Toward A Whole Family Perspective on Reproductive Mental Health:
Paternal Postpartum Depression
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"When we were at the hospital, the staff only focused on my wife and daughter - it really felt as if I just wasn't even there. That experience set a difficult tone for the first few months of my life as a father because I became convinced that I didn't have much to contribute and I just kind of withdrew at a time when I had always thought I'd be overjoyed." "Joaquín," a former patient, who gave me permission to print this text, conveyed these words to me in an email several years ago. The older that his then-three month old daughter became, the more that his mood and his relationship with his wife deteriorated. Joaquín felt trapped and had become convinced that the further along into fatherhood he went, the more clearly it would become evident to everyone that he was a failure. He had become very withdrawn, and his wife had contacted a local agency specializing in postpartum health issues. They had referred her to me, and he had contacted me several days later. His wife had literally dialed my number and put the phone into his hand to talk with me.

While he had heard of postpartum depression, Joaquín had understood it to be something that could only happen to mothers – and to be a type of failure only "allowed" for women. Although he entered treatment believing that he was useless and destined to fail his infant daughter as well as his wife, he quickly came to understand how his paternal postpartum depression (PPPD) was ~~be~~ rooted in biological, psychological, and social factors. Within four months of treatment consisting of a blend of CBT and Acceptance and Commitment Therapy in both individual as well as couples sessions, he turned his life around. He came to see the transition to his new role as father – and partner to his wife/new mom – as a solid foundation of his own identity and that of his newly-expanded family. The day that Joaquín terminated, he showed up to the session with his beautiful gurgling daughter in a Baby Björn along with a well-stocked "man baby bag," and a beaming smile. "I've got this now, doc," he said, "and even though I'm being mindful to appreciate her as she is now, I'm excited to keep learning about how I can play a positive role in her life as she grows up and we connect even more." While the cultural dynamics and the specifics of his family's situation were unique, Joaquín's struggle with depression – and total lack of understanding about what was happening early on - are unfortunately all too common. It bears noting that while there are a wide variety of family constellations (e.g., "dual dad" couples) which involve new fathers adjusting to parenthood; this article focuses narrowly on PPPD in male-female dyads.

While prevalence rates of paternal postpartum depression (PPPD) in the United States are cited in the scholarly literature as varying between 4-25% of all new/expectant fathers (4% at 8 weeks, and 25.5% at 4 weeks; Soliday, McCluskey-Fawcett & O'Brien, 1999), the most commonly cited figure is that one in ten of all fathers experience symptoms rising to the threshold of a major depressive episode at some point in the 18 months spanning from the second trimester through one year postpartum (Don & Mickelson, 2012). With nearly four million babies born in the U.S. each year, it's a reasonable estimate that 400,000 fathers suffer from PPPD each year – and most have no idea that it even exists. Similarly, many mental health providers are unfamiliar with the growing body of evidence which supports the idea that postpartum issues are very much a men's issue.

From a diagnostic perspective, postpartum depression is a "post-partum onset" subtype or specifier that describes an episode of a mood disorder such as Bipolar, Dysthymic, or Major Depressive Disorder which

occurs within four weeks of birth. Other postpartum disorders include Anxiety, Obsessive Compulsive Disorder, and Psychosis – but anxiety and depression are most common for men as well as women. However, for the same reason that the medical personnel who Joaquín felt ignored him in the hospital hadn't known to actively engage him in his newborn daughter's life, many therapists have never considered the nuances, risk factors or treatment of PPPD. Even more problematic is that many clinicians share a tacit assumption that parenting a newborn is best left to mothers and that the father's role is simply to support the mother. However, a wealth of research – largely being conducted internationally and outside of psychology by investigators in the fields of nursing, social work, and midwifery – is clarifying the specific positive outcomes related to having fathers highly engaged with their infants and partners prior to and immediately after birth. In a nutshell, the trick is to meet men where they are and to give them clear guidance about what to do.

One critical shortcoming of the existing prevalence data collected through epidemiological as well as rigorously-controlled clinical research studies involves the DSM-IV-TR criterion stipulating that PPPD symptoms must manifest within four weeks after birth. Most men's symptoms tend to take considerably longer to develop than do women's, and may even begin prior to the birth (Matthey, Barnett, Ungerer, & Waters, 2000). This line of research shows that fathers and infants bond slowly over the first two months, with fathers reporting having a tougher time than mothers in terms of feeling emotionally bonded to their babies. This normal bonding process – when contrasted with the more rapid development of the mother-infant bond – may account for fathers feeling particularly "useless" or helpless during this initial postpartum period.

The course of PPPD also appears to develop over a longer period of time than maternal PPD. Longitudinal studies indicate that rates of PPPD decrease immediately after the birth, but then increase during the first year postpartum. For this reason, prevalence data in studies using a strict 4-week timeline as per the DSM-IV-TR guidelines fail to capture the nature of the disorder. Similarly, most scales of postpartum depression were normed on women, but researchers apply their scoring criteria to men anyway. A few scales such as the Edinborough Postnatal Depression Scale have been shown to be reliable and valid with men (Heim et al, 2000). Studies addressing the psychometrics of these self-report scales have resulted in revised scoring norms for males which account for the need to decrease the cutoff score for men relative to women due to their tendency to manifest postpartum depression somewhat differently than women. The need to revisit how to assess PPPD parallels the need for clinicians to understand how to work most effectively with the men who experience it.

Yet another issue is that men tend to experience and express postpartum depression somewhat differently than women do. While a sad/depressed mood ~~or loss~~ or a loss of pleasure in daily activities for two weeks are necessary to a diagnosis of depression, paternal postpartum depression is often characterized by irritability, frustration, jealousy, and fatigue along with behaviors including social isolation, insomnia, overworking, substance abuse, spousal abuse – and even abuse of the infant in extreme cases. Partners and clinicians alike may have a feminized perspective on depression which manifests as predominantly sad mood with accompanying tearful expression, so making sense of the withdrawn, even angry behavior of the new father can be a challenge. Add to this mixture the tendency of men to have difficulty accessing – let alone naming and communicating - their feelings to a partner who is likely experiencing her own adjustment stress, and you get a perfect storm to keep PPPD off radar.

The most commonly-cited negative outcomes of PPPD on family include (Kim & Swain, 2007):

- Insecure attachment

- Child's emotional problems
- Child's behavioral issues – especially conduct problems and hyperactivity
- Increased parental conflict
- Decreased parental support
- Decreased parental relationship satisfaction

Fortunately, there are also well-documented positive outcomes for the child, partner, and the father himself which are shown to be a direct result of him being actively engaged with the infant as well as his partner (Gottman, 2006):

- Improved emotional regulation
- Increased empathy
- Higher verbal abilities
- Higher IQ test scores
- Superior academic performance

Taken together, the above outcomes indicate that parenting of a newborn is not "really just mothering," and suggest that clinicians need to work to keep new fathers directly involved with their infants from day one.

The causes of PPPD dovetail with common risk factors associated with depression in men, but the predictor which has been shown to correlate most highly with PPPD is maternal postpartum depression (Don & Mickelson, 2012). Clearly, the mother's own mental health and the status of the relationship play a predominant role in the development, expression, and resolution of PPPD. Other common risk Factors for PPPD include a paternal history of depression, history of mental health issues; other comorbid psychiatric problems; lack of support – inside the relationship and outside; and men's socialization to think of themselves as earners rather than care providers.

One factor which contributes to paternal involvement with their infants is the common media stereotype of the "bumbling" – or even completely absent – dad. Movies, books, and websites often convey fathers as being inept when it comes to caring for an infant, and ongoing exposure to these messages represents a type of vicarious learning that can drive down a father's sense of self-efficacy and therefore the likelihood that he will be highly involved with his baby (Coltrane, 1994; Parke & Brott, 1999). While it's fine to have a laugh at dad's expense, it is very important to help them to understand how this common stereotype can subtly impact their parenting style.

Another key consideration regarding how men adjust to new fatherhood involves their physiological changes. While the phenomenon of "sympathetic weight gain" in fathers during pregnancy is well-known, the changes in fathers' hormone levels during pregnancy and in the postpartum period receive much less press in the scholarly literature and popular media. There is a wealth of information regarding how women's perinatal and postpartum hormonal changes relate to depression, however there isn't much information regarding how men's hormonal changes may relate to mood dysregulation postpartum. Typical hormonal changes in fathers include:

- Decrease in testosterone during pregnancy and postpartum – leads to lower aggression, increased concentration, and stronger attachment.
- Estrogen level increases during the last month antenatal through early postpartum – may enhance parenting behaviors by having the father be more involved.
- Elevated cortisol levels in women correlate to higher sensitivity to infant, but it's unclear if this would generalize to fathers.

- Prolactin – key for developing and maintaining parental caregiving behaviors – in men rises steadily through the third trimester through the end of the first year of a baby's life.

Imbalances in any – or all – of these normal hormonal changes in men may relate to difficulty in adjusting to parenthood and the development of paternal PPPD. While there is no research directly supporting how hormonal factors contribute to PPPD, more research regarding men's neurohormonal systems is clearly needed.

New dads are part of a biopsychosocial system which starts between their ears, expands out to include mom and baby, and on into to the larger social context. In order to work most effectively with new fathers experiencing postpartum issues, psychologists need to move toward a whole family wellness perspective in reproductive mental health. Joaquín's experience is all-too-common, so it is critical to keep men front-and-center when working with anyone experiencing postpartum issue.

Pediatricians are in the best position to catch PPPD due to the sheer volume of patients they see, but they rarely screen them for depression or consider how paternal mental health affects the pregnancy and birth. For this reason, mental health and medical professionals need to develop greater awareness of risk factors and men's experience of PPPD in order to increase prevention and earlier intervention. In the same way, moms and dads need to be aware that post-partum issues are very much a men's issue and that the prospect of seeking help tends to be very difficult for men because they aren't socialized to deal with their feelings or to readily accept help. I will often couch getting therapy as a key way that new fathers are taking care of their family – by starting with themselves.

The strong correlations between maternal and paternal PPD suggests that getting support from their partner/spouse is the most likely way to prevent and intervene with PPPD. In particular, giving fathers clear input and encouragement about being involved during pregnancy as well as in the immediate postpartum period helps them to clearly see how to be directly involved with their baby. Sharing the parenting roles as much as possible and allowing new dads time alone with the infant are key in fostering self-efficacy and attachment bonds while decreasing jealousy, isolation, and concerns about bonding and role changes. Another key consideration is that both mom and dad both need "me" time to recharge. New dads might not have much practice in setting up times to hang out with friends, so helping them to do so – and to feel good about it – is good for the whole family.

Finally, I regularly include online "e-djunct therapy" in the lineup of at-home assignments when working with fathers who have PPPD. New dads are tasked to actively seek out movies, books, blogs – and live examples – of fathers being very effective and engaged in their infant's life. The Internet abounds with opportunities for "Dad 2.0" to connect with other like-minded dads, and a common resource I use to connect new dads is Daddit, the father-oriented section of the popular social media site Reddit (check it out at www.reddit.com/r/daddit). Giving new fathers a way to connect and support each other is hugely beneficial in helping them to navigate the transition to new fatherhood, and my clients with PPPD have universally indicated that connecting with other dads in the same situation has helped them to rebound from their anxiety and depression.

A whole family wellness approach to reproductive health means giving equal importance to both partners as well as to their baby. While there is a long way to go in terms of shifting media and policy perspectives related to paternal postpartum health, psychologists are in a position to make important advances in research, clinical work, advocacy, and theory regarding men's experience during the transition to fatherhood. As a scientist-practitioner passionately involved in this area, I am currently

working with several colleagues to develop a self-report paternal involvement scale to measure how extensively fathers are involved in their infant's care. Developing this scale is a key step toward the larger goal of clarifying a social cognitive model addressing how key factors such as support, self-efficacy, and paternal involvement with baby as well as partners relate to key outcomes such as fathers' parenting satisfaction and relationship satisfaction. I see this work as an important step toward developing an empirical basis fleshing out specific ways that fathers factor into their new family system. From a strictly biological standpoint, any time you are working with a new or expecting mother, there's a father involved somewhere – so be sure to keep him on radar to get the whole picture of the newly-expanding family.

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References

Coltrane, S. (2004). Research on household labor: Modeling and measuring the social embeddedness of routine work. *Journal of Marriage and Family, 62*, 1208-1233.

Don, B. P. Mickelson, K. D. (2012). Paternal postpartum depression: The role of maternal postpartum depression, spousal support, and relationship satisfaction. *Couple and Family Psychology: Research and Practice.* Advance online publication. Doi: 10.1037/a0029148.

Heim, C., Newport, D. J., & Heit, S. (2000). Pituitary-adrenal and autonomic responses to stress in women after sexual and physical abuse in childhood. *Journal of the American Medical Association, 5*, 592-597.

Kim, P. & Swain, J. E. (2007). Sad dads: Paternal postpartum depression. *Psychiatry, 36-47.*

Matthey, S., Barnett, M. S., Ungerer, B., & Waters, B. (2000). Paternal and maternal depressed mood during the transition to fatherhood. *Journal of Affect Disorders, 60*, 75-85.

Parke, R. D., & Brott, A. A. (1999). *Throwaway dads: The myths and barriers that keep men from being the fathers they want to be*. Hougton Mifflin, New York.

Soliday, E., McClusky-Fawcett, K., & O'Brien, M. (1999). Postpartum affect and depressive symptoms in mothers and fathers. *American Journal of Orthopsychiatry, 69*, 30-38.