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**Citation for published version:**

Marrs, J, Cossar, J & Wroblewska, A 2014, 'Keeping the family together and bonding: a father's role in a perinatal mental health unit', *Journal of reproductive and infant psychology*, vol. 32, no. 4, pp. 340-354. <https://doi.org/10.1080/02646838.2014.920951>

**Digital Object Identifier (DOI):**

[10.1080/02646838.2014.920951](https://doi.org/10.1080/02646838.2014.920951)

**Link:**

[Link to publication record in Edinburgh Research Explorer](#)

**Document Version:**

Peer reviewed version

**Published In:**

Journal of reproductive and infant psychology

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# **Keeping the family together and bonding: a father's role in a perinatal mental health unit.**

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## **Abstract**

### Objective

This study explores the father's paternal role and relationships when his partner and baby are admitted to a Perinatal Mental Health Unit. It contributes to an important and understudied area of perinatal mental health and makes clinical recommendations.

### Background

The importance of establishing good attachment in the first months of life has had increasing prominence in the development of good infant mental health in the last 60 years. Parental mental health and separation can negatively impact attachment. Furthermore, maternal postnatal mental health is known to affect the father's well-being which could impact on his ability to parent sensitively.

### Methods

Grounded theory methodology was used. Eight fathers were recruited from two Perinatal Mental Health Units. Transcripts were analysed and compared by researchers. Resulting categories were checked with one participant.

## Results

Fathers described the difficult experience they managed whilst creating and maintaining family bonds. Long admissions with infrequent visits were most difficult. Fathers wanted to bond and had concerns about bonding. They aimed to preserve the mother-baby bond. Fathers relied on family support. The couple's relationship was strained. Fathers experienced anxiety regarding the illness and felt relief when their partner was admitted. Fathers were uncertain about illness and treatment, and desired improved communication with professionals.

## Conclusion

Severe maternal postnatal mental illness and inpatient admission affects fathers. Fathers were not consistently available to babies, which could affect attachment and child development. Recognition of the father's experience and increasing father's knowledge of illness and skills in caregiving is recommended.

*Keywords:* father; paternal; postnatal; mother; baby; inpatient.

## **Introduction**

Establishing good quality attachment in the first months of life is central to future good infant mental health (Bowlby 1969). Poor maternal mental health can negatively impact attachment (Gerhardt, 2004). Mother and Baby Mental Health Units promote maternal-infant attachment by keeping the dyad together, as separation from a primary caregiver also impacts negatively on attachment. However, an often necessary consequence of admission is that they are separated from the rest of the family. Furthermore, maternal postnatal mental health is known to affect the father's well-being directly by an increased likelihood of mental health difficulties (Harvey & McGrath, 1988; Lovestone & Kumar, 1993), and indirectly via a compromised partner relationship (Meighan *et al.* 1999; Webster, 2002). Both these factors could impact on the father's ability to parent sensitively. This qualitative study explored the father's paternal role and relationships when his partner and baby were admitted to a Perinatal Mental Health Unit.

Bowlby's (1969) seminal work on attachment explains the impact of the emotional bond between a caregiver and a child on the child's psychological development. The first six months after birth are crucial to establish this bond (Bowlby, 1969). Children learn how to express their emotions through the way their attachment figure responds to them. The quality of the attachment relationship can influence whether an individual develops a resilient personality or whether they become prone to some forms of mental health difficulties. Once a pattern of attachment is developed it tends occur throughout the lifespan (Bowlby, 1988).

When a mother is depressed she can find it difficult to respond to her baby, sometimes becoming withdrawn and apathetic. The baby can become accustomed to a lack of positive interactions and interact in a depressed style (Gerhardt, 2004). In contrast, when a mother is

anxious she may be over-involved with the baby and continuously stimulate them, which can result in the baby being over-aroused (Gerhardt, 2004). These mother infant interactions can impact upon the development of a secure attachment style, or good emotional regulation. Similarly, if a father is experiencing mental illness, both may struggle to respond to the baby's needs appropriately.

When mothers experience severe postnatal mental illnesses (such as severe depression or puerperal psychosis), or if they have a continuing or historical psychiatric disorder, they may be admitted to a Mother and Baby Mental Health Unit with their baby. These units provide assessment and treatment for the mothers whilst promoting attachment.

Studies of fathers when their partners had postnatal depression found fathers experienced a strain on the couple's relationship (Meighan *et al.* 1999; Webster, 2002). These studies had several limitations but crucially they were from community samples where the mother was at home within the family. There is sparse research on fathers when their partner and child are admitted to a perinatal Mother and Baby Unit, yet the evidence suggests that they are vulnerable. Forty-two per cent (Harvey & McGrath, 1988) and 50 per cent (Lovestone & Kumar, 1993) of these fathers met diagnostic criteria for a psychiatric illness. Lovestone and Kumar (1993) reported a limited amount of qualitative data; the men discussed a stark contrast between the excited anticipation of the baby's arrival and the reality of coping with an empty house, work, and visiting their ill wife. Seeing the unused pram and toys at home emphasised a feeling of sadness. This study benefited from adequate control groups, and 100 per cent of fathers whose partner was in the mother and baby unit in one year participating. Importantly, this is the only study that begins to investigate the father's experience when his partner and child have been admitted to a psychiatric Mother and Baby Unit.

Father-infant interactions are affected by maternal mental health. Goodman (2008) found when the mother had postnatal depression the father displayed fewer optimal father-infant interactions, so they do not appear to compensate for the negative effects that maternal postnatal depression can have on the child. However, father-infant interaction was influenced more by how the mother felt about her own relationship with the infant than maternal depression. The quality of the couple's relationship also seems to affect parent-infant relationships. For example, Mantymaa *et al.* (2006) found that when mothers had mental health problems, a poor, disengaged marital relationship was associated with poorer mother-infant interactions. Therefore the father's role as a partner may influence the development of infant attachment.

Klaus, Kennell and Klaus (1995) describe how the developing connection from the parent to the infant is referred to as bonding whereas the term attachment is the connection from infant to parent. A strong bond from parent to baby is crucial for that child's survival as it facilitates the carer in sacrificing their own needs for that of their infant e.g. sacrificing sleep.

Behaviours such as kissing, cuddling and prolonged gaze are associated with bonding.

## **Study Aims**

To address a gap in the literature we were interested in the effect that a mother and baby's admission to a unit has on the father's role and relationship with his family.

## **Method**

### **Design**

Qualitative research can be a useful tool for learning about a person's experience with a particular phenomenon, uncovering what lies behind it and gaining fresh insights into

something about which little is known (Strauss & Corbin, 1990). This study used a Grounded Theory methodology. The purpose of Grounded Theory is to create a theory which illustrates, and remains faithful to, the area which is being studied (Strauss & Corbin, 1990). It involves moving back and forth between gathering data, coding, and analysis before returning to gather more data (Charmaz, 2006). In Grounded Theory the researcher stops recruiting when the categories are "saturated"; that is when gathering fresh data no longer triggers theoretical insights nor reveals new properties of the core categories (Charmaz, 2006).

### Recruitment

Professionals at two Mother and Baby Mental Health Units were informed about the study and asked to identify potential participants. Fathers were given information about the study either face-to-face by staff, or by post. The researcher contacted interested participants to arrange an interview.

### Inclusion criteria:

- Fathers of infants admitted to the Mother and Baby Unit during the recruitment period.
- The father must have visited their partner and child in the unit.
- The father must be over 18 years old.
- The father must be fluent in English.

### Exclusion criteria:

- Fathers experiencing high levels of distress as reported by clinicians.

## Participants

Sixty potential participants were identified across the two bases. Five fathers were excluded from base one as two were deemed too distressed by clinician judgement, and three were overnight stays where the father did not visit. Fifty-one fathers whose partner had been admitted to recruitment base one in the one year and 121 day long recruitment period were identified as suitable and invited to take part, as were 4 participants from recruitment base two (recruitment period 41 days). Recruitment periods varied due to ethics processes across trusts.

Eight fathers participated in total, three of whom had their partner in the unit at the time of interview. They were aged between 28 and 51 years (mean = 37.5, standard deviation (s.d) = 8.14) and all were married. Five participants were first time fathers, three had older children. Seven participants were of white British ethnicity and one participant was of black African ethnicity. Six participants were employed full time and two were self-employed. All participants scored within the normal range on the Depression Anxiety Stress Scales (DASS-21; Lovibond & Lovibond, 1995) (Henry & Crawford, 2005).

## Data Collection

One-off, individual interviews were conducted and recorded. Interviews lasted between 49-103 minutes (mean 69 minutes). The interview questions were devised to gather rich data without imposing preconceived ideas (Charmaz, 2006). They consisted of a number of open ended, non-judgemental questions that allowed the participants' stories to emerge. For example; "Tell me about your experience of your partner and child being in the Mother and Baby unit?" and "How do you spend your time during a visit?". Interviews were transcribed, analysed, and new questions developed before the next interview.

Memo-ing the analytical steps and discoveries is central to the resulting grounded theory (Charmaz, 2006). Memos aided the development of the results and were made about expectations, thoughts about interviews, recruitment, and analysis.

### Analysis

Line-by-line coding was used initially, followed by focussed coding, and theoretical coding. Line-by-line coding can help spark new ideas to pursue, and it helps to correct against the likelihood the researcher will superimpose preconceived notions on the data (Charmaz, 2006). Focused coding is used to synthesize and explain large segments of the data. This is done by making decisions about which initial codes are most relevant and using that information to sift through large amounts of data. Finally, theoretical codes are applied to explain relationships between categories and create a more coherent analytical story. It is a way of integrating the data back together after it has been fractured by the initial coding process. During theoretical coding it is important to question qualities of the codes such as; what causes them, in what context do they occur, what are the contingencies and consequences of the action being coded, what are the covariates and the conditions in which the action occurs. It is important to use theoretical coding to make the analysis objective but it is important to not impose a forced framework on the analysis (Charmaz, 2006).

Transcripts were given to supervisors to analyse, in order to compare ideas about emerging categories. Such a procedure is designed to counteract any potential bias of the researcher affecting the analysis.

To improve validity of the results feedback was obtained on the study's findings from one participant, and their response was then incorporated into the results (Mays & Pope, 2000; Willig, 2008).

## **RESULTS: MANAGING THE SELF AND OTHER RELATIONSHIPS**

The overarching category ‘managing the self and other relationships’ captures the father’s experience and how he tries to understand and manage it, and the role he takes in relation to making and maintaining bonds within his family. The subcategories are Bonding with Baby, Keeping the Family Together, Feeling Contained, Feeling Overwhelmed, and Experiencing and Managing Uncertainty, see figure 1.

### **BONDING WITH BABY**

#### ***Importance of mother being with baby***

The fathers strongly emphasised the importance of the mother being with baby and felt reassured by them being together. Having a mental health unit specifically designed to keep mother and baby together seemed to contribute to father’s understanding of the significance of this.

*I’m not sure what the evidence is here, or the factual information but ...I don’t know if it is an old-fashioned thing to say but I do think there is a bond between a mother and a child, a baby and its mother. And I think there must be in a sense. Surely that’s why there is a Mother and Baby Unit (Participant 2)*

This idea resulted in fathers aiming to strengthen and preserve the bond between their partner and baby, sometimes to the extent that they would restrict their own desires to interact with their infant.

*I think I was a bit cautious in the early days when I first started going down to [the mother and baby unit]. Maybe in some ways thinking to myself ...I suppose I did actually in the early days...thinking how important it was for (partner) and (baby) to be together (Participant 2)*

The fathers tended to take their cue from the mother and tailor their interactions with the baby to be supportive for her, for example being more hands-on if the mother needed a rest or spending time with their partner without the baby if they felt that she needed most attention.

### **Father needing to bond**

All fathers spoke of being involved in childcare in the unit. They wanted to get to know their baby, and meet his/her needs. During long admissions and particularly when the father was unable to visit frequently, the fathers had greater concerns about bonding.

*As much as she obviously recognises me. Erm it does still worry me that, obviously because I have been away for so long but I can see she recognised. Being away working for so long and being back, will she still remember me as a dad? ...She has still remembered. And I have known since first of all. My wife said do you see how she has reacted to me (father) differently to any of the other nurses in here.*

**Interviewer: So your wife sort of reinforcing...**

*Yer. So (partner) emphasises that my daughter remembers me, she remembers her dad. Because as much as a 6 month old knows what a daddy is she recognises me as that most significant man in her life. (Participant 5)*

### **A Fleeting Figure**

Fathers were concerned about being perceived as a 'fleeting figure' by their baby. They wanted to visit frequently and be involved in care so their baby could grow to know them. For fathers who were restricted in terms of visiting time there was a sense they were not able to be the stable figure sitting with their child for hours as they might at home.

*I would maybe do the feed at that point.*

**Interviewer: How did that feel?**

*It was always good to do. Felt as though you were being involved in the baby's life rather than sort of this fleeting figure that rushes in and out every so often. So that was good. (Participant 1)*

Getting involved with childcare helped combat the concern of being a fleeting figure. Fathers

reassured themselves that their infant may be too young to interact meaningfully and to notice their absence, but for long admissions the worry loomed that their baby may not recognise them as an important figure in their life.

*Whether it be this is someone I see an awful lot, this is someone I don't. But having said that, that is something I am not worried about, but I have in the back of my mind. I don't want to use the word worried but it's close to worry in a sense. I won't want him to be here till he gets to that sort of age where he and I begin to sense some funny feelings from him. Or he sees me and he sees me as the one who's scaring him or something like that for the first few minutes. You know what ever, basically I don't want him to grow, I don't want him to get to the point where he is spending more than half the week not seeing his dad. (Participant 7)*

Fathers handled any worries they had about separation from their baby by putting them on hold. They were reassured by mother and baby being together and tried to think ahead to the time when they could return home.

## **KEEPING THE FAMILY TOGETHER**

### **Relying on Support from Family and Friends**

Fathers received the majority of their support from family. The intensity varied but several participants received intensive daily help, on occasions even moving in with family. Fathers received both practical and emotional support and some acknowledged they would not have been able to cope without it.

*"I probably wouldn't be sitting here today if it wasn't for my mother in law" (Participant 2)*

Some fathers did not feel the need to rely on friends or family as much. However, it was clear that some fathers did not have a wide support network, and greater support from staff may be welcomed.

### **Adjusting the couple relationship**

When the mother experienced a severe postnatal mental illness it could be shocking for the father, particularly when the mother experienced changes in her personality. It could be difficult for the father to understand, particularly when he did not have knowledge about the illness or likely recovery. The experience of illness affected the security he felt about their relationship.

*It is quite easy I am sure to think oh my goodness this is the end of our relationship because it's not an illness where she is sick and she needs this medicine and she will be better after x weeks, you know. (Participant 5)*

All fathers spoke of having time with their partner, and the majority tried to be alone together. They felt they were supported in this by staff offering to care for their baby. There was a sense that fathers had to be protective of their partner and that this protective role was important in their partner's recovery. Participant 4 described his role as:

*"Keeping her alive. Giving a reason to live. Coz she didnae". (Participant 4)*

Many of the fathers felt their partner relied on them for support. This reliance could both strengthen and strain the relationship.

### **FEELING CONTAINED**

#### **Relief of admission holding care**

Fathers experienced a period of uncertainty and worry when their partners had been experiencing symptoms but had not yet received specialist help. Fathers felt relief when their partners were referred into the unit.

*I think at the time probably what I would...my overriding kind of emotion would have been relief that finally she was in a place where people understood what was going on. (Participant 3)*

The admission to the unit made the fathers feel better and provided hope of recovery.

*Overall I thought the experience was very good. It certainly did the mother the world of good. It has also made me feel better because that whole point, everything was quite, very upsetting and everything and obviously when she got to that unit she was finally receiving the help she was needing then as she got better it made everyone else, well it made me feel better in myself because then I could see things moving forward rather than things getting stuck and going backwards. (Participant 1)*

When it was time to be discharged some fathers experienced anxiety as they felt the care of their partner again going to be their responsibility.

## **FEELING OVERWHELMED**

### **Experiencing anxiety and stress**

All fathers discussed some anxiety and worry. Father's distress was particularly strong if this was their first experience of mental health difficulties, or when their partner's condition deteriorated.

*It was really scary, especially I think going home at night and things. Like just lying awake and then, I dunno, obviously I hadn't been sleeping well as well so the thoughts that (partner) was speaking to the psychologist, I was getting the same kind of thoughts. Not wanting to kill myself but just that I couldn't concentrate on anything. I couldn't relax because my mind was just racing... (Participant 4)*

This level of anxiety affected how available they were to care for their partner and child. When fathers were confident their partner was managing her illness, and they felt admission was for a short assessment, they were less anxious. Fathers also spoke of stress related to travelling

long distances to visit. When fathers had older children they also had to deal with their distress at being separated from their mother.

*The first four weeks in particular every night he cried. Things like that, as a father, when your wife, his mother is taken, when she is not in the environment he is used to, as in home. Dealing with that was quite hard. (Participant 2)*

In order to comfort their children fathers aimed to reassure them, retain their normal routines, and maintain bonds with their mother and new sibling.

## **EXPERIENCING AND MANAGING UNCERTAINTY**

### **Understanding illness and treatment**

Fathers were uncertain of their partner's diagnosis, precipitating or maintaining factors. The fathers' understanding did not appear to be affected by the length of admission but seemed to be linked with how fluently they could establish communication with staff.

*...for the last 3 months the diagnosis has been a bit...well it was only at that meeting (...) where the consultant said catatonic schizophrenia.*

**Interviewer: Was that the first time you had heard?**

*Well I have seen that and I have seen bi-polar disorder and I have seen depression and somebody had mentioned like a reaction to some sort of trauma.  
(Participant 6)*

A small number of fathers did not understand the serious nature of their partner's difficulties. For one participant, prior knowledge of mental health and the belief that postnatal depression was common may have contributed to this. With hindsight he wished he had found out more.

*I didn't think what was happening was strangely enough that concerning. Because, I mean, you hear about how often women experience postnatal depression and other things anyway. Erm and it's a relatively common occurrence and so if you are in that circumstance, if you are like me anyway, erm you are not immediately thinking oh dear this is horrific! You are thinking oh this is perfectly understandable, perfectly normal,*

*erm lets just get on with things. Try and see some improvement here. Do the necessary steps to improve certainly my wife's situation and you know I really wasn't that concerned about it at all. Erm obviously that wasn't the attitude that was held by other people, but my concerns at the time were definitely for the way my wife was feeling. (Participant 8)*

Fathers were uncertain about their partner's treatment plan, or duration of treatment. Those who had established good communication had the greatest knowledge of treatment. Some fathers had very little knowledge; they did not feel included in their partner's care and they felt this relegated them from next-of-kin status.

*Erm nobody had ever really explained to me I don't think the real purpose of her being in the unit. I don't think anybody ever really sat me down and said, you know, "this is what we are hoping to do. Not just to keep your wife and daughter together" Erm it felt a bit strange at times. It almost felt like you were going down to visit somebody in hospital. (Participant 2)*

What contributed to fathers' uncertainty were difficulties establishing communication with professionals and their partner giving them the impression they were better than they were. Perhaps due to their limited understanding fathers did not make many adjustments to their behaviour in order to facilitate her recovery.

### **Communicating with staff**

Improved communication with staff appeared to minimise uncertainty. All fathers felt communication could be improved. Some fathers were skilled communicators who were able to seek out information; others were more uncomfortable in this role. Although staff were always available, it was only the more socially confident fathers who seemed to use this opportunity to speak with staff and be persistent.

*I'm used to dealing with professionals and you know I speak to people for a living in a sense. So I always appreciated the more frank full explanations that I could get (...)*

**Interviewer: You got a lot of information. Do you feel you sought out people to talk to?**

*I think so yes. I think I did. I think sometimes you had to ask a couple of times. You had to convince people that actually you really did want to know what was going on. And you did understand what they were saying to you. But I think you find that when you are talking to doctors anyway. (Participant 3)*

The unit is designed as a service for the mother and baby, they are therefore the priority. The father recognises this; furthermore his partner and baby were also his priority. However, some fathers felt excluded by this.

*...in as much as (partner) is the patient it kind of feels like, you know, she 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. (Participant 7)*

The fathers felt they should be included in their family's care. Some fathers felt disempowered and restricted their communication with staff as a result.

*I do phone yer. Maybe not as much as I should. Maybe that's the thing, maybe I should phone more often. And I'm going (incomprehensible), as time goes by I have phoned a few times. Maybe I should have phoned more often but again I think to myself if I phone more often they will think there's so and so on the phone again, you know!! I don't want to put myself, and I don't want to put the doctors in a way they will think that of me. Which means I am probably less likely to get the best information. (Participant 5)*

### The model:

This study proposes a model of how a father manages himself and relationships in the mother and baby unit, see figure 2. Each father experienced a combination of demands and support which affected how he coped, his participation in the unit and his relationships. It is proposed that his ability to acquire knowledge and skills from professionals, which was influenced by his personality and attachment style, will affect his participation in the unit, relationships, uncertainty, and coping.

The father's adaptation to the admission falls into four broad categories. 1) The practical issues such as child care and travel which can be noted, advice given and barriers considered. 2) The father's role as caregiver which can be modelled and guided by professionals. 3) The demands of the partner's illness which can be alleviated through increased communication between professionals and the father. 4) The father's own beliefs and understanding should be considered.

### **Discussion**

This study provides a unique insight into an understudied area. There was no individual model in the literature which could explain how fathers manage the experience of their partners and babies being admitted to the unit and how he then develops his relationship with his infant. Therefore this grounded theory incorporates models from several fields. The main structure of the model is influenced by Lazarus & Folkman's (1987) cognitive relational theory of emotion and coping. It was also heavily influenced by McCubbin & McCubbin's (1993) resiliency model of family stress, adjustment and adaption, and Bowlby's (1969, 1988) attachment theory.

This study suggested that fathers develop their paternal role whilst managing the demands of the illness and admission, and ensuring all family relationships were maintained. Fathers clearly wanted to bond with their baby. Admission to the unit made the development of a father-infant attachment relationship difficult as they are separated. Fathers were aware they were not consistently available to their baby and had concerns about bonding and being perceived as a 'fleeting figure'. The longer the admission and the less frequently a father visited the more difficult this was. Fathers were sensitive to the mother's feelings about her mother-baby bond and were concerned about affecting it. This led them to consciously consider their own interactions which perhaps meant that they did not always respond

sensitively to their baby's needs. The father's sensitivity to the mother-baby relationship is vital, and has similarities with Goodman's (2008) finding that father-infant interaction was strongly influenced by how the mother felt about her own relationship with the infant, and Mantymaa *et al.*'s (2006) findings that a disengaged marital relationship was associated with poorer mother-infant interactions. In the present study when communication between the couple was good, and the mother encouraged father's interaction with their baby, the father seemed to do more.

Similar to findings by Meighan *et al.* (1999) and Webster (2002) the couple's relationship was under strain, particularly when the illness was severe. Fathers were supportive of their partners, and this helped to maintain their relationship. Unlike the literature which shows maternal perinatal mental health is associated with paternal mental health (e.g. Harvey and McGrath, 1988; Lovestone and Kumar, 1993), the fathers in this study did not present with any symptoms indicative of depression, anxiety, or stress as assessed by the DASS-21.

Fathers felt anxious when their partner became ill and they had considerable demands on them. Social support was very important. Father felt relief that the unit was looking after their partner and they appreciated their expertise. In this way the fathers felt contained by the unit. By responding sensitively to a family's needs healthcare professionals can provide the main functions an attachment figure would; to create a secure base and reduce anxiety (Adshead, 1998).

All fathers experienced uncertainties regarding the illness and treatment. Postnatal mental health can be uncertain and fluctuate rapidly. Fathers wanted to be involved and were aware information could have been shared to reduce uncertainty. However, some fathers struggled

to establish sufficient communication. It is likely that their attachment style, personality, and anxiety may have impacted on how easily they established communication with professionals.

There were similarities with literature about carers for people with mental illness. Factors found to affect carer burden include the severity of illness, and length of hospitalisation (Dyck *et al.* 1999). Rowe (2012) found barriers to carers providing care were their ability to cope, attitudes of staff, and inadequate communication. Again this shares similarities to fathers experience in the unit; fathers coping skills affected their participation in the unit and caregiving. Fathers wanted to be more included by professionals and to be given more information.

### Clinical implications

Scottish Intercollegiate Guidelines Network (SIGN 2012) and National Institute for Health and Clinical Excellence (NICE, 2007) guidelines recognise the adverse effect postnatal mental illness can have on fathers. They recommend good communication (SIGN, 2012) and promote the inclusion of fathers (NICE, 2007). This study supports this recommendation.

In order to reduce father's uncertainty and anxiety, and to enable him to optimally support his partner, it is essential a father develops an understanding of his partner's illness, treatment, and what he can do to facilitate recovery. This can be facilitated by initially recognising why some fathers struggle to communicate, then increasing communication between professionals and fathers, and encouraging inclusion in care meetings. One-to-one sessions may be helpful. Specific information leaflets for fathers detailing expectations and common concerns may facilitate discussion.

The findings show the baby's attachment to the father may be difficult to establish particularly over long admissions when the father visits infrequently. Fathers who acquire the skills to parent sensitively (perhaps through improved communication and exchange of childcare skills between professionals and fathers) may be more likely to achieve a secure attachment relationship irrespective of time together. Sensitive parenting can be more important than time together in the formation of secure attachments (Brown *et al.* 2007).

### Limitations and strengths

Previous research links maternal and paternal mental health yet no participants had current depression or anxiety. If a significant proportion of potential participants were experiencing mental health difficulties and chose not to participate this could have biased results. There was a lack of socio-demographic information on non-participants which makes it difficult to compare our sample to those who chose not to participate. The sample in this study is not representative and the results cannot be generalised due to the small sample size. However, the study provides valuable insights into these men's experiences of a perinatal mental health inpatient setting.

This study had resonance as when results were checked with a participant he strongly recognised the majority of categories as being relevant to his experience, and all the categories made sense to him. His responses helped to describe and finalise the categories displayed in the results section.

### Further research

Encouraging and facilitating open communication with fathers using written material, face-to-face interaction, and modelling of behaviour could increase his knowledge and skills. This could affect his participation in daily activities in the unit, stress and anxiety, and ability as a caregiver. Research is needed to validate each of these associations.

## **References**

- Adshead, G. (1998). Psychiatric staff as attachment figures. Understanding management problems in psychiatric services in the light of attachment theory. *The British Journal of Psychiatry*, 172, 64-69.
- Bowlby, J. (1969). *Attachment and Loss: Volume 1 Attachment*. Kent, England: Mackays of Chatham.
- Bowlby, J. (1988). *A Secure Base*. Cornwall: Routledge.
- Brown, G.L., McBride, B.A., Shin, N., & Bost, K.K. (2007). Parenting predictors of father-child attachment security: Interactive effects of father involvement and fathering quality. *Fathering*, 5(3), 197-219.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage.
- Dyck, D.G., Short, R., & Vitaliano, P.P. (1999). Predictors of burden and infectious illness in schizophrenia caregivers. *Psychosomatic Medicine*, 61, 411-419.
- Gerhardt, S. (2004). *Why Love Matters: How Affection Shapes a Baby's Brain*. Hove: Brumner-Routledge.
- Goodman, J. H. (2008). Influences of maternal postpartum depression on fathers and on father-infant interaction. *Infant Mental Health Journal*, 29(6), 624-643.
- Harvey, I., & McGrath, G. (1988). Psychiatric Morbidity in spouses of women admitted to a Mother and Baby Unit. *British Journal of Psychiatry*, 152, 506-510.
- Henry, J.D., & Crawford, J.R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. *British Journal of Clinical Psychology*, 44, 227-239.

Klaus, M.H., Kennell, J.H., & Klaus, P.H. (1995). *Bonding: Building the Foundations of Secure Attachment and Independence*. Reading, MA: Addison-Wesley Publishing Company.

Lovestone, S., & Kumar, R. (1993). Postnatal psychiatric illness: the impact on partners. *The British Journal of Psychiatry*, 163, 210-216.

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales*. Sydney: Psychology Foundation.

Mantymaa, M., Tamminen, T., Puura, K., & Luoma, I. (2006). Early mother-infant interaction: associations with the close relationships and mental health of the mother. *Journal of Reproductive and Infant Psychology*. 2(3), 213-231.

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal*, 320, 50-52.

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

National Institute for Health and Clinical Excellence. (2007). *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidelines*. NICE Clinical Guideline 45.

Rowe, J. (2012). Great expectations: a systematic review of the literature on the role of family carers in severe mental illness, and their relationships and engagement with professionals. *Journal of Psychiatric and Mental Health Nursing*, 19, 70-82.

Scottish Intercollegiate Guidelines Network. (2012). *Management of Perinatal Mood Disorders: A National Clinical Guideline*. SIGN Publication 127. Health Improvement Scotland.

Strauss, A., & Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. London: Sage Publications.

Webster, A. (2002). The forgotten father: the effect on men when partners have PND.  
*Community Practitioner*. 75(10), 390-393.

Willig, C. (2008). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method, Second Edition*. Berkshire: Open University Press.

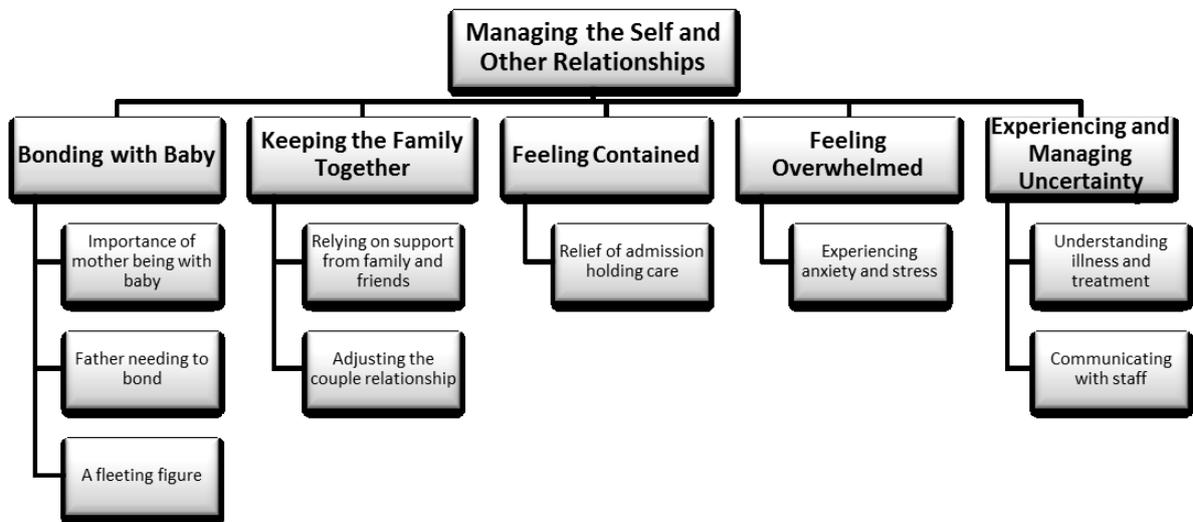


Figure 1. Categories of managing the self and other relationships; a father's experience.

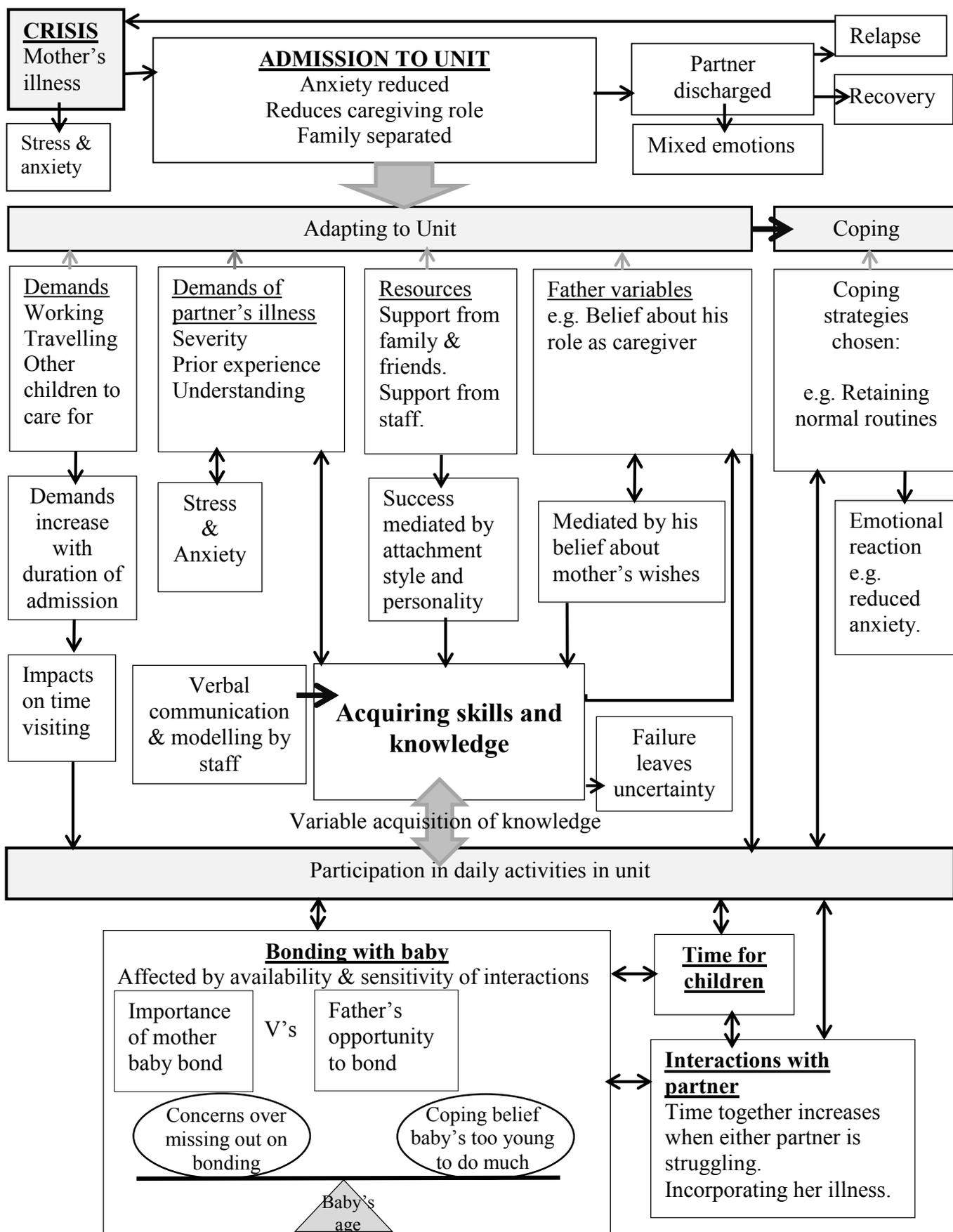


Figure 2. A model of how fathers manage themselves and relationships during their partner and baby's admission to a perinatal mental health unit.