Full title: How do women's partners view perinatal mental health services? A qualitative meta-synthesis

Short title: Partners' views of perinatal mental health services

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Abstract

Objectives: Perinatal mental health difficulties are prevalent among women and can adversely affect their partners too. There is also increasing recognition that a woman’s partner can play a vital role in relation to her perinatal mental health and should be supported and involved in decisions about her care. Yet it is unclear how services are experienced by the partners of women with perinatal mental health difficulties. This study aimed to synthesise qualitative evidence of partners’ views of perinatal mental health care.

Methods: A systematic search of five electronic databases identified twenty studies which met the inclusion criteria. The findings of these studies were synthesised using an approach based on meta-ethnography.

Results: Six themes were identified including: the marginalisation and neglect of women’s partners; an unmet need for information; partners’ ambivalence about involvement and support; practical barriers to involvement; views about support for women’s partners; and, the impact on partners of the care women received.

Conclusions: Given the importance of women’s partners in relation to perinatal mental health as well as to women’s engagement with support and treatment outcomes, greater consideration should be given to their needs to ensure they feel well-informed and involved in perinatal mental health care, rather than marginalised. However, professionals also need to challenge the barriers to involvement and support that women’s partners face and consider the ways in which services may reinforce these barriers.

Keywords: *perinatal; postnatal; systematic review; meta-synthesis; meta-ethnography; qualitative research*

Key Practitioner Message

- Partners of women with perinatal mental health difficulties play a vital role.
- However, they often feel uninformed and marginalised by services and professionals.
- They also face significant barriers to accessing support themselves or being more involved.
- Services and professionals may reinforce these barriers and need to challenge them.
- Further consideration must be given to the needs of women’s partners.

Introduction

Perinatal mental health difficulties during pregnancy and in the year after giving birth are common among women (Howard et al., 2014). There is increasing recognition that a woman's partner can play a vital role in relation to her perinatal mental health. For example, women who report lower levels of support from their partners in the postpartum period have been shown to be at an increased risk of developing postnatal depression (Dennis & Ross, 2006)). Similarly, having a supportive partner has been found to be strongly associated with shorter hospital stays among women admitted to hospital with perinatal mental health difficulties (Grube, 2004). In Canada, a randomised controlled trial of psychoeducation visits for women with postnatal depression found that their symptoms decreased significantly more when their partners were at the majority of visits with them (Misri, Kostaras, Fox, & Kostaras, 2000).

It has also been found that women are more likely to turn to their partners for support than to any other individual, including medical professionals (Holopainen, 2002). The findings of a survey of over 1,500 women who had experienced a perinatal mental health difficulty found that nearly half of women spoke to their partner about their difficulties first, and partners often picked up on signs of difficulties before anyone else, including the woman herself (Russell, Lang, Clinton, Adams, & Lamb, 2013). The importance of partners is further reinforced by the finding that some women with postpartum depression admit they were reluctant to seek help because their partners were dismissive of their symptoms (Letourneau et al., 2007).

In addition, it is clear that when a woman experiences a perinatal mental health difficulty, this can have negative consequences for her partner too. Qualitative research has shown that partners experience fear, confusion, concern, helplessness, frustration, isolation and stigma when a woman has postnatal depression (Davey, Dziurawiec, & O'Brien-Malone, 2006; Engqvist & Nilsson, 2011; Meighan, Davis, Thomas, & Droppleman, 1999). They describe a sense that their co-parent is 'absent', resulting in loneliness and feelings of responsibility for 'filling the void' (Beestin, Hugh-Jones, & Gough, 2014). Where women are admitted to hospital with severe perinatal psychiatric difficulties, partners report shock and disbelief, trauma, stress, financial and work-related difficulties, relationship problems and sleep deprivation (Muchena, 2007).

The findings of Russell et al.'s (2013) survey of women's experiences of perinatal mental health difficulties found that seven in ten women believed their relationship with their partner had been affected by their problems and two fifths thought their partner had also experienced anxiety or depression. Indeed, maternal postpartum depression is the strongest predictor of paternal postpartum depression, with a 25-50% incidence of postnatal depression among men whose partners experience postnatal depression (Goodman, 2004), although the direction of causality is not always clear. Infants whose parents both experience perinatal mental health difficulties are at greater risk of poor developmental outcomes than those where only one parent experiences a difficulty (Paulson, Dauber, & Leiferman, 2006), and there is also an increased risk for infants whose parents experience relationship conflict (Pauli-Pott & Beckmann, 2007).

In recognition of the importance of women's partners in relation to perinatal mental health, Russell et al (2013) conclude from their survey findings that: "It is important that the partner is encouraged, where appropriate, to have a significant role and should routinely be involved and so well informed and prepared" (p.3). Similarly, a report published as part of the UK's

National Society for the Protection of Cruelty to Children ‘All Babies Count’ campaign argues that “perinatal mental illnesses can have a significant impact on the families of women who are affected. Family members are also important sources of support for the mother, and can mitigate the effect of her illness on the baby. Therefore it is important that mental health services ‘think family’” (Hogg, 2013; p.37).

In the UK, national clinical guidelines do, at least to an extent, acknowledge the importance of partners. For example, national guidelines note that services should “take into account and, if appropriate, assess and address the needs of partners, families and carers that might affect a woman with a mental health problem in pregnancy and the postnatal period.” (National Institute for Health and Clinical Excellence, 2014; p.16). Similarly, national quality standards for perinatal mental health care state that “Quality standards recognise the important role families and carers have in supporting women with a mental health problem in pregnancy and the postnatal period. If appropriate, healthcare professionals, public health professionals and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care” (National Institute for Health and Clinical Excellence, 2016; p.15). Nevertheless, it has been argued that “on the whole, stretched maternity and mental health services do not provide fathers with information and support, despite the wider benefits that this would have for families” (Hogg, 2013, p.38). Indeed, a recent meta-synthesis of qualitative research into women’s experiences of perinatal mental health care in the UK notes that: “The benefits of information for partners on postpartum psychosis were highlighted, however, the information and support for partners and wider family was often insufficient” (Megnin-Viggars, Symington, Howard, & Pilling, 2015; p.754).

It is notable nonetheless that these findings are based primarily on women’s accounts of their partners’ needs, rather than exploring the views of partners themselves. Indeed, the great majority of studies exploring perinatal mental health care have focused exclusively on the experiences of women, while the voices of their partners have largely been neglected. For example, even though Russell et al (2013) included a significant focus on the importance of partners in their survey of experiences of perinatal mental health difficulties, only the views of women and healthcare professionals were sought; partners were not included. The question therefore remains: how do partners of women with perinatal mental health difficulties view perinatal mental health services?

Certainly the wider literature around perinatal maternity care (rather than purely perinatal mental health care) suggests that women’s partners feel ‘secondary’ and excluded. For example, a study focusing on fathers’ experiences of Quebec’s perinatal health care system found that fathers feel ignored and side-lined by professionals (Gervais, de Montigny, Lacharité, & St-Arneault, 2016), while a study of Australian perinatal services concluded that fathers may be “unintentionally marginalised by perinatal health services and by the maternal focus of social practices surrounding new babies” (Fletcher, Matthey, & Marley, 2006; p.461). Similarly, a meta-synthesis of 23 qualitative studies of fathers’ experiences of maternity care found that they feel left out, like ‘bystanders’ or ‘invisible parents’ (Steen, Downe, Bamford, & Edozien, 2012). These findings arguably reflect broader social attitudes towards fatherhood and child development, where it has been argued that fathers traditionally have been “relegated to the position of providing support for the mother, rather than having their own role to play” (Barrows, 1999, p.334). Indeed, even a recent qualitative study exploring ‘modern-day’ fathers’ experiences of the transition into fatherhood found that, although they were motivated to be equal parents and regarded ‘involved fatherhood’ as something of an ideal, they nevertheless felt that the reality of social norms, structures and policies kept them in traditional roles, resulting in exclusion and marginalisation (Machin, 2016). Experiences of marginalisation have also been voiced by lesbian and bisexual non-birth parents who report that they find it hard to access support for their health and wellbeing and feel they are treated as ‘lesser’ parents, in part due to narrow perceptions of what it means to be a ‘real parent’ (Abelsohn, Epstein, & Ross, 2013).

This review sought to expand on these findings by exploring the experiences of women’s partners of perinatal mental health care. In particular, the study goals were to understand how involved women’s partners feel in women’s care; how well they believe their own needs are, or are not, met; and what support they believe is helpful for women and their families. It should be noted that, as well as their partners, women’s wider families can also be vital to their perinatal mental health. For example, infants’ maternal grandmothers have been found to help reduce stress in single mothers by playing the role of ‘replacement’ parent and partner and offering their daughters both emotional and practical support (Harper & Ruicheva, 2010). However, as there is very little research to date focusing on other family members’ experiences of perinatal mental health services, it was not considered feasible to include them in this review.

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

Method

Data sources

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

Selection criteria

Titles and abstracts were reviewed for eligibility. The inclusion criteria were that studies had to: (1) use a qualitative research design; 2) consist of a sample of partners of women who experienced a perinatal mental health difficulty; 3) report on partners' views of professional care received by the woman and/or her family relating to the woman's mental health; 4) be published in journal articles, theses, dissertations or reports (studies reported in book chapters, conference papers, editorials, letters or general comment papers were excluded). Studies were excluded if they: 1) did not focus on the use of services for perinatal mental health; 2) did not include the views of women's partners; or 3) were not published in English.

Where studies included not only the views of partners but also of women and/or other family members as well, findings were only reported where it was clear that the points made related specifically to the views of partners. Likewise, only study findings relating specifically to partners' views of services or care were included (rather than, for example, their experiences of living with a woman with a perinatal mental health difficult more broadly). Following screening of titles and abstracts, full texts of potentially eligible studies were reviewed and included if eligible.

Data extraction and analysis

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

The selected studies were read and re-read by the first author (BLT) and the main themes from each study, along with a description of the study setting and participants, were extracted into a tabulated grid. Data extracted were initially labelled as 'first order' constructs (i.e. the views of participants such as direct quotations) or 'second order' constructs (i.e. the interpretations of study authors). The aim is that 'third order' constructs (i.e. the interpretations of the reviewers) can then be developed for the final synthesis (Schutz, 1971). However, meta-syntheses ultimately always offer interpretations of interpretations, and although some researchers do attempt to differentiate first, second and third order constructs, dividing and delineating data in this way has been critiqued (Atkins et al., 2008). This is in part because it can be difficult to identify such distinctions in practice, but also because it arguably masks the intricate and inextricable overlaps that exist between different 'orders' of data, such as the influence of researchers' own expectations, assumptions and interpretations on first order data, given their role in framing and posing questions, and selecting and editing participants' responses. Therefore these constructs were not separated in the final write-up.

Following the process of reading individual studies, the data extracted from each study were compared, contrasted and translated into one another, using ‘reciprocal translation’ whereby attempts were made to link or match themes from one paper with those from another, using thematic analysis of themes identified in step 3 (as per Atkins et al, 2008). This was then used to build an overarching model, including key themes or categories, which could be arranged into a coherent synthesis. The second author (JB) cross-checked a sample of the data extracted by the first author (BLT). Any discrepancies were discussed and a consensus reached.

Process of analysis and reflexivity

The process of analysis was inevitably complex and subjective and at times required choices to be made between different, potentially competing accounts. Care was taken to ensure that data that did not initially appear to ‘fit’ within the developing synthesis was retained and re-examined to allow apparent contradictions to be scrutinised so that nuance and discordance between and within studies was not lost. Meta-ethnography emphasises that this method is not about simply aggregating data, but rather is about constructing a ‘whole’, with greater explanatory power, out of separate parts (Dixon-Woods et al., 2006) . For this review though, as the purpose was to provide a preliminary outline of what has been found to date in this area, while new insights were generated and a critique of study findings included, data were approached from a predominantly critical realist position, whereby comments from participants and authors were taken to some extent at face value, though seen as mediated by perceptions and beliefs. Some aggregation of data was also included to show the spread of themes across the included studies.

Qualitative research encourages reflexivity, acknowledging the ways in which researchers inescapably influence how data are collected and interpreted through their own personal experiences, expectations and biases. In this case, it should be noted that the first author is a clinical psychologist and researcher specialising in perinatal mental health, with an interest in systemic and family approaches. While working clinically within perinatal mental health, she came to feel that women’s partners often seemed disregarded and excluded. Additionally, while carrying out this meta-synthesis she was simultaneously engaged in qualitative interviews with partners and relatives of women with perinatal mental health difficulties exploring their experiences of perinatal mental health care. This further reinforced her view that women’s partners seem excluded and poorly informed, while also expressing ambivalence about engaging with support. While these experiences were arguably valuable as the researcher was immersed first-hand in the relevant context, she also acknowledges that her experiences may have influenced her expectations and assumptions when approaching the analysis. Additionally, the researcher is herself a mother, but is not a partner of someone with a perinatal mental health difficulty. While this could have resulted in her missing nuances or not fully grasping partners’ perspectives, she attempted to minimise the likelihood of this by interrogating the data as comprehensively as possible in seeking to fully understand partners’ views.

Quality evaluation

In the absence of a gold-standard appraisal tool for qualitative research (Dixon-Woods et al., 2006) the methodological quality of studies was assessed using the criteria developed by Atkins et al, 2008 (Atkins et al., 2008), itself an adapted version of the Critical Appraisal Skills Programme (CASP) quality assessment tool (http://www.phru.nhs.uk). Studies were evaluated on a 13 item scale, which covered issues such as whether studies included appropriate description and justification of their methods of data collection, sampling and methodological approaches, and whether there was sufficient awareness of the role of researcher in qualitative research. Total scores were out of 13. In line with Atkins et al, 2008, no papers were excluded on the basis of their quality scores.

Results

Description of included studies

Figure 1 shows a ‘Preferred Reporting Items for Systematic Reviews and Meta-Analyses’ (PRISMA) diagram of the results of the search strategy. In total 1268 articles were screened after removing duplicates and 40 full-text articles were accessed (the remainder were excluded as screening of titles and/or abstracts revealed they did not meet the eligibility criteria outlined, while in two cases full-text articles could not be obtained). Out of these 40 papers, 20 studies were excluded because they did not report on views of services or care for mental health (n=7), did not include the views of women’s partners (n=6), did not relate to perinatal mental health (n=4), were conference presentations (n=2) or were not published in English (n=1).

Figure 1. PRISMA diagram of search results

Twenty eligible studies were included in the final review. Table 1 shows the characteristics of the included studies. The total number of participants was 233 (sample sizes for individual studies ranged from 4 to 40). All studies focused on postnatal rather than antenatal mental health difficulties, with most (n=12) focusing specifically on postnatal depression (PND). Of the remainder, one study focused on anxiety and depression, four on partners of women admitted with a perinatal mental health difficulty to a specialist mother and baby unit (MBU), two specifically on partners of women admitted with postpartum psychosis to a general psychiatric ward or MBU, and one on partners of women with any kind of postnatal psychiatric difficulty. Nineteen of the twenty studies exclusively focused on male partners, with the majority (n=15) explicitly stating that the partner was also the infant’s father (although precise definitions of ‘father’ or ‘partner’ were frequently vague or variable). The remaining study included one same sex partner, along with three male partners. Most studies relied on individual interviews with participants (n=17), while one study used online narratives, one used focus groups, and one used a questionnaire. Where analytic strategies were reported, these included thematic analysis, grounded theory, phenomenological analysis and frame analysis. In terms of quality, study ratings ranged from 2 to 13 (median score = 10 out of 13).

Themes

Through the synthesis we generated six overarching themes: 1) the marginalisation and neglect of partners; 2) an unmet need for information; 3) partners’ ambivalence about support and involvement; 4) practical barriers to involvement; 5) views on support for partners; and 6) the impact on partners of the care women received. The first four themes can be considered to relate to barriers to support/involvement, while the final two relate to views/impact of support. Coverage of the six themes across the included studies is outlined in Table 2.

Interpreting the studies ‘as a whole’ painted a picture of women’s partners feeling excluded, under-informed and struggling to identify or meet their own needs within a context in which attitudes towards masculinity and fatherhood, coupled with a predominantly mother-baby orientated environment, served to reinforce these difficulties. While the included studies varied in location and to some extent time, coverage of the themes identified appeared fairly consistent across year and location.

Marginalisation and neglect of women's partners

A key theme generated through the synthesis related to the exclusion, marginalisation or neglect of women's partners by the system and by healthcare professionals. The great majority of studies reviewed (n=18) alluded to this in some respect and interpretation of the studies overall gave the impression of women's partners being required to navigate a largely mother-baby oriented environment. There was one exception where the authors of one study reported that the partners they interviewed did not appear to feel marginalised (Murphy, 2014). However, closer inspection revealed examples of participants in this study, though not explicitly stating that they felt neglected, nevertheless reporting that they had been unclear what support was available from professionals to meet their needs. Most studies though included clear examples of partners feeling side-lined and disregarded.

"You know, I was never included. I mean, it was like, like I wasn't part of it. She told me that her OB/GYN said it was that [PND], but I didn't know what that meant for her. Well, for us really. That didn't feel good at all."

(Allen, 2010)

Even when partners attended appointments with women, they commented that health care providers didn't always ask their opinion, listen to what they had to say, or include them.

"The issue is about how the doctor spoke to [my wife] and really didn't include me in the conversation."

(Letourneau, Duffett-Leger, Dennis, Stewart, & Tryphonopoulos, 2011)

"When I just went there [to the public health nurse], they looked a bit like, what's he doing here, but I just went even though they didn't talk to me but just to the wife."

(Tammentie, Paavilainen, Tarkka, & Åstedt-Kurki, 2009)

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

"The hospital, it is mother-child, not mother-father or family. All the emphasis is on the woman. If the spouse doesn't know what to do to encourage her, to help her, it will be much more difficult. The father, he's an important person because he is the one accompanying, he is the one encouraging, he sees the tears, and he does everything...There is nothing for men."

(Feeley, Bell, Hayton, Zelkowitz, & Carrier, 2016)

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

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

In these studies, it was notable that partners also described unique issues relating to exclusion. In particular, they feared they might be perceived to have abandoned their family (Boddy, Gordon, MacCallum, & McGinness, 2017) and said the woman's admission left them feeling somewhat relegated from their role as father - like a "temporary father" (Reid, Wieck, Matrunola, & Wittkowski, 2016) or a "fleeting figure" (Marrs et al., 2014) - since they no longer felt as central to looking after the mother or baby. They also found they struggled to 'fit in' on the MBU.

> "It's quite uncomfortable as a man…you've gotta be one of the mums...It's not really a male environment, or an environment where they thrive."
>
> (Kemp, 2011)

An unmet need for information

A second, related theme centred on a lack of relevant information for partners. This too was identified within the great majority of studies reviewed (n=18). Partners said they wanted to help but did not know how and "had no idea how to get help" (Engqvist & Nilsson, 2011). They described a lack of awareness and understanding on their part, with some saying they had found it difficult to identify the mental health difficulties. They wanted more information about perinatal mental health difficulties (e.g. the signs, symptoms, and prognosis); the woman's treatment plan; medication; how to cope with her difficulties; how best to support her; and where they could turn for help.

> "I needed advice on how to handle the illness and what to say. Also, information on the early signs of relapse to watch for and if it was to the point that I needed to get help."
>
> (Doucet, Letourneau, & Blackmore Robertson, 2012)

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

Fathers emphasised that they wanted information from a male perspective, designed specifically for fathers. They requested that this information should focus on fathers' needs and emotions, common concerns fathers may have, acknowledgement of the father's role, and where to find resources for fathers to access help.

> “Women may get those brochures and whatnot but not for the dads. Maybe if some of that says, for the dad. I think if you want to reach the dad, then it has to be for the dads.”
>
> (Allen, 2010)

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

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

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

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

> “I called five psychiatrists in the community before we found one. It was hard finding the appropriate support. We could have been given contact information when leaving the [psychiatric] hospital. And even then, have them set it up. Take some pressure off us.”
>
> (Allen, 2010)

Partners’ ambivalence about involvement and support

Although partners reported feeling under-informed and neglected, there was at the same time a somewhat competing theme related to their own ambivalence about being better included and attended to. For example, a majority of the studies reviewed (n=14) also depicted partners themselves as struggling to identify their own needs, minimising their own desires, prioritising the woman, or expressing a reluctance to ask for or accept help or involvement. Study authors commented that, when asked to identify issues related to their own support needs, partners “often required a great deal of probing from the interviewer to access this information” (Doucet et al., 2012) and “had difficulty expressing or capturing their needs when probed” (Murphy, 2014).

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

Arguably, the mother-baby oriented context of care reinforced this. Indeed, it was notable that, at times, study authors also appeared to conform to and support the view that women were the priority, stating for example: “the [mother and baby] unit is designed as a service for the mother and baby; they are therefore the priority” (Marrs et al., 2014).

Some partners attributed their reluctance to reach out for support to pride, shame, not wanting to take attention away from women and a belief that they “had to be strong” (Doucet et al., 2012). Such issues appeared to be connected to underlying notions of masculinity and fatherhood.

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

Furthermore, three studies reported that partners were sometimes also reluctant for women to seek support, preferring to keep the difficulties ‘within the family’, as a result of stigma around mental health within their communities or because of previous negative experiences with professionals. One study was unique in noting how ethnic or cultural differences could lead to difficult interactions between partners and professionals, with one man from an ethnic minority background feeling his attitude to parenting (based on different cultural norms) was judged negatively (Kemp, 2011). However, the findings of another study suggest this finding may not in fact be uniquely related to culture, showing that other men were likewise anxious about seeking help or having greater involvement with services for fear that their approach to parenting may be criticised by professionals.

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

Practical barriers to involvement

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

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

Views on support for partners

Mirroring partners’ ambivalence around involvement and support, there was also divergence or discrepancy apparent between and even within studies about what support would be appropriate for partners. For example, several study authors (n=7) suggested support groups and mentoring by peers might be valuable to provide peer support and practical tips. However, in other cases study authors highlighted that partners expressed considerable anxiety about the idea of meeting similar others, and in particular attending groups.

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

Some had attended a group and found the experience uncomfortable.

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

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

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

In some cases, partners more broadly wanted 'a listening ear' or 'someone to talk to'. Some spoke of wanting greater acknowledgement and understanding from healthcare professionals of their own role and struggles.

> "I guess just take the father into consideration and make it seem like you can see, I mean everything falls on top of him."
>
> (Allen, 2010)

Others would have valued being asked proactively by healthcare professionals about their own difficulties, given that this could be hard for them to raise themselves.

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

Where emotional support or counselling had been offered and taken up this was generally positively received. However, one study reported that professional interventions had at times increased partner's distress and feelings as a failure as a husband (Everingham et al., 2006), although it was unclear what such interventions involved. When asked directly, partners said they wanted professional support to be face-to-face (in a local setting or in their home), although some did appreciate the greater anonymity afforded by telephone or online support

(Letourneau et al., 2012). Online support was seen as useful for providing resources about symptoms of perinatal mental health difficulties, tips on coping, links to local and national resources, and potentially chat rooms or forums. In general, the idea of additional support for partners offered separately to the woman was preferred over accessing support jointly (Everingham et al., 2006; Letourneau et al., 2012), although one study highlighted the possible benefits of couple's counselling (Muchena, 2007).

In one study (Marrs et al., 2014) partners spoke of valuing time alone with their partner where MBU staff offered to care for their baby, while in another (Boddy et al., 2017) they spoke of being able to 'recharge' while the mother and baby were looked after by MBU staff. In four studies, partners said they would have valued more practical support, such as help with childcare or to allow them the chance to have some respite.

> "Rest. Just rest. Breaks. Breaks would have been ideal. Counselling is great. Medication is great. But nothing actually beats relaxing, resting, and not like an hour. That's enough time to do your laundry that you haven't done in six months. Rest. That would have been very helpful."
>
> (Murphy, 2014)

However, many partners primarily relied on - or preferred - emotional or practical support to come from close friends and other family members, whose involvement, though at times overwhelming, they described overall as a "godsend", a "blessing" and a "turning point" (Murphy, 2014), with one even going as far as to say "I probably wouldn't be sitting here today if it wasn't for my mother in law" (Marrs et al., 2014). Nevertheless, in some cases partners did feel one-to-one professional support was preferable, as they said professionals could be more objective and provide greater expertise and reassurance.

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

Impact on partners of the care women received

Few of the studies focused in any detail on partners' views of women's care itself. However, partners did emphasise that above all they wanted professionals to help the woman get better (Letourneau et al., 2012) and in ten studies they described experiencing considerable relief themselves once they felt she was receiving appropriate treatment, for example where she had been admitted or where she had been given a clear diagnosis.

> "When she and the baby were admitted, I was able to relax a bit."
>
> (Reid et al., 2016)

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

Partners would have liked professionals to be more proactive in helping women access support sooner, for example following up with them after childbirth and responding to signs of potential difficulties (e.g. (Murphy, 2014). Partners described experiencing stress when they felt healthcare professionals were incompetent or disorganised, provided inconsistent advice, failed to respond appropriately and flexibly to women's needs, or where there were delayed responses from services (Muchena, 2007).

Discussion

Summary of findings

This meta-synthesis explored what is known about views of perinatal mental health care among partners of women who experienced a perinatal mental health difficulty. Across twenty qualitative studies reviewed, six themes were identified. The first four themes related to barriers to support and involvement for women's partners and the final two themes related to partners' views of support and its impact. These themes showed that overall, women's partners often feel marginalised, uninformed and neglected by perinatal mental health services and professionals, and seem to be confronted by a largely mother-baby oriented environment. Nevertheless, it was also apparent from the findings that women's partners have difficulty themselves identifying their own needs and accepting support or involvement. While practical challenges with fitting appointments around other commitments (e.g. work and childcare responsibilities) and a lack of time and energy are influential, the reluctance to reach out for support also appears to relate to stigma and feelings of pride and shame, wherein partners believe they have to 'be strong', and have concerns that they might be judged to be inadequate. The mother-baby oriented context they find themselves in coupled with broader underlying assumptions about masculinity and fatherhood appear to reinforce these barriers.

Connected to this, while some studies found that partners were reluctant to attend peer support groups, others nonetheless recommended these, at times arguably without sufficient consideration as to the potential barriers for such initiatives being taken up. Where men had taken part in peer support initiatives, they generally but not always spoke well of them, even if they had initially been wary of participating. But what was not always acknowledged within studies was the ways in which these men may have differed from others who may not have agreed to take part. Finally, while there was strikingly little focus within the included studies on partners' views of women's care itself, partners did speak of their relief once women appeared to be receiving effective care (e.g. following a diagnosis or hospital admission). By contrast, they experienced considerable stress when there were delays accessing support, or where the support was perceived as inadequate.

Viewed in the context of the wider literature, these findings reinforce earlier findings from studies of women with perinatal mental health difficulties, which report that information for partners is inadequate (Hogg, 2013; Megnin-Viggars et al., 2015). This meta-synthesis also suggests that the broader literature around maternity care, which shows that women's partners feel excluded and invisible (Abelsohn et al., 2013; Fletcher et al., 2006; Gervais et al., 2016; Steen et al., 2012) extends to perinatal mental health care as well. This may in part reflect pervasive social attitudes towards fatherhood and child development, where it has been noted that fathers have typically been relegated to a position of secondary importance (Barrows, 1999).

Indeed, even though more recently fathers have increasingly been encouraged to be equal, active parents, they are arguably prevented from achieving this in reality by societal constraints and ongoing traditional perceptions of masculinity (Machin, 2016). For example, a study of men's beliefs about what it means to be a father found that they expressed a desire to be more involved with their children and families, yet at the same time continued to subscribe to the view that their worth and status as a father were measured primarily by their ability to sustain employment and provide for their families (White, 1994). Such attitudes may also contribute to partners' apparent ambivalence about involvement and support, and this would merit further investigation.

Furthermore, the finding that women's partners struggle to identify their own needs and seek help also corresponds with previous research that notes how traditional masculine role models and norms emphasise self-reliance and emotional control (Addis & Mahalik, 2003), making it more difficult for men to ask for help (Lindinger-Sternart, 2014).

Clinical implications

The importance of healthcare professionals being well informed and providing relevant information about perinatal mental health and available support to women's partners was highlighted as a priority to help improve their experiences of perinatal mental health care.

Greater attempts also need to be made to consider the needs of women's partners and how best to ensure they feel involved in women's care and not marginalised. It is important to note though that women often perceive that healthcare professionals also marginalise women's needs in favour of the needs of their babies (Megnin-Viggars et al., 2015). Therefore care should be taken that an increased focus on women's partners does not serve to further tilt the balance away from the woman. Nevertheless, it appears that more acknowledgement is needed on the part of professionals of the unique and important role that partners play in supporting women, as well as better awareness and appreciation of the struggles and burdens they themselves face when a woman encounters difficulties. At the same time, given the complex issues identified around partners' difficulties identifying their own needs or engaging with support, due in part to time constraints but also to anxieties around stigma, pride and shame, clinicians need to be sensitive to potential barriers to involving partners or offering them support. When offering initiatives such as peer support, clinicians need to consider that, while these may prove valuable, some partners will have strong reservations about attending. Indeed, professionals should be aware that, just as women express concerns about being judged to be inadequate mothers (Dolman, Jones, & Howard, 2013), so too women's partners have concerns about being judged to be inadequate fathers or partners. Professionals therefore need to respond to women's partners in an explicitly reassuring and non-judgemental way to help encourage them to feel confident being open and involved.

More broadly, services and professionals need to give further consideration to the ways in which the help seeking behaviours of partners appear to be underpinned by traditional gender norms and expectations, which may in turn be further reinforced by the set-up of services and the implicit messages this sends about the role of fatherhood – for example, where a 'mother and baby' unit inadvertently reinforces the perceived secondary status of the father. Arguably services and professionals need to directly and proactively challenge these self-reinforcing gender roles and expectations rather than allowing them to continue to be reflected in and even to guide practice. From a practical perspective, initiatives aimed at women's partners will also need to be flexible enough to fit in around other commitments (e.g. work).

Limitations and future research

It is important to point out that this meta-synthesis and the studies it included have a number of limitations.

Conceptual limitations of the included studies

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

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

Methodological limitations of the included studies

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

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

It was also notable that sample sizes were often very small, with few attempts made to achieve representative demographic spreads of participants. While qualitative research does not necessarily aim to be representative, these small unreliable samples make it difficult to generalise the findings to the wider population of partners. Consequently, future research should include larger samples of partners and should make efforts to include greater demographic diversity.

Limitations of the meta-synthesis

This meta-synthesis focused on the views of women's partners, primarily male partners. Yet it was clear from the findings that extended family members are often vital players within women's support networks too. So far however, the views of extended family members remain almost completely unheard and should be further explored. Furthermore, little attention has been given to the complexities of women's social networks, the influence of 'non-traditional' family set-ups - such as non-resident fathers, non-biological fathers or same-gender partners - and the variations in roles that different family members may play. Future research should therefore focus on their voices too.

Finally, in seeking to offer a broad but concise overview of relevant findings, this meta-synthesis adhered to a predominantly critical realist position, taking participants' and authors' accounts largely at face value. We also aggregated studies to report the number referencing particular themes and arguably thus focused on emphasising commonalities across studies. While efforts were also made to highlight discrepancies, contrasts and nuances and to interpret and critique study findings, such an approach, with its emphasis on providing a broad overview of data, has been met with suspicion by some researchers, who argue that it risks undermining the integrity of individual studies, can 'thin out the thickness of particulars', and may offer a kind of 'averaging process', rather than adding interpretive understanding (Sandelowski, Docherty, & Emden, 1997; Stern & Harris, 1985). Indeed, the process of analysis inevitably resulted in subjective choices being made about how best to present the findings in a coherent analysis. As a result, it is recommended that readers not only consider the findings of this synthesis, but also interrogate the original research papers themselves to ensure original subtleties are not lost.

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Table 1. Characteristics of included studies (n=20)

Author(s)	Sample size	Population studied	Study country	Aims/outcomes considered	Data collection	Analysis	Quality rating
Allen, 2010	8	Fathers who were partners of women diagnosed with PND*	United States	To explore fathers' views where their partner experienced PND, exploring their needs and what was helpful in getting them through that period	Unstructured interviews (face-to-face; some questions given to participants prior to interview to reflect on)	Phenomenological analysis	12
Boath, Pryce, & Cox, 1998	23	Partners or close family members of women participating in a study on PND (23 partners were included)	UK	To explore the impact of PND on partners and other family members	Questionnaire	Not stated	2
Boddy et al., 2017	7	Fathers who were partners of women admitted to one of two MBUs	United Kingdom	To explore the experiences of men during their partner's admission to an MBU for first episode postpartum psychosis	Semi-structured interviews (face-to-face)	Interpretative Phenomenological Analysis	11
Davey et al., 2006	13	Male partners of women diagnosed with PND. All men had completed a psychoeducation /CBT treatment intervention for partners	Western Australia	To explore partners' experiences of PND and of participation in a 6-week group treatment program designed for male partners	Focus groups and written feedback	Phenomenological analysis	6
Doucet et al., 2012	8	Fathers who were male partners of mothers diagnosed with postpartum psychosis ad admitted to general psychiatric units	United States/Canada	To explore the perceived support needs and preferences of women with postpartum psychosis and their partners	Semi-structured interviews (telephone or face-to-face)	Inductive thematic analysis	10
Engqvist & Nilsson, 2011	11	Men with a partner or spouse with a postnatal psychiatric illness	Sweden	To explore men's experiences of women with postpartum psychiatric disorders	Online narratives	Not stated	8
Everingham et al., 2006	6	Fathers whose partner had signs of mild-moderate PND on EPDS or clinical assessment	Australia	To explore how couples talk about mothers' experience of mild to moderate PND	Semi-structured interviews (face-to-face)	Frame analysis	9
Feeley et al., 2016	30	Male partners of women with PND	Canada	To compare the preferences of couples who accept a mental health assessment and those who do not.	Semi-structured interviews (face-to-face)	Thematic analysis**	9
Kemp, 2011	6	Fathers whose partner had an admission to an MBU	UK	To explore fathers' experiences of a mother's admission to an MBU	Semi-structured interviews (face-to-face)	Interpretative Phenomenological Analysis	13
Letourneau et al., 2011	11	Fathers who were partners of women who experienced PND	Canada	To describe the experiences, support needs, resources, and barriers to support for fathers whose partners had experienced PND	Semi-structured interviews (telephone)	Thematic analysis	10

Author(s)	Sample size	Population studied	Study country	Aims/outcomes considered	Data collection	Analysis	Quality rating
Letourneau et al., 2012	40	Fathers who were partners of women who experienced PND	Canada	To describe the support needs and preferences for support of fathers whose partners have had PND	Semi-structured interviews (telephone)	Thematic analysis	10
Marrs et al., 2014	8	Fathers whose partners were admitted to one of two MBUs	UK (Scotland)	To investigate what impact a mother and baby's admission to an MBU had on the father's role and relationship with his family	Semi-structured interviews (not stated if face-to-face)	Grounded theory	12
Meighan et al., 1999	8	Fathers who were male partners of women with PND	United States	To help understand PND and its impact on the family through the experiences of fathers whose spouses suffered from it	Semi-structured interviews (face-to-face)	Existential phenomenology	10
Mizukoshi et al., 2016	7	Fathers whose partners had anxiety or depression diagnosed in their medical records	Japan	To explore the experiences of husbands of women with depressive or anxiety disorders	Semi-structured interviews (face-to-face)	Constant comparative method	11
Muchena, 2007	8	Fathers whose partners were admitted to an MBU with puerperal psychosis or PND	UK	To investigate men's subjective experiences when their partners are admitted to hospital with postnatal mental illness and offer insight into men's needs	Semi-structured interviews (face-to-face)	Thematic analysis	10
Murphy, 2014	6	First-time fathers with a female partner who experienced PND	United States	To explore the experience of fathers whose partners experienced PND to inform father-inclusive prevention/intervention	Semi-structured interviews (face-to-face)	Interpretative Phenomenological Analysis	12
Reid et al., 2016	17	Fathers whose partners were admitted to an MBU	UK	To understand how a woman's mental illness affects her family, and to explore how fathers view MBUs and children and family services	Semi-structured interviews (face-to-face or telephone)	Inductive thematic analysis	12
Roehrich, 2007	7	First time fathers whose partners experienced PND	United States	To identify the perspectives of men whose spouses or partners were diagnosed with PND	Semi-structured interviews (face-to-face)	Open coding and thematic analysis	12
Shaikh, 2011	4	Partners or family members of women with PND (the study included 3 male partners and 1 same sex partner)	Canada	To explore resilience among women who experienced PND and their partners	Semi-structured interviews (face-to-face)	Thematic analysis within hermeneutic phenomenological approach	13
Tammentie et al., 2009	5	Fathers whose partner had displayed symptoms of PND	Finland	To explore families' experiences of interaction with the public health nurse at the child health clinic in connection with a mother's PND	Unstructured interviews (no predetermined interview themes). Men were interviewed together with their partner.	Grounded theory	7

*PND=postnatal depression

**This study describes itself as using 'content analysis' but in fact appears to have used thematic analysis.

Table 2. Coverage of themes across included studies

Author(s)	Theme 1: marginalisation and neglect of women's partners	Theme 2: unmet need for information	Theme 3: partners' ambivalence about involvement and support	Theme 4: practical barriers to involvement	Theme 5: views on support for partners	Theme 6: impact on partners of the care women received
Allen, 2010	Fathers reported feeling left out of the process and wanted to be included. They also did not feel services were extended to them.	Fathers requested information from a male perspective better explaining PND as well as how, as the father, they could help and where they could go for help.	Fathers talked about difficulties for men opening up, and feared professionals judging them negatively. Some saw the mother as the priority. Some fathers also felt anxious about their partner accessing support feeling that problems should remain 'within the family'.	Fathers said they had difficulty finding time to seek help or resources.	Fathers wanted professionals to understand their struggles as a father, acknowledge them, and not judge them.	Once the mother had a diagnosis fathers said this helped them cope better with her symptoms.
Boath et al, 1998	Partners felt all help was geared to mothers, with no acknowledgement that fathers are affected and need help too.	There were comments from partners that they wanted to help the mother but did not know how.				
Boddy et al, 2017	Fathers commonly reported not feeling heard/valued by professionals and anger at a lack of involvement in decisions. Fathers feared their partner's admission might mean they were seen as abandoning their family and found it hard to establish family identity during admission.	Fathers felt they were denied information due to patient confidentiality and sometimes as a result of oversight by staff. They felt healthcare professionals had limited knowledge of postpartum psychosis.	The authors noted that fathers were sometimes uncomfortable about questioning professionals.	There were difficulties due to large distances to the hospital.	Fathers were grateful for help from family and friends. They also found it beneficial when they could develop their understanding of mental health.	MBU admission was described as a welcome relief with expertise from staff. Fathers reported feeling they had reached their personal coping limits and it gave them a chance to 'recharge'.
Davey et al, 2006	Fathers noted lack of organised support for men and limited avenues for them to seek help.	Fathers reported that improved awareness of PND and its impact on families was needed. They wanted more factual information about PND to help combat stigma. They wanted antenatal care to include a focus on PND.	Men reported wanting to keep up the appearance that 'everything is fine' and talked about embarrassment about seeking help.	Authors note after-hours support is necessary to help include men.	Fathers engaged well in a peer support group and reported valuing it highly, although they needed 'coaxing' initially to attend.	
Doucet et al, 2012	Fathers felt professionals excluded them, did not	Fathers wanted information on their partners' health status,	Fathers struggled to identify their own needs, and also felt they had		Fathers struggled with not knowing anyone in a similar	Fathers felt healthcare professionals were very clinical

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	listen to what they had to say and did not take their opinions seriously. Fathers weren't offered any professional support and some wanted professionals to be more proactive about inquiring about their needs.	treatment plan and long-term prognosis, as well as how best to handle their difficulties. They also wanted information about available community support after discharge from a psychiatric unit and help accessing it.	to keep their feelings to themselves and hold the family together. They wanted support but pride and privacy were barriers to asking.		position. They wanted a 'listening ear' and 'emotional outlet'. Wanted reassurance they were doing the right things and their partner would recover. They wanted group peer support to provide practical pointers, and one-to-one support from a professional to talk about their feelings. Fathers also wanted practical help with e.g. childcare, but preferred this to be from someone they knew. Some fathers felt family support was all they needed.	(too reliant on diagnoses) and inflexible to individual support needs.
Engqvist & Nilsson, 2011	Authors conclude that healthcare professionals need to pay more attention to fathers' postnatal mental health and support them to support their partners.	Fathers felt they got little information about postpartum mental health or where to get help. They said they received no information during antenatal care.	Fathers reported feeling that they should be able to sort out their difficulties privately with their partners, rather than via professional support.		Fathers' families provided most support to them, and they said this was good enough.	One father expressed relief once he knew wife had scored highly for PND as her difficulties now had a name.
Everingham et al, 2006			Some fathers talked about not feeling comfortable opening up in front of others in a group.		One father said he valued a video about PND professionals had lent him as he could watch it in privacy of his own home and it helped him understand his partners' difficulties. The authors recommended supporting fathers separately to mothers, and not in groups. For some fathers, intervention by professionals increased their distress and feelings of inadequacy.	
Feeley et al, 2016 (	Partners felt their needs were neglected, and the importance of their role	Fathers wanted a conversation with a professional about PND and information about how to provide				

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	overlooked. They wanted to be included in postpartum care.	support to their partners and seek help. They also wanted information about women's physical recovery, life with a newborn, infant development and parenting. Antenatal classes were considered inadequate. Fathers suggested routine visits or antenatal care appointments could be used to provide information, along with websites.				
Kemp, 2011	Fathers felt out of place on the MBU, marginalised and unsupported. They wanted to be 'thought about' by professionals and for them to treat difficulties as 'a family affair'	Fathers talked about not knowing who to ask to help them understand their partners' difficulties.	Male social stereotypes of needing to be 'strong' and to 'cope' were seen as a barrier to taking up support. One father felt cultural differences in childrearing left him feeling negatively judged by professionals, and said he struggled with having to take on aspects of his partners' role (e.g. feeding the baby) as this was seen as an 'abomination' in his culture.			Relief at admission to MBU, a place to recover and restart.
Letourneau et al 2011	Fathers spoke about being ignored by professionals, even when they attended appointments with the mother. Nobody asked fathers how they were finding the transition to parenthood.	All the fathers reported an information gap regarding PND that contributed to lack of recognition and early detection. They reported not knowing where to look for resources.	Fathers talked about stigma of seeking help, they wanted support but found it hard to seek it out or share their feelings (a 'guy thing'). They had trouble understanding their feelings.	Fathers said they had a lack of time and energy to seek help.	Fathers wanted someone who would listen. Friends' insight where they had experienced something similar. Support from friends and family cited as important.	Fathers spoke about their relief when trained professionals took over their partners' care (e.g. they were admitted).
Letourneau et al 2012	Fathers felt their own mental health was minimised. They felt professionals should be better at identifying difficulties in fathers, not dismissing their difficulties. Fathers felt the PND literature minimised	Fathers wanted additional information, e.g. warning signs that you might need help. They felt antenatal care did not include a focus on PND. Fathers stressed the importance of professionals being well informed. They felt available information should feature fathers more centrally.	Fathers were sometimes reluctant to take part in group support - one who did felt uncomfortable opening up due to group size.	Fathers spoke of stress when they had to travel long distances to visit their partners.	Fathers wanted someone to talk to. Peers were valued for their first-hand knowledge of PND and new parenthood. They also wanted professionals to 'bring their partners back' from PND. They generally preferred to receive help separately to their partners to allow them to be	

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	their role, and wanted more focus on how PND affects the whole family. They wanted to be involved in the diagnosis. They also wanted support for extended family.				open.	
Marrs et al, 2014	Fathers did not feel included in their partner's care when she was admitted to an MBU. They felt 'relegated' and sometimes disempowered.	Fathers felt they had to convince professionals they really did want information about what was going on. The authors also suggest specific leaflets for fathers detailing expectations and common concerns could be helpful.	Fathers were found to sometimes restrict their own desires in a bid to help preserve the bond between the mother and baby. Some fathers found it hard to approach and communicate with staff.	Fathers experienced stress when they had to travel long distances to the MBU.	Fathers valued MBU staff providing childcare to help them have time alone with their partner. Fathers reported receiving most of their care from their families.	Fathers felt relieved when their partner was admitted and contained by the knowledge the mother was receiving support and was with the baby.
Meighan et al, 1999	The authors recommend that fathers should be included in screening, education and treatment of PND.	The authors conclude that written information should be provided on PND during antenatal care or at discharge from hospital including steps to take if needed and telephone numbers.			Fathers expressed a willingness to share their experiences and offer support to others. The authors recommended a support group for partners.	Fathers felt professionals tended to minimise the mothers' difficulties.
Mizukoshi et al 2016	Fathers reported that the research interview was the first opportunity they had been offered to talk to someone about their partners' difficulties.	Fathers reported wanting to know how to deal with their partners' difficulties.				One father reported relief when he knew his partner would be given medication.
Muchena, 2007	The authors commented on a lack of resources for postnatal men.	Fathers reported not knowing where to turn or how to deal with their partners' difficulties.	Men in the study were reluctant to seek support (6 of the 8 participants reported struggling but only 2 sought support).	Men also reported difficulties attending the MBU and needed services to take account of their working hours.	Fathers tended to use informal sources of support, such as friends or chat rooms but found these only provided temporary relief. The authors suggested couples' counselling could also be beneficial. The authors also suggest fathers wanted help with access to childcare support, support groups, helplines and parenting skills	Fathers experienced high stress levels as a result of delayed responses from services. There was relief among fathers on admission of their partners to the MBU and they were usually happy with the support provided by the MBU, although they remained anxious, confused and sad.

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					classes.	
Murphy, 2014	In contrast to other studies, fathers did not feel their needs had been minimised by professionals.	Fathers reported not knowing what information to look for or who to ask. They wanted father-specific information, reflecting their role in the process. Fathers felt there was no emphasis on PND in antenatal classes.	Though they were open to help-seeking, fathers struggled to identify their own needs, or what would have been helpful for them.	Childcare issues made it hard for fathers to be more involved.	Fathers emphasised the importance of familial support. Fathers would also have valued help with childcare or the offer of respite. Two fathers found a postnatal parenting group helpful, as sharing their difficulties with peers normalised their experiences, provided them with information, and helped them identify their partners' PND.	Some fathers were frustrated that discharge seemed too quick, with no formal screening or follow-up care despite indications of difficulties.
Reid et al, 2016	The mother's admission could make their partners feels like a 'temporary father'. Some fathers felt visiting times were good and emotional support/counselling were offered. However others felt disengaged from the MBU and said they were not offered support.	Fathers wanted more information about their partner's mental health difficulties, medication and the MBU and wanted professionals to keep them informed.		Many fathers said balancing work and visiting their partner and baby was difficult. This was particularly problematic for fathers with more than one child.	Where it was taken up, emotional support/counselling offered by the MBU were received positively. Emotional and practical support from family and friends was highly valued, though continual requests from other family members for information could be stressful.	Fathers described feeling relieved when their partners were admitted and valued the MBU support. However, there were some reports of inconsistency in childcare advice between different members of staff.
Roehrich, 2007	Fathers felt professionals did not communicate with them effectively about what was happening. They felt professionals were negligent of their need to know as the father of the baby. They felt 'undeserved' and 'dismissed', and believed better connection with professionals could have helped them seek help sooner.	Antenatal information was considered inadequate. Fathers felt information in pregnancy would have helped them recognise PND in their partner and seek help earlier. Leaflets were discarded through lack of time to read them.	Shame and guilt prevented men from initially seeking help in relation to their partners.		Fathers appeared receptive to the idea of mentoring or peer support to gain information and allow them to vent frustrations. Most fathers received help primarily from their families.	Some fathers felt relief once their partner had a diagnosis. However, fathers reported anger and frustration when they felt professionals lacked accountability in helping families with the transition into parenthood, dismissed their concerns, and did not support their partners properly.
Shaikh, 2011	Partners felt there was a lack of informal and formal	Partners reported a lack of resources for how to deal with a	While some partners encouraged women to seek help, others did		Partners spoke about reaching out primarily to their personal	

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	support and resources for men.	woman's PND.	not due to previous negative experiences with healthcare professionals.		support networks.	
Tammentie et al, 2009	Fathers commented on an absence of 'family-centeredness'. They said they were encouraged to attend their partners' appointments, but when they did felt professionals spoke only to their partners.			Being at work at times prevented fathers being more involved.		