PARTNER INVOLVEMENT: NEGOTIATING THE PRESENCE OF PARTNERS IN PSYCHOSOCIAL ASSESSMENT AS CONDUCTED BY MIDWIVES AND CHILD AND FAMILY HEALTH NURSES

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ABSTRACT: Universal screening for maternal depression and assessment of psychosocial risks has been integrated into the routine perinatal care provided in many Australian hospitals, but to date, partners/fathers have been largely excluded from the process. This study explored the ways in which clinicians in health service settings include partners who attend antenatal and postnatal visits with women. Qualitative data were collected using observations (n = 54), interviews (n = 60), and discussion groups (n = 7) with midwives and child and family health nurses who conducted the appointments. Transcripts from observations, interviews, and discussion groups underwent qualitative analysis, and key themes were identified. Results showed partners to have little or no involvement in psychosocial assessment and depression screening. Thematic analysis revealed four key themes: negotiating partner exclusion, partial inclusion, women’s business or a couple concern? and they know anyway. Partner involvement appeared to be challenged particularly by mandatory interpersonal violence screening, which, according to health service policy, is to be conducted confidentially. Overall, results highlighted partner involvement in perinatal depression screening and psychosocial assessment processes and identified some of the benefits such as partner disclosure, but also the challenges and complexities of inclusion of partners. Clinical implications and directions for further education and research are discussed.

Keywords: psychosocial assessment, depression screening, women’s mental health, perinatal, postnatal depression, domestic violence screening

RESUMEN: Un examen universal para detectar la depresión materna y evaluar los riesgos sicosociales ha sido integrado dentro de la rutina de cuidado perinatal que se provee en muchos hospitales Australios, pero hasta ahora la pareja/el padre ha sido excluido por la mayor parte de este proceso. Este estudio exploró las maneras mediante las cuales los clínicos de lugares de servicio de salud incluyen a la pareja que asiste a las visitas antenatales y postnatales con la mujer. Datos cualitativos se recogieron usando observaciones (n = 54), entrevistas (n = 60) y discusiones de grupo (n = 7) con parteras y enfermeras de niños y familia que dirigieron las reuniones. Las transcripciones de las observaciones, entrevistas y discusiones de grupo fueron sometidas a un análisis cualitativo y se identificaron temas claves. Los resultados mostraron que las parejas tenían poca o ninguna participación en la evaluación sicológica y el examen de detección de la depresión. Análisis temáticos revelaron cuatro temas claves, entre ellos, ‘negociar la exclusión de la pareja’, ‘inclusión parcial’, ‘asunto de mujeres o preocupación de ambos?’, y ‘ellos saben de cualquier manera’. La participación de la pareja pareció ser retada particularmente por el obligatorio examen de detección de violencia interpersonal, el cual, de acuerdo con la política de servicio de salud, debe llevarse a cabo confidencialmente. En general, los resultados subrayan la participación de la pareja en la detección de la depresión perinatal y los procesos de evaluación sicosocial, e identificaron algunos de los beneficios tales como la revelación de quién es la pareja, pero también los retos y complejidades de la inclusión de la pareja. Se discuten las implicaciones clínicas y directrices para educación e investigación adicional.

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Palabras claves: evaluación sicosocial, detección de depresión, salud mental de la mujer, perinatal, depresión postnatal, detección de violencia doméstica

RESUMÉ: La detección universal de la depresión materna y el diagnóstico de riesgos psicosociales están integrados en el programa perinatal de atención integral para mujeres. Esta investigación exploró las maneras en que los profesionales en servicios de salud se involucran en la detección de la salud mental y mental de la madre durante el embarazo y el período posnatal. Los investigadores realizaron observaciones, entrevistas y grupos de discusión, que fueron analizados cualitativamente. Los resultados revelaron cuatro temas claves: "el exclusión del compañero", "participación parcial", "asunto de la mujer o una cuestión del par de parejas?" y "saben que lo saben". Los resultados sugieren que las parejas rara vez, o en absoluto, participan en la evaluación psicosocial y el diagnóstico de la depresión. Las implicaciones clínicas y las direcciones para futuras investigaciones se discuten.

Mots clés: Evaluation psychosociale, dépistage de dépression, santé mentale de la femme, perinatal, dépistage postpartum, dépistage de violence conjugale


Stichwörter: Psychosoziale Beurteilung, Depressionsscreening, psychische Gesundheit von Frauen, perinatal, postnatale Depression, Screening, von häuslicher Gewalt

抄録: 全部の母親への母性抑うつのスクリーニングと心理社会的リスクの評価、多くのオーストラリアの病院で提供されるルーチンの産後ケアに統合されてきた。しかし、現在パートナー/父親はこの過程から大部分除外されてきた。この研究では、健康サービスの場にいる医療者、女性と承認後の訪問に参加するパートナーを含む方法を実践した。研究者を行った助産師と子ども家庭の保健師とともに、観察（n = 54）、インタビュー（n = 60）、およびディスカッション・グループ（n = 7）を用いて質的データが集められれた。観察、インタビューおよびディスカッション・グループの世話記録、質的分析を受け、既報のテーマが見つけられた。結果から、心理社会的評価と抑うつのスクリーニングに、パートナーはほとんどまでは全く関わっていなかったことが示された。テーマ分析から4つの要素となったテーマが明らかにされた。すなわち「パートナーの排除と折り合いをつけること」「部分的に含まれること」「女性の仕事か二人の関心か?」「いずれにしろ彼らは知っている」である。パートナーの関与は、強制的な対人暴力のスクリーニングによって、特に課題をつけることのような見える。そのスクリーニングは、健康サービス政策の結果、守秘で行われなければならないうち事を全体として、結果は産後期抑うつのスクリーニングと心理社会的評価の過程におけるパートナーの関わりを強調する。そしてパートナーの開示のないいくつかのリスクも見つけられたが、しかしパートナーを含むことの課題と複雑さも見つけられた。臨床的な意味と、今後の教育と研究の方向性が考察される。

キーワード: 心理社会的評価、抑うつのスクリーニング、女性の精神面、周産期、産後抑うつ、家庭内暴力スクリーニング

摘要: 母親抑鬱症と心理社会的評価の評価が産婦人科の病院で提供されるルーチンの産後ケアに統合されてきた。しかしこの過程から大部分が除外されてきた。この研究では、総合的な保健サービスの場において、師助産や子ども家庭の保健師と観察（n = 54）、インタビュー（n = 60）、ディスカッション・グループ（n = 7）を用いて質的データが集められた。観察、インタビューおよびディスカッション・グループの世話記録、質的分析を受け、既報のテーマが見つけられた。結果から、心理社会的評価と抑うつのスクリーニングに、パートナーはほとんどまでは全く関わっていなかったことが示された。テーマ分析から4つの要素となったテーマが明らかにされた。すなわち「パートナーの排除と折り合いをつけること」「部分的に含まれること」「女性の仕事か二人の関心か?」「いずれにしろ彼らは知っている」である。パートナーの関与は、強制的な対人暴力のスクリーニングによって、特に課題をつけることのような見える。そのスクリーニングは、健康サービス政策の結果、守秘で行われなければならないうち事を全体として、結果は産後期抑うつのスクリーニングと心理社会的評価の過程におけるパートナーの関わりを強調する。そしてパートナーの開示のないいくつかのリスクも見つけられたが、しかしパートナーを含むことの課題と複雑さも見つけられた。臨床的な意味と、今後の教育と研究の方向性が考察される。
Given the known negative impacts of maternal perinatal mental illness (Howard et al., 2014; Stein et al., 2014), Australia, like many countries around the world, has acknowledged the importance of prevention and early intervention. The Australian federal government funded the beyondblue National Perinatal Depression Initiative, with the aim to improve prevention and early detection of women at risk of postnatal mental health difficulties and to provide better support and treatment for women in Australia experiencing depression and related disorders (Buist & Bilzta, 2006). Following this, national clinical practice guidelines for depression and related disorders were developed (beyondblue, 2011).

Many Australian states have developed and implemented early identification and intervention programs in line with these national recommendations. In New South Wales (NSW), for example, universal screening for depression and assessment of psychosocial risk has been integrated into routine perinatal care throughout the public sector under the Supporting Families Early policy and the Safe Start model of care (NSW Department of Health, 2009a, 2009b, 2009c). In this model, women are screened and assessed by midwives as part of the first antenatal booking-in visit and then by child and family health nurses (CFHNs) in the early postpartum period using a series of structured questions based on known risk factors for perinatal mental illness (beyondblue, 2011) and the Edinburgh Postnatal Depression Scale (EPDS; Cox, Chapman, Murray, & Jones, 1996; Cox, Holden, & Sagovsky, 1987). Site-specific referral pathways allow for the provision of further assessment, intervention, and support services where needed.

While the aim of the NSW Safe Start model is to improve mental health outcomes for “parents and infants” (NSW Department of Health, 2009b), in practice, the focus is primarily on mothers. Given the high prevalence of maternal mental health issues in the perinatal period (Gavin et al., 2005; Howard et al., 2014; Woolhouse, Gartland, Mensah, & Brown, 2014) and the known impacts of poor maternal mental health on child outcomes (Stein et al., 2014), this is an appropriate focus. There are, however, a number of reasons why the experience and involvement of fathers/partners in the perinatal psychosocial assessment process also requires attention. Recent studies have shown, for example, that the prevalence of paternal perinatal depression is similar to that for women (Giallo et al., 2012); that paternal psychological well-being also can predict infant outcomes, both independently and as a mediating factor against the effects of maternal mental illness (Carro, Grant, Gotlib, & Compas, 1993; Fletcher, Freeman, Garfield, & Vimpani, 2011; Hanington, Heron, Stein, & Ramchandani, 2012; Ramchandani, Stein, Evans, O’Connor, & the ALSPAC Study Team, 2005); and that there are links between maternal perinatal mental illness and the quality of support provided by the father/partner (Milgrom et al., 2008).

This suggests that there may be benefits from assessment of fathers/partners as well as women in the perinatal period (Buist, Morse, & Durkin, 2003; Fletcher, Matthey, & Marley, 2006; Fletcher, Vimpani, Russell, & Sibbritt, 2008). However, various practical issues may complicate efforts to do so. For example, midwives and CFHNs are required to screen women for domestic violence as part of the psychosocial assessment (NSW Ministry of Health, 2012) and also discuss potentially sensitive issues such as past terminations of pregnancy or other health issues. To ensure privacy and follow the recommended protocol when conducting psychosocial assessment, partners or others accompanying the woman are invariably excluded from this part of the care process. The way in which a midwife or CFHN introduces psychosocial assessment and negotiates the partners’ or others’ degree of involvement may impact on the woman’s and/or her partner’s experience of health services.
The aim of this article, therefore, is (a) to explore how midwives and CFHNs interact with the partners or others who attend appointments with pregnant women or new mothers when psychosocial assessment and depression screening will be conducted and (b) to describe women’s perceptions of their partners’ experience of this practice.

**METHOD**

Between September 2010 and October 2011, data were collected for an ethnographic study which investigated the process of psychosocial assessment and depression screening in two sites in NSW, Australia. During the study, the first author (M.R.) observed the approach that health professionals used to negotiate the involvement or exclusion of partners or others attending with the woman. The impact of this on women and partners or others in attendance was explored through interviews with women and through interviews and discussion groups with health professionals. Ethics approval for the study was obtained from the Human Research Ethics Committee in the two local health districts where the study was conducted and from the University of Western Sydney.

**Setting**

The study was conducted in two local health districts in NSW where psychosocial assessment was being conducted. These sites were selected because the assessment and depression screening processes had been in place in the antenatal period for over 5 years.

**Recruitment and Participants**

Participants included women, midwives, and CFHNs who were first informed about the study via information leaflets and information sessions facilitated by the first author (M.R.) on visits to the study sites. Research team members also were available on a regular basis in the waiting area of the antenatal clinic to provide women and midwives with information about the study. A total of 34 women agreed to be observed during their antenatal booking visit, and 16 midwives and 2 student midwives interacting with these women also agreed to participate in the study. Following birth, 20 of these 34 women were observed in interactions with 13 CFHNs either in their home or in a clinic setting. Women were required to speak sufficient English to participate in the study. Women requiring an interpreter were excluded.

**Data Collection**

Data collection included observations of interactions between women, midwives, and CFHNs, semistructured interviews following observations with women and health professionals, and discussion groups with midwives and CFHNs.

**Observations**

Data were collected via observation of interactions between women and midwife/CFHN at two time points, once antenatally and once postnatally. The first author observed 34 antenatal booking visits and 20 postnatal visits. Antenatal observations occurred with 15 women and 7 midwives (including one student midwife) at Site A and with 19 women and 11 midwives (including 1 student midwife) at Site B. Postnatal observations of interactions between 11 women with 7 different CFHNs took place at the home visit, 2 to 4 weeks after birth, and another 6 CFHNs were observed in interactions with 9 women in the health center.

**Fieldnotes**

An observation tool (4D&4R) was developed for the study (Rollans, Meade, Schmied, & Kemp, 2013). The 4Ds (introduce, deliver, deal, and debrief) was designed to record details about the approach taken by both midwives and nurses to the psychosocial assessment. The 4Rs (react, respond, real experience, and reflect) facilitated recording detail of the woman’s response. The observation tool was used in combination with fieldnotes (FNs) to document interactions between the woman and the midwife/CFHN during psychosocial assessment and screening.

**Interviews**

Semistructured interviews were conducted with 31 women in the antenatal period and 29 women following birth. Brief interviews with midwives and CFHNs occurred directly after the interaction. These interviews were comprised of a series of open-ended questions to elicit information about experiences of the assessment process; for example, “How do you think the assessment went? What do you think worked well? What would you do differently?” The interviews took approximately 15 to 40 min, and with permission, all interviews were digitally recorded.

**Discussion Groups**

Both midwives and CFHNs attended discussion groups (DGs) facilitated by the first (M.R.) and last (V.S.) authors. Seven group discussions in total were conducted, two with midwives and five groups with CFHNs). The groups each had between 10 and 30 participants, all of whom had been conducting psychosocial assessment and depression screening. With the participants’ permission, all DGs were digitally recorded and transcribed verbatim, with all identifying material removed.

**Data Analysis**

The observational tool data were analyzed descriptively using frequencies and proportions (Krippendorff, 2004) to describe the process of assessment and screening. Qualitative data from the FNs of the observations, including verbatim of interactions between
midwife/CFHN and women, and interview and DG transcripts were analyzed thematically. Codes were identified that described the process of psychosocial assessment, with illustrations of the interaction and the women’s response to the assessment. Emerging concepts and themes were constantly compared with other themes and refined (Liamputtong & Ezzy, 2005). This process resulted in identification of key themes (Braun & Clarke, 2006).

RESULTS

Fifteen women were recruited at Site A and 19 at Site B. On average, women participants were 30 years of age. Over half (20 of 34) were born in a country other than Australia. Five women were born in English-speaking countries such as Ireland, United Kingdom, and 15 women born in non-English-speaking countries such as Egypt, Laos, India, and China. Eighteen of the 34 women were having their first baby; however, 10 of these women had previous pregnancies, but had no living children. The participants were well-educated, with 30 of them having tertiary qualifications, and all were either married or living with their partner, who was the father of the baby. The average years of experience of the 16 midwives were 5 years, and 12 of these midwives had worked an average of 3 years in the antenatal clinic. The professional experience of the CFHNs ranged from 1 year to over 20 years. Of the 13 CFHNs who were observed, 8 had greater than 5 years of experience.

On some occasions, women’s partners or others were present for some of the antenatal booking visit or postnatal appointment with the CFHN. At Site B, partners were able to be present for part of the antenatal booking visit; at Site A, partners were told they were unable to attend the entire antenatal booking visit. At Site B, partners were asked to leave prior to the psychosocial assessment and depression screening. At both sites, therefore, partners were excluded from the psychosocial assessment.

Several themes emerged from the analysis of observation, FNs, DGs, and interview data related to the ways in which the midwives and CFHNs negotiate the role of partners or support person in the booking visit and in the postnatal visits, how inclusion and exclusion was negotiated, and their perceptions and experiences of this process. These themes include negotiating partner exclusion, partial inclusion, women’s business or a couple concern? and they know anyway.

Negotiating Partner Exclusion

The way in which midwives and CFHNs approached male partners and others who attended the visit varied at each site and depended on the local policy and protocol relating to the attendance of partners. At both Sites A and B, partners were not excluded by the CFHN at the first home visit; nurses adapted their assessment and screening practices if partners were present (i.e., omitting the interpersonal violence screening). Local policy at Site A meant that partners or others would be excluded from the entire antenatal booking visit, which appeared to place midwives in a difficult position if others arrived at the clinic with the woman. On three occasions, it was observed that a midwife had to explain to partners why they were not able to be present. In contrast, at Site B, midwives discussed with partners that there would be a time that they would be asked to leave the booking visit. Midwives and CFHNs adopted various strategies to negotiate these policy requirements, which included reading verbatim the explanations provided in local protocols or making light of the situation through the use of humor.

At Site A, 3 of the 15 women were accompanied by their partners or another person to the antenatal clinic. On each occasion, the midwife was observed explaining to the woman and her partner/others that they were not permitted to accompany the woman for the booking visit and requesting that they wait in the waiting room. In two of the three appointments, the person accompanying the woman acquiesced and returned to the waiting room without saying anything. However, on one occasion, the male partner indicated that he was distressed by this, stating in an irritated/angry voice that “She has nothing to hide” (FNW17). The woman also appeared displeased with the request, demonstrated by a perplexed facial gesture, crinkling of the forehead, and decreased eye contact (FNW17), but tried to console the partner by saying “It’s okay, just wait; we won’t be long” (W17).

At Site B, partners were present in 10 of the 19 antenatal observations; in one instance, the woman’s mother attended, but was treated by the midwife in the same way as would be a partner. Midwives and CFHNs in Site B appeared to have streamlined the process of dealing with the policy requirements. At the start of both the antenatal and postnatal visits, the midwife/CFHN would inform the partner/mother that they would be asked to leave the room for part of the appointment. For example, the midwife/CFHN stated:

“There’s a whole load of questions, about your physical health and there’s a section on your emotions and social supports and we’ll ask you (looks to partner) to leave the room during that section. (M5)

We’re going to run through a whole set of questions and at one point (turning to face the partner) just ask you to leave the room for a 5 minute chat. (SM2)

At times, midwives made reference to what would be asked during the partner’s absence. The following is an example of this explanation:

So the following questions are a little bit sensitive, so we get all family/partners out, we only do this questionnaire with the woman, so I’ll just get you to wait outside. (M14)

It’s been lovely meeting you, I’m going to get you to wait in the waiting room for the last 5 minutes or so, just while we ask you (turns to woman) a few more questions or so, those personal questions; we just do that as a routine thing. (M9)

Midwives on occasion used humor to approach this issue. For example, on one occasion, the woman’s partner explained that he was feeling “guilty” that he would have to leave the appointment
early, and the midwife responded with “Don’t worry, we’re going to kick you out at some point anyway.” (SM2)

During observations of the psychosocial assessment process, it was evident that the request by a midwife or CFHN for the partner to leave impacted negatively at times on the woman and also her partner. In the following interaction, the partner of one woman (W14) was asked by the midwife (M7) to complete some paperwork. When he returned to the interview room with the completed forms, the midwife had commenced asking the psychosocial assessment questions and refused him entry into the room without explanation. The partner looked concerned about this because his wife spoke limited English and he had been assisting with interpretation. As instructed, he waited in the waiting room; however, this was a long wait (FNW14). The assessment took approximately 40 min, and the midwife did not prepare the partner for this or provide any further explanation to the partner. The partner approached the receptionist of the antenatal clinic, who telephoned the midwife. On receiving this call, the midwife responded in a friendly manner stating “Tell him to wait” (M7).

Furthermore, the language used to describe what was to happen while the partner was out of the room also may impact negatively on the woman or partner. On one occasion, CFHN7 explained to a partner when requesting him to leave the room that “If she’s complicated, I’ll be more than a few minutes” (CFHN7), to which the partner replied “I’ll see you in an hour then.” The CFHN and the partner then laughed loudly together. The woman looked uncomfortable at this comment (puzzled expression on her face, crinkled forehead, and slouching in her chair). In another situation, the partner was asked to leave the clinic room because “We’re going to talk about you (turns to the partner) now” (M9).

Similar to the midwives, CFHNs used a range of strategies in the postnatal clinic setting to minimize the impact of a partner or other person being excluded and to promote partial inclusion. On two occasions when the CFHN requested a partner to leave the room during the psychosocial assessment, the CFHN offered the male partner the opportunity to complete the EPDS himself. This occurred with two different CFHNs and may have represented an attempt at partially including the partner in the process.

One CFHN introduced the EPDS to the partner in the following way: “Would you like to complete one of these, it’s a depression scale; you can do one of those while you’re out there” (CFHN7). In this instance, the woman (W12) then went on to describe to the CFHN (CFHN7) how her partner was tearful when leaving home to go to work, as he did not want to leave the baby. The CFHN7 then asked the partner to return to the room following the woman’s psychosocial assessment, at which point he handed the completed EPDS to the nurse. The nurse calculated the score and noticed that it was higher than was the woman’s score. The CFHN then attempted to explain the difference in the scores as seen in the following quote; however, no further resources or supports were offered: “Now that’s fine, because you’re very supported (looks at the woman), was only 3, and you (looks at the partner) taking the stress more, more stress on you probably (referring to the partner), 8, but they (the EPDS scores) are still fine” (CFHN7).

On one other occasion when a woman’s partner (P21) was asked to complete the EPDS, the nurse (CFHN13) simply took the completed paper-based EPDS from the man, reviewed it herself, and placed the copy of the EPDS in the woman’s file with no further conversation or feedback to man or the woman (W21).

**Partial Inclusion**

When the partner was present, midwives and CFHNs were observed to use a range of simple strategies to include partners in the antenatal or postnatal visit. For example, they greeted the partner by name, demonstrated sensitivity to the concerns of the woman and the partner, and created opportunities to discuss their feelings about becoming parents. For example,

M7: Thanks for coming today. It’s great to meet you both, and congratulations on becoming parents, how are you feeling about that?

FN10: (partner replies) It’s a bit daunting.

W10: (looks to partner and nods her head) Ohmm yeah.

M7: Really? How so?

When present, partners themselves were observed to be actively interacting or wanting to be involved during the antenatal booking visit. For example, they sought advice or guidance from the midwives, which demonstrated a concern for their female partner and the unborn baby, by asking the midwife or nurse a question. One partner inquired: “So the echo test that you mentioned . . . there’s no need for that is there, the amnio covers everything?” (FNW30).

**Women’s Business or a Couple’s Concern?**

During one-to-one, antenatal interviews with the women, 9 of the 34 discussed the issue of their partners being present. The majority of women (6 of 9) agreed that it was better that their partners were not present, describing the assessment process as “women’s business” and that they felt more comfortable and could speak more freely when their partners had left the room. In one instance, a woman stated that “I’m glad you didn’t ask me that question whilst he was around, that would have made me feel really uncomfortable” (W9). In another instance, one woman said that “I think it’s important these questions are asked of women when they feel safe and private so they can say how they really feel” (W4).

Finally, one CFHN reflected in discussion how a woman initiated a disclosure about previous violence prior to the intimate partner violence (IPV) screening once her partner had left the room, providing the following description: “When the husband left the room, the woman described that she’d been in a 10-year domestic violent relationship prior to this one, so she’d had some experience, but nothing was happening currently” (DG5).

In contrast, some women suggested that it would be useful to also ask the partner how he is feeling; that is, to undertake a psychosocial assessment with the partner:

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It was good that my partner was not there because I was able to talk very frankly but on the other side he should also be interviewed at some point, how does he feel so they can together calculate and plan for both of us.

(W18)

At Site A, where partners are excluded from the booking visit, 2 women discussed during interviews that they would have preferred their partners to be present for some of the booking visit and 1 woman would have liked him to be present during the psychosocial assessment. The women indicated that if their partners were there, it would have provided an opportunity for the partners to engage more with the pregnancy and gain a greater understanding of what was occurring: “He’s found it hard to identify with it (the pregnancy) . . . he would have understood a little bit more about what we’re about to do” (W9).

In addition, for these 2 women, their partners were perceived as their main support particularly if they felt “shy, alone and overwhelmed” (W17). A woman of Arabic background, who disclosed one negative life experience relating to domestic violence in a previous relationship 5 years prior, stated that “I would like him to be there for support . . . very hard for me to talk about those things and he understands he could have helped me” (W17).

This woman (W17) also described following her disclosure that she was quite distressed, and her husband was the person who provided support for her following the visit.

On two occasions, when the midwife was collecting information from a woman during the booking visit about her general health and reproductive history, the partner remained in the room. During the assessment of the woman’s mental health history, one partner disclosed his previous and current mental health diagnosis. In this instance, the midwife made an effort to ask further about this history and offer support; however, the woman was less enthusiastic about the disclosure:

M5: Any mental health history in the family? (looks to both the partner and the woman)
P10: I suffered from depression.

M5: Yes, can you tell me a little bit about that, was it a long period of time in your life?
P10: About 6 years in my early twenties.
M5: It was depression that they diagnosed?
P10: They labeled it schizophrenia, paranoid schizophrenia. I was just hanging out with the wrong crowd.
M5: What sort of follow up do you have now?
P10: I have a psychiatrist and I take my medication (antipsychotics) everyday. (FNW10)

In the interview with this woman (W10) following the antenatal appointment, she described feeling uncomfortable and vulnerable when her partner had to disclose this history:

I was a bit annoyed at the time, he didn’t have to go into everything . . . . She (the midwife) said we need to monitor that in respect of someone, I think comes to visit to check the psychological aspects of the child or after the baby’s born. (W10)

This woman went on to express concern that she and her family would be monitored by a range of health professionals and that their baby may be labeled as being “at risk.” “I know they’re going to think now that my baby is going to have it (schizophrenia) but I don’t believe in the genetic thing” (W10).

The presence of partners during some of the interview with midwives or CFHNs may at times provide a support for women, but in some instances may be a negative experience such as illustrated in the aforementioned examples. The tension that arises if partners are excluded, they may “know anyway” (W4) or what is being discussed, and thus the rationale for excluding becomes irrelevant or unclear.

“They Know Anyway”

The health professionals and women were both aware that when partners were asked to leave the room and were waiting for the midwife to complete the assessment, they would be thinking about what was being discussed between the woman and the midwife/CFHN. In most of the instances where a partner accompanied a woman to the antenatal appointment (6 of 9) and was asked to leave, the partners told the women following the visit that they knew what was being asked.

Some women in interviews described their partners as intuitive; “He is very intuitive, he knew exactly what was being asked” (W12) or “he said oh I know what they were asking you—probably it was that I hit you or something” (W28).

In one interview, a woman described what had occurred after the antenatal appointment: “He asked me when I came out what I was asked” (W11). The woman stated that she responded honestly to her partner and explained that they had discussed domestic violence screening and then laughed about it together:

Oh we were just talking about if I’d had any problems with him and that sort of thing. So he just—cracks a lot of jokes about me being asked about whether he beats me up. But he knows it wasn’t that anyone thought anything was happening. It’s just part of the routine of the appointment. (W11)

During DGs, midwives and CFHNs indicated that many women were now aware, as they had heard from other women, friends, and community, that they would be asked a range of sensitive questions at their appointments and that their partners would be asked to leave the room. They noted that some women now come to these appointments requesting the midwife to start with the psychosocial assessment and then invite partners back in:

Sometimes we start off with psychosocial screening first because they’ve (the women) told you that’s how they want things done. A lot of them (women) now expect the psychosocial questions. They say “Oh, yes I know my partner has to leave the room—because all their friends have told them.” (the partner) (DGM1)

One also added that men talk to men and discuss with each other what to expect at the booking visit, for example: “They talk to each other. . . . Most of the time men know what’s coming
anyhow, they know the types of questions we ask around violence and social issues” (DGM2).

**DISCUSSION**

This study explored the way in which midwives or nurses managed the presence of partners and others during the antenatal booking visit or postnatal appointment when the health professional was required to conduct the routine psychosocial assessment and depression screening. Across both observation sites, partners had little or no involvement in psychosocial assessment and depression screening, and at one site, partners were purposefully excluded from the entire antenatal booking visit. This created tension for some women and also for health professionals, particularly if partners reacted with frustration or anger toward the health professional in response to that exclusion. In the situation where the partner was present during part of the visit, midwives and CFHNs had to alter their approach to the introduction of the psychosocial assessment and find a way to ask the partner or other to leave prior to the psychosocial assessment. At times, the health professional was insensitive in their approach to this and may have provoked suspicion on the part of the partners and discomfort for the woman.

**Partner Involvement in Perinatal Care**

Research has pointed to the widespread benefits of involving fathers in perinatal care, with improvements shown in a range of areas such as the quality of father–infant interaction (Fletcher, 2009) and maternal psychological well-being (J.R. Fisher, Wynter, & Rowe, 2010; Misri, Fox, Kostaras, & Kostaras, 2000). While it is therefore heartening that recent decades have seen men become increasingly involved in antenatal and postnatal education and childbirth, it is clear from both this study and previous research that the focus of maternity care and perinatal services continues to be on women’s needs (Massoudi, Wickberg, & Hwang, 2011; Steen, Downe, Bamford, & Edozien, 2012). Midwives and CFHNs are well-placed to engage with fathers and include them in the planning of appropriate care for their newborn (NSW Department of Health, 2009a; Rollans, Schmied, Kemp, & Meade, 2013a), but results of the current study suggest that this is not always happening as well as it could be. A recent meta-synthesis similarly concluded that while fathers feel themselves to be “partner and parent,” their experience of maternity care services is as “not-patient and not-visitor,” leaving many men to feel excluded and fearful (Steen et al., 2012). These authors have argued that positive and authentic engagement, where fathers are active in the journey to parenthood, has the potential to increase trust, reduce fear, increase resilience in the face of uncertainty or adversity, and facilitate men’s experience as valued coparents rather than as spectators and bystanders.

**Routine Screening for IPV**

Common to all sites examined in this study was the exclusion of partners during the IPV screening, a practice that aligns with recommended guidelines (NSW Department of Health, 2009a). Findings presented here and in a previous article (Rollans, Schmied, Kemp, & Meade, 2013a) have indicated that most women valued the opportunity to discuss a personal or sensitive health issues alone with the midwife or CFHN. Indeed, with regard specifically to IPV, screening performed without the presence of the partner is likely to optimize honest disclosure and discussion about IPV issues (Anglin, 2009). Findings also have suggested, however, that excluding partners also can be associated with negative outcomes such as them feeling unwelcome or not needed, fearing that something is wrong with their partner, or frustration associated with a belief that the partner has nothing to hide. In some cases, it may be the woman herself who prefers to be able to access her partner’s support when talking about IPV issues in a previous relationship. Furthermore, although it was not observed in the current study, it is possible that in cases where IPV is present, resistance and dissatisfaction from the partner about being excluded from the interview may put the woman at greater risk of harm from the partner after the interview (e.g., arising from the partner’s resentment or displeasure at possible IPV disclosure). Given the issues identified in this study, it is not surprising that routine screening for IPV in healthcare settings has been controversial and met with some criticism (Taft et al., 2013). Despite the various complexities and challenges, however, screening for IPV in perinatal healthcare settings is justified by evidence of the significant, long-term consequences for women and their children of IPV (El Kady, Gilbert, Xing, & Smith, 2005; Golding, 1999; & Shah & Shah, 2010; Nelson, Bourgatsos, Blazina, 2012).

The current study highlights the complexities involved in integrating psychosocial assessment and IPV screening into routine practice while also encouraging partner involvement in perinatal services, but it also highlights the role that health professionals can play in facilitating a positive or negative experience for partners. Partner exclusion for the sake of IPV screening is likely to be more acceptable to women and partners when it is introduced and explained using a clear and sensitive communication style—aspects of clinical practice that should be a focus of supervision and training curriculums for midwives and ECHNs conducting perinatal psychosocial assessments and IPV screening. IPV screening is likely to be an aspect of practice that is challenging for health professionals; for this reason, additional support and training may be required (NSW Department of Health, 2009b; Rollans, Schmied, Kemp, & Meade, 2013b).

**Men and Screening in the Perinatal Period**

The current study provides evidence to support previous suggestions that psychosocial assessment, including depression screening, be introduced for men in the perinatal period as well as for women (Fletcher et al., 2008; Goodman, 2004). The prevalence of paternal depression in the period surrounding childbirth and its association with compromised infant and maternal outcomes are now well-documented (Fletcher et al., 2011; Giallo et al., 2012; Goodman, 2004; Paulson & Bazemore, 2010; Ramchandani et al.,
This suggests that a detailed assessment of fathers during the postnatal period, especially when their female partners are depressed, is warranted to allow for timely and appropriate treatment and interventions. As with maternal depression, a range of predictive factors have been implicated, such as a previous history of depression, high prenatal scores for depression and anxiety, and the presence of maternal depression (Goodman, 2004; Ramchandani et al., 2008). In this study, when the midwife asked about a family history of mental illness when the partner was present, it facilitated a disclosure from the partner about an existing mental health diagnosis, and this was explored in the context of the impact on the woman and their infant. Similarly in the postnatal period, some CFHNs were observed providing partners with the EPDS to complete while they waited outside the room when the nurse was conducting the psychosocial assessment with the woman. In one instance, a partner’s score exceeded the woman’s; however, this was not explored further by the nurse. Also note that when a health professional takes the initiative to screen women’s partners in the perinatal period, they are providing important education and information about the effect that postpartum depression and psychosocial issues can have on the whole family. Caution should be noted here because screening partners for depression can be conducted using the EPDS (S.D. Fisher, Kopelman, & O’Hara, 2012), connecting men with clinical services may present challenges.

Limitations

There are several limitations of this study. First, the data reported here about partners’ experiences were gathered via observations of interactions between clinicians, women with partners in attendance, and through interviews with pregnant and postpartum women and health professionals. It is therefore important that future research be conducted with women’s partners. None of the women participants in this study were in same-sex relationships, and although the term partner is used, in this study this refers only to male partners. Again, it will be important to ascertain the experience of female partners of pregnant women. The study also was limited to women who did not require a healthcare interpreter in their antenatal or postnatal appointments. The experience of being asked sensitive questions through the use of an interpreter may pose a significant barrier to effective communication and would be important to capture through research. Finally, this study was conducted in two metropolitan sites that had been engaged in assessment and screening for a long period. The experiences of conducting these assessments may be different in rural and remote areas and in sites that have only recently implemented the assessment process.

Implications for Practice

While current policy in NSW and elsewhere mandates screening for IPV, there is the potential to balance this requirement with the needs of women and their partners by reexamining procedural issues. For example, if midwives were afforded some flexibility to conduct IPV screening at later antenatal appointments rather than at the first booking-in visit, which partners often attend, they may be able to better accommodate the needs of women and their partners. Strategies to improve the interpersonal skills of clinicians appear to be crucial. Specifically, psychosocial assessment and depression screening appears to be more acceptable and inclusive of partners when the process is introduced and explained using a clear and sensitive communication style. Specialized training for midwives and CFHNs also should include negotiating the presence and absence of partners or others in attendance where psychosocial assessment is conducted.

Conclusion

This study explored the involvement of partners in the perinatal psychosocial assessment and depression-screening processes at two major Australian metropolitan health services. Overall, partner inclusion at these sites was minimal. Clinicians’ personal attributes and clinical skills (e.g., sense of humor, interpersonal communication skills, ability to build rapport, sensitivity to the unique situation and needs of individual families) played a significant role in whether partners were successfully included. However, various practical issues also impeded partner inclusion, most notably the requirement to assess sensitive issues such as IPV and obstetric history with the woman confidentially. Taken together, findings of this study highlight the need for the development of site-specific policies and procedures to facilitate the inclusion of partners in perinatal psychosocial assessment and depression-screening appointments. Education and training for clinical staff will be an essential aspect of this process.

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