Thesis submitted in partial fulfilment of the degree of Doctor of Clinical Psychology (DClinPsych)

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Abstracts

Critical Review of the Literature Abstract

Objective: Antenatal groups have gained popularity worldwide and have been shown to result in improvements in physical health outcomes for both the mother and baby (Ickovics et al., 2007; Lathrop, 2013). However, the same improvements have not been seen in parental mental health following antenatal groups. A previous systematic review reported that, although the quantitative outcome measures did not identify improvements in parental mental health following antenatal groups, the qualitative literature did identify improvements in wellbeing following antenatal groups (Wadephul et al., 2016). The current review aimed to understand the qualitative literature describing parents' experiences of attending antenatal groups to understand the discrepancy between the quantitative and qualitative data. It also aimed to explore whether Yalom and Leszcz's (2005) group process factors could offer a framework to understand the qualitative literature on antenatal groups.

Design: A systematic search of the literature was conducted using six databases (PsycINFO, Web of Science, Medline, PubMed, Embase and CINAHL). The search identified 4744 papers, of which 29 met the inclusion and exclusion criteria and were included in the review. Included papers were rated for quality using the Standards for Reporting Qualitative Research (O'Brien et al., 2014) and analysed using thematic synthesis (Thomas & Harden, 2008).

Measurements and Findings: Data analysis identified four themes, made up of ten sub-themes. These were: self-efficacy; social support; personal growth; and person-

centred care. These are described in detail, including illustrative quotes and relationship to theory.

Key Conclusions and Implications for Practice: This review identified that parents-to-be describe several benefits of attending antenatal groups which are not routinely measured using standardised questionnaires. Yalom and Leszcz's (2005) theory offered an explanation for the benefits described in the self-efficacy and social support themes, and partly explained the benefits within the personal growth theme. However, the theory did not offer an explanation for the benefits captured in the person-centred care theme. Limitations, clinical implications and directions for future research are discussed.

Service Improvement Project Abstract

Objective: Recovery rates for people with eating disorders are low; fewer than half recover and many develop longstanding eating disorders (L-ED). L-ED are often referred to as “SEED” (severe and enduing eating disorders) although this remains controversial and is not acknowledged in United Kingdom (UK) treatment guidance. The lack of agreement on how to define and support these patients means care is often inconsistent between services. This service improvement project aimed to generate recommendations for a lifespan L-ED pathway by understanding how to identify patients with L-ED; how to better support this group; and what proportion of the caseload could benefit from the pathway.

Method: A literature review was completed to create a provisional definition of L-ED. This was used to identify suitable patients with L-ED to take part in interviews and to recruit staff who work with patients with L-ED to take part in focus groups. Framework analysis was used to analyse the data. The qualitative analysis and literature searches were combined to create recommendations and a definition of L-ED which was used to establish how many patients could benefit from the pathway.

Results: The literature review identified twenty-seven papers which described L-ED using the terms “SEED”, “chronic” and “longstanding”. The literature frequently used a duration criterion as well as persistent symptoms, low weight, previous treatment failure, low quality of life and low motivation to recover. The results of the framework analysis were mostly consistent with this literature. However, participants disliked the term “SEED” and preferred to have no label, or use “longstanding” instead. The majority of the data was grouped into four themes and thirteen subthemes which described how to support patients with L-ED.

Conclusions: The project produced a set of recommendations for a tailored pathway for those with L-ED. These included promoting a hopeful message and establishing a consistent, available MDT with peer support. Involvement in the pathway should not result in a label or diagnosis of “SEED”, nor should it prevent access to recovery focused interventions. Other recommendations, implications and limitations are discussed.

Theoretically Driven Research Project Abstract

Background: Approximately 10% of fathers experience postnatal depression, yet fathers are not routinely offered support in the same way as mothers. Men are also less likely than women to seek help for depression due to barriers including stereotypical masculine norms and stigma. This research explored barriers to psychological help-seeking (PHS) amongst fathers with paternal perinatal depression (PPD).

Method: Data was collected using an online survey. Initially, fathers with PPD were compared to men experiencing depression at another time of their life in terms of their attitudes to seeking psychological help; conformity to masculine norms; self-stigma; and awareness of services. Secondly, a proposed model of PHS amongst fathers with PPD was evaluated. Finally, additional barriers to PHS for paternal postnatal depression were explored qualitatively.

Results and Conclusions: No between group differences were found which suggests that the existing literature into barriers to PHS for male depression may also apply to fathers. The results highlighted the need for better awareness of PPD, and better access to services. Limitations, implications for policy, and directions for future research are discussed.

Critical Review of the Literature Paper

A Systematic Qualitative Review of Parents' Experiences of Attending Antenatal Groups

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The authors declare no conflict of interests.

Proposed Journal: Midwifery

Rationale:

This review is intended for submission to Midwifery. This journal has been proposed as it is an international, multidisciplinary, academic journal with a current impact factor of 2.372. The journal was felt to be a good fit for this review as it publishes peer reviewed articles which specifically focus on the cultural, clinical, psycho-social and educational aspects of maternity services.

Abstract

Objective: Antenatal groups have gained popularity worldwide and have been shown to result in improvements in physical health outcomes for both the mother and baby (Ickovics et al., 2007; Lathrop, 2013). However, the same improvements have not been seen in parental mental health following antenatal groups. A previous systematic review reported that, although the quantitative outcome measures did not identify improvements in parental mental health following antenatal groups, the qualitative literature did identify improvements in wellbeing following antenatal groups (Wadephul et al., 2016). The current review aimed to understand the qualitative literature describing parents' experiences of attending antenatal groups to understand the discrepancy between the quantitative and qualitative data. It also aimed to explore whether Yalom and Leszcz's (2005) group process factors could offer a framework to understand the qualitative literature on antenatal groups.

Design: A systematic search of the literature was conducted using six databases (PsycINFO, Web of Science, Medline, PubMed, Embase and CINAHL). The search identified 4744 papers, of which 29 met the inclusion and exclusion criteria and were included in the review. Included papers were rated for quality using the Standards for Reporting Qualitative Research (O'Brien et al., 2014) and analysed using thematic synthesis (Thomas & Harden, 2008).

Measurements and Findings: Data analysis identified four themes, made up of ten sub-themes. These were: self-efficacy; social support; personal growth; and person-centred care. These are described in detail, including illustrative quotes and relationship to theory.

Key Conclusions and Implications for Practice: This review identified that parents-to-be describe several benefits of attending antenatal groups which are not routinely measured using standardised questionnaires. Yalom and Leszcz's (2005) theory offered an explanation for the benefits described in the self-efficacy and social support themes, and partly explained the benefits within the personal growth theme. However, the theory did not offer an explanation for the benefits captured in the person-centred care theme. Limitations, clinical implications and directions for future research are discussed.

Introduction

Antenatal Groups

Antenatal care for parents-to-be varies hugely across the world. Around the world, antenatal groups have been introduced to improve maternal and neonatal health outcomes and have been found to be effective in improving infant birth weight, increasing parental knowledge and reducing pre-term births (Ickovics et al., 2007; Lathrop, 2013). For the purposes of this review, the term 'antenatal group' will be used to refer to group sessions, attended during pregnancy by three or more parents-to-be. The term includes groups which are educational in nature, as well as those which incorporate psychological, therapeutic elements such as mindfulness or cognitive behaviour therapy (CBT). In the United Kingdom (UK), national guidelines state that all pregnant women should have access to antenatal groups, employers must grant women time off work to attend these and where possible partners should be invited to groups (Gov.UK, 2020; National Institute of Health and Care Excellence (NICE), 2021). Antenatal groups are extremely popular: the National Childbirth Trust (NCT) alone provides group-based antenatal interventions to 70,000 parents-to-be each year (Dodwell & Newburn, 2010). Despite the popularity of such antenatal groups, relatively little is known about the potential psychological benefits of attending antenatal groups during pregnancy.

Parental Mental Health

Despite improvements worldwide in rates of maternal deaths and physical health complications in birth over the last 25 years, research has shown that mental health

difficulties in the perinatal period remain extremely common (Hogg, 2013). For instance, postnatal depression is estimated to affect up to 19% of new mothers (Banti et al., 2011; Gavin et al., 2005). Postnatal depression is defined as experiencing low mood and a lack of interest or pleasure in activities as well as anxiety, sleep difficulties, thoughts of self-harm, and feelings of guilt for at least two weeks during the perinatal period (Howard et al., 2014). The actual prevalence of postnatal depression could be much higher than previously thought as studies often only include mothers, despite research that 7.8-9.8% of fathers also experience depression in the period following the birth of a child (Cameron et al., 2016; Gawlik et al., 2014). In addition to the impact on parental wellbeing, children whose parents experience mental health difficulties in the perinatal period are at increased risk of behavioural problems, poorer academic performance and developing mental health difficulties in adolescence (Barker et al., 2011; Netsi et al., 2018). Supporting families affected by perinatal mental health difficulties in the UK costs the National Health Service £8 billion per year (Bauer et al., 2014). Therefore, improving parental mental health in the perinatal period, could result in significant health and economic benefits.

Psychological Benefits of Antenatal Groups

Several attempts have been made to improve parental mental health by incorporating therapeutic approaches such as CBT, mindfulness, and psychoeducation into antenatal groups. Despite this, systematic reviews of quantitative research report that levels of postnatal depression, anxiety and stress do not improve following antenatal groups, even when groups were specifically designed to prevent postnatal depression (Dennis

& Dowswell, 2013; Wadephul et al., 2016). However, in contrast a review of qualitative research has found parents-to-be report improved wellbeing following antenatal groups as they provide alternative psychological benefits such as a sense of connection, being understood and feeling normalised through sharing common experiences (Wadephul et al., 2016). Wadephul et al. (2016) concluded that more research is needed to understand this disparity and to establish what the successful and unsuccessful elements of antenatal groups are. They also recommend exploring alternative methods to evaluate parental wellbeing following antenatal groups as it is possible that the use of quantitative screening measures which define wellbeing in terms of reductions in depression and anxiety symptoms may not capture the alternative wellbeing benefits parents describe in qualitative research.

An alternative method of evaluating whether a group is successful could be to establish whether the group produces positive changes through group process factors. Yalom and Leszcz (2005) describe eleven key interpersonal process factors which lead to psychological benefits in group psychotherapy, these are depicted in figure 1 and described in appendix 1.A. The theory was originally developed through work with those with substance misuse difficulties but has since been shown to also apply to different patient populations such family caregivers and psychosis (Diefenbeck et al., 2014; Restek-Petrović et al., 2014). Previous reviews of the qualitative literature exploring the psychological benefits of antenatal groups report themes which are in line with Yalom's principles such as group cohesiveness, interpersonal learning, catharsis, and universality (Wadephul et al., 2016; Yalom & Leszcz, 2005). These psychological processes are not routinely measured or captured on standardised

questionnaires or quantitative outcome measures. Therefore, reviewing the qualitative literature regarding parents' experiences of antenatal groups could firstly help to understand what benefits parents-to-be report, and secondly establish whether Yalom and Leszcz's (2005) principles could offer a framework to understand their experiences which are not currently understood through the quantitative literature. By gaining a better understanding of parents' experiences of the psychological benefits of attending antenatal groups, clinicians and researchers can ensure they are designing and implementing groups which best meet the needs of parents-to-be.

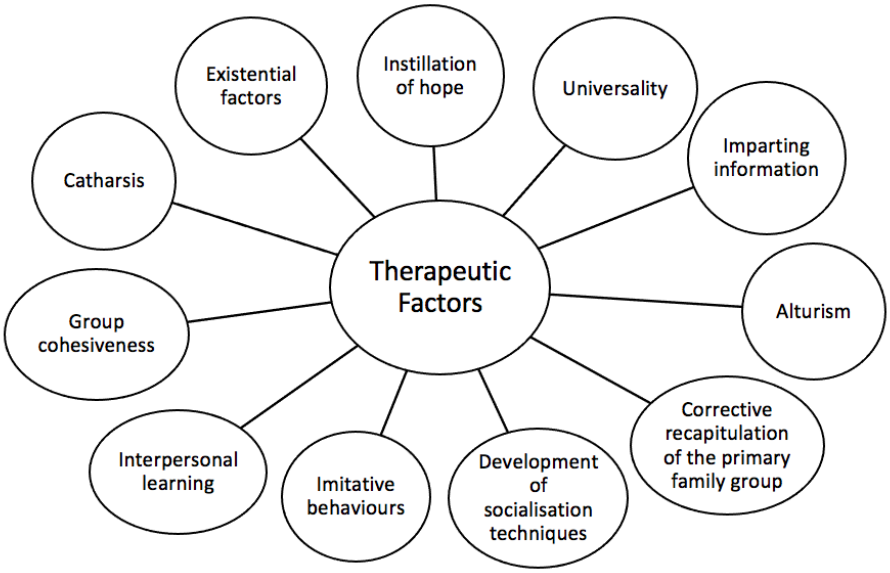


Figure 1: Yalom & Leszcz's (2005) eleven therapeutic factors for successful group psychotherapy.

Current Review

A previous review exploring quantitative and qualitative reports of parents-to-be's experiences was limited to therapeutic antenatal groups and only identified four qualitative studies (Wadephul et al., 2016). The current review aims to specifically explore the qualitative data regarding parents' experiences of attending antenatal groups and will be looking at data describing group process, as opposed to the content

of specific groups. Therefore, this review will include papers describing parents' experiences of attending all types of antenatal groups, as opposed to limiting the search to therapeutic groups. Specifically, this review aims to answer the following research questions:

1. What are the experiences of parents to be who attend antenatal groups?
2. Does Yalom and Leszcz's (2005) theory offer a framework to understand the experiences of parents-to-be's who attend antenatal groups?

Materials and Methods

Search Strategy

The search strategy used in the review was pre-specified and uploaded on PROSPERO prior to the search taking place (registration number CRD42021242667). The search was conducted using the following databases: psycINFO, Web of Science, Medline, PubMed, Embase and CINAHL. Papers were also identified by searching the reference lists of relevant papers. Details of search terms used can be found in appendix 1.B. Full details of the papers included at each stage of the search can be seen in figure 2.

Inclusion and Exclusion Criteria

The following inclusion and exclusion criteria were used during screening:

Inclusion:

- Describes an antenatal group which contains three or more members in the group

- The majority of sessions (> 50%) take place in the antenatal period
- Qualitative research or mixed methods designs, although only the qualitative data from mixed methods designs will be included
- Published in a peer-reviewed journal
- Published in English
- Reports data on parents' experiences of the process of attending antenatal groups as opposed to the specific content from the group

Exclusion:

- Quantitative research
- The group's primary focus is on managing physical health conditions in pregnancy e.g. HIV, diabetes or lupus
- Paper does not generate new data such as meta-analyses or literature reviews
- The group's primary focus is on exercise during pregnancy
- The report's sole focus is on professionals' experiences, or the report does not make it possible to differentiate between parents' views and professionals' views in the results

Screening

Searches were initially run in June 2021 which identified 7742 records which were imported into a reference management software. After removing duplicates there were 3926 references which were then exported into Microsoft Excel to be screened based on their title and abstract. To ensure reliability and trustworthiness, a subset of 20% of the abstracts were also screened by a second researcher (N=785) which

revealed inter-rater agreement to be 96.6% (Cohen's Kappa = 0.61). Although a Kappa statistic of 0.61 does still indicate a 'substantial agreement' (Landis & Koch, 1977), given that the data was highly skewed and Kappa is most accurate with balanced data, it may be more accurate to rely on the inter-rater agreement figure of 96.6%. Remaining titles and abstracts were then screened by the primary researcher; all papers which appeared to meet the criteria at this stage, or papers for which it was unclear, were put through to full text review.

The papers identified as relevant from the abstract screening (N=159) were then read in full by the primary researcher to determine whether they met the inclusion and exclusion criteria. If the full text was not available, a request was made to the authors for access. A subset of 25% of the full text records were also screened by the second researcher (N=40) and any disagreements resolved by discussion. This identified inter-rater agreement to be 95% with a Cohen's Kappa of 0.86 which indicates 'near perfect agreement' (Landis & Koch, 1977). Following full text screening, there were 28 relevant papers which were included in the review.

Searches were re-run in April 2022 which identified an additional 1690 records. After removing duplicates there were 818 new abstracts to screen, of which 9 appeared to meet the criteria and were put through to full text screening. Following full text screening, 1 additional paper met the criteria and was also included in the review. In total, there were 29 papers which met all criteria and were included in the review.

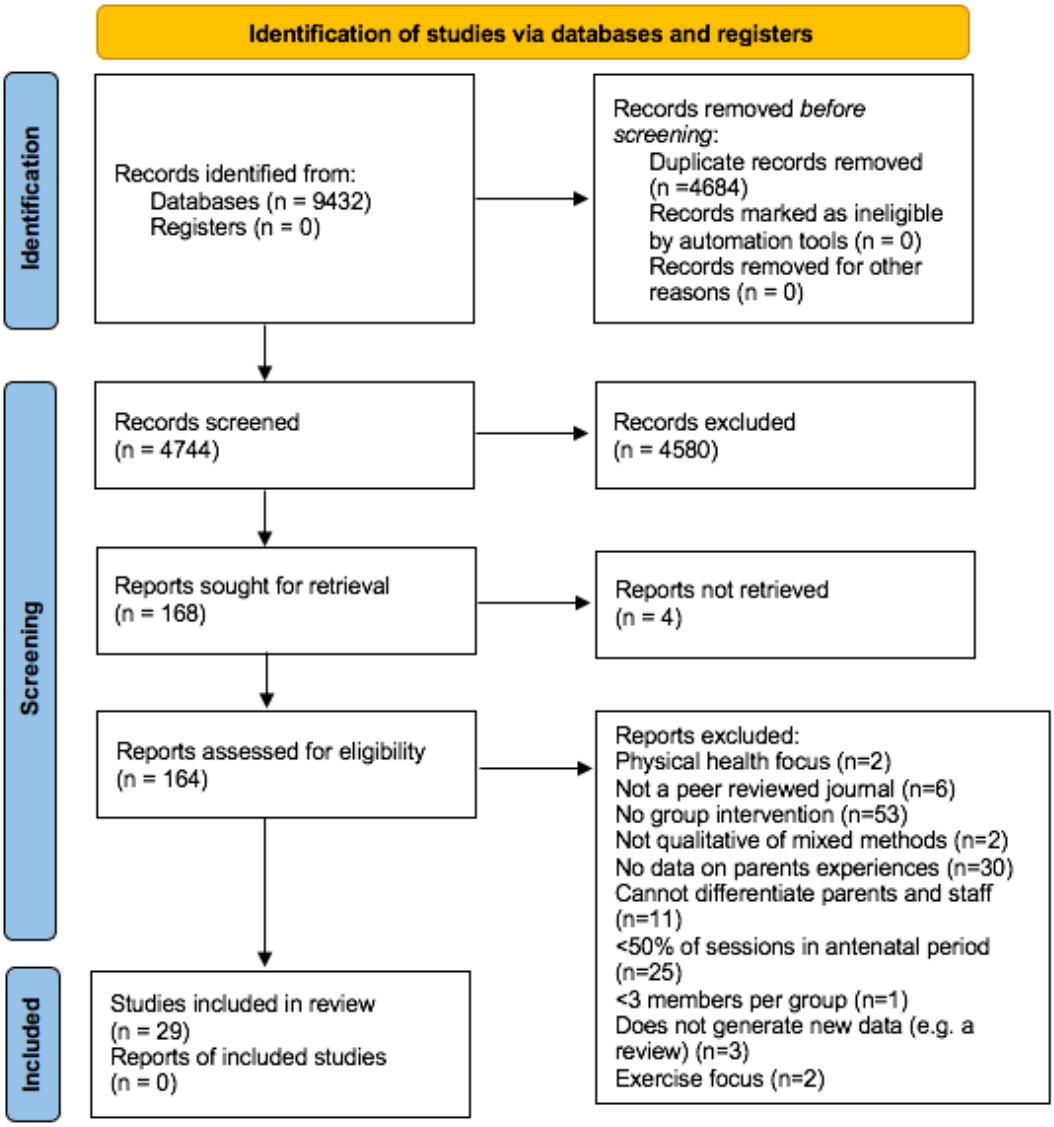


Figure 2: Flow chart detailing screening process for papers from both June 2021 and April 2022 searches. 'Records' refers to title and abstract data. 'Reports' refers to full text papers. Reports not retrieved refers to the four papers for which the full text was unavailable.

Quality Assessment

All papers were rated for quality using the Standards of Reporting Qualitative Research Checklist (SRQR) (O'Brien et al, 2014), a copy of this can be found in appendix 1.C. The SRQR is a comprehensive checklist of 21 items which is suitable for all types of qualitative research, not only interviews and focus groups. The SRQR was developed

through a systematic literature search as well as expert debate which makes it a credible tool for assessing quality (Majid & Vanstone, 2018). For each item, papers were scored 0 if they did not meet the criteria, 1 if they partially met the criteria and 2 if they fully met the criteria. First authors of papers which did not report the required information were contacted, if it was not possible to establish if the paper met the criteria it was scored 0. This gave a maximum score of 42. A second researcher also reviewed 30% of papers with an inter-rater agreement of 90% (Cohen's Kappa = 0.88). Any disagreements were resolved by discussion. A breakdown of quality assessment ratings can be found in appendix 1.D. No papers were excluded as a result of the quality assessment.

Data Extraction and Synthesis

An Excel spreadsheet was used to manage and extract relevant data from the papers included in the review. A second researcher checked extracted data for at least 50% of the papers. For papers where there was not sufficient information available in the paper, the first authors were contacted. The data extraction form can be found in table 1.

The qualitative data was analysed from an interpretive epistemological stance as researchers acknowledged that there is no single construct of the truth and attended to their role in interpreting and analysing the data. Data was synthesised using Thomas and Harden's (2008) thematic synthesis protocol using Nvivo-12 software to allow for a clear audit trail. This method was chosen as it provides a clear methodology to integrate Yalom and Leszcz's (2005) theory into the data analysis. As per the protocol,

the theory was initially suspended and the results section of each paper was coded inductively. before arranging inductive codes into descriptive themes to allow for 'translation' from one text to another. Yalom and Leszcz's (2005) theory was then introduced and used to generate analytical themes in relation to the research question. All coding was completed by the primary researcher, codes and ideas for themes were discussed with other researchers throughout the analysis process.

Reflexivity

All data screening, extraction and analysis was conducted by the primary researcher. Although analysis was discussed and compared with other researchers at all stages of the process, it is possible that the primary researcher's context may have influenced the process and results of the review. The primary researcher was a Trainee Clinical Psychologist completing this review as part of their doctorate in clinical psychology within an National Health Service (NHS) setting. They had an interest in the use of qualitative research in the field of mental health, particularly for under-researched groups such as fathers or those from disadvantaged backgrounds. To understand how their context could affect the interpretation and analysis of data, the primary researcher kept a reflexive diary throughout and received regular research supervision.

Findings

Papers Included in the Review

The review included 29 research papers which were published between 1999 and 2022, relevant details of the papers can be seen in table 1, the full data extraction

form can be found in appendix 1.E. The papers contained qualitative data from 1157 participants who had attended antenatal classes. Most papers reported data from mothers (N= 26), four of these papers also reported data from birth partners (Andersson et al., 2012; Fisher et al., 2012; Novick et al., 2011; Risisky et al., 2013), the three remaining papers only reported data from fathers (Kuliukas et al., 2019; Nash, 2018; Smith, 1999). In total, the papers included data from 443 mothers, 737 fathers and two grandparents. Two papers reported data from the same six mothers after attending a creative singing group (Carolan et al., 2012; Carolan et al., 2012b). Participants ranged in age from 14 years to 41 years. Data collection methods used included interviews (N=22), focus groups (N=8), questionnaires (N=4) and field notes (N=4). The review identified papers describing several different types of antenatal group, the most common was an educational group (N=18). This category included 'traditional' antenatal care classes (N=11), psychoeducation groups (N=1) and variations of Centering Pregnancy groups (N=6). Other types of antenatal groups included cognitive behaviour therapy (N=3), mindfulness (N=3), creative arts (N=3), social support (N=1) and interpersonal therapy (N=1).

Quality Analysis

All papers were rated for quality using the Standards of Reporting Qualitative Research Checklist (SRQR) (O'Brien et al, 2014). The average quality rating was 27 out of a possible 42 and scores ranged from 8 (Smith, 1999) to 38 (Nisbeth-Jensen & Fage-Butler, 2016). The highest scoring item was 'links to empirical data' with all papers receiving the top mark for this. The lowest scoring item was 'reflexivity' as only five

papers included any element of reflexivity. Full details of the quality assessment for each paper can be found in appendix 1.D.

Table 1: Data extraction table with details of studies included in the review. Blank spaces indicate that the required information was not available. N refers to number of participants. M refers to the mean number of participants.

Details of Publication (year, author)	Country	Mean age and range of participants	Ethnicity of participants	Total sample size	Details of Group intervention	Details of group (number per group, number of sessions and frequency)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method	Quality assessment rating (out of 42)
Aguila-Gonzalez, Henao & Ahles-Schmidt, 2022	United States of America	34	Hispanic N=12	12	Spanish Baby Talk, educational	6 weekly sessions for 2 hours	Surveys, interviews and focus groups	Immediately after group sessions	Thematic analysis	27
Alves et al. 2019	Brazil	19-31 years		24	Educational	6 members	Focus group		Thematic content analysis	21
Andersson et al. 2012	Sweden			28	Based on centering pregnancy, aims for discussion and empowerment and physical checks		Interviews and focus groups		Content analysis	27
Beattie et al. 2017	Australia	M= 28.9 years MiPP M=28.5 years PSP	Australian N=33 Other N=15	48 (24 per condition), only 20 did interview	Mindfulness in Pregnancy Program (MiPP) compared to control pregnancy support program (PSP)	8 weekly sessions	Questionnaires, field notes, interviews	6 weeks after group ended	Thematic analysis	30

Details of publication (year, author)	Country	Mean age and range of participants	Ethnicity of participants	Total sample size	Details of group intervention	Details of group (number per group, number of sessions and frequency)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method	Quality assessment rating (out of 42)
Breustedt & Puckering, 2013	Scotland	M= 27.75 19-38 years	White Scottish N=3 Black African N=1	4	Mellow Bumps, attachment and CBT strategies to reduce stress and provide education	6 weekly sessions for 2 hours	Interview	Within 18 months of group ending	Interpretative Phenomenological Analysis	28
Camlibel & Mete, 2020	Turkey	27- 37 years		13	Education Class for Awareness of Labour (ECAL) Psychoeducation & hypnobirthing	4 weekly sessions for 2 hours	Interview		Content analysis	30
Canuso 2003	United States of America		African American N=4 White American N=1 Latina N=1 Native American N=1	7	Pregnancy Care Campaign Luncheon Support, education	5 members, one off group	Interview	Within 2 months	Ely et al, 1991 method	22
Carolan et al., 2012	Ireland	M =32.67 29-35 years		6	Lullaby intervention, singing before traditional antenatal classes	4 weekly sessions for 45 minutes	Interview	3 months postpartum	Thematic content analysis	27

Details of publication (year, author)	Country	Mean age and age range of participants	Ethnicity of participants	Total sample size	Details of group intervention	Details of group (number per group, number of sessions and frequency)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method	Quality assessment rating (out of 42)
Carolan et al., 2012b	Ireland	M= 32.67 29- 35 years		6	Lullaby intervention, singing before traditional antenatal classes	4 weekly sessions for 45 minutes	Interview	4 months postpartum	Thematic content analysis	26
De Matos et al., 2017	Brazil	M= 24.5 16 – 32 years		10	Educational		Interview		Thematic analysis	20
Demecs, Fenwick & Gamble, 2011	Australia	26 – 38 years	Australian N=7	7	Creative Arts in Pregnancy (CAP). Singing, dancing, weaving, storytelling	6 sessions for 2 hours	Diaries, interviews, field notes, questionnaire	1 month of last session	Thematic analysis	27
Dunn et al., 2012	Australia	M= 35.33 mindfulness M= 27.67 control		10 mindfulness 9 control	Mindfulness based cognitive therapy (MBCT)	11 members, 8 weekly sessions	Interview			23
Fisher et al., 2012	Australia	M= 30.06 21 – 37 years		19 (12 mothers, 7 birth partners)	Mindfulness based childbirth education. MBSR and education	18 couples, 8 weekly sessions for 2.5 hours	Focus group	4 months after program	Thematic analysis	27

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Gao et al., 2012	China	M= 28.8 25-43 years		20	Interpersonal therapy group + control educational classes	2 sessions for 90 minutes (+ 2 regular antenatal classes)	Interview		Content analysis	27
Goodman et l., 2014	United States of America	M= 33.5 27- 45 years	White N=18 Asian N=3 Hispanic N=2 Other = 1	24	CALM pregnancy. Mindfulness, CBT, psychoeducation	6 – 12 members, 8 weekly sessions for 2 hours	Interview		Content analysis	24
Herman, Rogers, Ehrenthal, 2012	United States of America	18 – 35 years	Black N=23 White N=7 Hispanic N=4	33	Centering pregnancy (details not given)		Focus group		Iterative thematic analysis	27
Kuliukas et al., 2019	Australia	M= 33.9	Australian 661% UK 12.5%	678	Father focused antenatal breastfeeding class (FFAB) run by peer facilitator based on social cognitive theory	4 – 6 members, one off session for 50 minutes	Open ended questions on evaluation form	immediately after group	Content analysis	29

Details of publication (year, author)	Country	Mean age and age range of participants	Ethnicity of participants	Total sample size	Details of group intervention	Details of group (number per group, number of sessions and frequency)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method	Quality assessment rating (out of 42)
Le et al., 2013	United States of America	M= 27.82	El Salvador 53.8% 33.3% Central and South America unknown 12.9%	39 (24 MB group, 15 treatment as usual)	Mothers and babies' course (MB) based on CBT to prevent postnatal depression compared to usual care	11 sessions (8 antenatal and 3 postnatal)	Interviews	18 months postpartum	Inductive and comparative analysis	30
Little et al., 2013	United States of America	M= 34 25 – 41 years	Japanese	42 (20 were interviewed)	Culturally adapted centering pregnancy for Japanese families in United States of America with limited English	8 – 12 members, 5 monthly sessions for 2 hours	Interviews	6 - 10 weeks after birth	Team approach to open coding	28
McNeil et al., 2012	Canada	27 – 39 years	Caucasian N=8 Non-Caucasian N=4	12	Centering pregnancy	8 – 12 members, 10 sessions for 2 hours	Interviews	8-14 weeks postpartum	Team approach to open coding	37

Details of publication (year, author)	Country	Mean age and age range of participants	Ethnicity of participants	Total sample size	Details of group intervention	Details of group (number per group, number of sessions and frequency)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method	Quality assessment rating (out of 42)
Nash, 2018	Tasmania	M= 32.8 24 – 43 years	All Anglo-Australian	25	Parenting group for fathers, discuss transition to fatherhood and supporting their partner and government health educational group	One off group	Interviews	8-12 weeks after partner's birth	Thematic analysis	30
Nisbeth-Jensen & Fage-Butler, 2016	Denmark	25 – 36 years		16	Antenatal group consultations	2 sessions, 3 weeks apart	Interviews and observations of groups	Immediately after group	Content analysis	38
Novick et al., 2011	United States of America	M= 21.6 17 – 31 years	African American N=18 Hispanic N=3	21	Centering pregnancy	8 – 12 members, 8-10 sessions for 1.5 - 2 hours	Interviews (also observation but included staff)	2 during pregnancy and 1 postnatal	Inductive qualitative analysis	34
Queiroz et al., 2016	Brazil	14 – 19 years		16	Pregnant teenager's education group	6 monthly sessions	Focus group		Coded and grouped into categories	25

Details of publication (year, author)	Country	Mean age and age range of participants	Ethnicity of participants	Total sample size	Details of group intervention	Details of group (number per group, number of sessions and frequency)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method	Quality assessment rating (out of 42)
Riggs et al., 2017	Australia	19 – 40 years	Karen refugee women from Burma living in Australia	19	Healthy Happy Beginnings (education and peer support)	Fortnightly sessions	Focus group	Postnatal	Thematic analysis	27
Risisky et al., 2013	United States of America	20 – 29 years	Caucasian N=4 African American N=3 Hispanic N=2 Asian N=1	13 (10 women, 2 partners, 1 grandmother)	Centering pregnancy	4 – 9 members, 2-hour sessions	Focus group	3-11 months after birth	Coded and grouped into categories	29
Rueder-Neves et al., 2013	Brazil			5	Group educational sessions at childbirth house	Sessions every 15 days and then weekly in third quarter of pregnancy	2 interviews and observations of groups	1 at end of pregnancy, 1 postpartum	Thematic content analysis	25
Smith, 1999	United Kingdom			18	NHS and National Child birth Trust antenatal classes		Interviews			8
Sultana et al., 2019	Bangladesh	<20 N=2 20-24 N=13 >24 N=6		21	Peer support and education group vs individual	6 – 10 members, 4-6 sessions for 30 – 40 minutes	Interviews	within 20 months	Thematic analysis	32

treatment as usual

Data Analysis

Thematic Synthesis (Thomas & Harden, 2008) initially identified ten inductive, descriptive themes. As per the protocol, Yalom and Leszcz's (2005) theory was then introduced to support with arranging descriptive themes into the final, analytical themes in response to the research questions. A total of four analytical themes were

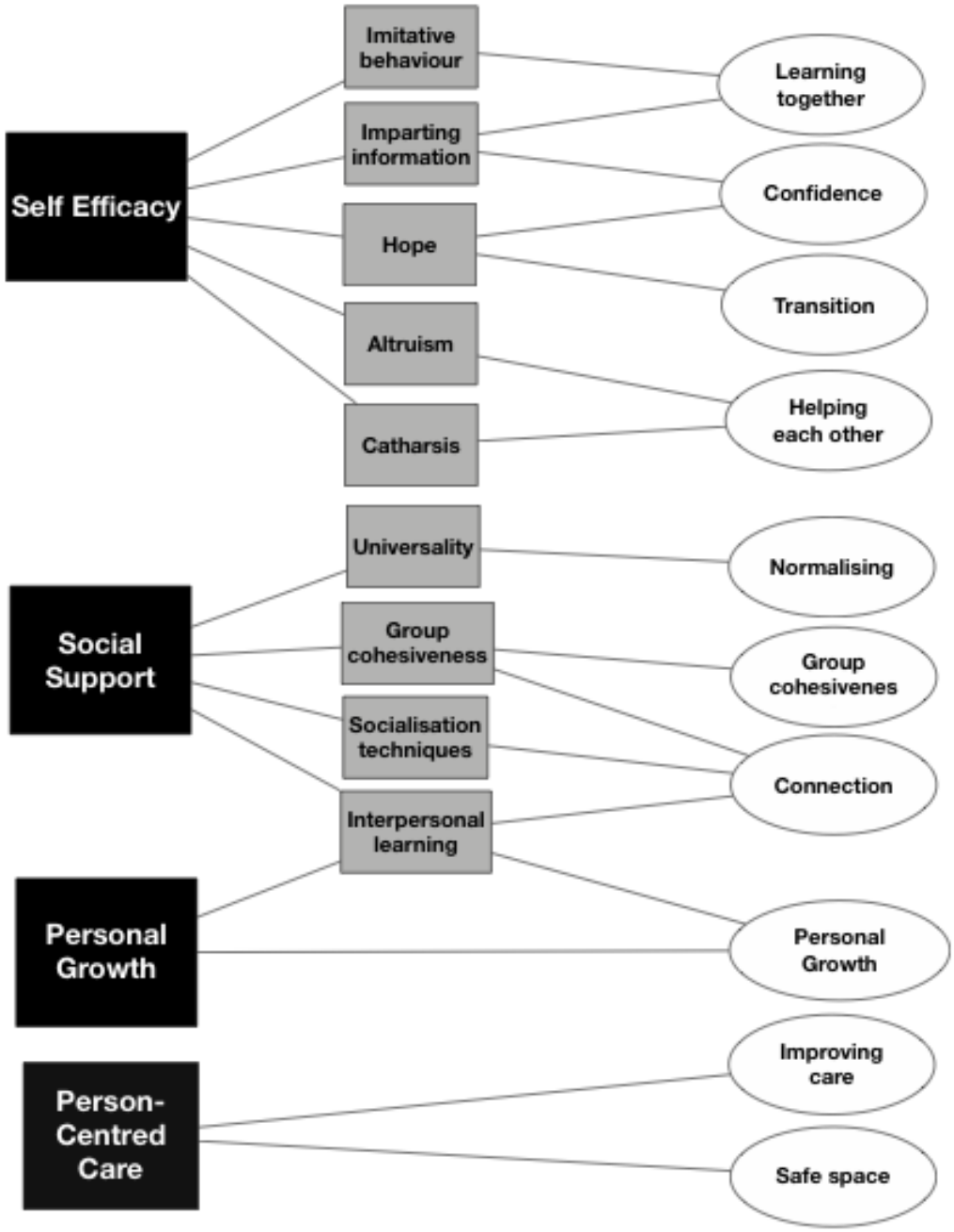


Figure 3: Map of themes. Analytical themes are depicted in squares on the left. Yalom & Leszcz's (2005) factors are depicted in rectangles in the centre. Associated descriptive themes are depicted in ovals on the right.

identified, these are depicted in figure 3 and described below, additional supporting quotes can be found in appendix 1.F. Although Yalom and Leszcz's (2005) theory provided a framework to understand the majority of the data, it was unable to adequately explain all of the themes identified.

Self-Efficacy

The first analytical theme identified was labelled Self-Efficacy. This term comes from Bandura's (1977) work which defines self-efficacy as an individual's belief in their capacity to exert control over their functioning, behaviours and social environment. Self-efficacy can be increased by improving one's belief and confidence that they can succeed, gaining mastery experiences, as well as through learning vicariously from observing others' successes. This concept was used alongside Yalom and Leszcz's (2005) theory to understand four descriptive themes which serve as subthemes and are described below.

The first was 'learning together' which describes the way in which antenatal groups increase parental self-efficacy through gaining mastery and confidence by increasing knowledge, both from formal didactic learning, and informal learning from peers. This relates to Yalom's factors of imparting information and imitative behaviour (Yalom & Leszcz, 2005). Parents-to-be described initially feeling unskilled for labour and parenthood but reported that their knowledge increased significantly following antenatal groups. Almost all groups contained some amount of pregnancy related education and parents-to-be appreciated the opportunities to *"clarify my doubts and learn a lot of stuff I didn't know"* (Rueder-Neves et al., 2013). However, they appeared

to particularly benefit from the peer-led education within the groups with one mother saying, *"when the moderator was not present, mothers continued to discuss various information matters, and we learnt from them"* (Sultana et al., 2019). Similarly, fathers stated that they valued "*learning from a father"* (Kuliukas et al., 2019).

The next sub-theme was labelled 'confidence' and describes parents-to-be feeling more confident and empowered following attendance at antenatal groups. This was found to occur partly as a result of imparting information as described above, but also through increasing hope. Yalom & Leszcz (2005) consider the instillation of hope to be an important process within groups as members gain confidence from other's successes and have their own successes recognised by others. By increasing their knowledge, hearing others share birth stories, and seeing others in the group progress *"both men and women said that being part of a group gave them strength and self-confidence"* (Andersson et al., 2012). Additionally, parents-to-be described that following antenatal groups *"the empowerment; it is very strong for me"* (Rueder-Neves et al., 2013) and they *"attributed changes in specific health attitudes or behaviours, as well as an increased sense of control, to receiving prenatal care in the group"* (Novick et al., 2011). This suggests that antenatal groups increase self-efficacy by increasing empowerment and confidence in a way which may not be possible in individual antenatal support.

The third sub-theme is 'transition' and also relates to Yalom & Leszcz's (2005) factor of hope. Parents described that antenatal groups supported them to prepare for parenthood and start to bond with their unborn baby through discussions with other

parents-to-be and seeing group members give birth ahead of them. Fathers particularly appeared to benefit from the opportunity to think about *"how to bond with baby, how to be a good dad"* (Kuliukas et al., 2019) as some fathers reported that they felt otherwise unable to *"discuss the transition to fatherhood with men in their social network, including their own fathers or male friends"* (Nash, 2018). Similarly, women reported that antenatal groups *"made me realise the whole feeling of motherhood, including happiness, loss, fatigue, responsibilities and demands"* (Gao et al., 2012) and a sense that *"there was the growing relationship between each woman and the child she was carrying"* (Breustedt & Puckering, 2013). Therefore, self-efficacy is increased through dedicating time to think and share experiences of becoming a parent.

The final subtheme was 'helping each other' which relates to Yalom's factor of altruism which is defined as the experience of benefiting from helping others in the group gain knowledge and experience (Yalom & Leszcz, 2005). For instance, one mother reported that they found it "*really rewarding to see the first time mothers getting a lot out of the story"* (Demecs et al., 2011). The other associated factor was catharsis which describes the personal benefits of sharing stories and experiences with others (Yalom & Leszcz, 2005). For instance, one paper reported *that "when they shared their situations with other group members, they felt less anxiety"* (Anderson et al., 2012). This suggests that antenatal groups offer a space for parents-to-be to benefit by helping other members increase their knowledge through sharing their own experiences.

Social Support

The second theme is named 'social support' and consists of three descriptive themes which serve as sub-themes, each of these is influenced by one or more of Yalom and Leszcz's (2005) factors. The first sub-theme is 'normalising' which maps directly on to Yalom and Leszcz's (2005) factor of universality. This describes the process in which group members experience relief from realising that they are not alone, and other members have had similar experiences. For instance, mothers reported that *"I learned that this is a shared human experience and I'm not the only one who suffers from it"* (Goodman et al., 2014) and "*it made me feel like, more relaxed, it was not just me and the world's not over"* (Novick et al., 2011). Normalising was so frequently described in the data that one paper reported that *"the most important impact of group sessions was normalising pregnancy and helping women not to feel alone during pregnancy"* (Andersson et al., 2012).

The next sub-theme is named 'group cohesiveness' and relates directly to Yalom & Leszcz's (2005) factor with the same name. Group cohesiveness describes the extent to which a group was experienced as an aligned, supportive unit. Parents-to-be felt that the cohesiveness increased with time as initially they felt "*a bit shy because I didn't know anyone"* (Riggs et al., 2017) but once the group ended they felt "*lost"* without it (Breustedt & Puckering, 2013). One mother stated that the group "*made me feel a lot safer, made me feel more loved and cared about"* (Canuso, 2003). It seems that cohesiveness was built through "*working together*" (Herman et al., 2012) and by *"women becoming invested in their groups and… feeling invested in by other group members and the group leader*" (Novick et al., 2011). The formation of a cohesive,

supportive group is something that is not possible during individual consultations and appears to be a factor in parents-to-be building a supportive network.

The final subtheme is 'connection' and refers to the relationships built between the parents-to-be, their staff team and their wider family and friends. This was the largest sub-theme and relates to three of Yalom and Leszcz's (2005) factors: group cohesiveness, socialisation techniques and interpersonal learning. These three factors relate to building and using social skills to form relationships within the group, which then allow group members to practice and learn skills through their interactions with others. Many women cited "*connecting*" as something which they valued as it led to a "*reduction of isolation*" (Beattie et al., 2017; Canuso, 2003). They also described benefits from building relationships with their care team for instance one woman shared that *"the connection that I felt with her [doctor], I felt so comfortable asking questions"* (McNeil et al., 2012). Others spoke of their improved relationships with those outside of the group for instance a woman described herself as a *"calmer mother, partner and daughter*" (Beattie et al., 2017) and others felt that *"the program helped them to establish relationships with their mothers-in-law"* (Gao et al., 2012). This sense of connection allowed parents-to-be to build a more robust support system around them.

<u>Personal Growth</u>

The next theme is named 'personal growth' and contains only one sub-theme which is also labelled 'personal growth'. However, 'personal growth' was not fully explained by Yalom and Leszcz's (2005) therapeutic factors; only interpersonal learning was a partial

fit as this refers to group members learning new ideas and skills through their interactions with others. Parents-to-be frequently spoke of feeling anxious, stressed and struggling to regulate their mood in pregnancy, however they reported that following group antenatal care they were able to "*minimize stress and fears*" (Alves et al., 2019). This partially occurred through the interpersonal process of hearing other perspectives and *"learning to think differently"* as well as *"learn[ing] to deal with stress and pain in a much calmer way"* (Goodman et al., 2014).

However, the 'personal growth' sub-theme encapsulates more than interpersonal learning and describes parents-to-be benefitting from taking time for themselves to learn to manage their stressors and find new perspectives independently. Parents reported that the benefits of attending antenatal groups included individual "*time to reflect, which led to increased insight and knowledge"* (Andersson et al., 2012). They also reported that they "*unanimously found participation in the programme to be beneficial in terms of alleviating stress, encouraging relaxation and providing some 'time out' from their busy lives*" (Carolan et al., 2012b). This theme highlights that the improvements to parents' mental wellbeing can occur in antenatal groups partially as a result of interpersonal learning, such as hearing other perspectives, but also through parents-to-be taking the time to reflect and work on themselves.

<u>Person-Centred Care</u>

The final theme is named 'person-centred care' and includes two subthemes: improving care and safe space. Unlike the previous themes, 'person-centred care' was not adequately described by Yalom and Leszcz's (2005) therapeutic factors. This theme

was frequently identified throughout the papers and describes the delivery of services and captures the positive experiences of parents-to-be, as well as areas for improvement.

The first sub-theme of person-centred care describes how care is delivered in antenatal groups, and how parents-to-be felt this could be improved. Most parents reported positive experiences of attending antenatal care, and felt it was "*far superior*" to previous, individual experiences (Herman et al., 2012). Although group antenatal care could be considered a large time commitment, many were pleased that they had had more time with their care team and even "*recommended conducting longer sessions (>2 hours) and/or continuing the program over a longer period of time"* (Beattie et al., 2017). Parents-to-be valued having "*more time with their physician and [having] more opportunity to ask questions"* (McNeil et al., 2012). They also felt that spending longer with the group allowed for care to be individualised with one mother commenting that "*I was made to feel like a person, not a robot or a babymaker*" (Herman et al., 2012). However, some fathers reported that the groups perpetuated *"outdated stereotypes of men"* (Nash 2018) and would have preferred more support for them as involved fathers, as opposed to focussing on how to support their partner. This sub-theme highlights the importance of person-centred care which antenatal groups are well equipped to offer due to the length of time parents-to-be spend together building relationships and getting to work with their care team.

The final sub-theme is 'safe space' and describes the importance of group leaders and members creating a safe, trusting environment. Many felt that group leaders played a

key role in creating a "*climate of trust and learning*" (DeMatos et al., 2017) as they were able to encourage members to "*open up*" by modelling through their own behaviour which one mother described as "*one of the ways I feel comfortable, because she [facilitator] can open herself and her own life and experience to us"* (Novick et al., 2011). Parents-to-be experienced antenatal groups as *"an open and supportive environment*" (Beattie et al., 2017) where they felt "*safe and comfortable*" (Andersson et al., 2012). Groups which involved fathers were mostly felt to be conducive to a safe environment, however, others felt less able to open up about certain topics with fathers present. Additionally, not all mothers experienced the groups as an entirely safe space as one stated "*I don't know if these girls are going to keep my business confidential*" (Novick et al., 2011). Therefore, some requested additional privacy as they had "*limits to what I personally feel like sharing in a group*" (Nisbeth-Jensen & Fage-Butler, 2016). Despite this, antenatal groups were predominantly described positively as a safe space where trusting relationships could be built.

Discussion

This paper reviewed the qualitative literature describing parents' experiences of antenatal groups to understand the psychological benefits reported by parents-to-be which were not previously reflected in the quantitative literature. Additionally, Yalom and Leszcz's (2005) group process theory was proposed as a framework to organise parents' experiences. The review used thematic synthesis (Thomas & Harden, 2008) to identify four analytical themes which captured parents' experiences of antenatal groups: self-efficacy; social support; personal growth; and person-centred care. It also

identified that Yalom and Leszcz's (2005) therapeutic process factors offer a useful framework to understand how most, but not all, benefits from attending antenatal groups can arise.

Theoretical Discussion

Parents Experiences of Antenatal Groups

The results of the first research question were consistent with a previous, smaller mixed-methods review of therapeutic antenatal groups which identified mothers experienced benefits following antenatal groups from connecting, sharing, understanding, and normalising (Wadephul et al., 2016). The current review also extends previous findings by suggesting that these psychological benefits are consistent across all types of antenatal groups, and apply to fathers, as well as mothers. The current review also identified that parents-to-be experience benefits through time to consider the upcoming transition, building confidence, taking time to work on themselves, and receiving good quality care that feels safe and person centred. Most parents-to-be reported positive experiences of antenatal groups, however, some felt that the inclusion of partners perpetuated masculine stereotypes and contributed to the group feeling less of a safe space. Whilst this dissatisfaction may partially explain why previous quantitative reviews have not found antenatal groups to be effective at improving parental mental health (Sockol, 2015; Wadephul et al., 2016), this is unlikely to be the case as the majority of parents-to-be reported satisfaction with antenatal groups and specifically spoke of improvements in their wellbeing and mental health as a result of attending antenatal groups.

As well as directly improving wellbeing amongst parents-to-be, the results identified several ways in which antenatal groups could lead to improvements in mental health indirectly through the processes within groups. For instance, the theme of 'self-efficacy' relates to Bandura's concept which is defined as "the conviction that one can successfully execute the behaviour required to produce the outcomes" desired (Bandura, 1977, page 193) and is increased by personal achievements, verbal encouragement or vicariously by watching others succeed. Self-efficacy has been found to mediate the relationship between daily stress and mental health and is a strong predictor of how successful an intervention will be at reducing mental health symptoms (Cheung & Sun, 2000; Schönfeld et al., 2018). Research in postnatal groups has evidenced that group interventions result in significantly higher increases in self-efficacy, and lower rates of postnatal depression compared to standard individual care (Shorey et al., 2015). Additionally, attending antenatal groups is known to lead to increased self-efficacy and reductions in child-birth related anxiety (Brixval et al., 2016; Serçekus & Baskale, 2016). The current review found that antenatal groups are well placed to improve self-efficacy, and therefore parental mental health, through Yalom's principles of gaining hope from others' successes, imitating others, imparting information and providing a sense of altruism and catharsis (Yalom & Leszcz, 2005).

Additionally, parental wellbeing could be improved through the theme of 'social support'. This is a less well-defined concept and can be used to describe support from care staff, family, friends or peers. Research with new mothers has found that increases in social support from both professionals and other mothers has been shown

to prevent the onset of postnatal depression (Dennis et al., 2009; Logsdon et al., 2005; Leahy-Warren et al., 2011). Additionally, a comprehensive review of social support interventions found that groups involving peers, such as antenatal groups, lead to perceived increases in social support, particularly if a family member is involved in the intervention (Hogan et al., 2002). It is possible that social support exerts a 'buffering' effect in parents-to-be by reducing the impact of stress on anxiety and depressive symptoms (Razurel et al., 2017). The results of this review were consistent with Yalom and Leszcz's (2005) suggestions that groups can increase social support through universality, group cohesiveness, socialisation techniques and interpersonal learning. However, there is evidence that the link between increased social support and reduced postnatal depression could be partially mediated by self-efficacy (Haslam, Pakenham & Smith, 2006; Zhang & Jin, 2014). This suggests that improved self-efficacy may be having a larger influence over parental wellbeing following antenatal groups than increased social support.

Applying Yalom and Leszcz's (2005) Framework

The secondary aim of this review was to establish if Yalom and Leszcz's (2005) therapeutic process factors could offer a framework to understand the group process factors that result in improved wellbeing for parents-to-be following antenatal groups. They state that a group's success can be measured by how able it is to generate their eleven factors. As described above, evidence was found for nine of the factors, however, this review did not find evidence of the corrective recapitulation of the family group or existential factors. This is consistent with other evidence which has found that these factors are not as common as others such as group cohesiveness or

catharsis (Diefenbeck, Klemm & Hayes, 2014). Additionally, the authors themselves suggest that corrective recapitulation of the family group is amongst the least important process factors in evaluating a group's success and the value of each factor will vary based on the type of group (Yalom & Leszcz, 2005). It is possible that antenatal groups are different to traditional therapy groups in that parents-to-be join as a result of their pregnancy, as opposed to necessarily experiencing emotional distress or trauma, therefore a successful group does not have to repair previous challenges within members' families or accept the inevitably of pain and suffering.

The results also identified that Yalom and Leszcz's (2005) factors were not able to adequately explain the theme of 'person-centred care' which was described by parents-to-be. Much of the data in this theme fits under the definition of person-centred care such as individualised support, continuity of care giver, involving family members and facilitating a safe environment (Catalyst, 2017; World Health Organisation, 2015). Although no known research exists evaluating the relationship between person-centred care in antenatal groups and group outcomes, this link is well established in other areas of health care. Person-centred care is consistently found to be associated with improved patient satisfaction and wellbeing, and some research has also found that it improves long-term clinical outcomes (Kuipers, Cramm & Nieboer, 2019; Rathert, Wyrwich & Boren, 2012). This suggests that in addition to therapeutic process factors, the extent to which antenatal groups are considered person-centred could contribute to the success of the group.

Overall, this review identified that the use of Yalom and Leszcz's (2005) theory was helpful in understanding most of the benefits that parents-to-be report following antenatal groups, however, it was not a perfect fit as important elements such as person-centred care are not captured by the framework.

Limitations

A limitation of this review was that, due to the limited qualitative literature evaluating antenatal groups, a wide range of papers were included in the review, including those of poorer quality. This could affect the strength of the conclusions drawn if they are based on low-quality research. However, in line with Thomas and Harden (2008), the relative contributions of the lowest quality studies (Alves et al., 2019; De Matos, et al., 2017; Smith, 1999) were explored to ensure that no themes or subthemes were based solely on these papers, and that all conclusions were also supported by papers of a higher quality.

An additional limitation of including a wide range of papers in the review is that some may consider the process of qualitative synthesis to be inappropriate as the data is taken out of the context in which it was collected and it is unclear to what extent the original contexts are comparable (Britten et al., 2021). Although it is expected that group process factors remain similar across groups, Yalom and Leszcz's (2005) also highlight that the relative importance of each factor will vary depending on the type of group. Therefore, including such a range of groups in the review may limit the extent to which the results are comparable (Finfgeld-Connet, 2010). However, this review has followed the suggestions made by Thomas and Harden (2008) to preserve the context

by including a detailed data extraction table and being clear if quotes came from mothers or fathers to enable successful qualitative synthesis. The review also took steps to increase the reliability and generalisability of conclusions by conducting the search systematically, triangulating screening and quality assessment ratings with a peer reviewer, and keeping a clear audit trail (Finfgeld-Connet. 2010; Leung, 2015).

Another threat to the generalisability of the results comes from the sample. Although many of the participants were fathers, the vast majority of these (N= 678) came from one paper which reported limited data from survey responses (Kuliukas et al., 2019) meaning that the experiences of mothers could be overrepresented in the data. Additionally, the majority of the data (75%) was drawn from antenatal groups conducted in Western societies, and several papers utilised variations of the same American Centering Pregnancy manual. This means that the voices of parents-to-be from other cultures and backgrounds may not have been represented adequately, and it is unclear to what extent the conclusions would be applicable in these settings.

An additional limitation of the review is that the samples within each included study may not be representative of the wider population. Many of the antenatal groups included in the review such as National Childbirth Trust (NCT) groups or Centering Pregnancy, can be expensive to attend. This means that the voices of parents-to-be who could not afford to attend these antenatal groups are missing from the review. Additionally, not all parents-to-be who attended these groups took part in the research interviews or focus groups, and no information is reported on those who did not take part. Therefore, the sample used in the review may only represent a sub-

section of the population of parents-to-be who have access to antenatal groups and are willing to participate in research. Therefore, the conclusions of this review must be interpreted cautiously until such time that the evidence base includes a wider range of high-quality, representative qualitative research.

Implications for Research and Practice

The results of this review identified that parents-to-be report several benefits from attending antenatal groups which are likely to lead to improved parental mental health. For instance, when designing antenatal groups, clinicians should consider the extent to which their groups increase social support and self-efficacy through person-centred care. They should strive to create a cohesive group which offers a safe space for parents to build relationships to learn and share experiences together.

As indicated above, further research is required to understand the experiences of parents-to-be attending different types of antenatal groups across a range of settings to understand which group process are most important in different types of group. Rather than evaluating antenatal groups using symptom measures which are based on the content of the group, future research should consider using alternative measures which capture the extent to which they achieved the four themes identified in this review. For instance, they could consider using measures which capture the extent to which the group was person-centred (DeSilva, 2014) or increased self-efficacy (Chen, Gully & Eden, 2001). Alternatively, they could use measures such as Yalom's (1995) Q-sort or the Therapeutic Factors Inventory (TFI) (Lese & MacNair-Semands, 2000) which

have both been designed to understand which process factors were most beneficial in a group.

Reflexivity

As described above, as the primary researcher, I kept a reflexive diary throughout the process of conducting the review. Having previously worked in a perinatal mental health team, I had heard from mothers how much they valued the connections they made during their antenatal groups. Additionally, when completing another qualitative research project into postnatal depression in fathers, many spoke of wanting safe spaces to meet with other men and discuss their mental health. Therefore, I felt surprised and disappointed at the lack of qualitative research into the experiences of parents-to be attending antenatal groups. Despite antenatal groups being a common practice around the world, parents-to-be's voices seemed to be missing from the discussion. It is possible that these experiences led me to expect to find parents reporting benefits from the social aspect of groups, however, the data did confirm that building a social network is something that parents-to-be value. It is also possible that my position could have led me to pay more attention to the positive comments from parents-to-be, as opposed to the criticisms of group antenatal care. However, this is something I was aware of throughout the data analysis process and I tried to accurately capture parents' experiences when selecting quotes to use under the 'person-centred care' theme.

Conclusions

This review was the first known paper to specifically explore the qualitative literature describing the experiences of parents-to-be following attendance at antenatal groups, and to consider if Yalom and Leszcz's (2005) group process model could explain the benefits reported by parents. The systematic search identified 29 relevant papers which were analysed into four analytical themes using thematic synthesis (Thomas and Harden, 2008). These themes were: self-efficacy; social support; personal growth; and person-centred care. The results of this review highlighted that parents' experiences of attending antenatal groups is mostly positive, with the majority of parents reporting a wide range of benefits from attending groups. Additionally, the results suggest that these benefits may occur through group processes which are not routinely measured using standardised questionnaires such as increased self-efficacy and social support. Yalom and Leszcz's (2005) theory was found to be a reasonably good model to explain the reported benefits, although it did not capture all of the themes identified. Researchers and clinicians designing antenatal groups in the future should specifically consider group process factors when implementing the group and consider evaluating the extent to which this contributes towards the success of the group.

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Service Improvement Project Paper

Creating a Care Pathway for Patients with Longstanding, Complex Eating Disorders

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Proposed Journal: European Eating Disorders Review

Rationale:

This paper has been formatted in accordance with the author submission guidelines provided by the European Eating Disorder Review journal. This journal allows for free format submissions therefore there were no limits on the number of words or the number of tables and figures included. This journal has been proposed as it is an international journal with a good impact factor (3.56). This project is relevant to this journal as the European Eating Disorders Review publishes articles which report on innovative projects to improve the clinical management of those with eating disorders, with a particular focus on the implications for diagnosis and treatment.

Abstract

Objective: Recovery rates for people with eating disorders are low; fewer than half recover and many develop longstanding eating disorders (L-ED). L-ED are often referred to as "SEED" (severe and enduing eating disorders) although this remains controversial and is not acknowledged in United Kingdom (UK) treatment guidance. The lack of agreement on how to define and support these patients means care is often inconsistent between services. This service improvement project aimed to generate recommendations for a lifespan L-ED pathway by understanding how to identify patients with L-ED; how to better support this group; and what proportion of the caseload could benefit from the pathway.

Method: A literature review was completed to create a provisional definition of L-ED. This was used to identify suitable patients with L-ED to take part in interviews and to recruit staff who work with patients with L-ED to take part in focus groups. Framework analysis was used to analyse the data. The qualitative analysis and literature searches were combined to create recommendations and a definition of L-ED which was used to establish how many patients could benefit from the pathway.

Results: The literature review identified twenty-seven papers which described L-ED using the terms "SEED", "chronic" and "longstanding". The literature frequently used a duration criterion as well as persistent symptoms, low body mass index (BMI), previous treatment failure, low quality of life and low motivation to recover. The results of the framework analysis were mostly consistent with this literature. However, participants disliked the term "SEED" and preferred to have no label, or use "longstanding" instead. The majority of the data was grouped into four themes and thirteen subthemes which described how to support patients with L-ED.

Conclusions: The project produced a set of recommendations for a tailored pathway for those with L-ED. These included promoting a hopeful message and establishing a consistent, available MDT with peer support. Involvement in the pathway should not result in a label or diagnosis of “SEED”, nor should it prevent access to recovery focused interventions. Other recommendations, implications and limitations are discussed.

Introduction

Background

Eating disorder is an umbrella term for several diagnoses which are characterised by abnormal eating behaviours alongside a preoccupation with food, weight and body shape concerns (World Health Organisation, 2018). In the United Kingdom (UK), approximately 16% of adults screen positive for a possible eating disorder (NHS Digital 2019) and 1.25 million people are living with an eating disorder (BEAT, 2020). The impact of eating disorders is large, and the mortality rate high (Arcelus et al., 2011; Winkler et al., 2014), therefore, finding effective treatments is a priority. Despite the range of treatments recommended in the UK National Institute of Health and Care Excellence (NICE) guidelines (NICE, 2017), fewer than half of patients with eating disorders recover and 20% develop longstanding eating disorders (L-ED) (Herzog et al., 1999; Steinhausen, 2002).

Several researchers have attempted to define or describe the group of patients experiencing L-ED by using the concept of a 'severe and enduring eating disorder' (SEED) (Robinson, 2009). One suggestion describes a 'Staging Model' which proposes that eating disorders lasting for seven years or longer would be defined as SEED (Treasure et al., 2015). This patient group are often complex with extended treatment histories and multiple hospital admissions as well as the highest mortality rate of all eating disorders and a poor quality of life (McCann et al., 2010; Robinson et al., 2015; Touyz & Hay, 2015). However, there is a lack of agreement amongst clinicians about

how to define L-ED (Tierney & Fox, 2009) and attempts to use statistical modelling to differentiate this group have been unsuccessful (Wildes et al., 2017).

There is little research into how to best support patients with L-ED and the NICE guidelines offer few specific recommendations (NICE, 2017). A review summarising the limited literature suggested treatment taking a multidisciplinary approach and focusing on creating a collaborative therapeutic relationship to establish appropriate treatment goals, which may not involve reducing eating disorder symptoms (Wonderlich et al., 2012). More recent research has suggested that existing evidence-based treatments can lead to recovery in those with L-ED (Touyz et al., 2013). However, clinicians and patients continue to report a desire to move from weight restoration being a primary goal and instead focus on harm reduction and quality of life (Russell et al., 2019). The lack of agreement on how to define and support patients with L-ED means that care is often inconsistent between services.

Theoretical Basis of Project

There is no evidence-based theory of L-ED, however, there are parallels with chronic health theories such as the Chronic Illness Theory (CIT) which can be seen in figure one (Moss-Morris, 2013). CIT makes several predictions about factors which contribute to adjustment such as high self-efficacy, acceptance, social support and treatment adherence. Although there is no known research testing CIT in relation to mental illness, it has face validity for L-ED and has previously informed interventions to support adjustment to chronic physical health conditions such as spinal cord injury,

diabetes, and kidney disease (Craig et al., 2015; Due-Christensen et al., 2017; Hudson et al., 2016).

While CIT may provide a useful framework for supporting those with L-ED, it neglects to consider eating disorder specific factors. For instance, eating disorders can be ego syntonic as many view symptoms positively and consider them to increase self-esteem and provide a sense of mastery (Gregertsen et al., 2017). Ego syntonic beliefs have been related to severity of illness and are often highly relevant in supporting those with "treatment resistant" eating disorders (Gregertsen et al., 2017; Vitousek et al., 1998). Therefore, it is important to be wary of "benefit finding" from CIT as this may not suggest positive adaption in L-ED in the same way as in physical health conditions.

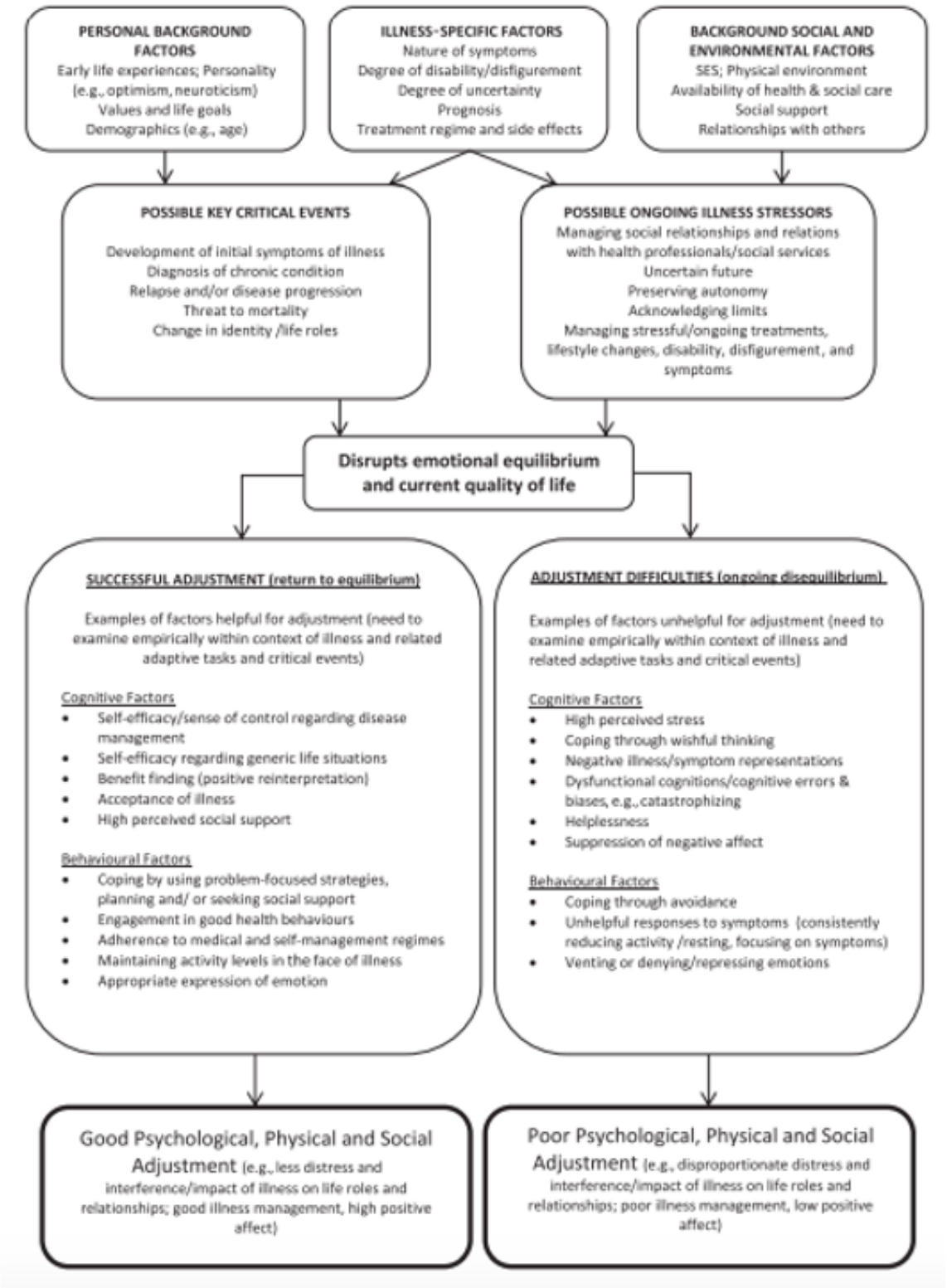


Figure 1: Moss-Morris (2013) Chronic Illness Theory.

The Current Service

Within Oxford Health NHS Foundation Trust (OHFT) (Oxfordshire and Buckinghamshire), eating disorder services consist of an outpatient child and adolescent eating disorder service (CAEDS), an adult outpatient service and specialist adult inpatient unit. In CAEDS, individuals with L-ED are offered a formulation-based care package, however, they fall outside of the evidence base, are often challenging to treat and many subsequently transition to the adult eating disorder service (A-ED). The Oxfordshire A-ED offers a support and monitoring pathway which predominantly monitors patients' physical health. Buckinghamshire has no designated pathway, instead a nurse consultant takes the lead for patients with L-ED and offers consultation to care coordinators. The services have no existing data on L-ED, however, anecdotally staff report that these patients require a large amount of staff time and resource due to their complex needs which do not fit with the existing evidence-based approaches offered within the service. In line with the NHS long-term plan, the service wished to offer patients increased control over service development and was keen to learn from their experiences to improve the provision of person-centred care (NHS England, 2019).

Aims of the Project

In order to offer patients with L-ED more consistent, person-centred and evidence-based care, the service required recommendations to inform the development of a lifespan pathway across OHFT eating disorder services. Therefore, to identify who may benefit from the new pathway, this project aimed to evaluate the most helpful way to

define and describe individuals with L-ED. Additionally, it aimed to synthesize research evidence, clinical expertise, and patient experience to understand how to best design a new pathway to meet the needs of such individuals. Specifically, the project addressed the following:

1. What is the best way for OHFT to identify patients within eating disorder services with longstanding eating disorders?
2. How can OHFT eating disorder services develop a care pathway to improve the care offered to patients with longstanding eating disorders?
3. Using a definition based on research evidence, clinical expertise and patient experience, what proportion of the current OHFT eating disorder service caseload have a longstanding eating disorder?

Methods

Design

This service improvement project utilised a mixed-methods design over three stages which are detailed below. The methodology and interview schedules were designed in collaboration with patients with L-ED. One dedicated staff member from each service was closely involved in the design and delivery of the project to ensure the impact on staff was limited.

Ethics

The project was approved by the OHFT Research and Development Team, see appendix 2.A. All eligible patients and staff were provided with an information sheet

and consent form which contained details about the project and the researcher's email address to allow them to ask any questions (appendix 2.B). All participants provided written informed consent before taking part in interviews or focus groups. Participants were guided to make a unique participant identifier which was used to store data anonymously and to allow participants to withdraw their data. Participants could also indicate if they wished to receive a summary of the results of the project; the email addresses of those that did were stored separately from their data.

Procedure

Stage 1: Literature Review

A literature search was conducted to answer the first question by reviewing the existing literature on defining and describing those with L-ED. The search terms can be found in appendix 2.C. The search was conducted via psycINFO; Web of Science; Medline; Embase; CINAHL and reference lists of relevant papers. If necessary, information was missing from the full text, or was unavailable, first authors were contacted via email.

Papers were included if they were a journal article published in English which provided a definition of L-ED. Reviews were not included unless they provided a definition, or criteria for L-ED in their results. Due to the relatively small body of literature on L-ED, all other relevant papers were included regardless of their methodology. A flow chart detailing which papers were included at each stage is seen in figure 2.

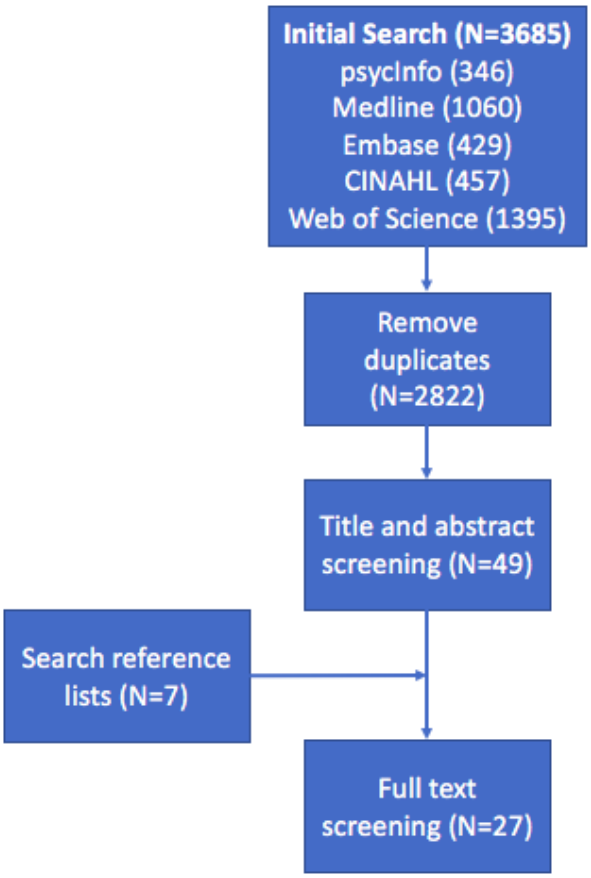


Figure 2:Flow chart detailing how many papers were included at each stage of the literature review.

A data extraction form was used to gather key information from relevant papers (table 3). This was used to draw comparisons and extract common criteria and terminology to support in creating a provisional definition of L-ED: This definition was used to identify suitable participants for stage two of the project and was discussed during interviews and focus groups.

Stage 2: Qualitative Data

The second stage of the project involved conducting staff focus groups and individual interviews with patients with L-ED. All patients who met the provisional criteria from

stage one were approached by their care coordinator about participating. Interested patients were provided with the information sheet and consent form and were contacted by researchers to arrange an interview.

All staff working in OHFT eating disorder services received the information sheet and invitation to take part in focus groups via email and during team meetings. Interested staff completed the consent form before attending one of three focus groups which took place via Microsoft Teams. CAEDS staff, A-ED staff and management staff were separated to allow for open discussions. All interviews and focus groups were conducted by the main researcher who completed a bracketing interview (appendix 2.D) prior to the first interview and kept a reflexive record of observations and biases throughout.

Interviews and focus groups followed a semi-structured interview schedule (appendix 2.E) and took place in person, on the phone or via video call based on patient preference and OHFT social-distancing guidelines. All interviews and focus groups were audio recorded and transcribed.

Stage 3: Quantitative Data

The final stage involved gathering information about how many patients would meet the L-ED criteria. The results of stage one and two were combined to create a final definition of L-ED. This was distributed to care coordinators who recorded all patients on their case load who met the criteria. The CAEDS teams did this together in their team meeting, whereas A-ED staff responded individually.

Participants

Twelve patients took part in interviews, demographic information about participants can be found in table 1. The mean length of eating disorder was 19.6 years, the two participants from CAEDS each had a duration of four years; when looking at only the adult participants, the mean duration of eating disorder was 22.7 years.

Table 1: Demographic information regarding the patients who took part in interviews.

Demographic Variable	**Mean (M) or Number of participants (N=12) [Standard deviation] (percentage)**	**Range**
Age	M=34.4 years[15.3]	17-68 years
Ethnicity	White British N=12(100%)	
Gender	Female N=12(100%) Male N=0(0%)	
Length of eating disorder	M=19.6 years[14.5]	4-51 years
Patient status	In patient N=5(42%) Outpatient N=7(58%)	
Location	Buckinghamshire N=7(58%) Oxfordshire N=5(42%)	
Service	A-ED=10(83%) CAEDS=2(17%)	

Twenty-eight staff took part in focus groups, details of the staff can be seen in table 2. The majority of staff were female, and they covered a wide range of professions across the services.

Table 2: Demographic information regarding the staff who took part in focus groups.

Demographic Variable	Mean or Number of participants (N=28) (percentage)
Gender	Female N=24(86%) Male N=4(14%)
Location	Oxfordshire N=17(61%) Buckinghamshire N=11(39%)
Focus Group Type	A-ED=10(36%) CAEDS=7(25%) Leadership=11(39%)
Job role	Administrator N=1(3.6%) Assistant Psychologist N=2(7.1%) Clinical Psychologist N=5(17.9%) Counselling Psychologist N=1(3.6%) Dietician N=4(14.3%) Nurse N=3(10.7%) Psychiatrist N=4(14.3%) Senior Mental Health Practitioner N=1(3.6%) Social worker N=1(3.6%) Support Worker N=1(3.6%) Systemic Family Therapist N=2(7.1%) Team Manager N=2(7.1%) Trainee Clinical Psychologist N=1(3.6%)

Data Analysis

Quantitative data was collected using Microsoft Excel. Qualitative data was analysed using Framework Analysis (Gale et al., 2013). The epistemological and ontological approach taken was contextualism and critical realism as authors looked for participants' truth or reality, whilst acknowledging that the project was influenced by the NHS context in which it was completed. To increase reliability, three researchers coded the first transcript independently before meeting to discuss codes. Two further transcripts were coded independently, and researchers met again to generate the analytical framework, a clear audit trail was kept. The analytical framework included a mixture of inductive and deductive codes based on CIT (Moss-Morris, 2013). The framework was then applied to the other transcripts; data saturation was reached as

no new codes were added from the later transcripts. Researchers continued to meet regularly throughout the process to carry out reliability and validity checks by discussing biases, discrepancies and ideas for themes. As per the Gale et al. (2013) protocol, a framework matrix was created to support researchers in interpreting the data and generating themes.

Results

The results of the literature review identified twenty-seven relevant papers which are summarised in table 3. This was used to create the following provisional definition of L-ED to identify suitable participants for stage two of the project:

1. Persistent Symptoms (severity)
    - A functional impairment
    - Require regular MDT monitoring
    - Shape and weight cognitions
    - Dietary restraint behaviors
    - Underweight (BMI <18.5 as per DSM-5 and WHO criteria)
2. Long duration (enduring)
    - 7 or more years for adults, 3 years for CAMHS
3. Treatment Resistance
    - Previous evidence-based treatment which has not worked.
    - Low motivation to recover

Table 3: Data extraction table from the literature review. Terminology and criteria used to describe L-ED were extracted alongside key information about each study.

Author and year	Country	Participants	Terminology used	Criteria for longstanding Eating disorder	Methodology	Results
Abd-Elbaky et al. (2014)	Australia and UK	63 with SE-AN	Severe and enduring anorexia nervosa (SE-AN)	≥ 7 years	Part of larger RCT. 30 sessions CBT or SSCM. Looked at stages of change and illness subtypes in SE-AN	Purging type sig more likely to drop out. Poor QoL also predicts drop out. No differences between type of therapy
Ambwani et al. (2019)	UK – SHARED trial	187 patients from 22 eating disorder services	Severe and enduring anorexia nervosa (SE-AN)	More info in supplementary material Severe psychological distress (DASS>60) AND duration ≥ 7 years	Secondary analysis to compare outcomes in SE-AN with early stage AN at postintervention, 6m and 12m	SE-AN more likely to have used inpatient or day patient care (82.9%), worse EDE-Q and WSAS scores than early stage
Bamford & Mountford (2012)	UK	n/a	Longstanding anorexia nervosa (L-AN)	Consistently ill for ≥10 years (short periods of weight restoration 6m or less included), at least one recognised therapeutic treatment in this time, show severe impairment across several life domains, express low motivation to recover	n/a	Describes how to adapt CBT for L-AN
Bamford et al., (2015)	UK	63 female's diagnosis of SE-AN	Severe and enduring anorexia nervosa (SE-AN)	≥7 years	RCT, 30 sessions or either CBT-AN or SSCM (specialist support and clinical management), measures baseline, 15 weeks, end of treatment, 6, 12-month f/u. EDE, EDQOL, SF-12, WSAS, BDI	BMI significantly related to future quality of life (QoL). EDE sig associated future QoL. In SE-AN should focus on QoL, but also need to improve BMI and ED symptoms

Broomfield et al., (2017)	Australia	32 studies in systematic review, 9 RCT, 23 non-RCT	Label in order of prevalence: chronic, SEED, longstanding, critical, refractory, prolonged, treatment-refractory, treatment resistant, persistent	84% use duration of illness, usually 7 years. 41% use previous failed treatment 6 articles use BMI below 17.5 3 articles say pattens related to behaviour + cognition "entrenched patterns of food restriction"	Systematic review to try to define criteria for SE-AN	Feel chronic shouldn't be used as implies in-curable, prefer SEED
Calugi et al., (2013)	Italy	95 women Consecutively underweight admitted to ED ward. Failure of previous treatment, no substance mis-use.	Longstanding eating disorder (L-ED)	≥ 10 years	Adapted CBT-E for inpatient setting (CBT-I). Compared longstanding with not longstanding	All L-ED pts improve BMI by end of treatment but no significant differences in recovery between groups
Calugi et al., (2017)	Italy	66 women with AN. Same criteria as above for admission	Severe and enduring anorexia nervosa (SE-AN)	> 7 years	Compared outcomes of CBT-E SE-AN vs non-SE-AN in an inpatient unit	Found improvements in BMI in both groups and at 12 months follow up: disagree that need to shift to focus on QoL in SE-AN
Dawson et al., (2014b)	Australia	8 women had AN for > 7 years but now recovered for ≥ 5 years	Chronic AN (C-AN)	> 7 years	Interviewed recovered pts about their experience of recovery, used narrative enquiry.	Create framework to understand how those with C-AN recovery. 4 phases of recovery 1)unready, 2) tipping

						point, 3) active pursuit recovery, 4) reflection and rehabilitation
Fox & Diab, (2015)	UK	6 patients in ED ward due to low BMI or risk to self	Chronic AN	≥ 6 years (all also had BMI 14/15; at least two previous unsuccessful therapies and had prior admissions, but not a requirement)	Interviews and IPA	Themes: making sense of AN; experience of treatment; interpersonal relationships; battling with AN; staff pessimism
George et al., (2004)	Australia	8 patients	Long-term/ chronic AN	≥ 7 years which had not improved following previous treatment. Refusing to engage in 'active' treatment.	Examine motivational enhancement therapy intervention with long-term AN	Pts showed increases in motivation to change after 6 months, found it helpful that no expectation of behaviour change, just explore barriers
Hay & Touyz (2018)	Australia	n/a	Severe and enduring anorexia nervosa (SE-AN)	Persistent state of dietary restriction, underweight and over evaluation of weight/ shape with functional impairment. Duration of ≥3 years of AN Exposure to at least 2 evidence-based treatments delivered appropriately with a diagnostic assessment and formulation that incorporates the persons eating disorder health literacy and stages of change	Aim to better define SEED using their clinical expertise and the literature base.	Identify 3 main areas: 1) Persistent, unrelenting symptoms, 2) of long duration (at least 3 years), 3) treatment resistance (accurate formulation and received all evidence-based treatments)

Hsu & Lieberman (1982)	USA	8 pts chronic anorexia	Chronic anorexia	≥ 5 years with no remission of ≥ 4 months, low weight, amenorrhea of 6 months or loss of libido, weight phobia or pursuit of thinness cognitions, behaviour directed towards losing weight	Used paradoxical intention with pts and followed up 2, 4 years later. Told to try to keep anorexia and explored reasons for keeping AN	50% in normal weight at follow up, none remained under psychiatric care
Le Grange et al. (2014)	USA, UK and Australia	63 pts SE-AN	Severe and enduring anorexia nervosa (SE-AN)	≥ 7 years ≤ BMI 18.5	Part of larger study 30 session CBT or SSCM. Looked at moderators and mediators	Reports predictors of QoL at end of treatment including being younger, shorter duration illness and being employed
Noordenbos et al. (1998)	The Netherlands	600 letters written to ED service analysed, 98 were chronic	Chronic AN	≥ 10 years	Qualitative analysis of letters from patients with and without chronic ED.	Chronic had tried more treatments and were negative about them Recommend patients and clinicians being optimistic and focusing on QoL
Raykos et al. (2018)	Australia	134 pts receiving CBT-E as outpatients	Severe and enduring anorexia nervosa (SE-AN)	≥ 7 years	Looked if duration, BMI or severity predict outcomes in CBT-E?	Duration did not predict changes in symptoms or QoL or BMI, pre-treatment EDE severity did not predict outcomes, pre-treatment BMI did not predict outcomes. Re-ran splitting int 7 years+/- but no differences between groups. SE-AN still improve the same as short duration ED

Robinson (2014)	UK	-	SEED (SEED-AN or SEED-BN)	Severity: Require regular monitoring for serious medical or psychological problems Require regular contact with at least 2 members of ED team Require regular (at least monthly) discussion at MDT Require MDT management review at least every 6 months How enduring: ≥7 years	Describes how to define and identify SEED patients and what the clinical features are from biological, psychological and social perspective. Discusses stigma Discusses treatment of SEED.	Describes medical implications of long-term ED
Robinson et al. (2015)	UK	8 patients mix of men and women and in and outpatients	SEED (SEED-AN or SEED-BN)	20 years+ (only wanted "extreme SEED" as unclear about other cut offs)	Interviewed patients	Generated 15 themes about their experience of living with SEED and their treatment
Stiles-Shields et al. (2013)	USA	63 pts SE-AN	Severe and enduring anorexia nervosa (SE-AN)	≥ 7 years	Compare role of therapeutic alliance in CBT-AN vs SSCM in SE-AN. Secondary analysis of another RCT where pts received 30 sessions of CBT or SSCM.	No difference in ratings of therapeutic alliance between treatments. Early therapeutic alliance predicted treatment outcome for restraint and shape concern but no other ED symptoms, depression symptoms or weight. Suggest can make good therapeutic relationship SE-AN

Stockford et al. (2018)	UK	6 women diagnosis SE-AN	Severe and enduring anorexia nervosa (SE-AN)	≥ 10 years, onset in adolescence or early 20s, now ≥ 30 years of age.	Interviews IPA	7 super ordinate themes – understanding development, experience as functional, negative effects of AN, lack of early intervention, cycle of accessing services, negative experience staff attitudes, experience of being with other patients
Tierney & Fox (2009)	UK	53 experts in ED	Chronic AN	Entrenched patterns of food restriction Entrenched "anorexic cognitions" Identity intertwined with anorexia BMI under 17.5	Delphi study – how do professionals define chronic AN?	Created criteria for C-AN mentioned. Less consistent for number of years as arbitrary. Also considered lack of motivation to change. No agreement on number of treatment attempts Also discussed treatment for C-AN but less consistency with this
Touyz et al. (2013)	Australia + UK	63 pts with SE-AN	Severe and enduring anorexia nervosa (SE-AN)	≥ 7 years	RCT CBT-AN or SSCM for pts with SE-AN. 30 sessions over 8 months, focus on treatment QoL not necessarily weight gain. Pre, post 6month and 12 months follow up	Both groups showed sig improvements post treatment and at follow up, CBT-E showed larger reductions in ED symptoms
Treasure et al. (2015)	UK	n/a	SEED	≥ 7 years	n/a	Describes staging model and features of eating disorders in SEED stage

						and how to try to treat these
Treasure et al. (2015b)	UK	n/a	SEED	≥ 7 years	Systematic literature search	Proposes staging model of eating disorders – high risk, early syndrome, full syndrome, SEED
Westmoreland (2016)	USA	n/a	SEED	6-12 years, BMI below 13, regular attention from an MDT. Physical effects e.g., osteoporosis	n/a	- Discuss what SEED is and describe a 'harm reduction' model. Also describes palliative care and futility of treatment in SEED.
Wildes et al., (2017)	USA	355 pts with AN diagnosis	SE-AN	Severity better than length of illness when finding subgroups of AN	Aim to create empirical definition of SEED, used structural equation modelling,	Found no evidence for a sub-group of chronic ED, instead split into low and high severity , were chronic in each group
Yager (2020)	USA	n/a	SE-AN	≥ 8 years despite receiving multiple evidence-based treatments by different clinicians	Discuss cases he has worked with	Consider when to stop treating AN. Describe patients who aim for 'autonomy' rather than weight loss, even if involving palliative care or maintaining very low BMI
Zhu et al. (2020)	Australia	n/a	SE-AN	Persistent dietary restriction, underweight, over evaluation of weight / shape, functional impairment, > 3 years AN, exposure to 2+ previous evidence-based treatments	Review of treatment trials which include pts with SE-AN	Highlight challenges defining SE-AN and very few specific studies, only 1 RCT

The results of the interviews and focus groups were grouped into six broad themes which were each divided into subthemes, these are depicted in figures 3 and 4. Illustrative quotes for each theme can be found in appendix 2.F.

What is the best way for the service to identify those with L-ED?

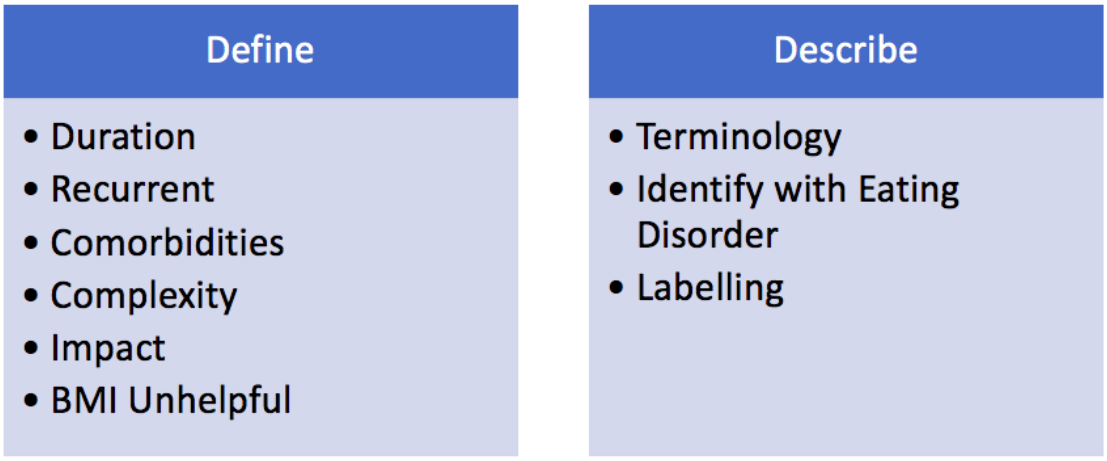


Figure 3: Map of the two themes and nine sub-themes in response to research question one; how can the service better identify patients with L-ED?

Define

The majority of papers in the literature review used a duration criterion which ranged from three to twenty years. The most common was seven years, however, several reported this was unhelpful and arbitrary (Tierney & Fox, 2009; Wildes et al., 2017). Other common criteria included previous evidence-based treatments which have not worked; persistent symptoms; requiring monitoring by a health professional; a low BMI; impaired quality of life; and low motivation to recover.

The 'define' theme from the qualitative analysis was divided into six subthemes to represent the six features that were felt to be important in differentiating L-ED. In line with the literature, the most common feature was duration. There was a sense that

the eating disorder had become lifelong, although some agreed that a specific cut off was "*arbitrary*" [staff, CH23].

Many also reported on the recurrent nature of L-ED whereby relapse is common and recovery short-lived. This was particularly evident when discussing in-patient admissions, with some describing the process of being hospitalised and discharged as a "*vicious cycle*" [patient, GT73] which "*just repeats itself*" [patient, BR13]. There was a feeling that this cycle was futile, and a new approach was needed to break the pattern.

Additionally, they described the eating disorder becoming more complex and frequently including physical or mental health comorbidities *as "over the years, the condition gets more complicated, because other problems come along"* [patient, HT84]. Participants reported that the severity of illness amongst those with L-ED was also great. They reported persistent, serious symptoms which had a large impact on their day to day functioning as well as a sense that their *"life has been lost"* [patient, RI30].

A clear message was that including a BMI cut off in the criteria would be unhelpful. Some commented on the validity of BMI "*comparing you to mere statistics*" [patient, BR13]. Others leant on personal experiences of being denied help if their BMI reached a certain level, whilst simultaneously struggling more as their BMI increased.

Describe

The results of the literature review revealed that the majority of articles use the SEED concept or a variant of this. However, five of these papers reported results from one

randomised control trial from a research group which used “SEED” to describe a L-ED. Other labels included “chronic”, “long-term” and “longstanding”.

Despite the literature frequently using “SEED”, patients and staff expressed a dislike for this term. Patients reported a preference for longstanding over chronic *“because longstanding kind of seems like it's been a long time, but it doesn’t have to always be that way, whereas chronic seems to imply that it's just gonna be there forever”* [patient, SM31].

However, others discussed the pitfalls of using any label at all with one patient stating “*you need to scrap that completely”* [patient, BR13]. Many reflected that their eating disorder had become intertwined with their identity and were concerned that an additional label or diagnosis could negatively impact on the care and treatment they receive. These results were used to create a definition the service could use to identify those with L-ED which was as follows:

Three years active treatment (i.e., not on waiting list, can be multiple episodes of care which add up to 3 years) with severe symptoms (cannot be discharged) which have a significant impact on day-to-day functioning (e.g., disruption to education or employment; significant time spent in hospital; social disruption).

- *May also have comorbidities, several hospital admissions and a low BMI, but these are not necessary to meet the criteria.*
- *Should have all been offered at least one evidence-based treatment which they have not responded to or engaged with.*

How can the service develop a care pathway which better meets the needs of patients with L-ED?

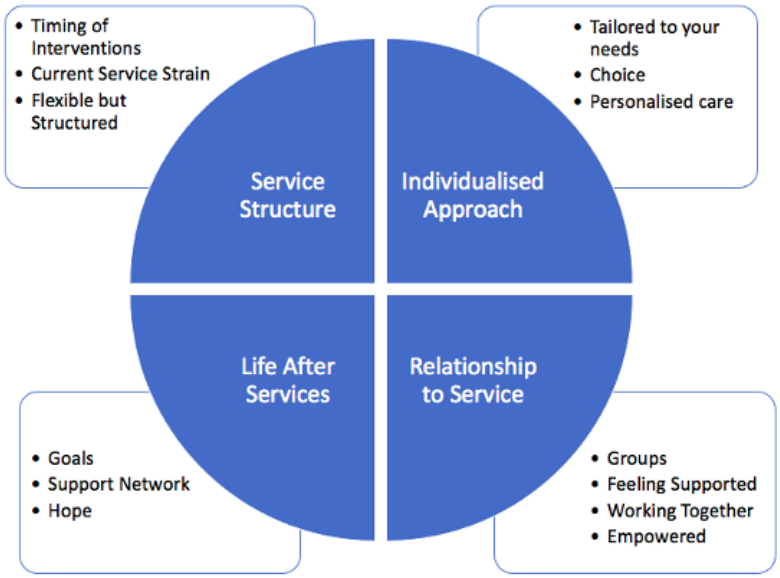


Figure 4: Map of themes and subthemes in response to research question two.

Service Structure

One theme described how the new pathway should be structured. The first subtheme highlighted the importance of matching the timing of interventions to patients' readiness to change as opposed to their level of physical risk. Patients described support not being available at the right time with many citing "*a massive gap*" [patient, HE12] between in and outpatient services. Some felt there were barriers to accessing support in the community when they have looked for it and felt that it was now too late for them.

The second subtheme highlighted the impact of NHS financial pressures on the current service structure, with one patient stating "*I'm not sure that they're meeting those*

needs [of those with L-ED], or that they feel they're able to" [patient, LE27]. Others drew comparisons to chronic illnesses such as schizophrenia or diabetes and called for L-ED services to be commissioned similarly to offer long-term, flexible support.

It was clear that the new pathway should offer "*greater flexibility*" [staff, ST63] and some cited the introduction of remote working during covid-19 as a successful example. However, others felt that providing structured support was important, such as utilising a *"CTO and... [the] parameters of that"* [patient, HE17] or having a clinic with clearly defined roles and expectations.

Individualised Approach

The second theme describes the need for *"an individualised approach"* [MA14]. The first subtheme relates to treatment being tailored to patients by offering access to a range of professionals, as "*having a multidisciplinary team is really important*" [staff, JQ14]. The provision of psychological therapy must also be individualised as some felt it should be readily available "*regardless of their weight*" [patient, LE27] whilst others did not want *"a continuous push for psychological interventions"* [patient, HE17]. The importance of having physical health checks to manage the risks of L-ED was clear, although this should be needs-led as some described "*too much emphasis on the weight"* [patient, FA26] and a desire to "*eventually move away from doing it every week" [patient, HE12]* as they felt this negatively impacts on their wellbeing.

The second subtheme described the importance of patient choice. Many felt that currently they were passive receivers of care and that they "*have no control"* [patient,

HT84]. Therefore, staff and patients were aware that it would be key to a new pathway that "*people should be given more choices*" [patient, GT73] and control over their care.

The final subtheme summarised the importance of offering personalised support. In particular, ensuring that treatment is age appropriate as older patients reported feeling *"as though they [staff] were just dealing with sort of run of the mill, 18 to 25-year-olds that have got an eating disorder*" [patient, PA11].

Relationship to Service

The next theme describes how patients relate to the service. The first subtheme describes how patients could build supportive relationships with each other. Many felt that peer-support groups would be beneficial, and staff suggested utilising technology to access groups remotely. Some proposed peer-support workers facilitating groups as patients found it "*inspiring*" [patient, SM31] to speak to recovered patients.

The second subtheme highlights the importance of *"building up trust with somebody*" [patient, HT84] from the team. This requires staff to provide consistent, responsive care and "*continuity*" [patient SM31] to allow patients to feel safe and supported.

The working together subtheme highlights the importance of patients, staff, and other professionals providing joined-up care. Patients described feeling blamed for not recovering and would like increased information to allow greater collaboration "*to work with them [staff] instead of against them"* [patient, HE12]. Due to the complex nature of L-ED, many patients are supported by multiple heath teams, and it was felt

that inter-agency working and communication required improvement as currently "*there isn't really a connect between the two*" [patient, LE27].

The final subtheme describes empowering patients to change their relationship to their eating disorder by becoming more independent and "*taking the reins*" [patient, GT73]. Several felt the pathway should build patients' confidence and self-efficacy in their abilities or encourage them to access community services which are separate from NHS services.

Life After Services

The final theme describes preparing patients for life after services. The first subtheme relates to the aims and goals of the pathway. Patients felt that currently the service defined recovery as weight-restoration and stated that "*if I'm not up for full recovery then I'm kind of not their business*" [patient, LE27]. Many felt the pathway should instead focus on learning to *"manage and maintain"* [patient, GT73] weight and improve quality of life. However, some staff had concerns about this approach as *"diseases that ruin life don't work with quality of life"* [staff, CH23].

The second subtheme describes the value of building a support network outside of eating disorder services. Many spoke of "*[losing] all my friends in the depths of eating disorder"* [patient, FA26] as "*it is a very isolating disease"* [patient, GT73]. Staff also described L-ED resulting in strained relationships and burnout as "*it can be emotionally very draining"* [staff, JQ14]. As a result, patients sought support from social media, although many recognised that this was not always helpful, and support was required

to navigate this. Therefore, the need to offer support to build helpful connections outside of mental health services was clear.

The final subtheme highlights the importance of providing hope. Many felt that the current service could feel hopeless as though "*they just give up on you*" [patient, SM31]. Therefore, the new pathway should promote a hopeful message and *"talk of recovery… that this can get better"* [patient, GT73]. These themes informed a series of recommendations to support the service to better meet the needs of those with L-ED, these can be found below.

What proportion of the current caseload have L-ED?

The data on how many patients in each team would meet the proposed criteria for L-ED can be seen in table 4. This data describes how many patients within OHFT eating disorder services met the criteria for the pathway in March 2021. The data does not describe the number of patients who expressed an interest in engaging with the pathway.

Table 4: Number of patients with a long-standing eating disorder in each service in March 2021.

Service	Total number on caseload	Total number who meet criteria L-ED (percentages)
Bucks CAEDS	156	7(4.49%)
Ox CAEDS	184	10(5.43%)
Bucks Adults	138	26(18.84%)
Ox Adults	298	66(22.15%)

Discussion

Recommendations

This project identified a clear need for a dedicated pathway to support patients who meet the L-ED criteria which offers structured, specialist, lifespan support. Crucially, the pathway may use the term 'longstanding eating disorder' however, inclusion in the pathway should not result in a label being applied to patients (such as SEED). Other recommendations are detailed in table 5.

Table 5: Full list of recommendations for the proposed pathway. Abbreviations used: NHS (National Health Service); GP (general practitioner); NICE (National Institute for Health and Care Excellence); CAEDS (child and adolescent eating disorder services); and A-ED (adult eating disorder).

Area	Specific Recommendations
Aim and Ethos	1. Main priority to improve quality of life and achieve physical stability.
	2. Provides person-centred care whereby patients' preferences and treatment goals are heard, respected and used to design an individualised, formulation-led care plan.
	3. Promotes a hopeful message about recovery but this is not necessarily defined as immediate symptom reduction, could instead be employment, relationships, education etc.
	4. Patients to be informed that the chances of full recovery are lower without weight restoration, however, should they wish to proceed without weight restoration, legal frameworks such as The Mental Capacity Act and Mental Health Act to be used to assess capacity to make unwise decisions and manage the risks associated with this.
	5. Accessing the pathway should not prevent patients from accessing recovery focused admissions or treatments in the future should they wish to do so.
Structure	6. An appropriately staffed multi-disciplinary team to allow patients to access support that suits their needs.
	7. Clear expectations and structured support to ensure patients can make an informed choice about joining the pathway.
	8. Clear timeframes for reviewing patients' engagement and progress with the pathway. As in chronic physical health settings, patients can leave and re-join the pathway in the future as needed.
	9. Support delivered flexibly by offering support virtually and outside of office hours.
	10. Patients to have a consistent key worker, or team of professionals who they are in regular contact with, including email and phone support.
	11. To consider a non-crisis phone line that patients can call if they require additional support outside of their allocated appointments.

	12. Regular physical monitoring by the service or GP with a clear rationale for the frequency of monitoring and good communication between professionals and patients.
	13. The option to access NICE recommended therapy.
	14. Offer a range of peer support groups with involvement from recovered patients.
Whole of Care Pathway	15. To build on the existing whole-of-care pathway model to offer intensive community support which aims to maintain stable health status, as well as providing an alternative to, or support following, discharge from an inpatient admission.
	16. To explore the possibility of technology enabling patients to attend treatment groups regardless of inpatient status.
	17. To consider specialist staff from the pathway offering consultation to other staff, including other health teams and during transition from CAEDS to A-ED services.
	18. To build links with non-NHS community services to encourage patients to become autonomous.

Relationship to Existing Literature

The results revealed that approximately 5% (CAEDS) to 20% (A-ED) of patients could benefit from a treatment pathway which currently sits outside of the NICE guidelines (NICE, 2017). Nevertheless, the recommendations are routed in guidance from the NHS Long-Term Plan (2019) which highlights that person-centred care, peer support and patient choice are integral to supporting those with severe mental illness. It is important to bear in mind that these figures relate to the number of patients who are eligible for the pathway, as opposed to how many wish to access it. A proportion may choose to pursue NICE recommended, recovery-focused treatments and should be supported to do so as these remain effective in this population (Dawson et al., 2014; Touyz et al., 2013).

This project highlighted the controversial issue of weight restoration in L-ED services. There was disagreement between staff, with management staff viewing weight-restoration as a “key goal” of treatment (NICE, 2017) and citing evidence that full

recovery remains possible in those with L-ED who opt for weight-restoration (Redgrave et al., 2021). On the other hand, many staff and patients wished to choose to focus on stabilisation, maintenance and improving quality of life. There is also research supporting this approach (Westmoreland & Mehler, 2016; Wonderlich, 2020) and it has been successfully implemented in other services (Saeidi, 2013). CIT describes both safe medical monitoring and perceived control over illness management as important (Moss-Morris, 2013), however a different approach may be warranted for L-ED as this project highlighted that these two elements may not always be compatible.

Adopting Prochaska and DiClemente's (1983) Stages of Change Model could resolve this dilemma by matching the intervention with patients' readiness to change. The results of this project and CIT (Moss-Morris, 2013) highlight that focusing on self-efficacy, social support, and good medical behaviours, such as appropriate physical monitoring and maintaining a stable physical health status, could reduce distress for those not yet ready to fully recover. Evidence shows that this type of work to increase motivation predicts better treatment outcomes in future recovery-focussed interventions (Geller et al., 2004; MacDonald et al., 2012). The pathway should also share that recovery is possible in L-ED (Radunz et al., 2020) to further motivate patients to move to the preparation and action stages of change. Matching the intervention to patients' readiness to change promotes a hopeful message as the community team can offer interventions to reduce distress, even if patients are not yet ready to pursue traditional recovery.

As indicated above, this project provided evidence that CIT (Moss-Morris, 2013) applies to L-ED, as CIT predicted many of the subthemes identified in the analysis. However, whilst CIT acknowledges the role of social support and professional relationships, it predominantly focuses on individual factors, whereas many of the subthemes identified in this project were relational. The benefits of peer-support for this population were clear and are supported by research that peer-mentorship provides hope and motivation, as well as allowing patients to re-engage with the world (Henly et al., 2020). The NHS long-term plan also specifically states that eating disorder services must develop their peer support workforce and offer more group support (NHS England, 2019). Therefore, although CIT remains a helpful overall framework for the pathway, it is important to also consider relational factors.

Strengths and Limitations

A strength of this project was that patient experience was at the heart of service development as patients could shape how they are described and supported. For example, patients disliked being labelled as "SEED", despite this term frequently being used in the academic literature. Their concerns are in line with other clinicians (Tierney & Fox, 2009) and patients with other chronic mental illnesses who report that labelling negatively impacts public attitudes towards them and serves as a barrier to treatment or employment (Angermeyer & Matschinger, 2003; Van-Den-Tilaart, Kurtz & Cash, 2009).

However, the sample size in this project was small and all patients were White British females which makes it unclear if their views represent others with L-ED. The patient

sample was consistent with the existing literature as all participants were female and of a similar age and illness duration to samples in previous research (Calugi et al., 2013; George et al., 2014; Touyz et al., 2013). However, these papers did not report data on ethnicity which makes it unclear if our sample all being White British is consistent with existing research. This could suggest that the current sample is representative of the clinical and research population of patients with L-ED, or alternatively it could suggest that both this project and the existing literature is biased towards certain demographic groups. It is important for future research to understand if the current evidence base is representative to ensure that definitions and treatment pathways developed for L-ED represent all patients with L-ED, as opposed to only certain demographic groups.

Additionally, as data was not collected anonymously, some staff or patients may have felt unable to take part or speak freely during interviews and focus groups. Despite these limitations, the project reached data saturation which suggests that the sample was adequate to represent the views of those within OHFT.

Impact and Dissemination

All participants who requested a copy of the results were sent a summary. The results were also shared with the clinical and operational leads for eating disorder services within OHFT to guide service transformation, including workforce planning, to develop a consistent pathway across teams for L-ED which could support up to 20% of the caseload. Additionally, the recommendations were presented directly to staff in each team, as well as in the Trust-wide monthly development slot. The project was also

presented as a workshop at the 2021 International London Eating Disorder Conference.

Implications for Future Research

It is important for future research to analyse the efficacy and acceptability of the proposed pathway. Research should consider the use of values-based outcomes which matter to patients such as quality of life, increased self-efficacy, improved relationships and reduced hospitalisations, whilst also establishing its cost effectiveness. Finally, this project was specific to OHFT and cannot be expected to generalise across other settings. Therefore, research should understand if the proposed model could meet the needs of patients elsewhere.

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Theoretically Driven Research Paper

Understanding the Barriers to Men Seeking Psychological Help for Depression: Comparing Fathers to Men Outside the Perinatal Period

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Proposed Journal: BMC Pregnancy and Childbirth

Rationale:

This manuscript has been prepared for submission in BMC Pregnancy and Childbirth. This is an open-access peer reviewed journal with an impact factor of 2.94. The project is relevant to this journal as it publishes work on all aspects of pregnancy and childbirth, including perinatal mental health. The journal has previously published qualitative research with fathers therefore it was chosen as the most appropriate journal.

Abstract

Background: Approximately 10% of fathers experience postnatal depression, yet fathers are not routinely offered support in the same way as mothers. Men are also less likely than women to seek help for depression due to barriers including stereotypical masculine norms and stigma. This research explored barriers to psychological help-seeking (PHS) amongst fathers with paternal perinatal depression (PPD).

Method: Data was collected using an online survey. Initially, fathers with PPD were compared to men experiencing depression at another time of their life in terms of their attitudes to seeking psychological help; conformity to masculine norms; self-stigma; and awareness of services. Secondly, a proposed model of PHS amongst fathers with PPD was evaluated. Finally, additional barriers to PHS for paternal postnatal depression were explored qualitatively.

Results and Conclusions: No between group differences were found which suggests that the existing literature into barriers to PHS for male depression may also apply to fathers. The results highlighted the need for better awareness of PPD, and better access to services. Limitations, implications for policy, and directions for future research are discussed.

Background

Paternal Perinatal Depression

Postnatal depression is defined as experiencing low mood and a lack of interest or pleasure in activities for at least two weeks during the perinatal period (Howard et al., 2014). It also includes features of anxiety, sleep difficulties, thoughts of self-harm, worthlessness, and guilt (Howard et al., 2014). Historically, postnatal depression was thought to occur only in mothers, however, research shows that postnatal depression is also seen in fathers. A meta-analysis of 43 papers estimates rates of paternal postnatal depression could be as high as 10% which is twice the rate of depression in men of the same age in the general public (Fisher et al., 2021; Paulson & Bazemore, 2010). This estimate rises again to 25-50% of men whose partner also has postnatal depression (Goodman, 2003). There is evidence that postnatal depression in fathers may present differently from mothers, with fathers expressing higher rates of irritability, anxiety, aggression and substance abuse (Baldoni & Giannotti, 2020). This has led researchers to suggest that fathers experience a different condition known as paternal perinatal depression (PPD) (Baldoni & Giannotti, 2020).

The Social Identity Model of Identity Change (SIMIC) suggests that people are particularly vulnerable to depression during life changes due to a loss of group identity (Iyer et al., 2009). Becoming a parent is a significant life transition that affects relationships and reduces access to hobbies and employment. Parents reporting reductions in group membership also report higher rates of postnatal depression (Seymour-Smith et al., 2016). Fatherhood can challenge men's identity as masculine

figures (Singley & Edwards, 2015) suggesting that fathers with PPD may face additional stressors compared to men experiencing depression at another time of life.

In addition to the implications for fathers' wellbeing, PPD is associated with lower relationship satisfaction and increased emotional and behavioural problems in children (Ramchandani et al., 2008; Ramchandani et al., 2011). Therefore, in the UK, it is recommended that fathers are included throughout antenatal care and all fathers are screened postnatally for depression (NHS England, 2019; NICE, 2021). Despite this, fathers are often excluded from specialist perinatal mental health services. Fathers and professionals report barriers including a lack of awareness, commissioning difficulties, and concerns about compromising the care offered to mothers (Darwin et al., 2021). As a result, many fathers do not access support they require.

Male Psychological Help-Seeking

Men are less likely than women to seek help for any health condition, including depression (Galdas, Cheater & Marshall, 2005). The Theory of Planned Behaviour (TPB) (Ajzen, 1991) states that behaviour, such as help-seeking, is predicted by one's intention to complete the behaviour. A person's intention is predicted by their attitudes towards a behaviour, their group's subjective norms and their perceived control. There is strong support for the TPB as an explanation of help-seeking in depression, with attitudes towards help-seeking proving to be the strongest predictor of help-seeking (Armitage & Conner, 2001; Schomerus et al., 2009; Zorrilla et al., 2019).

Similarly, research with university students reports that male psychological help-seeking (PHS) is predicted by conformity to masculine norms and stigma. They found that self-stigma shows the largest direct effect size on PHS and partially mediates the relationship between masculine norms and PHS (Pedersen & Vogel, 2007; Vogel et al., 2011; Wasylkiw & Clairo, 2018). Self-stigma is a subtype of stigma which occurs when negative attitudes are internalised (Pattyn et al., 2014). A literature review expanded on these results and proposed a model of male PHS for depression which closely mirrors the TPB (Latalova, Kamaradova & Prasko, 2014). The model states that willingness to seek counselling is directly predicted by men's attitudes towards counselling. Attitudes are directly predicted by self-stigma and masculine norms. Masculine norms and depression also predict attitudes indirectly through their impact on self-stigma.

There is limited research specifically looking at PHS amongst fathers. Research suggests that fathers prefer to access individual or couple psychotherapy, and consider psychological support more credible, than medication (Cameron et al., 2017). Qualitative interviews with fathers identify barriers to PHS including stigma, ideas of masculinity, exclusion from services, and a lack of awareness of postnatal depression or available help (Daniels, Arden-Close & Mayers, 2020; Pedersen, Maindal & Ryom, 2021; Rominov et al., 2018). This suggests fathers with PPD may face additional barriers to PHS compared to men with depression occurring at another time of life. However, it has not yet been established if these additional barriers result in lower PHS intentions amongst fathers with PPD.

Current Research

The SIMIC (Iyer et al., 2009) and qualitative research with fathers suggests fathers may experience additional stressors and barriers to PHS compared to men experiencing depression at another time of life. This is the first research to compare PHS between these two groups.

In addition, the TPB and Latalova, Kamaradova and Prasko's (2014) model were integrated to propose a model of PHS in PPD (figure 1). In the proposed model, self-stigma maps onto the attitudes described in TPB, and masculine norms relate to subjective norms from TPB. The proposed model also integrates findings that self-stigma partially mediates the link between masculine norms and PHS intentions (Smith, Tran & Thompson, 2008). Additionally, the model includes a third variable related to perceived behavioural control from TPB named "awareness of support". This is supported by qualitative literature reporting a lack of awareness as a common barrier to PHS (Fisher et al., 2021; Daniels, Arden-Close & Mayers, 2020).

In TPB help-seeking intentions are distinguished from help-seeking behaviour, with intentions directly predicting behaviour. As UK perinatal mental health services have not traditionally supported fathers, this research uses PHS intentions, rather than behaviour, as the primary outcome. PHS behaviour is included as a secondary variable.

The model also explores the role of several barriers for which there is insufficient research or theory to predict their influence upon PHS intentions. These are: current partner depression; current levels of depression; depression history; and history of help-seeking. In addition, demographic data on ethnicity, age and number of previous children are explored as they have been shown to impact on help-seeking for male depression (Dwight-Johnson et al., 2000; Dwight-Johnson et al., 2013; Parent et al., 2018).

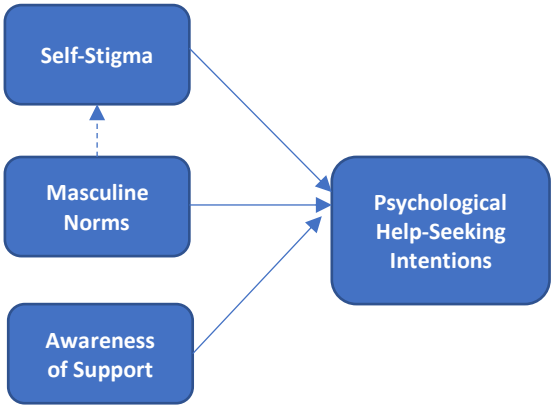


Figure 1: Proposed model of help-seeking amongst men with PPD.

Finally, to reduce the likelihood that results are subject to a confirmation bias, additional barriers for consideration, which were not captured by quantitative measures, are explored qualitatively using reflexive thematic analysis (Braun & Clarke, 2006; 2021).

Aims and Hypotheses

This research compared fathers with PPD to men with depression occurring at another time of life. The primary hypothesis was:

1. Fathers with PPD will show lower PHS intentions compared to men with depression occurring at another time of life.

It was also hypothesized that:

2. Compared to men with depression occurring at another time of life, fathers with PPD will show:
    a. Higher self-stigma
    b. Higher conformity to masculine norms
    c. Lower awareness of services

A model of PHS amongst fathers with PPD was also proposed by exploring the following hypotheses:

3. Higher self-stigma will lead to lower PHS intentions, above and beyond the contributions made by masculine norms and awareness of support.
4. Self-stigma will partially mediate the relationship between masculine norms and PHS intentions.
5. The following variables will have an effect on fathers' PHS intentions:
    a. Severity of depression
    b. Previous history of depression
    c. History of help-seeking
    d. Partner's depression
6. PHS intentions will predict PHS behaviour.

Barriers to PHS were explored qualitatively to answer the following question:

7. What are the perceived barriers to PHS amongst fathers with PPD?

Methods:

Design

The research used a cross sectional, between-groups design with data gathered online at one time point. Variables were naturally occurring; no experimental manipulation was involved. The two groups differed with regard to whether participants were in the perinatal period and therefore their depression was considered PPD, or not. This research defined the perinatal period as up to 24 months after the birth of your child to align with the NHS long term plan to expand mental health support in the perinatal period from 12 to 24 months (NHS England, 2019). Therefore, the father-depression (FD) group consisted of fathers who had experienced PPD following the birth of their child in the past 24 months. The male-depression (MD) group consisted of men who experienced depression within the past 24 months but had not had a child during this time, therefore their depression was not considered PPD. Participants in the MD group could be fathers, but were not in the perinatal period as any children were born more than 24 months ago. Both groups completed the quantitative measures; only the FD group completed the qualitative questions as these were specific to PPD.

Ethics

The project received ethical approval from the University of Oxford research ethics committee (R74370/RE001), see appendix 3.A for details..

Procedure

Data was collected online using Qualtrics between 1st April 2021 and 31st December 2021. Participants were recruited using electronic posters containing details of the project and URL and QR codes to access the survey, see appendix 3.B. As PPD presents differently in fathers (Baldoni & Giannotti, 2020) posters purposefully used the broad term "low mood" as opposed to "depression" or specific symptoms to avoid narrowing recruitment efforts. Posters were shared through social media accounts of researchers, third-party organisations and campaigners. Third-party organisations also distributed physical posters. The online information sheet then asked potential participants to indicate that they had experienced specific symptoms of depression from the DSM-5 (American Psychiatric Association, 2013) as well as male-specific symptoms such as agitation or irritability.

Measures

The below measures were completed electronically and can be found in appendix 3.C.

Demographics:

A demographic questionnaire captured age, ethnicity and number of previous children. Men were asked if they had previously experienced depression, if they had previously sought help for depression, and whether their partner currently experiences depression.

Self-stigma:

Self-stigma was measured using the Self-Stigma of Seeking Help Scale (SSSHS) (Vogel, Wade & Haake, 2006). This is a 10 item questionnaire with good reliability and validity (Vogel at al., 2013). Higher scores reflect higher self-stigma.

Masculine Norms:

Conformity to masculine norms was measured using the Conformity to Masculine Norms Inventory-46 (CMNI-46). This is a brief version of the original scale (CMNI) (Mahalik et al., 2003) which shows good reliability and validity and accurately measures 9 of the original 11 subscales (Winning, Emotional Control, Primacy of Work, Risk-Taking, Violence, Heterosexual Self-Presentation, Playboy, Self-Reliance, Power Over Women) (Parent & Moradi, 2009; 2011).

Awareness of services:

Participants reviewed a checklist of nine support services and indicated which they knew of, as well as any additional services they were aware of. These were totalled together to give a numerical value for awareness of services.

Depression:

Depression was measured using the Depression and Anxiety Stress Scale (DASS-21) (Lovibond & Lovibond, 1995). This is a shortened version of the original 42 item measure which both show good reliability and validity (Henry & Crawford, 2005). Scores for the DASS-21 are multiplied by two for interpretation giving a maximum score of 126.The DASS-21 allows for the calculation of depression, anxiety and stress subscale scores. This was used as PPD also includes stress and anxiety (Baldoni &

Giannotti, 2020), and specific postnatal depression measures include items relating to anxiety disorders (Brouwers, van-Baar & Pop; Matthey, 2008; Fisher et al., 2021).

PHS intentions:

PHS intentions were measured using the Attitudes Towards Seeking Professional Psychological Help Scale short form (ATSPPHS-SF) (Fischer & Farina, 1995). This questionnaire is specific to psychological help and includes three dimensions: openness to seeking professional help; perceived value in seeking professional help; and preference to cope on one's own (Picco et al., 2016). The scale has good internal consistency and validity (Elhai, Schweinle & Anderson, 2008). Higher scores reflect positive intentions to seek help.

PHS behaviour

Men were asked if they were currently receiving support for depression. Additionally, fathers' experiences of PHS were explored qualitatively using five open questions which were developed with the support of an expert by experience. Fathers were asked if they experienced barriers to PHS, if so, what these were, what help they would have liked to be available, and how they could have been supported to access this. The specific questions can be found in appendix 3.D.

Inclusion and Exclusion Criteria

The following criteria applied to all participants:

Inclusion criteria:

- Identifies as male

- Has experienced self-rated depression in the past 24 months
- Between 18-65 years of age

Exclusion criteria:

- No access to suitable technology to complete the study
- Self-report of a history of serious mental illness. Following advice from experts by experience no specific diagnostic labels were used as exclusion criteria, instead participants could determine for themselves if they had a history of a serious mental illness.

In addition, the fathers' depression (FD) group were required to meet the following:

- In the perinatal period (partner has given birth in the past 24 months)
- Biological fathers (e.g. not adoptive fathers or step-fathers)

Participants

As there has been no previous research into differences in PHS between fathers with PPD and men with depression, it was not possible to use established effect sizes to determine the number of participants required to power the primary hypothesis. Therefore, an estimated medium effect size (d=0.5) was assumed in power calculations; see appendix 3.E for details. Power calculations identified that a minimum of 102 participants were required (N=51 in each group) to adequately power the study.

Analysis

The demographic data for the FD and MD groups were statistically compared to better define and understand the groups. The main analysis then involved statistically comparing the groups in terms of their PHS intentions, levels of self-stigma, conformity to masculine norms and awareness of services, A hierarchical regression model was then used to address hypotheses 3, 4 and 5. A binomial logistic regression was used to address hypothesis 6. To answer question 7, qualitative data from fathers (FD) was analysed using reflexive thematic analysis (Braun & Clarke, 2021). See appendix 3.F for details.

Results

Participants

A total of 125 participants took part in the research, 64 men in the perinatal period (FD) and 61 men outside of the perinatal period (MD). Due to participant drop out, some participants did not complete all quantitative measures, and only 50 fathers completed the qualitative section. This resulted in differing numbers of responses for each measure, see table 1 for details.

As can be seen in table 1, there were no significant differences between the FD and MD groups in terms of their ethnicity, current depression levels, history of depression, partner's current depression, history of help-seeking or current help-seeking. The groups did differ significantly in terms of age; the FD group were significantly older than the MD group (p<.001). As expected, the groups also differed in terms of fatherhood status, with significantly more participants in the FD group being fathers

(N=64) compared to the MD group (N=18) (p<.001). All participants in the FD group had had a child in the past 24 months, whereas the MD group ranged in time since the birth of their youngest child from 2.79 years to 31.36 years, with an average of 9.85 years.

Table 1: Summary table of demographic information about participants and details of the between-subject comparisons. The number of participants varies in each measure due to participant drop out.

Demographic Variable	Father Depression (FD) N=64	Male Depression (MD) N=61	Significance Value
Age	N=64	N=61	
18-25 years	3	22	*p*<.001**
26-35 years	34	20	
36-55 years	27	16	
56+ years	0	3	
Ethnicity	N=64	N=61	
White British	52	51	*p*=.74
Black British	1	0	
Asian British	2	1	
White Other	7	5	
Black Other	0	1	
Asian Other	1	0	
Other	1	3	
Father status	N=64	N=61	
Father	64	18	*p*<.001**
Not father	0	43	
Total number of children	N=64	N=18 (fathers only)	
1	33	7	*p*=.64
2	24	9	
3	5	1	
4+	2	1	
Time Since Birth of Youngest Child (years)	N=62	N=18 (fathers only)	[a]
Mean (range)	1.07 (0.05-1.95)	9.85 (2.79–31.36)	
History of Depression	N= 60	N=57	
Yes	45	43	*p*=.96
No	15	14	
Partner Current Depression	N=58 [b]	N=37	
Yes	16	9	*p*=.73
No	42	28	
History of Seeking Help	N= 60	N=58	
Yes	31	28	*p*=.71
No	29	30	
Currently Seeking Help	N=60	N=58	
Yes	17	18	*p*=.84
No	43	40	
ATSPPH-SF	N=64	N=61	
Mean (SD)	18.88 (4.45)	19.33 (6.44)	*p*=.65
SSSHS	N=59	N=58	
Mean (SD)	25.76 (5.74)	24.45 (7.21)	*p*=.27
CMNI-46	N=53	N=56	
Mean (SD)	51.38 (9.46)	55.04 (13.74)	*p*=.11
Awareness of services	N=53	N=57	
Median	3	3	*p*=.18
DASS-21	N=62	N= 58	
Mean Depression (SD)	22.13 (9.96)	24.24 (12.72)	*p*= .32
Mean Anxiety (SD)	11.74 (8.42)	13.31 (10.29)	*p*= .36
Mean Stress (SD)	25.39 (9.56)	22.14 (9.75)	*p*= .07
Mean Total (SD)	59.26 (24.95)	59.69 (28.73)	*p*= .93

* indicates *p*<.05, ** indicates p<.001

a it was not possible to statistically compare means with a t-test or medians with a Mann-Whitney U test do the variation in distribution between the groups

b group sizes are lower as 1 man in the FD group and 18 men in the MD group indicated they did not have a partner.

Comparing Fathers (FD) with Male Depression (MD)

Prior to all statistical analyses the relevant assumptions were tested, see appendix 3.F for details. Means and standard deviations for between group comparisons are in table 1. Independent samples t-tests comparing the FD and MD groups found no significant difference in PHS intentions as measured by the ATSPPHS-SF , t=-0.46, *p*=.65.

Similarly, no significant differences between the FD and MD groups were found for levels of self-stigma, t=1.09, *p*=.27, or conformity to masculine norms, t=-1.63, *p*=.11. Due to data not being normally distributed, a non-parametric Mann-Whitney U test was used to compare awareness of services between the FD and MD groups which identified no significant differences, U= 1293, z=-1.334, *p*=.18.

A model of help-seeking

To explore a model of help-seeking amongst fathers, a hierarchical regression model was constructed using the FD data in a step-wise fashion (N=53). The third hypothesis was confirmed as adding self-stigma to the model, alongside conformity to masculine norms and awareness of services, significantly increased the amount of variance in PHS intentions (R2=0.19, *p*<.001). The overall model with all three predictors was significant, F(3, 49)=3.88, *p*=.02.

The regression model was then used to explore whether self-stigma mediated the relationship between conformity to masculine norms and PHS intentions, see appendix 3.G for details. Self-stigma did partially mediate this relationship as the observed beta

values for the relationship between conformity to masculine norms and PHS intentions decreased from -0.23 to -0.11 with the addition of self-stigma. Additionally, the full model, with both self-stigma and conformity to masculine norms as predictors was significant (p<.001). Therefore, a large proportion of the variance in PHS intentions which appeared to be explained by conformity to masculine norms, was better explained by self-stigma.

The exploratory predictor variables of current partners' depression; current depression; depression history; and history of help-seeking were then added to the regression model (N=52). Including current partners' depression led to a very small increase in the amount of variance explained from R^2=0.183 to R^2=0.184. Adding current depression further increased the amount of variance explained to R^2=0.23. The other variables did not increase the amount of variance explained, therefore were not included in the model. The final model was statistically significant, F(5,46)=2.65, p=.04, and is depicted in figure 2.

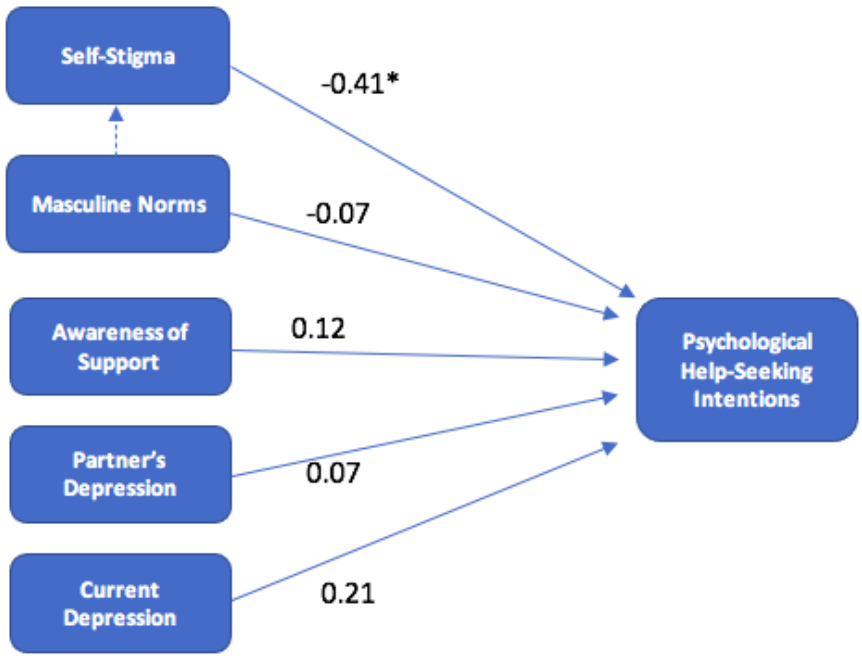


*Figure 2:Model of psychological help-seeking intentions amongst fathers. Standardised beta values are shown. * indicates a significant predictor variable (p<.05). A dashed line indicates a mediation effect.*

Finally, a binominal logistic regression model was created to understand whether PHS intentions predicted PHS behaviour in the FD group (N=60). PHS intentions did not significantly predict current PHS behaviour, and only explained 0.8% of the variance (*p*=.58).

Qualitative Analysis of Help-Seeking

Qualitative data was provided by 50 fathers. Reflexive thematic analysis (Braun & Clarke, 2021) was used to generate four themes consisting of 14 sub-themes which are depicted in figure 3 and described below with additional supporting quotes in appendix 3.H.

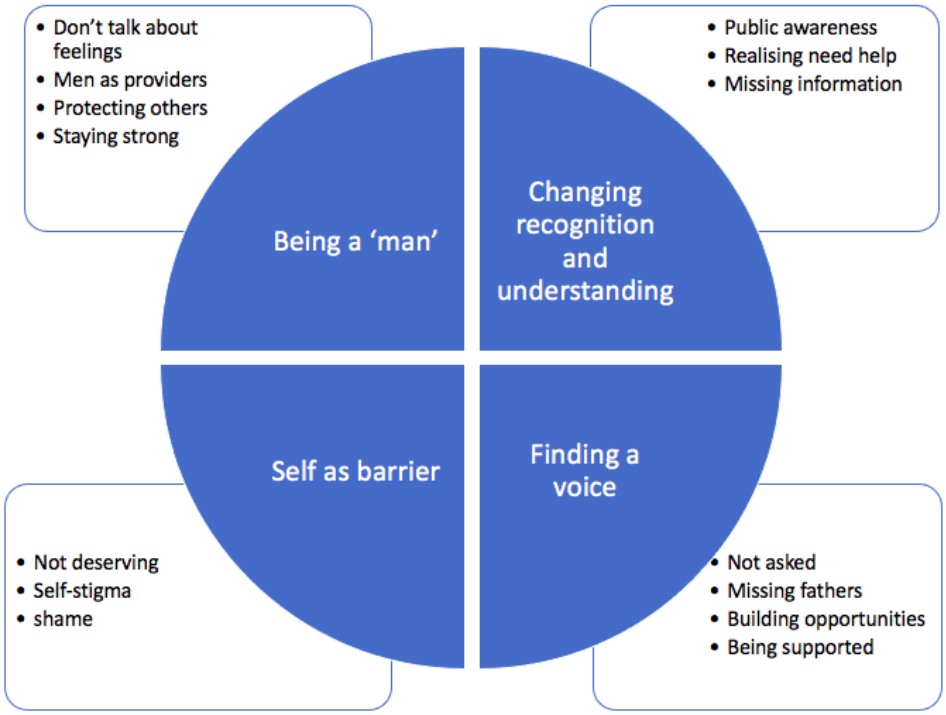


Figure 3: Summary of the four themes and fourteen sub-themes.

Being a 'man'

The first theme described barriers to PHS from societal pressure on fathers to act in ways that are considered culturally and socially appropriate for men.

Don't talk about feelings

Fathers described pressure to not discuss their feelings. Fathers spoke of a "*lack of practice*" [WH13] discussing emotions as "*men are not taught to tune into their emotional side*" [BI11] suggesting that, even if they had sought help, they would struggle to discuss their experiences.

Men as providers

This subtheme described fathers prioritising providing for their family over their wellbeing. Men described "*needing to keep going to work to support my family"* [FA08] and facing institutional barriers as workplaces offered "*no time off to do so [seek-help]"* [WY06].

Protecting others

Another barrier was societal pressure to protect others, resulting in concerns about becoming a "*burden*" [BI24] to others, and feeling "*selfish*" [SO20] for sharing struggles. Fathers worried about their partners as they "*actually had to give birth and have the physical stress of birth. I feel like surely my issues can't be as serious as that of the mother*" [SO4].

Staying Strong

The final subtheme described societal pressure to appear "*strong for family and not wanting to show weakness to friends*" [ED20]. Fathers felt they should be strong "*as a dad, I didn't want to show weakness*" [QU09]. There was a sense that had fathers wanted to break these stereotypes and seek support, they struggled due to lack of practice, societal pressure and institutional barriers.

<u>Changing recognition and understanding</u>

The second theme spoke to the need to change recognition and understanding of PPD to enable PHS. Fathers described a lack of public and professional knowledge making it hard to recognise the signs of PPD or access information and support.

Public awareness

The first subtheme described a lack of public awareness of PPD due to a "*view that it's not something that effects men*" [BO17]. They also felt professionals should increase their understanding to ensure PPD "*would be taken seriously*" [ST01].

Realising need help

Due to this lack of awareness, men struggled to recognise PPD as the concept "*just doesn't connect with me*" [MS01]. This made it challenging to recognise they were experiencing PPD and "*to accept that I needed it [help]"* [OP14].

Missing information

The final subtheme described the difficulties fathers faced when searching for information about PPD. Men described not knowing "*how to go about getting help, or what help I needed*" [WH18]. Fathers were not "*made aware of services by the midwife or health supporter*" [RO21] and struggled with a "*lack of available or clearly advertised services*" [BE17]. The lack of information and understanding hindered fathers from recognising PPD, or knowing how to seek support.

<u>Finding a voice</u>

This theme represented the barriers fathers faced at each stage of being heard and supported by professionals, peers and family members.

Not asked

The first subtheme relates to fathers "*not being asked"* [BE17] about their wellbeing by professionals. Fathers felt that "*any kind of engagement post birth to check in on my wellbeing*" [WO16] would have been beneficial and advocated for "*at least one occasion on which a medical professional talks to the father alone about their experiences and needs"* [FI08].

Missing fathers

The next subtheme details fathers' experiences of specialist services being unavailable to them as the "*system is geared to mothers, not fathers*" [ED20]. Many described the "*lack of dedicated paternal depression resources"* [MC08]. This was compounded by covid-19, with one father saying "*I think due to the pandemic and not being able to attend anything fathers should be getting more support and they're not. It's all about the mum but the dad needs to get help too*" [MC07] and another described becoming a "*passenger*" [SO4].

Building opportunities

The third subtheme described fathers looking for opportunities to form a *"community of people with similar experiences"* [MC08] through counselling or support groups. This felt important in creating a safe space for fathers to discuss their experiences. Men called for "*a male friend to talk to"* [CL10] and more professional input to access "*group therapy*" [LA20], "*phone based talking therapies*" [BE17] or "*self-help guides*" [WH13].

Being supported

The final subtheme described the sub-group of men who found a voice and sought help which was "*just right*" [WH18]. This commonly came from family rather than professionals due to fewer barriers. When asked about barriers to speaking to family and friends, approximately one fifth of fathers felt "*there were none, my family and wife were great*" [MC07]. This suggests that existing networks could be a useful resource for fathers to access support.

Self as a barrier

The final theme related to men frequently referencing themselves as a barrier due to negative beliefs and feelings about experiencing PPD creating high levels of self-stigma.

Not deserving

The first subtheme described fathers' beliefs that they did not deserve help as "*my form of depression wasn't worthy*" [ON5]. Others worried about not being "*depressed enough*" [BR27] to deserve help.

Self-stigma

The second subtheme described self-stigmatising attitudes held by fathers about PPD. Fathers described the "*stigma of a man having paternal depression [and] thinking this should be happiest time of my life*" [ON5]. Others felt too "*scared of what people will say*" [WI04] to seek help. These internalised negative attitudes prevented PHS.

Shame

The final subtheme described the emotional barriers associated with self-stigma. Fathers felt they "*should be enjoying my newborn and not feeling down, so the shame and guilt that comes with that*" [SE14]. Others stated that "*shame prevented me from talking to friends*" [ES11]. This theme highlights that, in addition to the societal, institutional and practical barriers men face to seeking help for PPD, they must also overcome their own internal barriers.

Discussion

This paper was the first to explore PHS amongst fathers with PPD. The results identified that fathers with PPD were not significantly different to men with depression occurring at another time of life in terms of their attitudes to PHS, self-stigma, conformity to masculine norms or awareness of services. The proposed model of PHS amongst fathers was supported. Qualitative responses also highlighted additional societal, institutional and practical barriers fathers faced to seeking psychological help for PPD.

Comparison to previous literature

The existing literature on barriers to male PHS for depression was found to also apply to fathers with PPD, as self-stigma, conformity to masculine norms, and level of depression predicted PHS intentions (Latalova, Kamaradova & Prasko, 2014). Self-stigma was evident in the qualitative data, explained the largest amount of variance in PHS intentions, and partially mediated the relationship between conformity to

masculine norms and PHS intentions (Latalova, Kamaradova & Prasko, 2014; Vogel et al., 2011). Therefore, reducing self-stigma is a key target in reducing barriers to PHS.

Support groups were identified in the 'building opportunities' sub-theme as a way to reduce barriers by connecting with others experiencing PPD. Groups such as 'Coming Out Proud' have been shown to reduce self-stigma associated with mental health difficulties (Corrigan, Kosyluk & Rüsch, 2013; Yanos et al., 2015). However, joining a group requires fathers to first overcome several other identified barriers. As self-stigma is a process whereby public stigmatising attitudes are internalised onto oneself (Corrigan & Rao, 2012), intervening at the public level may be more effective. For instance, interventions could increase visibility of men experiencing PPD; educate the public about PPD and work to reduce stereotypical masculine attitudes. Future research could explore the efficacy of such interventions.

Unlike in previous research, conformity to masculine norms did not significantly predict PHS (Vogel et al., 2011). This suggests that fatherhood may change men's levels of conformity to masculine norms. This is in line with Addis, Mansfield & Syzdek's (2010) proposal that conformity to masculine ideals varies as a result of the context. However, no differences were found in rates of masculine norms between men with PPD and men with depression at another time of life. Additionally, research suggests that masculine norms are instilled at a young age, and remain stable over time, even during significant life transitions such as going to university (McCready & Dahl, 2022; Vogel et al., 2011).

The addition of ‘awareness of services’ as a barrier to help-seeking was supported by the quantitative and qualitative data as well as the TPB (Ajzen, 1991). However, an interesting result of this project which contradicts the TPB (Ajzen, 1991) was that PHS intentions did not predict behaviour. These two results may be related as, even if men had wanted to access support, they could not due to a lack of awareness of available specialist services.

Crucially, the majority of participants experienced depression during the covid-19 pandemic at a time when many services closed. In the UK primary care referrals for depression were 43% lower than usual during the pandemic due to reduced healthcare usage (Carr et al., 2021). At the same time fathers reported the pandemic negatively impacted on their levels of stress, relationships with their children, and finances (Trumello et al., 2021). Additionally, during the pandemic fathers were mostly excluded from antenatal appointments which delayed the implementation of the NHS Long Term Plan (2019) to introduce mental health screening to fathers; exacerbating the barriers to PHS (Menzies, 2021). Therefore, to truly understand the relationship between PHS intentions and behaviour, specialist services should first be commissioned to support fathers, and information about these services should be readily available.

This research did not support the Social Identity Model of Identity Change (Iyer et al., 2009) as fathers did not experience increased barriers to help-seeking compared to men with depression at another stage of life. However, the qualitative data did propose several additional barriers fathers face which were not captured by the

quantitative measures including a lack of understanding of PPD, and exclusion from specialist services. This is consistent with previous research with fathers who reported struggling to access specialist services due to society not understanding PPD and feeling services only supported mothers (Daniels, Arden-Close & Mayers, 2020; Pedersen, Maindal & Ryom, 2021). Future research should build upon this by exploring these barriers using validated measures.

Limitations and Future Directions

A limitation of this research was the limited sample size. The sample may have been too small to detect smaller effect sizes as the power analysis was based on the between group comparison rather than the exploratory analyses. Fathers with PPD are a hard to recruit population due to high self-stigma. Future researchers could overcome barriers to research participation by offering paid incentives or simplifying recruitment processes (Tully et al., 2021). However, small effect sizes may not be clinically meaningful, therefore, future research could utilise qualitative methodologies with small samples to gain a detailed, clinically useful understanding of barriers to PHS.

The sample also lacked diversity as almost all participants were White British. It is possible that fathers with PPD from ethnic minority backgrounds experienced additional levels of stigma, referred to as double stigma (Gary, 2005) due to their ethnicity as well as being a male experiencing PPD. Double stigma makes it less likely that fathers from ethnic minority backgrounds would seek help for PPD, or participate in research. Therefore, future research must recruit minority populations to ensure that policies on PPD and clinical applications are relevant to all fathers.

A further limitation is that comprehensive data on mental health history was not collected. The majority of participants in both groups had experienced depression previously, but it is unclear how long their recent episode of depression lasted as no chronicity data was provided. Therefore it is possible that some participants in the MD group were experiencing depression which began in the perinatal period over 24 months ago. Whilst this would no longer be considered PPD, it poses a challenge to drawing firm conclusions about the lack of between-group differences. Additionally, the exclusion criteria of a self-rated history of serious mental illness is subjective meaning some potential participants with a history of depression may have been missed if they considered this a serious mental illness. Therefore, future research should collect data on chronicity of depression and introduce more rigorous exclusion criteria regarding fatherhood status and mental health history to allow for clearer conclusions.

Finally, due to the focus of this research being on PHS, it is possible that other forms of help-seeking, such as informal support or medication, were missed. Although research suggests most fathers prefer to seek psychological support (Cameron et al., 2017) the qualitative data highlighted a desire to also build informal supportive connections through groups. Therefore, focusing solely on PHS may have missed between-group differences in other types of support. Additionally, the wording of some questions meant that the focus on PHS was not always clear. For instance participants were asked if they were currently seeking help, or had previously sought help, without specifying if this help was psychological. This is a limitation as it is not clear what type

of help participants sought, and whether this differed between the groups. Future research should better define PHS and consider collecting data on informal support and medication use.

Conclusions

This research suggests that fathers with PPD experience many of the same barriers to accessing psychological support as men with depression occurring at another stage of life. These include awareness of services, depression, conformity to masculine stereotypes, and self-stigma. The results also proposed some additional barriers faced by fathers such as a lack of awareness of PPD and available support. Future research with larger, representative samples is required to understand the barriers fathers with PPD face to seeking help.

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Executive Summary

Background

Postnatal depression can occur during pregnancy or in the two years following the birth of a child. Features include low mood, anxiety, guilt and thoughts of self-harm. Postnatal depression is often associated with mothers, however, approximately 10% of fathers also experience postnatal depression.

Men are less likely than women to seek help for mental health difficulties such as depression. The Theory of Planned Behaviour (TPB) is a model which suggests that a persons' help-seeking intentions are predicted by their attitudes towards seeking help, the beliefs and norms of their peer group, and how able they feel to seek-help. This is supported by research which found that men face barriers to help-seeking including stigmatising attitudes and masculine stereotypes.

As there is little research on fathers, we wanted to understand how to better support fathers to access help for postnatal depression. We compared fathers with postnatal depression to men with depression occurring at another time of life to understand whether fathers face additional barriers, and therefore display lower help-seeking intentions. We also evaluated a model of help-seeking in fathers, which was based on the TPB, to help us to understand what the biggest barriers to seeking help are. Finally, we asked fathers to share details of their experiences seeking help for postnatal depression, and how they could have been better supported to access care.

Research Questions

The questions this research aimed to answer were:

1. Do fathers with postnatal depression have lower help-seeking intentions than men with depression occurring at another time of life?
2. Compared to men with depression occurring at another time of life, do fathers with postnatal depression show:
    a. Higher self-stigma?
    b. Higher conformity to masculine norms?
    c. Lower awareness of services?
3. Does self-stigma have a larger effect on fathers' help-seeking intentions than masculine norms and awareness of support?
4. Is self-stigma a better explanation of the relationship between masculine norms and help-seeking intentions?
5. Do the following variables have an effect on fathers' help-seeking intentions:
    a. Severity of current depression?
    b. A previous history of depression?
    c. A history of seeking help?
    d. Partner's depression?
6. Do fathers' help-seeking intentions predict whether they go on to seek help?
7. What do fathers' perceive as the barriers to seeking help for postnatal depression?

How the study was carried out

We recruited 125 participants online through social media. This included 64 fathers who had experienced postnatal depression in the past 24 months, and 61 men who had experienced depression in the past 24 months but had not had a child in that time. All participants completed an anonymous online survey which asked about their age, ethnicity and number of children. They were asked if they were currently seeking help for depression; if they had experienced depression previously, and if so, whether they sought support; and finally if their current partner experiences depression. Additionally, the survey contained five questionnaires which asked about levels of: self-stigma; stereotypical masculine norms; awareness of support services; current depression; and intentions to seek help. Lastly, fathers provided more detailed, written information about their experiences seeking help for postnatal depression, what help they would have liked to have been available and how they could have been supported to access this.

Key findings and Implications

The results found that fathers with postnatal depression did not report lower help-seeking intentions compared to men with depression occurring at another time of their life. Additionally, fathers did not show significantly different levels of self-stigma, conformity to masculine norms, or awareness of support services. This suggests that fathers with postnatal depression face the same barriers as men with depression occurring at another time. Therefore, existing interventions to reduce barriers could be

beneficial such as increasing visibility of fathers with postnatal depression; increasing public knowledge; and developing group interventions.

The results supported the proposed model of help-seeking amongst fathers with postnatal depression. Self-stigma had the largest impact on whether or not fathers intended to seek-help. The TPB was supported as masculine norms and awareness of services predicted whether fathers intended to seek help. Having a partner with depression; and current levels of depression were also found to predict fathers' intentions to seek help.

However, fathers' intentions to seek help did not predict whether or not they actually sought help. The exact reasons for this are unclear, although one possibility is that fewer services than usual were open and available due to the research taking place during the covid-19 pandemic. Therefore, even if fathers had intended to seek help, many services were not available.

The results of fathers' written responses were grouped into four themes: being a man; changing recognition and understanding; finding a voice; and self as a barrier. The written responses supported the questionnaire responses as stereotypical views of masculinity and self-stigma were identified as barriers to seeking help. Fathers also described barriers including a lack of awareness of postnatal depression in fathers, and difficulties being heard as support services were predominantly designed to support mothers. Fathers suggested creating opportunities to access support by building on existing family relationships and creating peer support groups.

Limitations

The main limitation of this project was that only a relatively small number of men took part. The participants also lacked diversity as they were mostly White British. This meant that the sample may not have been large enough for the statistical tests to accurately detect smaller effects. It also means that the barriers identified in this project may not apply to fathers from different cultural backgrounds. Therefore, future research should replicate the project with larger, more diverse samples.

Conclusions

This research identified that fathers with postnatal depression experience many of the same barriers to accessing support as men with depression occurring at another stage of their life. Fathers also described several additional barriers to help-seeking including a lack of awareness of male postnatal depression and exclusion from services. More research with larger samples is required to better understand the barriers fathers with postnatal depression face to accessing help.

Connecting Narrative

As somebody who did not have a strong research background coming in to the doctorate, I felt apprehensive about completing three doctoral level research projects. In my clinical roles I often felt frustrated that the evidence base and guidelines did not fit with the clinical reality for the patients I was working with, many of whom experienced comorbidities and complex social circumstances. This motivated me to develop my qualitative research skills and design projects which allowed patients' to share their experience in their own words, to give them more involvement in developing the evidence base.

Theoretically Driven Research Paper

My first assistant psychologist role was in a perinatal mental health team which sparked my interest in the field. At the time, NHS perinatal mental health services were relatively new which made it an exciting and rapidly developing field to work in. Despite this progress, I was struck by the lack of support offered to fathers. In my work with postnatal depression, I realised that many of the factors I was speaking to mothers about, such as lack of sleep and changing relationships, also applied to fathers. I also saw this in my personal life, with men sometimes struggling more than mothers to adjust to fatherhood, particularly those that have to return to work quickly after their child was born. Therefore, I was motivated to add to the evidence base by understanding fathers' experience.

When Dr Rebecca Knowles-Bevis and I started developing the project, we were surprised by the response of local NHS perinatal mental health services, all of whom said they could not help with recruitment as they did not have any contact with fathers. This was compounded by the covid-19 pandemic as fathers were not allowed to attend routine antenatal appointments and some could not even attend the birth of their child. I could only imagine the negative impact that this experience of exclusion had on fathers' mental health.

This led us to instead look online for third party organisations where we found Dr Andy Mayers and Mark Williams, who had personal and academic experience of paternal postnatal depression. Throughout the recruitment journey I feel fortunate to have spoken with campaigners and charities who are doing great work to raise awareness and offer support to fathers. However, I was also struck by the number of people in my personal life who took an interest in the project, many of whom had never previously heard of men experiencing postnatal depression. I feel proud that the project has raised awareness of paternal postnatal depression, and I hope the results can be used to encourage commissioners to extend perinatal mental health support to fathers.

Critical Review of the Literature

I found it challenging to find a research topic for my literature review. I initially planned to review the evidence for groups to prevent postnatal depression such as CBT or mindfulness groups, however I found several similar reviews had recently been published. In the process of looking for a research question I began to notice a curious pattern - all of the quantitative papers reported that groups did not successfully

prevent postnatal depression, yet the number of groups attended by parents-to-be each year highlighted their popularity. I became interested in what benefits antenatal groups might be providing. This led me to review the qualitative literature to hear from parents-to-be in their own words.

I have always been interested in the common factors theory that the most effective elements of therapy are common across therapies, rather than the specific skills or techniques that differentiate therapies. Therefore, as I was coding the results, I found it really interesting that, regardless of the type of antenatal group attended, parents were consistent about the aspects that they found most helpful. I think this raises interesting questions about how we evaluate interventions, and whether more focus should be given in the design and evaluation of groups to getting common factors right, as opposed to using measures which are more modality specific.

Service Improvement Project

This was the project which I found the most rewarding to complete. When Dr Joanna Holiday approached me about completing the project, I had not heard of the 'SEED' concept in eating disorders, nor was I aware of the controversy surrounding it. I found it fascinating that, despite services worldwide recognising that approximately one fifth of eating disorder patients experience longstanding, chronic eating disorders, there was no consensus on how to refer to this group, let alone how to support or work with them. It was an honour to hear the stories of all of the patients who took part in interviews, and I am particularly grateful to the patients who supported with the

design and dissemination of the project. I hope to use my qualitative skills to continue my involvement in similar service-development work throughout my future career.

The response to the results was particularly interesting to me. As I fed-back the results to NHS teams and those in attendance at the London Eating Disorders Conference, it became clear that there was a real split in the field in relation to longstanding eating disorders. I found that many clinicians who worked closely with this group welcomed the results and the recommendations and spoke highly of the project. On the other hand, others who often had a more academic background rejected the idea of moving to a model similar to addiction services, instead they drew on research evidence that recovery is possible, regardless of length of illness. Being emersed in this debate has led me to reflect on my own position on the topic. I do believe that recovery is possible regardless of length of illness, and that services should always give a hopeful message. However, I also believe strongly in patient choice, and feel eating disorder services could learn a lot from addiction services in how they manage patients making choices that professionals may view as unwise, yet continue to support them to build the best quality of life possible.

Acknowledgements

I would firstly like to acknowledge all of the participants who took part in my research, I hope that this thesis will go some way to having your experiences heard and valued.

I would also like to acknowledge all of my research supervisors for their support, advice and encouragement throughout the process. I would particularly like to thank Dr Joanna Adams who has been a listening ear throughout the whole of my doctorate experience. Jo, your support, patience and kindness has been invaluable in keeping me going, even when things felt overwhelming.

I would like to say a huge thank you to my wonderful housemates, Rebecca Eaton, Hannah Goodison and Cathy Ghalib – I genuinely could not have done it without each of you and will be forever grateful that we got to experience the doctorate together.

I would also like to thank all of my friends and family for putting up with me over the past three years. To my mum, dad and sister, I love you all very much, thank you for always encouraging and supporting me to follow my dreams.

Finally, to Matt, I will forever be grateful to you for you reorganising our lives around the doctorate. Hopefully this thesis marks the end of Sunday night drives up the M40! I cannot thank you enough for always loving me, making me laugh, and being there when I needed you.

Appendices

1.A – Description of Yalom & Leszcz's (2005) Eleven Therapeutic Factors

Therapeutic Factor	**Description**
Instillation of Hope	Gaining hope from seeing others recover and hearing stories of recovery. This creates higher expectations which lead to improved outcomes.
Universality	Group members sharing stories with one another normalises their experiences. There are often common themes and links between group members' experiences.
Imparting Information	Includes didactic information receiving from facilitators. Also includes advice given from one group member to another.
Altruism	Group members benefit from helping other members. This provides a sense of achievement and purpose and can interrupt rumination and negative self-focus.
Corrective Recapitulation of the Primary Family Group	Many entering therapy have had some negative experiences in the first group they belonged to – their family. Belonging to a supportive group can evoke similar responses to being with family and therefore allows group members to spot, and correct any unhelpful patterns of behaviour or interaction.
Development of Socialisation Techniques	Includes direct learning of socialisation skills by teaching or role play. Also includes informal learning by observing how other group members respond to their behaviour and practicing new skills.
Imitative Behaviours	Group members learn by observing the facilitator and other group members and can model themselves on their behaviour.
Interpersonal Learning	Based on the belief that psychological distress often occurs from interpersonal difficulties. The group can act as a social microcosm that provides as opportunity for group members to reflect on their patterns of relating to others. It offers a safe space to practice interpersonal skills and build new relationships.
Group Cohesiveness	In individual therapy the relationship between the therapist and client is the best predictor of outcomes. Similarly in group therapy, the relationship between group members and facilitators predicts outcomes. A cohesive group creates safety to disclose whilst feeling accepted and valued.
Catharsis	Group members benefit from telling their stories to others and expressing their feelings. This teaches skills in how to express emotions.
Existential Factors	Described as confronting the human condition. Includes group members recognising life can be unfair, that they cannot avoid suffering, that death in inevitable, and that they must take responsibility for their own life.

1.B – Search Terms

(group* OR class*)

AND (experience* OR opinion* OR view* OR preference*)

AND (antenatal OR pregn* OR perinatal)

AND (qualitative OR interview* OR “focus group”*)

NOT (HIV OR vaccin* OR opioid OR diabetes OR smoki* OR caesarean OR cesarean OR lupus OR sex* OR ebola OR contracept* OR diet OR weigh*)

1.C – Standards for Reporting Qualitative Research (SRQR)

Taken from O'Brien et al., 2014:

Title and Abstract	
Title	Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach or data collection methods is recommended
Abstract	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions
Introduction	
Problem formulation	Description and significance of the problem/ phenomenon studied; review of relevant theory and empirical work; problem statement
Purpose or research question	Purpose of the study and specific objectives or questions
Methods	
Qualitative approach and research paradigm	Qualitative approach and guiding theory if appropriate identifying the research paradigm is also recommended; rationale
Researcher characteristics and reflexivity	Researcher's characteristics that may influence the research including personal attributes, qualifications/ experience, relationship with participants, assumptions and/or presumptions; potential or actual interaction between researcher's characteristics and the research questions, approach, methods, results and/or transferability
Context	Setting/ site and salient contextual factors; rationale
Sampling strategy	How and why research participants, documents or events were selected; criteria for deciding when no further sampling was necessary; rationale
Ethical issues pertaining to human subjects	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues
Data collection methods	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation or sources/ methods, and modification of procedures in response to evolving study findings; rationale
Data collection instruments and technologies	Description of instruments and devices used for data collection, if/ how the instruments changed over the course of the study
Units of study	Number and relevant characteristics of participants, documents, or events included in the study; level of participation
Data processing	Methods for processing data prior to and during analysis, including transcription, data entry, data management and

	security; verification of data integrity, data coding and anonymisation. De-identification of excerpts
Data analysis	Process by which inferences, themes etc. were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale
Techniques to enhance trustworthiness	Techniques to enhance trustworthiness and credibility of data analysis; rationale
Results/ Findings	
Synthesis and interpretation	Main findings; might include development of a theory or model or integration with prior research or theory
Links to empirical data	Evidence to substantiate analytic findings
Discussion	
Integration with prior work, implications, transferability and contributions to the field	Short summary of main findings, explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship, discussion of scope of application/ generalisability; identification of unique contributions to scholarship in a discipline or field
Limitations	Trustworthiness and limitations of findings
Other	
Conflicts of interest	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed
Funding	Sources of funding and other support; role of funders in data collection, interpretation and reporting

1.D – Quality Assessment Ratings

	Title and Abstract		Introduction		Methods						
Details of Publication (year, author)	**Title**	**Abstract**	**Problem Formulation**	**Purpose**	**Qualitative Approach**	**Reflexivity**	**Context**	**Sampling**	**Ethics**	**Data Collection methods**	**Data Collection Instruments**
Aguila-Gonzalez, Henao & Ahlers-Schmidt, 2022	1	2	1	2	1	0	1	1	1	2	1
Alves et al. 2019	0	2	1	2	0	0	2	1	2	1	0
Andersson et al. 2012	0	2	2	2	0	1	1	1	1	0	0
Beattie et al. 2017	0	2	2	2	0	0	1	2	1	1	0
Breustedt & Puckering, 2013	2	1	2	0	2	0	0	2	1	2	2
Camlibel & Mete, 2020	2	2	2	2	1	1	2	1	1	2	2
Canuso 2003	1	1	2	2	0	0	1	1	1	2	1

Carolan et al., 2012	2	2	2	2	0	0	2	1	1	1	2
Carolan et al., 2012b	1	2	2	2	0	0	1	1	1	1	1
De Matos et al., 2017	0	2	1	2	1	0	1	1	1	1	0
Demecs, Fenwick & Gamble, 2011	1	2	2	2	1	0	0	1	1	1	1
Dunn et al., 2012	1	1	0	2	0	0	1	1	1	1	2
Fisher et al., 2012	2	2	2	0	1	0	1	1	1	2	0
Gao et al., 2012	1	1	2	2	0	0	1	2	1	1	2
Goodman et l., 2014	1	1	2	2	0	0	1	2	1	1	2
Herman, Rogers, Ehrenthal, 2012	2	2	2	2	0	0	0	0	1	1	2
Kuliukas et al., 2019	1	2	2	2	1	0	1	2	1	1	2
Le et al., 2013	1	1	2	2	0	1	1	2	1	1	2
Little et al., 2013	1	2	2	2	0	0	2	1	1	1	2

McNeil et al., 2012	2	2	2	2	2	2	1	2	1	1	2
Nash, 2018	2	2	2	2	0	0	1	2	1	1	2
Nisbeth-Jensen & Fage-Butler, 2016	1	2	2	2	1	2	2	2	1	2	2
Novick et al., 2011	1	1	2	2	1	2	2	1	1	2	1
Queiroz et al., 2016	1	2	2	2	1	0	1	2	1	2	2
Riggs et al., 2017	2	2	2	2	0	0	0	1	1	2	1
Risisky et al., 2013	1	1	2	2	0	0	2	2	1	2	2
Rueder-Neves et al., 2013	1	2	2	2	2	0	1	2	1	2	1
Smith, 1999	1	0	0	0	0	0	1	0	0	0	0
Sultana et al., 2019	1	2	2	2	1	0	2	2	1	2	1

	Methods				Results		Discussion		Other		Score out of 42
Details of Publication (year, author)	Units of Study	Data Processing	Data Analysis	Trustworthiness	Synthesis	Links to empirical data	Integration with prior work	Limitations	Conflict of Interest	Funding	
Aguila-Gonzalez, Henao & Ahlers-Schmidt, 2022	2	1	1	1	2	2	2	2	0	1	27
Alves et al. 2019	2	0	1	0	2	2	1	2	0	0	21
Andersson et al. 2012	2	1	2	1	2	2	2	2	0	1	27
Beattie et al. 2017	2	1	2	1	2	2	2	2	2	1	30
Breustedt & Puckering, 2013	2	1	2	2	2	2	1	2	0	0	28
Camlibel & Mete, 2020	2	0	1	2	2	2	1	2	0	0	30
Canuso 2003	1	1	1	1	2	2	1	0	0	0	22
Carolan et al., 2012	2	1	1	1	2	2	2	2	0	0	27
Carolan et al., 2012b	2	1	1	1	2	2	2	2	0	0	26

De Matos et al., 2017	2	0	1	0	2	2	2	0	0	0	20
Demecs, Fenwick & Gamble, 2011	2	0	2	2	2	2	2	2	0	0	27
Dunn et al., 2012	2	1	1	0	2	2	2	1	2	0	23
Fisher et al., 2012	2	1	1	1	2	2	2	2	2	0	27
Gao et al., 2012	2	1	1	2	2	2	2	2	0	0	27
Goodman et l., 2014	2	0	1	0	2	2	1	2	0	1	24
Herman, Rogers, Ehrenthal, 2012	2	1	1	1	2	2	2	2	2	0	27
Kuliukas et al., 2019	0	1	2	0	2	2	2	2	2	1	29
Le et al., 2013	2	1	1	1	2	2	2	2	2	1	30
Little et al., 2013	2	1	1	0	1	2	2	2	2	1	28
McNeil et al., 2012	2	1	1	2	2	2	2	2	2	2	37
Nash, 2018	2	1	1	0	2	2	2	2	2	1	30
Nisbeth-Jensen &	2	1	2	2	2	2	2	2	2	2	38

Fage-Butler, 2016											
Novick et al., 2011	2	1	2	2	2	2	2	2	2	1	34
Queiroz et al., 2016	2	1	0	0	2	2	1	1	0	0	25
Riggs et al., 2017	2	1	1	1	2	2	2	2	0	1	27
Risisky et al., 2013	2	1	1	1	2	2	2	2	0	1	29
Rueder-Neves et al., 2013	0	1	1	0	2	2	2	1	0	0	25
Smith, 1999	0	0	0	0	2	2	2	0	0	0	8
Sultana et al., 2019	2	1	2	1	2	2	2	0	2	2	32

1.E – Full Data Extraction Table

Full Data extraction table. Blank spaces indicate the required information was not available in the full text or on request from the first author.

Details of publication (year, author)	Journal	Country	Nature of participants (mother, father, professional)	Mean age of participants (parents only)	Age range of participants	Ethnicity of participants	Mean number of children	Total sample size
Aguila-Gonzalez, Henao & Ahlers-Schmidt, 2022	Kansas Journal of Medicine	USA	Mothers (partners in class but not study)	34 years		Hispanic N=12	2.6	12
Alves et al. 2019	Revista Gaucha de Enfermagem	Brazil	Mothers		19-31 years		0-6	24
Andersson et al. 2012	Midwifery	Sweden	Mothers and fathers					28
Beattie et al. 2017	Midwifery	Australia	Mothers	28.9 years MIPP 28.5 years PSP		Australian N=33 Other N=15		48 (24 per condition), only 20 did interview)
Breustedt & Puckering, 2013	British Journal of Midwifery	Scotland	Mothers	27.75 years	19-38 years	White Scottish N=3 Black African N=1	1.75	4
Camlibel & Mete, 2020	International Journal of Caring Sciences	Turkey	Mothers (partners in class but not study)		27-37 years		None	13

Details of publication (year, author)	Journal	Country	Nature of participants (mother, father, professional)	Mean age of participants (parents only)	Age range of participants	Ethnicity of participants	Mean number of children	Total sample size
Canuso 2003	Journal of community health nursing	USA	Mothers			African American N=4 White American N=1 Latina N=1 Native American N=1	All but one had other children	Expecting and Connecting (modelled on centering pregnancy)
Carolan et al., 2012	Midwifery	Ireland	Mothers	32.67 years	29-35 years			6
Carolan et al., 2012b	Midwifery	Ireland	Mothers	32.67 years	29-35 years			6
De Matos et al., 2017	Cuidado é fundamental	Brazil	Mothers	24.5 years	16-32 years		1.9	10
Demecs, Fenwick & Gamble, 2011	Women and Birth	Australia	Mothers		26-38 years	Australian N=7		7
Dunn et al., 2012	Archives Women's Mental Health	Australia	Mothers	35.33 years mindfulness 27.67 years control			5 mothers had another child	10 mindfulness 9 control

Details of publication (year, author)	Journal	Country	Nature of participants (mother, father, professional)	Mean age of participants (parents only)	Age range of participants	Ethnicity of participants	Mean number of children	Total sample size
Fisher et al., 2012	BMC Pregnancy and Childbirth	Australia	Mothers & birth partners	30.06 years	21-37 years		0	19 (12 mothers, 7 partners)
Gao et al., 2012	Nursing and Health Sciences	China	Mothers	28.8 years	25-34 years		0	20
Goodman et l., 2014	Archives Women's Mental Health	USA	Mothers	33.5 years	27-45 years	White N=18 Asian N=3 Hispanic N=2 Other = 1	18 = 0 6 = 1	24
Herman, Rogers, Ehrenthal, 2012	The American Journal of Maternal Child Nursing	USA	Mothers		18-35 years	Black N=23 White N=7 Hispanic N=4		33
Kuliukas et al., 2019	BMC Pregnancy and Childbirth	Australia	Fathers (facilitators too but analysed separately)	33.9 years		Australian 661% UK 12.5%		678
Le et al., 2013	Qualitative Health Research	USA	Mothers	27.82 years		El Salvador 53.8% 33.3% Central and South America unknown 12.9%	2	39 (24 MB group, 15 TAU) (217 in larger RCT)

Details of publication (year, author)	Journal	Country	Nature of participants (mother, father, professional)	Mean age of participants (parents only)	Age range of participants	Ethnicity of participants	Mean number of children	Total sample size
Little et al., 2013	Journal of the American Board of Family Medicine : JABFM	USA	Mothers	34 years	25-41 years	Japanese	8 = no other 24 = previous children 10 = no data	42 (20 were interviewed)
Mcneil et al., 2012	BMC Pregnancy and Childbirth	Canada	Mothers		27-39 years	Caucasian N=8 Non-Caucasian N=4	10 = no other 2 = existing children	12 (77 in wider study)
Nash, 2018	The Australian Journal of Rural Health	Tasmania	Fathers	32.8 years	24-43 years	All Anglo-Australian	All first time fathers	25
Nisbeth-Jensen & Fage-Butler, 2016	Patient Education and Counselling	Denmark	Mothers		25-36 years		12 = no other 4 = 1 other	16
Novick et al., 2011	Qualitative Health Research	USA	Mothers and partners	21.6 years	17-31 years	African American N=18 Hispanic N=3		21 interviewed (also 18 participant observation but analysed separately

Details of publication (year, author)	Journal	Country	Nature of participants (mother, father, professional)	Mean age of participants (parents only)	Age range of participants	Ethnicity of participants	Mean number of children	Total sample size
Oliverira et al., 2016	Revista Gaucha de Enfermagem	Brazil	Mothers		14-19 years		10 = no other 6 = previous children	16
Riggs et al., 2017	Birth	Australia	Mothers		19--40 years	Karen refugee women from Burma living in Australia	9 = no other 10 = previous children	19
Risisky et al., 2013	The Journal of Perinatal Education	USA	Mothers, partners, grandmother		20-29 years	Caucasian N=4 African American N=3 Hispanic N=2 Asian N=1	8 = no other 2 = other	13 (10 women, 2 partners, 1 grandmother)
Rueder-Neves et al., 2013	Online Brazilian Journal of Nursing	Brazil	Mothers					5
Smith, 1999	MIDIRS Midwifery Digest	UK	Fathers					18
Sultana et al., 2019	Plos ONE	Banglades h	Mothers		<20 N=2 20-24 N=13 >24 N=6		8 = no other 13 = other	21 interviewed

Details of publication (year, author)	Number per group	Number of sessions in group	Frequency / duration of group	Stage of pregnancy	Study design	Group intervention (CBT, mindfulness etc.)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method
Aguila-Gonzalez, Henao & Ahlers-Schmidt, 2022		6	Weekly, 2 hours	Less than 32 weeks		Spanish Baby Talk, educational	Surveys, interviews and focus group	Immediately after group	Thematic analysis
Alves et al. 2019	6			26-39 weeks		Educational	Focus group		Thematic content analysis
Andersson et al. 2012						Based on Centering Pregnancy, aim for discussion and empowerment and physical checks	Interviews & focus groups		Content analysis
Beattie et al. 2017		8	Weekly	24-28 weeks	RCT	Mindfulness in Pregnancy Program (MIPP) compared to control pregnancy support program (PSP)	Questionnaire, field notes, interview	6 weeks after group ended	Thematic analysis
Breustedt & Puckering, 2013		6	Weekly, 2 hours			Mellow Bumps, attachment and CBT strategies to reduce stress and provide education	Interview	Within 18 months of group ending	IPA

Details of publication (year, author)	Number per group	Number of sessions in group	Frequency / duration of group	Stage of pregnancy	Study design	Group intervention (CBT, mindfulness etc.)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method
Camlibel & Mete, 2020		4	Weekly, 2 hours	28-27 weeks	Phenomenological	Education Class for Awareness of Labour (ECAL) Psychoeducation & hypnobirthing	Interview		Content analysis
Canuso 2003	5	1	One off			Pregnancy Care Campaign luncheon Support, education	Interview	Within 2 months	Ely et al, 1991 method
Carolan et al., 2012		4	Weekly, 45 minutes	32-35 weeks		Lullaby intervention, singing before traditional antenatal classes	Interview	3 months postpartum	Thematic content analysis
Carolan et al., 2012b		4	Weekly, 45 minutes	32-35 weeks		Lullaby intervention, singing before traditional antenatal classes	Interview	4 months postpartum	Thematic content analysis
De Matos et al., 2017						Educational	Interview		Thematic analysis
Demecs, Fenwick & Gamble, 2011		6	2 hours	20-30 weeks		Creative Arts in Pregnancy (CAP). Singing, dancing, weaving, storytelling	Diaries, interviews, field notes, questionnaire	1 month of last session	Thematic analysis

Details of publication (year, author)	Number per group	Number of sessions in group	Frequency / duration of group	Stage of pregnancy	Study design	Group intervention (CBT, mindfulness etc.)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method
Dunn et al., 2012	11	8	weekly	12-28 weeks mindfulness 17-29 control	Quasi experiment	Mindfulness based cognitive therapy (MBCT)	Interview		
Fisher et al., 2012	18 couples	8	Weekly, 2.5 hours	18-28 weeks		Mindfulness based childbirth education. MBSR and education	Focus group	4 months after program	Thematic analysis
Gao et al., 2012		2 (+2 regular antenatal class)	90 min (+90 min regular antenatal class)	>28 weeks	Quasi experiment	IPT group + control educational classes	Interview		Content analysis
Goodman et l., 2014	6 to 12	8	Weekly, 2 hours	6-27 weeks		CALM pregnancy. Mindfulness, CBT, psychoeducation	Interview		Content analysis
Herman, Rogers, Ehrenthal, 2012						Centering Pregnancy	Focus group		Iterative thematic analysis

Details of publication (year, author)	Number per group	Number of sessions in group	Frequency / duration of group	Stage of pregnancy	Study design	Group intervention (CBT, mindfulness etc.)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method
Kuliukas et al., 2019	4 to 6	1	50 minutes	Partner 28-36 weeks	Part of larger mixed methods RCT	Father focused antenatal breastfeeding class (FFAB) run by peer facilitator based on social cognitive theory	Open ended questions on evaluation form	Immediately after group	Content analysis
Le et al., 2013		11 8 sessions and 3 post-natal boosters			RCT	Mothers and babies course (MB) based on CBT to prevent postnatal depression compared to usual care	Interviews	18 months postpartum	Inductive and comparative analysis
Little et al., 2013	8 to 12	5	Monthly for 2 hours		Mixed methods	Culturally adapted centering pregnancy for Japanese families in USA with limited English	Interviews	6 - 10 weeks after birth	Team approach to open coding
McNeil et al., 2012	8 to 12	10	2 hours	16-20 weeks	Phenomenological part of larger study	Centering Pregnancy	Interviews	8-14 weeks postpartum	Team approach to open coding
Nash, 2018		1	One off	>20 weeks		Parenting group for fathers, discuss transition to fatherhood and supporting their partner and government health educational group	Interviews	8-12 weeks after partner's birth	Thematic analysis

Details of publication (year, author)	Number per group	Number of sessions in group	Frequency / duration of group	Stage of pregnancy	Study design	Group intervention (CBT, mindfulness etc.)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method
Nisbeth-Jensen & Fage-Butler, 2016		2	3 weeks apart	35 and 38 weeks		Antenatal group consultations	Interviews and observations of groups	After group (38 weeks pregnancy +)	Content analysis
Novick et al., 2011	8 to 12	8 - 10 (mean attended 5.4)	1.5-2 hours		Naturalistic study	Centering Pregnancy	Interviews (also observation but included staff)	2 during pregnancy and 1 postnatal	Inductive qualitative analysis
Oliverira et al., 2016		6	Monthly	2nd to 3rd quarter of pregnancy		Pregnant teenagers education group	Focus group		Coded and grouped into categories
Riggs et al., 2017			Fortnightly			Healthy Happy Beginnings (education and peer support)	Focus group	Postnatal	Thematic analysis
Risisky et al., 2013	4 to 9		2 hours		Part of larger program evaluation	Centering Pregnancy	Focus group	Given birth 3-11 months ago	Coded and grouped into categories

Details of publication (year, author)	Number per group	Number of sessions in group	Frequency / duration of group	Stage of pregnancy	Study design	Group intervention (CBT, mindfulness etc.)	Data collection method (interviews, focus groups etc.)	Time since group	Qualitative analysis method
Rueder-Neves et al., 2013			Every 15 days then weekly in third quarter	24 weeks	Descriptive study	Group educational sessions at childbirth house	2 interviews and observations of groups	One at end of pregnancy, one postpartum	Thematic content analysis
Smith, 1999						NHS / NCT antenatal classes	Interviews		
Sultana et al., 2019	6 to 10	4 to 6	30-40 minutes		RCT	Peer support and education group vs individual TAU	Interviews	Within 20 months	Thematic analysis

1.F – Illustrative Quotes

Theme	Sub-theme	Illustrative Quotes
Self-efficacy	Learning together	"It gave me a lot of information. … Ways to cope and who I can talk to" (Beattie et al., 2017) "My spouse used to think labor was something very bad and extremely painful. After ECAL, he realized that it was not so bad, and he was relaxed" (Camlibel 2020) "After I gave birth I was told you're going to get blue and sad and it's perfectly normal, so I was expecting that" (Carolan et al., 2012) "The three first-time mothers were particularly interested in learning from other women." (Demecs et l., 2011) "In a sense having that calmness, [was due to] just that fact that you had that bank of knowledge....Whereas if you didn't have the bank of knowledge.. .then it would have, maybe been worse" (Fisher et al., 2012) "I needed to see how other people raise kids." (Herman et al., 2012) "There can be things you didn't know you didn't know [. . .] In that way, you got more knowledge than if you were there alone" (Nisbeth-Jensen & Fage-Butler, 2016)
	Confidence	"Participating in the group made me feel more confident" (Alves et al., 2019) "I was freaking out. … this is my first baby, I don't know what to do in term of dealing with stress and look after the baby but now I just - like, bring it on. I'm so ready." (Beattle et al., 2017) "It builds your confidence a bit, oh I can try this, and it meant it calmed you a little bit." (Carolan et al., 2012b) "Notably, women reported feeling empowered through learning about pregnancy and childbirth in the group setting and recounted feeling prepared." (Riggs et al., 2017) "The classes made me see how I could be useful, and truly useful" (Smith, 1999)
	Transition	"Also, the women were now able to perceive pregnancy from a different perspective, feeling closer to their babies." (Alves et al., 2019) "'Without Mellow Bumps I wouldn't have had the start of that process where I thought "I do love my baby and I'm excited to see her and hold her." Before that I didn't feel it was my baby." (Breustedt & Puckering, 2013) "The program made me aware that it would pose great stress on me to expect everything to be perfect about motherhood." (Gao et al., 2012) "It was good to get that bit of man-talk out in the open... Just talking about how we felt about being fathers." (Nash, 2018)

		"men who, despite wanting to be involved, felt detached from the pregnancy, found classes a way to focus on what was happening" (Smith, 1999)
	Helping each other	"It became more realistic when the woman told us about her experiences compared to when the midwife explained it" (Andersson et al., 2012) "reinforced their identities as mothers and gave them a sense that they have worthwhile knowledge and experience to offer to others." (Canuso, 2003) "a ''rewarding'' and ''empowering'' experience from both the perspective of hearing a story and telling a story." (Demecs et al., 2011) "It was great being around women who were in a similar situation to me and I liked being able to talk about my own experiences as well as get insight from them about certain situations and ideas." (Goodman et al., 2014) "we were encouraged to help each other, and that helped us" (Herman et al., 2012) "Well, I like it a lot because we exchange information with women who are already pregnant, women who have never had children, and women who are being assisted, so for me it is very good to participate and to be able to develop knowledge" (Rueder-Neves et al., 2013)
Social support	Normalising	"Both men and women said that being part of a group gave them strength and self-confidence by making them feel normal." (Andersson et al., 2012) "I felt like I could go and say, I don't enjoy my baby moving, I find it really strange, trying to break down the barriers." (Breustedt & Puckering, 2013) "I went to the GP and they were talking about antidepressants and all I needed was to talk to other people who were in the same situation." (Breustedt & Puckering, 2013) "It was good to meet other people and know you weren't the only person. Doing group discussions, it was good to know you were in a place where you felt comfortable to talk about it." (Dunn et al., 2012) "When I listened to my friends' problems, I understood that I wasn't the only one who has problems." (Le et al., 2013)
	Group cohesiveness	"In the beginning, being new to this group, I was a bit shy because I didn't know anyone. But as the program rolled out and the more time we spent together, I was able to open up, and share with the group … I was more comfortable." (Riggs et al., 2017) "One woman compared this to the anxiety experienced when starting a new school or a job. But these feelings changed over time; as others participated in the group, many women became more comfortable and trusting, and eventually they felt more willing to participate themselves." (Novick et al., 2011)

		"We all got along…it wasn't like I don't know her…we all wanted to know how everyone was. I don't mingle with people, so this group was important for me." (Herman et al., 2012) "So, it was really great to see... as we went along and just the confidence I think has grown in the group and by the end of it [MBCE] everyone was like "yes, you can do this". So, it was very transitional I think from the outset." (Fisher et al., 2012)
	Connection	"Over time, mothers felt comfortable in the group as relationships grew up among peers, discussion topics evolved, and they learnt by discussing with each other." (Sultana et al., 2019) "I made many friends there that I believe I will retain for my whole life." (Rueder-Neves et al., 2013) "I really like her [facilitator]. She's just so nice and stuff, and like I was just looking forward to just going and seeing her, because she's just polite and she's just—I don't know. She always puts a smile on my face." (Novick et al., 2011) "I tell everyone I've never had this much support and it really helped... it's the first time I didn't get postpartum depression and I think having all this support during my pregnancy is what kind of eliminated that" (McNeil et al., 2012) "We exchanged E-mails at the reunion, and I am still in frequent contact with one of the group members." (Little et al., 2013) "sharing stories, conversation and fostering relationships with other pregnant women were their primary reasons for remaining in class" (Aguila-Gonzalez, A. I., Henao, M. M., & Ahlers-Schmidt, C. R. (2022) "My relationship with my mother-in-law was not good, and I did not talk to her at all before the program. However, after the classes, I realized that I could improve relationship and tried to communicate with her, and our relationship was improved." (Gao et al., 2012) "I know my husband supports me both psychologically and physically. I've had more confidence in him in all aspects after ECAL" (Camlibel 2020)
Personal growth	Personal growth	"I'm more comfortable in myself… I'm a lot more accepting and looking forward to meeting him, and a lot less fearful" (Beattie et al., 2017) "'I went to the GP and they were talking about antidepressants and all I needed was to talk to other people who were in the same situation. If I hadn't had Mellow Bumps I would probably have gone on the tablets, but I didn't really want to" (Breustedt & Puckering, 2013) "it was good to be out of the house. I get irritable in the house. Nice to be without my kids and relax. I'm a good mom but I get stressed." (Canuso, 2003)

		"when you're pregnant, in looking after the baby physically, making sure that you eat properly, resting well and all that side of it . . . this course just reminded me to nurture the emotional side of pregnancy, put back a bit more balance there." (Demecs et al., 2011) "I learned about how I personally cope with stress and stressful situations, which in turn will hopefully help inform how I confront them moving forward" (Goodman et al., 2014)
Person-centred Care	Improving care	"Women in both programs recommended that partners be included in at least some sessions to enable partners to directly benefit." (Beattie et al., 2017) "Usually at the doctor's office you have to wait... like an hour... so this is only two hours and you're done... it's not so much more time that I'm spending, but I'm gaining more than just a doctor's visit" (McNeil et al., 2012) "We were not just a number…a pregnant woman…or a problem." (Herman et al., 2012) "Good to finally have a dad relevant session" (Kuliukas et al., 2019) "At the same time, the diversity of needs, experiences and ideas in the group resulted in women gaining more in one place at one time. As the group had its needs met, each woman also had her individual needs met." (Kuliukas et al., 2019) "Because somebody is actually like sitting there taking their time out with you, not worrying about, 'Oh, I've got this patient and that other patient." (Novick et al., 2011)
	Safe space	"My son has come, my sister has, my husband has and all of them really like it for the opportunity to obtain knowledge and for the welcome we get here." (Rueder-Neves et al., 2013) "I think she was really respectful also. . . . Like if you needed something extra she was there, you know, she [facilitator] was just always concerned with how you felt, like would always make sure that you were comfortable and you had everything you wanted" (Risisky et al., 2013) "I think it's good if they can come, but when they were present, there were things you did not want to ask in front of others. I did not want to raise questions in front of them" (Andersson et al., 2012) "I was on the floor listening, getting my belly listened to. My pants are open, of course, and then some guy walks in. And it just threw me off. I felt uncomfortable. Because my pants were open, and my belly was exposed." (Novick et al., 2011) "Leaders were also perceived as successful in balancing the needs of individual women and the group during discussions. This created a sense of inclusiveness," (Novick et al., 2011) "As time went on, women became more comfortable in asking their questions too because "you get people who aren't afraid to ask questions, so it makes you feel more comfortable," (McNeil et al., 2012) "Women felt they had a safe place to talk about their struggles as mothers and immigrant" (Le et al., 2013)

		“I found that the group setting was helpful and comforting. I felt very supported and the other women were non-judgmental.” (Goodman et al., 2014) “It made me feel a lot safer, made me feel more loved and cared about.” (Canuso, 2003)

1.G – Instructions for Authors: Midwifery

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2. Two authors: both authors' names and the year of publication;
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> Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T., 2015. Mortality data for Japanese oak wilt disease and surrounding forest compositions. Mendeley Data, v1. Http://dx.doi.org/10.17632/xwj98nb39r.1.

References to a book:

> Field, P. A., Morse, J. M., 1985. Nursing research: the application of qualitative approaches. Croom Helm, London.

Reference to a chapter in an edited book:

> Mettam, G.R., Adams, L.B., 1999. How to prepare an electronic version of your article. In: Jones, B.S., Smith , R.Z. (Eds.), Introduction to the Electronic Age. E-Publishing Inc., New York. Pp. 281-304.

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2.A – Approval Email from Research and Development

From: Rhodes Katie (RNU) Oxford Health <Katie.Rhodes@oxfordhealth.nhs.uk>
Sent: Friday, July 24, 2020 3:23:14 PM
To: Reay Megan (RNU) Oxford Health <Megan.Reay@oxfordhealth.nhs.uk>
Subject: FW: Service improvement project approval

HI Megan,

Your audit proposal has now been approved.

Please see attached copy of an Audit Report Template in which will need to be completed and returned once the project is complete.

Kind Regards,

Katie Rhodes
Senior Team Administrator
Oxford Health NHS Foundation Trust
The Whiteleaf Centre
Bierton Road
Aylesbury
HP20 1EG

2.B - Information Sheet and Consent Form

Project Title: Creating a Pathway for Longstanding, Complex Eating disorders

Aims of the Project

Currently there is no agreed upon definition of when an eating disorder becomes longstanding or difficult to treat. There is not enough research that specifically focuses on the needs of individuals with longstanding eating disorders and how best to support them. The local service is keen to capture the experience of those who live with, or work with, longstanding eating disorders in order to improve the support and treatment that is currently offered. Therefore, this project has been designed to consider how to develop an improved care pathway for individuals experiencing longstanding eating disorders across Oxfordshire and Buckinghamshire. The project was designed in collaboration with clinicians and patients who consider themselves or live with, or work with, longstanding eating disorders. The results of the project will be used to ensure that services are better designed to support people living with longstanding eating disorders.

Project Methodology

The project will be completed in three stages:

1. Review the existing scientific literature about longstanding eating disorders to understand existing ideas about how to define patients with longstanding eating disorders as well as gather research evidence regarding the best type of care or treatment to offer.

2. Conduct interviews and focus groups with patients and staff who could be seen as living with, or working with, longstanding eating disorders across Oxfordshire and Buckinghamshire. Responses from interviews and focus groups will be combined with the results from the first stage to create a definition of a longstanding eating disorder. The interviews will also be used to develop recommendations to improve the support and treatment offered to this group of individuals.
3. Once longstanding eating disorders have been defined, the final stage will involve using numerical data from online patient records to understand how many patients are living with longstanding eating disorders in Oxfordshire and Buckinghamshire. This data will ensure that the new pathway is able to meet the needs of patients.

Taking Part in the Project – Patients

We are looking to recruit patients who could be considered as living with a longstanding, complex eating disorder to take part in one-to-one interviews. These interviews will be conducted using an online video tool such as Zoom or Microsoft Teams. If you would prefer to meet in person or over the phone, we can try to arrange this too. Interviews will last approximately 30-45 minutes. Patients will have the opportunity to share their views on defining longstanding eating disorders and shape the future pathway by sharing their experiences of services, as well as how they might like things to be different.

Taking Part in the Project – Staff

We are also looking to recruit staff working in CAMHS and adult eating disorder services across Buckinghamshire and Oxfordshire. We will be running several focus group sessions for staff which will be conducted using Microsoft Teams. Focus groups will last approximately one hour. Staff will have the opportunity to share their views and experiences on how to define a longstanding eating disorder. They can also shape the new pathway by sharing their experiences of what currently does, or does not, work well in supporting these patients, as well as ideas of how the future pathway could look.

Data Management and Ethics

All data from interviews and focus groups will be recorded on an OHFT encrypted iPad and then transcribed and stored securely. Data will be stored securely for five years, as per trust policy, after this time all data will be destroyed.

All recordings and transcriptions will be stored anonymously, with any names or identifiable information removed from transcripts. Everyone who participates in an interview or focus group will be given a code which they can use to identify their own data. Only they will know which code relates to their data. Should they wish to withdraw their data from the study, they can use this code to do this at any time with no justification needed until 31/12/2020.

Interviews will be conducted by an external researcher from the Oxford Clinical Psychology doctoral programme. The interviewer will not be involved in patients' care

and their responses will not impact their current treatment in any way. The only time responses may be shared with the clinical team would be if an element of risk to themselves or others was disclosed during an interview. If this were the case, this would be discussed with the participant before sharing information.

Getting Involved

If you are interested in taking part in this project, please complete the form below. You can also indicate if you would like to receive a summary of the results of the project once it is completed. Please note that your contact details will be stored separately from your interview data and there will be no way of linking the two.

I have read and understood the above information sheet and consent to take part in the project: Yes / No

I am currently a: Patient / Staff Member

I consent to be contacted to arrange an interview or focus group: Yes / No

I would like to be sent a summary of the results once the project is completed Yes /No

Please complete the below information and indicate your preferred method of contact.

Name:……..

Telephone number:……. Preferred method?

Email address:……. Preferred method?

Signed ……

Date ……

Unique ID Code (first two letters of mother's maiden name, your date of birth)

e.g., Janet Purton 31/12/1945 = PU31

……

2.C - Search Terms

The search terms used in the literature review were as follows:

(chronic OR longstanding OR severe enduing)

AND (eating disorder OR anorexia OR bulimia)

AND (defin* OR treat* OR understand*)

2.D – Bracketing Interview

Why am I interested in the topic?

I am interested in this topic - I've always been interested in eating disorders. Ever since I had a friend with an eating disorder when I was a teenager, she was helped by a clinical psychologist and kind of motivated me to get into clinical psychology, so I've always had an interest in eating disorders. In terms of why chronic, longstanding, severe and enduing or whatever, eating disorders I hadn't really heard of it, to be honest until Jo and David talked about it at the research fair - placement fair whatever that was called. I just thought it sounded really interesting. I'm really interested in kind of novel areas of psychology so I'm doing projects in perinatal and severe and enduring so the fact that it's kind of sits outside the evidence base, I find really interesting. Yeah I think that's probably it. I'm also kind of interested in things other than just testing existing models, I like finding new things. So, yeah, a bit of service improvement about finding something new, really interested me.

What do I expect to find?

I think my expectations are that your classic treatments like CBT, are not going to be that helpful in this group, I think it's going to be more of a non-diagnostic trans- what is it called - transdiagnostic approach of kind of listening to the person, their goals, what they want to work towards improving quality of life. If I'm thinking of biases I'm aware of, I've worked in the psychosis service, on the ward. And I'm kind of influenced by that kind of hearing voices movement that comes from schizophrenia about, it's not about reducing symptoms, it's about reducing distress and improving quality of life so

I'm expecting that the results of this will kind of run parallel with that, and that people will be saying that it's not about weight gain, it's about living well with your eating disorder. What that looks like I'm not entirely sure. I imagine it's things like support to keep the minimum weight that they can to function, I imagine it's kind of getting back to the community, maybe or reaching goals that matter to them. What I'm not so sure about will be, how to manage when somebody is really quite unwell. Yeah, I haven't quite worked that bit out yet but yeah, those are my expectations, I think.

What do I hope the results will say?

I hope that they are useful. I hope that they suggest something different to the general NICE guidelines. I think from speaking with the team, it's quite clear that the current NICE guidelines, aren't working for this group. So, I would be kind of disappointed, I guess, if, if it came out of it that CBT and family therapy are the best things to do because that doesn't seem to be working. So, I'm, I'm hoping to find something new, I'm hoping that this will provide an alternative for those people for whom the kind of evidence-based treatments aren't working. And I'm hoping the results are kind of practical. It'd be a shame if the outcome is something that's unrealistic that the NHS just won't pay for. I'm hoping there's going to be some real kind of practical, hopefully fairly quick, solutions that can come of this. You know things like, I don't know a support worker to take you out or spending more time on things like getting a job or thinking about how to explain your eating disorder to friends and colleagues that that kind of stuff, rather than how to gain weight. Yeah, I don't know that - that's what I'm hoping.

How do I think this will influence my work in the way I approach it?

I think, naturally, I'm going to probably be listening out for those things you know it's a semi structured interview so there is scope for me to follow up slightly on some things. And I want to be mindful that I'm not just following up things that fit with my ideas. Yes, it's probably influenced already the questions I've written I've not included any specific questions about CBT or family therapy. They're very broad, and I've done that on purpose, because I, I guess I'm hoping to find something different. Yeah, I think that would be the main way I'm going to try and be mindful of this throughout though so hopefully it won't influence my work too much. In terms of how I kind of code it, I guess I'll be - I've already said I'm looking for some, like deductive themes that will be based on the theory and that is a CBT model so hopefully my less enthusiasm about CBT won't influence things too much because I'm going to be specifically looking out for those themes, and hopefully it will be positive because it will encourage me to look out for alternatives, but I think there is the possibility that that won't be the case. And again, in terms of how I wrote it up, you know, I've got my own views on if a one size approach does really fit all. So, I guess it's just being mindful checking out, making sure that actually, if the evidence goes against this and what people are saying is we want more CBT or more family therapy that I'm including that and I'm kind of reporting that accurately.

Who do I expect will be most helpful?

I think the most helpful information is going to come from the patients themselves. I'm slightly worried that it will become just a chance for them to kind of moan about the service they've received which won't be so helpful, but I'm really hoping I can get a

good bunch of patients that are quite keen to work on this pathway with me. And I think that's where the most value comes because I do worry that some of the staff might come into this with how can we make these patients gain weight, which isn't the purpose of this, it's not about how to gain weight it's how can we support them. So, I'm hoping I'm not gonna have too many conflicts there, I don't want it to become motivational interviewing to do the therapies we already have, I want it to be kind of thinking outside the box from the start so I guess I've got that bias, that maybe staff from medical backgrounds or perhaps nursing might be coming from different training and or dieticians, you know, about weight gain for eating disorders and I'm thinking about, quality of life gain. And I suppose I'm expecting the patients to be more on the same page as me with that they're not going to want to be gaining weight. So maybe that's why I think that will be more helpful, or possibly it's, it's just that obviously they're the experts in themselves. So that kind of makes sense as well.

Any difficulties, I'm expecting to come up?

I'm slightly worried that I'm going to have too many people want to do it and then how will we select. I've said first come first served, whether that kind of introduces any bias in the sort of person that sends the form back quickly is probably somebody different to a person that takes a long time, but rather than kind of picking out of a hat which felt quite unfair, I think that's the only way. I think those are my main biases that I have. I'm expecting a lot of the adults to be kind of 'CAMHS graduates' if you like so perhaps I'll have an assumption that they can speak for both services, and maybe I need to be mindful that CAMHS is ever changing and their experience of CAMHS might

not reflect the current CAMHS or they may have been out of area. So that's helpful to know as well. I think that's probably it for my questions.

2.E - Interview Schedules

Schedule for Patients

1. How would you describe or define somebody with a longstanding eating disorder?

   What term would you use? How would you decide who fits into this group?

2. How does [insert criteria from literature review] definition reflect your experience?

   Is it too broad? Does it miss out anything important? What changes would you make?

3. In your experience, what are the care needs of patients with longstanding eating disorders?

   What kind of support and monitoring, if any, do they need? Are all parts of CPA needed? (e.g., social care, support, finances, housing, therapy, medication, side effects, physical health, occupational support, risk, personal relationships)? What would you feel is more of a priority?

4. Which elements of your care do you find most and least beneficial?

   What was so helpful (or unhelpful) about them? Could anything have been done differently to change your experience?

5. In what way do you feel you have choice or control over your care?

   Do you have choice over practitioner? Of treatment options? Timing of appointments? Is this something which is important to you? How could this be done differently?

6. To what extent does the current service meet the care needs of patients with longstanding eating disorders?

   Why do you think this? Does it promote a hopeful message?

7. How does the current service promote building supportive relationships for patients with longstanding eating disorders?

   With staff? With family? With friends? With other patients?

8. If you could re-design the service for other patients with longstanding eating disorders from scratch, what would you do differently?

   How do you think these changes would better support patients? What would be helpful goals? How could it promote a positive message?

Interview Schedule for Staff Focus Groups

1. How would you describe or define somebody with a longstanding eating disorder?

   What term would you use? How would you decide who fits into this group?

2. How does [insert criteria from literature review] definition of a longstanding eating disorder reflect your experience of working with patients with longstanding eating disorders?

   Is it too broad? Does it miss out anything important? What changes would you make?

3. What are the care needs of patients with longstanding eating disorders? *What kind of support and monitoring, if any, do they need? Are all parts of CPA needed? (e.g., social care, support, finances, housing, therapy, medication, side effects, physical health, occupational support, risk, personal relationships)? What would you feel is more of a priority?*

4. To what extent does the current service meet the needs of patients with longstanding eating disorders?

   Why do you think this?

5. What elements of the current provision for patients with longstanding eating disorders do you think is the most helpful?

   What is so helpful about them? Could this apply to any other areas of the service?

6. What elements of the current provision for patients with longstanding eating disorders do you think is least helpful?

   What was so unhelpful about these things? Could anything be done differently to change this experience?

7. How could patients be more involved in their care?

   Choice over practitioner? Of treatment pathway? Timing of appointments? Is this something which is important? How could this be done differently?

8. If you could re-design the service for patients with longstanding eating disorders from scratch, what would you do differently?

   How do you think these changes would better support patients? What would be helpful goals? How could it promote a positive message?

2.F - Illustrative Quotes

Theme	Subtheme	Illustrative Quotes
Define	Duration	*"most of the people that I know that have longstanding eating disorders have had it all their adult life" [patient, HE17]* *"At first, I thought over 10 years and then I was like—not really, I think that's a bit too long. I was thinking maybe 5 to 7—after sort of 5 to 7 years." [patient, MA14]* *"I think the kind of slightly, slightly arbitrary seven year cut off or something like that is not always helpful" [staff, CH23]* *"because of age, if you go for the proportion for instance, three years history for a 15-year-old is like, what a fifth of their life isn't it"[staff, GR25]*
	Recurrent	*"someone who presents over and over again." [staff, LI08]* *"probably several hospital admissions with relapse." [patient, HT84]* *"Because, when you're a revolving door patient and being in hospital for so long, you just get stuck in the system and you don't ever get better. The more hospital admissions you have, the harder it gets to stay well and be well and to engage in the community and for the community team not to keep, you know, putting you back in all the time. And I think there has to be a way of stopping that for people like me." [patient, HE12]* *"if you've done the same thing like four or five times and it hasn't worked it seems a bit insane to keep going with it," [patient, HE17]*
	Comorbidities	*"I think once you've had an eating disorder for a certain amount of time, other things get - you can't just have just an eating disorder because it affects so many things of your life that, you're more - whatever is wrong with you becomes more than that, so you also have depression and stuff like that, so anxiety you know your self-esteem goes down. So, you know if it wasn't bad at the start, it's a lot worse at the end." [patient, RI30]* *"I've got lots of medical issues, so, for me, it would be somebody with both medical and psychological complex needs." [patient, PA11]* *"I think that it is quite common, those young people with a dual diagnosis, someone which might present with autistic spectrum disorder. Or there's a kind of medical, biological condition sometimes." [staff, TK85]*
	Complexity	*'difficult to describe" [patient, HE17]* *"I have such complex needs," [patient, MA14]* *"this particular group of patients is one, you know, that all services have, find challenging. In part because, in part because they may be - they don't necessarily fit with what services want to view their role as being." [staff, PG14]*
	Severity	*"I think the longer you have it the more intense your thoughts are, the more destroying the thoughts are" [patient, GT73]*

		"when your eating is in the eating disorder you don't see it as that, you don't see it as ruining in your life, but it has ruined mine." [patient, GT73] *"the severity of the illness has just got worse" [patient, HE12]* *"there are ongoing things like memory is a major thing and just thinking clearly sometimes is difficult," [patient, LE27]* *"chronic is when they can't function with it I think. When they're struggling to have some quality of life." [staff, PU31]*
	BMI unhelpful	*"you don't have to be underweight to have a long-term eating disorder." [patient FA26]* *"the NICE guidelines actually they make the specific point people shouldn't be kind of discriminated against if they have a certain BMI or a certain length of illness." [staff, JQ14]* *"they said my BMI wasn't low enough to go in hospital even though I was not in a good place" [patient, LP02]* *"I know when I I've been at healthy weight I've actually found it harder because you're having to manage how you feel and like your body changes and stuff" [patient LP02]*
Describe	Terminology	*"I think a little while ago people were referring to patients as SEED patients, but it appears to have gone by the by." [staff, SK28]* *"the different terms I've heard like chronic, or enduring and long-standing. But I think long-standing is quite a nice way of saying it." [patient, MA14]*
	Identify with eating disorder	*"Because my whole identity is now anorexic, really." [patient, HT84]* *"I think that's really important not to see you as the disease." [patient, GT73]* *"it was sort of giving up on the idea of a career and sort of just, just seeing myself, I suppose it's sort of like almost adopting the label anorexic more you know just sort of accepting that that was who you are. So, I shifted my identity."[patient, HT84]* *"Because it's a combination of, you know, it's ego syntonic so people kind of identify themselves as, as people with eating disorders" [staff JQ14]*
	Labelling	*"I'm seeing up and down in the country is that the SEED patients don't get active treatment, they don't get admitted to hospital for weight restoration but they kind of go around in revolving door admission and discharge" [staff, JQ14]* *"I've found that once you've got an eating disorder, you're sort of put into a box, and then one team won't see you because you're under that team." [patient, MA14]* *"we're all just individuals that's, I think that's just the- having labels, I mean everyone's always like 'oh yeah it's really good to have a label and then you can like you know target it or whatever' or all these stupid things. But I think, I think the worst thing is to have a label" [patient, RI30]*
Service Structure	Timing of interventions	*"I think if it had been picked up quicker then it could have been more helpful" [patient, LP02]* *"The gap between inpatient and outpatient treatment is vast and frightening and does not meet need." [patient, HE17]* *"And sometimes if you are motivated, then yeah, you don't get the support" [patient, MA14]*

		"I guess the out-patient team, they just wait for you to drop, until you come back in again, they just, they're there, but they're not there in some ways." [patient, HE12]
	Current service strain	*"someone told me that, like, you know, we've spent all this money on individual people and stuff like that and we've kind of like, ran out of money for me" [patient, FA26]* *"I know it's funding but that is - you're just going to have those people coming back into the service." [patient, PA11]* *"it's expensive, everything is expensive, if you think about it from an expense point of view. Why not two appointments a week, if you know realistically that this person probably—maybe three or four weeks, needs to go to general hospital, it would be cheaper to give them the support in the community than ship them off to in-patient soon after." [patient, BR13]* *"Whereas say if it was someone with like schizophrenia you'd really tamper with their medicine, you'd do all sorts of things so that they could be sustainable in, you know, in society. You'd, you know if it was someone with bipolar disorder you wouldn't just cast them aside and say 'we tried all the things, so we'll just cast them aside'" [patient, RI30]* *"Which other services manage, you know self-harm, addictions, have, you know, harm reduction services. Eating disorder having a real issue with harm reduction we always kind of want to think that we're curing them when in fact sometimes we're not." [staff, PG14]* *"I'm not sure if you had someone with severe diabetes would they be, kind of, discharged from secondary care. So, so it kind of feels like the sort of finished consultant episodes or whatever, finished episode, doesn't really suit some of these real chronic patients but I - again I kind of think that we probably need to go back to our commissioners and say can we have a better model." [staff, JQ14]*
	Flexible but structured	*"I would like to do an intensive CBT thing but it's all during work hours, so, that doesn't suit me because I work." [patient, LE27]* *"Maybe online now, during the pandemic, online, courses on getting ready for work or something" [patient, BR13]* *"I'd like to see is more outreach and more of that sense of being able to maybe meet people … you know out the building" [staff, BL06]* *"I think we have to go back to the drawing board again and kind of thinking about well what technologies can we use for remote monitoring, how can we work more creatively?" [staff, JQ14]* *"I can see there is a value to having a structured clinic so that there is different personal in that clinic who can take on different roles, or different, you know parts of managing the different needs of the patient." [staff, LE31]* *"the CTO and that kind of parameters of that are the most helpful" [patient, HE17]*
Individualised Approach	Tailored to your needs	*"Having like regular catch-ups with like the nurses, the doctors, the consultants, the psychologists, and stuff, and to having a bit more time"[patient, HE12]* *"So, the individual identifies all of their need and then we put the support in for who does what" [staff, PU31]* *"the benefit of having a clinic is that you can have different people within that clinic so obviously you can have access to the support worker or a social worker and a dietician and a nurse, a medic." [staff, LE31]*

		"definitely some occupational therapy input to plan, plan activities, how you're going to use your time, what you're going to do with your life." [patient, HT84] *"I'd probably say more therapists, yeah. Because they know what they're, kind of, like I don't want to say they know what they're talking about more, but like, it's, like, more helpful to speak to them" [patient, FA26]* *"I think, I think it was a bit of a combination because I think sort of CBT-E techniques would- it wouldn't be that you are necessarily doing CBT-E, but you'd be taking, you know, CBT, DBT techniques and skills and coaching those in sort of live time with young people." [staff, ST63]* *"being given like psychologists and stuff like that, that I've said from the start that I don't get on with and then it being blamed for me like not performing or whatever." [patient, RI30]* *"I think definitely, the physical monitoring. I know that some people might not want that, but you know even the basic stuff, like being weighed and having blood tests, for me, with bulimia, that is really important." [patient, LE27]* *"So, it depends on the monitoring, some people could be seen once a month and some would need to be seen weekly, it depends on their physical and the medical." [staff, PU31]* *"once you're at a safer point, not to always home in on the physical stuff. Because for me, just having that all the time, is always going to keep me in the loop and the battle of dealing with this illness." [patient, HE12]* *"people could have a physical health check-in and then just a separate therapy." [patient, BR13].*
	Choice	*"I found that a lot of control seems to be taken away from you" [patient, GT73]* *"you didn't feel in charge of yourself, you didn't feel in charge of your care, you didn't feel listened to and the decisions were made without you" [patient, HE17]* *"maybe and having more say in treatment, in a way and what you want to happen, but keeping it obviously in a safe, in a safe way." [patient, HE12]* *"just listening to your reasons why. Like if an admission isn't gonna be helpful then like understanding why it's not going to be helpful and what they can do instead" [patient, LP02]* *"So, there's something really important in choice and how you engage with the young person and look at outcome." [staff, HA12]*
	Personalised Care	*"I think the crux of that is to treat everybody individually" [patient, PA11]* *"I would probably think about it in terms of someone who's exhausted, the kind of options of evidence-based treatment and probably need something a little bit more tailored, I guess." [staff, LI08]* *"I know it probably is effective for some people, but I don't know whether it's as effective for all people" [patient, FA26]* *"the age difference, and the life expectation difference can be difficult. So, when you're younger you can have goals like thinking I want to go to university or I want to go back to university or I want to get a job or, you know I want to get back to work, all those things which feel no longer relevant to me" [patient, HT84].*

Relationship to Service	Groups	*"I think would be very helpful I think if you had had a sort of regular support group for people who you know were long-term sufferers. Or, and also for people who had recovered after a long-term, so you'd have that element of hope in there as well" [patient, HT84]* "I guess it would be good to meet people like me, who are under that care too, to have more groups going on for the out-patient team. So, just things you can attend to and meet people with similar, like you, to have more time to discuss things, or just to meet people and just have more of a community group, or a programme structure." [patient, HE12] *"So, I guess if you had that sort of group project - group sort of thing, having people that have properly recovered as well taking some sort of leadership in that group." [patient, SM31]* *"that's been really helpful so to see people who are older, who have recovered or are working on recovery that helps you know" [patient, HT84]* *"we could ask patients to join to remote groups. So, the formation group that was set up in the, in the inpatient unit as part of the CBT model seems to have been really helpful in that engagement and giving hope to the patient because they are all of a sudden are asking questions about their own illness, are asking questions about how can I do things differently" [staff, JQ14]*
	Feeling supported	*"it might sound a bit simple, but having one, one person that is consistently been there for quite a long time." [patient, FA26]* *"I don't know they could have like a mailbox that could be monitored by someone"[patient, HE17]* *"the most important thing that anyone can do is just show that they genuinely actually care. And that they're willing to risk it for a biscuit." [patient, RI30]* *"I think more time needs to be allocated, more regularly. Not just an hour—it's not always an hour—but an hour a week, I don't think that's anywhere near enough. And I don't think there should be a limited number of sessions because you don't have an eating disorder a limited amount of times"[patient, PA11]* *"they tend to be really quite distrusting people so really that engagement and continuity is really quite important." [staff, JQ14]*
	Working together	*"maybe having a compromise between you and you know, the hospital as to where would be a safe place" [patient, GT73]* *"The patient should also be included in the weekly meetings about them" [patient, PA11]* *"there was a lot of miscommunication around what was happening in my care and the people who were coordinating my care didn't really communicate with each other very well." [patient, HE12]* *"So, that is all just connecting the dots, except that breast cancer was separate from the eating disorder but the trouble is, you're all one person." [patient, PA11]* *"I think it might be helpful to have maybe better links to the inpatient services because these young people who are in our service for a long time can have several admissions so it might be longer discussions outside of these admissions with inpatient settings to discuss why they're reoccurring and if there's anything further that either team could do." [staff, HO26]*

	Empowered	*"And these little things that build up your confidence you think, I can actually do that. And then, getting a job feels more realistic, and having friends feels easier" [patient, BR13]* *"now I'm in control and it's the first time I've been able to put on weight myself, you know, so that's quite an achievement." [patient, GT73]* *"It's, it's about reminding them as well that they don't need you to do, you know, they've learnt the tools." [staff, PU31]* *"And sort of supporting them maybe when they are at school or they are doing things, but they've lost their confidence and lost their ability to do some of these things. So, you pick up that wider issue of life again." [staff, BL06]*
Life After Services	Goals	*"making your life have meaning, building connections and- so that the, you know, even if you can't recover completely, so that your life had, had more meaning you had more, you know, was richer" [patient, HT84]* *"I think, for me, a better quality of life, is more being able to manage my illness and do all the things that make me happy and try and be okay." [patient, HE12]* *"I think maybe it's using positive ways of talking so like, say someone was in - someone couldn't go to school it's thinking about how they can increase like their, their wellbeing in like their health, rather than their weight, to be able to go to school and to do everything that they want to do." [patient, FA26]* *"this group are people who you're moving the focus away from recovery from an eating disorder because, with the, you know, otherwise you're kind of setting them up for something that they may say they want to do, or they think they ought to say they want to do, otherwise they're not going to get help, but they actually, you know, given the enduring nature of the illness, [erm] you're focussing more on- on the quality of life and keeping them well and safe, out of hospital and out of acute services." [staff, LE31]* *"[my] anxiety about the quality-of-life approach if you kind of say 'well you can have a quality of life at BMI 13' well you can't" [staff, JQ14]*
	Support network	*"I've got one really solid friend but- and she's helped me a lot, but I don't think that they emphasize very much relationships as such. I don't think it's an emphasis and I think it should be because having a support system at home as well in CAMHS is really, really important." [patient, FA26]* *"in the past it has been the connections that has been most important going for a coffee, ringing a friend, reading" [patient, HT84]* *"You know, because they're lonely, they're - as we've said their social lives, their work lives their family relationships have been torn apart." [staff, SK28]* *"Really telling carers or people who come along to the meeting or whatever not - or advising the patient, the out-patient to not have these recovery accounts."[patient, BR13]* *"I have one [recovery account] because I think it's the only support you can kind of get off other people at times" [patient, LP02]*

		"because there is clinician fatigue when you have these patients for a long time and there might be progress, but the progress is incredibly slow or there's new issues arising adding to the complexities. It's very hard as the support team to continue." [staff, MW21]
	Hope	*"they kind of told me a couple years ago, even like, I was probably there for about a year and a half and they told me, they, they'd done everything that they could at that point" [patient, FA26]* *"Not that I have any hope for myself, but it would be nice to have – to find some hope somewhere but I definitely don't think the, the eating disorder service has ever offered that" [patient, RI30]* *"I explained it at the time that they gave me glimpses of what was bright instead of locking me away." [patient, BR13]* *"but I find, you know, encouragement to think of the possibility of recovering despite the time you've been ill is helpful." [patient, HT84]* *"Because the aim I think has always still got to be towards recovery- well towards helping them with whatever is distressing them in their lives. So, yeah, I suppose that doesn't have to be recovery." [patient, LE27]* *"I guess to hold some hope that that, that is possible, and I guess, I imagine many of us have had experience with people with very long-term illness that had actually at some point changed and made some massive steps towards full recovery in many cases. So, I guess holding on to that hope is really important." [staff, CH23]*

2.G – Instructions to Authors: European Eating Disorder Review

Free Format Submission

European Eating Disorders Review now offers Free Format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this should be an editable file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, conclusions and highlights. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.
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Abstract

All manuscripts should contain an abstract of up to 200 words. An **abstract** is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published

work. It must be structured, under the sub-headings: Objective; Method; Results; Conclusions.

Highlights

Highlights are mandatory for European Eating Disorders Review. These should appear as three bullet points that convey the core findings of the article.

Keywords

Include up to five **keywords** that describe your paper for indexing purposes.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used

and define/explain all abbreviations and units of measurement.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. **Click here** for the post-acceptance figure requirements.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

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3.A – Details of Ethics

The project received full ethical approval from the University of Oxford research ethics committee, reference R74370/RE001. All participants were provided with a digital information sheet before they were able to access the online survey. Participants had to indicate that they had read and understood the information sheet before they could give consent to participate. This contained details of the project, data storage information and dissemination plans.

Participants were also asked to create a unique participant identifier which they could use to withdraw their data at any time prior to April 2022 without explanation. This was created by taking the first two letters of their mother's maiden surname and the day from their date of birth (e.g. Janet Purton 21/03/1995 becomes PU21). This was also used to identify quotes from participants to protect their anonymity.

All data was collected and stored anonymously on Qualtrics and participants could exit the survey at any time. Once recruitment was complete, data was downloaded from Qualtrics and saved on the University of Oxford secure Nexus 365 OneDrive for Business for three years, as per university guidelines. After completing the survey, there was space for participants to indicate if they wished to receive a summary of the results of the project. For those that did provide a contact email address, their email addresses were stored separately from the rest of their data and deleted upon completion of the project.

After completing the survey, all participants were taken to a debrief page providing signposting to organisations and charities which support men who are struggling with their mental health (e.g. IAPT, Mind, Dad's in Mind, CALM, Samaritans). They were also advised to contact A&E if they had serious concerns about their own, or someone else's safety. This page also included contact details for student Megan Reay (megan.reay@hmc.ox.ac.uk) in case participants had any questions or comments about the research, or wished to withdraw their data. They were also informed about how to make a formal complaint about the research if they wished to do so.

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, University of Oxford, Wellington Square, Oxford, OX1 2JD
Tel: +44(0)1865 616577
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Megan Reay
Oxford Institute for Clinical Psychology Training
(OxICPT)
Isis Education Centre
Warneford Hospital
Oxford

12 March 2021

Dear Megan,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R74370/RE001

Study title: Understanding the barrier to men seeking help for depression: comparing fathers to non-fathers

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for Ethical Approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted for a period of **18 months**, commencing on **12th March 2021**.

Approval is **subject to:**

a) **you following the BPS guidelines for online research**
b) **the PI agreeing to comply with the requirements for administering any tests or questionnaires and, if in doubt, to contact the publisher of those tests or questionnaires**
c) **the PI ensuring that, where new research staff are engaged, they are suitably qualified by training and/or experience.**

I would like to remind you that your study may be selected for review for the purposes of monitoring and/or audit.

Amendments

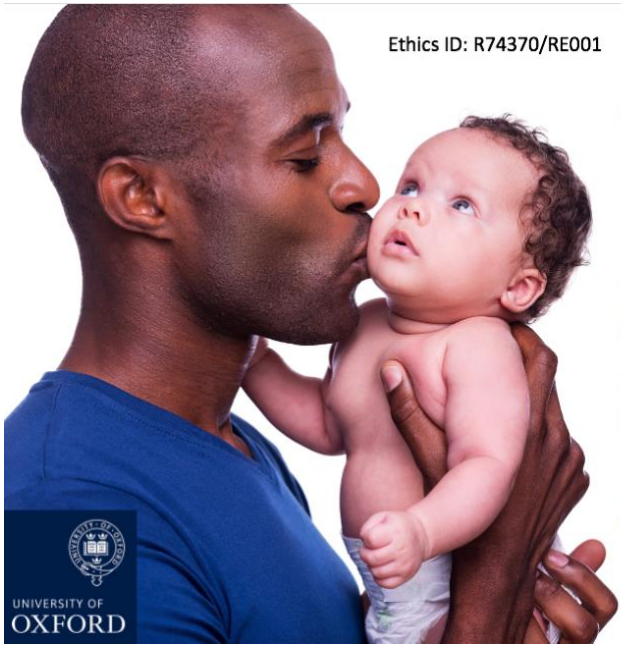
Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

H. Barnby-Porritt

Dr. Helen Barnby-Porritt
Research Ethics Manager, Medical Sciences

3.B – Recruitment Posters



Ethics ID: R74370/RE001

Are You a Father Who Has Struggled with Low Mood Following the Birth of Your Child?

Are you willing to take part in research to understand how to better support new fathers with their mental health?

I am conducting research at the University of Oxford to understand the barriers men face when seeking mental health support in the postnatal period.

I am currently recruiting men whose child was born in the past 24 months who have since experienced low mood or depression. You will be asked to complete a one off, anonymous, online survey.

A £1 contribution will be made to Make Birth Better for each father who takes part in the research.

For more information or to take part please visit
http://bit.ly/OxFathersMH
or contact megan.reay@hmc.ox.ac.uk

Ethics ID: R74370/RE001



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or contact megan.reay@hmc.ox.ac.uk

Are You a Man Who Has Struggled with Low Mood in the Past 24 Months?

Are you willing to take part in research to understand how to better support men to access support for their mental health?

I am conducting research at the University of Oxford to understand the barriers men face when seeking mental health support.

I am currently recruiting men who have experienced low mood or depression in the past 24 months. You will be asked to complete a one off, anonymous, online survey.

A £1 contribution will be made to Make Birth Better for each man who takes part in the research.

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Ethics ID: R74370/RE001

Are You a Man Who Has Struggled with Low Mood in the Past 24 Months?

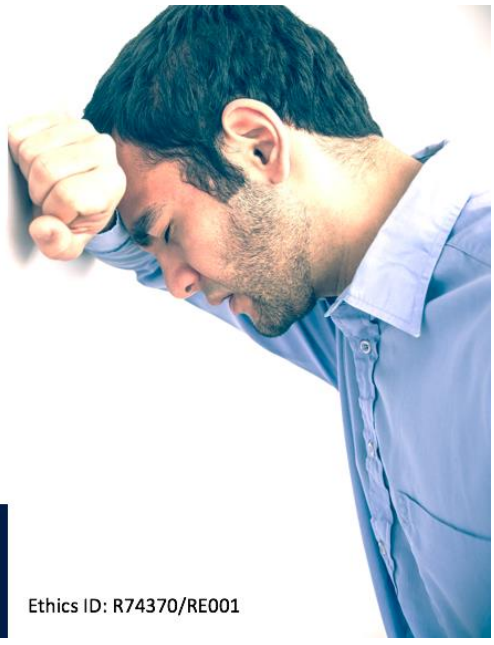
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Ethics ID: R74370/RE001



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Ethical Approval ID
R74370/ RE001

If you have any questions about the research, please contact megan.reay@hmc.ox.ac.uk

Now Recruiting

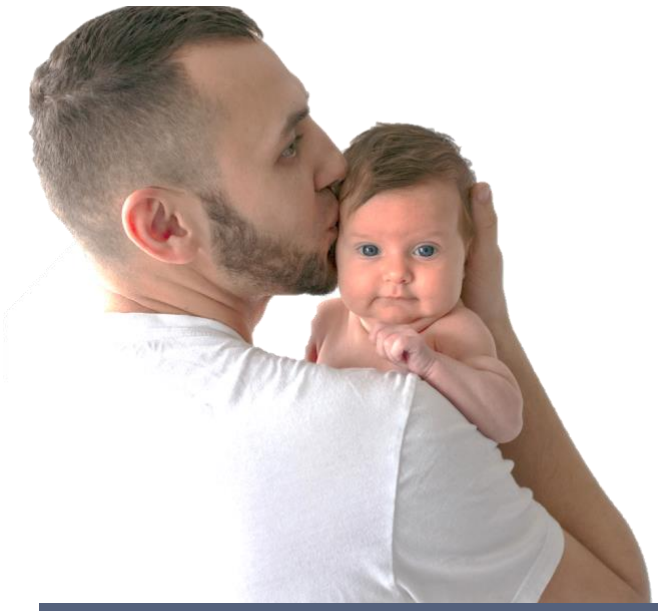
Fathers of Children Under Two Years

Are You a Father Who Has Struggled with Low Mood Following the Birth of Your Child?

Are you wiling to take part in research to understand how to better support new fathers with their mental health?

For more information or to take part in a one off, anonymous survey please scan the QR code or follow this link:

HTTP://BIT.LY/OXFATHERSMH



UNIVERSITY OF OXFORD

Ethical Approval ID
R74370/ RE001

If you have any questions about the research, please contact megan.reay@hmc.ox.ac.uk

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HTTP://BIT.LY/OXFATHERSMH

3.C – Quantitative Measures Used

Demographic Questionnaire

1. What is your age (18-25, 26-35, 36-55, 56+, prefer not to say)
2. What is your ethnicity (White British, Black British, Asian British, Other British, White Other, Black Other, Asian Other, Other – please state, prefer not to say)
3. Are you a father? (yes, no)

   If yes

   a. What was the date that your youngest child was born (month, year)
   b. How many other children do you have, not including the child mentioned in Q3a (free text)

Attitude toward Seeking Professional Psychological Help (short form)

Responses can be agree, partly agree, partly disagree or disagree

1. If I believed I was experiencing severe depression, my first inclination would be to get professional attention
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I would find relief in psychotherapy
4. There is something admirable in the attitude of a person who is willing to cope with their conflicts and fears without resorting to professional help
5. I would want to get psychological help if I were worried or upset for a long period of time

6. I might want to have psychological counselling in the future if I experienced depressive symptoms
7. A person with emotional problems is not likely to solve it alone, they are likely to solve it with professional help
8. Considering the time and expense involved in psychotherapy, it would have a doubtful value for a person like me
9. A person should work out their own problems, getting psychological counselling would be a last resort
10. Personal and emotional troubles, like many things, tend to work out by themselves

Depression Anxiety Stress Scales (DASS21)

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0- Did not apply to me at all

1- Applied to me to some degree, or some time

2- Applied to me a considerable degree or good part of time

3- Applied to me very much or most of the time

1) I found it hard to wind down
2) I was aware of dryness of my mouth
3) I couldn't seem to experience any positive feeling at all
4) I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)
5) I found it difficult to work up the initiative to do things
6) I tended to over-react to situations
7) I experienced trembling (e.g. in the hands)
8) I felt that I was using a lot of nervous energy
9) I was worried about situations in which I might panic and make a fool of myself
10) I felt that I had nothing to look forward to
11) I found myself getting agitated
12) I found it difficult to relax
13) I felt down hearted and blue
14) I was intolerant of anything that kept me from getting on with what I was doing
15) I felt I was close to panic
16) I was unable to become enthusiastic about anything
17) I felt I wasn't worth much as a person
18) I felt that I was rather touchy
19) I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)
20) I felt scared without any good reason
21) I felt that life was meaningless

Depression Factors Questionnaire

1. Have you experienced depression or low mood prior to your recent episode of depression? (yes, no, prefer not to say)
2. Would you consider your partner to have depression? (yes, no, n/a, prefer not to say)
3. Are you currently seeking help for depression? (yes, no, prefer not to say)
4. Have you sought help for depression in the past? (yes, no, prefer not to say)

Self-Stigma of Seeking Help Scale

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.

2. My self-confidence would NOT be threatened if I sought professional help.

3. Seeking psychological help would make me feel less intelligent.

4. My self-esteem would increase if I talked to a therapist.

5. My view of myself would not change just because I made the choice to see a therapist.

6. It would make me feel inferior to ask a therapist for help.

7. I would feel okay about myself if I made the choice to seek professional help.

8. If I went to a therapist, I would be less satisfied with myself.

9. My self-confidence would remain the same if I sought professional help for a problem I could not solve. 10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.

Conformity to Masculine Norms -46

The following pages contain a series of statements about how men might think, feel or behave.

The statements are designed to measure attitudes, beliefs, and behaviours associated with both traditional and non-traditional masculine gender roles.

Thinking about your own actions, feelings and beliefs, please indicate how much you personally agree or disagree with each statement by circling SD for "Strongly Disagree", D for "Disagree", A for "Agree," or SA for "Strongly agree" to the left of the statement. There are no right or wrong responses to the statements. You should give the responses that most accurately describe your personal actions, feelings and beliefs. It is best if you respond with your first impression when answering.

[Response scale: Strongly Disagree – Disagree – Agree – Strongly Agree]

1 In general, I will do anything to win

2 If I could, I would frequently change sexual partners

3 I hate asking for help

4 I believe that violence is never justified

5 Being thought of as gay is not a bad thing

6 In general, I do not like risky situations

7 Winning is not my first priority

8 I enjoy taking risks

9 I am disgusted by any kind of violence

10 I ask for help when I need it

11 My work is the most important part of my life

12 I would only have sex if I was in a committed relationship

13 I bring up my feelings when talking to others

14 I would be furious if someone thought I was gay

15 I don't mind losing

16 I take risks

17 It would not bother me at all if someone thought I was gay

18 I never share my feelings

19 Sometimes violent action is necessary

20 In general, I control the women in my life

21 I would feel good if I had many sexual partners

22 It is important for me to win

23 I don't like giving all my attention to work

24 It would be awful if people thought I was gay

25 I like to talk about my feelings

26 I never ask for help

27 More often than not, losing does not bother me

28 I frequently put myself in risky situations

29 Women should be subservient to men

30 I am willing to get into a physical fight if necessary

31 I feel good when work is my first priority

32 I tend to keep my feelings to myself

33 Winning is not important to me

34 Violence is almost never justified

35 I am happiest when I'm risking danger

36 It would be enjoyable to date more than one person at a time 37 I would feel uncomfortable if someone thought I was gay

38 I am not ashamed to ask for help

39 Work comes first

40 I tend to share my feelings

41 No matter what the situation I would never act violently 42 Things tend to be better when men are in charge

43 It bothers me when I have to ask for help

44 I love it when men are in charge of women

45 I hate it when people ask me to talk about my feelings

46 I try to avoid being perceived as gay

Awareness of Services

Which of the following services, if any, are you aware of? (please tick all that apply):

- Improving Access to Psychological Therapies (NHS)
- Mind
- Father's Reaching Out
- Dad's in Mind
- Campaign against living miserably (CALM)
- Samaritans

- Make Birth Better
- Private psychology or counselling
- Association for Postnatal Illness (APNI)
- Other (please state) – free text

3.D – Qualitative Questions

1. Do you think there were any barriers to you seeking help for paternal depression?

2. If so, what were the barriers to you talking about depression with your friends or partner?

3. What were the barriers to you seeking help for paternal depression?

4. What help would you have liked to be available to you?

5. How could you have been supported to seek help?

3.E – Power Calculation

As there has been no known research into differences in help-seeking intentions between men with depression and men with postnatal depression, it was not possible to use established effect sizes to determine the number of participants needed to power the between-subjects comparison. Therefore, effect sizes from similar papers were used to estimate the effect size. One paper compared help-seeking between people with depression and people without depression and found an effect size of d=0.5 (Sherwood, Salkovskis & Rimes, 2007). Another paper used the Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPH) and compared help-seeking intentions between heterosexual and homosexual men with depression, they also reported an effect size of 0.5 (Vogel et al., 2011). Therefore, a medium effect size (d=0.5) was assumed for power calculations. In order to achieve 0.8 power in a between group comparison of a one-tailed hypothesis with a 0.05 significance level, 102 participants was required (N = 51 in each group).

Power calculations were also completed to ensure that the secondary hypotheses would be adequately powered. Previous research indicates that the relationship between self-stigma and attitudes towards seeking psychological help produces a large effect size (d^2=0.658) (Vogel et al., 2011). Using a standardised large effect size (d^2=0.35) suggests that a sample of at least 37 men with postnatal depression would be required to power the regression analysis of a model of help-seeking intentions in men with postnatal depression.

In addition, qualitative researchers have suggested that a sample size of 50 should be sufficient to detect themes using Thematic Analysis when collecting free text responses (Braun & Clarke, 2013). This suggested that recruiting 51 men in each group would also adequately power the secondary qualitative analysis.

3.F –Additional Details of Analyses

Demographic Data:

The FD and MD groups were compared in terms of their age, ethnicity fatherhood-status and number of children. All data was first explored to check if it met the assumptions for a chi-squared comparison, if it did not, a fishers exact test (rx2) was used instead.

For age, the chi-squared assumptions were not met as 25% of cells had an expected frequency of less than 5, therefore a fishers exact test was used. This identified that the probability distribution between the FD and MD groups was statistically different (p<.001).

For ethnicity, the chi-squared assumptions were not met as 66% of cells had an expected frequency of less than 5, therefore a fishers exact test was used. This identified that the probability distributions between the FD and MD groups was not statistically significant (p=.739).

Data on fatherhood status did meet the assumptions for a chi-squared test as the independent variance and dependent variance were both dichotomous, the groups have independent observations, sampling was purposive and all expected frequencies were greater than 5. The chi-squared analysis identified that there was a significant different in the proportion of participants in the FD and MD groups that were fathers, with significantly more men in the FD group (N=64) than MD group (N=18) being fathers (p<.001).

Data on number of children was then compared using fisher's exact test as 20% of the cells had an expected frequency of above 5. This identified that there was not a significant difference in the distribution of number of children between the FD and MD groups. However, this data should be interpreted with some caution as only data from fathers was collected, making the groups very unequal in size (FD=64, MD=18).

It was not possible to statistically compare the data describing time since youngest child was born in the FD and MD groups. This was partly because the sample sizes were so different in size (FD=64, MD=18) and partly due to the large variance in the distribution of results in each group. All children in the FD group were born between 0-24 months ago, whereas the data in the MD group ranged from 2.79 to 31.36 years. This meant that it was not possible to run an independent samples t-test due to significant numbers of outliers. Additionally, the non-parametric Mann-Whitney U test was not possible as the distribution of the two groups varied too much.

DASS-21 Data:

The DASS-21 data from the FD and MD groups was compared statistically using a series of independent sample t-tests. The assumptions for independent samples t-tests were first checked. The total score, anxiety subscale and stress subscale met all assumptions as the data was continuous, from two independent groups with a large enough sample size. There were also no significant outliers, the data was normally distributed and had homogeneity of variance. For the depression subscale the data did

not meet the assumption of homogeneity of variance so equal variance was not assumed for the analysis.

The results highlighted that the two groups did not significantly differ in terms of their total DASS21 score t(118)=-0.88, *p*=0.93. Nor did they differ in terms of depression (t(108)=-1.01, *p*=0.315); anxiety (t(118)=-0.92, *p*=0.36); or stress (t(118)=1.84, *p*=0.07).

Depression Exploratory Factors

The FD and MD groups were also compared in terms of if they had experienced depression in the past, if they had sought help for depression in the past and if their partner currently had depression. All data met the assumptions for chi-squared tests.

The results of the three chi-squared analysis identified that there were no significant differences between the FD and MD groups in terms of how many men had a history of depression (*p*=.956). Similarly, there was no significant difference in how many men had sought help for depression in the past (*p*=.713) or how many men's' partner was currently experiencing depression (*p*=.725).

Current Help-Seeking

Finally, fishers exact test (2x2) was used to compare current help-seeking between the FD and MD groups. All assumptions for fishers exact test were met as both the independent variable and dependent variable were dichotomous, the groups had independence of observations and the data was from a cross sectional, purposive sample. This analysis identified that there was not a significant difference between the

FD and MD groups in terms of how many men reported that they were currently seeking help for depression (*p*=.841).

Hypothesis 1:

For the between group comparisons, independent sample t-tests were conducted to compare the FD and MD groups. The assumptions for a t-test were explored for each planned comparison. For help-seeking intentions, the data was normally distributed. The data did not meet Levene's test for homogeneity of variance therefore equal variance was not assumed. There was one identifiable outlier, therefore the analysis was run with and without this data, and it was found that including this data did not change the results significantly. The analysis identified that there was no significant difference in ATSPPH scores between the FD and MD groups t(106.08)=-0.455, *p*=.65.

Hypothesis 2:

When comparing levels of self-stigma between FD and MD groups, all assumptions for an independent samples t-test were met as the data was normally distributed, with homogeneity of variance and no significant outliers. The results of the independent samples t-test identified no significant difference between the FD or MD groups t(115)= 1.092, *p*=.27.

When comparing conformity of masculine norms, the data did not meet Levene's test for homogeneity of variance therefore equal variance was not assumed. There were three identified outliers, removing this data meant that the data was normally distributed, making it possible to run a t-test. This analysis identified that there was no

significant difference between the FD and MD groups in terms of conformity to masculine norms t(97.924)= -1.627, *p*=.107.

When comparing awareness of services, the data did not meet the t-test assumptions as the data had seven significant outliers and was not normally distributed, even after removing outliers. Therefore a non-parametric Mann Whitney U test was used instead. The data met the assumptions for a Mann Whitney U test. This analysis did not find any significant difference in awareness of services between the FD and MD groups U=1293, *p*=.182.

Hypothesis 3:

Prior to creating the regression model, all assumptions were tested. The assumptions were tested with all variables, including the main three predictors (self-stigma, masculine norms, awareness of services) as well as the four exploratory predictors (depression history, help-seeking history, partner's depression and current depression). All assumptions were met as there was homoscedasticity of residuals, no multicollinearity, the residuals were normally distributed and there were no significant outliers.

A hierarchical, stepwise regression model using data from the FD group was constructed which initially included masculine norms and awareness of services as predictors; the dependent variable was PHS intentions. Self-stigma was then added to determine whether self-stigma explains the variance in PHS intentions, above and beyond the other predictor variables. Adding self-stigma to the model, alongside

conformity to masculine norms and awareness of services, significantly increased the amount of variance in PHS intentions (R2=0.19, *p*<.001). The overall model with all three predictors was significant, F(3, 49)=3.88, *p*=.02.

Hypothesis 4:

This model was used to conduct a mediation analysis to address hypothesis 4. (See appendix 3.G). Self-stigma did partially mediate this relationship as the observed beta values for the relationship between conformity to masculine norms and PHS intentions decreased from -0.23 to -0.11 with the addition of self-stigma. Additionally, the full model, with both self-stigma and conformity to masculine norms as predictors was significant (*p*<.001).

Hypothesis 5:

The remaining exploratory predictors of current partners' depression; current depression; depression history; and history of help-seeking were then added to the regression model to explore if they explained any additional variance in PHS. (N=52). Including current partners' depression led to a very small increase in the amount of variance explained from R^2=0.183 to R^2=0.184. Adding current depression further increased the amount of variance explained to R^2=0.23. The other variables did not increase the amount of variance explained, therefore were not included in the model. The final model was statistically significant, F(5,46)=2.65, *p*=.04

Hypothesis 6:

To address hypothesis 6, a binomial logistic regression was used to understand whether fathers' PHS intentions predicted PHS behaviour. Before running the binomial logistic regression to explore if help-seeking intentions predicted help-seeking behaviour, the relevant assumptions were tested. All assumptions were met as there was a linear relationship between the independent variable and dependent variable, no multicollinearity and no significant outliers. PHS intentions were not found to be a significant predictor of PHS behaviours as they only explained 0.8% of the variance in PHS behaviour, *p*.575.

Hypothesis 7:

The epistemological and ontological approach taken to the reflexive thematic analysis was contextualism and critical realism. Authors looked to find a level of truth or reality in respect to the barriers described by fathers, whilst acknowledging that fathers' responses, and the data analyses, were influenced by the context and culture in which they were studied. Reflexive thematic analysis was utilised as the approach is suited to the above theoretical positioning. Additionally, the method's flexibility allowed for the analysis of survey responses, which are often briefer than other qualitative data (Braun & Clarke, 2021; 2006). An inductive approach was taken to coding, as authors aimed to understand fathers' experiences, without being influenced by previous research or theory. A reflexive diary was kept throughout analysis to support authors to identify biases bought to the interpretation and analyses.

3.G - Mediation Analysis

The regression model was used to conduct a mediation analysis to explore whether self-stigma mediates the relationship between conformity to masculine norms and help-seeking intentions. According to Baron and Kenny (1986), completing a mediation analysis involves first establishing whether conformity to masculine norms predicts help-seeking intentions, and if this relationship is significant. Secondly, conformity to masculine norms must be established as a significant predictor of self-stigma. Finally, to confirm a mediation effect, the observed beta values for the first relationship between conformity to masculine norms and help-seeking intentions should decrease with the addition of self-stigma.

Our results did not find conformity to masculine norms to be a significant predictor of help-seeking intentions (standardisedβ= -0.23, p=0.09). According to Baron and Kenny (1986) would suggest that a mediation analysis is not advisable. However, their approach to mediation analysis has been heavily criticised by more recent researchers who state that researchers should continue with the planned mediation analyses if there is a strong rationale for believing a mediation effect exists, or it is suspected that the first relationship may have appeared non-significant due to a small effect size (Shrout & Belgerm, 2002).

It was therefore felt appropriate to continue with the planned mediation analysis as there was previous research indicating that a mediation effect exists (Latalova, Kamaradova & Prasko, 2014; Vogel et al., 2011). Additionally, it was possible that a significant relationship was not found due to the sample size being too small to detect

the effect size, as opposed to no effect existing, as previous effect sizes for the relationship between masculine norms and help-seeking intentions have been shown to be smaller than the relationship between self-stigma and help-seeking (Latalova, Kamaradova & Prasko, 2014; Vogel et al., 2011).

In relation to the remaining steps of mediation analysis, conformity to masculine norms was found to significantly predict self-stigma (standardisedβ= 0.30, *p*=0.03). Finally, the full model, with both self-stigma and conformity to masculine norms as predictors was significant (*p*=0.00) and the observed standardised beta values for the relationship between conformity to masculine norms and help-seeking intentions decreased with the addition of self-stigma (standardisedβ=-0.11, *p*=0.42). These results suggest that self-stigma does partially mediate the relationship between conformity to masculine norms and help-seeking intentions. This means that a large proportion of the variance in father's help-seeking intentions which was thought to be explained by men's conformity to masculine norms, is better explained by their levels of self-stigma.

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Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*(6), 1173–1182.

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3.H – Supporting Quotes

Theme	Subtheme	Supporting quotes
Being a 'man'	Don't talk about feelings	"don't find it helpful to talk" [BU24] "I never talk to people about my feelings, just something I have never really done and I feel like they would worry all the time and it would then become an irritant" [RO21 "lack of experience discussing feelings, and a sense that I'd be thought of as just making a fuss about nothing" [ST01] "it feels awkward and I didn't want to bring up such as 'depressing' subject" [WH18]
	Men as providers	"didn't have much time for friends due to covid/ work (front line)/ two babies" [HA16] "there is very little time when supporting a newborn and wife to focus on yourself" [LO04] "child care, lack of support to enable me to attend and locations are some distance away" [RO21] "time limitations from being self employed and needing to [be] available to support partner and children" {TE11]
	Protecting others	"not wanting to overshadow my partner's needs" [BE17] "my friends don't have children so I don't feel they understand or want to hear about it" [BU27] "not wishing to exaggerate the importance of my feelings in circumstances where my wife was under far greater strain" [CL10] "felt partner was also not coping" [HA16] "my wife became depression after our childs birth, that was a barrier as I was worried if she knew how I was it might make her worse or blame herself. She was suicidal so I couldn't risk it" [HI81] "I couldn't talk to my friends incase my wife found out through them, she would have been upset I didn't speak with her first. Her mood and sense of worth were already low" [HI81] "seems selfish when partner does more than me" [SO20] "not wanting to burden partner" [WE6] "there isn't really room for me to voice my own struggles when they are struggling with their own" [WO16]

	Staying strong	"I'm the man, and the world thinks we should just get over it" [MC07] "perceived mental weakness" [MC08] "my own perception of the pain I was feeling and not wanting to be seen as weak" [QU09] "becoming the dad, the man who should be in control and strong for his family" [SE14] "need for being strong for partner and children" [TE11]
Changing recognition and understanding	Public awareness	"if the doctor/ midwife could have told me men go through this not just women" [MS01] "more awareness on the matter that fathers can feel this way not just mothers & being given information to understand why I'm feeling like this" [ON5] "never knew it existed" [BI24]" "having better awareness" [ON5] "there's no awareness of GPs and other professionals for it" [SI02] "reassurance that I would be taken seriously" [ST01] "knowledge of it" [VA29] "antenatal information to cover stress and MH issue for fathers" [WE6] "a lack of acknowledgement of it as a common phenomenon and general difficulties in obtaining referrals for appropriate mental health services" [WO16]
	Realising need help	"realising that you might need help is hard" [BI11] "my own sense that no matter how bad I was feeling, I will just making a fuss or being ridiculous" [ST01] "unsure" [VA29]
	Missing information	"clear signposting of services" [BE17] "more information maybe" [BI11] "wouldn't know where to go for help" [BR27] "information given about available support" [CO04] "there's no reference to it on Google's first hits. There's a lot on women scenarios and focus that makes me feel uncomfortable even to suggest paternal depression" [SI02] "advice on where to go, who to talk to, common methods for dealing with issues" [SO4] "not knowing what help was available" [WE6]

		“better information on who you should contact and how they can help” [WH18] “knowing where to go” [WI17]
Finding a voice	Not asked	“health visitors asking me how I feel. Making it clear that men can have issues and warning us before birth. Having opportunities to speak to men, [not] just women” [ED20] “pre-emptive support from work knowing that a child have arrived” [HA16] “asked prophylactically if there was any support required” [HA16] “just would’ve been nice to get a call from my wifes doctor/ nurse for an update and to ask how I was” [MC07] “it’s just not spoke about and I was never asked” [MS01] “follow up after birth as ‘standard’ by midwife and health visitor” [SI02] “why shouldn’t a health assessor talk to the father?” [SO4]
	Missing fathers	“there should have been someone there and there wasn’t” [BI24] “a program for father. I have anger issues and anxiety, I was sent to a workshop with people getting angry with their cat! Something for fathers specifically is needed” [ED20] “generally speaking, almost all of the support services are target at the mother. Covid only compounded this” [FI08] “more services available” [MO12] “post natal fatherly support… alongside motherly postnatal support” [OP14] “all external focus is on the mother. Particularly during covid as a father in the pre natal stages you couldn’t be involved so became a passenger.” [SO4] “individual check or appointment with health worker after leaving maternity ward, same as female 2 week post check up” [TE11]
	Building opportunities	“just someone to talk to and maybe some parental advice not necessarily professionals advice just someone who had been in the [same] boat” [BR27] “pre natal birth classes” [CH07] “maybe someone to vent/ get perspective from” [CO04] “virtual or phone support on an ad hoc basis” [FA08] “even one of two counselling or psychotherapy sessions would have been very helpful” [FI08]

		"I don't know, maybe just someone to talk to. I haven't told anyone how I've been. I've felt suicidal, worthless, hopeless, I know talking would have helped" [HI81] "support groups" [MO12] "maybe couples support with mental health as I believe most parents are experiencing the same things" [RO21] "virtual therapy – a light weight (in terms of time) approach" [SO20] "easier access to counselling" [WY06]
	Being supported	"nothing out of what I received" [BU24] "none with partner" [ES11] "none" [OL28] "people around me reminding and offering help" [SO20] "wider network of family support with childcare" [WI05] "I thought the help I got was just right" [WH18]
Self as a barrier	Not deserving	"I don't feel I'm depressed enough" [BI11] "Wouldn't know where to go for help and I'm not sure I deserve help" [BR27] "a feeling that perhaps I was making a mountain out of a molehill" [CL10] "I didn't think it was bad enough and I didn't want to take the service away from someone who needed it more" [WH18]
	Self-stigma	"own mind" [CH07] "I was very supported, I was my biggest barrier" [MC08] "my ego" [OP14] "the stigma and expected cost" [WH13] "myself. Scared of what people will say" [WI04]
	Shame	"Embarrassment, didn't want pity" [ON5] "I feel ashamed to even suggest [postnatal depression] as there's no concern about men at all" [SI02] "shame" [VA29]

3.I – Instructions for Authors: BMC Pregnancy and Childbirth

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list the full names and institutional addresses for all authors

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The Abstract should not exceed 350 words. Please minimize the use of abbreviations and do not cite references in the abstract. Reports of randomized controlled trials should follow the CONSORT extension for abstracts. The abstract must include the following separate sections:

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The methods section should include:

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Results

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2011. http://dx.doi.org/10.5524/100012.