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Partners' experiences of Bariatric Surgery and Perinatal OCD

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Module Code: D44PY

This thesis is submitted in partial fulfilment of the requirements for the degree of
Doctorate in Clinical Psychology

Coventry University, Faculty of Health and Life Sciences

University of Warwick, Department of Psychology

May 2018

Contents

| | |
|--|-----------|
| Acknowledgements..... | 5 |
| Declaration..... | 6 |
| Summary..... | 7 |
| Chapter 1: Systematic Literature Review..... | 8 |
| Partner's experiences of relationships following bariatric-surgery and post-operative weight-loss: a review of the literature | 8 |
| 1.0. Abstract..... | 9 |
| 1.1. Introduction..... | 10 |
| 1.1.1. Obesity..... | 10 |
| 1.1.2. Lifestyle interventions for obesity..... | 10 |
| 1.1.3. Bariatric surgery for obesity | 11 |
| 1.1.4. Factors that influence outcomes after bariatric surgery | 12 |
| 1.1.5. Rationale for current review | 13 |
| 1.1.6. Aims..... | 14 |
| 1.2. Method | 14 |
| 1.2.1. Literature search..... | 14 |
| 1.2.1.1. Search terms | 15 |
| 1.2.1.2. Search strategy | 15 |
| 1.2.1.3. Initial screening | 16 |
| 1.2.1.4. Specific inclusion criteria..... | 16 |
| 1.2.2. Classification of studies | 17 |
| 1.2.3. Quality assessment framework | 18 |
| 1.2.3.1. Procedure..... | 18 |
| 1.2.3.2. Reliability | 18 |
| 1.2.4. Characteristics of Studies | 19 |
| 1.3. Results | 25 |
| 1.3.1. Aim 1: how do partners' experience and adjust to their spouses' weight-loss following bariatric surgery? | 25 |
| 1.3.2. Aim 2: what happens to a partner's weight when their spouse has bariatric surgery?..... | 30 |
| 1.3.3. Aim 3: what is the impact of the bariatric surgery process on their partner's spousal relationship?..... | 32 |

| | |
|--|-----------|
| 1.4. Discussion..... | 33 |
| 1.4.1. Significance of the main findings | 33 |
| 1.4.2. Implications for Policy and Practice | 35 |
| 1.4.2.1. Bariatric surgery readiness groups and post-operative support | 36 |
| 1.4.2.2. Assessment of prior weight-loss and the reactions of significant others | 36 |
| 1.4.3. Research Limitations and Future Directions | 36 |
| 1.4.3.1. Research and review limitations | 36 |
| 1.4.3.2. Future directions | 37 |
| 1.4.4. Conclusion..... | 37 |
| References | 38 |
| Chapter 2: Empirical Paper | 47 |
| 2.0. Abstract..... | 48 |
| 2.1. Introduction..... | 49 |
| 2.1.1. Obsessive-Compulsive Disorder | 49 |
| Table 2.1. Descriptions of common OCD sub-types | 49 |
| 2.1.2. Perinatal Obsessive-Compulsive Disorder..... | 50 |
| 2.1.3. Existing research on partners' experiences | 51 |
| 2.1.3.1. Partners not being involved in care discussions..... | 51 |
| 2.1.3.2. Partners lacking information about mental health | 52 |
| 2.1.4. Aims..... | 52 |
| 2.2. Method | 53 |
| 2.2.1. Research Design | 53 |
| 2.2.2. Sample size..... | 53 |
| 2.2.3. Inclusion and exclusion criteria | 54 |
| 2.2.4. Procedure | 55 |
| 2.2.4.1. Materials..... | 55 |
| 2.2.4.2. Recruitment | 55 |
| 2.2.4.3. Interview | 55 |
| 2.2.4.4. Ethical processes | 56 |
| 2.2.5. Analysis | 56 |
| 2.2.4.1. Credibility of the study | 56 |
| 2.2.4.2. Researcher's position..... | 57 |
| 2.2.6. Participants..... | 57 |

| | |
|---|-----------|
| 2.3. Results | 59 |
| 2.3.1. Overview of themes | 59 |
| 2.3.2. Superordinate theme 1: Making sense of OCD | 59 |
| 2.3.2.1. Subordinate theme 1a: “I had never heard of this perinatal OCD” | 60 |
| 2.3.2.2. Subordinate theme 1b: “Gulf between you and me” | 61 |
| 2.3.2.3. Subordinate theme 1c: “This must be eating you alive” | 64 |
| 2.3.3. Superordinate theme 2. Loss | 65 |
| 2.3.3.1. Subordinate theme 2a: “Being led down a blind alley” | 66 |
| 2.3.3.2. Subordinate Theme 2b: “A real bastard of a thing and spoils a lot of stuff” | 68 |
| 2.3.4. Superordinate theme 3. Support..... | 70 |
| 2.3.4.1. Subordinate theme 3a: “There’s a limit to what you can do” | 70 |
| 2.3.4.2. Subordinate theme 3b: “Bugger’s muddle” | 73 |
| 2.3.4.3. Subordinate theme 3c: “I can really help now” | 75 |
| 2.4. Discussion..... | 76 |
| 2.4.1. Significance of the main findings | 76 |
| 2.4.2. Discussion of findings..... | 76 |
| 2.4.2.1. Superordinate theme 1: Making sense of OCD | 76 |
| 2.4.2.2. Superordinate theme 2: Loss | 77 |
| 2.4.2.3. Superordinate Theme 3: Support | 77 |
| 2.4.3. Implications for policy and practice | 78 |
| 2.4.3.1. Increased awareness, prevention and support | 78 |
| 2.4.3.2. Reassurance-seeking | 78 |
| 2.4.4. Research limitations and future directions..... | 79 |
| 2.4.4.1. Research limitations..... | 79 |
| 2.4.4.2. Future directions | 79 |
| 2.4.5. Conclusion..... | 80 |
| References | 81 |
| Chapter 3: Reflective Paper | 89 |
| 3.1. Introduction..... | 90 |
| 3.2. Early research on interviewing male participants | 90 |
| 3.3. Experience of interviewing male participants | 91 |
| 3.3.1. Dilemma 1: interview questions..... | 91 |
| 3.3.2. Dilemma 2: self-disclosure | 92 |

| | |
|---|-----|
| 3.4. Discussion..... | 93 |
| 3.5. Key learning points | 94 |
| 3.6. Conclusion..... | 94 |
| References | 95 |
| Appendix A: Author guidelines for the submission to the Journal of Obesity Surgery | 97 |
| Appendix B: Ethical approval certificate for systematic literature review | 98 |
| Appendix C: Quality Assessment Framework | 99 |
| Appendix D: Inter-rater reliability scores for systematic literature review. | 101 |
| Appendix E: Author guidelines for the Journal of Clinical Psychology | 102 |
| Appendix F: Ethical approval for empirical paper | 103 |
| Appendix G: Recruitment poster for empirical paper | 104 |
| Appendix H: Participant consent form for empirical paper..... | 105 |
| Appendix I: Participant information sheet for empirical paper | 106 |
| Appendix J: Participant debrief sheet for empirical paper | 109 |
| Appendix K: Interview guide for empirical paper | 111 |
| Appendix L: HRA approval for empirical paper | 112 |
| Appendix M: Example transcripts with exploratory notes and theme development for empirical paper..... | 113 |
| Participant 1 | 113 |
| Participant 5 | 114 |
| Appendix N: List of conceptual codes and early stages of theme development | 115 |

Acknowledgements

Firstly, I would like to say a special thank you to all the participants who shared their experiences with me. I would also like to thank Maria Bavetta and Diana Wilson from Maternal OCD, and Ashley Curry, for their support and promotion of the research. Secondly, I would like to thank my supervision team for their encouragement and support in helping me pursue my interests in the topics covered in this thesis. I have appreciated your time and efforts in reviewing multiple drafts and motivating me when I have needed it. Finally, I would like to thank my wife Louise for her love, patience and encouragement.

Declaration

This thesis has not been submitted for any other degree or to any other institution. The thesis was carried out under the academic and clinical supervision of Dr Helen Liebling (Clinical Psychologist, Coventry University), Dr Sarah Simmonds (Clinical Psychologist, Coventry University) and Dr Fiona Challacombe (Clinical Psychologist, South London and Maudsley NHS Foundation Trust), all of whom were involved in the initial formulation of ideas and the development of the research design. Apart from the collaborations stated, all the material presented in this thesis is my own work.

The literature review paper will be submitted to the Journal of Obesity Surgery; the empirical paper will be submitted to the Journal of Clinical Psychology and Psychotherapy, and the reflective paper will be submitted to the Journal of Reflective Practice.

Summary

Chapter one is a critical review of the literature exploring partners' experiences of bariatric surgery. A database search yielded 13 studies that met eligibility criteria and were included in the review. Some partners experienced their spouse's bariatric surgery and subsequent weight-loss positively and reported many benefits, e.g. increased intimacy and participation in social activities. However, some partners experienced their spouse's weight-loss negatively, with the heightened awareness of their own weight-struggles and insecurities. Some partners gained weight following their spouse's bariatric surgery. Consequently, future research could explore weight gain in partners following bariatric surgery.

Chapter two is an empirical study that explored partners' experiences of perinatal OCD. Five partners were interviewed to gain an in-depth understanding of their experience. Three themes emerged from the data; how partners came to understand OCD (*Making sense of OCD*), how they experienced living alongside OCD (*Loss*) and their experience of accessing healthcare support (*Support*). Partners have a crucial role in supporting mothers with perinatal OCD, and future research could explore whether there are any differences or similarities with other OCD sub-types or related disorders, and understanding perinatal OCD in fathers.

Chapter three is a reflective account on my experiences as a Trainee Clinical Psychologist conducting research with men and the dilemmas I encountered. These dilemmas provided useful learning opportunities to refine and develop my skills as a qualitative researcher. It is important to consider similarities and differences between participant-researcher and how these factors, as well as the social context, can influence the interaction. Bracketing methods and preparing for events such as requests for self-disclosure, are important to consider as a Trainee Clinical Psychologist conducting qualitative research.

Overall word count: 17,895

Chapter 1: Systematic Literature Review

Partner's experiences of relationships following bariatric-surgery and post-operative weight-loss: a review of the literature

Written in preparation for submission to Obesity Surgery

Overall chapter word count (excluding tables, figures and references): 6,744

1.0. Abstract

Rationale: Bariatric surgery is an effective intervention for obesity. Following bariatric surgery, patients must adhere to long-term lifestyle change to maximise the health benefits. These lifestyle changes will affect the patient, as well as those around them.

Aims: The aim of this review was to critically evaluate the empirical findings of research that has explored partners' experiences of bariatric surgery.

Method: A systematic literature search of five databases yielded thirteen studies involving $n= 373$ partners' perspectives of bariatric surgery. Following adherence to the inclusion criteria, thirteen studies were reviewed. Of these, five studies were qualitative and eight were quantitative.

Results: Partners reported a breadth of experiences; both positive and negative. Some partners experienced increased social and physical opportunities in the year following surgery, whereas other partners experienced weight gain and heightened insecurities in their relationship.

Conclusions: The main finding of the review was that bariatric surgery has many benefits for the partners and their relationships. However, this review found that a small proportion of partners' accounts revealed psychological struggles and weight gain following their spouse's bariatric surgery. The authors recommend that future research could explore weight gain in partners following bariatric surgery.

Keywords: *bariatric surgery, partners, experience*

1.1. Introduction

1.1.1. Obesity

The World Health Organization (WHO, 2013) has declared obesity to be an international public health issue due to its associated risks of developing common diseases such as diabetes, cardiovascular disease and cancers. In the United Kingdom (UK) a survey by Kopelman (2007) indicated that around 25% of adults are obese, with national statistics rating obesity to be the fourth biggest risk factor of deaths (Moody, 2016). Bray, Frühbeck, Ryan and Wilding (2016) emphasise the complex nature of obesity which includes genetic, physiological, behavioural, social and environmental factors that lead to an imbalance between energy intake and expenditure over an extended period. Table 1 presents the weight classifications table (NHS Choices, 2018) typically used in the UK, known as Body Mass Index (BMI).

Table 1: Weight classifications (NHS Choices, 2018)

| Body Mass Index (BMI) | Classification |
|-----------------------|---------------------|
| BMI < 18.5 | Underweight |
| BMI 18.5 - 25 | Normal |
| BMI 25 - 30 | Overweight |
| BMI 30 - 35 | Moderately Obese |
| BMI 35 - 40 | Severely Obese |
| BMI 40 > | Very Severely Obese |

1.1.2. Lifestyle interventions for obesity

The National Institute for Health and Clinical Excellence (NICE, 2014) recommends lifestyle interventions as a first-line treatment for obesity. Lifestyle interventions focus on increasing a person's physical activity level, altering unhealthy eating habits and improving diet. In a recent large-scale randomised controlled trial involving 1882 obese patients recruited from fifty-seven doctor's surgeries in the UK, Aveyard et al (2016) found that those attending community weight-loss programmes for one

year lost an average of 2.43kg. The authors found that those receiving lifestyle advice solely from their General Practitioner (GP) lost an average of 1.04kg. The study did not report results in BMI therefore we cannot ascertain whether these weight changes had a significant impact. However, many authors have highlighted the limited effectiveness of lifestyle interventions for people with a high BMI (McTigue et al., 2003; Avenell et al., 2004; Chauhan, Vaid, Gupta, Kalanuria & Parashar, 2010; Lara, Kothari & Sugarman, 2005; Ochner, Gibson, Carnell, Dambkowski & Geliebter, 2010; Chang, Stoll & Colditz, 2011).

1.1.3. Bariatric surgery for obesity

NICE (2014) recommends bariatric surgery as a treatment for people who have tried numerous lifestyle interventions but struggle to lose weight long-term. To qualify for bariatric surgery in the National Health Service (NHS), patients need to be classified as severely obese (i.e. having a BMI of 35 or more) and have multiple chronic conditions such as, diabetes, sleep apnoea, and hypertension. Patients can also access bariatric surgery through private health insurers. The UK National Bariatric Surgery Registry (2014) reported that 18,283 procedures were conducted between 2011 and 2013, and the most common procedures were gastric bypass, sleeve gastrectomy and gastric banding. All procedures work on the same premise to physically reduce the amount of food intake and decrease food absorption in the stomach and intestines. The registry also reported that bariatric surgery candidates had an average BMI of 48.8 which is almost twice the 'normal' body weight (BMI of 18 - 25).

In a systematic literature review, Hopkins et al. (2014) found the most commonly reported outcomes by bariatric surgery providers were excess weight-loss (EWL), resolution of obesity-related co-morbidities, and rates of surgical complications. A series of systematic literature reviews and meta-analyses found bariatric surgery to be an effective long-term intervention for excess weight-loss (Buchwald et al., 2004; Puzziferri et al., 2014; Chang et al., 2014) and resolution of obesity-related comorbidities (Chang et al., 2011; Christou et al., 2004; Marsk, Naslund, Freedman, Tynelius & Rasmussen, 2010; Matarasso, Roslin & Kurian, 2007; Bradley et al., 2012). Cheng, Gao, Shuai, Wang and Tao (2016) compared lifestyle interventions to

bariatric surgery in a systematic literature review and found surgery was superior for this group of patients with a high BMI. Bariatric surgery is not without its risks, with the UK National Bariatric Surgery Registry (2014) reporting the complication rate to be 2.9% and mortality rate from surgery to be 0.07%.

1.1.4. Factors that influence outcomes after bariatric surgery

Patients having bariatric surgery will experience rapid weight loss in the first few months due to the physical restriction of food afforded by the procedure (Wittgrove & Clark, 2000). The rate of weight loss will gradually slow down until it reaches a plateau at approximately twenty-four months post-surgery (Sjöström et al., 2004). Therefore, patients have a window of opportunity to reduce as much weight as possible in this time frame to maximise potential health benefits.

There are known factors which influence the amount of weight loss occurring in the context of bariatric surgery. For example, Brolin, Robertson, Kenler and Cody (1994) found patients who had a gastric bypass lost more weight than patients who had gastric banding. There are also psycho-social factors which influence weight loss in this context. For example, Gustafson et al. (2006) found higher prevalence rates of trauma, abuse and psychiatric disorders in bariatric surgery candidates compared to the general population. These issues provide no reason to exclude patients from accessing bariatric surgery, however, they can be contributing factors in weight gain prior to surgery, and can also be influential in weight gain after surgery if not managed effectively (van Hout, Verschure & van Heck, 2005).

The most researched factor on weight loss and weight gain in this context is on the patient's commitment to long-term lifestyle change following bariatric surgery (Mitchell et al., 2016; Freire, Borges, Alvarez-Leite & Correia, 2012; Toussi, Fujioka & Coleman, 2009; Rusch, Andris & Wallace, 2009; Sarwer et al., 2008). These lifestyle changes include avoiding high fat foods, chewing extensively and increasing physical activity. As such, these changes are likely to impact on the patient's home, social and work domains (Wallwork, Tremblay, Chi & Sockalingam, 2017). For patients in relationships, partners can provide a valuable support in helping the

patient adhere to the lifestyle changes required following bariatric surgery (Ferribly et al., 2015; Vidot et al., 2015; Wallwork et al., 2017). It has also been found that partners can undermine and sabotage patient's attempts at weight loss, which can lead to weight returning to pre-surgical level. (Whale, Gillison & Smith, 2014). Therefore, having a focus on partners' experiences of bariatric surgery is an important and under-researched area. It could be said that partners, like patients, will also go through a period of adjustment following bariatric surgery. For example, couples may not eat out together as often and may no longer consume certain foods previously enjoyed together (Bond, Phelan & Wolfe, 2009). Through the adoption of new behaviours, patients may increase their social networks around new activities which may mean time spent less together as a couple. Bariatric surgery therefore requires the patient to adhere to long-term lifestyle changes, and where possible, receive on-going support from significant others for bariatric surgery to be effective (Freire et al., 2012; Sarwar et al., 2008).

1.1.5. Rationale for current review

The current evidence suggests that successful weight loss for bariatric surgery patients involves many factors e.g. lifestyle modification, and that partners have an impact on their weight loss experience, which could then in turn impact upon outcome. Therefore, it is important to understand more about how partners experience and respond to these changes in the relationship. However, there have been no reviews of studies on partners' experiences of bariatric surgery.

A review of the literature could illuminate what happens to partners following their spouse's bariatric surgery, whether they experience any changes in weight themselves and whether there are any indications of what happens to the status of the relationship following surgery. Furthermore, the review could highlight which relationship factors support and hinder long-term lifestyle change. Previous studies recommend the inclusion of partners in the surgery process. However, no research has explicitly set out what this would look like. Therefore, it is hoped that this review will help to guide the practice of bariatric surgery providers, and lead to recommendations of how to support both patient and partner. If there are common

factors found in the research regarding the impact on relationships, it may be helpful to inform patients seeking bariatric-surgery of these.

1.1.6. Aims

This literature review seeks to critique the relevant evidence to answer the following research aims:

- How do partners' experience and adjust to their spouses' weight-loss following bariatric surgery?
- What happens to a partner's weight when their spouse has bariatric surgery?
- What is the impact of the bariatric surgery process on their partner's spousal relationship?

1.2. Method

1.2.1. Literature search

A systematic search of the literature for qualitative and quantitative studies that have investigated partner's experiences of bariatric surgery was carried out between September 2017 and August 2018. The most relevant databases covered literature within psychology, medicine and nursing: PubMed, PsychINFO, Medline, CINAL, SCOPUS and Embase. Searches for online literature and relevant websites were carried out using Google Scholar and Science Direct. The reference lists of extracted articles were examined by hand for additional relevant articles. Searches were also carried out using non-electronic sources including library book catalogues. Finally, attempts were made to search for unpublished work via a combination of sources including Locate.

1.2.1.1. Search terms

Table 2 presents an overview of the key search terms used relevant to the subject area of interest.

Table 2: Key search terms

| Main Concepts | Synonyms | Location |
|----------------------|---------------------|-----------------|
| Bariatric surgery | Weight loss surgery | Title |
| | Obesity surgery | Abstract |
| Partner | Husband | Title |
| | Wife | Abstract |
| | Spouse | |
| | Family | |
| Experience | Adjustment | Title |
| | Living | Abstract |
| | Life | |
| Weight | Weight loss | Title |
| | Weight gain | Abstract |
| Relationship | Marriage | Title |
| | Divorce | Abstract |
| | Separation | |

Key terms for the search were: bariatric surgery and partner; (weight-loss surgery, obesity surgery, husband, wife, spouse, family, romantic, relationship) and located in the title and abstract of the database search.

1.2.1.2. Search strategy

The boolean search strategy involved: bariatric surgery OR weight loss surgery OR obesity surgery AND partner OR husband OR wife OR spouse OR family AND

experience OR adjustment OR living OR life OR weight gain OR weight loss OR relationship OR marriage OR divorce OR separation. These terms were included in a single search string.

1.2.1.3. Initial screening

Article titles and abstracts were initially screened and retained if they: (a) were written in English; (b) were peer-reviewed; (c) described an empirical study; (d) empirically explored or measured partners' experiences of bariatric surgery and (e) the full text was accessible. Following initial screening, full text articles were obtained and assessed for eligibility for review according to the following set of specific inclusion criteria.

1.2.1.4. Specific inclusion criteria

Table 3 highlights the inclusion and exclusion criteria used in this systematic review.

Table 3: Participant inclusion and exclusion criteria

| Criteria | Include | Exclude |
|-----------------|--|---|
| Participant | Partners experiences, and couple/family experiences (where it is possible extract partner experiences) | Patient only experiences and non-relevant research subjects |
| Type | Peer reviewed Described an empirical study Full-text available | Non-peer reviewed |
| Language | English speaking | Non-English speaking |

Studies were included if participants were partners of patients who had undergone bariatric surgery. Studies were included for review if participants also included patients, children and grandparents but only if it was possible to extract partner-specific experiences as this is the focus of the review.

1.2.2. Classification of studies

The process of study selection was recorded on a 'Preferred Reporting Items for Systematic Reviews and Meta-analyses' (PRISMA) flow diagram (see Figure 1).

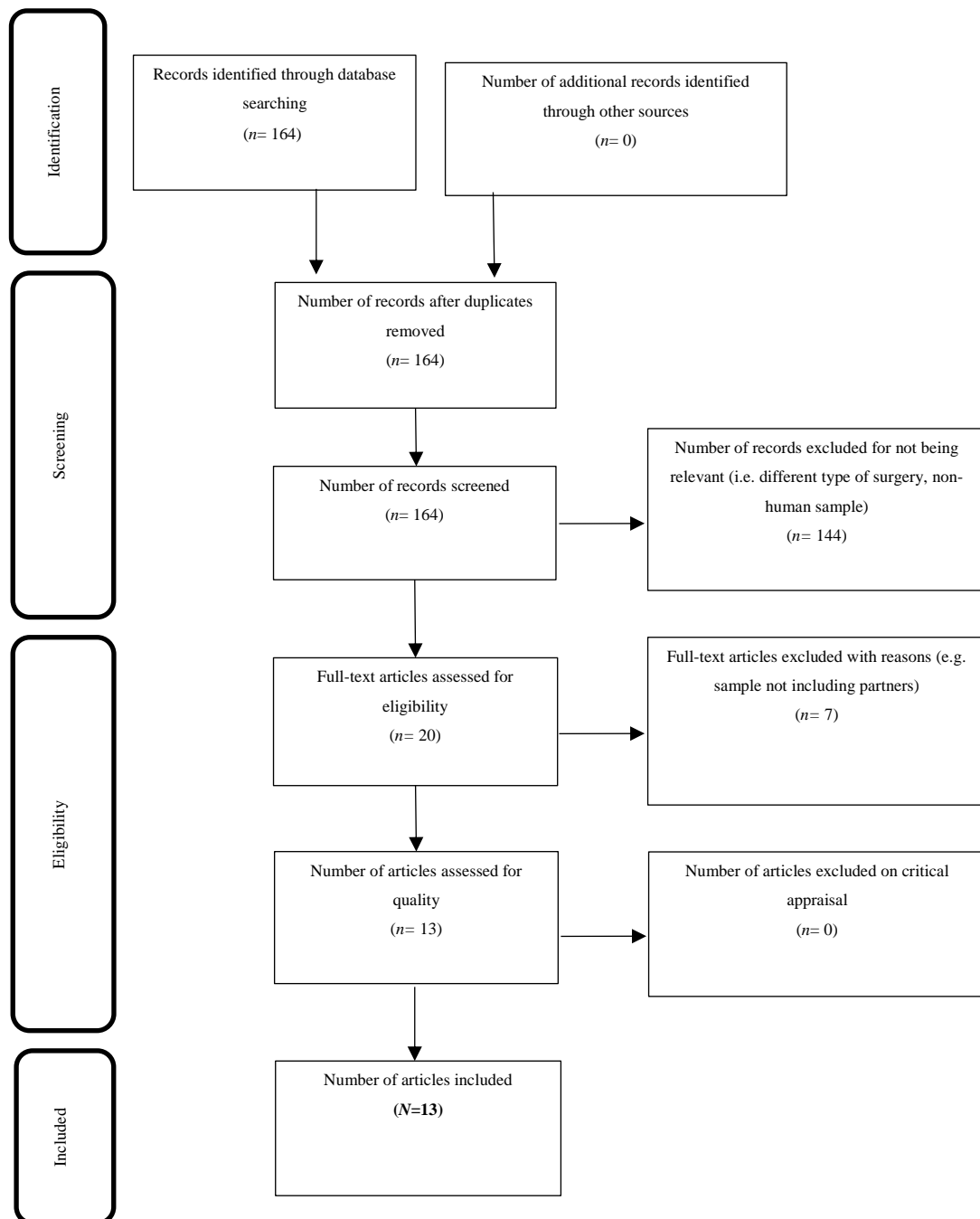


Figure 1: Preferred Reporting Items for Systematic Reviews (The PRISMA Group, 2009).

In total 164 articles were initially identified from databases and screened for eligibility (PubMed 152, CINAHL 4, Science Direct 3, Medline 3, PsychINFO 1, SCOPUS 1, Embase 0). Following a manual review of the title and abstracts, a further 144 were excluded as not being relevant (i.e. studies which involved other types of surgery, and using non-human samples). The full-text for the remaining 20 articles were reviewed and a further 7 were excluded due to not meeting the specific inclusion criteria (i.e. only included patient experiences of life following bariatric surgery and not partners). This resulted in 13 relevant studies which satisfied the review's inclusion criteria. No further studies were obtained from additional sources such as hard copy and grey literature searches. Thus, following a search of the literature, a total of 13 studies met the inclusion criteria and so were retained for systematic review.

1.2.3. Quality assessment framework

In order to assess the quality of the 13 studies identified from the systematic review process, the assessment framework developed by Caldwell, Henshaw and Taylor (2011) was used. This framework was considered suitable for the current review because it can be applied to both qualitative and quantitative research methodologies.

1.2.3.1. Procedure

Qualitative and quantitative studies were assessed separately. All studies were scored against 18 quality criterion and for each criterion studies were rated as 0 if criterion was not met, 1 if the criterion was partially met and 2 if the criterion was fully met. The rating for each article was calculated by adding the scores for all 18 criteria, so that each article would receive a score between 0 and 36. A midpoint was set at 18 to meet a satisfactory level of rigour in terms of quality assessment. Please find the quality assessment ratings in Appendix C.

1.2.3.2. Reliability

To enhance the reliability of the quality assessment another peer researcher rated the 13 studies independently against the same quality assessment criterion and an inter-

rater reliability analysis using the Kappa statistic was performed (this can be found in Appendix D). The results ($Kappa = 0.80$) suggest moderate inter-rater reliability. Kappa scores for each study were no lower than 0.56. Consequently, no papers were excluded through the quality assessment process.

1.2.4. Characteristics of Studies

A summary of the key characteristics of the fourteen studies included in this review can be found in Table 3. All studies were conducted outside the UK; eight in North America (United States of America and Canada), four in Northern Europe (Sweden and Netherlands) and one in Australasia (Australia). Five studies were qualitative (using semi-structured interviews) and eight studies were quantitative using fixed response measures. The thirteen studies involved 373 partners and 137 patients. All participants were recruited from bariatric-surgery clinics and the most common bariatric-procedure was gastric bypass. Where ethnicity was recorded, the majority of patients and partners were White. However, most studies did not include this information. There was a wide variation in partner ages; ranging from 20 years old to 73 years old. However, most studies did not include this information. The largest sample was a survey-based study involving seventy-four partners (Aarts et al., 2015). The smallest samples were two semi-structured interview-based studies involved ten partners in each project (Pories et al., 2015; Wallwork et al., 2017).

Table 3: Characteristics of the reviewed studies

| Author, date, country of origin, quality rating, reliability score. | Aims | Sample size, sampling method and location of recruitment. | Research Design, Data collection (method, location, timing) and data analysis. | Participant details: ethnicity, relationship status, patients type of surgery | Summary of key findings and themes |
|---|---|--|---|---|--|
| Aarts et al. 2015 Netherlands 31 k = 0.79 | To investigate whether patients gastric bypass surgery results in weight loss in overweight partners | 74 partners. Purposive sampling. Recruited in post-surgery review clinic. | This study was an observational prospective study with a repeated measures design. Baseline height and weight measurements were taken by a member of the bariatric surgery team before surgery, and again at 3, 6 and 12 months postoperatively. Descriptive statistics were computed for demographics, weight and eating behaviour. Means and standard deviations were calculated for continuous variables, and percentages were used to describe categorical data. | Majority of partners were male ($n= 67$) and the average age was 49.3 years. All partners lived with their spouses. No other demographic information was included in the study. | <i>Key findings:</i> From baseline to 12 months' post-surgery, partners experienced a small, but statistically significant, reduction in weight from 90.58kg to 88.87kg ($p< .01$, $SD =16.69$). <ul style="list-style-type: none"> 66.2% of partners lost weight ($n=49$) 25.7% of partners gained weight ($n=19$) 8.1% of partners experienced no change in weight ($n=6$). |
| Alegria & Larsen. 2017 USA 35 k = 0.64 | To investigate what relationship maintenance activities contribute to a couple's positive adjustment following bariatric surgery. | 11 partners; 11 patients. Purposive sampling. Recruited in post-surgery review clinic. | This study used a cross-sectional qualitative interview design. Male partners of females having gastric bypass surgery were invited to attend a semi-structured interview in their own homes or in their community. Each couple member was interviewed separately. Constant comparative method (Glaser & Strauss, 1967). | Male partners who identified themselves as White. Age of partners ranged between 23 and 68 ($M= 44.5$). Length of relationships ranged from 2 to 41 years ($M=18$). Time since surgery ranged from 3 to 51 months ($M=22$ months). | <i>Key themes:</i> <ul style="list-style-type: none"> Six types of relationship activities proved beneficial following weight loss surgery; <i>openness, assurances, food/meals as shared tasks, joint activities, antisocial and affection.</i> The authors highlighted the limitations of the study as lacking diversity as all participants were white. |
| Berglind et al. 2014 Sweden 30 k = 0.89 | To investigate whether bariatric surgery increases physical activity and decreases sedentary activity in family members. | 33 partners. Purposive sampling. Recruited in post-surgery review clinics across 5 different hospital sites. | This study was an observational prospective study with a repeated measures design. Baseline height and weight measurements, as well as data from an activity tracker were taken by the bariatric surgery team at 3 month's prior to surgery, and again at 9 months post-operatively. Data was analysed through means comparison. P values were calculated using the Wilcoxon matched-pairs signed-ranks test and McNemar's | Male partners. No other demographic information was included in the study. | <i>Key findings:</i> <ul style="list-style-type: none"> Partners experienced a significant reduction in weight ($p<.001$) following their spouses' bariatric surgery from 95.6kg ($SD =22.3$) to 92.5kg ($SD =20.6$). |

test.

| | | | | | |
|---|---|---|---|--|--|
| Bylund, Benzein & Sandgren 2017 Sweden 31 k = 0.56 | To provide a theoretical framework of understanding family members adjustments to bariatric surgery | 36 partners; 12 patients. Recruited in post-surgery review clinic. | Family members were recruited for interview when patients attended a 2-year surgery follow-up review in a university-affiliated bariatric surgery clinic in Sweden. Grounded Theory (Glaser, 1998). | Male partners of female patients who underwent gastric bypass surgery. Age of partners ranged between 18-67 years. Partners had been in relationships with the patient for 7+ years. No other demographic information was included in the study. | <i>Key themes:</i> <ul style="list-style-type: none"> Gastric bypass surgery created change in families. This change can be a challenge for families to experience and resolve. The degree to which the surgery is a challenge is influenced by life situation, life-stage and relationship quality. Partners who were not satisfied with the surgery may have declined participation in the study. |
| Camps, Zervos, Goode & Rosemurgy 1996 USA 26 k = 0.80 | To investigate the impact of bariatric surgery on Body Image Perception and sexual activity. | 16 partners; 28 patients. Purposive sampling. Recruited in post-surgery review clinic. | This study used a cross-sectional survey design. Surveys were posted to participants by the bariatric surgery team. The survey was posted to both patients and partners, who were instructed to fill out individually. The partners were of patients who had gastric bypass surgery between 1984 and 1995 from the lead authors' bariatric surgery clinic. Descriptive statistics (frequencies and percentages) were applied to participants' responses. | Of the partners' who completed the survey 63% were male and 37% were female. The average time post-surgery was 4.1 years. The majority of partners ($n=11$) had been in a relationship with their spouse prior to surgery. Five partners had formed relationships with their spouse following surgery. | <i>Key findings:</i> <ul style="list-style-type: none"> Almost all partners subjectively reported an improvement in the patient's appearance. 73% of partners reported that sex was more enjoyable. Partners reported an increase in sex by more than 1.5 times per month. When partner ratings were compared against patient ratings, the authors suggested that partners appeared more satisfied than patients with the results of surgery. |
| Hafner 1991 Australia 22 | Morbid obesity: effects on the marital system of weight loss after gastric restriction. | 41 partners; 55 patients. Purposive sampling. Recruited in a post-surgery review clinic | This study used a repeated measures design. Male partners of women having gastric bypass surgery were asked to complete an unvalidated measure of marital adjustment, which involved rating their spouse based on varying domains e.g. attractiveness, sociability. Data was collected at | All 41 partners were male. No other demographic information was included in the study. | <i>Key findings:</i> <ul style="list-style-type: none"> Partner ratings on the marital adjustment measure indicated that they viewed their spouses' as becoming <i>excessively sociable</i> following surgery than what they |

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| k = 0.67 | | in South Australia. | baseline (before surgery) and 12 months' post-surgery, and compared using an independent <i>t</i> -test. | | would ideally want of their partner ($p<0.05$). <ul style="list-style-type: none"> The author viewed this finding as having a slight negative effect on the marital system as they suggested increased sociability in spouses following surgery could be perceived as a threat to their relationship. |
| Madan, Turman & Tichansky 2005 USA 22 k = 0.81 | To investigate whether partners' experience weight changes following their spouses' bariatric surgery. | 59 partners. Purposive sampling. Recruited in a pre- and post-surgery review clinic in Tennessee, USA. | This study used a repeated measures design. Partners were invited to give their weight measurements on the day their spouse had bariatric surgery and again 12 months later in their spouses post-surgery review clinic. Partners' weight measurements were compared and analysed using a Chi-squared test. Significant weight change was regarded as having an increase or decrease of >4.55 kg. | No demographic information was included in this study, other than the partners were 'mostly male' and their spouses' had gastric bypass surgery. | <i>Key findings:</i> At 12 months post-surgery: <ul style="list-style-type: none"> 22% of partners lost weight ($n=13$) 33.9% of partners gained weight ($n=20$) gained weight. Obese partners were more likely to gain weight following spouses weight-loss surgery than non-obese partners. |
| Pories et al. 2015 USA 36 k = 0.81 | To explore how couples experience life following bariatric surgery. | 10 partners; 10 patients. Purposive sampling. Recruited in post-surgery review clinic in East Carolina, USA. | This study used a cross-sectional qualitative interview design. Each couple were invited to attend a semi-structured interview. The interview lasted between 1 hour and 1.5 hours. Five of the interviews were conducted in the participants' homes, four interviews were held at the bariatric surgery provider and one interview at a participants' workplace. Interview transcripts were analysed using Colaizzi's (1979) phenomenological method. | The ten couples consisted of eight females and twelve males. Eight couples were heterosexual and two couples were homosexual. The ages of the participants ranged between 30-73 years ($M= 53$). Two couples were African-American, seven couples were Caucasian, and one couple recorded as bi-racial. Nine couples were married; one couple was cohabitating. | <i>Key themes:</i> <ul style="list-style-type: none"> All partners' reported positive changes in their spouses' mood and shared greater intimacy following surgery. Five themes emerged: <i>changes in physical health, changes in emotional health, changes in eating habits, greater intimacy in the relationship and the joint journey.</i> Partners reported that they felt included in the surgery process and weight loss was regarded as a 'joint journey'. No negative outcomes reported and this may be due to selection bias and/or bias associated with interviewing the couples together instead of individually. |

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| Rand, Kowalske & Kulda 1984 USA 22 k = 0.81 | To investigate relationship quality in married couples following bariatric surgery. | 13 partners; 14 patients. Purposive sampling. Recruited in post-surgery review clinic. | A cross-sectional study. Patients and partners were interviewed by telephone individually. The interview lasted 25-minutes. Participants were asked the same questions based on a brief marital history, an overall evaluation of their marital satisfaction and whether gastric bypass surgery had changed their relationship in any ways e.g. social activity, sexual activity. Participants had to respond using scales which were then analysed using a Fisher test of probability. | Only patient demographics were reported in the study. 13 of the patients were White, and one was recorded as 'unspecified'. Seven patients rated themselves as being 'middle class' and seven rated themselves as 'working class'. No other demographic information was included in the study. | <p><i>Key findings:</i></p> <ul style="list-style-type: none"> All partners ($n=13$) rated their spouses as being more confident and more attractive following weight-loss through bariatric surgery Eight partners rated their relationships as having 'improved'. Eight partners reported an overall improved sex life with their spouse following bariatric surgery. <p>The authors concluded that the following characteristics are present in good marriages following surgery; <i>increases in patient mobility, appearance and self-esteem leading to greater shared activities</i>. However, in some marriages, these changes can heighten personal anxieties and stresses.</p> |
| Romo & Dailey 2014 USA 35 k = 0.64 | To explore whether relationships change when one member of a couple experiences significant weight-loss. | 7 partners; 7 patients. Recruited through advertisements in weight-loss surgery support groups in the USA, and online weight-loss blogs. Partners had to be cohabitating with a spouse who had lost at least 14kg through bariatric surgery. | A cross-sectional survey study. Participants who expressed an interest contacted the researchers and were invited to complete an online questionnaire. Questionnaire completion times ranged from 20 minutes to 4 hours. Responses were analysed using Thematic Analysis. | Partners were aged between 20-61 years ($M = 38.4$). No other demographic information was included in the study. | <p><i>Key themes:</i></p> <ul style="list-style-type: none"> Partners experienced conflict in their relationships if they did not adopt similar lifestyle changes to spouses who had lost weight following surgery. Existing relationships issues remained, and were not solved by weight loss. <p>The authors highlighted the limitations of study as having a small sample with a relatively non-diverse sample.</p> |
| Wallwork, Tremblay, Chi & Sockalingam 2017 Canada 36 | To explore partners' experiences of adjusting to life following their spouses bariatric surgery and weight loss. | 10 partners. Purposive sampling. Recruited from a post-surgery review clinic in Toronto, Canada. | A qualitative cross-sectional study. Partners were invited to attend a 45-60minute semi-structured interview at the bariatric surgery clinic or over the telephone. The questions were open-ended, and focused on participant experiences regarding lifestyle, health and relationships following their spouses bariatric surgery. Thematic Analysis was applied to participants' | All ten participants were male. Ages ranged between 38-73 years ($M= 56.1$). The time post-surgery ranged between 1-3 years. Ethnicity not recorded in the study. | <p><i>Key themes:</i></p> <ul style="list-style-type: none"> The authors reported that bariatric surgery acts as a critical incident which impacts on partners' relationships in many ways e.g. dietary behaviours, physical and leisure activities. Partners' who experienced |

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| k = 0.56 | | | responses. | | improvements in their lifestyle had a good understanding of what their spouses surgery entailed and saw the weight loss process as a 'joint endeavour'. |
| Willmer et al. 2016 Sweden 30 k = 0.77 | To investigate whether families experience changes in eating behaviour following in relation to a mother having bariatric surgery. | 37 partners. Purposive sampling. Recruited from five bariatric surgery providers across Sweden. | This study used a repeated measures design. A member of the research team would visit participants at home to obtain weight measurements and complete validated eating behaviour questionnaires (Three-Factor Eating Questionnaire; Food Frequency Questionnaire). Measures were taken three months' prior to the spouses bariatric surgery and nine months post-surgery. Scores on questionnaires and weight measurements were compared pre- and post-surgery using paired <i>t</i> -tests. | All partners were male (<i>n</i> =37), with an average age of 42 years. The average BMI was 29.7, and 16 partners were classified as obese. No other demographic information was included in the study. | <i>Key findings:</i> <ul style="list-style-type: none"> Partners experienced a statistically significant reduction in waist circumference (<i>p</i><.001). Partners experienced no significant change on measures of Body Mass Index (<i>p</i>=.007) The number of partners classified as obese reduced from 16 to 13. |
| Woodard, Encarnacion, Peraza, Hernandez-Boussard & Morton 2011 USA 31 k = 0.83 | To investigate whether family members experience weight and behaviour changes following bariatric surgery. | 26 partners. Purposive sampling. Recruited from a bariatric surgery provider in the California, USA. | Partners accompanying their spouses for bariatric surgery appointments were invited to participate in the study. Participation involved filling out validated measures on quality of life, eating behaviour; wearing an activity tracker and completing food diaries. This study used a repeated measures design, with data compared at baseline (2 weeks prior to surgery) and 12 months' post-surgery. Data was compared and analysed using a paired <i>t</i> -test. Partners' data was compared at 2 weeks prior to surgery and twelve months' post-surgery. | The majority of partners were male and white (exact figures not reported). The average weight of partners before their spouses' surgery was 99.7kg with an average BMI of 33.1. 60% of partners were classified as being obese. No other demographic information was included in the study. | <i>Key findings:</i> <ul style="list-style-type: none"> Obese partners achieved a statistically significant reduction in weight from <i>M</i>= 106.1kg at baseline to <i>M</i>= 102.5kg at 12 months post-surgery (<i>p</i>< .01). Obese partners experienced reductions on measures of emotional and uncontrolled eating (<i>p</i><0.1). All partners experienced a significant increase in physical activity (from 7.8 to 16.8 metabolic equivalent task-hours) on the Seven-Day Physical Activity Recall questionnaire (<i>p</i><.005).. <p>The authors reported issues in the accuracy of the physical activity data trackers however.</p> |

1.3. Results

The study findings are presented according to each aim of the review and the main themes that resulted.

1.3.1. Aim 1: how do partners' experience and adjust to their spouses' weight-loss following bariatric surgery?

The five studies which explored partners' experiences of adjustment to their spouses weight-loss following bariatric surgery were Alegria and Larson (2017), Bylund, Benzein and Sandgren (2017), Pories et al. (2015), Romo and Dailey (2014) and Wallwork et al. (2017).

Pories et al. (2015) interviewed ten couples, where one member of the couple had experienced bariatric surgery, to understand their experiences of life after surgery. The couple were interviewed together, and their responses were analysed using thematic analysis. The overall themes were largely positive. For example, partners reported increased intimacy and physical activity, and this led to greater feelings of closeness with one another, as described:

"We talk more trash to one another in a positive way and we fool around a little bit...we flirt."

(Pories et al., 2015: 57)

Both partners and spouses talked about having smaller portion sizes now, and partners were reported to be content in accommodating their spouse's post-operative lifestyle changes. For example:

"I thought, well, I can either kind of sneak around or I can be more diligent about what I'm eating and support him by eating the same things."

(Pories et al., 2015: 58)

No negative experiences were reported, and the authors made reference to possible selection bias as it maybe that only content couples may have come forward to participate in the research. A further limitation of the study was couples being interviewed together, instead of individually, as this may have contributed to only positive experiences of life following bariatric surgery being reported.

Wallwork et al. (2017) interviewed ten male partners of patients who underwent bariatric surgery. The interview questions were focused on understanding how they experienced life after bariatric surgery. Unfortunately, the study did not include the interview schedule which would make the study difficult to replicate.

Findings from Wallwork et al. (2017) highlighted a broader range of partners' experiences. Some partners found increased intimacy, physical activity and social experiences following their spouse's weight-loss. For example:

"She's obviously walking, biking and doing more physical things and I would be with her most of the time so therefore, I'm walking and biking more...I think it's quickly approaching the longest period of time that I've been active."

(Wallwork et al., 2017: 1976)

However, some partners reported not wanting to adopt similar lifestyle changes to their spouse following surgery. For example:

"I enjoy foods way too much so I have not been one to eliminate things like she has."

(Wallwork et al., 2017: 1976)

Seeing their spouse engage in new lifestyle changes had a negative relationship impact for some partners, with feelings that their spouse had moved on in their relationship. For example:

"When you're overweight together it's a different story right? You've got each other to rely on....I was feeling neglected and not really involved."

(Wallwork et al., 2017: 1976)

Furthermore, partner's witnessing their spouse lose weight led to an increase in awareness of their own issues with weight. For example:

"I feel fat. It's depressing for me because compared to her, I am fat. It makes me feel sad and disappointed...I got to wear big clothes and....I don't like looking at myself in the mirror."

(Wallwork et al., 2017: 1975)

This study highlighted both positive and negative partner experiences which extended the previous work of Pories et al. (2015). This study also highlighted potential variables that could be targeted in support interventions. The authors noted that the sample generally reflected older couples experiences, with a mean age of 56.1 years. The authors report that there may be differences between older and younger partners, with older couples potentially having more experiences of navigating life changes compared to younger couples, and therefore able to adjust better. However, this is an area which has not been formally researched yet.

Alegria and Larsen (2017) also interviewed eleven couples, where each member of the couple was interviewed separately, to investigate what they perceived helped in terms of adjusting to weight-loss. The authors wanted to find out what self-identified positively adjusted couples did together and how they managed to overcome any difficulties in the relationship following bariatric surgery. Using a constant comparative method, six themes emerged from the interviews. This included increasing joint activities, for example:

"Since she's lost weight, we do more together. This took a lot of encouragement on my part at first. She's still somewhat self-conscious. But we do hikes and other outdoor stuff. We both love that, so that's been a big step forward."

(Alegria & Larson, 2017: 21)

Here, this partner reported that his spouses weight loss had led to an increase in shared activities with hiking mentioned as a joint hobby. Another theme was on assurances, and partners feeling that they could support their spouse in the recovery period from surgery. For example:

"She had some tough times following the surgery...I feel she relied on me heavily during that period, and I felt good knowing that I could be there to support and encourage her."

(Alegria & Larson, 2017: 21)

In this example, the partner reported that he could provide emotional support to his spouse during difficult circumstances, and he felt good being able to do so. However, some partners reported that their spouses' weight loss created a shift in their relationship and felt that they were not getting as much attention since surgery. For example:

"Everything seems to be so focused on her whereas before we were a partnership. But everything shifted and now everything in the relationship is focused on her and it's frustrating. I feel I am left on the side-line."

(Alegria & Larson, 2017: 23)

Alegria and Larson (2017) included their interview schedule in the study which meant that the study could be replicated and applied to different groups of patients, as the authors noted that their sample was predominately white and middle-class.

Romo and Dailey (2014) sent online questionnaires to twenty-one couples, where one member of the couple had lost a significant amount of weight, and responses were analysed. Spouses lost weight through diet, exercise and medication, or through bariatric surgery. Therefore, only findings which clearly relate to spouses who had bariatric surgery will be reported on for the current review. Similar to findings in Pories et al. (2015) and Wallwork et al. (2017), some partners reported increased intimacy and were supportive of their spouse's weight-loss. For example in the study by Romo and Dailey (2014:199) one partner stated:

"It will be better for us both because we can do more together and experience more in our lifetime."

Some partners reported a heightened awareness of their own health following their spouses' weight loss. For example:

"It made me more aware of myself and my issues."

(Romo & Dailey, 2014: 197)

This heightened awareness appeared to affect partners in different ways. For some partners, this awareness instigated change into healthier and more active lifestyles. Whereas other partners reported increased relationship insecurities with spouses becoming more confident and assertive following weight-loss. One partner reported that his spouse decided to end their twenty-four-year relationship following her weight-loss; and narrated:

"She talks about how much better she looks and taunts me that I'll never see it."

(Romo & Dailey, 2014: 201)

Bylund, Benzein and Sandgren (2017) interviewed family members of patients who had bariatric-surgery, and used grounded-theory in their approach to interview data. The majority of the participants were partners, however, children and grandparents were also included in the study. Therefore, only partner's perspectives will be reported in this review. In this study, some partners reported that they did not fully understand their partner's bariatric surgery and what lifestyle changes they were required to make. For example, some partners did not expect their spouse to experience increased irritability and mood swings in the weeks following surgery. Furthermore, some partners lacked understanding about bariatric-surgery specific difficulties such as, dumping syndrome, which led to some partners remarking *"if we knew the consequences...we would not have taken the decision [of surgery] so lightly"* (p. 3). The authors theorised that partners will go through a social process of making decisions to either stay *"connected to old patterns"* or to *"remodel and refigure"* family life in the context of the weight-loss surgery (p. 5). Unfortunately, this study did not include many direct quotes from the participants, therefore interpretation is limited to the authors reporting.

The five research studies critiqued the breadth of partners' experiences of adjusting to life following their spouses' bariatric-surgery. Partner's experiences ranged from increased intimacy and shared social activity to becoming insecure in themselves and feeling that their spouses' weight-loss created distance in the relationship.

1.3.2. Aim 2: what happens to a partner's weight when their spouse has bariatric surgery?

Five of the reviewed studies documented weight change in partners following bariatric surgery (Aarts et al., 2015; Berglind et al., 2014; Madan et al. 2005; Willmer et al., 2016; Woodard et al., 2011). The above studies had a total sample of 229 partners who were mostly male. Aarts et al. (2015) and Maden et al. (2005) failed to include complete demographic information regarding the gender of the partners. In all of the studies, partners self-reported their weight in the 12 months following their spouse's surgery. This is useful as it may account for seasonal variations in weight. With exception of Willmer et al. (2016), studies in this review used kilograms as a weight measure which provided some consistency across the studies.

Aarts et al. (2015) study conducted in the Netherlands involved taking weight measurements of seventy-four partners before and after their spouses' bariatric surgery. The time points were; three months before, and three, six and twelve months after bariatric surgery. When looking at the sample as a whole, partners experienced a small but statistically significant, reduction in weight from 90.58kg to 88.87kg ($p < .01$, $SD = 16.69$). However, this finding may be influenced by the large variance in partner's weights. Therefore, more helpfully, the authors also reported weight changes in percentages. In doing so, 66.2% of partners lost weight ($n = 49$), 25.7% gained weight ($n = 19$) and 8.1% saw no change in their weight ($n = 6$) The authors were inconclusive in understanding why a quarter of the partners in the sample gained weight, and recommended further research to understand this issue.

Willmer et al.'s (2016) study involved taking weight and height measurements of thirty-seven male partners at two time points; three months before their spouses' bariatric surgery

and nine months following the surgery. BMI and waist circumference was reported in the results, with partners experiencing a reduction in BMI by 0.9 units and waist circumference of reduction of 4.7cm. The reduction in waist circumference was statistically significant ($p=0.001$).

Woodard et al. (2011) study involved taking the weight, BMI and waist circumference measurements of twenty-six partners between two and six weeks before the surgery and at one year following the surgery. Obese partners achieved a statistically significant reduction in weight (3.6kg, $p<.01$) compared to non-obese partners (1.81kg, $p<.69$). However, this calculation was based on a small sample which lacks statistical power to generalise the findings to a wider population.

Berglind et al. (2014) replicated Woodard et al's. (2011) USA study for patients accessing bariatric surgery at five hospital sites in Sweden. The authors also measured partner's weight three months before their spouse's bariatric surgery and nine months following. The authors found a statistically significant reduction in partner's weight following their spouses' bariatric surgery with an average reduction in weight of 3.2kg ($p<.01$; $SD=5.1$) in thirty-seven partners.

Madan et al.'s (2005) study in the USA involved comparing the measurements of fifty-nine partners weight on the day of their spouse's bariatric surgery and twelve months post-surgery. The authors found 34% of partners gained weight by more than 4.55kg ($n=20$), 22% lost weight by more than 4.55kg ($n=13$) and 44% saw no change in weight ($n=26$). The authors understood the weight gain in partners as the 'garbage can effect' whereby partners will finish their spouses' leftovers due to having less quantities in food post-surgery. However, the authors highlight the small sample size in the study limits any generalisability in findings.

The five studies reported the weight changes in partners following bariatric surgery. Four of these studies reported statistical significance in partner's weight loss and one study reported statistical significance in obese partners only. The most significant weight

reduction in partners was found in the Berglind et al. (2014) study, with a third of participants ($n=20$ partners) losing more than 4.55kg in the following year after bariatric surgery. However, all studies experienced similar issues with small sample sizes and large variations in partner's weight at baseline and follow-up. Two studies documented weight gain in partners (Aarts et al., 2015; Madan et al., 2005) in the 12 months' post-surgery but did not provide any robust explanation as to why this occurred, and recommended research to further understand this issue. Madan et al. (2005) reported that obese partners in their sample were more likely to experience weight gain compared to non-obese partners. However, this does not appear to be the case in the other studies. Wilmer et al. (2016) found obese partners were more likely to drop down from 'obese' into the 'overweight' classification in the following twelve months' post-surgery.

1.3.3. Aim 3: what is the impact of the bariatric surgery process on their partner's spousal relationship?

In total, three of the studies reviewed focused on relationship quality post-surgery (Camps et al., 1996; Hafner 1991; Rand et al., 1984).

Camps et al. (1996) posted questionnaires to partners of patients who had bariatric surgery. Sixteen partners returned their questionnaires, and eleven of these partners had been in a relationship with their spouse since before their surgery so they could comment on their experience before and after weight loss. 73% of partners reported that sex with their spouse was more enjoyable following surgery, and experienced an increase in sexual activity. As the questionnaire was limited to rating scales, the findings did not elucidate why partners found sex more enjoyable or any qualitative information about the 27% who did not find sex more enjoyable. The authors did not state whether the 27% was *less enjoyable* or just rated as the *same* level of enjoyableness.

Hafner (1991) interviewed 41 male partners before and after their spouses' bariatric surgery, and were given a binary measure to complete rating their spouse on a number of attributes e.g. sociable-unsociable, attractive-unattractive. These responses were compared before surgery and at 12 months after surgery. Partners rated their spouse more favourably on most scales. However, the authors reported that some partners rated their spouses as

'excessively sociable' on one scale, and in a follow-up interview understood this to mean some partners had viewed their spouses increase in social activity as a potential threat to their relationship. Hafner (1991) also interviewed the wives of these partners, and they reported that their husbands had become less interesting in the 12 months after their surgery, suggesting relationship discord amongst these participants.

Rand et al. (1984) conducted telephone interviews with couples where one member had bariatric surgery. Partners and patients were interviewed separately as to reduce bias in responses, and were asked for their experience and evaluation of their relationship following bariatric surgery. Thirteen partners provided their accounts, and all reported that they found their spouse more attractive. Ten partners reported an increase in sexual activity, and eight partners reported that their relationship had improved because of bariatric surgery. The authors reported that the benefits for partners were largely related to an increase in shared activities with their spouse. The authors also reported that bariatric surgery could act as a catalyst for the heightening of personal anxieties and insecurities in partners if it meant that their spouse was became more socially active without them.

These three studies (Camps et al., 1996; Hafner, 1991; Rand et al., 1984) highlighted that the majority of partners experienced benefits from their spouses bariatric surgery and a strengthening of their relationship through increased shared activities. However, also highlighted by the studies is a proportion of partners who experience an increase in personal insecurity and conflict with their spouse in the following months after surgery. However, it is possible that there were already high rates of conflict in these relationships prior to the surgery. It is important to note that many of the survey studies used measures that were not validated and used small sample sizes.

1.4. Discussion

1.4.1. Significance of the main findings

The current review critically analysed the literature regarding partner's experiences of bariatric surgery and had three aims. The first aim was to understand in more depth the

interpersonal adjustment process of partner and spouse getting used to changes following surgery and embarking on a new lifestyle regime.

The findings encompassed a range of experiences. Considering the main themes across the qualitative studies, it appeared that more positive experiences were attributed to partners who considered the surgery as a joint endeavour. This included viewing weight-loss as a gateway to increased social and physical activities, and partners successfully adopting similar lifestyle changes to their spouse, for example, making similar food choices and reducing portion sizes. The evidence concludes that partners reporting these perspectives were more likely to view bariatric-surgery as a relationship enhancer.

It appeared that those partners that had negative experiences of spousal weight loss had been impacted upon by an increase in self-awareness of personal insecurities around their own weight. Seeing their spouse lose weight and gain confidence made them feel worse about their own health and appearance. Where some partners used their spouses' lifestyle changes as a motivator to instigate their own lifestyle change, other partners were resistant to change or felt they could not change by their own accord. It was also found that some partners did not understand what the bariatric-surgery process involved or what their spouse would experience in the initial weeks following surgery.

Authors such as, Andrews (1997) have theorised why some relationships appear to struggle in the context of change. Family Systems Theory (Patterson & Garwick, 1994) suggests that any changes a person makes will impact on other members of their system, and has the potential to disrupt existing power dynamics. Bariatric surgery may therefore act as a catalyst for change, and may lead to some partners experiencing this as a threat to their relationship. It is possible that some partners may resist or sabotage their spouses attempts at weight-loss to maintain the status quo. There are concepts from the Motivational Interviewing literature (Miller & Rollnick, 2013) which may be applicable as to why some partners appeared to adjust to the lifestyle changes successfully. Motivational Interviewing suggests that people will be at different stages in relation to any change; from a pre-contemplative stage to a committed-action stage. It is possible that partners who took on-board lifestyle changes were at a stage where they felt ready to make such changes,

possibly because they came to the decision themselves about making changes or because the benefits outweighed any potential negatives. Partners who struggled with their spouses changes may have been in a pre-contemplative stage, and any suggestion of change could have been experienced as 'nagging' or being 'told what to do'.

The second aim focused on what happened to a partner's weight when their spouse has bariatric surgery. Two studies documented weight gain in partners (Aarts et al., 2015; Madan et al., 2005) in the twelve months' post-surgery. This is an important issue to consider as many partners who participated in the research studies were classified as overweight or obese at the time of surgery. Any further weight gain could lead to the development of health problems associated with obesity or experience an exacerbation of existing health conditions. Unfortunately, both studies did not provide any qualitative information as to why they thought the weight gain occurred.

The third aim of the current review was to determine how bariatric surgery impacts on spousal relationships. It was found that in most cases, relationships and sexual functioning improved following surgery. This was attributed to an increase in attractiveness, self-esteem and mobility. However, relationships did not all improve, with separation and divorce rates also higher with this group of patients compared to the general population (Rand et al., 1984). The research does not indicate what role, if any, bariatric surgery has in these circumstances. However, these findings suggest that may be beneficial to have pre-surgery discussions about how the surgery could impact on personal relationships.

1.4.2. Implications for Policy and Practice

The current review, to the author's knowledge, is the first attempt at critiquing the literature on partners' experiences of bariatric surgery. From the evidence reviewed, the authors conclude that bariatric surgery does not just affect the individual seeking surgery; partners are also affected and they can provide a valuable role in supporting their spouse make lifestyle changes. The purpose of these clinical and policy recommendations is to target the small groups of patients and partners who do not benefit as much from bariatric surgery.

1.4.2.1. Bariatric surgery readiness groups and post-operative support

From the evidence reviewed, some partners struggled with understanding what was happening to their spouse physically and emotionally in the initial weeks following bariatric surgery. In a survey involving twenty-two bariatric surgery providers in the UK, only 47% of services offer pre-operative groups to patients and partners, and none reported to offer structured post-operative interventions (Ratcliffe et al., 2014). Therefore, it would seem beneficial for 'readiness' groups and structured post-operative support for patients and partners to be available in all bariatric surgery providers.

1.4.2.2. Assessment of prior weight-loss and the reactions of significant others

From the current review, partners' experiences of their spouses' weight-loss was broad and impacted the relationship in different ways. As a predictor of how partners will experience bariatric surgery and their spouses' adherence to post-operative guidelines, it would be helpful to assess a patients' history of weight-loss attempts and how significant others experienced these. This could help identify any relationship dynamics which could act as barriers to the adherence to post-operative guidelines.

1.4.3. Research Limitations and Future Directions

1.4.3.1. Research and review limitations

This systematic review is, to the author's knowledge, the first attempt to synthesise the literature regarding partners' experiences in the field of bariatric surgery. The studies in this review relied heavily on surveys and measures that had not been validated. Studies which used interviews were based on small samples. This review relied heavily on qualitative research, and although qualitative research does not aim to be representative, the findings cannot be generalised to the wider population. Furthermore, there were sampling limitations where partner's perspectives were reported alongside other family members such as, children and grandparents, which creates issues with the homogeneity of the sample. These limitations mean that any conclusions drawn should be done so with caution.

1.4.3.2. Future directions

This review identified further gaps in current understanding. Firstly, all fourteen studies included were conducted outside of the UK. It would be of interest to explore partners' experiences of bariatric surgery in the UK healthcare context, and to note whether there are any cultural differences. Secondly, it is recommended that further research is carried out to see if there are any differences in terms of partner's experience of bariatric surgery in relation to ages, demographics and gender. Thirdly, some partners experienced a poorer quality of life following their spouses' bariatric surgery and some partners experienced weight gain. An exploration of weight gain in partners is important to research, especially given the health implications of this.

1.4.4. Conclusion

The aim of this systematic review was to gain a clearer understanding of partners' experiences of bariatric surgery. A significant evidence base from fourteen studies and three hundred and sixty-three partners indicates that bariatric surgery does not just affect the patient, but partners too. Some partners experienced their spouse's bariatric surgery and subsequent weight-loss positively, and reported many benefits, e.g. increased intimacy and participation in social activities. However, some partners experienced their spouse's weight-loss negatively, with heightened awareness of their own weight-struggles and insecurities. Some partner's gained weight following their spouse's bariatric surgery. Consequently, future research could explore weight gain in partners' following bariatric surgery.

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Chapter 2: Empirical Paper

Fathers' experiences of their partners' OCD during the perinatal period

Written in preparation for submission to the
Journal of Clinical Psychology and Psychotherapy

Overall chapter word count (excluding tables, figures and references): 9,406

2.0. Abstract

Rationale: Partners are uniquely placed to provide invaluable support to mothers experiencing perinatal mental health problems, however, many partners feel routinely excluded from discussions about care and often lack information on how best to provide support. Previous research on partners' experiences have largely focused on post-natal depression and post-partum psychosis.

Aims: The present study aims to provide an in-depth account of partners' experiences of perinatal OCD as it has a distinctly different clinical presentation to other perinatal mental health problems.

Method: Five volunteer participants were recruited from a national mental health service specialising in the treatment of perinatal OCD and through online service-user networks. Semi-structured interviews were conducted and analysed using Interpretative Phenomenological Analysis.

Results: Three superordinate themes emerged from the findings: '*Making sense of OCD*' which was an exploration of how participants came to understand their partners' difficulties; '*Loss*' which described participants' experiences of living alongside their partners' OCD; and '*Support*' which focused on how participants became a key support to their partner as well as experiences of accessing mental health services.

Conclusions: The key findings of the study highlight the crucial role partners have in supporting mothers with perinatal OCD, and the disorder has a significant impact on partners' quality of life. It is recommended that future research could explore whether there are any differences or similarities with other OCD sub-types or related disorders.

Key words: *perinatal OCD, partners, experience, phenomenological*

2.1. Introduction

2.1.1. Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is a term used within medical and psychiatric literature to characterise recurrent and persistent thoughts, urges or images that are experienced as intrusive and inappropriate, and that in most individuals cause marked anxiety and distress (American Psychiatric Association, 2013). The person attempts to ignore or suppress such thoughts, impulses or images or to neutralise them with another thought or action. Actions may include repetitive behaviours; for example, hand washing, ordering, checking or mental acts; for example, praying, counting, repeating words silently, that the person feels driven to perform in response to an obsession. Table 2.1 displays common OCD presentations adapted from Bream, Challacombe, Palmer and Salkovskis (2017).

Table 2.1. Descriptions of common OCD sub-types

| OCD sub-type | Description |
|-------------------|--|
| Contamination | Fear of contact with and/or passing on germs and disease, e.g. HIV, swine flu, toxoplasmosis, Ebola, leading to excessive washing, cleaning and avoidance. Estimated to affect 25-50% of people with OCD (Ruscio, Stein, Chiu, & Kessler, 2010; Rasmussen & Eisen, 1990, 1992) |
| Checking | Having a need to make sure something did or did not happen, or that particular things are performed in a certain way. Often associated with harm avoidance (Bream, Challacombe, Palmer, & Salkovskis, 2017). |
| Symmetry/Ordering | To physically line up items or performing actions in a certain order, e.g. having to silently count the corners of all the windows in a room. Can be driven by a fear that something bad will happen if items are not ordered (Einstein & Menzies, 2004). |

These obsessions and compulsions cause marked distress, are time-consuming and significantly interfere with the person's usual routine and functioning.

OCD affects both the individual and those around them. Previous research has revealed that families can be affected directly for example, becoming involved in giving reassurance or following obsessional rules, and indirectly for example, worrying about their loved one with OCD (Stewart et al., 2008; Calvocoressi et al., 1995, 1999). Family involvement is a mediating factor for OCD symptom severity and treatment outcome (Van Noppen & Steketee, 2009; Chambless & Steketee, 1999; Renshaw, Chambless, & Steketee, 2003). Research also indicates that relationship satisfaction decreases in partners of individuals with OCD (Boeding et al., 2012).

2.1.2. Perinatal Obsessive-Compulsive Disorder

Perinatal Obsessive-Compulsive Disorder (Perinatal OCD) is diagnosis given when mothers develop OCD, or experience an exacerbation of the disorder in the perinatal period. The perinatal period is defined as pregnancy through to the first year from birth. According to retrospective studies, it appears childbirth and the transition into a role of increased responsibility have been identified as key events leading to the development of OCD (Maina, Albert, Bogetto, Vaschetto, & Ravizza, 1999; Neziroglu, Anemone, & Yaryura-Tobias, 1992; Williams & Koran, 1997).

In a survey asking parents without OCD whether they experienced unwanted, intrusive thoughts about their child coming to harm, most parents reported having such thoughts (Abramowitz, Schwartz, & Moore, 2003). Having unwanted, intrusive thoughts is therefore a common experience in parents with and without OCD. There may be benefits for parents to experience these thoughts as a means of keeping a vulnerable infant safe (Leckman et al., 1999). However, a proportion of parents develop an *excessive* pre-occupation with preventing harm to their infant which causes a significant interference in daily living. For example, mothers not being able to be left alone with the baby in fear that they may do something accidentally to harm them, or not letting anyone else hold the baby, including the father, in fear that they will harm the baby. In a study examining sub-types of OCD, contamination fears were more prominent during pregnancy, whereas intrusive

thoughts of harming the baby were more prominent following birth (Challacombe et al., 2016). Perinatal OCD is estimated to affect between 0.7% and 9% of the Western population (Kitamura et al., 2006; Navarro et al., 2008; Wenzel, Haugen, Jackson, & Brendle, 2005; Zambaldi et al., 2009). Estimates vary considerably, and this may be due to poor identification of perinatal OCD in mothers. If clinicians are not aware of perinatal OCD, it can be misdiagnosed as post-natal depression or post-partum psychosis which can be distressing for mothers accessing perinatal mental health services and may delay appropriate treatment (Challacombe & Wroe, 2013).

As highlighted previously, OCD appears to have a significant impact on families. However, to the author's knowledge, no research has been conducted on partners' experiences of OCD at the point of transitioning into parenthood. Looking further afield, related research has been conducted on partners' experiences of other perinatal mental health problems.

2.1.3. Existing research on partners' experiences

Studies have largely focused on partners of mothers with post-natal depression or post-partum psychosis. In a recent systematic literature review involving twenty studies, Taylor, Billings, Morant and Johnson (2017) highlighted a number of important issues affecting partners of mothers with perinatal mental health problems.

2.1.3.1. Partners not being involved in care discussions

Despite being regarded the main form of support for their spouse, partners reported that they felt routinely excluded from discussions with healthcare providers on the management of their spouse's care (Doucet, Letourneau, & Robertson-Blackmore, 2012). This is important to consider, as it is often the partners which mothers are likely to turn to for support in first instance (Holopainen, 2002). Holopainen's study was on help-seeking in mothers with post-natal depression, and this finding has been supported by a large-scale study involving the views of 1,500 mothers accessing perinatal mental health services (Russell, Lang, Clinton, Adams, & Lamb, 2013). It appears that partners are uniquely placed to identify and support their spouse, but are then excluded from key discussions

about accessing professional support. This counters evidence from studies which have shown positive outcomes in reducing maternal distress and healthcare utilisation when partners have been involved routinely (e.g. Grube, 2004).

2.1.3.2. Partners lacking information about mental health

Another consistent finding across studies is partners reported that they lacked the information and understanding about their spouse's perinatal mental health problem (Taylor et al., 2017). By not knowing, partner's report feeling unable to best help their spouse (Engqvist & Nilsson, 2011) and in some cases, attempts at support can be perceived as unhelpful (Grube, 2004). Robertson and Lyons (2003) found the onset of perinatal mental problems can lead to relationship instability and relationship breakdown.

The systematic review by Taylor et al. (2017) concluded that father's experiences of perinatal mental health services are inadequate, with partners expressing feelings of marginalisation from health providers and that their needs are not considered beyond that of the mother. The research included in the review is limited to post-natal depression and post-partum psychosis. It is unclear how perinatal OCD is experienced by partners due to its distinct clinical presentation to that of other disorders in the perinatal period (Buttolph & Holland, 1990; Sichel, Cohen, Dimmock, & Rosenbaum, 1993).

2.1.4. Aims

No research to date has been conducted on partners' experiences of perinatal OCD. Given the significant impact OCD has on the individual, and on those around them, there is a need to explore this further. Our research aims to focus on a detailed description and exploration of the experience of perinatal OCD from the partners' perspective.

2.2. Method

2.2.1. Research Design

There is currently limited research in the area of partners' experiences of perinatal mental health problems, and there is no qualitative research on partners' experiences of perinatal OCD specifically. The current study has an exploratory focus with aims to understand what it is like for partners living alongside a spouse with a clinically distinct, and often misunderstood, mental health problem and to reveal how partners' in this study make sense of their experience. As such, a qualitative methodology was selected, with Interpretative Phenomenological Analysis (IPA) chosen to meet the research aims due to its idiographic and phenomenological basis. IPA is influenced by several key concepts; phenomenology, idiography and hermeneutics (Smith, Flowers, & Larkin, 2009). Phenomenology is a philosophical approach to the study of experience, with a key emphasis on understanding what is important to the individual (Smith, Flowers, & Larkin, 2009). Experience is complex and unique to the individual, and the idiographic influence in IPA can provide insight into the personal perspective of participants and their relationship with the phenomena concerned. Whereas other qualitative approaches such as, Thematic Analysis, focus on similarities across participant's experiences, IPA allows for both convergence and divergence across cases, thus developing richer levels of understanding. Finally, a key component of the IPA process in psychological research is the hermeneutic cycle (Smith, Flowers, & Larkin, 2009). In order to gain an in-depth analysis of a participant's experience, we need to understand what they say and how they communicate this in relation to wider social, cultural and theoretical contexts. This is important given the socio-cultural construct of OCD. Furthermore, IPA is considered as established approach for understanding life transition (Larkin, Watts, & Clifton, 2008; Smith, Flowers, & Larkin, 2009; Smith, Jarm, & Osborn, 1999) therefore regarded as an appropriate method for the current study with participants transitioning into the role of parent.

2.2.2. Sample size

Five participants were recruited for the current study. This size of sample allows connections and differences to be drawn *between* and *within* participants' experience. A distinctive feature of IPA is its idiographic lens offering detailed readings of each case before moving to more general conclusions (Smith & Rhodes, 2015). This means sample

sizes are relatively small as the intention is to gain in-depth understanding of the experience of the participants included.

2.2.3. Inclusion and exclusion criteria

The inclusion and exclusion criteria for the current study were generated based on in-depth discussions with the research supervisors and the clinicians of the recruiting site. The following inclusion criteria were agreed upon and outlined in Table 2.2.

Table 2.2. Participant inclusion and exclusion criteria

| Criteria | Include | Exclude |
|----------------------------|---|--|
| Diagnosis | If their partner (mother of their child) had a primary diagnosis of perinatal OCD and were currently in active-treatment for this i.e. accessing psychological therapy. | If their partner (mother of their child) did not have a recognised diagnosis of perinatal OCD and were not receiving support for this i.e. on a waiting list or not wanting to access support. |
| Relationship to the mother | If they were in a current romantic, married or long-term cohabitating relationship with the mother. | If there were any other relationships e.g. ex-partner, friend, sibling, parent. |
| Relationship to the baby | If they were the biological father to baby. | If they were not the biological father to the baby. |
| Language | If they were fluent in English | If they were not fluent in English |

It was deemed important to ensure that participants were the partners of mothers' who had a diagnosis of perinatal OCD, as OCD is clinically distinct from other perinatal mental health problems (Buttolph & Holland, 1990; Sichel et al., 1993).

2.2.4. Procedure

2.2.4.1. Materials

Semi-structured interviews were utilised as this form of data collection is the preferred means for IPA research (Reid, Flowers, & Larkin, 2005). An interview-guide was co-created between the research team and consultation with OCD service-user groups in line with the research aims (Appendix K). The interview guide was informed by IPA principles (Smith, Flowers, & Larkin, 2009) and used open and expansive questions.

2.2.4.2. Recruitment

A recruitment poster was placed in the waiting room of a national mental health service specialising in the treatment of perinatal OCD in London, UK (Appendix G). The current study was also advertised online on the webpages of two OCD charities; Maternal OCD and OCD Action. Four participants were recruited through the mental health service, and one participant was recruited through the online advertisement.

2.2.4.3. Interview

All participants who expressed an interest in the study contacted the researcher by email. The researcher responded the participants' expression of interest with a participant information sheet (Appendix I), consent form (Appendix H), and an interview date was arranged. Participants were given the choice of attending a face to face interview at the mental health service where their partner was accessing treatment in London, at Coventry University or through Skype. Skype and other Voice over Internet Protocol (VoIP) technologies have been used NHS healthcare settings for many years (e.g. NHS England, 2014) and are regarded as a viable method for data collection in qualitative research (e.g. La Iacono, Symonds & Brown, 2016). Skype interviews were included as means for collecting data following service-user consultation, as it was deemed appropriate to make the study accessible for any participants who could not travel to the interview in person.

One interview was carried out in person at Coventry University. The remaining four interviews were carried out through Skype; with participants citing flexibility around other commitment. Importantly, participants reported that they would not have been able to

participate if Skype was not offered as a means of accessing the current study. The interviews were conducted between October 2017 and January 2018. All interviews were audio recorded and ranged between 45 to 65 minutes in duration, and there was no difference in duration or perceived level of engagement between Skype and face to face interviews. On completion of the interview, a participant debrief sheet (Appendix J) was given to all participants.

2.2.4.4. Ethical processes

The research was designed and conducted under the principles of the British Psychological Society (British Psychological Society, 2010). Ethical approval was granted from Coventry University (Appendix F) and the Health Research Authority (Appendix L). Any identifiable characteristics of the participants such as, names and ages, were removed/altered to preserve anonymity. Participants were assigned aliases.

2.2.5. Analysis

Audio recordings of the interviews were transcribed verbatim and any identifiable information was removed. The transcriptions were analysed using Smith, Flowers and Larkin's (2009) procedure for IPA. This included reading a participant's responses multiple times and writing exploratory notes and themes alongside the transcript (examples of these can be found in Appendix K). Bracketing methods were utilised (i.e. discussions with the supervision team and the use of a reflective diary) to suspend presuppositions to allow the researcher to engage fully with the data (Husserl, 1999). From this process, themes from the transcripts were identified to best capture the essential qualities of the interview, and formed into key concepts. A hierarchical relationship or super-ordinate and sub-ordinate themes was developed which the research team thought best captured the participants experience of being a partner to a spouse with perinatal OCD.

2.2.4.1. Credibility of the study

All coding and interpretations were reviewed by each member of the research team (JP, HL and SS). Furthermore, the study has an audit trail that consists of the project proposal, interview guide, annotated transcripts, draft reports and the final report as recommended in

IPA studies (Smith, Flowers, & Larkin, 2009; Yin, 1989). This transparent process ensures a high level of credibility for the current study.

2.2.4.2. Researcher's position

Reflexivity is a crucial aspect of qualitative research as it enables the researcher to recognise and critically reflect upon their own contribution to the research process (Yardley, 2000). In this case, the researcher had previous experience of providing psychological interventions for people with OCD. There are benefits to having prior experience. For example, the researcher used established relationships with the recruiting site, and had an awareness of the issues related to OCD which aided rapport-building. Using a reflexive approach, the researcher managed their own assumptions and pre-conceptions so as not to influence the data analysis (Ahern, 1999). A bracketing interview and reflective discussions were held by the research team in an attempt to ensure the analysis remained true to the data collected.

2.2.6. Participants

Participant characteristics are detailed in Table 2.3. Participants were allocated pseudonyms to protect anonymity.

Table 2.3. Participant characteristics

| Participant | Age | Ethnicity | Employment | Age of child | new onset / previous OCD | OCD sub-type |
|--------------------|------------|---------------------|-------------------|--------------------------|---------------------------------|---------------------|
| Matt | 68 | White British | Full-time | <1 year | previous OCD | contamination |
| Tom | 34 | White Australian | Full-time | 1< year | previous OCD | contamination |
| Martin | 40 | White British | Full-time | 14 months | new onset | checking |
| John | 27 | White British | Full-time | 1< year; 20 months | new onset | checking |
| Adrian | 39 | White British | Full-time | 15 months | previous OCD | contamination |

All participants were partners to mothers who had been diagnosed with perinatal OCD and were currently receiving psychology therapy for this. All participants were in long-term relationships with the mothers' accessing treatment. Three mothers had previous episodes of OCD, and had sought intervention because they had experienced an exacerbation of this during the perinatal period which prompted treatment. Two mothers had no previous history of OCD or other mental health problems, and had sought treatment in the months following childbirth. The mean age of the participants was 41 years. All participants were working full-time. One participant (Matt) had children from a previous relationship but only the details of his current relationship are presented in the table.

2.3. Results

2.3.1. Overview of themes

On completion of data analysis, three superordinate themes emerged; making sense of OCD, loss and support. Each superordinate theme consists of subordinate themes. These findings are displayed in Table 3.1 and are highlighted using verbatim quotations from participants. Throughout the chapter, consideration is given to convergence and divergence within themes.

Table 3.1. Superordinate and subordinate themes

| Superordinate Themes | Subordinate Themes |
|------------------------|--|
| 1. Making sense of OCD | a) “I had never heard of this perinatal OCD” b) “Gulf between you and me” c) “This must be eating you alive” |
| 2. Loss | a) “Being led down a blind alley” b) “A real bastard of a thing that spoils a lot of stuff” |
| 3. Support | a) “There’s a limit to what you can do” b) “Bugger's muddle” c) “I can really help now” |

2.3.2. Superordinate theme 1: Making sense of OCD

All participants communicated their reflections on how they had come to understand and conceptualise their partners’ OCD. This emerged through discussion about their experiences of relationships, parenting and OCD. This superordinate theme contains the subthemes; “I had never heard of this perinatal OCD”, “Gulf between you and me” and “This must be eating you alive”.

2.3.2.1. Subordinate theme 1a: *"I had never heard of this perinatal OCD"*

Four participants reflected on their previous understanding of OCD, and how this had changed over time to reflect the reality of living with their partner with this difficulty. For Matt and John, they told me about their prior experiences of seeing family members whom they felt might have displayed OCD-type idiosyncrasies. As Matt narrated:

"They [relatives] have counting and checking issues...he's a bit of a checker....he cleans a lot....but compared to Beth, he's just an amateur. It doesn't affect his life as far as I can tell. It doesn't affect his life as it does hers."

(Matt, lines 99-102)

From Matt's description, it appeared that he had some prior knowledge of OCD from his experience of being with family members who would count, check and clean things. Here, the focus was predominantly on behaviours he had observed, and maybe he had thought were strange or excessive to him. Interestingly, his reference of a family member being an 'OCD amateur' suggested that his partners' OCD was more pervasive and distressing than what he had previously experienced and/or expected in this context. John also made reference to a family member whom he suspected had OCD, and said:

"I'd heard of OCD but personally I thought it was people who had to have the light switches turned off and the plug sockets turned off and have to check before leaving the house. I had never heard of this perinatal OCD."

(John, lines 129-131)

John described to me an uncle he had seen turning all the electrical sources off whenever he was about to leave house. Importantly for John, the term perinatal OCD was new to him, and he had not considered that OCD could apply to new mothers in the way in which he would go on to experience.

Whereas Matt and John had more personal prior experience of OCD, Martin and Adrian's understanding had come from more distal sources such as, portrayals of OCD on television, as Adrian told me:

"[OCD is] Lining everything up and in order, like you sometimes see on the television....this is not her struggle at all. It is very much a contamination issue. So when she explained that to me, I started to understand more."

(Adrian, lines 103-104)

Adrian wanted to emphasise to me the contrast of how OCD was portrayed on television, to the reality of seeing his partner in great distress. He suggested that both his knowledge of OCD, and how OCD was described on television, was limited to making sure items are lined up and ordered in a particular way. His knowledge had developed over time by speaking to his partner about her difficulties with OCD, and how it interfered at different life stages, such as parenthood. Martin shared a similar experience to Adrian, and narrated:

"I was a bit surprised. It's not what I had perceived OCD to be. I have probably got a fairly stereotypical impression of OCD as the compulsive ordering of things and checking, and stacking books on a shelf."

(Martin, lines 129-131)

Martin's use of the words "surprise" and "stereotypical" was a way of communicating the contrast of having had a narrow portrayal of OCD to the breadth of difficulties his partner had experienced. Martin's choice of tense; using "have" instead of "had" also communicated that he is still in the process of updating his understanding of OCD to include these personal experiences into his conceptualisation.

2.3.2.2. Subordinate theme 1b: "Gulf between you and me".

Four participants talked to me about their early engagements with their partners' OCD. For John, the context of parenthood was a factor in his difficulty in understanding OCD in the early stages. For example, John reported:

"...for any new parent, you don't really know what's normal....she didn't like to be away from the baby. For me, it was more kind of....well okay that must be normal....She would have moods up and down, and again I just put that down to becoming a new parent."

(John, lines 51-52)

John's account revealed how difficult it was for him to disentangle the impact of his partner having OCD from other common experiences of being a parent. John reflected that it took around six months from the birth of his daughter to come to the conclusion that the problems his spouse was experiencing was above and beyond that of 'normal' parenthood. Where John's experience was of noticing a problem emerge over time, Adrian's first experience was seeing his partner in an acute state of heightened anxiety, as he described:

"She was deeply deeply upset, hyperventilating. And then I finally got her to talk and explain. She mentioned it was OCD for the first time...I had a huge sigh of relief because I had thought it was something serious. Now obviously that wasn't necessarily the best thing to say."

(Adrian, lines 48-51)

Adrian told me he had come home from work and saw his partner distressed. He had assumed that the level of distress he had witnessed would be proportionate to, in his mind, to that of hearing of a death in the family. As such, anything other than death was not considered serious. He reflected that his response may have led to his partner not feeling understood in that moment.

Martin talked to me about recent situations where he felt that he had misunderstood his partner. For example, Martin narrated:

"I think both of us can get slightly frustrated with the other not seeing each other's point of view. I think she thinks I just don't get this or understand. Equally I might be thinking that this isn't a big problem."

(Martin, lines 228-229)

Martin's description is complex in that it involved different perspectives; his own and what he perceived his partner to think. He expressed that at times his partner had sought

understanding from him but he had considered her concerns as not serious to him. For Martin and his partner, this mismatch in perspectives led to frustration.

Matt reflected that he had come to view OCD as having created a “gulf” between him and his partner over time (lines, 273-274). This metaphor is a powerful one with multiple meanings. Matt may have been talking about a theoretical gulf, in an acknowledgement that there are differences in understanding about OCD as well as opinion on how best to help. His use of the term "gulf" also suggested that the OCD had created a physical and emotional distance in the relationship between them as a couple, and as parents. He goes on to say:

"I struggle to understand it's severity and what I can tell you is that my earliest engagement with it was increasingly futile efforts to talk her out of it by explaining how pointless it was....and it took me a couple of years for me to realise that it doesn't help and arguably makes things worse."

(Matt, lines 105-107)

Matt described that he would attempt to help his partner by referring to OCD as 'pointless' and had tried to 'talk her out of it'. This approach appeared to 'make things worse' which suggested that it reduced the opportunity to understand his partner's experiences of OCD. Furthermore, Matt's account is one of helplessness in his perceived ability to provide support. Similarly, Adrian described himself as 'practical', and in his view, OCD was 'ridiculous', and stated:

"...[OCD] had manifested itself in her head and I'm a practical person....it's rubbish...I just want her to see that it's bloody ridiculous and that upsets her more."

(Adrian, lines 108-109)

Adrian was rageful in his account. This rage was fuelled by seeing his partner in distress and not being able to take this distress away through any practical means. Furthermore, his attempt at helping, by saying that OCD is ridiculous, appeared to have the opposite effect

as it made his partner more upset. It is possible that by saying *OCD* is ridiculous, his partner may have perceived him as saying *she* is ridiculous.

For Martin, Matt and Adrian, approaching OCD with rationality, as they would a work problem, and attempts to shift their partner's perspectives to that of their own, was ultimately unhelpful. John's experience differed here, as he described ways in which he sought to understand his partner's distress. However, this was frustrating process for him, as he told me:

"Naturally you want to find out, want to know what's wrong and talk to me about it. I'll be like 'what's up what's up? What's wrong with ya?' and I didn't really get anything back. And me being me, I'd keep...I'd say nagging really. And I still didn't find out what was wrong anyway. And that you know, I'd get wound up myself."

(John, lines 225-227)

By wanting to find out what was wrong and understand what was upsetting his partner, John found himself asking more questions, which appeared counter-productive as his partner withdrew further into herself and this did not improve his understanding or their relationship.

2.3.2.3. Subordinate theme 1c: "This must be eating you alive"

Despite acknowledgements in gaps in their own understanding of OCD, participants expressed their appreciation of their partners' strength and resilience in managing the negative impact of OCD alongside motherhood. For example, Adrian said:

"I can only imagine...it must be pressing on her mind a lot."

(Adrian, lines 73-74)

Adrian described how OCD was a psychological process that preoccupied his partner considerably. A similar understanding of the psychological aspect of OCD is expressed by John:

“It was almost as if, she had to set a standard, and she had to be like that. There was no give and take. I used to think this must be eating you alive. The amount of energy, the mental energy, it must take to be like this all day, everyday.”

(John, lines 126-128)

John had come to understand OCD as being rule-bound, demanding, and a considerable drain on his partner's mental energy. As well as regarding his partner as resilient, Matt also viewed OCD as resilient, and expressed:

“I have a greater understanding of it's....terrifying resilience. How it is something that is always as she feels latent inside her, and just always trying to come out. Like a monster. I have a better understanding of how it inflicts her, and a better understanding of...how little I can do. And how best not to make it worse.”

(Matt, lines 326-328)

Matt's description here is complex and contradictory. He describes his partners' OCD as having "terrifying resilience", which suggested that he viewed OCD as being an ever-present feature of his partner. However, he also described OCD as a latent "monster" 'waiting to get out'. This powerful image holds a different meaning. In some way, viewing OCD as a monster depersonalises it and decenters the problem away from her as a person. In this view, his partner is a sufferer of OCD for which he has compassion for.

2.3.3. Superordinate theme 2: Loss

All participants described how the difficulties associated with their partners' OCD had eroded their sense of control and had become a threat to their independence and their relationships. Participants' accounts described a restriction on daily living and loss of opportunities to socialise. Participants' experiences were diverse, and contained the subthemes, “being led down a blind alley” and “a real bastard of a thing that spoils a lot of stuff”.

2.3.3.1. Subordinate theme 2a: “Being led down a blind alley”

Both Martin and Tom talked to me about how they would find themselves in conversations which would go 'over and over' the same thing. The content of these conversations were associated with preventing risk of harm occurring to their partner or baby. For example, concern that the baby may eat something poisonous which would make them unwell and die, or that their partner would become unwell and die. Both Martin and Tom described how they felt compelled to provide assurances of safety, but this was often short-lived. Martin described his experience here:

“It’s the repetition of the argument that’s the thing which become noticeable through the latter points of pregnancy. It’s the re-hashing of the same argument again and again without any different conclusion or options...it’s like she gets caught in a loop. I don’t think we’ve got to the point where I can affect that [reduce her distress] ...but it doesn’t stop me reassuring her”

(Martin, lines 78-79)

These conversations appeared to wear Martin down over time, and he reported that he would get frustrated with hearing the ‘constant risk being played back to him’. Although there was an understanding that giving assurance or solutions does not tend to help his partner, Martin reported that he will continue to do so because he is unsure of any other alternative. Feeling that there are limited options of helping was a similar experience shared by Tom:

“I think you have to break the cycle you’re in and you can’t just keep on going round and round. So I almost think walking away is sometimes the only option but I guess it’s the way you do it is key.”

(Tom, lines 122-123)

Tom's experience suggested that conversations would reach a point where it was not benefitting him or his partner, and felt the only helpful thing he could do in that moment was to walk away. Tom reflected that walking away was a difficult thing to do in this context as it might lead to a negative emotional or behavioral response from his partner.

Tom also described how he had to follow certain rules and behave in a particular way because of his partner's OCD, as he described:

“She would spray the door and take off her clothes and have a shower and make sure her shoes were clean...If we went out together, I would have a shower too you, see. And that would be, you know, a rule for all the places she thought were dirty, we would have to have a shower and clean all those places of contamination. That was a big impact on my life you see.”

(Tom, lines 105-109)

Tom's description of doing the OCD rituals and saying that it had a big impact was a major admission for him. Much of Tom's account was talked through in a 'matter of fact' way, and rarely disclosed what it was like for him emotionally. Therefore him saying that the demands placed on him were impactful, carried greater meaning than the words suggest. Tom valued choice and freedom to live his life and to do so under his own volition. OCD had placed this liberty under threat, as it had started to encroach on his life and felt that he had to become involved with doing OCD rituals alongside his partner.

Matt also reported that he had felt pressure to change his behavior in the context of his partner's OCD but differed to the extent of which he was willing to, as he expressed:

“At times it feels like you're being led down a blind alley. It's easier sometimes to modify my behaviour a bit but, going back to wheeling the buggy for instance. I will not check for dog shit when we're out walking. I don't do that. I said to her that I don't have OCD and I'm not going to behave as if I have OCD.”

(Matt, lines 220-222)

Although Matt mentioned that he had modified his behaviour slightly, he communicated his defiance to such requests as he feared OCD would develop further.

2.3.3.2. Subordinate Theme 2b: *“A real bastard of a thing and spoils a lot of stuff”*

Adrian and Tom described how their lives had changed over time as their partners' OCD got more severe. Adrian told me that he has not been on holiday for a long time due to his partner's OCD and said:

“We’ve not been abroad for a long time. Last time we went abroad, we had a major meltdown...It was a disaster because her luggage got covered in fluid and of course, that was the start of everything wrong. When we have gone on holiday, and stay places...it doesn’t become any easier.”

(Adrian, lines 156-158)

Adrian described here that OCD had made family holidays stressful, and his use of the word "disaster" suggested that it had impacted on both him and his partner. Adrian summed up his view on his partner's OCD:

“It’s just...a real bastard of a thing and spoils a lot of stuff.”

(Adrian, line 302)

Adrian experienced his partner’s OCD as having a pervasive impact which encroached on different domains of his life making it feel more restricted over time. Tom expressed how his partner's OCD had a more specific impact on his social life, and social support as a parent, and said:

“There was a time when we didn’t really want anyone coming over, because of the impact it would cause...they would come in and they wouldn’t take their shoes off in the right way. Rachel would be having the anxiety about whether they touched things and walked around the house, then she would have to Hoover and clean...and this would be a big thing for her to deal with.”

(Tom, lines 185-188)

In this instance, Tom reported that having friends and family over to their house had become such a problem that it made them question as a couple whether it was worth the distress it caused. Having people round had been a prior trigger for distress, which had become worse since having the baby as family members would want to come and visit more often. OCD presented a dilemma to him in which he had to choose an option which would cause the least distress for his partner. John had a similar experience of OCD impacting on social support and networks:

“With Lucy, she didn’t like handing her to other people...mum’s, parents or anything like that do you know what I mean. And because of that, she didn’t really like to socialise and things like that. So I’d say it did impact.”

(John, lines 277-278)

John described how his partner feared handing her baby to other people in case the baby came to accidental harm. As a result, both John and his partner had socialised less with friends and family since having the baby. John himself experienced limited opportunities to spend time with the baby alone, as he described here:

“Yeah it obviously effects the bond in it... if you can’t spend time just you and the baby it affects that bond. It’s only just recently that my five month old will take a bottle from me. She would just scream. I’m not saying that wouldn’t happen if I did have alone time with the new born but I think it’s a contributing factor.”

(John, lines 186-188)

John wanted to communicate to me the impact which OCD had on his experience of bonding with his baby. He talked to me with such sadness about feeling that he had missed out on the experiences of being a parent with his newborn because of the fears his partner held about the baby coming to accidental harm. John spoke about the special relationship between a father and daughter, and the loss of confidence he felt as a parent during that time.

Whereas the above examples were experienced as having a significant impact, Martin wanted to emphasise to me that OCD was no more than a 'background annoyance' to him and his partner, as he reported:

“For me it’s something that whatever happens, we’ll deal with. It’s not a shadow that overcasts on everything. It’s not completely de-railing us in to a horrible life which we can’t enjoy.”

(Martin, lines 274-275)

This suggests that the OCD had a lesser impact on him at that current time, and may reflect where he and his partner were in regards to experiencing recent onset OCD.

2.3.4. Superordinate theme 3: Support

All participants described how they had become a support to their partners' with OCD, as a spouse and parent, and also how they experienced accessing professional support through the National Health Service (NHS). This theme contains the subthemes: “there’s a limit to what you can do”, “bugger’s muddle” and “I can really help now”.

2.3.4.1. Subordinate theme 3a: “There’s a limit to what you can do”

Matt, Tom, Martin, John and Adrian narrated that they often felt conflicted in their role as a spouse. On one hand, they wanted to support their partner in reducing distress even it meant they had to adapt their life in order to do so. On the other hand, they did not want to be seen as 'lending themselves' to OCD or becoming their partner's therapist. All participants described their experiences where they felt they were able to help their partner. This 'help' formed many guises; offering practical help around the house, sharing parenting duties, giving their partner space with the baby or away from the baby, and supporting their partner to access professional help.

John found a role in helping by receiving guidance from a health visitor trained in the awareness of perinatal OCD:

“Personally when there’s an issue I just want to sort it out and he [the health visitor] advised to just take yourself away and do chores. Because it’s not them being ignorant, it’s them trying to shout at all these thoughts, and you keep asking them what’s wrong.....it’s...as if they are allowing these thoughts to manifest.”

(John, lines 214-217)

In order to help, John had to change his natural instinct of wanting to find out more about the problem. Having guidance from a health visitor gave John clarity on how to support his partner through doing chores. Matt found a practical role in helping his spouse:

“What helps her I think, is physically helping, particularly with the baby. What really helps is, you know, wash the bloody bottles, take a feed, take him out for two hours, look after him....that’s just parenthood”

(Matt, lines 309-311)

In Matt's experience, he felt he could help support his partner through being available to care for the baby and giving his partner time for herself to rest. Matt wanted to emphasise that he views this type of support as part of being a parent, and not specifically related to his partner's struggle with OCD. Providing practical help was another positive experience shared by Tom:

“Changing the bin or putting a wash on or doing the hoovering....most of those jobs end up at my doorstep because of how easy it is for me compared to her.”

(Tom, lines 215-216)

In Tom's experience, he found roles he could do because these were particularly difficult for his partner. In this case, it appeared relatively straightforward in identifying ways he could provide support. Sometimes, helping was a reflection on the limits of what they could offer and knowing when to encourage their partner to seek professional support, as Martin expressed:

“I was feeling it was getting a little bit ridiculous. I think it was that point we said you should go and talk about this. I didn’t know what that would lead to but I think you need to talk to someone who isn’t me as there’s only a limit to what I can do.”

(Martin, lines 173-175)

John reported that he felt he could help support the mother with practical things but also reflected that there was a limit to support he could offer in regards to OCD. This provided the motivation to seek specialist support, as John described:

“We’re getting help because you get to a point where you can’t do anything to help the situation. Talking about it makes her feel worse, taking the baby away to help her sleep makes it worse as she can’t sleep. So there isn’t really a lot you can do to be honest. Apart from as I say, things which may help like cleaning, making bottles...do you know what I mean, the practical stuff. And looking after the other child while I’m there, so she can have the baby.”

(John, lines 205-206)

John's experience of helping was to focus on practical duties in the house, and to leave the baby with his partner. This experience of helping differed from Martin's experience who said:

“I can walk in, if the baby was having a moment and crying or whatever, or beginning to get into slight toddler tantrums, I can literally just pick her up and that will be enough to calm her down...I think that’s been really important to both of us and I think it’s helped her a lot when she’s been struggling with the worry.”

(Martin, lines 315-317)

Whilst both John and Martin have spouses that had OCD behaviours that centred on protecting their child from harm, Martin was able to take control of the baby at times and this was supportive. However, John's spouse found this more distressing than helpful.

Adrian talked about how he had to tolerate his spouse's distress and recognised that he could not help:

"To avoid it, to try and help her having to deal with it...when something has happened, it's in her mind and there's not much I can do to make it go away. I just try and give her space."

(Adrian, lines 212-213)

In this case, it was important for Adrian to give his partner space which may have been difficult to do when she was distressed and he may have wanted to help.

As demonstrated earlier, partners expressed that they felt limited in their capacity to help with the OCD at times, and wanted to retain their role as a partner as opposed to a therapist as Matt reported here:

"I didn't think of myself as being her therapist. I just thought of myself as addressing this problem with common sense, rationally. Only as I realised that approach absolutely doesn't work and she would say things to me like 'you can't be my therapist'."

(Matt, lines 139-141)

2.3.4.2. Subordinate theme 3b: "Bugger's muddle"

"Buggers muddle" is a phrase which refers to a mess, or a situation when multiple things have gone wrong. This phrase was used by Adrian when describing his experience of navigating health services and seeking support for his partner's OCD. John, Adrian and Tom told me about their experiences of being with their partner when seeking support from health services. John's experience of seeking support in the early stages of his partners OCD was challenging as he described:

"Personally, I just thought she was just severely depressed....because the thing is, the first port of call the person goes to is the GP....and if they're unable to say [what it is]or here's some antidepressants...which doesn't help at all."

(John, lines 161-162)

John expressed his frustration towards the General Practitioner (GP) for not being able to provide clarity, or confirmation, on what his partner's problem was and had no confidence that the prescription of antidepressants was going to help. For John, the moments after seeing the GP was the most upsetting for him as he reflected:

"She was coming out of the doctors thinking 'I don't know what's wrong with me. I must be the only one who feels like this'. And that's when she felt she wasn't good enough to look after them [the children]..."

(John, lines 167-168)

John described how frightening it was for him hearing his partner saying that she felt alone and not being good enough to care for the children, in the context of himself not knowing what was wrong and feeling that there was no effective support in place. John's uncertainty in what the problem was similar to Adrian's:

"Hugely hugely frustrating...we went to the GP's and kept seeing a different person. Saw the GP, they said tell us it all from the start. No-one had any notes. You can't explain from the start each time. Huge amount of history."

(Adrian, lines 252-255)

Adrian's experience of being with his partner to access support was of frustration towards the inconsistencies in care with seeing different GP's each visit and the request to provide a detailed description of the history of the problem at each visit. For Adrian, seeking support may have been experienced as not being listened to by the GP, or that his partner's OCD was not being taken seriously. However, in contrast, Tom reported that his experience of accessing support was a straightforward process:

"Yeah I mean before we had the baby and before seeing a gentleman psychiatrist who didn't really improve her condition very much...she went back to the doctors and they referred her to the usual obstetrician and that...and allowed other people to come in to speak to her. She got her place in the Maudsley. And ermm..I'd say the Maudsley has been one of the best support she's had."

(Tom, lines 268-272)

Tom's experience appeared to suggest that due to the pregnancy, the mother was able to get support in place prior to the birth of the baby fairly quickly. Tom appeared to suggest that the mother benefitted due to health professionals having a good understanding of OCD and a clear route for accessing psychological support.

2.3.4.3. Subordinate theme 3c: *"I can really help now"*

Accessing specialist psychological therapy for OCD appeared to be important to the participants. Tom reported:

"Now, she won't necessarily ask for me to have a shower, and she would say how bad is this and think I could live with this, and she would do half the rituals from the normal rituals, or none at all. She's made a bit of a transformation."

(Tom, lines 113-114)

Tom reported that the support they gained led to a transformation in how his partner dealt with OCD behaviours which impacted positively on their day to day life. Accessing specialist psychological therapy meant that partners could feel more assured in their approach to supporting their spouse, as Adrian reported:

"...But I can really help [now], if we're walking down a lane, and we see some stuff on the ground, we'll walk straightforward even if we weren't going to. We'll walk through and stamp our feet through. She's been really good at that."

(Adrian, lines 226-228)

Adrian talked here about getting involved and being alongside the mother in her therapy. This appeared to be helpful for the mother, as well as empowering for him as her partner.

All fathers told me that despite the struggles with living alongside their partners' OCD, it would not prevent them from having further children as they had experienced benefits of accessing psychological therapy and now felt that they had the support in place to cope.

2.4. Discussion

2.4.1. Significance of the main findings

The present study aimed to explore partners' lived experiences of perinatal OCD. By gaining an in-depth understanding of partners' experiences of this unique, and clinically distinct, perinatal mental health problem it was hoped to inform clinical practice. Three themes emerged from analysis of participant's accounts, which are now discussed within the context of existing literature. Methodological limitations, clinical implications and directions for future research are also discussed.

2.4.2. Discussion of findings

2.4.2.1. Superordinate theme 1: Making sense of OCD

This theme conveyed the difficulties participants encountered in trying to understand the complexity of their partner's OCD. Findings were similar to the research on partners' experiences of post-partum psychosis and post-natal depression as many participants reported that they struggled to understand the perinatal mental health problem (e.g. Engqvist & Nilsson, 2011; Grube, 2004). However, the findings in the present study differed from existing research in a number of ways. Firstly, participants reported having pre-conceptions about OCD as having items ordered in a neat way and liking things to be symmetrical. This view differed considerably to the reality of seeing their spouse in distress. It therefore suggests that pre-conceptions can interfere with the identification of OCD, and participants reflected that it took time for them to develop a more accurate understanding of the disorder. Secondly, participants reflected that they felt OCD created distance between themselves and their spouse; emotionally and physically. Participants reported that they felt they could truly never understand the disorder the way their spouse experienced it. Participants stated that they often struggled to help the mother because of their lack of understanding of OCD. Furthermore, the nature of OCD meant that some mothers struggled to disclose what they were thinking and feeling to their partner. A typical feature of some types of OCD is 'thought-action fusion'; the fear that if they articulate their intrusive thoughts aloud, the feared consequences are more likely to happen (Shafran, Thordarson & Rachman, 1996). This could make it difficult for mothers to disclose thoughts of harm coming to their baby due to the perceived 'risk' in doing so. Furthermore, shame is a common experience for people with OCD (Weingarden &

Renshaw, 2015) as sufferers may perceive themselves to be morally wrong for having intrusive thoughts and will go to great lengths to conceal this aspect of themselves from others through fear of rejection (Gilbert & McGuire, 1998).

2.4.2.2. Superordinate theme 2: Loss

This theme conveyed participants' experiences of perceived loss of control on their daily living. Participants reported that OCD had impacted on their freedom and seeing family and friends. This finding is consistent with research on family accommodation of OCD, whereby families significantly adapt family life because of the disorder.

The most common experience participants talked about was getting involved in providing repeated assurances and requests for certainty. This is not a new finding, as reassurance-seeking is a typical feature of OCD (Kobori & Salkovskis, 2013; Parrish & Radomsky, 2006, 2010, 2011; Salkovskis & Kobori, 2015). Reassurance-seeking is understood to be the person with OCD experiencing threat, thus attempting to gain information from another person to provide a sense of security or relief (Starcevic et al, 2012). Unfortunately, relief is often short-lived and the person with OCD requires more reassurance over time. This was apparent in the present study when participants expressed feeling frustrated that they were going over the same arguments again and again. This poses a dilemma for partners, who debated whether they should stop giving re-assurance or whether health-services were better placed to advise partners to stop.

2.4.2.3. Superordinate Theme 3: Support

This theme conveyed the process of partner's finding a support role in themselves to better help the mother, as well as experiences of being with the mother during help-seeking and accessing health services. Some participants reported that they found the process of getting help relatively straightforward and timely, and it appeared awareness of the disorder in health visitors, GP's and any other health professional involved in maternity services was crucial. However, other participants had a long and frustrating process, which highlights inconsistencies in care.

Accessing healthcare support has the potential to be incredibly frightening for mothers with OCD (Weingarden & Renshaw, 2015; Shafran, Thordarson & Rachman, 1996). It is crucial that health-services have a sophisticated awareness of the disorder in order to respond sensitively to people presenting with OCD. Without awareness, there is the risk that the mother feels more distressed and any perceived negative reaction could be interpreted as a confirmation of their fears. Challacombe & Wroe (2013) describe issues in clinical practice where perinatal OCD has been misunderstood as the mother being at 'high risk' of harming their children and given restricted access. This highlights the potential ramifications of being misunderstood. Participants in the present study reported their experiences of health professionals not accurately identifying OCD and mistaking it for depression which delayed intervention.

2.4.3. Implications for policy and practice

2.4.3.1. Increased awareness, prevention and support

The present study, to the author's knowledge, is the first attempt at understanding partners' experiences of perinatal OCD. Partners' experiences of accessing support for perinatal OCD showed great inconsistencies in how it was identified and what support was offered. These inconsistencies could be resolved long-term by providing information, psycho-education and training for organisations that come into regular contact with expectant and new mothers such as, the NHS, National Childcare Trust (NCT) and other community initiatives. It is likely that any interventions that normalise and de-stigmatise OCD will be helpful, as well as how to sensitively assess for perinatal OCD and distinguish the disorder from common morbid problems such as, post-natal depression.

2.4.3.2. Reassurance-seeking

Reassurance-seeking was a common experience by partners in the present study which created dilemmas. In a study exploring partners' experiences of reassurance-giving (Halldorsson, Salkovskis, Kobori, & Pagdin, 2016), partners reported a number of perceived benefits for doing this despite an acknowledgement that it may contribute in maintaining OCD. Firstly, partners reported that they give reassurance because they want to provide relief for their spouse, even if it is only temporary. Secondly, partners report that they simply do not know what else to do or offer. Thirdly, partners reported that they

feared negative emotional or behavioural responses if they were to withhold reassurances in the form of anger or aggression directed towards them. Therefore, reassurance-seeking is a complicated phenomenon that requires a shared understanding of its function and awareness of its potential to maintain OCD in the context of a comprehensive psychological formulation.

2.4.4. Research limitations and future directions

2.4.4.1. Research limitations

The present study should be considered in light of its limitations. Firstly, only male participants were recruited, therefore the results are related to fathers' experiences of perinatal OCD and excludes same-sex partners, non-biological fathers and other significant family members e.g. grandparents. Including women partners and other family members may have elucidated interesting gender and generational differences in relations to understanding and support. Secondly, there was limited diversity amongst the participants. Having broader samples of people from other backgrounds and cultures may have provided interesting alternative understandings of OCD in the context of parenthood. Thirdly, the present study was based on a small sample size in-fitting with qualitative research, therefore there are limitations to how these findings translate to wider populations. Replicating or adapting this study with a combination of qualitative and quantitative methodologies would further our understanding on partners' experiences of perinatal OCD.

2.4.4.2. Future directions

The mothers' experiences of OCD in the present study were related to contamination fears and checking. These types of OCD are often associated with clear observable behaviours e.g. washing excessively, and family involvement is common. It would be interesting to see whether there are similarities and differences with other types of OCD, for example, mothers with intrusive thoughts of sex/violence, or 'just-right' experiences related to ordering and symmetry. The former is a common presentation in terms of mothers accessing psychological help. Both these forms of OCD can be more subtle, and less observable in terms of overt behaviours, therefore it would be of interest to understand how partners' understand these types of OCD.

Fathers are also vulnerable to developing perinatal OCD (Abramowitz, Moore, Carmin, Wiegartz, & Purdon, 2001), therefore it would be interesting to understand how partners' experience this from a female-mother perspective.

2.4.5. Conclusion

The aim of the present study was to explore partners' experiences of perinatal OCD. Five partners were interviewed to gain an in-depth understanding of their experience. Three themes emerged from the data; how partners came to understand OCD, how they experienced living alongside OCD and experiences of accessing healthcare support. Partners have a crucial role in supporting mothers with perinatal OCD, and future research could explore whether there are any differences or similarities with other OCD sub-types or related disorders.

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Chapter 3: Reflective Paper

"You're too young to have children": Experiences of conducting research with fathers as a Trainee Clinical Psychologist

Written in preparation for submission to the Journal of Reflective Practice

Overall chapter word count (excluding tables, figures and references): 1,745

3.1. Introduction

This chapter focuses on my experiences as a male Trainee Clinical Psychologist conducting research with men. My research included; a systematic literature review on partners' experiences of weight-loss surgery (unpublished Doctoral dissertation) and an empirical study on partners' experiences of perinatal Obsessive-Compulsive Disorder (unpublished Doctoral dissertation). It seemed appropriate to reflect on gender in research for two reasons. Firstly, the majority of partners in my research were men and secondly, there are few accounts of male researchers reflecting on gender relations (Robertson, 2006).

3.2. Early research on interviewing male participants

There a number of influences which gender can have in conducting research with men. Many authors of qualitative research have commented on men talking about problems in a third-person and factual way (Brannen, 1988; Davis, 1992; Jackson; 1990; McKee & O'Brien, 1983), and are more likely to avoid direct questions (Hearn 2013). Allen (2005) explained this way of relating as males presenting their masculine identities to the researcher.

The gender of the interviewer also appears to have an influence on the interview process (Flood, 2013). Men are more likely to confide in female interviewers and disclose greater detail than with male interviewers (Broom et al., 2009; Scully, 1990. Furthermore, female interviewers are less likely to be subject to 'jokey male-male talk' than male interviewers (McKee & O'Brien, 1983). However, the authors note that this style of communication is not necessarily a hindrance to qualitative research as it is an empirical resource and provides insight into relations. In Thurnell-Read's (2016) personal account of conducting research with male firefighters, he talked about participants being reserved initially in the early stages of the qualitative research process. He commented on issues with rapport building, and how he had found it a long and slow process. In his account, he described a key moment when he had not turned up to the fire station as expected due to being hung-over from a previous evening's drinking session with friends. Thurnall-Read reported that this experience had been a turning point for him as felt he had become accepted by the firefighters he was researching, and they had begun to talk more openly to him about their experiences.

These studies suggested that I would encounter challenges when conducting qualitative research with men as a male interviewer. Not only would my participants not disclose their experiences with me at deep and meaningful level to preserve a front of masculinity, I also did not have the time afforded by Thurnell-Read's (2016) study to build rapport over a number of weeks.

3.3. Experience of interviewing male participants

I will now describe my experiences of interviewing men as a male researcher for an empirical study on partners' experiences of perinatal OCD (unpublished Doctoral dissertation). I have framed these experiences as dilemmas because it placed me as the researcher in a position where I had to evaluate how best to respond to a male participant, and how I reached a Thurnell-Read (2016) moment where I felt 'accepted' by the participant.

3.3.1. Dilemma 1: interview questions

I was interviewing a male participant who held a senior and powerful professional role. Within the first few minutes, he told me that the questions I was asking were too broad and whether I could be more specific. This created a dilemma for me. If I changed questioning style to a specific and closed approach, then there was a risk that the information gained would only provide a brief, surface-level understanding of his experience. However, I perceived a greater risk in losing his engagement in the interview altogether if I did not adjust the questions to make his participation more accessible. Therefore, the main feeling I experienced at that moment was of anxiety and perceived incapability as a qualitative researcher. I then began to empathise with my participant. I had gained an understanding of his work in Law, where there was an emphasis on specificity and getting into the minutiae of details. Plus, my participant is more familiar with being in the position of asking the questions, therefore becoming the one being questioned had the potential to be unfamiliar and threatening. Consequently, I apologised for the use of broad questions, reflected how these types of questions can be tricky to answer, and followed this up with a series of specific questions. The participant went on to give relatively matter-of-fact responses to the questions I was asking, and showed similarities to the findings from the earlier research outlined in the previous section (Brannen, 1988; Davis, 1992; Jackson, 1990; McKee & O'Brien, 1983.).

3.3.2. Dilemma 2: self-disclosure

During an interview, I had asked the participant whether he could describe a recent occasion of this spouses' perinatal OCD. The participant was describing a situation which involved pouches of baby food when he stopped suddenly and said "*you're too young to have children.....do you have children?*". The participant made an assumption about my age and wanted to know what my position was in order to know how to respond to my question. I disclosed that I had recently become a father and that I was aware of the baby food pouches he was referring to but my daughter was too young at that stage to use them. I also disclosed in a light-hearted way that I felt sleep-deprived and I was just about getting through the day most days.

Requests for self-disclosure has the potential to influence a number of factors on the research process. Smith, Flowers and Larkin (2007) discuss the benefits and pitfalls of self-disclosure as a researcher when carrying out interviews with participants. It has also been argued that self-disclosure can, for some participants, facilitate rapport, and may lead to more detailed responses. Self-disclosure is encouraged in some qualitative approaches for this reason, for example in feminist and discursive research (see Burman., 1994; Gubrium & Holstein., 2002). However, the authors argue that for some participants, self-disclosure can lead to competitive dynamics within the interaction. Competitive dynamics can lead to response-bias, for example, not wanting to disclose difficulties or appear vulnerable.

In this experience, disclosing that I was a father appeared to have a beneficial effect as the participant appeared to become more comfortable in his body language as well as describing his experiences. This meant his responses became more detailed, and he was more receptive to more open and expansive questions as the interview went on. I felt that competitive dynamics were mitigated by my disclosure that I was a new father, which placed the participant in the position of knowledge and wisdom; a position which would be safe and familiar to him given his profession. The participant expressed that he remembered what it was like to feel sleep-deprived, which was an experience we could both relate to, which facilitated rapport further. I felt this was my Thurnell-Read moment of acceptance.

3.4. Discussion

This chapter was a reflection on experiences of conducting qualitative research with men as a male researcher. I appreciate that gender does influence the research process, as do other factors such as age, ethnicity, class, religion, spirituality and disability. It is important to be aware of potential barriers in conducting qualitative research where differences and similarities are present within the researcher-participant interaction.

I could identify with some of the difficulties encountered with the earlier research on interviewing men. However, I felt this was more related to my experience of being a novice qualitative researcher than a gender issue per se. Smith, Flowers & Larking (2009) highlight that the importance of building rapport, getting the participant used to talking and feeling comfortable before the first question on the interview schedule. The interview was my first one of the study (unpublished Doctoral dissertation) therefore I felt my nerves and excitement for the project could have influenced my approach to the interview and has since provided a useful learning experience for me. I would take more time to build rapport at the start of interviews and not use the interview schedule until the participant appeared more relaxed. In subsequent interviews, I arranged to meet the participant beforehand, to get them a coffee and spend time talking to them beforehand which meant they were settled by the time we started the interview.

I question how transferable the findings are from the earlier research on interviewing men. Many of these studies were conducted in the 1980's and 1990's, and it is likely that attitudes towards masculinity have shifted. Many of the men I interviewed (unpublished Doctoral dissertation) reported that they felt they were "not like most fathers" and they identified "taking a hands-on approach to parenting". Participants eloquently disclosed their anxieties and frustrations of seeing their spouse afflicted with perinatal OCD, and how helpless they felt. Participants reflected that they did not identify with traditional views of masculinity. My experience of interviewing men is more akin to other studies which reported high levels of personal disclosure between men and male researchers (e.g. Flood, 2013), therefore I feel it is important to be critical of the evidence-base and to be aware of assumptions about researching specific groups.

3.5. Key learning points

My experiences of conducting research with men have highlighted a number of key learning for my own development as a qualitative researcher. These are:

- Be aware of prior-assumptions about working with men and use a bracketing method or discuss with your supervision team about how these assumptions may influence the research process
- Engagement and rapport is important to make the participant comfortable prior to asking the first question of the interview guide. Appropriate use of humour and self-disclosure can facilitate this
- Prepare for the event of requests for personal-disclosure in advance with your research team and discuss what you would/would not be prepared to disclose to participants, and how you would do this

3.6. Conclusion

This reflective account was on my experiences as a Trainee Clinical Psychologist interviewing men as part of my empirical project (unpublished Doctoral dissertation). I described my experiences of interviewing participants and the dilemmas I faced. These dilemmas provided useful learning opportunities to refine and develop my skills as a qualitative researcher. It is important to consider similarities and differences between participant-researcher and how these factors, as well as the social context, can influence the interaction. Bracketing methods and preparing for events such as requests for self-disclosure, are important to consider as novice qualitative researcher.

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Appendix A: Author guidelines for the submission to the Journal of Obesity Surgery

INSTRUCTIONS FOR AUTHORS

1. ABOUT OBSU

Obesity Surgery is published by Springer Science+Business Media LLC and is the official journal of the International Federation for the Surgery of Obesity and metabolic disorders (IFSO). Obesity Surgery publishes concise articles on Original Contributions, New Concepts, How I Do It, Review Articles, Brief Communications, Letters to the Editor and dedicated Video Submissions. Requirements are in accordance with the "Uniform Requirements for Manuscripts submitted to Biomedical Journals," www.icmje.org.

All manuscripts submitted to OBSU are received, blind-reviewed and decided upon through the online Editorial Manager (EM) System center. URL: <http://www.editorialmanager.com/obsu>. Articles that are accepted for publication are done so with the understanding that they, or their substantive contents, have not been and will not be submitted to any other publication.

2. SUBMISSION CHECKLIST

Authors: Make sure that all of the items below are ready and available when you submit.

TITLE PAGE REQUIRES:

- ☐ Full Title, and Short Title for Running Head
- ☐ All Contributing Authors, Full Names/Degrees, and Email Addresses/Affiliations
- ☐ "Correspond To" Information
- ☐ Detailed Acknowledgments, Grant Information, and non-blinded COI Statement

MAIN MANUSCRIPT TEXT REQUIRES:

- ☐ Blinded Text
- ☐ Abstract (N/A for Letters to the Editor; optional for Brief Communications)
- ☐ Required Ethical, COI, and Human/Animal Rights Statements (blinded)
- ☐ References in PubMed style
- ☐ Tables (Optional)
- ☐ Figure Legends (if providing figures)

FIGURES/IMAGES:

- ☐ For vector graphics, the preferred format is EPS; for halftones, use TIFF format.
- ☐ Figure width should be 39 mm, 84 mm, 129 mm or 174 mm, and no higher than 234 mm
- ☐ No identifying information about patients
- ☐ Patient and/or publisher permissions, if needed

VIDEO/ELECTRONIC SUPPLEMENTARY MATERIAL:

- ☐ Any Video or multimedia in either .MP4 or .MOV file format
- ☐ Supplementary videos not to exceed 2 MB in size
- ☐ Narration in English

REQUIRED OFFICIAL ICMJE CONFLICT OF INTEREST FORM(S):

- ☐ One form completed by each author (ex: 5 authors = forms)

REQUIRED FOR REVISIONS ONLY:

- ☐ One copy of clean, revised text, tables and figures
- ☐ One copy of annotated, revised text, tables and figures
- ☐ Point-by-Point Reply to Reviewer Comments

INSTRUCTIONS FOR AUTHORS – 1

Full guidelines can be viewed at:

<https://www.elsevier.com/journals/surgery-for-obesity-and-related-diseases/1550-7289/guide-for-authors>

Appendix B: Ethical approval certificate for systematic literature review



Certificate of Ethical Approval

Applicant:

Jolyon Poole

Project Title:

Partners Experiences of Weight-Loss Surgery: A Qualitative Meta Synthesis.

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:

13 November 2017

Project Reference Number:

P61808

Appendix C: Quality Assessment Framework

| |
|---|
| Quality Assessment Framework for systematic reviews Caldwell, K., Henshaw, L., & Taylor, G. (2011) |
| Criterion 1 Does the title reflect the content? |
| Criterion 2 Are the authors credible? |
| Criterion 3 Does the abstract summarise the key components? |
| Criterion 4 Is the rationale for undertaking the research clearly outlined? |
| Criterion 5 Is the literature review comprehensive and up to date? |
| Criterion 6 Is the aim of the research clearly stated? |
| Criterion 7 Are all ethical issues identified and addressed? |
| Criterion 8 Is the methodology identified and justified? |
| Criterion 9a Is the study design clearly identified and is the rationale for the choice of design evident? (for quantitative studies) |
| Criterion 10a Is there an experimental hypothesis clearly stated? Are the key variables clearly defined? (for quantitative studies) |
| Criterion 11a Is the population identified? (for quantitative studies) |
| Criterion 12a Is the sample adequately described and reflective of the population? (for quantitative studies) |
| Criterion 13a Is the method of data analysis valid and reliable? (for quantitative studies) |
| Criterion 9b Are the philosophical background and study design identified and the rationale for choice of design evident? (for qualitative studies) |
| Criterion 10b Are the major concepts identified? (for qualitative studies) |
| Criterion 11b Is the context of the study outlined? (for qualitative studies) |
| Criterion 12b Is the selection of participants described and the sampling method identified? (for qualitative studies) |
| Criterion 13b Is the method of data collection auditable? (for qualitative studies) |
| Criterion 14b Is the method of data analysis credible and confirmable? (for qualitative studies) |
| Criterion 15 Are the results presented in a way that is appropriate and clear? |
| Criterion 16 Is the discussion comprehensive? |
| Criterion 17a Are the results generalizable? (for quantitative studies) |
| Criterion 17b Are the results transferable? (for qualitative studies) |
| Criterion 18 Is the conclusion comprehensive? |


Quality Assessment Ratings for studies selected in the review

| Criterion | Aaris 2015 | Alegria 2017 | Berglund 2014 | Byland 2017 | Campa 1996 | Hadier 1991 | Madan 2005 | Ponies 2016 | Rand 1984 | Romo 2014 | Wallwork 2017 | Werner 2016 | Woodard 2011 |
|-----------|---------------|-----------------|------------------|----------------|---------------|----------------|---------------|----------------|-----------|--------------|------------------|----------------|-----------------|
| 1 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 4 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 |
| 5 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 | 1 | 2 | 2 | 2 | 2 |
| 6 | 1 | 2 | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 7 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 2 | 2 | 0 | 0 |
| 8 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 | 1 | 2 | 2 | 1 | 2 |
| 9a | 2 | x | 2 | x | 1 | 1 | 1 | x | 1 | x | x | 2 | 2 |
| 10a | 2 | x | 2 | x | 1 | 1 | 1 | x | 1 | x | x | 2 | 2 |
| 11a | 1 | x | 2 | x | 1 | 1 | 1 | x | 1 | x | x | 2 | 2 |
| 12a | 1 | x | 1 | x | 1 | 1 | 1 | x | 1 | x | x | 1 | 1 |
| 13a | 2 | x | 2 | x | 2 | 2 | 2 | x | 1 | x | x | 2 | 2 |
| 9b | x | 2 | x | 2 | x | x | x | 2 | x | 2 | 2 | x | x |
| 10b | x | 2 | x | 2 | x | x | x | 2 | x | 2 | 2 | x | x |
| 11b | x | 2 | x | 2 | x | x | x | 2 | x | 2 | 2 | x | x |
| 12b | x | 2 | x | 2 | x | x | x | 2 | x | 2 | 2 | x | x |
| 13b | x | 2 | x | 1 | x | x | x | 2 | x | 2 | 2 | x | x |
| 14b | x | 2 | x | 1 | x | x | x | 1 | x | 2 | 2 | x | x |
| 15 | 2 | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 2 |
| 16 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 2 | 2 | 2 |
| 17a | 1 | x | 1 | x | 1 | 1 | 1 | x | 1 | x | x | 1 | 1 |
| 17b | x | 2 | x | 2 | x | x | x | 2 | x | 2 | 2 | x | x |
| 18 | 1 | 2 | 1 | 1 | 1 | 1 | 0 | 2 | 1 | 1 | 2 | 1 | 1 |
| Score | =31 | =35 | =30 | =31 | =26 | =22 | =22 | =36 | =22 | =35 | =36 | =30 | =31 |



Appendix D: Inter-rater reliability scores for systematic literature review

| Author/Date | Quality Rating | Reliability Test (Kappa rating) |
|---|----------------|---------------------------------|
| Aarts et al. (2015) | 31 | 0.79 |
| Alegria & Larsen (2017) | 35 | 0.64 |
| Berglind et al. (2014) | 30 | 0.89 |
| Bylund et al. (2017) | 31 | 0.56 |
| Camps et al. (1996) | 26 | 0.80 |
| Hafner (1991) | 22 | 0.67 |
| Madan et al. (2005) | 22 | 0.81 |
| Pories et al. (2015) | 36 | 0.81 |
| Rand et al. (1984) | 22 | 0.81 |
| Romo & Dailey (2014) | 35 | 0.64 |
| Wallwork et al. (2017) | 36 | 0.56 |
| Willmer et al. (2016) | 30 | 0.77 |
| Woodard et al. (2011) | 31 | 0.83 |
| Overall Reliability Score = 0.80 | | |

Appendix E: Author guidelines for the Journal of Clinical Psychology



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Sections

1. Submission
2. Manuscript Categories and Requirements
3. Preparing The Submission
4. Editorial Policies and Ethical Considerations
5. Author Licensing
6. Publication Process After Acceptance
7. Post Publication
8. Editorial Office Contact Details


1. SUBMISSION


Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a meeting or symposium.


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<https://onlinelibrary.wiley.com/page/journal/10990879/homepage/ForAuthors.html>

Appendix F: Ethical approval for empirical paper



Certificate of Ethical Approval

Applicant:

Jolyon Poole

Project Title:

Fathers' Experiences of Their Partner's Perinatal OCD: An Interpretative
Phenomenological Analysis.

This is to certify that the above named applicant has completed the Coventry
University Ethical Approval process and their project has been confirmed and
approved as Medium Risk

Date of approval:

20 September 2017

Project Reference Number:

P60441

Appendix G: Recruitment poster for empirical paper



Are you the male partner of a mum with OCD?
Is your child under 3 years old?

We want to learn more about your experiences in order to
better support mums and dads in this situation

My name is Joe and I am the Lead Researcher for this unique study looking at
fathers' perspectives of perinatal OCD. The research is being supported by the
Universities of Coventry and Warwick.

You may be eligible to participate in the research study if:

- ✓ You are a father
- ✓ You have a child under 3 years old
- ✓ Your partner (the mother) has a diagnosis of OCD

If you would like to find out more about the research study and could be
available for an informal 45-minute interview in London or over Face
Time/Skype at a time convenient for you, please contact me on:

Joe Poole Trainee Clinical Psychologist
Email: jolyon.poole@nhs.net

Thank you

Wx 3.0 dated 28.11.2017

Appendix H: Participant consent form for empirical paper



Fathers' Experience of Their Partner's Perinatal OCD: An Interpretative Phenomenological Analysis

Participant Consent Form

Please tick if you agree to the following conditions:

1. I confirm that I have read and understood the Participant Information Sheet (ver 3.0 date 28.11.2017) for the study and I have had the opportunity to ask questions ☐
2. I agree to have the interview audio recorded on a password protected iPad and that the recording will be stored securely until the interview it has been transcribed for analysis, after which the recording will be deleted ☐
3. I understand that my participation is voluntary and that I am free to withdraw from the interview at any time without giving any reason ☐
4. I understand that it may not be possible to withdraw from the study after the 1st February 2018 ☐
5. I agree to allow the researchers to use quotes in the write up of the results which will be academically assessed and may be used for publication ☐
6. I understand the information about confidentiality in the Participant Information Sheet (ver 3.0 date 28.11.2017) and that **any disclosures made which could result in the risk to self, or to others**, the researcher would pass this information on to the appropriate authority ☐
7. I agree to take part in the study ☐
8. I wish to have a summary of the research findings emailed to me on completion of the study (expected Sept 2018) ☐

Participant Initials: _____ Date: _____

Participant email (if condition 8 is ticked): _____

Lead Researcher: Jolyon Poole _____ Date: _____

Participant Consent Form NHS ver 3.0 28.11.2017

Appendix I: Participant information sheet for empirical paper



Fathers' Experience of Their Partner's Perinatal OCD: An Interpretative Phenomenological Analysis

Participant Information Sheet

You are being invited to take part in a research study. Before you decide it is important for you to understand why the study is being carried out and what it will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. Thank you for reading this.

What is the purpose of the study?

The main purpose of the study is to explore and understand the experience of being a father and having a partner with OCD during pregnancy and/or during the first three years of parenthood. We hope by listening to your experiences, the findings will inform recommendations to improve clinical practice.

Why have I been chosen?

You are being asked to take part in the study because you are a parent, have a child (or children) under the age of 3 years old and have a partner who is experiencing OCD.

What am I being asked to do?

We would like to invite you to take part in an informal interview. This interview may last for up to an hour, depending on how much you feel comfortable in sharing.

What will happen in the interview?

The interview will be guided by a researcher from Coventry University, and you are encouraged to share your experiences. You will be asked some questions to help you share your views. The researcher will audio record the interview so that we can have an accurate record of your views. You are free to say as much or as little as you feel comfortable with. What you choose to tell the researcher will be anonymised, and no information will be attributed to specific individuals.

Do I have to take part?

You do not need to take part. Once you have read this information sheet and had a chance to ask questions about the study, it is completely up to you whether you would like to take part and share your views. You do not need to give a reason for withdrawing and there are no repercussions should you wish to do so. If you do decide to take part, you will be asked to complete a consent form.

You may withdraw from the study up until 1st February 2018. After this date, the data will be anonymised and analysed in order to identify themes arising from the data. At this point, we cannot guarantee that we will be able to identify and remove your data contribution.

What are the possible benefits of taking part?

We hope that by taking part in the study, you will feel that your views have a chance to be listened to by a whole range of people, including people within and outside the NHS.

What are the possible risks of taking part?

We do not expect any disadvantages or risks of taking part in the study. If you experience any distress and feel upset by the issues raised, you can end the interview and withdraw your participation or take a break. If the researcher notices that you are becoming upset, they will ask you if you want to end the interview or to take a break. If you are upset or distressed following the interview, you are encouraged to either contact your GP for support or to contact one of the support organisations listed in the Debrief Sheet that you will be given at the end of the interview. If you have any questions about this study, you can contact the Lead Researcher (details at bottom of this page). You can also end the interview at any point. You can also ask for the information you provide at the interview to be withdrawn from the study by contacting the Lead Researcher (contact details at bottom of this page).

Will my information be kept confidential?

No identifiable information such as, full names, addresses will be asked for during the interview. We will have your first name and your email address as this is the method of contacting us to participate in the study. This information will not be kept on completion of the study. The electronic consent form and interview will be stored on a password-protected iPad. The researcher will transfer this data on to a password-protected computer where the interview will be transcribed. Following transcription, the audio recording will be deleted. Transcriptions from the interview will be analysed with the other participant's responses. In the write up of the study, comments and quotes may be used to illustrate themes that have been found. Any comments or quotes which could lead to the identification of a participant will be removed/altered in the write up of the study.

The transcripts and the electronic consent forms will be stored on a Coventry University password-protected computer for a period of five years after which, they will be safely destroyed.

If you disclose information during the interview that indicates risk to the welfare of yourself or others, the researcher has a duty of care to pass this information on to an appropriate authority. You will be asked to sign a consent form if you agree to these conditions.

What will happen to the results of the study?

A summary of the results will be fed back to everyone who has taken part in the study. The study will be written up as an academic requirement for completion of the researcher's Clinical Psychology Doctorate at Coventry University. Findings may be published in an academic journal. None of the people taking part in the study will be identified in any way.

Who has reviewed the study?

The study has been reviewed and approved by:

CU Ethics
Coventry University
Priory Street
Coventry
West Midlands CV1 5FB
024 7765 7688

South London and ~~Maudsley~~ NHS Foundation Trust
R&D Department
Institute of Psychiatry, Psychology & Neuroscience
De ~~Crespigny~~ Park
London SE5 8AF
020 7848 0251

Who is organising the study?

The study is being conducted by Coventry University and receives no external funding. The study is organised by:

Mr Jolyon Poole
Lead Researcher & Trainee Clinical Psychologist
Coventry University

Dr Fiona ~~Challacombe~~
Clinical Supervisor & Clinical Psychologist
South London and ~~Maudsley~~ NHS

Dr Sarah Simmonds
Senior Lecturer-Practitioner in Clinical Psychology
Coventry University

Dr Helen Liebling
Senior Lecturer-Practitioner in Clinical Psychology
Coventry University

Who can I contact for further information?

Please contact Jolyon Poole if you need any further information.

Mr Jolyon Poole
Department of Clinical Psychology
Coventry University
Coventry CV1 5FB

Email: poolej9@uni.coventry.ac.uk
Tel: 024 776 583 28

Appendix J: Participant debrief sheet for empirical paper



Fathers' Experience of Their Partner's Perinatal OCD: An Interpretative Phenomenological Analysis

Participant Debriefing Sheet

What happens now?

Thank you for taking part in this study, your participation is greatly appreciated.

Your responses will be analysed along with the other participant's responses. From this, themes about being a father with a partner who has Perinatal OCD will be identified and written up as an academic requirement for completion of the researcher's Clinical Psychology Doctorate at Coventry University.

If you decide after the interview that you do not want your interview data to be used in the study, you can request that your data is withdrawn by contacting Jolyon Poole by 1st February 2018 at poolej9@uni.coventry.ac.uk. After this date, the data will be **anonymised** and **analysed** and we cannot guarantee that we will be able to identify your data contribution after this point.

Findings may be published in an academic journal and/or presented at conferences where stakeholders in the NHS may hear the themes from the research. Please note, no information that will lead to the identification of a participant will be shared.

If you have requested for a summary of the research findings, this will be sent to you by September 2018.

We understand that due to the sensitive nature of the topics discussed, this may have at times been distressing. If you have any problems or queries related to the study itself, please contact Jolyon Poole on the details below.

Who can I contact?

Lead Researcher Jolyon Poole

Email: poolej9@uni.coventry.ac.uk

Where could I get further information?

If you would like to seek further support, you may wish to contact one of the following organisations:

OCD-ACTION

Information, advice and support for anyone affected by OCD.

Web: www.ocdaction.org.uk

Debriefing Sheet NHS **var** 2.0 Date: 13.08.2017

Email: support@ocdaction.org.uk
Tel: 0845 390 6232

Maternal OCD

Information, advice and support for mothers who experience OCD

Web: www.maternalocd.org
Email: info@maternalocd.org

OCD-UK

Information, advice and support for anyone affected by OCD.

Web: www.ocduk.org
Email: support@ocduk.org
Tel: 0845 120 3778 (Mon to Fri 9am to 5pm)

Mind – The Mental Health Charity

Information and support for those experiencing mental health problems, as well as families and carers.

Web: www.mind.org.uk
Email: info@mind.org.uk
Tel: 0300 123 3393 (Mon to Fri 9am to 6pm)

Samaritans

Providing confidential support available 24 hours a day, 365 days per year.

Web: www.samaritans.org
Tel: 116 123 (24 hours a day, 365 days per year)

Carers UK

Practical, emotional and financial advice and support for carers.

Web: www.carersuk.org
Tel: 0808 808 7777 (Mon to Fri 10am to 4pm)

NHS Choices: Carers Direct

Information, advice and support for carers from the NHS and social services.

Web: <http://www.nhs.uk/conditions/social-care-and-support-guide/pages/carers-direct-helpline.aspx>
Tel: 0300 123 1053 (Mon to Fri 9am to 8pm; Sat to Sun 11am to 4pm)

We hope that you find this helpful.
Please contact the researcher if you have any questions.

Appendix K: Interview guide for empirical paper

Interview Schedule

I am interested in what you have to say about your experiences of being a father with a partner who has OCD, and what is important to you. I will ask a few questions and these are designed to encourage you to talk openly about your experiences and there may be long periods where I just let you talk. There are no right or wrong answers; I am interested in what's important to you.

I'd like to remind you that you don't have to answer any questions that you don't feel comfortable with. We can take a break if you need, and you can ask to end the interview at any point if you feel that you need to stop.

Are you okay to start? I'll start recording now.

1) To start with, can you tell me about you and your family?

Possible prompts: What was it like becoming a father?

2) Can you describe your experiences of living with a partner with OCD?

Possible prompts: What were your initial experiences? What was it like for you? What was it like for your partner?

Note to interviewer: consider using: can you say a bit more about that? Can you expand a bit on that? Can you give an example of that?

3) How did you understand what was happening for your partner?

Possible prompts: How did you make sense of your partner's OCD? Do you have any thoughts on how or why your partner developed OCD?

Note to interviewer: consider using: can you say a bit more about that? Can you expand a bit on that? Can you give an example of that?

4) How has living with a partner with OCD impacted on your experiences of fatherhood?

Possible prompts:

- In what ways has this impacted on your parenting?
- In what ways has this impacted on your relationship with your partner?

Note to interviewer: consider using: can you say a bit more about that? Can you expand a bit on that? Can you give an example of that?

5) What helps you to support your partner?

Possible prompts: in what ways do you support your partner?

Note to interviewer: consider using: can you say a bit more about that? Can you expand a bit on that? Can you give an example of that?

6) What have been your experiences of seeking support?

- From friends / wider family
- From services?

Note to interviewer: consider using: can you say a bit more about that? Can you expand a bit on that? Can you give an example of that?

7) How has the experience of your partner's OCD impacted on how you see the future as a family?

Possible prompts: Have your plans or expectations changed because of the OCD? How has your experience of the OCD influenced your ideas about having further children? Has your experience of OCD left you with any concerns about the future?

Note to interviewer: consider using: can you say a bit more about that? Can you expand a bit on that? Can you give an example of that?

8) Final question...

Do you have any other thoughts or comments that we haven't covered about your experiences of being a father with a partner who has OCD, or anything else that you'd like to add?

Appendix L: HRA approval for empirical paper



Health Research Authority

Mr Jolyon Poole
Clinical Psychology Department
Coventry University
Coventry
CV1 5FB

Email: hra.approval@nhs.net

04 December 2017

Dear Mr Poole

| | |
|-------------------------|--|
| Study title: | Fathers' Experiences of Their Partner's Perinatal OCD: An Interpretative Phenomenological Analysis. |
| IRAS project ID: | 221758 |
| REC reference: | 17/LO/1924 |
| Sponsor | Coventry University |

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read *Appendix B* carefully, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating

Appendix M: Example transcripts with exploratory notes and theme development for empirical paper

Participant 1

Participant 1 – 9/11/2017

| Exploratory Coding | | Descriptive Coding |
|---|--|---|
| <p>as far as I can tell. It doesn't affect his life as it does [redacted].</p> <p>What was it like for your partner when she was telling you?</p> <p>No I don't. This is <u>really difficult</u> because <u>neither of us actually remember how it came</u> about. It's just seemed to me...<u>sorry</u> she's distracting me....<u>erm</u>...<u>not having OCD myself</u>. Not being I would say, <u>not being afflicted by any psychological issues beyond the norm of a man my age</u>. I <u>struggle to understand it's severity</u> and what I can tell you is that my earliest engagement with it was <u>increasingly futile efforts to talk [redacted] out of it by explaining how pointless it was</u>. There's no point in washing your hands washing your hands washing your hands because you're moving through a sea of viruses, moulds, I would say to her. And it <u>took me a couple of years for me to realise that it doesn't help and arguably makes things worse</u>. So that was my engagement with it. It <u>engages me cerebrally, like an intellectual puzzle rather than an emotional thing</u>. I couldn't <u>really connect with it emotionally because it doesn't seem to make sense</u>.</p> <p>Stating he doesn't have her problems - distancing himself from her? struggle to understand but I'm not like her?</p> <p>Helpless in attempts to help?</p> <p>Attempts to dismiss OCD because I cannot help in any other way?</p> <p>OCD causing conflict in the relationship. My approach causes conflict in the relationship.</p> <p>Thinking about OCD challenges me? Not wanting to engage with it emotionally? What would happen if I did? Become OCD?</p> | | <p>Not having <u>OCD</u> myself</p> <p>Not having psychological <u>problems</u> myself</p> <p>Struggle to understand its severity</p> <p>Futile efforts to talk partner out of OCD</p> <p>Trying to help is pointless</p> <p>Realisation that talking her out of it is pointless</p> <p>Relationship conflict</p> <p>Not able to connect to OCD on an emotional level</p> <p>OCD doesn't make sense to me</p> |

Participant 1 – 9/11/2017

| Exploratory Coding | | Descriptive Coding |
|--|--|---|
| <p>Power? needing to be right? Self as fixer or logical?</p> <p><u>Really delighted</u> or sadness that partner doesn't respond well to his attempts at helping?</p> <p>Personal fears?</p> <p>Uncertainty about the future?</p> <p>Blame?</p> | <p>How did that make you feel? Giving similar messages but something about the differences. Did that lead to...</p> <p>It doesn't bother me. I get a perverse satisfaction from feeling that quite a lot of what I have said is what the therapists have said. I'm just delighted that she goes somewhere and she gets some assistance. I never get a sense of 'well I said that...' That's <u>just my intellectual arrogance wanting to see that I was right</u>, but it doesn't bother me. I'm just delighted that she's seeking professional help. I've said to <u>her</u>, she should see a therapist regularly if it helps. I don't care if they say exactly what I say [laughs].</p> <p>Can I ask you a bit about how the OCD impacted on fatherhood? Has living with [redacted] with OCD impacted on your experiences of fatherhood in anyway?</p> <p>This is peculiar because in many ways, she hasn't...there was a big fear going forward when we discovered [redacted] was pregnant. <u>This was a really big fear of mine, that our son [redacted] would pick up OCD by observation of what she does</u>. Because children are incredibly observant and they</p> | <p>Satisfaction that I am right</p> <p>Delighted that partner gets support</p> <p>Big fear about son would develop OCD through observing mum.</p> |

Participant 5

| Exploratory Coding | | Descriptive Coding |
|---|--|---|
| not wanting OCD as a secret? attempts at helping? Partner wanting other people to know?! | <p>when I saw her for the first time, staying at a friend's house, must have been 6 years ago. She came out of the shower and had dropped the towel on the ground, and that it had been contaminated. That's when I had told her friends as well – as they were her best friends. I said look, you need to share this.</p> <p>What was it like getting that understanding about the OCD? It sounded like, when [redacted] initially told you about it, how did it fit in with your ideas of what OCD was? Had you heard of it?</p> | <p>telling her friends needing to share her experience</p> <p>Telling partner to share OCD with friends</p> |
| OCD preconceptions | <p>I had heard of it. Sometimes I don't tell everybody this, I don't expect my friends to understand like I did. I know what they may assume it is. Lining everything up and in order, like you sometimes see on the television. And some people say I'm really OCD, which is not [redacted] struggle at all. It is very much a contamination issue. So when she explained that to me, I started to understand more. She asked me to do some research and read some books. I never did. Which isn't very supportive of me. But my initial reaction... I told her I didn't believe in it. I do believe it's in your mind. And I think the more we talk about it and give it a name, the more it will lend itself. And I have said to my family, and to her, that that was maybe wrong. But that reaction to it. And a lot of anger. That.....it had manifested itself in [redacted] head and I'm a practical person, and it's rubbish. And that probably took a year or two and probably upset [redacted] a little bit but it was with best intentions.</p> <p>How did it impact on things? Anything which helped or didn't help?</p> | <p>OCD as lining things up like on television. People say I'm OCD</p> <p>Started to understand more when speaking to partner</p> <p>More we talk about OCD the more it will lend itself</p> <p>Anger towards OCD Practical person and OCD is rubbish Upset partner with best intentions</p> |
| Seeking to understand Not being supportive Not accepting OCD? Fears about the more we talk about it, the more it will develop? | | |
| Frustration Self as logical? | | |
| Relationship conflict? | | |
| Frustration Not accepting of OCD? Seeing partner distressed | <p>My reaction didn't help – sometimes it doesn't still. I mean we talk very openly. And I hope you appreciate that I am talking openly with you because I don't have any embarrassment about and I encourage [redacted] not to. It's about being open. And I know my approach can be a bit heavy handed and short tempered – especially when I come home when I've been away. And I don't want to hear it. I'm sad to hear it when she's struggling. So I might just tell her it's ridiculous. It's ridiculous. At the end of the day I</p> | <p>Acknowledgement that reaction doesn't help Encouraging partner to be open about OCD Heavy handed approach, short-tempered Don't want to hear about OCD Sad to see partner struggling.</p> |

Appendix N: List of conceptual codes and early stages of theme development

List of Conceptual Codes

