A Case Report: Peripartum Onset of Major Depressive Disorder for Father

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Abstract.
Background: Depression symptoms in parents during the pregnancy-to-postpartum period significantly impact their child's cognitive, social, and behavioural development.[1] Major depression with peripartum onset refers to depression occurring during the antepartum and postpartum period, up to 4 weeks after delivery. Interestingly, paternal depression often requires a more extended recovery than the maternal aspect. Prenatal and postpartum depression in a father can result in suffering, impaired functioning, and reduced quality of life.

Case Report: This report focused on a 22-year-old married male who had recently become a father to a newborn. The patient had experienced symptoms such as difficulty sleeping, persistent fatigue, feelings of loneliness, guilt, worthlessness, and depression. This individual tended to isolate himself, withdraw from his surroundings, have a reduced appetite, and lose interest in previously enjoyed activities. He initially experienced these symptoms during his wife's first pregnancy when the child was three months old, but he ignored them. However, these symptoms consistently resurfaced over the past four months following the birth of their first child. The patient had no history of psychiatric issues and abstained from illegal drugs, alcohol, and cigarettes.

Conclusion: Major depression with peripartum onset in a father is a significant mental health condition that can occur during the period surrounding childbirth. It is distinguished by chronic sorrow, decreased interest during activities, disturbances in eating and sleeping habits, and feelings of worthlessness or guilt. Timely intervention and treatment are essential for the recovery of a father and to minimize any negative impact on the family's well-being.

Keywords: *Major depressive disorder, Peripartum onset, Father*

M. M. Amin et al. (eds.), *Proceedings of the 6th International Conference on Neuroscience, Neurology and Psychiatry (ICONAP 2023)*, Advances in Health Sciences Research 71,
https://doi.org/10.2991/978-94-6463-310-8_11

Introduction

Peripartum Depression is a kind of severe depression that is characterized by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders V* (DSM V). It pertains explicitly to depression occurring during the antepartum and postpartum period, up to 4 weeks after childbirth. Recommendations propose extending the diagnostic criteria to cover the entire 6-month period following delivery due to the heightened risk of depression. Major depression with peripartum onset is characterized by anhedonia lasting a minimum of two weeks, along with at least five symptoms, such as weight loss or reduced appetite, sleeplessness or hypersomnia, irritability, fatigue or exhaustion, overwhelming guilt, diminished concentration, suicidal thoughts.[1]Although postpartum depression is commonly associated with mothers. It can also affect a father. [2]

Prenatal depression in males varies across trimesters, with rates of 9.76%, 13.59%, and 10.12% during the first, second, and third trimesters, respectively. [1] Specifically, about 25% of a father experience postpartum depression. [3] The prevalence of postpartum depression in males within the first month after childbirth is 8.98%, which decreases to 7.82% at three months and then increases to 9.23% at six months. Even after one year, the prevalence can reach 8.75%.[4] In Asian countries, postpartum depression ranges from 26% to 85%, and in Indonesia, it is around 50% to 70%.[5]

Maternal depression, a record of severe depression, and symptoms of depression and anxiety throughout a pregnancy influence depression in males. Physiological changes, including decreased testosterone, cortisol, and prolactin levels, can contribute to depression.[6] Postpartum depression symptoms in a father, occurring one month after birth, are associated with mental health disorders, prenatal psychological stress, low income, and caring for a sick infant. After six months postpartum, depression symptoms in males become linked with prenatal psychological stress, unemployment, and maternal postpartum depression.[7]

Criteria for Major Depressive Episode based on DSM-V [8]

1. a period of two weeks, when at least five of the following nine symptoms occur and indicate a change from previous functioning, it is necessary to consider the situation. At least one of the symptoms is:
    a. Sad mood
    b. Loss of enjoyment or interest
        - A pervasive sad disposition, felt for the majority of nearly every day, is either reported subjectively (e.g., feeling sad, empty, hopeless) or observed by others (e.g., appearing to cry)
        - Loss of enthusiasm or reduced satisfaction from daily activities (according to subjective judgment or remark)
        - • Significant weight loss or weight gain when not dieting (e.g., a change in diet in weight in a month of greater than 5% or a reduction or rise in appetite most days)
        - Almost daily insomnia or hypersomnia
        - Nearly every day, psychomotor agitation or retardation (visible by others, not just subjective feelings of restlessness or being sluggish)
        - Tiredness or energy loss almost every day
        - Excessive or inappropriate Feelings of inadequacy or guilt (which may be delusory) daily (not just self-deprecation or shame for being ill)
        - Reduced almost every day, capacity to thought or focus, or indecision (either by use of their subjective judgment or as viewed by others)
        - Recurrent thoughts of death (not just fear of death), persistent suicidal thoughts without a defined plan, or suicide attempts or a specific strategy to commit suicide

2. The symptoms produce clinically considerable distress or impairment in social, vocational, or other vital areas of functioning.
3. The episode does not result from a substance's immediate physiological effects or other medical conditions.

Risk factors such as strained relationships, limited social aid, legal issues, unintentional pregnancy, immature personality characteristics, and substance addiction can influence depression in a father. Comparatively, overprotective parenting within the father's family can elevate the risk of depression compared to the mother's family. When the mother directs her attention toward the newborn, it can generate feelings of rejection. During the birth of a first child, a father plays a crucial role in adapting to infant care but often experiences inadequacy and withdrawal. Disrupted circadian rhythms from nighttime baby care can reduce sleep duration and contribute to depression.[9]

Males experiencing major depression during the peripartum period can benefit from various treatments. *Selective serotonin reuptake inhibitors* (SSRIs) such as sertraline are the primary choice. Psychotherapy, including *cognitive-behavioral therapy* (CBT) and *interpersonal therapy* (IPT), has effectively alleviated depressive symptoms.[8]

Case Report

A 22-year-old male was brought in by his mother, complaining of difficulty sleeping and persistent fatigue. During the three-month pregnancy of his wife, he initially had these complaints but disregarded them. They resurfaced after the birth of their first child and persisted for about four months. The patient was involved in balancing childcare, household chores, and his responsibilities as a farmer during harvest; he often stayed up late, resulting in extreme exhaustion. Therefore, he admitted to feeling more irritable and sensitive towards his wife.

The patient's ongoing conflicts with his wife resulted in communication difficulties, leading to feelings of loneliness. Additionally, the patient experienced guilt and a sense of inadequacy toward his wife and child due to his perceived inability to provide sufficient support. These challenges significantly impacted his ability to concentrate on daily activities. Furthermore, these emotions persisted consistently throughout the day for about four months.

The patient felt overwhelmed by the pressure of providing for his wife and child and fulfilling his role as a father and husband. This pervasive feeling persisted during the day, causing him to withdraw and become isolated. Previously, the patient regularly attended church but lacked the motivation to go. He also experienced a loss of appetite and disinterest in daily activities, including hobbies he once enjoyed, due to constant fatigue and preoccupation with his problems. After work, the patient preferred seclusion in his room and avoided social interactions. As a result, he became physically weak, losing approximately 5 kg of weight in the past four months. The patient also struggled to fall asleep at night, reducing his overall sleep duration and intensifying his fatigue. These challenges for the past four months have significantly disrupted his work and daily activities.

The patient had no psychiatric disorders or systemic disease history and denied substance use. His general condition and vital signs were normal. The patient current complaints have not been treated with medication. Appropriate emotional expression was observed during the mental status assessment, but his mood was unstable. There were no disturbances in thinking, orientation, perception, memory, abstract thinking, or reality testing. However, there was a noticeable disturbance in concentration. The patient had not experienced hallucinations and had not previously received medication. Based on the described symptoms, he was diagnosed with peripartum onset of major depression.

Discussion

The diagnosis was based on the Guidelines for Classification and Diagnosis of Mental Disorders (PPDGJ III) and the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V). During the interview, the patient reported symptoms consistent with depression, starting when his wife was pregnant and re-emerged in the past four months postpartum. He feels pressure and fears about providing for his family and fulfilling his role as a father. Additional symptoms include loss of interest in hobbies, 5 kg weight loss, difficulty initiating sleep, decreased activity, fatigue, and reduced concentration. These symptoms have persisted for over two weeks, significantly interfering with his work and daily activities. The patient has no psychiatric or systemic illness history and does not use illegal drugs. Based on the diagnostic criteria, he has been diagnosed with major depression with peripartum onset. This diagnosis relies on the patient's depressive symptoms during both the antepartum and postpartum periods, which fulfil the criteria for depression.

Fathers usually experience milder and less distinct depressive symptoms during pregnancy than mothers. These symptoms may involve a general sense of a sad state, restlessness, irritability, lack of interest, difficulty focusing, decreased productivity, social withdrawal, diminished or heightened appetite, reduced sexual desire, and sleeplessness. Clinicians frequently undervalue most of these signs, excluding the depressed mood, regarding them as typical occurrences during the perinatal phase.[10]

The cause of depression of a father remains unclear. Contributing factors include the first pregnancy, socioeconomic circumstances as a farmer, disrupted circadian rhythms, and various physical and psychological influences. In the previous study, Psychosocial characteristics such as lower social support, lower marital satisfaction, financial stress, and more life events were also linked to increased father depression symptoms.[11] A detailed interview is needed to explore additional risk factors such as postpartum depression in the mother, undiagnosed depression or anxiety in the father, social dynamics with the family, and the personality of the father and parenting style.

Currently, there are no approved screening techniques for effectively evaluating affective disorders in males during the prenatal period. During the psychodiagnostic examination, clinicians often utilize self-report questionnaires, sometimes along with individual or couple clinical interviews.[12] The *Gotland Male Depression Scale (GMDS)* is a 13-question screening device for assessing depressive symptoms in males. Each question is scored on a Likert scale of 0-3, with a final score of 39.[13] The patient scored 28, indicating signs of depression and a need for psycho-pharmacological therapy. An SSRI drug, such as sertraline, is the preferred treatment. Monthly evaluations can adjust the medication dosage based on the symptoms and complaints of the patient.

Depressive symptoms can fatigue individuals juggling work and childcare, limiting rest time. Depression, coupled with family withdrawal, significantly hampers child development. The father-child bond shapes stress response and communication. However, paternal depression reduces eye contact and disrupts communication, negatively affecting child development. Research confirmed that the depressed mood of a father fosters a negative temperament in children.[9] Early detection and intervention are both critical crucial. Reducing symptoms of Paternal depression will likely improve parenting abilities such as emotional sensitivity and responsiveness, decrease the likelihood of attachment issues between a father and his child, and strengthen the bonds between first-time parents. Although there is still much to learn about how best to engage fathers and treat paternal peripartum depression, Existing research implies that pharmacologic or psychological interventions are beneficial.[14]

The most effective therapies during the prenatal phase involve audio and video recordings capturing interactions between parents and kids. These recordings encompass Prototypes of video feedback protocols such as Systematic Instruction in Effective and Pleasurable Parenting, intervention with video feedback to foster good parenting, and Child Adult Relationship Experimental (CARE) Index video feedback. These videos are captured and then watched alongside the physiotherapist's input, recommendations, and motivation

to enhance parental sensitivity. This process facilitates adopting a more suitable approach towards the child and the partner. An alternate method involves "conscious parenting," rooted in mindfulness-based interventions. This approach emphasizes being fully present at the moment, accepting without judgment, recognizing emotions, maintaining emotional equilibrium, regulating the parent-child relationship, and cultivating self-compassion and compassion towards one's child.[12],[15]

Conclusion

The peripartum onset of major depression in a father is a significant mental health condition that can impact him before and after childbirth. Contributing factors include first-time pregnancy, socioeconomic circumstances such as farming, disrupted circadian rhythms, and specific physical and psychological factors. A depressed father often has poor interactions, reduced eye contact, and disrupted communication with his children, affecting their development. Early detection and appropriate treatment are crucial for a better prognosis based on trust and rapport between the doctor and the patient. Furthermore, patient compliance with treatment is essential.

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