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Article

Breaking the Silence: Exploring Fathers' Perspectives on Perinatal Mental Health and Navigating Fatherhood

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Abstract: Traditionally, mental health support during the perinatal period is focused on women, leaving paternal mental health unnoticed. However, literature evidence suggests that addressing paternal mental health issues and promoting fathers' emotional well-being can benefit the whole family. This study explores fathers' perspectives and first-hand experiences with paternal perinatal mental health. This study used semi-structured interviews to collect qualitative data from fathers who met specific criteria. Fifty individuals completed mental health and well-being questionnaires, and 15 were purposively selected for interviews based on their scores, ensuring a diverse representation of well-being outcomes. Data was analysed using thematic analysis, and the authors adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines. In this paper, we use perinatal mental health as an umbrella term that encompasses mental health problems such as anxiety, stress and depression. Five major themes were identified: 'Factors contributing to paternal mental health problems', 'Interaction with partner', 'Birth and first post-partum days', 'Providing for the family' and 'Engagement with maternity services'. The study emphasises the significant impact mental health problems have on fathers during their transition to parenthood, causing increased stress and feelings of being left out. Adapting to new parental duties often results in psychological stress, with many fathers feeling they do not deserve support. A notable gap exists in perinatal support networks and services tailored for fathers, underscoring an urgent need for dedicated resources to enhance paternal mental health and overall well-being.

Keywords: perinatal care; mental health; fathers; qualitative research; Health Services Accessibility

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1. Introduction

Perinatal mental health refers to mental health throughout pregnancy, delivery and the first year after birth (National Institute for Health and Care Excellence, 2014). In this study, we use the term perinatal mental health to refer to mental health problems such as depression, anxiety and emotional distress.

A child is a meaningful and life-changing event (Letourneau et al., 2012). Fathers may experience emotional changes and concerns prompted by their parental journey (Cameron, Sedov and Tomfohr-Madsen, 2016). The exploration of mental health issues during the perinatal period has primarily been focused on mothers. Moreover, the challenges and facilitators of seeking and receiving support for women are well documented. However, there is a lack of information on men's experiences with their perinatal mental health and how to appropriately manage fathers' mental health, including whether they have unique concerns and requirements (Pilkington, Whelan and Milne, 2015; Rominov et al., 2016). Furthermore, the pressures of becoming a parent have been exacerbated by the COVID-

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19 epidemic, which has resulted in public health restrictions affecting everyday family life and accessibility to services (DeYoung and Mangum, 2021; Vasilevski et al., 2021).

According to recent studies, a substantial proportion of males encounter depression during the perinatal period. Studies of paternal perinatal depression reveal a prevalence of 10% in Australia (Giallo et al., 2012), 9.8% in Germany (Gawlik et al., 2013) and 12.5% in China (Mao, Zhu and Su, 2011). A comprehensive meta-analysis of fathers' perinatal depression has revealed an overall prevalence rate of 8.75% (Rao et al., 2020). These rates of depression are above those seen in the general male adult population, which are estimated at 4.7% (National Institute of Mental Health, 2023). Moreover, the process of transitioning into fatherhood can also elicit feelings of anxiety. A systematic review of the prevalence of fathers' perinatal anxiety reported that between 2% and 18% of fathers exhibited perinatal anxiety symptoms (Leach et al., 2016). Stress has been identified as a significant risk factor for the development of both depression (Cohen and Janicki-Deverts, 2012) and anxiety (Wee et al., 2015).

It is also speculated that the incidence and prevalence of paternal mental health issues are significantly higher than currently recorded because the screening methods used for detecting maternal mental health problems may be less reliable when used on fathers (Psouni, Agebjörn and Linder, 2017). Men are known to exhibit their emotional anxiety differently than women in the general population (Johnson et al., 2011). They are typically less inclined to seek mental health treatment, and when they do, they often use different terminology and exhibit symptoms dissimilar to mothers.

Anxiety and depressive symptoms in men during the perinatal period can impair their ability to work and cause short-term memory loss (Pio de Almeida et al., 2012). They also negatively affect how well fathers can perform everyday tasks at work (Melrose, 2010). Inadequate perinatal adjustment and mental health difficulties can have a severe influence on fathers' view of life, shrink marital satisfaction, impact the quality of father-child relationships and disrupt offspring's development (Bruno et al., 2020), resulting in adverse and long-lasting effects. Without appropriate intervention, all members of the family system are impacted. Although research evidence indicates that mental health problems among fathers and their effects on their families are prevalent and persistent, health policies currently fail to address this.

In an attempt to promote paternal perinatal mental health, it is critical to comprehend what views and experiences fathers have and to establish what support and interventions would be acceptable to them (Baldwin et al., 2018).

This qualitative study aimed to uncover particular areas of concern (themes) related to fathers' perspectives and direct experiences about their mental health during the perinatal period and to provide insight into their physical and emotional well-being.

2. Methods

2.1. Design

An interpretative qualitative study using semi-structured interviews with first-time or subsequent fathers.

2.2. Procedure

The region of Thesprotia was designated as a recruitment area. Thesprotia is located in the northwest part of Greece and is classified as a non-urban area. Most of the population lives in Igoumenitsa, and the participants were recruited through private maternity services. Men were from across the region. Fathers were invited to participate face-to-face or via the mother, regardless of their biological connection to the child. This study was designed to identify specific concern areas related to fathers' mental health in the perinatal period. Therefore, the researchers ensured that the sampling framework included both men whose partners were expecting a baby and fathers who already had a baby/babies. Men were contacted and sent a general questionnaire form.

The eligible participants were then asked to complete mental health and well-being questionnaires in Greek (File 2). A purposive sampling method was employed to select participants

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based on their mental health questionnaires to ensure that a diverse range of scores were included in the study.

2.3. Ethics

The university's ethics committee approved all procedures. All fathers who participated voluntarily received an information booklet detailing their rights and a comprehensive consent form. The interviews were transcribed with the principle of anonymity in mind. All data were handled and stored in compliance with the European Union General Data Protection Regulations.

2.4. Sample

Eighty-four Greek men were initially contacted with recruitment questionnaires, and 50 met the study's eligibility criteria and agreed to participate. The eligibility criteria included consent to be contacted, a child born within the past 12 months at a gestational age of ≥37 weeks, both the mother and child in good health before being discharged from the hospital, being free of multiple pregnancies, maternal or baby health problems, preterm pregnancies and significant stressful events in the past six months, such as the death of a close relative. The 50 participants completed mental health questionnaires; their scores are presented in Table 1. Additionally, 15 fathers with diverse mental health scores (Table 2) were selected for interviews. All 15 fathers consented to be interviewed.

Table 1. Basic information and mental health scores of 50 Participants.

NUMBER OF PARTICIPANTS	AGE	INCOME IN EUROS	ATTENDANCE IN ANTENATAL CLASS	IS PARTNER PREGNANT NOW?	NUMBER OF BABIES AT HOME	STAI 1: LEVEL of state anxiety (score)	PHQ-9: LEVEL of depression (score)	STAI 2: LEVEL of trait anxiety (score)
1	40	>3000	NO	YES 1ST TIME	0	HIGH (48)	NO (1)	MODERATE (38)
2	39	>3000	NO	YES 1ST TIME	0	HIGH (63)	MODERATE (10)	HIGH (52)
3	33	1001-2000	NO	YES 1ST TIME	0	MODERATE (38)	NO (3)	MODERATE (42)
4	43	1001-2000	NO	NO	1	NO (26)	NO (1)	NO (24)
5	39	1001-2000	NO	NO	2	LOW (36)	NO (4)	HIGH (47)
6	37	1001-2000	YES	YES 1ST TIME	0	MODERATE (38)	NO (3)	LOW (36)
7	38	501-1000	NO	NO	1	MODERATE (44)	MILD (5)	LOW (30)
8	30	1001-2000	NO	YES 1ST TIME	0	HIGH (45)	NO (3)	LOW (24)
9	35	1001-2000	NO	YES 2ND TIME	1	NO (27)	NO (2)	NO (23)
10	33	2001-3000	NO	NO	2	HIGH (45)	MILD (5)	NO (26)
11	30	1001-2000	NO	NO	2	MODERATE (38)	MILD (7)	MODERATE (44)
12	36	501-1000	NO	YES 1ST TIME	0	LOW (34)	NO (2)	LOW (34)

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13	32	1001-2000	NO	NO	1	MODERATE (48)	NO (4)	NO (24)
14	28	501-1000	NO	YES 1ST TIME	0	HIGH (45)	NO (3)	NO (26)
15	32	1001-2000	NO	YES 2ND TIME	1	LOW (35)	NO (4)	LOW (35)
16	32	1001-2000	NO	NO	1	LOW (36)	NO (4)	NO (25)
17	40	1001-2000	NO	NO	2	LOW (32)	NO (4)	NO (27)
18	29	501-1000	NO	YES 1ST TIME	0	LOW (29)	NO (1)	NO (28)
19	35	2001-3000	YES	YES 1ST TIME	0	MODERATE (44)	MILD (7)	LOW (29)
20	35	1001-2000	YES	YES 1ST TIME	0	LOW (31)	NO (1)	NO (23)
21	32	2001-3000	YES	YES 1ST TIME	0	NO (28)	NO (1)	NO (22)
22	28	1001-2000	NO	NO	2	LOW (34)	NO (4)	NO (26)
23	24	2001-3000	YES	YES 1ST TIME	0	NO (22)	NO (0)	NO (22)
24	27	1001-2000	NO	YES 1ST TIME	0	LOW (3)	NO (2)	NO (24)
25	38	1001-2000	YES	NO	4	MODERATE (41)	NO (3)	LOW (33)
26	42	1001-2000	NO	NO	2	LOW (31)	NO (4)	NO (24)
27	34	501-1000	YES	YES 1ST	0	NO (24)	NO (2)	NO (23)
28	32	1001-2000	YES	YES 1ST TIME	0	NO (24)	NO (0)	NO (21)
29	34	2001-3000	NO	NO	1	NO (27)	NO (3)	NO (24)
30	26	501-1000	NO	YES 1ST TIME	0	NO (22)	NO (0)	NO (22)
31	31	1001-2000	YES	YES 1ST TIME	0	NO (25)	NO (0)	NO (22)
32	27	1001-2000	NO	NO	1	NO (26)	NO (1)	NO (24)
33	43	2001-3000	YES	NO	2	LOW (35)	MILD (7)	NO (25)
34	30	1001-2000	YES	NO	1	NO (23)	NO (1)	NO (21)
35	29	1001-2000	NO	NO	2	MODERATE (41)	MILD (5)	NO (25)
36	35	1001-2000	YES	NO	1	NO (26)	NO (4)	NO (23)
37	48	1001-2000	YES	YES 1ST TIME	0	LOW (33)	NO (3)	NO (25)

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38	34	2001-3000	YES	YES 1ST TIME	0	NO (28)	NO (4)	NO (25)
39	31	1001-2000	NO	NO	1	NO (24)	NO (2)	NO (22)
40	36	2001-3000	YES	YES 1ST TIME	0	NO (23)	NO (1)	NO (20)
41	39	2001-3000	YES	NO	2	NO (23)	NO (4)	NO (26)
42	34	1001-2000	YES	YES 1ST TIME	0	NO (22)	NO (1)	NO (24)
43	40	1001-2000	NO	NO	1	LOW (31)	NO (2)	LOW (28)
44	37	2001-3000	YES	YES 1ST TIME	0	NO (28)	NO (3)	NO (26)
45	33	1001-2000	NO	YES 1ST TIME	0	MODERATE (42)	NO (1)	LOW (29)
46	39	2001-3000	NO	NO	2	NO (27)	NO (2)	NO (24)
47	35	1001-2000	NO	NO	2	MODERATE (39)	MILD (6)	LOW (31)
48	25	2001-3000	NO	NO	1	NO (24)	NO (1)	NO (21)
49	34	1001-2000	NO	YES 1ST TIME	0	NO (25)	NO (0)	NO (23)
50	38	501-1000	NO	NO	1	MODERATE (44)	NO (3)	MODERATE (44)

Table 2. Basic information and mental health scores of 15 interviewees.

NAME OF INTERVIEWEE	AGE	INCOME IN EUROS	ATTENDANCE IN ANTENATAL CLASS	IS PARTNER PREGNANT NOW?	NUMBER OF BABIES AT HOME	STAI 1: LEVEL of state anxiety (score)	PHQ-9: LEVEL of depression (score)	STAI 2: LEVEL of trait anxiety (score)	NUMBER OF PARTICIPANTS
A	40	>3000	NO	YES 1ST TIME	0	HIGH (48)	NO (1)	MODERATE (38)	1
B	39	>3000	NO	YES 1ST TIME	0	HIGH (63)	MODERATE (10)	HIGH (52)	2
C	33	1001-2000	NO	YES 1ST TIME	0	MODERATE (38)	NO (3)	MODERATE (42)	3
D	43	1001-2000	NO	NO	1	NO (26)	NO (1)	NO (24)	4
E	39	1001-2000	NO	NO	2	LOW (36)	NO (4)	HIGH (47)	5

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F	37	1001-2000	YES	YES 1ST TIME	0	MODE RATE (38)	NO (3)	LOW (36)	6
G	38	501-1000	NO	NO	1	MODE RATE (44)	MILD (5)	LOW (30)	7
H	30	1001-2000	NO	YES 1ST TIME	0	HIGH (45)	NO (3)	LOW (24)	8
I	35	1001-2000	NO	YES 2ND TIME	1	NO (27)	NO (2)	NO (23)	9
J	33	2001-3000	NO	NO	2	HIGH (45)	MILD (5)	NO (26)	10
K	30	1001-2000	NO	NO	2	MODE RATE (38)	MILD (7)	MODE RATE (44)	11
L	36	501-1000	NO	YES 1ST TIME	0	LOW (34)	NO (2)	LOW (34)	12
M	32	1001-2000	NO	NO	1	MODE RATE (48)	NO (4)	NO (24)	13
N	28	501-1000	NO	YES 1ST TIME	0	HIGH (45)	NO (3)	NO (26)	14
O	32	1001-2000	NO	YES 2ND TIME	1	LOW (35)	NO (4)	LOW (35)	15

2.5. Data Collection

Semi-structured interviews were employed to collect data, with all fathers being asked the same questions. The first researcher (Author 1) recorded the answers via audio while retaining flexibility during the interview to encourage participants' responses to be explored. All interviews were conducted in person and diligent notes were taken, with attention also paid to non-verbal cues and body language.

Several decisions were required of the researchers during the design of this study, both before and during the data collection, as well as during the coding analysis. These inquiries were part of an ongoing reflective process between the researchers and culminated in the development of the following framework:

The data set will include 15 interviews.

Thematic analysis (Braun and Clarke, 2006) will be used to code the data.

The prevalence of mentioning the theme in all interviews will count as a theme.

The data set will be detailed so the reader can understand the predominant themes.

We will use a semantic approach to identifying the themes within the data's surface, not looking beyond what a participant said.

An essentialist epistemology approach will assume a simple unidirectional relationship between meaning, experience and language.

All research questions will not necessarily relate.

We will adhere to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Undertaking thematic analysis comprised six indispensable phases. Data were managed using NVivo software. The first researcher (Author 1), who conducted the interviews and transcribed the data verbatim, considered verbal and non-verbal information and punctuation, which can impact meaning.

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The first researcher produced initial codes by systematically working through the data set and identifying recurring patterns. Additionally, another researcher (Author 2), unaware of the first researcher's codes, independently coded the transcripts. Identifying themes involved categorising relevant coded extracts at a broader level and grouping them under the appropriate themes. The researchers (Authors 3 and 4) reviewed the themes and sub-themes produced at the level of the coded extracts to ensure that they formed a coherent pattern and also at a 'thematic map' level to verify that they accurately reflected the meanings in the entire dataset. During a face-to-face meeting, the candidate themes and sub-themes were discussed with input from all coders. Naming and defining the themes followed, aiming to capture the essence of each theme. Finally, the researchers produced a report that provides a concise, coherent and engaging account of the story told by the data.

3. Results

We identified five key themes:

Factors contributing to mental health problems (Sub-themes: 'Physical & mental burnout', 'Transitioning into a new role', 'Feeling 'out of the picture'' and 'Poor coping strategies').

Interaction with partner.

Birth & first post-partum days.

Providing for the family.

Engagement with maternity services (Sub-themes: 'Quality in questioning' and 'Living in a non-urban area').

Theme 1. Factors contributing to mental health problems

Physical and mental burnout

Demands associated with early parenting, such as sleep disturbances and exhaustion, were common among fathers, negatively affecting their mental health. One participant, Father B, described fatherhood as a 24-hour, non-stop job that never allowed for rest, stating, "(...) I believe the non-stopness of it is the main reason I am so stressed out." Father A also expressed his surprise at the impact of exhaustion, mentioning, "I never thought that being so tired would make me feel moody. My body aches at the end of the day, and I'm drained of energy." The majority of men in this study reported feeling overwhelmed and anxious due to the significant changes in their daily routines brought about by parenthood, with physical and mental burnout being widely discussed.

Transitioning into a new role

Fathers' mental health was significantly impacted by the shift from being a couple to expecting a child and then becoming a parent. Father H expressed that fatherhood challenges one's ideas of autonomy and independence, and the realisation that someone depends on them entirely can be overwhelming and stressful. Father K also discussed the difficulty of giving up a part of one's identity and the constant worry of providing for and protecting one's family. Both first-time and experienced fathers reported a change in priorities and self-evolution over time, which can be a source of anxiety and emotional exhaustion.

Feeling 'out of the picture'

According to the majority of interviewees, maternity health workers have routinely overlooked their mental health. Father M stated, "No one ever asked me how I feel! Everyone was so focused on my wife, which I understand, but inside me was chaos. I would have appreciated a word of encouragement". Another participant, Father J, commented, "I know my partner goes through a more difficult time than me, and I should not complain, but sometimes I feel invisible". Some fathers also expressed a shared social belief that the baby's health is the top priority and nothing else is significant. This belief appears to compromise paternal mental health, as men interpret it as evidence that they should not express their feelings or seek advice.

Moreover, when fathers needed guidance and support, there were no services to refer to. Father D lamented, "There is no one to help me when I am struggling. My partner can talk to the midwife, but what about me? ". The majority of fathers indicated that the lack of services focused on fatherhood and mental health harms their emotional well-being.

Poor coping strategies

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Most participants reported employing maladaptive coping mechanisms to suppress their anxieties. Father G, for example, recounted his use of avoidance to cope with daily stress: "The first few weeks after our daughter, Mary, came home were overwhelming. I often found reasons to be away from the house as much as possible". Withdrawal and isolation were also common among the fathers, and some resorted to toxic positivity to manage their anxiety: "I maintain a 'good vibes' only mentality and believe that everything happens for a reason" (Father N). Regrettably, these unhealthy coping strategies provided only temporary relief to the fathers without addressing the underlying issues. As a result, these fathers could not discover long-term solutions and remained trapped in a cycle of distress.

Theme 2. Interaction with partner

Parenting imposes a considerable amount of strain on couples' relationships, and this is negatively affecting paternal mental health. Several parents concurred with Father A's statement that having a child has highlighted the flaws in their marriage. They reported that constant arguing was taking a toll on their relationship. New fathers, in particular, found the early post-partum period to be emotionally exhausting and fraught with tension. Some expressed concern that they had lost touch with their partners, while others highlighted the loss of intimacy and quality time spent with their spouses. Father F articulated these sentiments by stating, "My wife has no free time anymore. She is either breastfeeding or doing chores. She is always fatigued, and I feel neglected and alone". Many men felt excluded by their partner once the baby arrived. Father O mentioned: "I am not permitted to express an opinion on how to look after the baby. I'm overridden on everything. I feel angry and sad". Having a new child entails unforeseen stresses for many fathers. Finding personal and couple time while preserving pre-parenthood interests proves exceedingly challenging.

Theme 3. Birth and first post-partum days

A large number of the interviewees found their journey into fatherhood demanding. The challenges were more noticeable towards the end of the pregnancy, reaching a climax during birth and the first post–partum days. Father E said: "During birth, I could hear my heart pounding! I was worrying about the delivery itself; would they be ok? My anxiety went through the roof!". Several fathers have stated that the maternity team disregarded the birth plan. Regrettably, the absence of communication between the maternity team and both parents created a stressful environment that affected them adversely. Men also talked about their role in preparation for their baby's arrival, referring to attending prenatal classes. However, most stated they did not feel prepared and that fatherhood only became 'real' once they started 'doing' it. Father L's comment resonated with the views expressed by many other new parents when he said: "The first few days at home after the baby arrived were the most stressful I've experienced so far. Our daughter never slept for more than an hour (…). My partner also had difficulties with breastfeeding, and I was trying to help her the best I could. Simple things like holding and bathing our daughter made me feel nervous. I never thought I would be so intimidated by her (the baby). It takes a while to get used to it and be comfortable with it'.

Low support networks and specifically not having someone outside the family who can be trusted with the responsibility of looking after the newborn were also vocalised as stressful issues for many participants.

Theme 4. Providing for the family

Many interviewees have referred to financial matters and worries in this study as an extra stressor. Father G said: "(…)we have two children to look after now and I'm tormented about money". Low income was also stated as a significant burden by men, affecting their emotional well-being. Father L expressed his frustration, saying, "(…) not earning enough means I have to ask for assistance from my parents. It's embarrassing! I'm 36 years old and still can't provide for my family. This situation is so stressful that I can't sleep at night". Compliance with the societal expectation of being the breadwinner significantly impacts the emotional well-being of fathers. It is not uncommon for fathers to experience heightened levels of stress when they are unable to fulfil this role.

Work-related issues and financial concerns are intricate for numerous participants. The combination of long working hours, a stressful work environment and insufficient paid paternity

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leave significantly impacts their transition to parenthood. Father E mentioned: "(…)my supervisor gives me a hard time (…) I don't get enough leave either. I was allowed off work for ten days. Just 10! Well, tell me, how can I manage? My wife says we'll pull through it, but I doubt it. The baby is home, and I will return to work the day after tomorrow. It just gives me the shivers…".

Theme 5. Engagement with maternity services

Quality in questioning

All participants in this study noted that quality in maternity care domains, such as patient safety, patient-centeredness, access to care, continuity of care and effectiveness, is low.

Father B recalled: "We were not listened to during prenatal visits! We both wanted to discuss the birth plan, but the doctor shut us down (…). Eventually, everything was completely different from what we imagined, and Helen ended up with a caesarean section. It's so disappointing when I think about it". COVID-19 restrictions, which remain in effect in public hospitals in Greece, have been affecting fathers, as they are not allowed to be present during prenatal visits and birth. Father H said: "She (the mother) is in (the building) for the ultrasound, and I'm waiting outside. I'm the father, and I can't be with her! Just imagine how that feels". Long waiting hours have also been addressed as an extra stressor: "(...) our appointments never run on time. We usually wait over one hour. Moreover, when Sofia finally gets in, she will come out in ten minutes. That's ridiculous! How can you tell if they're ok (mother and baby)? I'm worried that she (the doctor) might miss something" (Father N).

Lack of continuity of care in the community setting has been specifically referred to as a significant concern for first-time fathers. "(…) It's also frustrating that there is no community midwife to talk to. We must always go to the hospital no matter how big or small the problem is" (Father O). The lack of experience, in combination with limited access to community maternity services, has a significant impact on men's mental health.

Living in a non-urban area

Hospital restrictions and a shortage of health professionals drive changes in maternity care access, especially in non-urban areas. In semi-rural locations, the geographical distances between hospitals and residences have become a source of worry for parents. Father A's comment resonates with many men: "It is an hour's driving distance from our home, about 80 kilometres one way! Kathrine is close to her due date, and whenever my phone rings, I'm shivering from anxiety! Will we have enough time to drive to the hospital?"

The scarcity of specialised maternity services puts an extra strain, as they are outsourced privately. Men feel the pressure of financing these services. If they fail to fulfil this requirement, they struggle emotionally: "(…) mid-pregnancy, the obstetrician said there might be a problem. We had to visit a specialised doctor and go privately, as no one in the hospital could do this extra check. The cost was 800 euros, and I couldn't afford it. I felt like a complete failure, which hit me hard!" (Father N).

Furthermore, low support networks in non-urban areas are common issues. This lack of network is mainly due to the absence of community midwives and peer support groups. Inevitably, parents turn to close family members for advice and 'hands-on' assistance, causing agitation and emotional strain for fathers, who are often subjected to patronising and judgmental behaviours from their relatives.

4. Discussion

This interpretive qualitative study adds to the research on men's perceptions and first-hand experiences about their mental health during the perinatal period. Our objective was to explore the perceptions and experiences of Greek first-time and subsequent fathers regarding their mental health and well-being across the spectrum of emotional distress, as evidenced by interviews and self-reported measures of depression and anxiety symptoms.

In this study, fathers preferred to talk about 'stress' as opposed to mental illness. This is consistent with the literature on men's health (O'Brien, Hunt and Hart, 2005).

Our results indicated that although men experience emotional discomfort during the perinatal period, they may question the legitimacy of their feelings, highlighting their partner's needs first. The

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individuals involved in this study wanted to address their physical well-being. However, they simultaneously struggled with the potential conflict between addressing fathers' mental health issues and prioritising the needs of mothers, whom they perceive as the primary focus of care. This sentiment is echoed in the scientific literature (Bogren Jungmarker, Lindgren and Hildingsson, 2010).

Fathers defined their perceptions around stress and fatherhood, positioning the intra-parent interaction at the centre. Stress can be triggered by changes in their relationship with partners, by trying to balance family and work demands and by attending to their personal needs. The outcomes of this study align with the findings of meta-syntheses of qualitative data on parenting transitions (Kowlessar, Fox and Wittkowski, 2014; Matud, 2004). These studies reveal the desire of fathers to be 'good fathers' and the challenges they face due to the loss of their former selves, changes in their relationships with their partners, inadequate preparation for birth and parenthood, and alienation from services.

Our research showed that male participants felt overwhelmed because their usual coping mechanisms proved inadequate. The literature suggests that gender-specific coping strategies exist, with men favouring problem-focused approaches and women leaning towards emotional-focused ones (Matud, 2004). A problem-focused approach should be considered to strengthen fathers' emotional well-being and provide efficient partner support.

Tailored resources for fathers could improve their mental health. Few interventions are available for men (Rominov et al., 2016), and fathers may feel more eased with partner-inclusive initiatives that are encased around the father's role as partner and co-parent, as opposed to presenting them in distress. In line with the broader literature on men's health, it has been found that men typically require justifications to seek assistance. At the same time, such help should not compromise their adherence to traditional masculine norms, characterised by perseverance, prudence and emotional control (Galdas, Cheater and Marshall, 2005).

This study's questionnaires indicated that first-time fathers desired greater involvement and attended antenatal classes. Participation in antenatal classes can lead to a positive and fulfilling experience, and recent research has demonstrated the benefits of male peer support groups that encourage fathers-only, information-based prenatal meetings (Kuliukas et al., 2019).

Although some studies have explored fathers' experiences during the COVID-19 pandemic, the full extent of its impact on their transition to fatherhood remains unclear. The present study highlights the significance of social isolation, as reported by fathers and due to limitations on attendance at routine maternity appointments, ultrasounds and births, fathers in this study reported feelings of loneliness and disconnection. These experiences contributed to significant psychological responses and a sense of inadequate preparation and bonding with the mother-baby dyad. Our findings echoed recent studies demonstrating how uncertainty about COVID-19 affected men in the perinatal period, contributing to increased self-reported worries and anxieties (Cameron et al., 2023).

This study revealed that inadequate parental leave benefits and limited paid time off were offered to fathers, causing adverse effects on their mental well-being in multiple ways. Despite the absence of literature on the subject, it is suggested that more generous leave schemes could alleviate fathers' mental health problems (Heshmati, Honkaniemi and Juárez, 2023).

Participants in the study consistently reported that the distance between their homes and the hospital and the absence of community midwifery care were significant concerns that impacted their physical well-being. This finding is not unexpected, considering that childbirth practices in Greece have transitioned from a homebirth culture to a medicalised birth model in which women give birth in a hospital under the supervision of an obstetrician and autonomous midwifery practice is almost non-existent (Vehviläinen-Julkunen and Sapountzi-Krepia, 2006). Research has demonstrated that first-time and multiparous fathers can significantly benefit from midwives' professional and social support to enhance their mental health (Wells and Aronson, 2021). Nevertheless, Greek maternity services do not offer midwifery-led care.

5. Strengths and Limitations

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The strengths and limitations of this study contribute to the overall understanding of fathers' perspectives on perinatal mental health, shedding light on crucial methodological and interpretative aspects that shape the reliability and applicability of our findings.

5.1. Strengths

1. Focused Inquiry on an Underrepresented Population: The study addresses a significant gap in the literature by focusing on paternal perinatal mental health, a relatively underexplored area compared to maternal mental health. This focus provides valuable insights into the experiences and needs of fathers during the perinatal period.

2. Qualitative Methodology: Employing semi-structured interviews allows for in-depth exploration of fathers' experiences, perspectives, and emotional states. This method enables the capture of rich, nuanced data that quantitative methods might overlook, offering a more comprehensive understanding of paternal mental health during the perinatal period.

3. Diverse Participant Selection: The purposive selection of participants based on varying mental health and well-being outcomes ensures that a wide range of experiences are captured, contributing to the depth and breadth of the study's findings.

4. Adherence to COREQ Guidelines: Following the Consolidated Criteria for Reporting Qualitative Research (COREQ) enhances the study's rigour, transparency, and reproducibility. This adherence signals to the academic community the quality and reliability of the research.

5. Practical Implications for Support Services: The study's findings highlight the need for targeted support services for fathers during the perinatal period, providing a solid basis for developing interventions to improve paternal and family well-being.

5.2. Limitations

1. Generalizability: As with many qualitative studies, the findings may have limited generalizability due to the participant pool's specific demographics and geographic location. Fathers' experiences in different cultural, socioeconomic or healthcare contexts may vary significantly.

2. Self-Selection Bias: The reliance on volunteers for participation may introduce self-selection bias, as individuals who are more engaged with or affected by the topic are more likely to participate. This could limit the representation of broader paternal experiences.

3. Recall Bias: Given the study's retrospective nature, asking fathers to reflect on their perinatal experiences could be subject to recall bias, mainly if interviews are conducted several months after the birth.

4. Interpretation Bias: Despite efforts to mitigate bias through reflexivity and adherence to COREQ guidelines, qualitative research is inherently interpretive. The researchers' perspectives and theoretical orientations can influence data interpretation and theme development.

5. Limited Quantitative Data: While the qualitative approach provides depth, the lack of quantitative data means that certain aspects of paternal perinatal mental health, such as prevalence rates or the strength of associations between factors, cannot be addressed.

5.3. Relevance for Clinical Practice

The Greek healthcare system fails to support men during their journey to fatherhood, and there is a need to broaden the scope of maternity services to include fathers' and partners' needs. A midwifery-led care model has the potential to improve health outcomes, and initiatives that focus on the role of fathers as partners and co-parents are necessary to safeguard their mental health. It is recommended that prenatal classes be more inclusive of fathers and that local male support groups be promoted.

6. Conclusions

The perinatal period, which encompasses the time surrounding the birth of a child, can be a period of psychological adjustment for fathers. Paternal mental health issues are a significant concern

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and represent a notable challenge to public health, as they can have a negative impact on fathers and their families.

Our research has shown that men are often reluctant to seek help for mental health issues, and when they do, they may not have access to services that are tailored to their needs. Additionally, men may struggle during the transition from being a partner to becoming a father, particularly in the context of public health policies that exclude them from antenatal and birthing experiences, especially during the post-pandemic period. Furthermore, a lack of social support networks and inadequate paid paternity leave can exacerbate mental health issues in fathers.

Further research is necessary to understand men's requirements and actively identify and promote their psychological well-being.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by University of West Attica Ethics Committee (Approval Code: [66024]; Approval Date: [May 10, 2023]).

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