Perinatal anxiety and depression: Awareness and attitudes in Australia

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Abstract
Background: Better community mental health literacy is associated with positive help-seeking behaviours and reduced stigma. There are relatively few published surveys of perinatal mental health literacy.
Aims: To provide a profile of current awareness, knowledge and attitudes in relation to the mental health of women and men in the perinatal period.
Method: A cross-sectional online survey (n = 1,201) of adults (≥18 years) in each state and territory of Australia was conducted in early 2016. Survey questions were based on a previous 2009 survey, with the addition of several novel items designed to assess knowledge around both postnatal anxiety and men’s perinatal mental health.
Results: Depression (including postnatal depression) was the most frequently cited general health problem for women in the first postnatal year (52% of spontaneous first responses). Over 70% of adults believed that postnatal depression requires specialised treatment and checks for depressive symptoms should occur routinely in pregnancy and the first postnatal year. Women identified postnatal depression at a higher rate than men. Most commonly, postnatal depression was perceived as having a biological rather than psychosocial etiology (34.5%). Men and women differed in their knowledge about the symptoms of postnatal depression with more women correctly identifying core depressive symptoms. The specific term ‘postnatal depression’ was not well recognised. Although not well recognised as a general health issue, when prompted, 39% of respondents were aware of anxiety as a specific perinatal mental health issue. Most adult Australians (60%) were unaware that perinatal depression and anxiety could be experienced by men.
Conclusion: Awareness of postnatal depression appeared high. However, areas including anxiety, antenatal mental health, and men’s mental health were less well-understood. There remains considerable scope, and a need for, continued awareness-raising around anxiety, mental health in pregnancy and men’s mental health.

Keywords
Perinatal anxiety, perinatal depression, men’s mental health, mental health literacy, postnatal depression

Introduction
Depression and anxiety in the perinatal period (pregnancy and the first 12 months postpartum) are prevalent (Gaynes et al., 2005), under-identified (Gavin, Meltzer-Brody, Glover, & Gaynes, 2015) and involve some unique considerations for management (Buist et al., 2005; Payne & Payne, 2007; Pearlstein, 2008). Better community mental health literacy is associated with positive helping and help-seeking behaviours, reduced stigma and reduced social distancing towards individuals with mental health problems and higher resilience in families affected by a mental health difficulty (Barney, Griffiths, Jorm, & Christensen, 2005; Fraser & Pakenham, 2009; Have et al., 2000; Kitchener & Jorm, 2002).

In Australia, a previous survey carried out in 2009 (Hight, Gemmill, & Milgrom, 2011) focused specifically on community awareness, attitudes and knowledge in respect of depression in perinatal women (antenatal and postnatal depression). Results suggested that while awareness of postnatal depression was relatively high in the community, men and women differed in their knowledge and perceptions. Furthermore, both antenatal mental health difficulties and the prevalence of perinatal anxiety appeared under-recognised (Hight et al., 2011). Although there are relatively few published surveys of perinatal mental health literacy, similar patterns of variation in community knowledge and awareness have been detected by other researchers in Australia and Canada (Kingston, ²Parent-Infant Research Institute, Heidelberg Repatriation Hospital, Austin Health, Melbourne, VIC, Australia
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McDonald, Austin, et al., 2014; Kingston, McDonald, Tough, et al., 2014; Sealy, Fraser, Simpson, Evans, & Hartford, 2009; Thorsteinsson, Loi, & Moulynox, 2014).

The present study, conducted by Perinatal Anxiety and Depression Australia (PANDA), aimed to provide an updated, current snapshot of perinatal mental health literacy in the Australian population. In addition, the survey included a new focus on the issue of perinatal anxiety and on awareness regarding perinatal mental health difficulties in men. There has been an increasing research focus on men’s perinatal mental health in recent years (Fletcher et al., 2013; Paulson & Bazemore, 2010) alongside an emerging recognition of the importance of fathers’ mental health for early infant development (Da Costa et al., 2015; Fletcher, Feeman, Garfield, & Vimpani, 2011). As such, the inclusion of these new items seemed timely in the current survey.

Methods

The online survey was structured similarly to those used in a previous study of perinatal depression literacy in Australia (Hightet et al., 2011) and aimed to replicate the sample size used in that study (n = 1,201). Additional items were developed in response to issues identified through the National Perinatal Anxiety and Depression Helpline service run by PANDA. These new questions were added after the original questions were asked to ensure comparability by avoiding possible question order bias.

The target sample was selected, in proportion to Australian Bureau of Statistics population estimates for age and gender in each State and Territory population, from the online panel provider PureProfile. Conduct of the survey followed the ICC/ESOMAR international code of marketing and social research practice. Survey responses were collected from 1 June 2016 to 9 June 2016. Respondents were invited to take part in a survey about ‘general health and wellbeing before and after having a baby’ and were unaware that its focus was perinatal anxiety and depression. The survey took approximately 15 minutes to complete.

After collecting data on age, gender and residential location, the survey commenced by recording up to four open-ended responses to the question, what do you consider to be the major health problems which may be experienced during pregnancy? This was followed immediately by a similarly worded item concerning major health problems in the postnatal period. Next, the survey asked, thinking about mental health in particular, what do you consider to be the major mental health problems which may be experienced during pregnancy? This was followed by an equivalent question concerning mental health in the first postnatal year, again with up to four spontaneous responses recorded from each participant.

Subsequent items in the survey focused on awareness of and attitudes to depression and anxiety in the perinatal period, and on literacy about their prevalence, symptoms, causes and treatments. Next, respondents were asked to rate their agreement on a 4-point scale (from strongly agree to strongly disagree) with a number of statements designed to measure the prevalence of some specific attitudes to antenatal and postnatal anxiety and depression. Sociodemographic data were collected including parental status, indigenous status and history of work or training in the field of mental health.

Statistical analysis

Percentage responses on each item were calculated by applying survey weights according to gender, age and location (state, territory and metropolitan vs. regional locations) using the latest Australian Bureau of Statistics projections, based on the 2011 census (http://www.abs.gov.au/AUSSTATS). Differences in response frequencies between demographic groups were tested by \( \chi^2 \). Since multiple significance tests were carried out, a conservative alpha level of .01 was applied when assessing statistical significance (\( p < .01 \)). Computations were executed in IBM SPSS Statistics Version 22.

Results

Sample characteristics

A total of 1,201 eligible adult respondents completed the survey. The regional, gender and age-group representations achieved in the un-weighted sample were very close to the target ABS population projections. Five hundred eighty-eight men (49%) and 613 women (51%) took part. The breakdown by state and territory was New South Wales, 390 (32.2%); Victoria, 289 (24.1%); Queensland, 243 (20.2%); Western Australia, 127 (10.6%); South Australia, 92 (7.7%); Tasmania, 28 (2.3%); and Territories, 32 (2.6%). Eighteen respondents identified themselves as Aboriginal or Torres Strait Islander (1.5%). Seven hundred eighty-four respondents (65.3%) lived within the major metropolitan areas (Adelaide, Brisbane, Melbourne, Perth, Sydney). Three hundred seventy-nine respondents (31.6%) were aged 18 to 34 years, 441 were aged 35 to 54 years (36.7%) and 381 (31.7%) were aged 55 years or more. Seven hundred six (58.8%) identified themselves as parents and 68 (5.7%) reported that they had some training in the mental health field.

Awareness of health problems in the perinatal period

Perceptions of the major health problems experienced during pregnancy. In the weighted sample, the most frequent
spontaneous responses for major health problems during pregnancy were diabetes/gestational diabetes (33.6%), blood pressure (23.2%) and preeclampsia (13.6%). In total, only 4.7% of respondents cited anxiety, depression or other mental health problems when answering this general item about health in pregnancy. Considering first responses only (‘top-of-mind’ responses), mentions of mental health problems as key health problems in pregnancy were even rarer (1.3% of top-of-mind responses).

Perceptions of major health problems experienced by women in the first postnatal year. In total, the list of issues spontaneously cited as major health problems during the first year following birth was headed by postnatal depression (38.1%), followed by unspecified depression (19%), fatigue (11.2%) and weight issues (7.1%). Of top-of-mind responses to this item on general postnatal health, postnatal depression was cited by 35% of those surveyed. This was compared with 24.8% of top-of-mind responses in a previous Australian survey in 2009 (Highet et al., 2011). Furthermore, unspecified depression was the top-of-mind response of a further 16.9% of respondents (Supplementary Table 1). The most frequent responses related to a range of other mental health symptoms or difficulties: stress (5.4%), mood swings (1.2%), psychosis (0.9%), bipolar or eating disorders (1.3%) and post-traumatic stress (0.7%).

The next survey item, referencing the first postnatal year, yielded a broadly similar pattern of response frequencies (Supplementary Table 1). The most frequent responses cited postnatal or postpartum depression, followed closely by unspecified depression, ‘don’t know’, anxiety or panic attacks, fatigue or lack of sleep and bipolar disorders. Furthermore, a range of other mental health-related symptoms or disorders (not tabled) were also mentioned, which together totalled 2.4% of all responses: psychosis, post-traumatic stress, eating disorders, emotionality, mood swings and negative thoughts.

As shown in Supplementary Table 1, women were significantly more likely to identify postnatal depression and anxiety as mental health problems in the first postnatal year. Men were significantly more likely to answer ‘Don’t know’ in response to this survey item. Statistically, older Australians (55 years and over) were not significantly (ns) less likely to identify postnatal depression (32.6% vs. 37.2% of under-55s, $\chi^2=2.34$, $p=.126$, ns) or unspecified depression (26.5% vs. 29.4% of under-55s, $\chi^2=0.99$, $p=.318$, ns). However, those aged 55 years and over identified anxiety less readily (8.9% vs. 14.9% of under-55s, $\chi^2=8.56$, $p<.01$) and were also significantly less likely to mention stress (2.3% vs. 5.8%, $\chi^2=6.98$, $p<.01$).

In response to a prompting question, have you heard of the term ‘perinatal depression’, awareness of the term was 45.2%. This included 43% of men versus 47.3% of women ($\chi^2=2.09$, $p=.148$, ns) and 42.1% of those aged 55 years and over ($\chi^2=2.38$, $p=.123$, ns). Among respondents who reported having had some training in the field of mental health, awareness of the term was significantly higher (75.4% vs. 43.2% for those with no history of training, $\chi^2=27.49$, $p<.001$). Awareness was not significantly higher among parents (46%) or those expecting a child (45.2%).

Knowledge about perinatal depression

The next question in the survey, ‘what do you think “perinatal depression” means’, elicited the following responses. Most commonly (37.0% of responses) the term ‘perinatal depression’ was thought to mean depression or stress occurring during pregnancy, followed by depression or stress in the postnatal period (17.0%). Understanding of the term was clearly differentiated from ‘baby blues’, which accounted for 0.9% of responses and from ‘postnatal depression’ (1.5%). Only 8% of responses correctly associated the term with depression occurring in either pregnancy or the postnatal period.

The survey next asked ‘approximately what proportion of Australian women suffer from depression during pregnancy’. This was followed by a similarly worded postnatal item. More than one third of respondents answered ‘don’t know’ to these two items (42.8% and 38.3% of respondents for the antenatal and postnatal question, respectively), indicating that many Australian adults were not readily able to give an estimate as to prevalence. Among those who gave an estimate, the prevalence of depression in both pregnancy and the postnatal period was, on average, seen as high. Of the respondents, 52.3% indicated that depression affected 15%–50% of pregnant women and 56.5% of respondents said it occurred in 15%–50% of mothers in the first postnatal year.

When asked, what are the signs and symptoms of postnatal depression, one in four respondents replied ‘Don’t know’ (Table 1). The most frequent responses included
three symptoms that correspond closely to clinical criteria (American Psychiatric Association, 2013) used to diagnose a depressive episode (the core symptom of sadness or low mood, as well as fatigue/sleep disturbance and irritability), but fewer than 4% of respondents correctly identified the other core symptom of depression, namely, loss of pleasure (anhedonia). Other relatively common responses included a woman’s failure to bond with her infant, social isolation and feelings of anxiety. Women were substantially more likely than men to identify most of these items as symptomatic of postnatal depression, and men were also significantly more likely to answer ‘Don’t know’ (χ² = 38.5, p < .001).

When asked to identify the causes of postnatal depression, 29.1% of those surveyed could not identify any (Table 2). The most commonly cited response was that the causes are biological in nature (including hormonal, genetic/hereditary and biochemical explanations), followed by the change of lifestyle involved in the transition to parenthood (Table 2). Women were almost twice as likely as men to identify a biological cause underlying postnatal depression and men were more likely to be unable to identify any cause (‘Don’t know’). Among those who reported having some training in the mental health field, the biological explanation was cited by 45.6% (χ² = 10.9, p = .001).

The survey next asked for respondents’ views about suitable treatments for ‘a woman with postnatal depression’. By far the most frequent responses were counseling/psychological therapy and the use of antidepressant medication. These two prevailing views on suitable treatment were substantially and significantly more common among women (Supplementary Table 2). Respondents with training in mental health also viewed antidepressant medication as a suitable treatment significantly more frequently (48.5% of those with some mental health training: χ² = 11.4, p = .001). Practical help with household chores and child care tasks was cited significantly more often by women (Supplementary Table 2).

In total, 27.5% of respondents reported that they or someone close to them had suffered perinatal depression or anxiety. The next survey question asked, If you (your wife/
partner or woman close to you) had postnatal depression, who would be your first choice to go to? (who would you recommend they go to first?)

With up to four spontaneous responses recorded from each respondent. Supplementary Figure 1 shows the frequencies of the help-seeking routes nominated in response to this item. Men were significantly less likely to nominate seeking help from a doctor (χ² = 6.4, p = .01), while women were significantly more likely to indicate that support from friends and family would be their recommendation (χ² = 149.1, p < .001).

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Attitudes and beliefs

Table 3 summarises the extent of agreement with a number of possible beliefs about antenatal and postnatal depression. Most responses regarding attitudes to depression and to expectations of women and motherhood appeared positive. There was generally a high rate of disagreement with negative stereotypes about depression and motherhood, such as the statement ‘Women with postnatal depression can’t be good mothers’. In total, 73.5% of respondents agreed or strongly agreed that all women should routinely be checked for depression during pregnancy and 72.3% agreed that this should also be done postnatally (Table 3).

Knowledge about perinatal anxiety

When prompted (are you aware that some women experience clinical anxiety ... ?), 39% of the survey sample indicated that they were aware of clinical anxiety as a perinatal mental health problem. At the same time, as shown in Table 1, more than 40% of those surveyed could not name a symptom when asked, what are the signs and symptoms of anxiety suffered during pregnancy or in the year after giving birth. Among those who responded, anxiety/panic

<table>
<thead>
<tr>
<th>Table 2. Causes of postnatal depression citeda.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Causes</td>
</tr>
<tr>
<td>Biological causes</td>
</tr>
<tr>
<td>Change of lifestyle</td>
</tr>
<tr>
<td>Lack of support</td>
</tr>
<tr>
<td>Not coping with parenting</td>
</tr>
<tr>
<td>Stress/pressure</td>
</tr>
<tr>
<td>Fatigue/lack of sleep</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
</tbody>
</table>

Note: χ² comparisons were made between male and female respondents.

aMultiple responses to the question, why do you think women get postnatal depression, were recorded.

bns = not significant at α = .01.

cAll responses cite hormonal/chemical imbalance, genetic/hereditary cause or predisposition.

<table>
<thead>
<tr>
<th>Table 3. Beliefs about perinatal women with depression.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belief</td>
</tr>
<tr>
<td>It is normal to be depressed during pregnancy</td>
</tr>
<tr>
<td>Postnatal depression is a normal part of having a baby</td>
</tr>
<tr>
<td>Women with postnatal depression cannot be good mothers</td>
</tr>
<tr>
<td>Postnatal depression is not serious</td>
</tr>
<tr>
<td>Postnatal depression requires special treatment</td>
</tr>
<tr>
<td>It is only postnatal depression when you are thinking about suicide</td>
</tr>
<tr>
<td>It is when you want to harm or kill the child</td>
</tr>
<tr>
<td>Knowing how to look after a baby comes naturally to women</td>
</tr>
<tr>
<td>All women should be checked for depression during pregnancy</td>
</tr>
<tr>
<td>All women should be checked for depression after the baby is born</td>
</tr>
</tbody>
</table>
attacks, sleep difficulty, depression and some physiological symptoms used to diagnose some anxiety disorders (sweating, shaking) were the most commonly named. Women were more likely than men to correctly nominate several symptoms used in clinical diagnosis of anxiety disorders including exaggerated/constant worry and intrusive thoughts (American Psychiatric Association, 2013).

The survey then asked about the causes of perinatal anxiety. The most commonly given response was that perinatal anxiety is due to a change in hormone levels (12.3% of responses), and this view was more than twice as common among women than it was among men (16.5% vs. 8.0%: \( \chi^2 = 19.7, p < .001 \)). Next in order of frequency came fear of not being a good mother (11.4%), stress (6.5%) and difficulty coping with life changes (5.4%). Those aged 55 years and over were significantly more likely to cite stress (8.4%, \( \chi^2 = 11.2, p = .001 \)), and difficulty coping with change (7.9%: \( \chi^2 = 6.8, p = .009 \)). Thirty nine percent of respondents answered ‘Don’t Know’. Knowledge about men’s perinatal mental health

When prompted by the question, Are you aware that a father can experience antenatal anxiety or depression? 30.1% of men and 41.0% of women responded in the affirmative (\( \chi^2 = 14.9, p < .001 \)). Those aged 55 years and over were not substantially less likely to give a positive answer to this question (37.6% vs. 32.1%: \( \chi^2 = 3.4, p = .06 \), ns). However, when the equivalent question regarding the first postnatal year was asked, those aged 55 years and over appeared to be significantly less aware (30% vs. 38.3% of those under 55 years: \( \chi^2 = 7.9, p = .005 \)).

When asked where new or expectant fathers could turn for information, the most frequent suggestions were online parenting sites (49.1%), the man’s partner (46%), parenting publications (43%) and friends (42.5%). Women cited all of these responses at higher rates than men.

Finally, 39.6% of those surveyed agreed that the signs and symptoms of perinatal anxiety and depression are manifested differently in men compared with women. However, over 40% were unable to specify in what ways the symptoms were different for men compared with women. The most common perceptions (Table 4) were that depressed or anxious men hide their emotional state, withdraw socially, display anger or violence, and that their symptoms are not as severe or as serious as those experienced by women. Less than 2% of Australians believed that the symptoms of perinatal depression and anxiety are no different in their presentation in men than they are in women.

### Table 4. How are men’s symptoms of perinatal anxiety and depression different from women’s?

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Percentage of respondents</th>
<th>All Australians</th>
<th>Men</th>
<th>Women</th>
<th>( \chi^2 ), p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hide emotions</td>
<td></td>
<td>11.8</td>
<td>7.9</td>
<td>15.1</td>
<td>5.2, .02 (ns)</td>
</tr>
<tr>
<td>Distance themselves/withdrawal</td>
<td></td>
<td>7.2</td>
<td>3.3</td>
<td>10.4</td>
<td>8.0, .005</td>
</tr>
<tr>
<td>More aggressive/angry/violent</td>
<td></td>
<td>4.2</td>
<td>1.9</td>
<td>6.2</td>
<td>4.4, .04 (ns)</td>
</tr>
<tr>
<td>Less severe than for women</td>
<td></td>
<td>4.2</td>
<td>3.2</td>
<td>5.0</td>
<td>0.54, .46 (ns)</td>
</tr>
<tr>
<td>Symptoms not any different</td>
<td></td>
<td>1.9</td>
<td>1.4</td>
<td>2.3</td>
<td>0.16, .68 (ns)</td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td>40.6</td>
<td>43.1</td>
<td>38.6</td>
<td>0.79, .37 (ns)</td>
</tr>
</tbody>
</table>

*ns = not significant at \( \alpha = .01 \).

### Discussion

Prevailing community knowledge and perceptions regarding perinatal mental illness form an important part of the context in which many new parents attempt to navigate their own emotional difficulties. In this regard, unhelpful or inaccurate beliefs can hinder both help-seeking and timely treatment among perinatal women experiencing a mental health difficulty (Chew-Graham et al., 2008; Chew-Graham, Sharp, Chamberlain, Folkes, & Turner, 2009; Dennis & Chung-Lee, 2006). Better understanding of the population’s attitudes towards perinatal mental health is, therefore, valuable in informing public health initiatives, health promotion efforts and the acceptability of clinical interventions.

The current study provides an updated picture of awareness and knowledge in Australia since the last comparable survey in 2009 (Highet et al., 2011). Depression remained the most commonly cited potential health problem for women in the first year following childbirth. Indeed, awareness of mental health difficulties in general was high, but problems in pregnancy were somewhat less well recognised. Disagreement with a number of stigmatising and unhelpful attitudes towards women with perinatal depression appears to have been maintained in the time between the two surveys. However, it is notable that in response to such items, as well as those items covering possible causes and symptoms of perinatal depression, there was generally a higher rate of ‘Don’t Know’ responses.
Similarly, in the current study, a substantially lower proportion of respondents were able to give any estimate of the prevalence of perinatal depression than in the previous survey (the rate of ‘Don’t know’ responses more than tripled between the two surveys). Just over half the respondents to the current survey estimated the antenatal or postnatal prevalence of depression as being between 15% and 50%. In 2009, over 75% of respondents did so. It is not clear whether this apparent difference might be due to a true shift in population knowledge, connected to the change to an online survey method, or a reflection of an unmeasured difference between the make-up of the two survey samples. In any case, the current estimates, as in 2009, are not inconsistent with the actual meta-estimates of period prevalence reported in the scientific literature of around 20% of women suffering from a major or minor depressive disorder at some point during pregnancy or the first postnatal year (Gavin et al., 2015; Gaynes et al., 2005).

Understanding of the specific term ‘perinatal depression’ was relatively low, with the most frequent interpretation being that it referred only to depression during pregnancy. As in 2009, the most established risk factors for postnatal depression were not coherently recognised by the public or by those with training in mental health. Meanwhile, the notion of postnatal depression being primarily biological in its etiology endures and appears to have increased in frequency as a commonly held belief. While there is evidence that perinatal depression is associated with changing hormone levels, the strongest associations found in large population surveys of risk factors and in systematic reviews tend to be with levels of social supports, prior history of mental health difficulties and other psychosocial factors (Beck, 1996, 2001; Milgrom et al., 2008).

A positive finding was that negative and unhelpful stereotypes about mental health difficulties and motherhood were not prominent in community attitudes in either 2009 or 2016. Further, the great majority of Australians continue to indicate their support for universal screening for depression and anxiety in the perinatal period to be part of routine health care, which has been the national recommendation for clinical practice since 2011 (Beyond Blue, 2011).

Men and women differed in their understanding of the causes, symptoms and most suitable treatments for perinatal depression and these differences were broadly in line with the findings of the previous survey in 2009. For example, women who much more frequently cited biological causes for depression, were more likely to identify the two core clinical diagnostic symptoms of a depressive episode (feelings of sadness and loss of pleasure). Women were more likely to nominate both psychotherapy and antidepressant medication as suitable treatments, both of which are evidence-based options for the treatment of depression (O’Hara, Dennis, McCabe, & Galbally, 2015).

While men favoured contact with a GP or other doctor in terms of recommended help-seeking routes, women more readily cited support from family and friends. Given that the great majority of female respondents were able to nominate at least one preferred help-seeking route and a suitable treatment, it may appear slightly paradoxical that, in practice, the evidence suggests that most women experiencing perinatal depression never seek or receive any help (MacLellan, Wilson, & Taylor, 1996; McGarry, Kim, Sheng, Egger, & Baksh, 2009; Smith, Howell, Wang, Poschman, & Yonkers, 2009). The current survey aimed to collect novel information on community attitudes and knowledge about both perinatal anxiety and the mental health of men in the perinatal period. Perinatal anxiety had a lower recognition than depression and respondents were less able to cite its causes and symptoms, yet, it is prevalent and often co-morbid with depression (Wisner et al., 2013). This may be an important finding since lack of knowledge around mental health issues is likely to be associated with lower rates of help-seeking. Just as in the case of depression, the most prevailing opinion was that perinatal anxiety has a hormonal origin. Women correctly cited clinically recognised symptoms of anxiety more frequently than men. This somewhat confused picture may in part be due to the quite wide spectrum of clinically recognised anxiety disorders, not all of which share the same core symptoms. For example, the presence of intrusive thoughts is a diagnostic criterion (American Psychiatric Association, 2013) for obsessive-compulsive disorder but not for generalised anxiety disorder. Similarly, the recurrence of unexpected panic attacks defines neither of the former two anxiety disorders, but is central to the diagnosis of panic disorder. It may, therefore, be unsurprising that there is community uncertainty about symptoms when a survey item asks only about ‘anxiety’ in a more general sense.

Awareness of the perinatal mental health of fathers appears relatively low, yet estimates suggest around 10% of men experience depression in the perinatal period (Paulson & Bazemore, 2010). Although, when prompted, many respondents said that they were aware men could have perinatal anxiety or depression, this awareness was relatively higher among women and relatively lower among older Australians. While, almost four in 10 respondents agreed that the signs and symptoms or perinatal anxiety and depression are manifested differently in men compared with women, relatively few were able to specify in what ways the symptoms might be different. Most frequently, the perceptions that emotionally distressed men hide their emotional state, withdraw socially and display anger or violence were cited, all of them at a higher rate by female respondents. Research into the identification of possible male-specific symptoms of perinatal distress is in its early stages, but may prove to be important for our understanding of the prevalence and nature of male
emotional distress in the perinatal period (Fletcher, Garfield, & Matthey, 2015). Notably, only around 1 in 20 Australians thought the symptoms of depression and anxiety were differentiated by being less severe and less serious than when experienced by a woman. Men were less able to nominate a suitable route to getting support for a man experiencing difficulties. The leading suggestion was for accessing online resources or obtaining support from a partner/spouse.

One limitation on the interpretation of the current survey compared with the previous one conducted for Beyond Blue is presented by the change in contact methodology. While the core survey items themselves were identical to those used in 2009 (Highet et al., 2011) and were presented in the same order, the current study replaced telephone-based contact methodology with panel-based online data collection. In light of the declining number of household landlines and the increasing familiarity of the public with an online environment, online collection may well be a more valid and accurate method. However, it may introduce a difficulty in definitively ascribing any change in the frequency of item responses to a real change in community knowledge across time. For example, in the Second Australian Young and Well National Survey 2014 online methods were found to increase response rates to sensitive survey items compared with telephone-based administration of the same items (Milton, Ellis, Davenport, Burns, & Hickie, 2017). It was also thought possible that some ‘avidity bias’ was operating, such that people who are more interested in a specific topic are more likely to sign up to an online survey (Milton, Ellis, Davenport, Burns, & Hickie, 2017). Research also suggests that the two methodologies may produce some differences in survey response rates (Lee, Kim, Couper, & Woo, 2019). Given such possible differences, it may, therefore, be useful in any future repetition of this survey to give careful consideration as to whether contact and data collection methodology should be Internet-based, telephone-based or, perhaps, a deliberate combination of both, as was done by Milton and colleagues (2017).

Conclusion

The continued discrepancies between male and female perinatal mental health literacy suggest that future public health and awareness raising efforts could be usefully targeted towards men. There are opportunities within existing health services to improve knowledge of expecting and new fathers about perinatal mental illness. For example, antenatal classes commonly include expecting fathers and could be used to provide information about paternal mental health and key online resources providing support for men’s perinatal mental health. Similarly, in the postnatal period key health professionals such as child and family health nurses and general practitioners, could be educated to enquire about the mental health of both mothers and fathers. In Australia, we have seen recently national awareness raising activities targeting anxiety and depression in men such as Beyond Blue’s Dadvice campaign (https://healthyfamilies.beyondblue.org.au/pregnancy-and-new-parents/dadvice-for-new-dads). Sustainable campaigns of this type have the potential to specifically reach the target population of perinatal men into the future.

The lack of understanding about mental health difficulties during pregnancy compared with the postnatal period also continues to pose a challenge for awareness raising and health promotion. It may be useful for health professionals involved in women’s antenatal care to remain mindful of this lack of community awareness, and perhaps consider a more active role in dissemination of mental health information during pregnancy. Finally, it appears that while awareness of depression (at least depression affecting perinatal women) remains high among the Australian public, the same is not true for recognition and knowledge regarding perinatal anxiety and men’s mental health. It would therefore be of interest to specifically target awareness raising efforts in coming years and to explicitly re-examine public understanding of this issue in future community surveys.

Acknowledgements

The study was undertaken by PANDA—Perinatal Anxiety and Depression Australia. Survey interviews were conducted by GalKal Consulting. Beyond Blue generously shared their 2009 survey details to assist with this work.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The research was made possible by funding from the Priceline Sisterhood Foundation.

Supplemental material

Supplemental material for this article is available online.

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