

“I Wanted to Be There as a Father, but I Couldn’t”: A Qualitative Study of Fathers’ Experiences of Postpartum Depression and Their Help-Seeking Behavior

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Abstract

Postpartum depression (PPD) is one of the most common mental health problems among new parents. Past studies have examined PPD in women; however, the condition is less understood in men. This study aimed to explore the lived experiences of men or fathers with PPD and to understand the barriers and facilitators of help-seeking among fathers with PPD. Eight fathers with PPD were interviewed and data were subsequently analyzed through interpretative phenomenological analysis. The fathers perceived fatherhood as an overwhelming experience and feelings of inadequacy and powerlessness were two of the main themes in the fathers’ experiences of PPD. The feeling of inadequacy and powerlessness was related to the fathers’ expectations for themselves and their role as a father. The fathers’ sense of inadequacy and powerlessness sometimes turned into anger and frustrations. In addition, the fathers experienced a variety of contributing stressors around the birth of their child. Further, the analysis revealed how the fathers’ help-seeking behavior was influenced by five contributing factors: recognition and perception of depressive symptoms; knowledge and beliefs about PPD; taboo, stigma and conforming to masculine norms; the fathers’ partner; screening and perinatal healthcare services. Paternal PPD has a significant impact on the fathers’ wellbeing and everyday lives. Findings indicate that parents-to-be may benefit from education on paternal PPD, and they highlight the importance of screening for paternal PPD and support tailored to the needs of fathers with signs of PPD.

Keywords

help-seeking, depression, fathers, postpartum, qualitative research

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For many, becoming a parent is a lifechanging and positive experience, but for other parents it can be an overwhelming and vulnerable experience with great impact on one’s psychological wellbeing (McLanahan & Adams, 1987; Umberson et al., 2010). Postpartum depression (PPD) is a common mental health problem among new parents (Cameron et al., 2016; Shorey et al., 2018). PPD is a non-psychotic depressive disorder, and the symptoms range from mild to severe. The word “postpartum” refers to the timing of the depression, occurring during the first year after childbirth (Gibson et al., 2009). Meta-analyses have estimated that 7–9% of new fathers and 8–17% of new mothers experience postpartum depression (Cameron

et al., 2016; O’hara & Swain, 1996; Rao et al., 2020; Shorey et al., 2018). The identified prevalence of paternal PPD depends on the screening instrument used for identification, as some fathers with PPD symptoms are detected

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only with a 'male symptoms' screening instrument (Madsen & Juhl, 2007). Studies have shown that maternal and paternal PPD are moderately correlated and that PPD in mothers is the strongest predictor of paternal PPD (Goodman, 2004; Paulson & Bazemore, 2010). New fathers having a history of depression, lack of social support, low educational background, low income, financial worries, marital dissatisfaction and poor relationships with their own parents, are more likely to suffer from paternal PPD (Bradley & Slade, 2011; Goodman, 2004; Kumar et al., 2018; Matthey et al., 2000).

PPD affects not only the parent suffering from depressive symptoms; it also has a profound impact on the well-being of the whole family (Gentile & Fusco, 2017; Goodman, 2004). Studies have shown that maternal as well as paternal PPD is associated with increased risk of long-term adverse behavioral and emotional outcomes in children (Gentile & Fusco, 2017; Kumar et al., 2018; Sweeney & MacBeth, 2016). PPD can affect parents' early interactions with and initial attachment to the baby (Martins & Gaffan, 2000). Identifying, treating and preventing PPD in fathers (as well as mothers) is therefore not only important for the father's own wellbeing but can potentially benefit the whole family.

In Denmark, all families with newborn children are offered free homebased visits from a health visitor. The health visitors are nurses with specialized training in pediatric care who offer support and guidance to new families. One of the primary goals of these visits is to promote the health of the family, and the health visitor has a key-role in meeting and providing support to parents with PPD (Danish Nurses Organization, 2017). Routine assessment or screening of PPD is an important and cost-effective way of identifying paternal as well as maternal PPD (Asper et al., 2018; Wilkinson et al., 2017). In Denmark it is recommended by the Health Authorities to screen for post-partum depressive symptoms when the child is 6 to 8 weeks old by the health visitor (Danish Health Authority, 2013). The screening is usually conducted at the second visit, but in a recent examination of fathers' participation in the perinatal healthcare and maternity services in Denmark, only one third of all fathers participated in the second visit from the health visitor (Men's Health Society Denmark, 2017). Consequently, more mothers than fathers are screened and identified with PPD (Madsen, 2018, 2019; Men's Health Society Denmark, 2017).

To help parents with PPD it is important to understand the experiences of those suffering from PPD and the perceived barriers and facilitators of parents with PPD in regards of seeking help. However, much of the available research literature has primary focused on maternal PPD while little is known about fathers' lived experiences of PPD and their help-seeking behavior. (Holopainen &

Hakulinen, 2019). To our knowledge, only three qualitative studies based on interviews with fathers having personal experiences with PPD have been published (Dallos & Nokes, 2011; Edhborg et al., 2016; Johansson et al., 2020). The purpose of these studies was to describe and explore fathers' experiences with PPD and all emphasized the significant impact PPD has on everyday lives. Still, further research is needed to help healthcare professionals understand what fathers with PPD undergo after childbirth, especially in relation to help-seeking. In this study, help-seeking behavior is defined as any action of energetically seeking help from the health care services or from trusted people in the community and includes understanding, guidance, treatment and general support when feeling in trouble or encountering stressful circumstances. (Rickwood & Thomas, 2012). The purpose of this study is first to explore the lived experiences of fathers' with PPD and, second, to understand the barriers and facilitators of help-seeking behavior.

Method

Research Design

This qualitative study was based on semistructured interviews with eight fathers previously suffering from PPD, using Interpretative Phenomenological Analysis (IPA) as an analytical methodical approach (Pietkiewicz & Smith, 2014). IPA aims to produce in-depth examinations of certain phenomena by examining how individuals make meaning of their own life experiences (Pietkiewicz & Smith, 2014). The qualitative research design thus facilitated an in-depth understanding of the fathers' lived experiences with PPD and their help-seeking behavior (Miles et al., 2019).

Participants and Recruitment

The sample consisted of eight men between 29 and 38 years old. Most of the participants were recruited through social networking platforms, on which invitations to the study were shared through Facebook, particularly pregnancy and paternity groups or other forums for new and future parents. To be recruited in the sample, the participants had to have personal experience with PPD, be above 18 years of age and Danish speakers. Before interviewing, the first author contacted the participants personally and asked about current or prior depressive symptoms or diagnosis. All of the participants had self-reported experience with postpartum depressive symptoms and had been diagnosed with depression by their general practitioner or psychologist during the postpartum period. All participants had sought or received mental healthcare and considered themselves to be recovered

Table 1. Key Characteristics of the Participants.

Participants	Coded as	Age ¹	Number of children ²	Age of children ¹	Type of delivery	Highest educational level
Participant 1	P1	34	1	2.5	Planned caesarean section	Vocational
Participant 2	P2	35	1	5	Unplanned caesarean section	Vocational
Participant 3	P3	37	1	2	Unplanned caesarean section	Vocational
Participant 4	P4	32	1	1.5	Vaginal birth	Vocational
Participant 5	P5	38	2	2 & 5	Vaginal birth	Vocational
Participant 6	P6	29	1	1.5	Vaginal birth	Vocational
Participant 7	P7	38	1	5	Vaginal birth	Lower secondary
Participant 8	P8	30	1	3	Unplanned caesarean section	Bachelor's degree

Note. ¹At the time of the interview.

²At the time of depression.

from depression at the time of the interview. For further description of the participants, see Table 1.

Data Collection

Data were collected by the first author using a semi-structured interview manual. The manual was developed by existing literature and interviews with two health visitors (nurses with specialized training in in pediatric care). These health care visitors had participated in different courses about father-engagement, as part of their position as father-ambassadors in their respective municipality. A central part of their work involved screening and giving support to both fathers and mothers with PPD. A small group of academic experts from the Department of Public Health at Aarhus University discussed the themes and questions from the interview manual. Then the first author conducted a pilot interview and made slight changes to the interview manual in order to increase the comprehension, depth and quality of the interview questions. The semistructured interview covered ten themes and facilitated a coherent narrative of the perinatal period. The interviews lasted between 92 and 164 min (averaging 124 min) and were audio recorded and transcribed verbatim in Danish.

According to the National Committee on Health Research Ethics in Denmark, non-interventional studies and studies using interviews that do not involve human biological material, do not need to be notified to a research ethics committee (The Danish National Committee on Health Research Ethics, 2019). In compliance with the Helsinki Declaration of ethical principles, the participants were informed about the study's purposes and gave their written and oral consent to participate. The Participants were assured that they could withdraw themselves from the study at any time and that any personal information, that could be used to uniquely identify the individual participant, was anonymized (World Medical Association, 2018).

Data Analysis

The process of the data analysis was inspired by Pietkiewicz and Smith's (2014) IPA-guidelines. In the first phase of data analysis, transcripts were read thoroughly multiple times, in attempts to understand the individual's perspective while noting the particular themes of each transcript. In the following phase, a systematic coding of each transcript was carried out using the First and Second Cycle Coding (FCC/SCC) strategy by Miles, Huberman & Saldaña (Matthew et al., 2019). The process of reading, note taking and coding resulted in a non-hierarchical coding-list, which consisted of 533 codes. These codes were transformed into hierarchical list of codes consisting of emerging themes and subordinate categories, from which all transcripts were re-coded. All data were managed using NVivo12.

Findings

Participants

The sample consisted of eight participants with prior history of PPD. A sample of eight participants is considered to be appropriate in IPA studies as it allows for comprehensive in-depth analysis as well as the examination of similarities and differences between the participants without having an overwhelming amount of data (Pietkiewicz & Smith, 2014; Turpin et al., 1997). The majority of the participants were first time fathers, with only one being a second-time father when they suffered from depression. At the time of the interview, their children were between 1 and 5 years old. Five of the participants lived in smaller cities with less than 6.000 inhabitants, and three of the fathers lived in larger cities with more than 35.000 inhabitants. All of the participants lived with their child and the child's mother. Most of the participants worked in manual labor and were vocationally educated. All participants were Danish citizens. A summary of key characteristics is shown in Table 1.

The findings from the data analysis are separated in two sections according to the twofold purpose of the study. Each section presents an overarching theme with emerging subthemes. In section one, Experiences of Fatherhood, four subthemes were identified: The feeling of being overwhelmed; the feeling of being inadequate; sense of powerlessness; contributing stressors. In section two, Help-Seeking Behavior, analysis revealed how the fathers' help-seeking was influenced by different contributing factors which were divided into five subthemes: Recognition and perception of depressive symptoms; knowledge and beliefs about PPD; taboo, stigma and conforming to masculine norms; the fathers' partner; screening and perinatal healthcare services.

Section one

Theme 1: Experiences of Fatherhood

The Feeling of Being Overwhelmed. Five of the fathers described the period of pregnancy as a time of happiness, full of positive expectations about fatherhood. The positive expectations were described as "normal," as they expected that fathers who did not experience PPD felt these same feelings during their partner's pregnancy: "I had the same romantic expectations as any other [father]" (P1). These expectations were likely derived from stories from friends and families, personal experiences with childcare and normative conceptions of fatherhood. However, it was evident that the fathers' great expectations were later replaced by a very different reality of fatherhood. Four of the fathers expressed that the transition to fatherhood was a radical change, which was emotionally harder than they expected: "It's a radical change that you just can't imagine" (P2). Two of the fathers expressed the discrepancies between their expectations and reality: "Nobody tells you how hard it really is, and thank God for that, because then there wouldn't be born any more children into this world" (P1); "All of these false fantasies, which are set up by other parents, society, everything. It's not what you think" (P2).

The Feeling of Being Inadequate. In addition to the fathers' general overwhelming feeling of fatherhood, three of the fathers had different unmet expectations about how they needed to be in order to be a perfect dad. These unmet expectations often left them with a feeling of being inadequate. Some of their expectations centered on their ability to take care and provide for their family: "There are a few things a father needs to handle [. . .] He needs to have a job, and he needs to have a garage [. . .] and I didn't have any of those things" (P6). Another father said: "I felt like everything had to be perfect. [I wanted] my family to thrive, and in the end, it backfired" (P4). These unmet expectations seemed to be a central

part of the fathers' experience of PPD, as two of fathers perceived these expectations as an explanation for their own depression: "It is these thoughts that stress me out a lot [. . .] it's an expectation pressure" (P6).

Two of the fathers also expected the transition to fatherhood to be a lifechanging experience that had the power to change the identity of the fathers themselves - a transition and change that would help them mature, grow in confidence and self-worth and become more responsible in relation to everyday life. Changes that ultimately would help them take better care of their newborn child. One of the fathers expressed: "I imagined that I would be overwhelmed by phenomenal cosmic powers which would cause me to protect [my child] from everything" (P8). However, for these two fathers the expectations of fatherhood were replaced by feelings of unfulfillment and inadequacy as they found that fatherhood did not give the personal developments and changes that they hoped for. The same father described the discrepancies between his expectations and his actual experience of fatherhood: "[. . .] the strength as I imagined. The magic, if you can call it that, I never felt it" (P8).

Their expectations of fatherhood were often rooted in stories from the participants' own childhood. When the fathers were asked about their own fathers, they tended to express a negative view of them, and six of the fathers emphasized that they grew up with a father who was, to some degree, emotionally or physically absent. It is notable that three of them grew up in a family where alcohol abuse was prevalent. It seemed that six of the fathers were trying to distance themselves to their own fathers by being the father figure they did not always have growing up. This was expressed in the following way: "There are some things that I grew up with that I don't want [my child] to experience" (P3); "I just thought that I shouldn't be like my own father [. . .] He wasn't there for us" (P5); "I think a lot about what [my son] thinks about me, and I think a lot about the fact that I don't want my relationship [with my son] to be like the one I have with my father" (P6).

The participants wanted to be emotionally and physically present in their child's life, but during the time of their depression, these kind-hearted intentions changed into feelings of guilt and inadequacy as the participants did not feel they had enough energy and mental strength to become the kind of fathers they wanted to be. One of the fathers said: "There was this pressure [. . .] I wanted to be there as a father, but I couldn't. I wanted to be with my son [. . .] but I couldn't" (P4). During the interviews, six of the fathers repeatedly talked about how emotionally difficult it was to comfort their own child. Their perceived inability to comfort and meet the basic needs of their child, left them with a feeling of being helpless and inadequate: "When [my daughter] became upset [. . .] I

felt the frustrations building up inside, and then I gave up [. . .] I simply couldn't do it [. . .] and then I felt guilty [. . .] I'm not even good at that" (P1).

Sense of Powerlessness. When the fathers were asked if they found any situations difficult in particular, six of the fathers reported strong emotional distress when they needed to comfort their crying child: "It's when he cries. I simply can't have it" (P7). The same fathers also reported a strong sense of emotional distress and powerlessness, when the child was crying and needed changing, feeding or comfort in the middle of the night: "It is during the night [. . .] he just screams. Imagine a child who just screams, and you cannot do anything. You don't know what to do about it" (P2).

Four of the fathers also spoke about their expectations of equal parenting. Three of them felt, however, that their expectations about equality were replaced by a feeling of neglect and powerlessness when comparing their role to the role of the mother. A father described his parenting role as follows: "I feel totally unimportant [. . .] what is it, that my role is then? [. . .] I hoped [. . .] that we would be equal" (P1). Another father elaborated: "I'm just a service organ. And, that is what you are as a father [. . .] it is mom who has the breast and that's it [. . .] I really found it difficult to get used to [. . .] that this is not a 50/50 baby. This is actually a 95/5 baby" (P6).

The participants described powerlessness as an overwhelming feeling, often connected to feelings of anger, frustrations and inadequacy. These feelings often arose from specific situations at home, and for three fathers, home suddenly had many negative associations and became a place in which they tried to avoid by working extra shifts, taking up more activities outside home or by making a detour on their way home from work. Two of the fathers used work as a way to escape the negative thoughts and emotional distress at home: "I mostly used work to escape [. . .] because I knew that I would come back home to a screaming kid and a moody wife" (P1). Talking more about work, another father said: "The only place I actually feel good is when I am at work" (P7).

Two fathers generally felt a great sense of powerlessness as they felt trapped and unable to escape from the reality of fatherhood: "I didn't feel frustrated, I felt [. . .] a hate, almost [. . .] my life was so good before I met [my wife]. Why in hell did I agree to this? [. . .] This child [went] from being something fantastic to be a drag, a major source of irritation in my everyday life" (P1). The feeling of being trapped was also expressed in other manners: "It is this anxiety, the feeling of not being able to escape from the situation [. . .] especially during the hard periods when we were tired and exhausted" (P8).

For some, the feeling of being powerless and inadequate ultimately became so intense that four of the fathers

had strong regrets about becoming a father. Two of the fathers even expressed painful thoughts about suicide and harming their own child. A father, who was dealing with chronic pain while adjusting to his new role as a father, said: "I was cooking in the kitchen and I thought [. . .] I wonder what would happen if I cut [my son's] throat" (P2). None of the fathers wanted to act on these thoughts but felt very ashamed of them. The same father said: "When you have these thoughts inside your head, you become completely broken inside. Because it is so shameful" (P2).

Contributing Stressors. The fathers mentioned a variety of experiences and complications during pregnancy and childbirth which four of the fathers perceived as contributing stressors or explanations for their PPD. During their partner's pregnancy, five of fathers' partners experienced pregnancy complications such as pelvis pain, pre-eclampsia or gestational diabetes. In addition, five of the fathers experienced different stressors during the birth of their child, which left them with feelings of uncertainty and helplessness: "[I] had no idea about what was happening to my wife. It was very traumatizing" (P2). This was especially true for three of the fathers, whose partners had unplanned cesarean sections. These fathers described the birth as an intense and traumatic experience during which they feared for the lives of their wife and unborn child: "I just thought [. . .] In worst case . . . I lose them both" (P2).

In the following weeks after the birth of their child, many of the fathers experienced further stressors, as seven of the fathers' partners had trouble with breastfeeding. Breastfeeding was a subject of concern for five of the fathers and their partners as it was connected to worries about their children's health and strict breastfeeding routines. Talking about breastfeeding, one father said: "[my daughter] wouldn't eat because she was so weak [. . .] on the seventh day [after delivery] we had a child who looked like a skeleton. [She] was completely weakened" (P1). Two of fathers often found themselves in a situation wherein they did not know how to help their wife and newborn child: "what can I do, really? [. . .] No matter how many times I run up and down the stairs, she won't necessarily put on weight" (P8).

The interviews also suggest that the uncertainty related to sick-leaves and dissatisfaction with work might have contributed to some distress among three of the fathers. One father, who was dissatisfied with his new job, explained his job situation as one of the main causes of his emotional distress during the postpartum period: "I felt, that [my job situation] was where it all originated from" (P6). In addition, in the period around the birth, two fathers were physically injured at work, and after several months of sick leave, they both needed to change

to a different line of work because of their work-related injuries. Looking back, one of these fathers perceived his changing job situation and work-related injury as a contributory cause of PPD: "I got a work-related injury [. . .] which puts additional pressure on us" (P2).

Five of the fathers also reported that their partners experienced various degrees of emotional distress during the postpartum period. In fact, two partners were diagnosed with PPD. At the same time, seven of the fathers explained that the emotional difficulties of PPD affected their relationship with their partner negatively, which could have contributed to further stress during the postpartum period.

Section Two

Theme 2: Help-Seeking Behavior. All of the fathers sought formal help from their general practitioner or health visitor, and seven of the fathers received help from a psychologist, therapist or psychiatrist. Two of the fathers sought help right after birth, but six of them went through several months of depressive symptoms before they sought and received any help. None of the fathers had previously experience with depression. Three of the fathers' decisions to seek help seemed to be related to specific experiences of extreme emotional distress, such as an emergency caesarean section or suicidal thoughts. However, it seemed that most of the fathers' help-seeking behavior was influenced by five factors: Recognition and perception of depressive symptoms; Knowledge and beliefs about PPD; Taboo, Stigma and Conforming to Masculine Norms; The fathers' partner; Screening and perinatal healthcare services.

Recognition and Perception of Depressive Symptoms. In retrospect, all of the fathers recognized different changes in their mood and behavior, but many of them did not perceive these changes as signs of depression before diagnosis: "You know that something is wrong, but you don't know what it is" (P7). Two fathers explained that they did not acknowledge their changing mood as a sign of depression since they tried to normalize their emotions: "I kept saying to myself that [my feelings] were normal [. . .] Somehow, [I] kept challenging the narrative [regarding PPD]" (P8). One father perceived his feelings of inadequacy and anger toward his life as a father as a natural reaction to his circumstances: "At that time, I did not think 'I have postpartum depression'. I just thought, 'This is normal', because it is so damn hard" (P1).

Knowledge and Beliefs About PPD. When the fathers were asked whether or not they had heard about PPD before fatherhood, five of them replied that they had primarily heard about maternal PPD, and three of them had

never heard about paternal PPD before becoming a father themselves: "I had [heard about PPD], but it was primarily about women" (P2). In addition, three of the fathers who sought information about PPD after diagnosis, found it difficult to find any information about paternal PPD online: "I googled it [. . .] But there is not a lot of information because [information about PPD] is only directed towards women" (P3).

Three of the fathers previously believed that PPD was a condition, which only women could have: "Why should a man have [PPD]? He is not the one giving birth" (P3). Believing that PPD is a gender-specific condition might prevent fathers from recognizing its symptoms and thus seeking help. A father, who showed signs of depressive symptoms when screened for PPD by his health visitor, said: "[My girlfriend and I] took the screening, but I thought that it was my girlfriend [who would show signs of PPD]. I never thought that the father [. . .] would go down with PPD" (P4). In Denmark, there is only one word for prenatal, postpartum and perinatal depression. This word directly translates to 'birth depression'. Given the fact that only biological females are able to give birth, the Danish word 'birth depression' might contribute to some of the fathers' misunderstanding about PPD as a gender-specific condition.

False beliefs about the severity and characteristics of postpartum depressive symptoms might also hinder fathers with mild symptoms in seeking help from their general practitioner or health visitor. One of the fathers, who had listened to a podcast about paternal PPD, was left with the belief that all fathers with PPD do not love their children, which was opposite to his relationship with his own child: "I love [my son] [. . .] I have never been close to throwing him out from a balcony, ever [. . .] It is crazy, the things they talk about [in the podcast]. It is not even close to what I'm feeling" (P6). Later, this belief made him question whether he actually had PPD, even though he was diagnosed with depression by his general practitioner and showed signs of PPD when his health visitor screened him: "I find it difficult to believe that I had PPD because it wasn't [my son]. It was an existential crisis [. . .] there were so many other things that [. . .] put pressure on me. It may well be that him being born [. . .] gave a push to some things" (P6).

Taboo, Stigma and Conforming to Masculine Norms. Four of the fathers expressed that they experienced paternal PPD as taboo: "it is taboo" (P3); "[. . .] people are afraid to say something [about their experiences with PPD]" (P7). Three of the fathers did not discuss their experiences with PPD with anyone but their partner and psychologist. A combination of false beliefs, stigma and masculine norms might have contributed to many of the fathers' experience of paternal PPD being taboo, which

adds to a vicious cycle that could prevent fathers from seeking help.

Two of the fathers spoke about the issues that might prevent fathers with PPD from reaching out to others: “They won’t open up because they are afraid that they get stigmatized [. . .] as someone [. . .] weak or inadequate” (P1); “As soon as you are [reaching out], you’re judged in some way. That is the fear you have. Then you become THAT [person]” (P2).

During the interviews, four of the fathers spoke about different normative masculine expectations. Some of the fathers described men as “proud,” “cynical,” “protective,” “strong,” and another described men as those expected to provide for their family. Their feelings of inadequacy and powerlessness challenged their normative expectations of masculinity, and three of the fathers considered these normative masculine expectations as a barrier in seeking help: “I think [. . .] that it is hard, as a man, to ask for help. There is no doubt that [men] are supposed to be big and strong and take care of everything. And suddenly, you can’t” (P7). Another father also expressed: “Men don’t consult a doctor when their toe is a little red, they consult a doctor when the toe is red, blue and black [. . .] So, for men to admit [. . .] ‘I have PPD. I need [anti-depressives]’. I think that [. . .] many men would see that as a giant failure” (P1).

The Fathers’ Partner. As established earlier, many of the fathers did not recognize their changing behavior and mood as signs of depression. For that reason, four of the fathers acknowledged that their partner or other family members could have had a great influence on the father’s help-seeking behavior: “Maybe the mothers need to be better at saying something [. . .] because, we don’t say anything in the beginning. It takes a long time before we say anything” (P7); “I don’t think [fathers] know that they have [PPD]. I think someone needs to grab [the fathers] and say, ‘you need help’ [. . .] just like [my wife] said to me” (P3). In retrospect, two of the fathers also acknowledge, that their partner probably had realized that something was ‘wrong’ before the fathers realized it themselves: “[My girlfriend] probably saw the signs before I could [. . .]” (P5).

Screening and Perinatal Healthcare Services. All of the fathers, except one, were screened for PPD or depression by a health professional. Five of them were screened for PPD by their health visitor and two of the them by their general practitioner or psychologist. The screening was an important part of the help-seeking process as this was the first time two of the fathers were introduced to paternal PPD: “When the health visitor told me that men also could get [PPD] [I thought] ‘Oh! You can?’” (P8). In addition, the screening helped five of them to acknowledge how

changing mood might be signs of depression: “It is one thing that [my partner and I] have talked about me having a problem, and that I have a short fuse [. . .] But now we have [. . .] scientific evidence that I’m not all right” (P6); “[My general practitioner] tested me, [and] it was only then that I actually started to believe that I had [PPD]” (P5).

Even though it took several months for four of the fathers to seek medical help after screening by their health visitor, the screening had the potential to spark conversations about PPD that potentially further the recognition and destigmatization of PPD (Schuppan et al., 2019). However, the fathers had very different experiences of the health visitors’ interests in each father’s well-being, and three of them did not perceive screening as an invitation to talk about PPD or even his experiences in becoming a father. Instead, they felt that the potential conversation was closed down by referral to his general practitioner. Talking about screening, two of the fathers expressed: “[The health visitor] did not do much about it, really. No other than saying, ‘you have this score, you can pass that on to your general practitioner’” (P8); “I was just told that it did not look well [. . .] Maybe I just needed someone to say [. . .] what is it that you feel, exactly?” (P6). At the same time, three of the fathers expressed, that they feared, that speaking openly about suicidal thoughts and thoughts about harming their own child, would be used against them: “[The health visitor] is a public authority [. . .] She has to go forward with the [information], if it is [necessary] [. . .] If I say too much about something, will they take [my son]?” (P2).

The wish to retain information from the health visitor or seeking help might also be influenced by four of the fathers’ conception of the perinatal healthcare services being geared toward women: “If a woman gets PPD today [. . .] then there is lots of help to get [. . .] There is just no such things [for men]. So, I got the help there was, and that was nothing, unfortunately” (P1). Three of the fathers also had specific negative expectations about current treatment options, which could postpone the help-seeking process: “[Anti-depressives] is not an option for me” (P7); “I’m not one to believe in psychologist. They just read from a book. That I have always told myself” (P5).

On the other hand, three of the fathers found their health visitor to be supportive and understanding about their situation, and in two cases the health visitor contacted the fathers’ general practitioner or mental health services on their behalf. This support was necessary for a father who found it difficult to make his general practitioner understand what he was going through: “my doctor did not take it seriously because, as [the general practitioner] saw it, ‘what nonsense’” (P2). Additionally, three of the fathers had trouble finding a therapist or psychologist with experience or expertise in paternal PPD.

Discussion

Studies concerning new parents' experience of PPD have primarily focused on maternal PPD and often from a female perspective, while little is known about fathers' lived experiences with PPD (Holopainen & Hakulinen, 2019) and their help-seeking behavior. Thus, this qualitative study adds to the limited research on the lived experiences of fathers suffering from PPD and their help-seeking behavior.

Theme 1: Experiences of Fatherhood

The fathers in this study described fatherhood as an overwhelming experience, and the majority had great expectations for themselves as a father and for fatherhood in general. However, many of them experienced a discrepancy between their own expectations and the reality of fatherhood, and they felt inadequate in their attempts to become the kind of father they strived to be. Unmet expectations and underlying feelings of inadequacy have also been identified in similar qualitative studies of fathers' experiences with PPD (Dallos & Nokes, 2011; Edhborg et al., 2016; Johansson et al., 2020). These findings also cohere with findings from a qualitative meta-analysis of maternal PPD, which found that most women with PPD feels inadequate and struggles to live up to cultural standards for a 'good mother' (Knudson-Martin & Silverstein, 2009).

In addition to the general feeling of inadequacy and powerlessness, many of the participants in the current study felt powerless when they engaged with their own child, such as when their child was crying, needed comfort, changing or feeding. In such situations, the participants described powerlessness as an overwhelming feeling, often connected to feelings of anger, frustration, and inadequacy. A few of the participants even expressed a temporary hate toward their own child. Consequently, many of the participants' withdrew from certain interactions with their child, and some of the participants used work as a way to escape from their distressing realities at home. These findings reveal some of the greatest negative effects of PPD, as disengaged and remote father-infant interactions are linked to PPD and early behavioral problems in children (Parfitt et al., 2013; Ramchandani et al., 2011). Findings from the current study suggest that fathers with PPD could benefit from additional support from the healthcare visitor in relation to their interaction with their infant, as positive interactions between father and child potentially could strengthen the father's self-efficacy in relation to his role as a father.

A few of the fathers in this study also reported that they had shameful and intrusive thoughts of suicide or harming their own child. Looking at the extensive

research on depression, several studies have reported that depression increases the risk for suicidal thoughts (Franklin et al., 2017). One study, with a sample of 92 new mothers and 64 new fathers, found that 65% of the parents experienced unwanted intrusive thoughts, such as accidents, suffocation or harming their own infant (Abramowitz et al., 2003). Another study, with 44 postpartum couples, found that 44% of these parents experienced intrusive thoughts of infant-related harm in response to infant crying (Fairbrother et al., 2019). These findings did not depend on the gender of the participating parents, and the mentioned studies found non or minimal association between depressive symptoms and intrusive thoughts among fathers (Abramowitz et al., 2003; Fairbrother et al., 2019). Due to the very limited numbers of fathers with depressive symptoms in the samples used in both studies, one should interpret these findings with caution. Additionally, these studies did not consider how the impact of intrusive thoughts might vary among parents with and without depressive symptoms. In this study, intrusive thoughts about suicide and harming one's child were connected to strong feelings of shame. These findings suggest that one of the aspects of the information tailored to parents and parents-to-be should target intrusive thoughts of infant related harm as these thoughts are common and experienced by many new parents (Abramowitz et al., 2003; Fairbrother et al., 2019). Normalization of intrusive thoughts could potentially open the way for parents to discuss its impact on their mental health with healthcare professionals.

Two systematic reviews have explored the predictors and psychosocial associations of paternal PPD in the year following birth of their newborn children (Bradley & Slade, 2011; Kumar et al., 2018). These reviews associated some of the same stressors identified in this study with paternal PPD. Stressors such as uncertain job situations, maternal depression in partners and relationship problems (Bradley & Slade, 2011; Kumar et al., 2018). Relationship problems have also been reported in other qualitative studies of paternal PPD, and paternal PPD has been connected to lack of intimacy, conflicts and separation (Dallos & Nokes, 2011; Edhborg et al., 2016; Johansson et al., 2020). Negative birth experiences have also been linked with paternal and maternal PPD (Bradley & Slade, 2011; Etheridge & Slade, 2017; Gurber et al., 2017), and since several of this study's participants experienced trauma during the birth of their child, these stressful experiences could be connected to some of their depressive symptoms. Similar qualitative studies of paternal PPD also reported that negative life events and complications during pregnancy and delivery affected the fathers negatively (Edhborg et al., 2016; Johansson et al., 2020). This study's findings also indicate that breastfeeding was a subject of great concern for many of the fathers

since the subject of breastfeeding was brought up often with no motivation from the interviewer (neither was it part of the interview manual). These findings further suggest that health care professionals should pay attention to the fathers' birth experience and experience with breastfeeding, as these aspects of parenthood potentially have an impact on fathers' mental health.

Theme 2: Help-seeking behavior

Several studies have examined the help-seeking behavior among men with depressive symptoms (Möller-Leimkühler, 2002; Seidler et al., 2016; Sierra Hernandez et al., 2014; Yousaf et al., 2015). This study, however, is the first to explore the help-seeking behavior in relation to paternal PPD.

In the current study, several participants recognized different changes in their own mood and behavior, but it was a barrier for their help-seeking behavior, that it sometimes took several months for them to recognize these changes as signs of PPD. These findings resemble findings from a systematic review of help-seeking behavior among men with depressive symptoms which found that men rarely interpreted depressive symptoms (such as moodiness and irritability) as signs of mental illness (Seidler et al., 2016).

Before diagnosis, some of the participants of this study believed that PPD was a gender-specific disease that only pertained to women. Additionally, this study's participants found it difficult to find any information about paternal PPD after their diagnosis. A recent examination, based on CAWI-interviews with 1056 Danish fathers, showed that only 15% of fathers with children between 0 and 6 years remembered being informed about the psychological reactions of parenthood by their general practitioner, midwife or health visitor (Men's Health Society Denmark, 2017). These findings indicate that there is a general lack of information and awareness about paternal PPD online and in society. Lack of knowledge and information about paternal PPD could affect the fathers' ability to recognize, cope and manage PPD and is potentially one of the greatest barriers in the process of help-seeking. These findings correlate with findings from a British study, which found that both male and female participants identified maternal PPD more easily than paternal PPD (Swami et al., 2019). To support help-seeking behavior among fathers with postpartum depressive symptoms, our findings highlight the need of education and information about paternal PPD as one of the key elements in future interventions directed toward new parents and parents-to-be.

Some of this study's participants expressed that they considered men's expectations to conform to masculine

norms as one of the barriers in seeking help. This issue has been identified as a problem in other studies of depression and help-seeking among men (Seidler et al., 2016; Sierra Hernandez et al., 2014). The participants of this study identified men and their role as a father with 'masculine characteristics' such as being strong, providing and caretaking. This could explain why the fathers tended to underestimate their symptoms of depression, and why they did not seek help before experiencing severe symptoms or after encouragement from family members or health visitors.

Another barrier or explanation of the participants' delayed help-seeking behavior could be connected to some of the participants' experiences of being what they felt was the secondary parent. The participants' feeling of powerlessness in relation to equal parenting was also reported by fathers with postpartum depressive symptoms in a similar study by Edhborg et al. (2016). These fathers expressed that even though they wanted equal status with the mother in parenthood, they felt that the mother's opinions were seen as more important than the father's by the health care professionals and society (Edhborg et al., 2016). It is possible that masculine ideals and experiences with inequality in early parenthood are barriers for fathers in their help-seeking process as expectations to conform to masculine norms and feelings of being the secondary parent might question the fathers' legitimacy of their own mental healthcare needs in the perinatal period. In a qualitative study of new fathers' views and experiences of their own mental health, the authors found that fathers questioned the legitimacy of their experiences with psychological distress in the perinatal period and their entitlement to support by health professionals, as the focus 'should' be on the mother and baby (Darwin et al., 2017).

Masculine ideals and parental inequality within the family and healthcare system are major barriers for fathers' help-seeking behavior and these findings highlight the need for healthcare professionals to create an inclusive environment and help parents understand the importance of mental health of both parents, especially in this particular period of their lives. To increase fathers' legitimacy of their own mental healthcare needs and promote equality in parenthood, it is necessary to offer support to both parent suffering from PPD. In Denmark, however, the distribution of healthcare services offered for PPD is unequal in favor of maternal care, and a recent examination revealed that only 6% of the Danish municipalities offered support to fathers with PPD in 2017 (Madsen, 2019). Some of the participants in this study experienced the consequence of this prioritizing, as some of the fathers found it difficult to find a therapist or psychologist with experience or expertise in paternal PPD.

In this study, some of the participants' partners were aware that something was 'wrong' before the fathers knew themselves, and some of the fathers' partners helped the participants acknowledge their postpartum depressive symptoms. These findings suggest that family members could facilitate fathers' help-seeking process, and that education about paternal PPD should not only target the father himself but the family as a whole. These findings further suggest that it is important for health visitors to ask the fathers' partner about changes in the father's mood or behavior if he is not present at the healthcare visit himself. Just as this study has highlighted the fathers' partner as a facilitator in relation to help-seeking, several studies have linked lack of social support with paternal PPD (Bradley & Slade, 2011; Goodman, 2004; Kumar et al., 2018; Matthey et al., 2000). Fathers' need of social support, however, could be challenged by paternal PPD being experienced as something taboo and stigmatized. In addition, paternal PPD is moderately correlated with maternal PPD (Goodman, 2004; Paulson & Bazemore, 2010), and in situations where both parents experience postpartum depressive symptoms, the need of support is even greater.

Findings from this study indicate that screening by health visitors is an important facilitating tool in each father's process of recognizing symptoms and seeking help. However, routine assessment or screening of PPD is challenged by the fact that only one third of new fathers in Denmark are present at the second visit by the health visitor, where the screening usually takes place (Men's Health Society Denmark, 2017). Work obligations might hinder fathers with PPD to be screened by health visitors, and fathers might benefit from the availability of self-screening tools, as this might initiate detection and early help-seeking behaviors among fathers who are working at the time of the routine assessment of PPD (Edward et al., 2019). Self-screening tools, however, should not replace routine assessment in company with a health visitor as this health promoting action potentially spark conversation about PPD that could further the recognition and destigmatization of PPD (Schuppan et al., 2019). Our findings also suggest that fathers' help-seeking behavior might be challenged by the lack of awareness and knowledge of paternal PPD by the healthcare professionals. Hammarlund et al. (2015) examined Child Health Center (CHC) nurses' experiences of observing depression in fathers during the postpartum period, and they found that the CHC nurses, who specializes in infants and meets the parents in their home, had limited experiences with paternal PPD and found it vague and difficult to detect PPD in fathers (Hammarlund et al., 2015). Our findings highlight the need for specialized training in paternal PPD among healthcare professionals and information and treatment options tailored to the needs of fathers with PPD.

Strengths and Limitations

To ensure high-quality and validity of the findings, this IPA-study has drawn on Smith's (2011) quality assessment criteria focusing on core features of high-quality IPA studies (Smith, 2011). In particular, this study has sought to achieve strong data, rigorousness and to create carefully written analysis concerned with both patterns of similarities and the particular individual experience (Smith, 2011).

High quality data were ensured through well-prepared semistructured interviews and the first author's involvement in all aspects of data collection and analysis. This process enabled an in-depth exploration of the participants lived experiences with PPD (Malterud, 2001; Pietkiewicz & Smith, 2014). Quotations were carefully selected from different participants to give indication of both convergence and divergence within each theme and thereby ensuring rigorousness and trustworthiness (Smith, 2011).

During the interviews, the participants' children were between 1 and 5 years old. Because of this retrospective perspective, recall bias could be a potential limitation of this study. However, this perspective also provided the fathers with the ability to reflect on and highlight what they felt were the most important experiences of fatherhood.

The findings, regarding experiences of fatherhood, contribute to the body of literature of paternal PPD in particular, as this study include fathers from working- and middle class. Fathers from this study, which include fathers from the working- and middle class, might represent a group of fathers who are of higher risk of PPD, compared to highly educated fathers investigated in the few previous studies of paternal PPD (Edhborg et al., 2016; Johansson et al., 2020). Some of the findings, however, resonate with findings from these similar studies, which suggest that it is possible to draw some parallels across socioeconomic levels in similar sociocultural settings (Dallos & Nokes, 2011; Edhborg et al., 2016; Johansson et al., 2020). However, in regards of help-seeking, this study's sample only represented fathers who sought or received help from mental health care services, which excludes the voices of fathers who, for various reasons, didn't seek or receive help for their post-partum depressive symptoms. These fathers' perspectives are equally if not more important if we want to understand the barriers and facilitators of fathers' help-seeking behavior in relation to PPD.

Implications for Practice and Research

Based on this study's findings we propose four recommendations. First, to increase parents' awareness, recognition, knowledge and help-seeking in relation to paternal PPD.

Future interventions should focus on the educational need about PPD, unwanted intrusive thoughts and mental health in the perinatal period. Additionally, fathers might also benefit from a general increased awareness about paternal PPD in different settings linked to the family's everyday lives, such as workplaces, kindergartens, and primary healthcare. Education and awareness on mental health and PPD could potentially help normalize and destigmatize PPD and thereby hopefully help parents seek support and discuss their mental health with friends, family and healthcare professionals. Second, masculine ideals and parental inequality within the family and healthcare system are potential barriers for fathers' help-seeking behavior and findings from the current study have demonstrated a need for healthcare professionals to create a supportive, equal and inclusive environment around both parents and to help parents understand the importance of their mental health, especially in this particular period of their lives. Third, screening for PPD can potentially help fathers acknowledge and recognize postpartum depressive symptoms and has the potential to spark conversations about fatherhood and mental health with the health visitor. To increase help-seeking among fathers with postpartum depressive symptoms it is important to implement systematic screening of paternal PPD by healthcare professionals in all municipalities. Finally, to address the difficult challenges and experiences many fathers with PPD and their families face, our findings highlight the need for specialized training in paternal PPD among healthcare professionals.

To address current challenges, future research should focus on identification of educational needs about paternal PPD among both parents, health care professionals and other professionals taking care of new families. To reduce the unequal distribution of healthcare services offered for paternal and maternal PPD, more investigation is needed in relation to support and treatment options tailored to the needs of fathers with PPD. Research is needed to understand how we can increase fathers' screening uptake in relation to PPD. Finally, our findings have demonstrated that more investigation is needed in relation to fathers' birth experience and experiences with breastfeeding, as these aspects of fatherhood potentially have an impact on fathers' mental health.

Conclusion

This study explored fathers' experiences with PPD and their help-seeking behavior. The findings demonstrate that paternal PPD has a significant impact on fathers' wellbeing and everyday lives, as the fathers felt inadequate and powerless in relation to their new role as a father. Several contributing stressors, such as maternal PPD, uncertain job situation and problems with breastfeeding, were

identified. Barriers for help-seeking were identified as false beliefs and lack of knowledge about PPD, conforming to masculine norms and PPD being perceived as something taboo and stigmatized. The fathers' health visitors and partner were identified as potential facilitators in the fathers' process of recognizing symptoms of PPD and seeking help. Additionally, the findings highlight screening for paternal PPD as a potential facilitator for father's help-seeking behavior. To improve fathers' help-seeking behavior, our findings suggest that it is important to increase parents' and healthcare professionals' awareness, recognition, and knowledge about paternal PPD. To promote parental equality and mental health among new parents and prevent adverse behavioral and emotional problems in their children, it is important for health care professionals to engage fathers in perinatal healthcare and maternity services and offer screening and adequate help and support to fathers as well as mothers with postpartum depressive symptoms.

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