How to assess and treat birth-related depression in new fathers

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Only recently has paternal postpartum depression (PPD) received much attention. Research has shown that maternal PPD is associated with negative outcomes in the child's cognitive development and social and marital problems for the parents. Likewise, depressed fathers are less likely to play outside with their child and more likely to put the child to bed awake.[1]

Recent studies reported that 10.4% of men experienced depression within 12 month of delivery.[1] Edmondson et al[2] estimate the prevalence of paternal PPD to be 8% between birth and 3 months, 26% from 3 to 6 months, and 9% from 6 to 12 months.

Risk factors

Risk factors for paternal PPD have not been studied extensively. Some studies have shown that immaturity, lack of social support, first or unplanned pregnancies, marital relationship problems, and unemployment were the most common risk factors for depression in men postnatally.[3] A history of depression and other psychiatric disorders also increases risk.[4] Psychosocial factors, such as quality of the spousal relationship, parenting distress, and perceived parenting efficacy, contribute to paternal depression.

Similarly, depressed postpartum fathers experience higher levels of parenting distress and a lower sense of parenting efficacy.[5] Interestingly, negative life events were associated with increased risk for depression in mothers, but not fathers.[3]

Clinical presentation

Paternal PPD symptoms appear within 12 months after the birth of the child and last for at least 2 weeks. Signs and symptoms of depression in men might not resemble those seen in postpartum women. Men tend to show aggression, increased or easy irritability, and agitation, and might not seek help for emotional issues as readily as women do. Typical symptoms of depression often are present, such as sleep disturbance or changes in sleep patterns, difficulty concentrating, memory problems, and feelings of worthlessness, hopelessness, inadequacy, and excess guilt with suicidal ideation.[6]

Making the diagnosis

Maternal PPD commonly is evaluated using the Edinburgh Postnatal Depression Scale-Partner (EDPS-P) or Postpartum Depression Screening Scale. However, studies are lacking to determine which diagnostic modality is most accurate for diagnosing paternal PPD.

A paternal PPD screening tool could include the EDPS-P administered to mothers. Edmonson et al[2] determined an EDPS-P score of >10 was the optimal cut-off point for screening for paternal depression, with a sensitivity of 89.5% and a specificity of 78.2%, compared with a structured clinical interview. Fisher et al[4] determined that the EDPS-P report was a reliable method for detecting paternal PPD compared with validated depression scales completed by fathers. Madsen et al[5] determined the Gotland Male Depression Scale, which detects typical male depressive symptoms, also was effective in recognizing paternal PPD at 6 weeks postpartum.[7]

Treatment of paternal PPD

Specific treatment for paternal PPD has not been studied extensively. Psychotherapy

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targeted at interpersonal family relationships and parenting is indicated for mild depression, whereas a combination of psychotherapy and pharmacotherapy is recommended for moderate or severe depression.

Depending on specific patient factors, pharmacotherapy options include selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, and atypical antipsychotics.[8] SSRIs often are used because of their efficacy and relative lack of serious side effects, as demonstrated in numerous trials.[2] Recovery is more likely with combination therapy than monotherapy.[9] Fathers with psychosis or suicidal ideation should be referred for inpatient treatment.

Men with PPD tend to show aggression, irritability, and agitation, and may be hesitant to seek help for emotional issues

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