

Men's experiences of having a partner who requires Mother and Baby Unit admission for first episode postpartum psychosis

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Men, postpartum psychosis and Mother and Baby Units

**Men's experiences of having a partner who requires mother and baby unit admission
for first episode postpartum psychosis**

ABSTRACT

Aims: To explore the experiences of men during their partner's admission to a Mother and Baby Unit for first episode postpartum psychosis.

Background: Postpartum psychosis can be life-changing for women, however little is known about the impact on their partners or their partners' needs.

Design: An Interpretative Phenomenological Analysis approach was used to analyse interview transcripts.

Methods: Semi-structured interviews were conducted with seven participants. Interviews were conducted in 2014 - 2015.

Findings: Two main themes emerged: 'What the f*** is going on?' and 'Time to figure out how your family works'. Partners experienced shock and confusion during postpartum psychosis onset. Most felt hospital admission was beneficial, although there were barriers to accessing help and involvement in their partner's care. A process of understanding changes to roles, relationships and family identity was described. Loss was a common experience, with a potentially lasting impact.

Conclusions: Men reported a range of challenging and positive experiences associated with their partner's postpartum psychosis. Improvements are needed in awareness of postpartum psychosis, access to appropriate services and support of partners.

Keywords: postpartum psychosis, spouses, mental health, acute care, mother and baby unit, qualitative approaches, psychiatric nursing, midwifery, nursing

SUMMARY STATEMENT

Why is this research or review needed?

- Postpartum psychosis can have a life-changing effect on women's experience of motherhood and their intimate relationships.
- Women's partners are often expected to support their recovery from postpartum psychosis.
- Very little is known about partners' experiences or needs during this time.

What are the key findings?

- Partners experienced significant confusion and uncertainty whilst their partner was unwell.
- There were several barriers to feeling included or able to contribute to their partner's care throughout their contact with various health services.
- Partners expressed multiple changes in their role, relationships and identity during this time. Men were more strongly affected by the separation and sense of loss felt for their partner than by the separation from their child during mother and baby unit admission.

How should the findings be used to influence policy/practice/research/education?

- Improved public and professional awareness of postpartum psychosis and perinatal mental health is needed.
- Health professionals should aim to include women's partners in their care and offer appropriate support.

Men, postpartum psychosis and Mother and Baby Units

- Specialist perinatal mental health services and mother and baby units were seen as valuable, although more equitable provision and improved access is required.

INTRODUCTION

Postpartum psychosis (PP) is estimated to affect 1-2 women per 1000 births (NICE 2014).

Whilst the prognosis is considered better than other psychoses, women report a life-changing impact on their experience of motherhood, sense of self and relationships with their partners (Robertson & Lyons 2003).

For many women PP is their first and only experience of mental health difficulties (Valdimarsdottir et al. 2009). Early symptoms such as irritability and restlessness usually occur within two weeks postpartum and rapidly progress into symptoms characteristic of psychosis (Seyfried & Marcus 2003, Heron et al. 2005). Early recognition and treatment is essential; delays can result in longer, more severe and difficult to treat episodes and increased risks to mother and baby (Lewis 2007). Hospital admission is usually required, with Mother and Baby Units (MBUs) recognised internationally as the preferred inpatient service (Lewis 2007, Green et al. 2015). MBUs offer conjoint admission for the mother and baby, allowing mothers to access specialist care whilst staying with their infants. Improved safety, mother-baby bonding, parenting confidence and patient satisfaction are reported for these units (Neil et al. 2005, Antonysamy et al. 2009, Friedman 2010, Christl et al. 2014).

There is patchy provision of specialist perinatal services within and between countries (Elkin et al. 2009, Glangeaud-Freudenthal et al. 2014). The current study was conducted in the UK, where the quality and availability of services varies significantly with only 15% of regions offering comprehensive community and inpatient service provision (Maternal Mental Health Alliance 2014, Bauer et al. 2014). The UK has seventeen MBUs, although none in Wales or Northern Ireland. This is considered inadequate to meet national need and there are calls to increase bed numbers (NICE 2014, Bauer et al. 2014).

Background

Experiencing PP can bring great uncertainty, with mothers expressing need for informational support about the condition, treatment and prognosis (Doucet et al. 2012). Women can feel isolated and access to peer support networks is considered beneficial (NICE 2014).

Additionally, women's partners (also referred to as fathers) are valued by professionals as 'co-workers' in supporting recovery (Engqvist & Nilsson 2013). One study found having a supportive partner was associated with shorter inpatient admissions, although only a third of women described their partner as supportive (Grube 2004). Furthermore, some mothers report PP as a factor in relationship breakdown (Robertson & Lyons 2003). In addition to supporting their partner, fathers may need to take on additional childcare responsibilities during this time (Engqvist & Nilsson 2011, Doucet et al. 2012). Partners of women with perinatal mental health problems can feel frustrated, angry, helpless, fearful, overwhelmed, isolated and confused (Engqvist & Nilsson 2011). These challenging reactions may conflict with cultural expectations of a stereotypical 'male' role of being strong and contained 'co-workers'.

There are few known published studies examining men's experiences of PP. Doucet et al. (2012) found like mothers, partners experienced great uncertainty but struggled to ask for support. All participants' partners had been treated in US general inpatient facilities whilst separated from their infants, so generalizability to international use of MBUs is restricted. A recent study exploring the impact of PP on couples' relationships found some ultimately became stronger (Wyatt et al. 2015). However, data were gathered using dyadic interviews, which may have affected the experiences disclosed by couples. Additionally, hospital admission was not discussed. It remains unclear how fathers are affected by the severe and sudden nature of PP or by the separation from their family during MBU admission. Further understanding of these experiences could help improve men's own wellbeing and their ability to support their partners (Grube 2004).

THE STUDY

Aims

The aim of the study was to explore fathers' experiences during their partner's MBU admission for first episode PP, focusing on their experiences of early fatherhood and relationships during this time.

Method

Design

Interpretative phenomenological analysis (IPA) was used to achieve an in-depth qualitative understanding of fathers' unique experiences in this context (Smith et al. 2009). IPA's double hermeneutic stance, where the researcher takes a position of exploring and making sense of how people understand their experiences was relevant given the lack of research in this area (Smith 2004).

Participants

Fathers were recruited from two UK MBUs whilst their partners were receiving inpatient treatment for their first episode of PP. Men who did not speak English were excluded. As mothers remained under the units' care, ward staff obtained their verbal consent prior to approaching their partner. Staff approached fathers meeting the inclusion criteria during their routine clinical care to give study information and seek consent to be contacted by the researcher (first author) by telephone or email.

Seven participants were recruited from August 2014-March 2015. Ten additional men were identified who did not take part. Three did not meet inclusion criteria; three were not approached due to changes in circumstances or risk concerns; three declined to participate and one mother did not consent to contacting her partner.

Data Collection

A semi-structured interview schedule was developed by the researcher and supervision team. Questions were based on the study aims and themes from similar studies (Robertson & Lyons 2003, Engqvist & Nilsson 2011). The schedule was designed to allow participants to explore relevant experiences through open-ended, non-directive questions (Willig 2008, Smith et al. 2009).

The researcher conducted face-to-face individual interviews in clinic rooms at the MBUs. Interviews lasted 40-84 minutes (average 60 minutes). Participants received debriefing information, including signposting for further support. Interviews were digitally recorded and transcribed verbatim, with identifying information changed or removed.

Ethics

Ethical approval was obtained from the relevant healthcare and academic organisations. Issues regarding potential distress caused and maintaining anonymity were considered in the study design. All participants provided written consent, including consent to use interview quotes in dissemination.

Analysis

The researcher analysed interviews using the method detailed in Table 1, based on steps proposed by Smith et al. (2009).

Rigour

Credibility checks of analysis were conducted, in line with qualitative research standards guidelines (Elliot et al. 1999). Extracts of transcripts were coded by a colleague and research supervisors, followed by comparison of identified themes. An audit trail of materials was maintained to facilitate checking, transparency and validity (Shinebourne 2011). The researcher engaged in a bracketing interview to identify potential biases and recorded personal reflections to encourage reflexivity and objectivity (Ahern 1999, Yardley 2000, Rolls & Relf 2006).

Position of the Researcher

The study was completed as part of the female researcher's role as a Trainee Clinical Psychologist. The researcher had previously worked at one of the recruiting MBUs and had prior understanding of the unit and staff. During the study, she was interested in systemic approaches and involvement of carers and families in clinical practice. The bracketing interview identified assumptions that fathers would be distressed by the separation from their child and it would be their partner's first experience of a mental health problem.

FINDINGS

Participants' demographic information is presented in Table 2. To preserve anonymity, pseudonyms are used. The mean age was 31.3 years (range: 23-42 years). All participants' partners were awaiting discharge following some periods of home leave. Participants' stories reflected the natural uncertainty surrounding the birth of a child, amplified by the additional, unexpected onset of a severe mental health problem. Table 3 details the themes identified.

Superordinate theme 1: 'What the f* is going on?'**

'What the f*** is going on?' captures participants' lack of understanding, experienced during the onset and treatment of PP.

Subordinate theme 1: PP as an unexpected arrival

PP was most participants' partner's first experience of mental health difficulties. During the early stages, participants described trying to make sense of the changes they observed in their partner's behaviour:

- I... didn't really see the more acute signs because A. I'm not experienced in them and
- B. I knew there was something up but I put it down to her being absolutely over exhausted. (James)

Like James, others attributed these changes to their partner recently giving birth. For all participants, it was their first child with their partner (one mother had two children from a previous relationship). Many described not knowing what is normal for a new mother:

I couldn't understand it, really, but I had nothing to compare it with, so I just thought oh, is it just hormones and things after having the baby and it'll settle down. But maybe somewhere in the back of my mind I knew something wasn't quite right.

(Michael)

A range of emotions were expressed as participants talked about the progression towards more acute signs of PP. They often identified a key, sometimes 'traumatic' moment they realised something was wrong. This was accompanied by shock, confusion, embarrassment or fear, perhaps due to having missed or minimised earlier signs:

She was ranting and raving and my friends... both looked at me and I was like, 'what the fuck is going on?' (Tim)

When we went to the [general practitioner] she was... effectively playing word association on her own, flicking switches on and off and it was just very, very uncomfortable. (Matthew)

Seeking medical help sometimes created more uncertainty due to health professionals' limited awareness of PP. For instance, Matthew's partner was initially diagnosed with postnatal depression, despite him disagreeing with this. When PP was diagnosed participants continued to feel confused and worried due to not understanding the diagnosis:

The midwife said to me, 'I think it could be this thing called postpartum psychosis'. Which at the time, if I remember rightly, I didn't even hear the postpartum... it was just psychosis... So I didn't even relate to any giving birth.... It was just, my wife's gone psychotic. (Neil)

In response to this uncertainty, most participants sought more information. Some used resources like internet forums, others connected with family who worked in health services.

Having a name for their partner's difficulties often provided some understanding and hope of recovery. However, there was sometimes an underlying sense of embarrassment or stigma:

I just went to check on [internet search engine] and search...her situation and asking people... if they had something similar... they keep telling me... yeah, it happens, it's normal. In our community...they don't have that much experience with that situation of illness because...in our country we don't know about this mental health. (Sam)

No one really else knows... a few people know she's gone back into hospital because she's, um, what we've told them is getting over her caesarean and over exhaustion.

(James)

Many tried to understand why this had happened to them by identifying potential causes of PP. For some, this helped establish some control and predictability for the future.

Alternatively, it could lead to a more unhelpful dissection of events and blaming themselves and others for not helping enough:

My hope is that, [difficult birth] caused it, because it's something that... [is] not going to happen every day. She's not going to be walking down the street and it happens. If there was an actual reason for it happening, that's my hope. (Michael)

Several participants described benefiting from the chance to develop their understanding of mental health and improve wider awareness of PP. This was perhaps a way of finding positivity from an otherwise difficult experience:

I think talking about it is better than just pretending it hasn't happened... My partner is quite willing.... to say to people, 'look, this is what could happen afterwards'... what people need to look out for... I'm a great believer in that people need to shout about things to get people to listen. (Neil)

Subordinate theme 2: Not feeling heard

In trying to understand their partner's PP, all participants sought involvement in their healthcare. However, a common experience was not feeling heard or valued by professionals. From their first contact with services some felt their concerns were not taken seriously:

[Healthcare helpline] could hear her screaming... They were asking me things like what's her blood pressure like... and I'm like, 'look, you need to send somebody out now'. 'We can't do that yet, we need to go through these questions', 'Can you not hear her?'. (James)

In contrast, some participants did not recognise a need for hospital admission. A lack of involvement in decisions led to some expressing frustration and anger with services. This was perhaps due to feeling they had no understanding or power over what happened to their family. A key theme in both Tim's and Ashley's stories was feeling excluded during their partner's admission:

I couldn't do anything about it. So I just had to get over it... I said, 'why are we here? What's the point?' and... they just said, 'because we think it's worse than it is'... I tried to explain to them but obviously, I don't think they all get it. (Ashley)

For the first five days, all I got was, 'you're not married, your son's not registered, you've got no right to know where they are or what's going on'. And that's all I got, from everybody. So all I knew was, my son had disappeared, my girlfriend had disappeared. (Tim)

Several participants expressed frustration with being denied information due to patient confidentiality prior to and during admission. The lack of information was sometimes seen

simply as an oversight by staff. The implication was men's involvement was not considered important, as the priority was on their partner. Several participants noted appreciation when they felt more involved, as it helped them understand their partner's situation:

[On acute psychiatric unit] They wouldn't really give me any information. They wouldn't talk to me and they weren't very approachable, sort of kept themselves at a distance and most of them didn't even know what was going on... [On MBU], totally different story. Everybody knew what was going on. (Matthew)

Whilst some actively sought information others were uncomfortable in questioning professionals who they perhaps perceived to be in a more powerful position, despite feeling they could contribute:

I think I might have got on the doctor's nerves a little bit. Because [the doctor] was... like, 'well, this is about me and your partner', but obviously [my partner]... might not even think of the questions that I think of. (Neil)

Summary of superordinate theme 1

Most participants went through a process of missing early signs of PP, recognising acute signs, seeking help, then trying to improve their own understanding. Lack of awareness of PP, feeling dismissed by professionals and limited involvement in their partner's care were common difficulties. Frustration and anger were frequently expressed, perhaps in response to deeper experiences of powerlessness, fear and embarrassment.

Superordinate theme 2: ‘Time to figure out how your family works’

This theme reflects the impact on participants’ roles, relationships and identity in the family. Again, their experiences involved changes well beyond what was expected when becoming a parent.

Subordinate theme 1: ‘Holding the fort’

Most participants described an increased sense of responsibility to care for their family as their partner’s PP progressed. The unpredictable and sometimes frightening nature of symptoms led to most feeling protective of their baby. Many reflected on the demands of needing to split their attention between their partner and baby:

She picked up the baby in quite a... I wouldn’t say aggressive manner, but not in a soft manner... And I was like, ‘what are you doing?’... At that point I took her off her and I felt a little bit uneasy to... leave the baby alone. So I just kept hold of her and... phoned my mum and said, ‘Can you come over? Obviously, we really need you here.’
(Neil)

Several participants’ partners were not immediately admitted to an MBU, often due to lack of availability. Some participants were required to look after the baby whilst their partner was admitted to an acute psychiatric unit. Some, like Sam, welcomed this as an opportunity for personal and relationship growth, suggesting it was their duty to care for their family:

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

Most felt unable to meet these demands alone and were grateful for help from family or friends. MBU admission was usually a welcome relief, as many reported feeling they had reached their personal coping limits. Most expressed believing they had done their best and now had permission look after themselves, which could enable them to provide better care for their family:

We were doing the right thing... It was a relief that somebody else was going to look after her and the medication.... I could come in, give her... all my attention for... a few hours in the morning, a few in the afternoon, a few in the night... And I knew the baby was being taken care of. But then I'd go back and have time to... recharge my batteries. (Michael)

Many participants considered MBU staff as the best people to care for their family and valued their expertise; some reflecting on the opportunity to learn from them. For others, handing over responsibility provoked more difficult feelings. Whilst some were concerned about being perceived as abandoning their family, others alluded to power dynamics between themselves and staff:

[The baby]'s crying... and they're just sitting there talking... when they're doing the level five (observation of baby)... and I just walked up and went, 'excuse me'. I pick him up and just walk and they're like, 'but he's on level...' and I just said, 'I'm taking this level five'. (Tim)

Subordinate theme 2: Loss and reconnection

Most participants reflected on losses felt in their relationship. Some described feeling alone in their experiences, like a bystander watching their partner become more unwell. Several men

described now having a different perspective to their partner, having initially shared the experience of starting a family with them:

I felt a bit like... there's nothing I can do for her, all I can do is go and visit for my own benefit not for hers... So I suppose initially I didn't feel like a partner at all... I don't think she understood at first how beneficial it was being here. (Matthew)

There was a strong sense of PP changing their partner's identity or personality. Some participants rationalised PP as something external which had temporarily taken over, perhaps protecting against a fear that their partner was permanently changed:

It was somebody else in her body I suppose, that's the only way of putting it... and it wasn't a normal person either (laughs)... It was like dealing with a malfunctioning robot. (Matthew)

Some participants viewed their partner and PP as more interlinked, resulting in difficult emotions. Ashley spoke about feeling he had lost the person he loved and appeared to go through a grieving process, as did others:

She was here but I thought her personality was dead, so my relationship with her personality is dead ... My personality clicks with her personality, yeah and if she's not there... our relationship isn't there... it felt like she was dead. So when I was at home I felt like I was single. I felt like I'd lost everything. (Ashley)

In most cases, loss for their child was not felt as strongly. Some participants attributed this to having not yet formed a strong attachment, as their child was still very young. The separation was more challenging for those who had felt more attached:

It was very difficult... I'd come to know his little quirks... Although my partner might know as well... It's more that, the staff probably don't... I'm leaving him... in a different county... leaving them both in a different county. (James)

Most men viewed the relationship with their baby positively. It perhaps offered something stable and unaffected by PP, whilst maintaining some connection with their partner. Tim spoke of the joy he felt with his son despite being repeatedly 'pooed on', perhaps an appropriate metaphor for others' experiences:

I had poo on one hand, poo on the other hand... his feet went into the poo. What did he do next? Kicked me straight in the face! So I had poo on my chin, poo on my nose, poo on both my hands and I'm like, 'he won't stop pooing, it's everywhere!' (laughs)... He just started laughing at me ... At the time it can be stressful but... it makes you laugh... I love being father. (Tim)

Most described a process of reconnecting with their partner as they started to recover. Views differed on the long-term impact on the relationship. Some described feeling closer to their partner whilst working through the experience together. Others reflected on the negative impact of their partner's presentation whilst unwell:

I guess there is a level of trust that kind of needs to be rebuilt... with how she is around the baby... I'm... very protective and will sometimes, without realising, take over. (James)

Many participants envisaged future losses as they strongly felt they did not want any more children following this experience. Despite a sense of pragmatism and detachment from this decision, for many there was an underlying sadness or disappointment:

It's just not worth... the risk... to my partner. And obviously the baby would be there as well. That's... one of my concerns... she might never have a brother or sister... I've got a brother and he's my best mate... My child won't have that and I feel guilty about that, for her. But... I just don't think, well, at this point in time anyway, that it would be an option. (Michael)

Subordinate theme 3: Adjusting to family life

Most participants viewed PP as delaying their adjustment to being a family. Disruption was sometimes exacerbated by large distances between home and hospital. In addition to financial and practical implications, some felt they had left part of their lives behind. Many reflected on lost opportunities to do normal activities with their baby with some disappointment for their unmet expectations of parenthood:

You feel, a bit deflated.... Because you've got two weeks off from work, you have all these plans to do these great things and bed down and suddenly that two weeks is gone. Because you're in hospital. And then you... need to go back to work but we haven't had time to bond at home. (Neil)

Whilst some felt they had parental autonomy and responsibility with their child, several participants discussed difficulties parenting the way they wanted to in hospital. Some experienced feeling watched by staff as uncomfortable or embarrassing, others felt scrutinised or criticised:

You do the smallest thing and, 'oh no, you're doing it wrong'. Let her get on with it. Ok, it might not be your way but if each of your people and us have different ways of doing it, it doesn't mean we're wrong it just means it's different. (Ashley)

All participants' partners had been allowed home leave and were awaiting discharge. Their recovery was often viewed tentatively and there was some apprehension about how things would be at home. Some implicitly communicated resentment that their future could be very different to previously imagined:

I don't want to say it's made us grow up... but I suppose it has... It's made us... become my parents... It's a different life to the one we'd sort of planned, even while she was pregnant. (Matthew)

Some felt more positively and described things as 'back to normal', wanting to move forwards and leave this experience behind them. These participants had possibly detached from the experience, not yet fully integrating it into their lives. This perhaps provided some hope and protection from painful feelings:

It feels like a certain part didn't exist, never happened... When my partner was over on the weekend, it just feels like, we've gone back two months. Cut out this part and everything's gone back to normal. (Ashley)

Summary of superordinate theme 2

A new baby inevitably brings changes to roles and relationships; however experiencing PP seemed to amplify this process. Loss was an unexpected but common and painful experience. PP was perceived as delaying adjustment to family life and impacting on future plans. Forming a family identity was often challenging in the MBU environment.

DISCUSSION

This study sought to explore men's experiences of their partner being admitted to an MBU for first episode PP, giving fathers a voice in a previously neglected area of research.

'What the f*** is going on?' captures the confusion surrounding the development of PP and MBU admission experienced by all participants. This was emphasised by the rapid onset of symptoms and minimal prior experience of mental health difficulties. The lack of awareness of PP for participants and the healthcare professionals they encountered is consistent with previous research (Doucet et al. 2012). Participants' frustration was increased by limited information which could have helped improve their level of understanding and support in the period leading up to hospital admission.

Restricted involvement in their partner's care was a source of concern and anger for most. This reflects a wider picture of men feeling excluded from perinatal healthcare (Shirani et al. 2009, Fenwick et al. 2012). Additionally, PP presenting as a rapidly developing, emergency situation may mean health professionals are required to make decisions quickly, whilst men have little time to adjust and understand events. 'Holding the fort' highlights the 'carer' role adopted by participants, which possibly made their lack of involvement more pertinent. Beneath the anger expressed towards services, participants may have felt powerless in caring for their loved ones (Wilkinson & McAndrew 2008). Additionally, there may be an implicit anger towards their loss of intimate relationship (Jones 2001, Wyatt et al. 2015).

Many participants acknowledged positive aspects of their partner's MBU admission, such as specialist staff knowledge. Those whose partners were initially admitted to acute psychiatric units felt these services were not appropriate. This mirrors previous research with women, who viewed PP as different to other mental health difficulties and felt safer on MBUs

(Robertson & Lyons 2003, Antonysamy et al. 2009). Despite this, many of the emotions reported here reflect previous research with those who were not treated on an MBU (Engvist & Nilsson 2011, Doucet et al. 2012). This suggests the fundamentally distressing nature of the experience is not fully compensated for by perceived specialist care.

A unique aspect of this study is participants were interviewed during their partner's admission; so the experience and associated emotions were current and the long-term impact of PP remained unclear. Much of the confusion regarding roles, responsibilities and identities mirror processes experienced by new parents and those with other perinatal mental health difficulties (Beck 2002). The losses reported by participants were consistent with previous studies (Doucet et al. 2012, Wyatt et al. 2015). Reported anxieties surrounding planning for future children should be considered by healthcare professionals encountering families post-recovery.

In contrast to previous research, full recovery and post-traumatic relationship growth had not yet occurred (Wyatt et al. 2015). This likely reflects the study's timing and the on-going nature of experiences. Less intense feelings of loss for their baby was attributed to having not yet formed a strong attachment, perhaps partly reflecting men's perceptions that it takes them longer to bond with infants (Goodman 2005).

Limitations

The primary study limitation is the homogeneous participant group, limiting the transferability of findings. Whilst the sample size was appropriate for IPA, almost all participants were white, well educated professionals with one child and spouses with minimal past mental health difficulties. Families with differing circumstances may experience different demands. Participants did not reflect the units' usual patient demographics perhaps due to the exclusion of non-English speakers, although characteristics of non-participants

were not available for comparison. Secondly, recruitment focused on a specific geographical area. Experiences may differ for families in other areas depending on their access to services. Finally, the long-term impact of PP cannot be established due to the recruitment timing.

Conclusion

Participants strongly expressed not knowing enough about their partner's illness or healthcare, whilst trying to make sense of changes to their role, relationships and identity.

There is increasing acknowledgement of the importance of good perinatal mental health care. This study identifies several areas where support could be improved. Firstly, improved public and professional awareness campaigns could facilitate earlier detection, effective intervention and reduced stigma. Secondly, better engagement of fathers at all service levels is necessary. Some good examples of involvement of fathers in MBU care can be found in international practice; admission of partners with the mother and child, inclusion of the father in day-care and routine mental health screening and support for spouses (Glangeaud-Freudenthal et al. 2014).

The timing and type of support offered to fathers should be considered on an individual basis, as needs will vary throughout the progression of PP and treatment. This study found men required more practical support in the early stages of PP, followed by informational support after diagnosis and admission. Emotional support may be needed later, when fathers have had time to process the initial shock of events. In this study, some men coped by detaching and denying any need for support. This, along with potential high expressed anger may present a challenge for health professionals trying to engage with fathers. Supervision, support and reflective space may prevent staff burnout or detachment when working with families at such an emotive time (Jenkins & Elliott 2004).

Finally, the lack of MBU availability created stresses for families and delayed admissions.

Inappropriately treated perinatal mental health problems have many consequences for mothers' and children's health and development (Bauer et al. 2014). Improved MBU provision should be prioritised and supported by evidence-based practice guidance and cost-benefit analyses, which are currently lacking (Bauer et al. 2014, Glangeaud-Freudenthal et al. 2014).

More longitudinal research studies may clarify the long-term impact of PP for men, particularly given the life-changing effects identified for women. Additionally, research involving men whose partners were treated for PP in community or general mental health settings is needed, given the reported difficulties in using these services. Finally, research using more ethnically and socially diverse participants may be beneficial, including men with multiple children.

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