs despite partners being provided

with little support themselves, and seldom having their opinions and observations regarding their spouses' presentation and individual difficulties being attended to or valued.

4.1.5. Superordinate Theme Two: United vs. Individual Coping

Partners described having varied experiences of trying to cope during the episode of PP, with some partners finding their own strategy whilst others united with their spouse to find a joint strategy. Common strategies described by partners in the current study included seeking normality, and trying to source information about PP. This resulted in partners self-labeling as a 'specialist' in PP. These strategies echo those found by Marrs *et al.* (2014), and are illustrated in their proposed model of how partners' cope when their spouse was admitted to an MBU; for example, seeking normality, acquiring skills and knowledge about the illness, and incorporating daily functioning around their spouse's illness. This indicates that these coping strategies may be shared among partners when spouses experience postnatal mental health problems, rather than being specific to PP. These strategies also demonstrate the ways that partners attempt to cope when provided with no support, with partners often questioning their own limits and capacity to cope.

Partners often felt the need, as a couple, to compromise on their values in order to cope with the specific demands of the PP episode. For instance, making the decision not to breastfeed, although previously valuing this, in order for their spouse to receive medication. This type of compromise appears common when there are postnatal mental health problems; Engqvist *et al.* (2012) identified that unfulfilled dreams or wishes was a theme extracted from narratives of women who had experienced PP. Needing to make such decisions, which go against what the couple had originally wanted, further adds to the lack of control and powerlessness felt during the episode of PP.

The benefit of familial support was clearly communicated by partners, noting that it would have been 'impossible' to comprehend coping without such support. This finding echoes the thankfulness expressed by spouses for familial support (Heron *et al.*, 2012). The importance of support can be further understood by considering Weiss' (1974) social relationship model, which outlines six social provisions that may be met through interactions and relationships with others. It is clear that partners meet these provisions for their spouse during the PP episode and that they may provide a buffering effect on postnatal mental health, yet it is questionable as to whether these provisions are being met for partners when their spouse is unwell (Cutrona & Russell, 1987). One potential route through which such social provisions are met may be through extended family interactions and support. However, some partners identified the need to establish boundaries around familial support, and at times feeling the need for families to step back. This has not previously been noted within the research literature but may link to the sense of powerlessness that partners report during the episode of PP, and their need to feel in some way in control of how to manage the situation.

Partners valued being provided with appropriate support and reassurances by healthcare professionals, although this was rarely offered. Partners reported not knowing what support was available to them, and struggled to believe the reassurances of healthcare professions due to inaccurate information that was previously relayed about their spouse's condition or the best course of treatment. If healthcare professionals had a greater awareness of PP, this may reduce the delay in accessing appropriate care and the disbelief experienced by partners regarding reassurances made by healthcare professionals. McGrath *et al.* (2013) noted that reassurance was also of key importance for mothers. Therefore, more focus on providing reassurance to the couple that there will be an improvement is likely to be of benefit.

Partners also stated that they found it difficult to negotiate the recovery process and that they continued 'second guessing' whether their spouse would become unwell again. Partners commented that they often looked for signs that their spouse was becoming unwell, and at times misinterpreted humour, or energy, as a sign of mania or psychosis returning. This finding has not previously been identified within the research literature, but importantly illustrates the ongoing concern experienced by partners throughout the recovery process, and links with the monitoring role that partners adopt. It also provides an example of the change that can occur in the couple relationship, as the partner adopts a carer role and this ultimately changes, to some degree, the relationship dynamic. More generally, this result indicates a potential shift in the partner's frame of reference by which they interpret and understand their spouse's actions, and this may endure after their spouse is considered recovered.

4.1.6. Superordinate Theme Three: Hypothesising and Hindsight

Partners identified that a process of reflection, particularly as a couple, helped make sense of their experiences of PP. It was very common for partners to communicate one particular theory or trigger for their spouse's PP. Some triggers identified by partners included those postulated within the existing research literature exploring triggers for postnatal mental health problems; for example, sleep loss, or antidepressant medication resulting in mania (Burt & Rasgon, 2004; Lawson *et al.*, 2015). However, it remains debatable as to whether sleep loss can be attributed as a cause of PP, as it may be a coincidental new occurrence typical of having a newborn infant. In the current study, partners suggested triggers not mentioned within the existing research literature, such as birthing choices. Partners specifically discussed the role of abdicating control in the birthing process as the start of a sense of powerlessness as the episode of PP emerged. There is no research supporting a link between birthing choices and PP, but it demonstrates a need by partners to find and develop a

particular theory, or explanation for their experiences. This result links in with research by McGrath *et al.* (2013), who proposed a theory of recovery from PP which stressed the importance of evolving an understanding in the recovery process.

Partners in the current study considered a process of reflection as beneficial. Although, the use of language denotes a perceived vulnerability of the infant and the increased responsibility to care for 'this little person' in the context of also caring for the spouse. Themes of guilt and regret also emerged through this reflective process, with a number of partners talking in 'should have' statements. This indicated that as well as seeking and considering external triggers, partners also looked to themselves and what they may, or may not, have done which contributed towards the development of PP. This result has not been reported previously, yet provides insight into some of the thoughts and emotional experiences of partners at the time of PP and may provide a basis when developing support for partners.

Regret was also communicated by partners surrounding decisions relating to future pregnancies. Some partners reflected that if they had been provided with information as to the likelihood of any future episodes of PP, this might have overturned the couple's decision not to have more children. Research by Blackmore *et al.* (2013) stated that the likelihood of a second PP episode in a subsequent pregnancy was 54.4%. Part of a PP awareness campaign for healthcare professionals could include communicating this statistic to them, so that they can disseminate this information to couples, and enable couples to make an informed decision regarding future pregnancies. This would be particularly useful for primary care providers, such as GPs, who are most likely to be consulted by couples when discussing potential future pregnancies.

4.1.7. Superordinate Theme Four: Barriers to Accessing Care and Unmet Needs

Partners identified a number of barriers to care and unmet needs which they advocated needed changing. Firstly, the current findings indicate that healthcare professionals often failed to identify PP, despite NICE (2014) guidelines stipulating that healthcare professionals need to be alert to any signs of PP within the first two weeks after childbirth. The guidelines also advise the assessment and treatment path that should be followed, which based on partners reported experiences appear largely unmet, or only followed after some delay. Partners in the current study report experiences that indicate a failure by many services not to adhere to the guidelines, and that further awareness campaigns for healthcare professionals, regarding PP and avenues for treatment, would be clinically beneficial to both the spouse and the partner. Some failure in compliance of the guidelines, with reference to the current study results, may be partially explained if the spouse experienced PP prior to the guidelines being issued.

Secondly, when care was provided to spouses, partners reported a lack of consistency in what care and advice was offered and that continuity in care was lacking. A system resembling a 'postcode lottery' appears to apply, as to whether or not couples lived within close vicinity of an MBU. Partners also noted a lack of communication between healthcare professionals when care was provided. This typically seemed to relate to communication between primary care staff, or between primary care staff and higher levels of care. This result indicates a lack of adequate perinatal mental healthcare service provision, and a need for more MBUs and specialist perinatal mental healthcare services to be implemented. Partners heavily praised MBUs, describing them as a 'lifesaver' and the only place that they felt that they and their spouse had been listened to and understood. Such a lack of specialised services has been recognised within the recent Chief Medical Officer's annual report, which calls for increased

access to perinatal mental healthcare services (Department of Health, 2015). Moreover, the Welsh Government (2016, p.8), in their proposed Together for Mental Health Delivery Plan: 2016-2019, has stated the need 'to provide better outcomes for women, their babies and families with, or at risk of, perinatal mental health problems'. The Welsh Government (2016) has outlined that changes will be made to offer information and support pre-, during, and post-pregnancy, and to ensure that there are accessible community perinatal mental healthcare services in every health board.

Thirdly, partners felt their concerns and own needs were ignored. The lack of consideration of partners, and their unmet needs, is of ongoing concern within the research literature; especially as previous research has shown partners of women with postnatal mental health problems to be of increased risk of their own mental health difficulties whilst their spouse is unwell (Lovestone & Kumar, 1993; Marrs *et al.*, 2014). Moreover, there is continued expectation placed on partners to provide ongoing support and care for their spouse, yet recognition of this role, or valuing partners and the couple relationship, seems neglected by healthcare professionals.

Fourthly, partners who have experienced more than one episode of PP with their spouse, stated that they found it beneficial to know more about the condition and that it helped them feel prepared for what may happen. This result demonstrates the potential benefit of including partners more readily in the intervention process, and equipping partners with knowledge about PP and what they might expect. This would help engender in partners a greater sense of control and limit their sense of uncertainty.

4.1.8. Superordinate Theme Five: Managing Multiple Roles

One of the main experiences described by partners in the current study surrounded attempts to manage and balance new roles; this was noted as especially difficult in the context of trying to maintain a job. Such conflicting demands placed on partners have also been recognised by Marrs *et al.* (2014), in their model of how partners cope when their spouse was admitted to an MBU. In the current study, partners provide a richer description of their experiences when attempting to fulfill multiple roles, such as taking on a primary carer role for their spouse but also a compensatory caring role for their infant. The descriptions provided by partners of each role communicated a relentless experience with little support or respite.

One of the roles often taken on by partners of women with PP is that of primary caregiver to their infant. Previous research literature has explored the impact that postnatal mental health problems can have on mother-infant (M-I) interactions and early attachment, with some research demonstrating that M-I interactions became more rejecting, angry, and anxious, with insecure attachments and decreased maternal responsiveness (Hipwell *et al.*, 2000; Pearson *et al.*, 2012). Previous research has also indicated the difficulties that mothers can have when trying to meet their infant's care needs and their reactions to the crying cues of their infant (Cooper *et al.*, 1993; Seeley *et al.*, 1996). The current study indicates that partners often take on a greater caregiving role at the time of PP, which may attempt to meet the attachment development needs of their infant and provide their infant with the reciprocal interactions required to develop secure attachments (Ainsworth, 1973; Bowlby, 1969; 1973). This finding is further supported by research proposing that partners take on a buffering role in the development of attachment in their infant, in the context of postnatal mental health problems (Albertsson-Karlgren *et al.*, 2001; Edhborg *et al.*, 2003). However, there is some evidence to

suggest that negative M-I interactions may be more a representation of the negative self-perception of the mother's own bonding experiences, than an actual experience (Hornstein *et al.*, 2006). Other research has proposed that a partner's greater investment in the relationship with their infant indicates an adaption to loss of the shared parenting experience, and a filling of the void created by their spouse's mental health problem (Beestin *et al.*, 2014).

Another role identified by partners within the current study, is that of partners modifying and filtering interactions with their spouse. Partners reported that when their spouse was unwell, they actively attempted to minimise the communication of any potentially stressful information to their spouse and likened communicating with their spouse to that of 'speaking to a child'. Partners also noted that they had to avoid their spouse having too much contact with people who did not understand PP, as their spouse often ended up more stressed and unwell as a result of those interactions. The couple relationship seemingly shifted, with the partner taking on a protector and carer role, rather than being part of a mutually supportive relationship. Some partners reflected that they frequently had to mend relationships when their spouse had spoken to individuals in an uninhibited way which may have caused offence. Such a role has not been demonstrated before in the research literature, and provides insight into the extent of the complex roles that partners struggle to manage on a daily basis.

A clear finding in the current study is that partners deprioritise their own needs; self-neglect and bottling up of their own emotions from their spouse was common. This result supports the findings of one of the few studies which has considered partners' support needs, namely that partners typically reported the support needs they felt their spouse required, and neglected to identify their own needs other than noting feelings of isolation (Doucet *et al.*, 2012). Although partners reported bottling up their experiences and emotions from their

spouse, previous research by Heron *et al.* (2012) noted that spouses recognised that their partners needed access to psychological support. Therefore, at some level, it would appear that spouses may be aware of their partner's emotions despite their partner's attempts to hide them.

4.1.9. Superordinate Theme Six: Loss

The sense of loss was strongly communicated by partners in the current study and was multi-dimensional, incorporating: loss of the expected; physical loss; loss of the couple relationship; and a feeling that life stops. One of the main areas of loss, loss of expectation, was also communicated by spouses in a study by Heron *et al.* (2012), who reported that mothers experienced a loss of what they expected from motherhood. Similarly, partners in the current study identified a loss of what they expected fatherhood to be like and a loss of the shared experience of the couple and the initial weeks at home together with a newborn, instead having to rely on others for support rather than having a shared couple experience. This result links in with expectation-loss theory of what might, or what could, have been, and shares some similarity to the reported experiences of parents when their infant was born with an unexpected disability or illness (Luterman, 2008). In the case of PP, the unexpected factor is the spouse's mental health problem and the impact of this on the expected experience following childbirth.

Within the systematic review, 'Partners' Expressed Concerns and Sense of Loss' was one of the main areas noted within PND partner literature. This included research by Meighan *et al.* (1999), who stated that partners equated the birth of their infant with the loss of their spouse, a loss of control, loss of intimacy, loss of expectation and routine, and feelings of helplessness in containing and caring for their family. These are very similar themes to those

noted within the current study, and indicate that partners' experiences surrounding loss may be indicative of postnatal mental health problems in general, rather than those specific to PP. Similarly, Beestin *et al.* (2014, p.717) highlighted that PND led to physical and psychological maternal absence and 'fracturing' of the family unit. Accordingly, in this current study partners described being 'ripped apart' from their spouse during the PP episode. Moreover, Marrs *et al.* (2014) identified the additional difficulty in maintaining relationships and attachment during admittance to an MBU for PND, as this is associated with a physical loss of the infant and spouse from the partner; an experience also noted by some partners within the current study.

The degree of loss communicated by partners was considerable. Partners repeatedly reflected that they felt they had 'lost' their spouse, and that their spouse had become unrecognisable. Furthermore, partners felt that they did not know if their spouse, as they had known them, would ever return. Such descriptions indicate that partners have experienced this loss as a trauma. A criterion of Post-Traumatic Stress Disorder now includes the perceived, or threatened, loss of a loved one, which fits with the descriptions provided by partners (APA, 2013). The emotional impact that such trauma and experience of PP can have on partners, and on the couple relationship, is vast. This provides even further evidence that partners require support and consideration when developing interventions for PP.

4.1.10. Superordinate Theme Seven: Positive Changes from PP

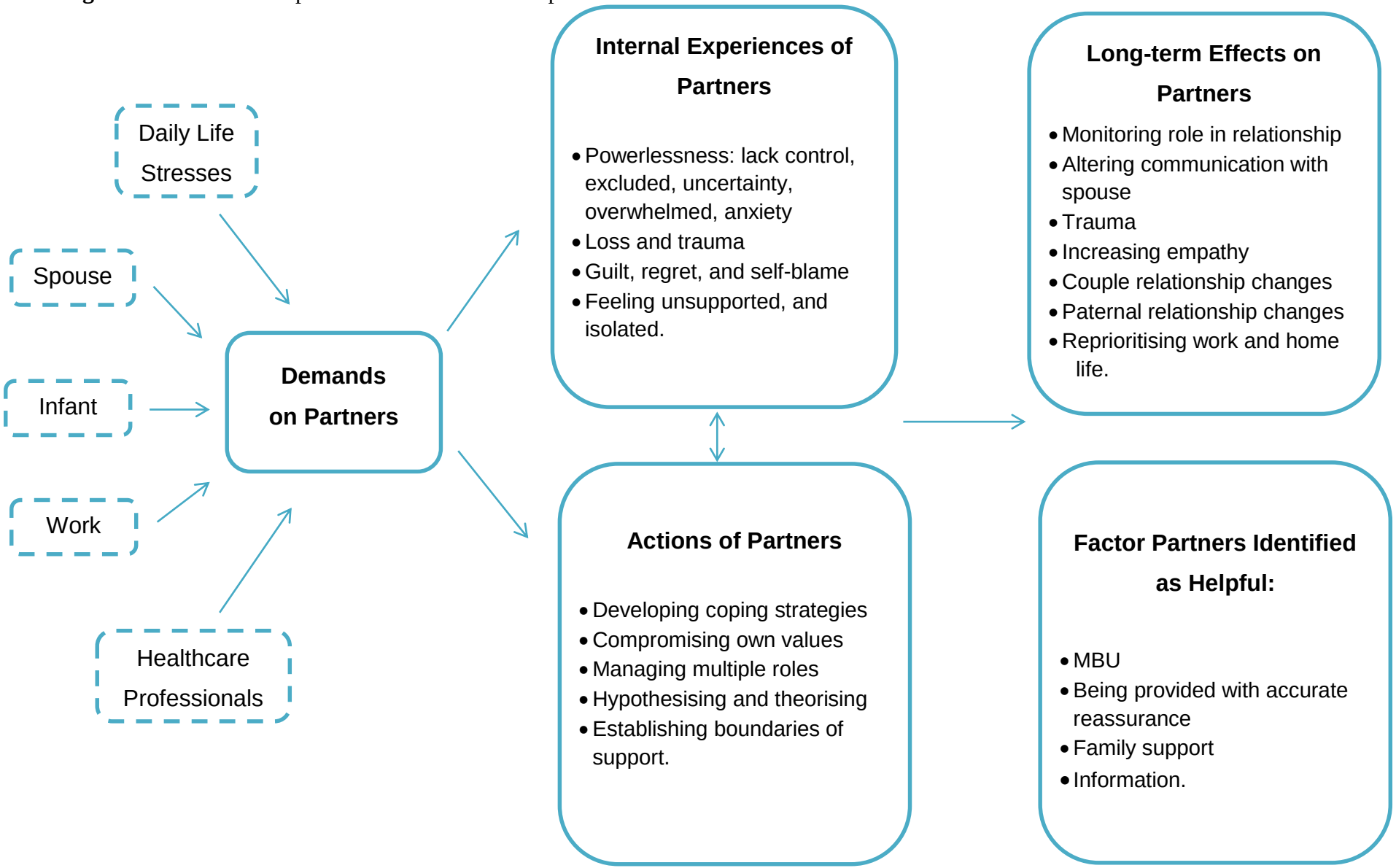
One of the unique findings of the current study is that some partners communicated that positive changes had occurred as a result of experiencing PP. These positive changes included: increased empathy; having more time to bond with their infant; and long-term changes in their priorities, shifting from prioritising work to prioritising time with their

family. A few partners noted a strengthening of the couple relationship as a result of having experienced PP. These reflections may, in part, function to help partners cope with the traumatic experiences they have been through, by thinking of positives that may have developed as a result of their experiences. However, they may also demonstrate the benefit of hindsight, and that during an episode of PP it may be hard to identify positives, therefore, communicating any positives may provide some hope to other partners experiencing PP, or their future selves following subsequent pregnancies.

4.1.11. Conceptualising Links Between Themes

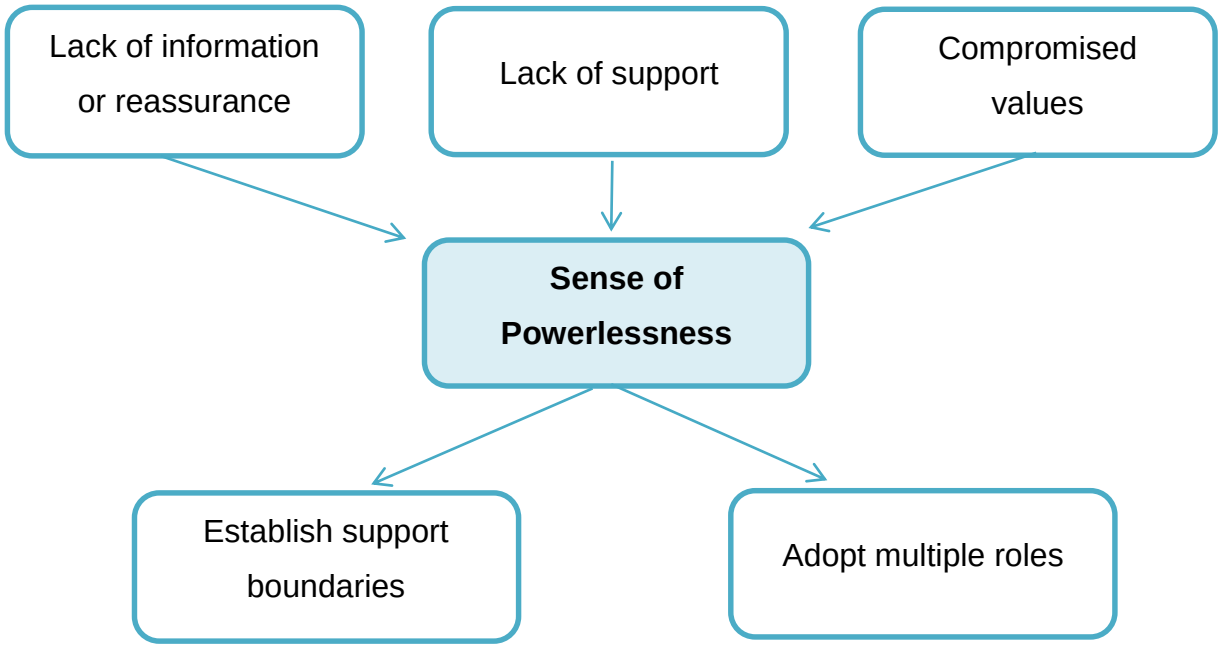
Some key links can be identified across the seven superordinate themes to further aid our understanding of partners' experiences. The themes can be categorised into a diagrammatical representation of partners' experiences, encompassing: the demands placed on partners; partners' internal experiences; actions of partners; long-term effects on partners; and factors partners identified as being helpful (see Figure 12).

Figure 12. Visual Conceptualisation of Partners' Experiences



One key link could be made through the theme of powerlessness (see Figure 13). This sense of powerlessness, and relinquishing of control, can be further compounded by partners having to compromise on values, and through the lack of support, information or reassurance provided to partners. As an attempt to regain some sense of power and control over their experiences, partners may adopt multiple roles and establish boundaries as to the support provided by others. Moreover, the sense of powerlessness may be considered stronger in the context of first-time fatherhood, whereby partners have not had the chance to build their parenting competencies through previous pregnancies and parenting experience.

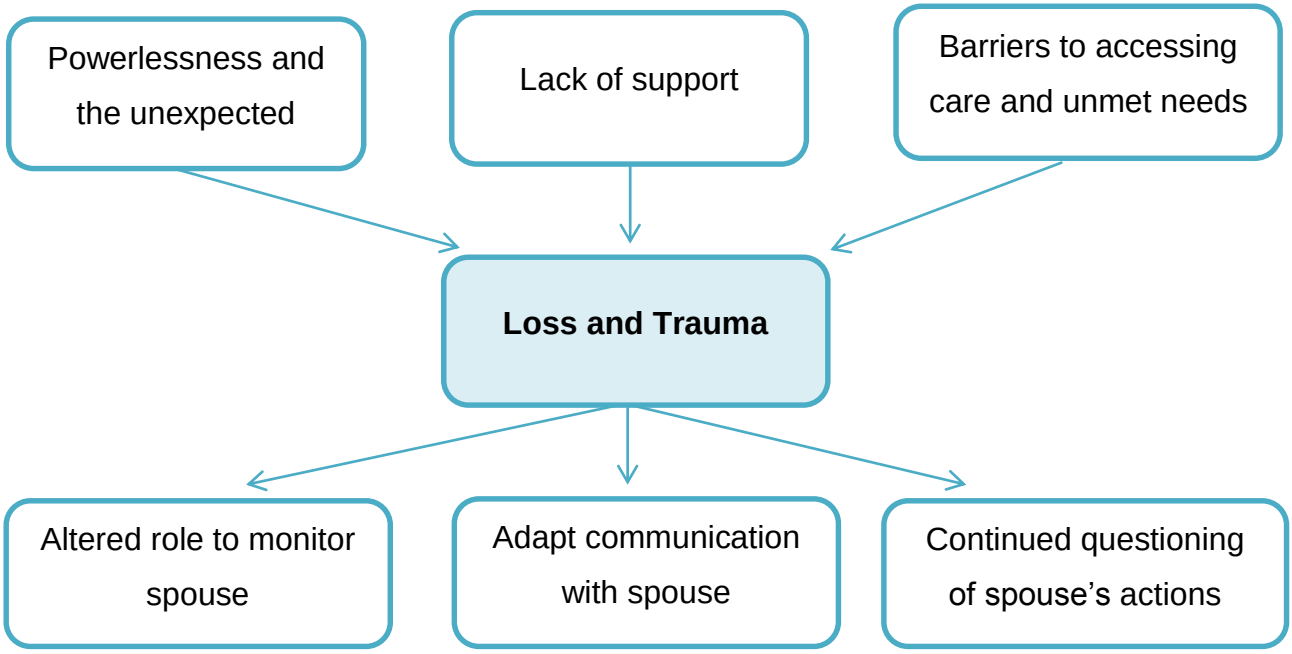
Figure 13. Links Through the Theme of Powerlessness



Another key link could be through the theme of loss (see Figure 14). Partners' experiences of loss and trauma impact on the couple relationship: how they adapt their role within the couple relationship to meet their spouse's needs; monitor their spouse; alter their communication style; and, in the long-term, continue to question their spouse's actions and behaviours out of fear that they will 'lose' their spouse again. This occurs within a context of

little, if any, reassurance from healthcare professionals that things will improve. Moreover, a sense of loss may be more powerful for first-time fathers due to them not having prior experience of a smooth perinatal experience, couple unity, and fatherhood following childbirth.

Figure 14. Links Through the Theme of Loss



4.2. Clinical Implications

4.2.1. Awareness

Partners raised the issue that there was a lack of awareness and knowledge of PP by healthcare professionals. The Department of Health's (2015) report identified barriers to better health outcomes for women with perinatal mental health problems; these included a lack of awareness, information, and staff training, as well as stigma surrounding perinatal mental health problems. In light of both the information gained from the current study, and the Department of Health's (2015) report, one clinical recommendation would be to establish

an awareness campaign directed at healthcare professionals as to the nature of PP. A clinical psychologist could work alongside a charity, such as Action for Postpartum Psychosis (APP), to develop this campaign. Based on feedback from partners, this campaign would be best directed at primary care staff, such as GPs, but also work to educate some secondary and tertiary care services, for instance, general adult mental health services and crisis teams. Other healthcare professionals who may benefit from an increased awareness of PP, and who may be best placed to help identify PP sooner and so prevent a delay in appropriate interventions being offered, would be midwives and health visitors who have close involvement during the perinatal window with the new mother, infant, and occasionally the couple.

Partners also identified their lack of awareness of PP, with most noting that they had not heard of PP prior to their spouse's diagnosis. For partners who had heard of it, it was only through having read a single sentence referencing it in a larger leaflet about pregnancy and the postpartum. Partners stated that they did not feel informed enough to be able to recognise any symptoms, nor to make the link that PP was what their spouse was experiencing. Therefore, another awareness campaign focusing on parents-to-be may be beneficial. Parents-to-be are already provided with a lot of health-related information and leaflets during pregnancy, from information about antenatal screening tests, and vaccinations, to PND. A brief leaflet about PP could be developed, outlining incident rates, and what symptoms to look out for; this could be included in the information pack provided for parents-to-be. Alternatively, within antenatal classes, a portion of time could be taken to discuss PP at the same time as PND is discussed. One partner suggested that part of an antenatal class could be dedicated solely to partners, where signs of PP and PND could be outlined, as well as informing partners as to how best to support their spouse during the perinatal period,

especially if their spouse started to display signs of perinatal mental health problems. One partner in the current study suggested this approach, as he felt that partners would be best placed to first recognise if their spouse became unwell; also, it would limit the stress and anxiety that such information may have if imparted to the spouse as to what may happen following childbirth.

4.2.2. Communication

A contributory factor to partners' sense of powerlessness were their feelings of being excluded, unheard and ignored. Healthcare professionals appeared not to value the concerns or observations made by partners. Partners hold a wealth of information and insight, as a result of their continual interaction with their spouse and knowledge of their spouse's symptom-free self. It seems important, and neglectful, not to include partners in the care system, especially when reliance is largely on them to provide pre-admission and post-discharge care for their spouse. One way to better incorporate partners within the care system would be by specifically requesting partner attendance at review meetings, and seeking out the partner's views as to their spouse's presentation or noticed changes. This may encourage healthcare professionals to value partners and their contribution and role. However, some flexibility and awareness needs to be incorporated, as some spouses may specifically not want their partners to be involved in their care nor be present at appointments. Communication between healthcare professionals and partners would be further improved through rapport building, by enquiring as to how partners are feeling and coping, and thus helping to make partners feel valued. Results from the current study clearly indicate that partners' own needs are not enquired about, nor considered, which echoes that of Blackwell *et al.* (2015) who noted that partners called for better communication with healthcare professionals.

Another area of communication that requires addressing is that of effective communication between healthcare professionals. Partners commented that healthcare professionals often failed to know what other healthcare professionals were doing, or had recommended, or did not take the time to seek out this information. This needs to be addressed both within and across primary, secondary, and tertiary levels of care.

4.2.3. Continuity of Care

Partners in the current study described the process of having to take their spouse to various different healthcare professionals before they were directed to an appropriate service. This often included attendance at accident and emergency departments, frequent visits to GPs, and involvement with the crisis team; with each visit including interactions with new staff and having to once again explain the situation. This lack of continuity of care was identified as a barrier, and often resulted in delays in accessing appropriate care. Information relating to appropriate interventions and recommendations for couples could be included within the developed awareness campaign for healthcare professionals, stressing the importance of continuity in care and the allocation of a key worker.

Partners highlighted the benefit of continuity in care when couples went on to consider whether to have future pregnancies. Knowing whom to contact, and the familiarity of unit staff if a second admission was required for a later pregnancy, was identified as important. Having previously built a rapport and trust with certain healthcare professionals was reported as aiding this process, with partners who experienced a second episode of PP commenting that they felt more prepared and in control. A clinical recommendation could be made that couples have direct re-access to perinatal mental health services, to enable consultation on

future pregnancies and to develop relapse prevention, or management plans, should PP reoccur.

4.2.4. Service Enhancement

Partners chiefly emphasised the benefit of specialised perinatal services, specifically describing MBUs as a 'lifesaver'. However, partners stressed that the locality of MBUs was important, as many areas did not have one or required the partner to travel considerable distance to visit their spouse and infant. Moreover, partners noted that healthcare professionals seemed unaware that the couple could be directed to an MBU for care. Healthcare professionals in other services were often reported as struggling, or failing, to identify PP, or not knowing where to refer clients, or what treatments should, or should not, be offered. One partner reported that a GP prescribed an antidepressant medication, despite a specific warning having been issued by a psychiatrist not to prescribe this medication.

A call by partners to improve perinatal services is shared by spouses, who also expressed the need for greater training and understanding of staff regarding PP (Engqvist *et al.*, 2012). One recommendation would be to increase access to, and availability of, specialised perinatal mental healthcare services, such as MBUs. This recommendation is in line with the Chief Medical Officer's (Department of Health, 2015) report calling for increased access to perinatal mental healthcare services, yet the Department of Health (2015) has noted that only 3% of clinical commissioning groups in England had a strategic plan for commissioning perinatal services. A further recommendation therefore would be to develop strategic plans within each area for the commissioning of perinatal services.

Another potential service enhancement suggested by a partner, was to include a follow-up phone call from a healthcare professional during the week after birth, where partner and spouse could independently voice any concerns they had. This could be included within the normal postnatal checks, and would be of limited cost to services as would only require a follow-up or visit if concerns were expressed.

4.2.5. Intervention Development

One of the main clinical implications derived from this research is to develop an intervention to better support partners and couples. A clinical psychologist could be best placed to develop this new intervention, based on their clinical and research competencies. Currently, service provision mostly considers the spouse and infant, in isolation of their home environment and support network, yet partners provide a crucial care-giving role and may themselves experience stress and trauma. Partners' needs should be recognised and addressed, to enable them to continue to provide the best possible support for their spouse and infant. A specific intervention for partners is required, addressing the following points:

- Enquire as to how the partner is coping and feeling;
- Provide an opportunity for the partner to talk about, reflect, and make sense of their experiences;
- Explore the partner's sense of powerlessness and lack of control;
- Seek the partner's views, opinions, and concerns regarding their spouse;
- Consider any of the partner's experiences, or thoughts, surrounding loss and trauma;
- Encourage discussion of the partner's feelings, such as those of isolation, anxiety and fear;

- Provide support in managing the partner's stress associated with becoming a carer, and in multiple role management;
- Support the partner's development of effective coping strategies;
- Issue the partner with advice, or tips, on caring for their infant and supporting their spouse.

4.3. Strengths and Limitations

4.3.1. Study Aims

The aims of the current study have been considered and addressed as follows:

1) Explore the lived experiences of partners of women who have experienced PP

The completed interviews have provided a great insight into the lived experiences of partners of women who have had PP. The themes extracted from these interviews have been explored to help assist in the understanding of PP and the impact that it can have on partners.

2) Consider the impact of PP on partners' lives and relationships

The questionnaire provided some insight into the detrimental impact that PP can have on the quality of the couple relationship; whilst the interview provided information relating to the impact on partners' lives beyond relationships, looking towards their work, life, emotional health, and needs.

3) Gather information which may help inform future clinical interventions to support partners and couples experiencing PP

Information gathered from both questionnaires and interviews has informed suggestions as to how best to development new, accessible interventions to meet the needs of partners. The value of addressing these needs has been considered, in terms of the ongoing support and care that partners provide to their spouse and the insight that they hold.

4) *Help progress research within the area of PP and develop a stronger theoretical understanding of the effects of PP*

Results of the current study have been considered in relation to existing literature and psychological theory to help engender a greater understanding of PP, and the effects that it can have on those supporting and caring for the spouse. It also provides a stronger foundation on which to base future research. At this time, research that looks into the effects of PP on partners is largely unique and is, therefore, a strength of the current research. An additional strength of the current study is in completing the research alongside APP, as this means that the research is more likely to be disseminated and influence policy and future research.

4.3.2. Design

The qualitative design of the current study is a strength as it attempts to maintain the voice and personal experience of partners. However, some of the themes extracted that relate to partner experiences could be argued to represent the experiences of new fathers, without the context of PP. Partly due to the qualitative nature of the research, the design of the study does not allow for an easy comparison between partners' experiences, with and without the context of PP. Subjective interpretation of the results can postulate that some of the experiences may be shared with new fathers, such as managing multiple roles; however, the extent of this experience, and the number of roles partners manage, are greater when in the

context of PP. A study utilising the same design, but with first-time fathers not in the context of PP, would provide the most accurate comparison. A recent study by Kowlessar *et al.* (2015) considered first-time fathers' experiences using a qualitative design. Some similarities can be noted between the themes emerging from the current study, namely that of powerlessness, with that of helplessness as identified by Kowlessar *et al.*'s (2015). Interestingly, many of the other themes noted by Kowlessar *et al.* (2015) do not overlap with the current study and appear more heavily to denote the practical demands placed on new fathers, such as the theme of trial and error parenting.

Interpretative Phenomenological Analysis (IPA), as with any qualitative design, involves, to some degree, the subjective interpretation and understanding of information that is reported. Attempts have been made by the researcher to limit this subjectivity, through the use of quality assessments outlined by Elliott *et al.* (1999), and Yardley (2000; 2008). In addition, bracketing interviews and keeping a reflexive diary have been utilised to try and limit subjectivity and bias in analysis (Ahern, 1999; Chan *et al.*, 2013).

Recruiting a sample of eight participants is considered a good sample size for IPA, especially considering the low incident rates of PP at 1 to 2 per 1000 births (Mishra *et al.*, 2011; Smith *et al.*, 2009). Involvement of the charity APP has been of great benefit in the recruitment process and enabled service user involvement. Consultation was sought with APP staff who had experienced PP, both at the design stage for the online questionnaire and for the semi-structured interview, as well as at the dissemination stage when discussing and reporting results. The researcher found this involvement and insight to be of great value to the research.

Another factor that seems to have aided interview completion rates, is that partners were provided with the opportunity to select the mode of the interview. Interestingly, the majority of partners opted for the interview to be conducted either via the telephone or by Skype or Facetime. This appeared to be the least disruptive for partners, and could be completed at a time convenient to them (often in evenings). It also enabled privacy during the interview, as it did not require the researcher to attend the family home, or cause any disruption to the family routine by a stranger visiting the house. Providing such flexibility for completing the interview appeared to make the interview process more convenient and less disruptive to partners, which resulted in very open and fluid discussions.

4.3.3. Sample Demographics

One criticism of the study is that the recruited sample is inherently biased. The sample was homogenous with the majority of partners reporting having achieved a master's degree, being in full-time employment, being married or co-habiting, and having been with their spouse for a long period of time prior to the episode of PP occurring. All partners were white, Caucasian and in heterosexual couples. No partner volunteered who was separated from their spouse, yet research by Milgrom and McCloud (1996) established that there are high rates of separation and divorce following postnatal mental health problems. The biased sample may represent the recruitment method, as the majority of members of APP are women. It is possible that these women have then directed their partners towards advertisements for the study. It would be difficult to reach partners, or ex-partners, of women who have experienced PP through other means, due to the low incident rate of PP. The only other source of recruitment could be through the National Health Service, but, similarly, only partners still with their spouses may volunteer. One benefit of using APP has been that their website, forum, and social media feeds are available to members internationally, and led to

the recruitment of one participant who lived outside of the United Kingdom (UK). Interestingly, this partner shared the same themes, and similar experiences, as those living within the UK.

Another potential criticism of the study is that no one in the sample reported their spouse as having a pre-existing diagnosis of Bipolar Disorder (BD), which may have been expected given research by Jones and Craddock (2001; 2005) indicating that if women have a diagnosis of BD they are more at risk of PP. The ability to specifically question the spouse's mental health history was limited due to ethical constraints on indirectly seeking information about another individual without their consent. Within the current study, the partner consented to participation, and their spouse did not. However, all partners who completed the interview volunteered information that indicated their spouses had no prior history of BD. The fact that none of the partners reported their spouse as having a history of BD, leads to some questioning of Mishra *et al.*'s (2011, p.5) description of PP as an 'overt presentation of Bipolar Disorder that result from tremendous hormonal shifts during delivery'. Results from the current study demonstrate that PP can occur in the absence of a BD diagnosis, and may help further an understanding of PP.

4.3.4. Data Collection and Analysis

A strength of the current study is that the personal voice of partners has tried to be retained throughout the analysis process. The researcher has tried to achieve this through the use of direct quotes to support themes, and by providing partners with a pseudonym. The researcher also considered using quotes as theme names; however, the researcher was unable to find short quotes which encompassed all of the subordinate themes within a superordinate category. The researcher thus generated superordinate theme names to best encompass the

breadth and specificity of partners' experiences within each category. Consultation was sought with APP staff members, including those who had experienced PP, following theme identification to discuss the themes which emerged from the interviews. This consultation provided added insight and understanding, and enhanced the analysis process.

One area of questioning which could have been better defined by the researcher related to the PP episode duration. The question regarding duration was asked through the online questionnaire and this required the question to be brief, but responses from partners indicated that they may have interpreted duration as referring only to the acute phase of the episode. If the question had been worded differently, specifying that duration is defined as the period between the onset of their spouse's episode of PP until they felt their spouse had recovered, longer durations may have been noted which would have been more in keeping with existing literature.

4.4. Future Research and Direction

Future research would look at developing an intervention to help support partners and the couple; this would be achieved through consulting PP clinical specialists, service users, and their partners. Following on from results presented within this current study, the intervention would look to address experiences of loss and trauma, feelings of guilt and self-blame, conflicting demands placed on partners, coping, and psychosocial education around PP. The intervention would be piloted and evaluated and, if found to be beneficial, steps would be made to implement it across perinatal services.

Another area of interest would be to look at the long-term impact of PP on partners and the couple relationship. One of the main potential long-term changes noted within the current

study is that of change in the couple relationship. This predominately included change in the couple dynamic, whereby partners continue to monitor their spouse for any signs that they might be becoming unwell again. It would be interesting to explore and gather more information regarding this experience, gaining separate perspectives from the partner and the spouse. Moreover, it would be useful to identify with couples if they have noticed other changes in their relationship over a much longer time period after the episode of PP. This would provide a more thorough illustration of changes, or shifts, in the relationship dynamic over time, and would help inform any support that could be offered to couples.

It would also be informative to consider any potential long-term impact of PP on the infants. The current study has discussed the heightened role that partners can take in caring for their infant in the context of their spouse's PP. However, little information was provided by partners regarding the impact that this may have had on their relationship with their infant. Some partners reported having spent more time caring for their infant, whilst others noted increased initial separation from their infant due to admission to an MBU. It would be interesting to consider how the parent and infant relationship develops and emerges over time based on these different early perinatal care, attachment, and separation experiences.

Results from the current study, and any future research, will be disseminated back to clinical communities (from primary care staff to specialist perinatal services), to try and further their understanding of PP and the support that can be offered to couples, and more specifically partners. It is clear from the current study results, that there is the need for healthcare professionals to be further educated regarding PP, which may consequently result in quicker recognition and access to appropriate interventions, and more support provided to partners.

4.5. Conclusions

The current study has helped develop a more thorough understanding of PP and the impact that it can have on partners and the couple relationship. Some similarities have been noted with the experiences of partners of women with PND; however, distinct themes and results have also been identified. The study has provided a unique insight into partners' understanding of their experiences of PP, and has formed the basis from which new interventions for partners, and the couple, can be developed. Seven superordinate themes have been identified: powerlessness; united vs. individual coping; hypothesising and hindsight; barriers to accessing care and unmet needs; managing multiple roles; loss; and positive changes from PP. Areas of particular clinical interest stemming from these themes are: loss and trauma in partners; partners emotional experiences (such as those of guilt, regret and self-blame); partners multiple roles and associated demands; and the impact on the couple relationship. The study has also helped to identify current barriers to care and unmet needs, from a lack of awareness of PP and delays in accessing appropriate treatment, to a lack of support for, or consideration of, partners. This study has highlighted current service failures in meeting the NICE guidelines (2014) for perinatal care, and has informed the development of future intervention proposals. The impact of PP on partners is not limited to the episode of PP, partners have also identified ongoing changes as a result of PP; for example, the impact of loss and trauma, deterioration in the quality of the couple relationship, and altered interactions with their spouse. Interestingly, partners also highlighted some of the positives emerging from PP and the things that have helped them; for instance, access to a local MBU, being provided with reassurance, support and information by healthcare professionals, and being able to seek out advice and support regarding their spouse. Overall, the impact of PP on partners is broad and great, and requires consideration by healthcare

professionals in order to secure the best clinical outcomes for the spouse, the couple, and the infant.

References

Ahern, K.J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research, 9,* 407-411.

Ainsworth, M. (1973). The development of infant-mother attachment. In B. Cardwell & H. Ricciuti (Eds.) *Review of child development research* (Vol. 3, pp.1-94) Chicago: University of Chicago Press.

Albertsson-Karlgren, U., Graff, M. & Nettelbladt, P. (2001). Mental disease postpartum and parent-infant interaction – Evaluation of videotaped sessions. *Child Abuse Review, 10,* 5-17.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (*5th edn). Virginia: APA.

Anderson, M.L. (2003). Embodied cognition: A field guide. *Artificial Intelligence, 149,* 91-130.

Appleby, L., Mortensen, P.B. & Faragher, E.B. (1998). Suicide and other causes of mortality after post-partum psychiatric admission. *British Journal of Psychiatry, 173,* 209-211.

Beestin, L., Hugh-Jones, S. & Gough, B. (2014). The impact of maternal postnatal depression on men and their ways of fathering: an interpretative phenomenological analysis. *Psychology and Health, 29* (6), 717-735.

Benedek, T. (1959). Parenthood as a developmental phase: a contribution to the libido theory. *Journal of the American Psychoanalytic Association, 7,* 389-417.

Bergink, V., Burgerhout, K., Keerengevel, K., Kamperman, A., Hoogendijk, W., Lambregtse-van den Berg, M. *et al*. (2015). Treatment of psychosis and mania in the postpartum period. *American Journal of Psychiatry, 172* (2), 115-123.

Blackmore, E., Rubinow, D., O'Connor, T., Liu, X., Tang, W., Craddock, N. *et al.* (2013). Reproductive outcomes and risk of subsequent illness in women diagnosed with postpartum psychosis. *Bipolar Disorders, 15,* 394-404.

Blackwell, A., Ives, J., Berrisford, G. & Heron, J. (2015). *The experiences of men when their partners suffer postpartum psychosis: a qualitative study.* Manuscript submitted for publication.

Bowlby. J. (1969). *Attachment and loss. Vol. 1: Attachment.* New York: Basic Books.

Bowlby (1973). *Attachment and loss, Vol.2: Separation.* New York: Basic Books.

Bridges, L.J. & Grolnick, W.S. (1995). The development of emotional self-regulation in infancy and early childhood. In N. Eisenberg (Ed.), *Review of personality and social psychology, Vol. 15*. New York: Sage.

Brockington, I. (1996). *Puerperal psychosis in motherhood and mental health.*. Oxford: Oxford University Press.

Burt, V.K. & Rasgon, N. (2004). Special considerations in treating bipolar disorder in women. *Bipolar Disorders, 6,* 2-13.

Chan, Z.C.Y., Fung Y. & Chien, W. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process? *The Qualitative Report, 18, article 59,* 1-9.

Chandra, P.S., Bhargavaraman, R.P., Raghunandan, V.N. & Shaligram, D. (2006). Delusions related to infant and their association with mother-infant interactions in postpartum psychotic disorders. *Archives of Women's Mental Health, 9,* 285-288.

Conrad, P. (1987). The experience of illness: recent and new directions. *Research in the Sociology of Health Care, 6,* 1-31.

Cooper, P.J., Murrary, L. & Stein, A. (1993). Psychosocial factors associated with the early termination of breastfeeding. *Journal of Psychosomatic Research, 37,* 171-176.

Crotty, M. (1996). *Phenomenology and nursing research.* Melbourne: Churchill Livingston.

Cutrona, C. & Russell, D. (1987). The provisions of social relationships and adaptation to stress. In W.H. Jones & D. Perlman (Eds.) *Advances in personal relationships, Vol. 1* (pp.37-67). Greenwich, CT: JAI Press.

Davidsen, A. (2013). Phenomenological approaches in psychology and health sciences. *Qualitative Research in Psychology, 10,* 318-339.

DeMulder, E., Denham, S., Schmidt, M. & Mitchell, J. (2000). Q-sort assessment of attachment security during the preschool years: Links from home to school. *Developmental Psychology, 36* (2), 274-282.

Dennis, C. & Ross, L. (2006). Women's perceptions of partner support and conflict in the develop of postpartum depressive symptoms. *Journal of Advance Nursing, 56* (6), 588-599.

Denzin, N. (1995). The experiential text and the limits of visual understanding. *Educational Theory, 45* (1), 7-18.

Department of Health, (2015). *Annual report of the Chief Medical Officer, 2014, The health of the 51%: women.* Retrieved 2 January 2016 from www.gov.uk/government/uploads/system/uploads/attachment_data/file/484383/cmo-report-2014.pdf

Di Florio, A., Jones, L., Forty, L., Gordon-Smith, K., Robertson Blackmore, E., Heron, J. *et al.* (2014). Mood disorders and parity – a clue to the aetiology of the postpartum trigger. *Journal of Affective Disorders, 152,* 334-339.

Don, B.P. & Mickelson, K. (2012). Paternal postpartum depression: the role of maternal postpartum depression, spousal support, and relationship satisfaction. *Couple and Family Psychology: Research and Practice, 1* (4), 323-334.

Doucet, S., Jones, I., Letourneau, N., Dennis, C-L, & Robertson Blackmore, E. (2010). Interventions for the prevention and treatment of postpartum psychosis: a systematic review. *Archives of Women's Mental Health, 14,* 89-98.

Doucet, S., Letourneau, N. & Robertson Blackmore, E. (2012). Support needs of mothers who experience postpartum psychosis and their partners. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 41,* 236-245.

Dudley, M., Roy, K., Kelk, N. & Bernard, D. (2001). Psychological correlates of depression in fathers and mothers in the first postnatal year. *Journal of Reproductive and Infant Psychology, 19* (3), 187-202.

Edhborg, M., Lundh, W., Seimyr, L. & Widstrom, A. (2003). The parent-child relationship in the context of maternal depressive mood. *Archives of Women's Mental Health, 6,* 211-216.

Elliott, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative researcher studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229.

Engqvist, I., Ferszt, G., Ahlin, A. & Nilsson, K. (2012). Psychiatric nurses' descriptions of women with postpartum psychosis and nurses' responses – An exploratory study in Sweden. *Issues Mental Health Nursing, 30* (1), 23-30.

Engqvist, I. & Nilsson, K. (2014). The recovery process of postpartum psychosis from both the women's and next of kin's perspective – an interview study in Sweden. *The Open Nursing Journal, 8,* 8-16.

Essex, M.J., Klien, M.N., Miech, R. & Smider, N.A. (2001). Timing of initial exposure to maternal major depression and children's mental health symptoms in kindergarten. *British Journal of Psychiatry, 179,* 151-156.

Frayne, J., Brooks, J., Nguyen, T., Allen, S., Maclean, M. & Fisher, J.R.W. (2014). Characteristics of men accompanying their partners to a specialist antenatal clinic for women with severe mental illness. *Asian Journal of Psychiatry, 7,* 46-51.

Glangeaud-Freudenthal, N., Sutter, A., Thieulin, A., Dagens-Lafont, V., Zimmermann, M., Debourg, A. *et al.* (2011). Inpatient mother-and-child postpartum psychiatric care: Factors associated with improvement in maternal mental health. *European Psychiatry, 26,* 215-223.

Goodman, J. (2008). Influences of maternal postpartum depression on fathers and on father-infant interaction. *Infant Mental Health Journal, 29* (6), 624-643.

Goodman, S.H., Rouse, M.H., Connell, A.M., Broth, M.R., Hall, C.M. & Heyward, D. (2011). Maternal depression and child psychopathology: A meta-analysis review. *Clinical Child and Family Psychology Review, 14,* 1-27.

Hay, D., Pawlby, S., Sharp, D., Sten, P., Mills, A. & Kumar, R. (2001). Intellectual problems shown by 11-year-old children whose mothers had postnatal depression. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 42* (7), 871-889.

Heron, J., Gilbert, N., Dolman, C., Shah, S., Beare, I., Dearden, S. *et al.* (2012). Information and support needs during recovery from postpartum psychosis. *Archives of Women's Mental Health, 15,* 155-165.

Heron, J., McGuinness, M., Robertson Blackmore, E., Craddock, N. & Jones, I. (2008). Early postpartum symptoms in puerperal psychosis. *British Journal of Obstetric Gynaecology, 115,* 348-353.

Hipwell, A.E., Goossens, F.A., Melhuish, E.C. & Kumar R. (2000). Severe maternal psychopathology and infant-mother attachment. *Developmental Psychopathology, 12,* 157-175.

Hornstein, C., Trautmann-Villalba, P., Hohm, E., Rave, E., Wortmann-Fleischer, S. & Schwarz, M. (2006). Maternal bond and mother-child interaction in severe postpartum psychiatric disorders: Is there a link? *Archives of Women's Mental Health, 9,* 279-284.

Hughes, D., Baylin, J. & Siegel, D. (2012). *Brain-based parenting: The neuroscience of caregiving for healthy attachment.* New York: W.W. Norton & Company.

Jarvis, W. (1962). Some effects of pregnancy and childbirth on men. *Journal of the American Psychoanalytic Association, 10,* 689-700.

Johnstone, S., Boyce, P., Hickey, A., Morris-Yatees, A. & Harris, M. (2001). Obstetric risk factors for postnatal depression in urban and rural community samples. *Australian and New Zealand Journal of Psychiatry, 35,* 69-74.

Jones, I. & Craddock, N. (2001). Familiarity of the puerperal trigger in bipolar disorder: results of a family study. *American Journal of Psychiatry, 158,* 913-917.

Jones, I. & Craddock, N. (2005). Bipolar disorder and childbirth: the importance of recognising risk. *British Journal of Psychiatry, 186,* 453-454.

Kingston, D., Austin, M., Heaman, M., McDonald, S., Lasiuk, G., Sward, W. *et al.* (2015). Barrier and facilitators of mental health screening in pregnancy. *Journal of Affective Disorders, 186,* 350-357.

Kowlessar, O., Fox, J.R. & Wittkowki, A. (2015). First-time fathers' experiences of parenting during the first year. *Journal of Reproductive and Infant Psychology, 33,* 4-14.

Kuipers, L. (1992). Needs of relatives of long-term psychiatric patients. In G. Thornicroft, C.R. Brewin, & J. Wing (Eds.) *Measuring Mental Health Needs* (pp. 291-307). London: Gaskell.

Lane, A., Keville, R. Morris, M., Kinsella, A., Turner, M. & Barry, S. (1997). Postnatal depression and elation among mothers and their partners: prevalence and predictors. *British Journal of Psychiatry, 171* (12), 550-555.

Larkin, M., Eatough, V. & Osborn, M. (2011). Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory and Psychology, 21* (3), 318-337.

Lawson, A., Murphy, K., Sloan, E., Uleryk, E. & Dalfen, A. (2015). The relationship between sleep and postpartum mental disorders: A systematic review. *Journal of Affective Disorders, 176,* 65-77.

Lazarus, R. & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1,* 141-169.

Letourneau, N., Dennis, C.L., Benzies, K., Duffett-Leger, L., Stewart, M., Tryphonopoulos, P. *et al.* (2012). Postpartum depression is a family affair: Addressing the impact on Mothers, Fathers, and Children. *Issues in Mental Health Nursing, 33,* 445-457.

Lija, G., Edhborg, M. & Nissen, E. (2011). Depressive mood in women at childbirth predicts their mood and relationship with infant and partner during the first year postpartum. *Scandinavian Journal of Caring Sciences, 26,* 245-253.

Logsdon, M. & Usui, W. (2001). Psychosocial predictors of post-partum depression in diverse groups of women. *Western Journal of Nursing Research, 23,* 563-574.

Lovestone, S. & Kumar, R. (1993). Postnatal psychiatric illness: the impact on partners. *British Journal of Psychiatry, 163,* 201-216.

Luterman, D. (2008). *Counseling Persons with Communication Disorders and Their Families* (5th edn). Austin, TX: ProEd.

Lyons, E. & Coyle, A. (2007). *Analysing Qualitative Data in Psychology.* London: Sage.

Main, M. & Solomon, J. (1990). Procedures for identifying infants as disorganized-disoriented during the Ainsworth Strange Situation. In M. Greenberg, D. Cicchette & E. Cummings (Eds.) *Attachment in the preschool years: Theory, research and intervention* (pp.121-160). Chicago: University of Chicago Press.

Marks, M., Wieck, A., Checkley, S. & Kumar, C. (1996). How does marriage protect women with histories of affective disorder from post-partum relapse? *British Journal of Medical Psychology, 69,* 329-342.

Marrs, J., Cossar, J. & Wroblewska, A. (2014). Keeping the family together and bonding: a father's role in a perinatal mental health unit. *Journal of Reproductive and Infant Psychology, 32* (4), 340-354.

Martins, C. & Gaffan, E. (2000). Effects of early maternal depression on patterns of infant-mother attachment: a meta-analytic investigation. *Journal of Child Psychology and Psychiatry, 41,* 737-746.

McCubbin, M. & McCubbin, H. (1993). Families coping with illness: The resiliency model of family stress, adjustment and adaption. In C. Danielson, B. Hamel-Bissell, & P. Winstead-Fry (Eds.) *Families: Health and illness, perspectives on coping* (pp.20-64). St. Louis: Mosby.

McGrath, L., Peters, S., Wieck, A. & Wittkowski, A. (2013). The process of recovery in women who experienced psychosis following childbirth. *BioMed Central Psychiatry, 13,* 341.

McNeil, T.F., Perrson-Blennow, L., Binett, B., Harty, B. & Karyd, U.B. (1988). A prospective study of postpartum psychoses in a high-risk group. 7 Relationship to later offspring characterics. *Acta Psychiatrica Scandinavica, 78,* 613-617.

Meighan, M., Davis, M. & Thomas, S. (1999). Living with postpartum depression: The father's experience. *American Journal of Maternal Child Nursing, 24* (4), 202-208.

Milgrom, J. & McCloud, P. (1996). Parenting stress and postnatal depression. *Stress Medicine, 12,* 177-186.

Mishra, S., Kar, S., Reddy, P. & Swain, S. (2011). Postpartum Psychosis: Review. *The Orissa Journal of Psychiatry, 2,* 5-9.

Morgan, M., Matthey, S., Barnett, B. & Richardson, C. (1997). A group programme for postnatally distressed women and their partners. *Journal of Advanced Nursing, 26,* 913-920.

Morinaga, K. & Yamauchi, T. (2003). Childbirth and changes of women's social support network and mental health. *Shinrigaku Kenkyu, 74,* 412-419.

Murray, L., Cooper, P. & Hipwell, A. (2003). Mental health of parents caring for infants. *Archives of Women's Mental Health, 6* (2), 1434-1816.

Murray, L. & Hipwell, A. (1995). The impact on the child of maternal psychiatric disorders occurring after childbirth. *Current Obstetrics and Gynaecology. Mini-symposium: Mental disorders in Pregnancy, 5,* 75-80.

Murray, L., Sinclair, D., Cooper, P., Ducournau, P. & Turner, P. (1999). The socioemotional development of 5-year-old children of postnatally depressed mothers. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 40* (8), 1259-1271.

National Institute for Health and Care Excellence (2014). *Antenatal and postnatal mental health: clinical management and service guidance.* Retrieved 2 January 2016 from *www.nice.org.uk/guidance/cg192*

Noorlander, V., Bergink, V. & van den Berg, M. (2008). Perceived and observed mother-child interaction at time of hospitalization and release in postpartum depression and psychosis. *Archives of Women's Mental Health, 11,* 49-56.

Patel, V., Rodrigues, M. & DeSouza, N. (2002). Gender, poverty, and postnatal depression: a study of mothers in Goa, India. *American Journal of Psychiatry, 159,* 43-47.

Paykel, E., Emms, E., Fletcher, J. & Rassaby, E. (1980). Life events and social support in puerperal depression. *British Journal of Psychiatry, 136,* 339-346.

Pearson, R.M., Melotti, R., Heron, J., Joinson, C., Stein, A., Ramchandani, P.G. *et al.* (2012). Disruption to the development of maternal responsiveness? The impact of

prenatal depression on mother-infant interactions. *Infant Behavior and Development, 35,* 613-626.

Poh, H., Koh, S., Seow, H. & He, H.G. (2013). First-time fathers' experiences and needs during pregnancy and childbirth: A descriptive qualitative study. *Midwifery, 30,* 779-787.

Reicher, S. (2000). Against methodolatry: Some comments on Elliott, Fischer and Rennie. *British Journal of Clinical Psychology, 39,* 1-6.

Riordan, D., Appleby, L. & Faragher, B. (1999). Mother-infant interactions in post-partum women with schizophrenia and affective disorders. *Psychological Medicine, 19,* 991-995.

Robertson, E., Jones, I., Haque, S., Holder, R. & Craddock, N. (2005). Risk of puerperal and non-puerperal recurrence of illness following bipolar affective puerperal (post-partum) psychosis. *British Journal of Psychiatry, 186,* 258-259.

Robertson, E. & Lyons, A. (2003). Living with puerperal psychosis: a qualitative analysis. *Psychological Psychotherapy Theory and Research Practice, 76,* 411-431.

Rolls, L. & Relf , M. (2006). Bracketing Interviews: addressing methodological challenges in qualitative interviewing in bereavement and palliative care. *Mortality, 11,* (3), 286-305.

Seeley, S., Murray, L. & Cooper, P.J. (1996). The detection and treatment of postnatal depression by health visitors. *Health Visit, 64,* 135-138

Sit, D., Rothschild, A. & Wisner, K. (2006). A review of postpartum psychosis. *Journal Women's Health, 15,* 352-368.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11,* 261-271.

Smith, J.A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5* (1), 9-27.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research.* London: SAGE Publications.

Stewart, D.E., Klompenhouwer, J.L., Kendall, R.E. & Van Hulst, A.M. (1991). Prophylactic lithium in puerperal psychosis: the experience of three centres. *British Journal of Psychiatry, 158,* 393-397.

Takeda, F., Miyaji, F., Yamaguchi, T. & Nozaki, S. (1998). Postpartum depression and social support. *Japanese Journal of Public Health, 45,* 564-571.

Tissot, H., Scaiola, C., Frascarolo, F., Despland, J.N., Stiefel, F. & Favez, N. (2014). Family alliance as a moderator of the link between maternal postpartum depression and child symptoms assessed by both parents. *Journal of Family Issues, 35* (11), 1520-1542.

Vondra, J., Shaw, D., Swearingen, L. Cohen, M. & Owens, E. (2001). Attachment stability and emotional and behavioural regulation from infancy to preschool age. *Development and Psychopathology, 1*, 13-33.

Wee, K.Y., Skouteris, H., Pier, C., Richardson, B. & Milgrom, J. (2011). Correlates of ante- and postnatal depression in fathers: a systematic review. *Journal of Affective Disorders, 130,* 358-377.

Weiss, R. (1974). The provisions of social relationships. In Z.Rubin (Ed*.) Doing Unto Others* (pp.17-26.). Englewood Cliffs, NJ: Prentice-Hall.

Welsh Government Consultation Document (2015*). Chief Medical Officer for Wales Annual Report 2014-2015: Healthier, Happier, Fairer*. Retrieved on 2 January 2016 from www.gov.wales/docs/phhs/publications/160323cmoreporten.pdf

Welsh Government Consultation Document (2016). Together for Mental Health Delivery Plan: 2016-2017 (Number: WG27588). Retrieved on 2 January 2016 from www.gov.wales/docs/dhss/consultation/160118documenten.pdf

Wisner, K.L., Peindl, K. & Hannusa, B.H. (1994). Symptomatology of affective and psychotic illness related to childbearing. *Journal of Affective Disorder, 30,* 77-78.

Zelkowitz, P. & Milett, T. (1996). Postpartum psychosis disorders: Their relationship to psychological adjustment and marital satisfaction in the spouses. *Journal of Abnormal Psychology, 105* (2), 281-285.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15,* 215-228.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J.A. Smith (Ed.) *Qualitative psychology: A practical guide to methods* (2nd Edn., pp.53-80). London: Sage.

Zhang, R., Chen, Q. & Li, Y (1999). Study for the factors related to postpartum depression. *Chinese Journal of Obstetrics and Gynecology, 34,* 231-233.

Appendices

Appendix A. **Table 8.** Establishing the Quality of Studies Considered, According to Critical Appraisal Skills Programme - Qualitative Checklist

Reference	1. Clear Statement of Aims?	2. Methodology Appropriate?	3. Research Design Appropriate to Aims?	4. Recruitment Strategy Appropriate to Aims?	5. Data Collection Addressed Research Issue?	6. Considered Relationship between Researcher and Participant?	7. Ethical Issues Considered?	8. Data Analysis Sufficiently Rigorous?	9. Clear Statement of Findings?	10. How Valuable is the Research?	QUALITY RATING
Beestin *et al*. (2014)	2 To understand impact of PND on partners & fathering.	2 IPA focused on lived experience.	2 Qualitative exploration.	1 Formal diagnosis of PND was not required but focused on perception from partner as to PND present. But recruitment through NSPCC support group for women with PND, or via NCT fathers' group. Therefore, some recruitment via spouse.	1 Author provided some voice to partners' experiences. But not stipulate all questions asked so cannot fully ascertain.	0 No mention of researcher participant relationship. No consideration of reliability or biases.	1 University ethics provided.	2 Discussed themes within research group to avoid narrow focus on one researcher. Considered Yardley's (2000) criteria for quality in qualitative investigations.	2 Key themes identified were stated.	2 Partners' view not previously considered in this depth.	15/20 75%

Marrs *et al.* (2014)	2 To understand impact of admission to MBU on partners' role and relationships.	2 Grounded Theory of impact of MBU admittance of partners.	2 Qualitative exploration	1 Professionals at MBU identified potential participants. But maternal illness resulting in admission not considered – partners' experiences may have been different depending on maternal illness (e.g. PND or PP).	2 Open-ended questions sought to explore partners' experiences. Some question examples provided.	1 Portion of transcripts secondary coded to check for researcher bias in coding.	2 Ethical Approval. Issues around informed consent reported.	1 Discussed emergent themes with secondary researchers. Gained feedback from participant on study findings. No apparent consideration of quality framework for qualitative research.	2 Generated model to encompass findings.	2 Valuable to consider impact of separation from mother and infant in partners' experiences.	17/20 85%
Meighan *et al.* (1999)	2 To gain deeper understanding of PND and impact on families.	1 Qualitative analysis appropriate, but IPA may have been better to explore lived experience.	2 Qualitative design appropriate to study aims.	1 Recruitment occurred through spouse engagement in other project or through healthcare professionals. Little is known of how sample was selected other than through support group for PND. Little information provided about sample obtained.	2 Statements provided by participants seem rich in detail.	0 Not reported.	1 Considered under institutional review board but no comment on ethical considerations.	1 Two groups analysed transcripts.	2 Findings clearly noted through extraction of key themes.	1 Gaining an understanding of impact on partners is important, but responses reported in the article may reflect the presence of spouse in the room at time of interview.	13/20 65%

Table key:

Questions scored on scale: *0 = not present/not reported, 1 = partially present, 2 = present.* Total achievable score = 20. Scores achieved converted to percentages.

Appendix B. Table 9. Establishing the Quality of Quantitative and Observational Studies According to Critical Appraisal Skills Programme - Case Control Checklist

Reference	1. Did the Study Address a Clearly Focused Issue?	2. Methodology Appropriate?	3. Acceptable Recruitment Strategy?	4. Acceptable Selection of Controls?	5. Exposure Measured Accurately ? (minimising bias)	6. Confounding Factors Accounted For?	7. What are the Results of the Study?	8. How Precise are Results?	9. Believe Results?	10. Can Results be Applied to Local Population?	11. Results Fit with Other Available Evidence?	QUALITY RATING
Albertsson-Karlgren *et al*. (2001)	2 Explored impact of mental health problems on parent-infant interactions through observation.	2 Observational.	2 Random visits to four psychiatric and health hospitals in Sweden.	1 Only health control provided. No 'well' woman control.	2 Observations measured through sensitivity and specificity ratings and by Parenting Coding System trained rater. Little discussion on reliability ratings of scores, but rater coded videos blinded to which group mothers were in.	1 Considered socio-demographics of health sample to be roughly equivalent to experimental group.	At 10 months, mothers with mental health problems showed less sensitivity, and at 2 years showed less positive affect and less link-infant follow. Fathers in clinical group showed more warmth compared to mothers. In health group, partners showed higher autonomy and lower link-infant follow than mothers. Concluded partners have more active	1 Precise scores obtained for interactions	1 Sample remained small therefore larger sample would make results more substantial.	1 Sample is small so generalise with caution.	1 Mostly, although authors' commented results from this study deviate slightly from their previous findings.	14/20 70%

							parenting role when mothers mentally unwell and act as buffer to mother-infant relationship.					
Edhborg *et al.* (2003)	2 Examined parent-child interactions at 15-18 months in PND and non-PND families.	2 Appropriate, well-established scoring of interactions using PCERA.	0 Not state how community sample accessed.	1 Community sample screened with EPDS to identify controls and sample. Not report the range of scores within each group.	2 Control and experimental groups completed same interaction activities. Observational coders both trained to use PCER and blinded to the EPDS scores. Scores from two independent raters.	1 Parity, parental age, SES, sex of infant - found not to differ across groups, therefore considered consistent across groups.	Partners compensate for the mothers' depressive symptoms.	1 Results considered individual parent – infant interaction (not collectively as infant and parents).	1 Due to low sample of complete data sets considered, would want to repeat with larger sample and indicators of range of EPDS scores.	1 Community sample, so translatable, but require larger sample size, and repeat to generalise.	2 Other research also indicate partner providing buffering or moderating role as to the impact of PND.	13/20 65%
Goodman (2008)	2 Explored influence of maternal PND on partners and partner-infant interaction.	2 Mixed – observational (interactions) and quantitative questionnaires.	1 Women provided with study information and permission to contact 4-6 weeks postpartum to inform and complete research. Not clear how partners consented, other than indirectly recruited through women.	2 Utilised EPDS to distinguish experimental vs. control groups. Groups considered equal in socio-demographic factors.	1 Most questionnaires self-reported. Couples instructed to complete questionnaires separately but as questionnaires completed without researcher present, this may not always have been the case. Researchers were trained to score interactions.	1 Age, race, education level.	Maternal PND associated with increased paternal PND, and higher paternal parenting stress. Partners of women with PND show less optimal interaction with infants, indicating partners not compensate for any negative effect of the mother's PND.	1 Most data analyses in terms of correlation data. Some factors not clearly controlled for (e.g. impact on infant interaction with both mother and father demonstrating PND).	0 Results provided may be accurate but explanation for them may be different – e.g. mothers with PND have infants who display less interactions with partners, but potentially this is when partners also have PND.	1 Sample size large but sample limited to white, educated and middle-class.	0 Results conflict with previous research evidence.	11/20 55%

							Maternal interaction not influenced paternal interaction, but how mother felt about her relationship with infant did.					
Lovestone & Kumar (1993)	1 Explore the impact of postnatal mental health problems on partners.	1 Title not clearly related to methodology. Methodology appropriate to ascertain presence of mental health problems in partners.	2 Recruited through MBU, general psychiatric unit, and maternity ward. Recruited indirectly through spouse.	2 Two controls (one spouses with mental health problems no infants, and one spouses on maternity ward with no illness).	2 All questionnaires administered are well-established and standardised.	2 Controlled for becoming a father, low birth weight infant, twins, teenage mother, severe medical complications, birth deformity, non-English speaking.	12/24 partners of women in MBU demonstrated mental health problems. MBU partners also more likely to have poor relationships with their own fathers, and history of chronic social problems.	2 Results are precise based on measures to obtain, and use controls, although sample small.	2 Due to measures to obtain and control groups.	1 To some degree, but would advise repeat with larger samples. Also unclear extent results demonstrate impact of PND, rather than pre-existing mental health problems in partners (8/12 prior mental health problems).	2 Results fit with other research.	17/20 85%
Milgrom & McCloud (1996)	2 Considered impact of PND on parenting stress.	2 Longitudinal study with control group utilising standardised measures.	1 Recruited through MBU and other agencies (but not specified).	1 Controls screened for depression and other mental health problems. Another control group could have been set up of women admitted for physical health reasons to	2 All measures are standardised tools.	1 Matched control group.	Significant difference in parenting stress, parent mood, and perception of infant and themselves when PND present.	2 Precise given measures all standardised	2 Sample size adequate, controls provided, and measures standardised.	2 Generalisable results.	2 Fits with research showing impact of PND on partners and their perceived relationship.	17/20 85%

				hospital.								
Zelkowitz & Milett (1996)	2 Explored stress and social support to psychological adjustment, attitudes to parent role and perceptions of infant behaviour.	2 Through clinical interview and questionnaire.	2 Through two community health care centres.	2 Control established during screening procedure (scores below 10 on EPDS)	1 Most factors measured using well-established measures, apart from stress and support which were seemingly measured using a set of questions with yes/no answers.	2 Women recruited who lived with partners, no health concerns with infant, and singleton birth.	High stress associated with more partner psychological symptoms. Partners of women with PND displayed more stress, work stress, economic pressure, and less likely to report supportive in-laws, or other relatives, or friends. Stress was associated with more negative perceptions of marriage, parental role, and infant behaviour. Work related stress had impact on paternal attitudes.	2 Precise as all quantitative measures.	1 Standardised measures mostly used. Supports previous research noting impact of PND on partners.	1 Both recruitment sources urban setting, perhaps having another sample within rural area would increase generalisability of results. Results as stand can be generalised to couples in equivalent urban settings.	2 Results support other research looking at impact of PND on partners.	17/20 85%

Table key:

Questions scored on scale: *0= not present/not reported, 1= partially present, 2= present.* Total achievable score = 20. Scores achieved converted to percentages.

Appendix C. Ethics Approvals

From: psychethics
Sent: 25 November 2014 10:07
To: Nia Holford
Cc: Sue Channon
Subject: Ethics Feedback - EC.14.11.11.3914R2

Dear Nia,

The Chair of the Ethics Committee has considered the further revisions you made to your postgraduate project proposal: The Impact of Postpartum Psychosis on Partners (EC.14.11.11.3914R2).

The project has now been approved.

Please note that if any further changes are made to the above project then you must notify the Ethics Committee.

Best wishes,

Natalie

From: psychethics <psychethics@cardiff.ac.uk>
Subject: Ethics Feedback - EC.14.11.11.3914R2A
Date: 23 February 2015 15:13:54 GMT
To: Nia Holford <HolfordN1@cardiff.ac.uk>
Cc: Sue Channon <ChannonS2@cardiff.ac.uk>

Dear Nia,

The Ethics Committee has considered the amendment to your postgraduate project: The Impact of Postpartum Psychosis on Partners (EC.14.11.11.3914R2A).

The amendment has been approved. The Committee recommended that participants are provided with details of where they may find suitable support if they were to become distressed as a result of reflecting on a disturbing time.

Please note that if any further changes are made to the above project then you must notify the Ethics Committee.

Best wishes,

Natalie

Appendix D. Recruitment Information

A STUDY INTO PARTNER's EXPERIENCES OF POSTPARTUM PSYCHOSIS

I am a Trainee Clinical Psychologist with the South Wales Clinical Psychology Doctoral Programme based at Cardiff University. I am conducting research along with Professor Ian Jones (Chair of Action for Postpartum Psychosis (APP)) into the experiences of partners of women who have had Postpartum Psychosis. The main aim of the research is to explore partner's experiences of Postpartum Psychosis with the hope that this will help us to understand their experiences, and help inform and improve what support can be offered both to partners but also to the new mothers.

You may have heard Postpartum Psychosis referred to as Puerperal Psychosis, Perinatal Psychosis or simply PP. We generally use the term Postpartum Psychosis but if you know it by any other name we are still interested to hear from you. Postpartum Psychosis is a severe episode of mental illness that starts suddenly shortly after childbirth, and occurs in 1-2 in 1000 deliveries. As it occurs rarely, only limited research has been conducted on it but we know that there are certain risk factors in developing Postpartum Psychosis, what symptoms women tend to experience, and that with treatment most women recover fully. However, not much is known about the experiences of the partners of women who have experienced these episodes.

We are looking for partners of women who have had a diagnosed episode of psychosis following childbirth to complete a brief questionnaire about their experiences. We are looking for partners of women who have had an episode of Postpartum Psychosis less then 10 years ago and more than 6 months ago. This is a retrospective study so we are not looking for partners of women who are currently experiencing PP.

If you are a partner of someone who has had Postpartum Psychosis, and would like to take part, please explore the following link for more information and the option to complete the brief questionnaire online. Alternatively, paper copies of the questionnaire can be requested through the below email address. If you have had postnatal psychosis yourself, and think your partner (who was with you at the time of your PP episode) would be interested in completing this questionnaire, please forward this onto your partner for their consideration.

https://cardiffunipsych.eu.qualtrics.com/SE/?SID=SV_9S9HBXpvI2QHSy9

Many thanks.

If you have any further questions about this research, please contact me - Nia Holford (Trainee Clinical Psychologist) on HolfordN1@cardiff.ac.uk

This study was given ethical approval by Cardiff University.

Appendix E. Participant Questionnaire Information and Consent Form (online)

"The Impact of Postpartum Psychosis on Partners"

I am a Trainee Clinical Psychologist with the South Wales Clinical Psychology Doctoral Programme based at Cardiff University. I am conducting research along with Professor Ian Jones (Chair of Action for Postpartum Psychosis (APP)) into the experiences of partners of women who have had Postpartum Psychosis.

The main aim of the research is to explore partner's experiences of Postpartum Psychosis with the hope that this will help us to understand their experiences, and help inform and improve what support can be offered both to partners but also to the new mothers.

You may have heard Postpartum Psychosis referred to as Puerperal Psychosis, Perinatal Psychosis or simply PP. We generally use the term Postpartum Psychosis but if you know it by any other name we are still interested to hear from you. Postpartum Psychosis is a severe episode of mental illness that starts suddenly shortly after childbirth, and occurs in 1-2 in 1000 deliveries. We are looking for partners of women who have had a diagnosed episode of psychosis following childbirth to complete a brief questionnaire about their experiences. We are looking for partners of women who have had an episode of Postpartum Psychosis less then 10 years ago and more than 6 months ago. This is a retrospective study so we are not looking for partners of women who are currently experiencing PP.

If you would be willing to complete the questionnaire please click next.

NEXT

"The Impact of Postpartum Psychosis on Partners"

Please check each box to say you have read and understood the following statements:

- ☐ *I confirm I am over 18 years of age.*
- ☐ *I confirm that I have read and understood the information provided about the following study.*
- ☐ *I understand that my participation is voluntary and that I am free to withdraw at anytime without giving reason.*
- ☐ *I consent to taking part in the study.*

NEXT

Appendix F. Online Questionnaire – Partners' Postpartum Experience

Thank you very much for expressing an interest in our research and agreeing to complete this questionnaire. You will now be asked a series of questions, some will focus on your experiences but some may also ask about your partner to try and provide a detailed background to help us understand your experiences.

Study ID Number:_____ Date of Completion:___/___/___

To start with it would be useful to know a bit of information about you.
Please Circle the relevant responses

1. Age:

18-24 25-29 30-34 35-39

40-44 45-49 50+

2. Marital Status:

Single Co-Habiting Married/Civil Partnership

Divorced Widowed

3. Educational Attainment level:

No qualifications GCSEs 'A' Levels Diploma

Undergraduate Degree Masters PhD/Doctorate

4. Employment Status:

Unemployed Volunteer Part -Time worker

Full-Time worker

5. Family:

5.1 How many children do you have from your current relationship?

0 1 2 3 4 5+

5.2 Do you have any children from previous relationships? *If so*, how many?
0 1 2 3 4 5+

6. Pregnancy:

We would now like to ask you about the pregnancy after which the postpartum episode started. If you and your partner have experienced multiple pregnancies resulting in postpartum psychosis, please focus on the first pregnancy where psychosis occurred.

6.1 Was the pregnancy planned?

YES NO

6.1a Was the child born from this pregnancy your…?

1st child 2nd child 3rd child 4th child other(please specify)

6.1b How long had you and your partner been together before this pregnancy?

_____ _____
(Months) (Years)

6.2 Did you have any reason to expect your partner to become unwell during/after pregnancy?

YES NO

6.2a *If Yes*, please describe your reasons

_____

_____

_____

6.2b *If yes*, did you consult any help/support/advice in planning your pregnancy?

YES NO

6.2c *If yes*, what form of help/support/advice did you seek/receive?

- ☐ Informational support on conceiving
- ☐ Consultation from perinatal psychiatrist
- ☐ Consulting community mental health team
- ☐ Consulting GP
- ☐ Other (*please specify*)_____

6.2d Did you have a history of mental health difficulties prior to your partner's pregnancy?

YES NO

6.2e *If yes*, what was the nature of your mental health difficulty?

_____

_____

7. Postpartum Episode:
We would now like to ask for a few details about your experience of the episode of postpartum psychosis.

7.1. In your opinion, approximately when did the episode begin?

_____ _____
(Month) (Year)

7.2. In your opinion, approximately how long did the total episode last?

<7 DAYS 1-4WEEKS 1-3MONTHS

4-6MONTHS 7-12MONTHS >1 YEAR

7.3. Did the episode start during pregnancy or after birth?

DURING AFTER

7.3a *If the episode occurred during pregnancy*, how many weeks pregnant was your partner when you noticed they started to become unwell? (Please note NA if occurred after birth)

_____
(Weeks)

7.3b *If the episode occurred after birth*, how soon after pregnancy did you notice your partner start to become unwell? (Please note NA if occurred during pregnancy)

_____ OR _____
(Days) (Weeks)

8. During Episode of Illness

It would be really useful for us to know about what support and help was offered to you and your partner, and you both as a couple during this time.

8.1 Was any professional support, information or advice provided during the episode *(please tick all/any that apply*?

	Self	Your Partner	As a Couple
Information on illness			
Information on baby			
Support group information specific to those having experienced perinatal mental health difficulties			
Support group information relating to having a baby			
Talking therapy (e.g. counselling or psychological support)			
Psychiatric review (e.g. Medication)			
Ongoing community support relating to mental health difficulties (e.g. regular visits from CPN or Social Worker)			
Ongoing community support relating to caring for baby (e.g. regular visits from health visitor, or midwife)			
Other… (*please specify*)			

8.1a Who provided the support? *(please tick all/any that apply*?

	Self	Your Partner	As a Couple
Peer Group/Community Led Group			
GP			
Health Visitor			
Midwife			
Perinatal Mental Health Team			
Community Mental Health Team			
Community Psychiatric Nurse/Mental Health Nurse			
Social Worker			
Counsellor			
Clinical Psychologist			
Psychiatrist			
Other… (*please specify*)			

8.2. Did the episode of illness involve your partner being admitted to hospital? *Please specify.*

- ☐ No
- ☐ General Psychiatric Unit/Ward
- ☐ Perinatal Psychiatric Unit/Ward
- ☐ Mother & Baby Unit

8.4. During your partner's episode of illness, did you seek help or support for your own mental health difficulties?

YES NO

8.4a Since your partner's episode of illness, have you sought help or support for your own mental health difficulties?

YES NO

8.5. Do/Did you and your partner plan to have future pregnancies after this episode?

YES NO

8.6. Are you still with your partner (N.B. partner who experienced this with you)?

YES NO

8.7 How would you rate your relationship prior to this episode? (10 being excellent)

0 1 2 3 4 5 6 7 8 9 10

8.7a How would you rate your relationship during this episode? (10 being excellent)

0 1 2 3 4 5 6 7 8 9 10

8.7b How would you rate your relationship since this episode? (10 being excellent)

0 1 2 3 4 5 6 7 8 9 10

9. General Comments:

Thank you for completing this questionnaire – your contribution to our research is much appreciated. We may want to contact you to ask you some more in-depth questions regarding your experiences of PP in the form of a one-off interview. If you would be happy for us to contact you to explain a bit more about the interview so you can decide if you would be willing to take part, please tick the box and provide contact details below. Many thanks.

☐

Contact Information

Name: _____

Telephone Number: _____

Email Address: _____

Address: _____
_____
_____
_____
_____

Is there a particular day or time of day that it would be best to contact you?

	AM	PM	EVENING
Monday	_____	_____	_____
Tuesday	_____	_____	_____
Wednesday	_____	_____	_____
Thursday	_____	_____	_____
Friday	_____	_____	_____

Should you feel distress as a result of completing this study please seek support from your healthcare provider or contact Nia Holford for information on sources of support. Many charities offer support for individuals experiencing distress, for example, The Samaritans 08457 90 90 90 (24 hour helpline), or Action for Postpartum Psychosis offer an online PPtalk forum, and a peer support network (see www.app-network.org).

Appendix G. Follow-Up Information Sheet About Postpartum Psychosis Research and Interview

Dear….
Thank you for completing the questionnaire regarding your experiences of your partner's Postpartum Psychosis episode. The information that has been provided was very informative and has already helped our research greatly. As was mentioned at the end of the questionnaire, we are looking for some participants to also complete a one-off interview about their experiences. You marked at the end of the questionnaire that you would be happy to be contacted for us to provide you with some more information about this interview.

We are looking to interview 10-20 partners of women who have had PP in order to try and provide a rich description of their experiences. The main aim of the research is to help promote understanding of partner's experiences, and inform and improve what support can be offered to partners but also to new mothers.

The choice to take part in a further interview is optional and does not impact on the information you have already provided in the questionnaire.

The interview would be a one-off, and would last the maximum of one hour. Questions within the interview would be focused on asking more details about your experiences of PP. We would try to arrange the interview at a time that is convenient with you. Depending on your location and preference, this interview may occur face-to-face in your home, or through Skype/Facetime, or as a telephone interview. The interview would be audio recorded (with your permission) so that the information you provide can be accurately considered. Please note that all audio recordings will be deleted following transcription, and all information gathered during the interview will be kept confidential (including the audio recording). The interview transcription will be anonymised and only anonymised information will be shared with supervisors on the project and included when writing up the results of the research.

If you decided to take part in the interview, you may still opt to withdraw without providing a reason, until your interview is anonymised. If you decide to withdraw from this study, all information you have provided will be destroyed and not used further in the research. It will not be possible to withdraw following your interview being anonymised as we will then not be able to identify which is your data.

If you would like to take part in this interview please contact us to arrange a day/time for the interview. *Similarly, if you have any further questions about this research, please contact Nia Holford (Trainee Clinical Psychologist) on HolfordN1@cardiff.ac.uk*

This study was given ethical approval by Cardiff University.
Address: South Wales Clinical Psychology Doctorate Programme, School Of Psychology, Cardiff University, Tower Building, 70 Park Place, Cardiff. CF10 3AT Tel.: 02920 870582

Appendix H. Consent Form for Interview

CONSENT FORM

AGREEMENT TO TAKE PART IN THE STUDY:
"The Impact of Postpartum Psychosis on Partners"
Please carefully read the following statements and if you are happy with each statement please ***initial*** *each box and sign at the bottom.*

1. *I have read the attached information sheet on the above project and have been given a copy to keep.* ☐
2. *I have had the opportunity to ask questions about the project and understand why the research is being done.* ☐
3. *I agree to a one-off interview regarding my experience of Postpartum Psychosis. I understand that if I agree to the interview, it will be audio recorded. All audio recordings will be deleted following transcription.* ☐
4. *I understand that participation in this project is voluntary and that I am free to withdraw from the study, without giving a reason, prior to my data being anonymised. After this time, it will be impossible to trace the information provided due to it having been anonymised.* ☐
5. *I understand that I will not financially benefit from taking part in this research.* ☐
6. *I understand that all information I provide during this interview will be held in a confidential form by the researcher (with the exception of any information about harm to children in which case the researcher has a duty to inform the relevant agencies). The interview transcription will be anonymised and only anonymised information will be shared with supervisors on the project and included when writing up the results of the research.* ☐
7. *I know how to contact the researcher (Nia Holford) if I need to.* ☐

*PRINT NAME:*_____ *SIGN NAME:*_____ *DATE:*_____

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

Address: South Wales Clinical Psychology Doctorate Programme, School Of Psychology, Cardiff University, Tower Building, 70 Park Place, Cardiff. CF10 3AT
Tel.: 02920 870582

Should you feel distress as a result of completing this study please seek support from your healthcare provider or contact Nia Holford for information on sources of support. Many charities offer support for individuals experiencing distress, for example, The Samaritans 08457 90 90 90 (24 hour helpline), or Action for Postpartum Psychosis offer an online PPtalk forum, and a peer support network (see www.app-network.org)

Appendix I. Interview Question Topic Guide

1) Tell me about your experiences of PP? What happened?

2) What do you feel triggered the episode?

3) How did you cope?

4) What did a typical day look like to you at that time?

5) If you compared your role and responsibilities within your immediate family during that episode to before the episode, would it look different? If so, how?

6) If you compared your role and responsibilities within your immediate family during that episode to now, would it look different? If so, how?

7) Do you feel PP impacted on your relationship with your partner at the time? If so, how? What about now?

8) Do you feel your communication style with your partner changed during the episode of PP, or since?

9) Do you feel your sexual relationship with your partner changed during your partner's recovery, or since?

10) Do you feel PP impacted on your relationship with your child at the time? If so, how? What about now?

11) Do you have any other children? Do you feel it impacted on your relationship with your other child/children? If so, how? What about now?

12) Do you feel the episode of PP effected your decision to have more children? How did you and your partner make this decision? Do you feel this decision making process impacted on your relationship with your partner?

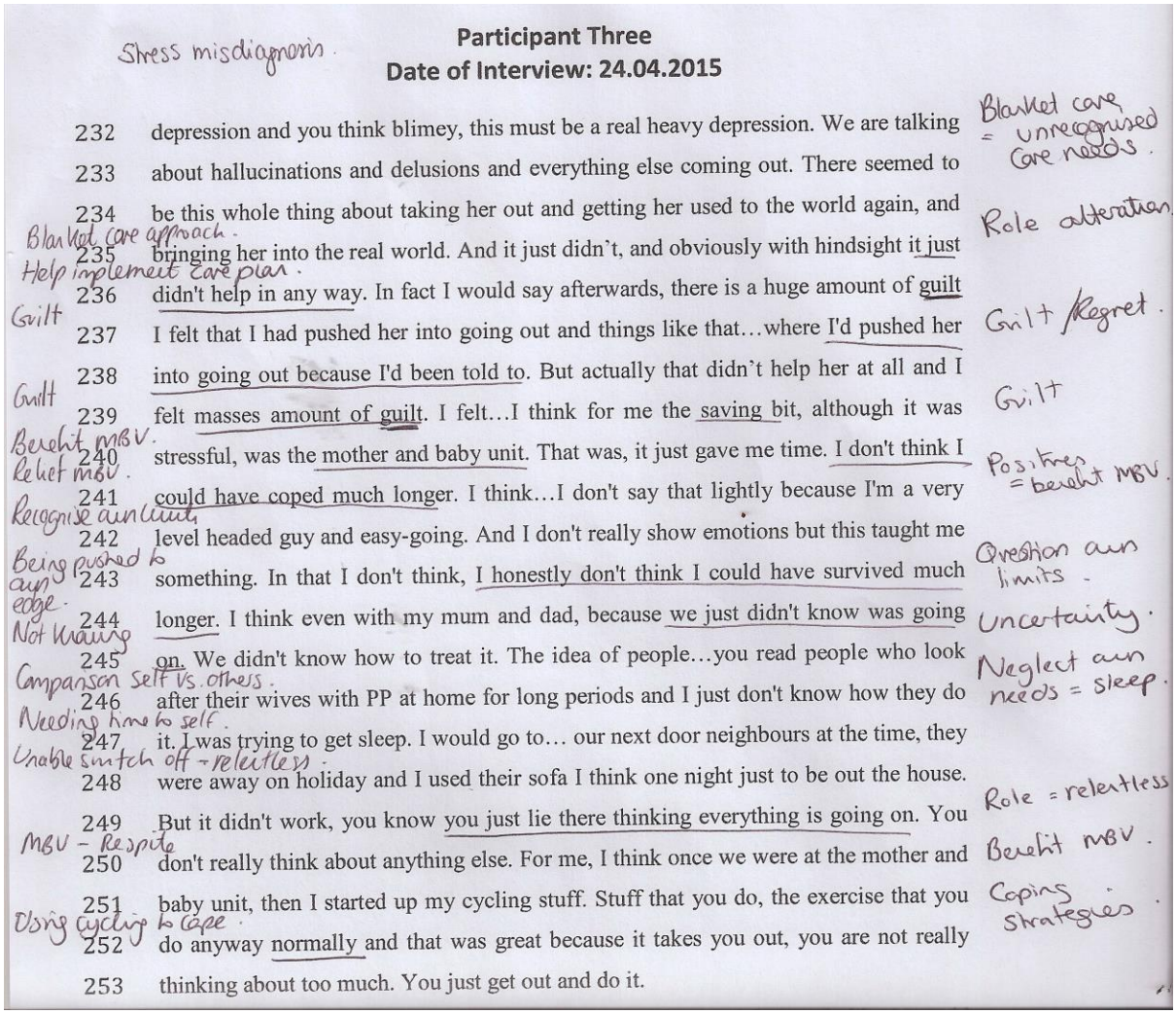
13) Do you feel PP impacted on other areas of your life at the time? If so, how? What about now?

14) Do you feel PP impacted on other relationships you had at the time? For example, family, friends, work colleagues?

15) Do you feel there have been any enduring effects from PP?

16) Looking back, what things do you feel would have helped at the time? Any unmet needs?

Appendix J. Example of an Annotated Transcript



Stress misdiagnosis.

Participant Three
Date of Interview: 24.04.2015

232 depression and you think blimey, this must be a real heavy depression. We are talking
233 about hallucinations and delusions and everything else coming out. There seemed to
234 be this whole thing about taking her out and getting her used to the world again, and
235 bringing her into the real world. And it just didn't, and obviously with hindsight it just
236 didn't help in any way. In fact I would say afterwards, there is a huge amount of guilt
237 I felt that I had pushed her into going out and things like that…where I'd pushed her
238 into going out because I'd been told to. But actually that didn't help her at all and I
239 felt masses amount of guilt. I felt…I think for me the saving bit, although it was
240 stressful, was the mother and baby unit. That was, it just gave me time. I don't think I
241 could have coped much longer. I think…I don't say that lightly because I'm a very
242 level headed guy and easy-going. And I don't really show emotions but this taught me
243 something. In that I don't think, I honestly don't think I could have survived much
244 longer. I think even with my mum and dad, because we just didn't know was going
245 on. We didn't know how to treat it. The idea of people…you read people who look
246 after their wives with PP at home for long periods and I just don't know how they do
247 it. I was trying to get sleep. I would go to… our next door neighbours at the time, they
248 were away on holiday and I used their sofa I think one night just to be out the house.
249 But it didn't work, you know you just lie there thinking everything is going on. You
250 don't really think about anything else. For me, I think once we were at the mother and
251 baby unit, then I started up my cycling stuff. Stuff that you do, the exercise that you
252 do anyway normally and that was great because it takes you out, you are not really
253 thinking about too much. You just get out and do it.

Blanket care approach.
Help implement care plan.
Guilt
Guilt
Benefit MBU.
Relief MBU.
Recognise own limits
Being pushed to own edge.
Not knowing
Comparison self vs. others.
Needing time to self.
Unable switch off - relentless.
MBU - Respite
Using cycling to cope.

Blanket care = unrecognised care needs.
Role alteration
Guilt / Regret.
Guilt
Positives = benefit MBU.
Question own limits.
Uncertainty.
Neglect own needs = sleep.
Role = relentless
Benefit MBU.
Coping strategies.