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PANDA title page

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Male callers to an Australian perinatal depression and anxiety help line - understanding issues and concerns

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Ethics approval

The study analysed de-identified data. The study was approved by the Human Research Ethics Committee of The University of Newcastle, NSW. Approval number H-2015- 0264.

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Competing interests

The authors declare that they have no competing interests.

Abstract

There is increasing recognition of the issues facing men in the perinatal period. Vulnerability factors and issues in the partner relationship contribute to mental health risk and can impact the quality of the father-infant relationship. Yet there is limited understanding of fathers' help seeking when they or their partner are experiencing mental health issues in the context of caring for a new baby. The present study examines fathers' contacts with the Perinatal Anxiety and Depression Australia (PANDA) national helpline. The study reviewed contacts from fathers and their identified needs for assistance, relationship issues and support needs: 70% of male callers (N=129) reported concerns about the mother's mental health and 57% were concerned about relationship breakdown. Significant numbers of men raised issues about their own mental health (43%) and many were concerned about the impact of maternal mental state on the relationship with the infant. When compared to community data, there were elevated rates of concerns about depression and anxiety. Men also described difficulties with the fathering role and with regulating their own feelings of guilt

and frustration. These findings highlight the needs of men for support when a mother experiences perinatal problem and also the risk for distress in fathers.

Keywords

Fathers, depression, help-seeking, partner-support

Introduction

In the perinatal period, defined as from conception to 1 year after birth, both women and men are at increased risk of mental health disorders. Between 10 and 20 % of women will report depressive symptoms at some point in pregnancy or postnatally (Buist & Bilszta, 2005; Schmied et al., 2013) while between 3 and 5% will experience severe depression and 0.2% will be diagnosed with a psychotic disorder (Oates, 2003; Sit, Rothschild, & Wisner, 2006). The seriousness of maternal mental health has been recognised as maternal perinatal deaths due to suicide have been included in national data collections (Austin et al 2011).

According to the severity of the symptoms mothers will experience feelings of worthlessness, lack of enjoyment in usual activities, dysphoria, anxiety, inability to make decisions, extreme agitation and, in severe cases, delusions and psychotic symptoms. (O'Hara & Wisner, 2014). Affected mothers may be "remote, silent, verbally and behaviourally intrusive, self-absorbed, insensitive and unresponsive" in their parenting (Riordan, Appleby, & Faragher, 1999). Infants of mothers with perinatal mental disorder may experience anxiety and disruptions to the development of their attachment relationship and the effects of mothers' difficulties in sensitive and attuned care may contribute to elevated rates of cognitive, psychosocial, emotional, and behavioural problems documented in children and adolescents (Stein et al, 2014).

Although fathers' mental health is less well understood a recent meta-analysis found an average rate of 10.4% for paternal depression over the perinatal period (Paulson & Bazemore, 2010) and case reports of new fathers' psychosis have been published (Pinheiro et al., 2011). Fathers experience unique stressors during the perinatal period and those with previous depression, those whose family income is low or where the marital relationship is poor are particularly vulnerable to mental health issues such as depression, anxiety and psychological stress (Philpott et al, 2017;. Figueiredo et al, 2017). The effects of paternal mood disorders on infants are similar to those reported for affected mothers. Infants of fathers reporting symptoms of postnatal depression are three times more likely to exhibit behaviour problems as pre-schoolers (Fletcher, Freeman, Garfield, & Vimpani, 2011) and twice as likely to receive a psychiatric diagnosis by 7 years of age (Ramchandani & Psychogiou, 2009). Children of fathers diagnosed with severe mental illness are at risk of physical and mental harm (Fletcher et al, 2013).

The high cost of perinatal mental illness to the individuals involved and to the community has stimulated the development of services targeting mental health, with a focus on maternal illness. In Australia, the National Perinatal Depression Initiative (NPDI) was instituted to identify maternal perinatal depression, anxiety and psychosocial distress, and provide pathways to appropriate treatment and support (Austin, Reilly & Sullivan, 2012). For more serious mental illness Mother Baby Units have been established to offer residential care where mothers and their infants can be admitted (Milgrom, Burrows, Snellen, Stamboulakis, & Burrows, 1998). However, many mothers, including those reporting high levels of mood disorder symptoms, do not seek help from professionals or services (Reay, Matthey, Ellwood, & Scott, 2011; Woolhouse, Brown, Krastev, Perlen, & Gunn, 2009; Schmied et al, 2013).

Among the barriers and facilitators influencing mothers' willingness to seek treatment the role of the partner has been highlighted.

In a study of 460 mothers, more than half of whom had been diagnosed or experienced symptoms of depression, partners normalizing their depressed mood was a major barrier to seeking treatment. An additional barrier for almost 70% of mothers was preferring to discuss feelings with their partner (Kingston et al., 2015). In a longitudinal study (n= 83) of mothers rated 'low' or 'medium to high' risk on the Antenatal Risk Questionnaire (ANRQ) few sought help from mental health services in the 12 months after the birth, however more than 90% in both risk groups said that they were most likely to seek help from their intimate partner (Schmied et al., 2013).

Fathers (partners) are also reported to be a major influence in mothers' recovery from perinatal mood disorders including major depression and psychosis (Séjourné, Vaslot, Beaumé, Goutaudier, & Chabrol, 2012; Brandon et al., 2012). When mothers who had recovered from postnatal depression (n=158) were asked to list the 'essential' elements in their recovery, three of the eight factors were: emotional support from partner; improved communication with partner; and, practical support from partner (di Mascio, Kent, Fiander, & Lawrence, 2008). Fathers' involvement in infant care when mothers are depressed may also reduce the effects of impaired mother-infant care on the infant's development. In a 10 year longitudinal study interviewing mother-child dyads (n= 6652) over the ages 0-10 years the effects of the mothers depressed mood on the child's development varied by the level of the father's positive involvement such that the development of child problem behaviour was inversely related to positive involvement of the father (Chang, Halpern, & Kaufman, 2007).

For their part, fathers' mental health seems to be particularly influenced by the relationship with the mother. Several studies examining the transition to parenthood have reported associations between maternal and paternal depression (Anding, Röhrle, Grieshop, Schücking & Christiansen, 2016; Goodman, 2008; Paulson & Bazemore, 2010). However paternal perinatal depression has been linked both antenatally and postnatally not only with maternal depression but with the quality of the relationship with mother (Anding, Röhrle, Grieshop, Schücking & Christiansen, 2016; Gawlik et al, 2014).

Taken together, the evidence reviewed above points to the significance of the family context of perinatal mental illness and suggests that fathers be included alongside mothers in perinatal mental health services, a view shared by researchers across the field (Fletcher, May, StGeorge, Stoker, & Oshan, 2014; Ledenfors & Berterö, 2016; Letourneau et al., 2012; Paulson & Bazemore, 2010; Ramchandani & Psychogiou, 2009). However, our understanding of how services might respond to fathers who are struggling with their own or their partner's mental illness is lacking.

A recent systematic review of 11 interventions targeting perinatal paternal mental illness found limited evidence of effectiveness; three out of five psychosocial group programs and two out of three teaching fathers massage reported intervention effects using a range of self-report measures. However methodological quality was poor across studies (Rominov, Pilkington, Giallo, & Whelan, 2016). Similarly, while an integrative review of treatment options for new fathers' depression and anxiety reported examples of father-specific sessions added on to CBT treatment programs for mothers no evidence of effectiveness was found. The authors also pointed to masculine gender role

norms discouraging men from seeking help and the limited access to health services and information relevant to fathers' mental health (O'Brien et al., 2016).

Fathers whose partners may be experiencing postnatal mental illness may have particular needs. These fathers may be simultaneously attempting to support their distressed partner, meet the needs of their new infant and provide the family income (Bell et al., 2016; Doucet, Letourneau, & Blackmore, 2012). Qualitative studies have described the fathers' emotional turmoil, fear, confusion and anger when coping simultaneously with the arrival of a baby and their partner's illness (Beestin, Hugh-Jones, & Gough, 2014; Boddy, Gordon, MacCallum, McGuinness, 2017. Unfulfilled expectations of family life and relationships were identified as extremely distressing "Do you know how soulwrenching it is to listen to the woman you love more than anyone in this world say she doesn't want to be with you and your infant son?" (Engqvist & Nilsson, 2011; 139). Like fathers experiencing mood disorders, those with mentally ill partners struggle to identify suitable sources of help from an unfamiliar health system and in the face of perceived stigma (Bell et al., 2016; Doucet, Letourneau, & Blackmore, 2012).

The potential for embarrassment or shame when men seek professional assistance for relationship issues has prompted the creation of specialised male-specific telephone counselling services (https://mensline.org.au/about-us/). A key feature of such helplines is the opportunity they provide to discuss the caller's situation, to clarify their needs and to make them aware of the services available in order to effectively resolve the situation, or seek appropriate assistance (Coman, Burrows, & Evans, 2001). The anonymity and immediacy of the telephone helpline may be attractive to fathers in families where they or their partner are depressed, since the fathers may have little

knowledge or understanding of available services at the same time as they are experiencing high levels of distress. In Australia, the Perinatal Anxiety and Depression Australia (PANDA) National Helpline is promoted as a free service available to fathers, as well as mothers specifically to assist with mental health problems in the perinatal period (Perinatal Anxiety and Depression Australia [PANDA], 2017). An examination of calls made by fathers to this helpline may provide a window into the perspective of distressed fathers in the context of perinatal depression. In this paper, the concerns and needs recorded during telephone conversations over 12 months with males who had contacted PANDA are analysed to identify the help that is being sought by male parents when reporting distress themselves or within their partner.

Methods

In Australia, the PANDA helpline offers information, support and referral to "anyone affected by post and antenatal mood disorders, including partners" (PANDA, 2017). Launched in July 2010, the national helpline is available Monday to Friday 9am to 7.30pm AEST/AEDT. Approximately 12,000 contacts (incoming and outgoing calls are made each year involving 13,700 persons. Calls to PANDA are prompted by web searches, word of mouth and professional referrals. Callers are rated as mild to moderate if they assessed to be experiencing mild to moderate perinatal mental health issues and/or transition difficulties, with no suicide plan or intent, no family violence, no drug and alcohol abuse, no self-harm, and no concerns about child safety. Callers rated moderate to severe are assessed to be experiencing moderate to severe perinatal mental health issues and/or psychosocial complexity, for whom risk assessment has identified suicide history, plan or intent; self-harm; acute mental illness; alcohol and other drug use; family violence; or risk to child. Mild to

moderate callers are supported by a trained peer support volunteer, while callers rated as moderate to severe speak with a professionally trained counsellor. A detailed assessment is conducted using a narrative inquiry style and details are recorded in a Service data record. Follow up calls may continue counselling and ensure callers are linked to local community support. When family violence is disclosed by a caller, risk is fully explored and assessed, following organisational processes developed to respond to family violence in the perinatal context. This may involve linkages and referral to specialist services or notification to external bodies as required.

The majority of calls to the PANDA Helpline are from parents or family members seeking support or information from the service. An electronic Service data record is used to record call details. Mandatory data includes basic demographic (e.g. caller's gender, nationality and mental health status) and administrative information (e.g. type of support needed, how they heard about the helpline) recorded using pre-determined responses. Information about physical, emotional, cognitive, social, and behaviour issues/factors is also recorded using pre-determined responses. Counsellors then use a narrative approach to assess the biological, psychological, and social needs of callers, and further explore key areas of concerns such as; the interpersonal relationship; social support, and the caller's emotional state at the time of the call (e.g. crying, agitated, flat, calm). The 'story' of the caller obtained through this narrative is also recorded by the counsellor as brief annotations, descriptions, or summaries in the Service record. At the discretion of the counsellor and request of the caller, follow-up calls are scheduled to track caller progress. These Service data records therefore provide a progressive albeit brief account of a caller's support history with PANDA.

Data sources

Ethics approval for the study was obtained from the Human Research Ethics Committee from the University of Newcastle, Australia. In the current study, de-identified Service data records from 462 calls with men were provided to researchers for review. Data records included all calls conducted with male callers over a 12-month period between [1 Jan 2014] and [31 Dec 2014]. Only calls from closed cases were included. Prior to supplying the case notes for examination by researchers, PANDA staff manually removed all identifying information (e.g. caller information such as nationality and suburb, counsellor's name, organisations or locations discussed within the context of the calls).

Data analysis

To identify the concerns and needs of fathers calling for assistance, we analysed the frequency of the following fixed-response categories in the Service records: 1) callers' identified need for support; 2) emotional, physical and relationship issues as reported by callers. Call characteristics (e.g. frequency and duration of calls) were also analysed. Initial response to those identified as high risk (of suicide for example) or referrals to external agencies (in cases of domestic violence for example) were not recorded in the Service data records.

The narrative data recorded by the counsellors were analysed thematically (Bazeley, 2009; Braun & Clarke, 2006). Categories were created that summarised the main concerns and stressors pertaining to the caller's current distress; these were discussed in research team meetings, Code labels were created and refined to reflect a common interpretation of the texts. Codes were compared to each other and patterns across the codes were used to identify common themes in paternal help-seeking behaviours with the PANDA Helpline.

Results

In 2014, the PANDA helpline provided counselling support to 129 male callers. Of these, one male called on behalf of his sister, and another male called on behalf of his daughter; these callers are not included in the analysis. The counselling and support comprised 462 calls involving 154 hours of one-on-one telephone support, an average of 20 minutes per call. For 39 of the male callers (31%), only a single call was required. Fifty five callers (43%) required two, three, or four calls, and a further 25 callers (19.7%) received between five and 10 calls. A small group of callers (n = 8, 6.3%) required more than 10 calls during their contact with the service. In the results section, we first describe the findings of the quantitative analysis of responses to the pre-determined categories. We then present the findings of the qualitative thematic analysis of the annotated service records.

Reasons for calling, emotional, physical, and relationships issues raised

1) Reason for calling

The 'reason for call' category is a mandatory field, whereby a minimum of one category is selected by the counsellor during the initial call. For nine out of 10 callers (89.7%) the main reason for contacting the PANDA service was support. Information about postnatal depression was more frequently sought (43.3%) than information for antenatal depression (4.7%). Information about PANDA was sought by 28.3% of callers and 18.9% contacted the service enquiring about a referral to another organisation for support. Crisis intervention was only identified as a 'reason for call' in 8.7% of the screening calls. Table 1 provides a summary of the 'reason for call' data.

Documentation of distress in psychological, physical, or social functioning is not mandatory but counsellors determine a caller's issues in each category through their conversation.

Counsellors recorded an emotional issue for more than 83% (106/127) of the male callers. In this category callers most frequently reported feeling overwhelmed (*n* = 54; 50.9%) and anxious (*n* = 53; 50%). Approximately 4 in 10 were recorded as feeling irritable or angry, and between 24% and 30% were recorded as feeling depressed (*n* = 32; 30.2%), crying (*n* = 27; 25.5%) and feeling hopeless (*n* = 26; 24.5%). Guilt (*n* = 25; 23.6%) and an inability to cope (*n* = 25; 23.6%) were equally identified by almost a quarter of the callers. Panic attacks were the least reported emotional issue. A summary of the emotional issues recorded by counsellors is provided in Table 2.

Physical and relationship-based issues were recorded for 50.4% and 62.2% of all cases respectively. Low energy was the most frequently reported physical issue with almost 50% of the male callers reporting experiencing low energy (*n*= 31; 48.4%) and poor sleep (*n*= 31; 48.4%). Exhaustion, fatigue and low appetite were recorded for 43.8% (*n* = 28), 31.3% (*n* = 20) and 15.6% (*n* = 10) of the men reporting physical issues, respectively. All other physical issues were recorded for less than 10% of the cases (see Table 3).

There were three options for recording relationship issues; 'relationship strain'; 'relationship breakdown', and 'relationship with infant'. Strain and breakdown were the most frequently reported relationship issues. For just over 83% of the callers reporting relationship issues (*n* = 66) counsellors recorded that the men described their partnered relationship as strained; for 31.6% (*n* = 25) of the men, a breakdown in the relationship with their partner was indicated. Relationship with the infant accounted for less than 10% of the recorded relationship-based issues (*n* = 7; 8.9%). Table 4 provides an overview of the frequency of male callers' relationship issues as recorded by the counsellors.

Qualitative findings: Fathers' concerns identified by counsellors

In this section, we report on the concerns articulated by 127 fathers during their calls, as recorded by the counsellors in the Service data records, and thematised through the qualitative analysis.

Concerns about mothers

Mothers' mental health. Men calling about their partner's mental health, their most common concern (89 callers 70%), discussed serious mental health issues such as mood instability, irrationality, psychosis, suicide attempts and psychological dysfunction, which their partner was currently experiencing. Men were seeking advice, information, or guidance on how to respond to crises within the home, mothers' instability or hospitalisation, or caring for her post-discharge. A number of men commented that their calls were clandestine, as their partner was either not aware of, or not acknowledging, her own mental decline. Fathers reported that their partners were "falling apart" and overwhelmed, some quoting their partner: that she was at the "end of the rope" and "non-functioning". There were also descriptions of women's expression of guilt, self-criticism, and unrealistic expectations. Men also described how their partner had become avoidant and isolated, and resisted contact, assistance or connection with friends and family, with some reporting that their partner, with baby, had left the home.

Mothers' anger. Men also discussed their partner's anger and violence towards others. This was described by many as uncharacteristic and illogical, and the men attributed it to causes such as depression, relationship dysfunction, and alcohol misuse. The violence was related to emotions such as anger and frustration, the men describing outbursts of "uncontrollable rage", of partners going "berserk". Men described their shock and confusion at the ferocity of their partners' anger, which was associated with hostility, dismissiveness, criticism, and condescension. Physical violence by women was described as breaking, throwing, stomping

or kicking, with men being scratched, hit, punched, bitten, pushed, and slapped. Verbal abuse included name calling, swearing, and death curses. When it was directed at children, there were descriptions of rough handling, spanking, and verbal hostility.

The mother-child relationship. Fathers discussed their concerns about their partner's connections with the new baby. In general, the concerns occurred in the context of relationship difficulties, both parents' mental health, and strong negative emotions. Fathers described that the mother appeared to be disconnected and rejecting, with no desire to see or engage with the infant; added concerns were mothers' negative reactions to infant crying and their inability to enact safe boundaries. Fathers also discussed with counsellors their fears about the outcome of these disconnections: for some it was specifically how to proceed following the mother's discharge from care, for others, a more generalised fear for the family's future. Counsellors discussed with fathers the plans for infant care given the mothers' inability, and fathers talked about their own efforts as well as support from family. Fathers were also concerned for their own relationship with their spouse given the difficulty of the mother-child relationship.

The spousal relationship. Of the 127 callers, 73 (57%) spoke of the breakdown of their spousal relationship. Much of the relationship dysfunction appeared to occur in the context of partner's mental ill health, with many fathers also discussing multiple additional stressors, such as social isolation, their partner's and their own drug or alcohol use, and work-family strain. Some fathers talked about disagreements between partners about parenting, socialising, and parents-in-law. However, the majority of conflict reported was more serious in terms of argument, verbal abuse, and "communication breakdown", including some violence (as reported earlier). Furthermore, many callers spoke about separation from their partner, whether threatened or actual, and this was

associated with deep grief and concerns about the father's relationship with their child. In their discussions with the counsellors, the men described many different ways in which their partners perceived or interpreted the fathers' actions. Men spoke of how their partner blamed the father for their "selfishness", his lack of support, and for being the cause of their depression, "it's all your fault". Some men heard how they were despised and had "never been loved", others felt they could "do nothing right". Another aspect of the relationship breakdown was men's perceptions that the mother had become dependent, was expecting her partner to manage her anxieties, "she downloads her issues", and that she expects him to understand her. The overall discussion highlighted that many men were also struggling with their own mental health, either as a precursor to the relationship breakdown, or as a consequence.

Men's emotional experiences

Fifty five (43%) of the men discussed their own mental health, either as a primary reason for the call, or following discussion of their partner's mental health. In response to a traumatic birth, a partner's mental health issues, or a hostile spousal relationship, men described anxiety, grief and distress that was highly intense and disruptive. Men felt lost and at "breaking point". Physical and emotional issues included intense crying, withdrawal, and not eating or sleeping. The callers felt they had no motivation, were "burnt-out", with "knots", and a "sick and churning stomach". They felt irritable, uptight, "strung-out with frustration", and "out-of-control". Some men described how it was difficult to stay strong in face of the extreme pain, struggles and fears.

Several men discussed how their negative thoughts were distressing and intrusive, which seemed to "come out of the blue", and be overwhelming, "like in a nightmare I can't get out of". Some men discussed having had suicidal thoughts, but these were described as

"fleeting", and without a plan. Men said that their family, friends, or prior experiences were protective factors here. Although some men were aware that they "bottled" their emotions, keeping a "stiff-upper lip", many felt that this level of distress and anxiety was not characteristic, and they were not used to seeking help, some feeling incompetent, like a "failure" and embarrassed. Some named their feelings as depression, anxiety, or grief, while others emphatically described the "heart-sinking" reality of their current situation.

The contexts that triggered these extreme mental health concerns for men varied; many men were highly distressed about their partner's mental health, and felt they were taking the brunt of their partner's dysfunctional behaviour and child caring. Others were concerned about their own capacity or desire to father, sometimes linked to their own fathering experiences, and often linked to their work-family life balance, where financial and work-time hours were looming constraints. Some men talked about using alcohol or drugs as a coping mechanism, although realising this was problematic; others described coping through exercise and meditation.

Father's negative feelings. Some men (19, 15%) discussed their own feelings of anger and frustration, articulating whether or not this led to physical violence, and what they felt were the causes. The most powerful perceived causes for men's frustration and anger were their spousal relationship, their partner's ill health, and work-family balance. The disconnection from their child accompanying the breakdown of their relationship was of particular concern. Others felt they could no longer cope with looking after their partner's mental health crisis, and their baby, and maintain their regular work schedule.

At one level, these issues caused significant anxiety, whereas at a more extreme level, others described "exhaustion", which usurped their ability to cope adaptively, they were in "survival mode". "Lashing out" verbally was most typical of these expressions, happening when men

felt anger, frustration, resentment, or anxiety. For many men, the concatenation of discouraging feelings about self, about their partner, and about the baby devastated their resilience: for example, one father was described as angry about his wife's situation, but sad about his wife's illness, and "despondent" about the future.

Some men expressed concern that their feelings would escalate out of control into physical violence. A couple of men described physically aggressive exchanges between themselves and their partner, and two men talked of "punching the wall". For the most part, men emphasised that their anger was not directed at their partner or baby. By talking to PANDA, the men appeared to be seeking ways to defray their tiredness, frustration, and anger before this occurred.

The Fathering Role

Fathers' connection with their children, both the new baby, and existing children, was discussed by 14 (11%) men. Some men were disturbed that they were not connecting with their new child as they should: "thought he would fall in love with baby immediately". Men gave reasons such as their own anxiety, their availability to the child, or their partner limit-setting on father involvement. Some men revealed their ongoing distress from a traumatic birth experience. A number of fathers discussed their distress about losing their new baby (and other children) due to the breakdown of their spousal relationship. Fathers described that this anxiety, and its implications for the child, impeded their ability to bond with their child. There was also a difficulty in maintaining a strong relationship with older children due to the presence of the new baby, as well as their partner's ill health.

Consequently, a number of men experienced a sense of failure in the parental role and associated guilt. These feelings also related to men's own experiences of being fathered, not feeling competent in caring for the infant, or feeling isolated from other fathers, or from

family members. About half of the men discussing their own issues about the transition also had partners who were unwell and this could be emotionally overwhelming. Some expressed reluctance to share their distress with their partner given her own current vulnerability, "worry about over-burdening her". Additionally, men's anxiety and self-doubt increased as spousal tension predating the birth now resurfaced in the fatiguing postnatal period.

Work-life balance. As part of the transition to family life, 26 men (20%) experienced work-life/family-life tension. Financial difficulties were core concerns for some, "need to repair the roof and make the home warmer". Long work hours, travel, job stress and dissatisfaction were problematic for men who were also experiencing significant relationship problems and personal mental health issues. Some men discussed how personal and family stress spilled over into their work place, and the overall sense was that under the cumulative strain of work and family problems, there was risk of "burn-out", frustration, exhaustion, and withdrawal.

Discussion

Male callers to PANDA, as captured in the Service data records analysed here, are experiencing significant distress in their relationships and describe experiences of high stress and concerns regarding unravelling relationships. High levels of distress and physical strain such as fatigue and exhaustion were recorded by the counsellors and more than four out five of the callers identifying feelings of being overwhelmed, anxious or angry. The most frequent purpose of callers was seeking advice on how to cope with a partner who they perceived as psychologically dysfunctional.

What was particularly distressing for the men calling PANDA was the anger and violence displayed by their partners towards others and themselves. While anger and hostility are missing from standard screening instruments used to identify maternal postnatal depression recent qualitative studies have highlighted the coexistence of mothers' anger, directed at herself, infants or others, with depression (Ou & Hall, 2018). Maternal irritability has been recommended as a valid indicator of maternal depression that could be used in assessing mothers' mental health (Williamson, O'Hara, Stuart, Hart, & Watson, 2015) and the possibility of males being victims of domestic violence has also recently been given more prominence (Drijber, Reijnders, & Ceelen, 2013; Machado, Santos, Graham-Kevan, & Matos, 2017). However, the scenarios noted by the PANDA counsellors do not fit the common understanding of domestic violence as an expression of male power carried out in a systematic fashion using emotional and physical abuse (Toews & Bermea, 2017; Jewkes, 2002). Rather than feeling abused in an ongoing way by a dominating partner, these fathers were astonished at the sudden change in their partner. It was the uncharacteristic outbursts that were most disturbing. It is also important to recognise vulnerability factors such as personality traits, difficulties in emotional regulation and stress adaptation that may contribute to increasing anger and irritability in the context of low mood and parenting stress. Relationships where there has been pre-existing conflict and difficulties are also challenged by parenting and more likely to experience an increase in tension on the birth of a child. A particularly vulnerable group to both parenting/relationship difficulties and mood disorder in the perinatal period are those with a history of early trauma/abuser, attachment disruption and long-term personality issues (such as Borderline Personality Disorder or complex Post Traumatic Stress Disorder) (Buist & Janson, 2001; Newman, 2008). Difficulties in clear

diagnosis are common but the implications are that it is important to screen and identify these vulnerabilities in postnatal mood disorder

What is not possible to discern from the counsellors reports of their conversations with fathers is the causal pathway leading to the current crisis that precipitated the call to PANDA. Family violence, most commonly male to female, is recognised as common in the perinatal period (Gartland, Hemphill, Hegarty, & Brown, 2011) and has been linked with the development of maternal postnatal depression (Ludermir, Lewis, Valongueiro, de Araújo, & Araya, 2010; Delara, 2016). The alarming behaviours of the mothers described by fathers contacting the PANDA helpline could equally be the result of father's abuse behaviours or part of a pattern of joint aggression and violent conflict (Olson, 2002).

Whatever the origin, as the majority of calls were made post birth, the mother's hostility and fathers' self-reported anger as well as the frustration and exhaustion of both parents are of particular concern for the wellbeing of their newborn (Parfitt & Ayers, 2012). While the wellbeing of the infant is a focus of the assessment carried out by PANDA at the outset other mental health services for mothers may need to assess the risk of violence as part of their support.

Violated expectations has been identified as a contributing factor in the development of maternal postnatal depression (Harwood, McLean, & Durkin, 2007) and a similar process may be operating among fathers calling the PANDA helpline. In Australia, fathers can expect to return to work soon after the birth and leave care of the baby to the mother (Fletcher, Matthey, & Marley, 2006). Having a partner whose behaviour is erratic or dismissive of the infant's needs was a cause of grave concern for some fathers who perceived that they had no choice but to leave the infant in their partner's care. Fathers role expectations, to be a

financial provider while have a secondary role in caring role for the new infant appear to have been violated by the mothers' multiple severe issues, such as psychosis, alcohol use and violence, heightening fathers' awareness of their own inability to effectively manage the families' needs. Thus many experienced frustration, a sense of failure, guilt, loss, or grief.

The rates of mental health concerns (50% anxious, 30.2% depressed) recorded for the men calling PANDA, are considerably higher than current maximum Australian population estimates of anxiety (16%) and depression (10%) reported for men across the perinatal period (Leach, Poyser, Cooklin, & Giallo, 2016; Giallo et al., 2013). However the elevated levels of distress do accord with the high levels of depression, up to 50%, reported for fathers whose partners were experiencing postpartum depression (Goodman, 2004). Given the reasons for their seeking help described by the fathers, a relatively high level of stress, anxiety and depression are not surprising. What is perhaps unexpected, is that these fathers took the initiative to seek assistance for emotional, relationship-based difficulties.

Men's reluctance to seek help for mental health issues has been attributed to personal, societal and service delivery factors (Holden, Allan, & McLachlan, 2010; Mansfield, Addis, & Courtenay, 2005; Harding & Fox 2015). Men's inability to recognize symptoms of mental illness as requiring attention, the perceived social stigma attached to men needing help and services' focus on mothers' needs have been suggested as contributing to men's delay in seeking help (beyondblue 2015; Addis & Mahalik, 2003). Father-specific studies have identified a more complex picture. In the context of the mother's role in bearing and delivering their infant fathers may actively resist identifying their own needs for fear of distracting attention from the needs of the mother (Darwin et al., 2017). As well,

the understanding that fathers, as males, will prefer concrete, practical solutions to their perceived problems may not fit the situation of fathers calling the PANDA helpline. An analysis of male callers to a counselling help line found that callers wished in the first place for someone to talk to about their situation; they wished to be heard rather than be offered solutions (Feo & LeCouteur, 2013). It is possible that the fathers calling PANDA initially for support in dealing with their partner are able, through the conversational style offered, to identify and request assistance with their own mental health issues. The PANDA telephone service, which is widely recognised as for mothers and babies may provide a point of entry for distressed fathers to seek help not only with their partner but for their own mental health.

Limitations

The analysis in this study was limited to records made from conversations with the callers. As such the data reflect the concerns of the men who called, as perceived and noted by the counsellors. In addition, certain aspects of the service provided to the callers, for example referrals to outside agencies, were not included.

Conclusion

While mothers and fathers may experience distress and be at risk of mental disorder, research and service delivery in perinatal mental health is overwhelmingly focused on the experience of maternal mental illness. The concerns identified in this study give voice to the fathers who are struggling with their own mood at a time of relationship reorganisation with a distressed partner and the disruption and demands of a new baby. The agitation, confusion, exhaustion and distress of male callers (fathers) described in the service records of PANDA strongly suggest that the early detection and support of distressed fathers would improve outcomes for both fathers and mothers and their infants. The gap in support is most obvious when the mothers' illness is severe; fathers' comments in

this study call attention to their need for information and support throughout mothers' treatment. Whilst some services attempt to involve fathers it is important to develop programs to better identify distress in fathers and see them as active participants in the recovery process when their partner is ill. From the evidence presented here all perinatal services should aim to include fathers in early intervention and treatment, for themselves or when mothers are being treated. On a wider level, publicising the availability of support services for new families where the mother or fathers are experiencing symptoms of depression or anxiety, and their relevance for fathers, would help dispel the automatic association between perinatal depression and mothers and encourage distressed fathers to ask for help.

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Table 1. Summary of PANDA calls with males

	All Callers	Mild to Moderate	Moderate to Severe
	N = 257	*n* = 204	*n* = 46
Reason for call	N (%)	*n* (%)	*n* (%)
Support	114 (44.4)	94 (46.1)	20 (43.5)
Postnatal depression information	55 (21.4)	44 (21.6)	11 (23.9)
Find out about PANDA	36 (14.0)	29 (14.2)	7 (15.2)
Referral	24 (9.3)	19 (9.3)	5 (10.9)
Follow up	11 (4.3)	8 (3.9)	3 (6.5)
Crisis intervention	11 (4.3)	4 (2.0)	7 (15.2)
Antenatal depression information	6 (2.3)	6 (2.9)	-

Table 2. Emotional issues as reported by male callers by risk category

	All Callers N = 106	Mild to Moderate (*n* = 84)	Moderate to Severe (*n* = 22)
Emotional Issues	N (%)	*n* (%)	*n* (%)
Overwhelmed	54 (50.9)	41 (48.8)	13 (59.1)
Anxious	53 (50.0)	38 (45.2)	15 (68.2)
Irritable	43 (40.6)	35 (41.7)	8 (36.4)
Angry	38 (35.8)	27 (32.1)	11 (50.0)
Depressed	32 (30.2)	26 (31.0)	6 (27.3)
Crying	27 (25.5)	23 (27.4)	4 (18.2)
Feeling hopeless	26 (24.5)	20 (24.4)	6 (27.3)
Unable to cope	25 (23.6)	19 (22.6)	6 (27.3)
Guilt	25 (23.6)	22 (26.2)	3 (13.6)
Flat	18 (17.0)	14 (16.7)	4 (18.2)
Lack of interest	10 (9.4)	9 (10.7)	1 (4.5)
Panic attacks	2 (1.9)	1 (1.2)	1 (4.5)

Table 3. Physical issues as reported by male callers by risk category

	All Callers N = 64	Mild to Moderate *n* = 53	Moderate to Severe *n* = 11
Physical Issues	N (%)	*n* (%)	*n* (%)
Low energy	31 (48.4)	28 (52.8)	3 (27.3)
Poor sleep	31 (48.4)	25 (47.1)	6 (54.5)
Exhaustion	28 (43.8)	14 (26.4)	4 (36.4)
Fatigue	20 (31.3)	17 (32.1)	3 (27.3)
Low appetite	10 (15.6)	6 (11.3)	4 (36.4)
Physical agitation	5 (7.8)	4 (7.5)	1 (27.3)
Feeling sick	3 (4.6)	3 (5.7)	-
Poor birth recovery	3 (4.6)	3 (5.7)	-
Pain	2 (3.1)	2 (3.8)	-
Poor personal hygiene	2 (3.1)	2 (3.8)	-
Impaired speech	1 (1.6)	-	1 (27.3)

Increased appetite	1 (1.6)	1 (1.9)	-

Table 4. Relationship issues as reported by male callers by risk category

	All Callers N = 79	Mild to Moderate *n* = 61	Moderate to Severe *n* = 18
Relationship Issues	N (%)	*n* (%)	*n* (%)
Relationship strain	66 (83.5)	54 (88.5)	12 (66.7)
Relationship breakdown	25 (31.6)	19 (31.1)	6 (33.3)
Poor attachment to baby	7 (8.9)	5 (8.2)	2 (11.1)
Fear of baby	-	-	-