

Gendered Experiences of PPMD

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Depression and anxiety are known to be common disorders in women in the postnatal period and post adoption period (Foli, South & Lim, 2014; Gawlik et al., 2014). Postpartum Mood Disorders (PPMD) have been described as one of the “most disabling disorders” for women during the perinatal period (O’Hara, 2009, p. 1258) effecting one in five biological mothers, one in four adoptive parents and one in ten dads (Gawlik et al., 2014; Letourneau et al., 2012; Paulson & Brazemore, 2010). Recently, researchers have argued the importance of recognizing the unique aspects of PPMD and Post Adoption Depression (PAD) for fathers as these issues are linked to adverse implications for children, families and parental relationships (Foli, South & Lim, 2014; Gawlik et al., 2014; Goigineri & Newmark, 2010) and result in higher community care costs over the course of time (Edoka, Petrou & Ramchandani, 2011). Paternal depression in the postnatal period has been shown to have independent adverse effects on child development (Edmondson et al., 2010). Additionally, fathers have been shown to have a limited ability to mitigate the effects of maternal depression on children (Goodman, 2008). Overall the issue of PPMD for fathers has received limited attention, and there are currently no programs in Ontario for routine screening or treatment of fathers for depression or anxiety during this postnatal period.

A review of the literature listed in the attached references has revealed three main themes pertaining to male experiences of PPMD and PAD. These include: (1) gender specific stressors and resulting risk factors, (2) gender specific depressive symptoms, (3) tools and measurements for PPMD and PAD in men.

Gender Specific Stressors & Risk Factors

During the transition to parenthood all parents are transforming their relationship(s) within in the family and community (Gawlik et al., 2014). For fathers’ this transformation can bring unique stressors connected to their expectations of themselves and their perception of what society may expect of them (Gawlik et al., 2014; Gogineni & Newmark, 2010). Paternal stress has been shown to relate to paternal dissatisfaction with the couple’s relationship and negative perceptions of parenthood (Goodman, 2008). Psychosocial stressors for men often include: (1) societies expectations; (2) low social support, (3) low self esteem, (4) problem fatigue, (5) increasing family responsibility,

including concern about the future; (6) a focus on financial provision, (7) demands of workplace and, (8) a reduced confidence in the relationship with co parent (Gawlik et al., 2014; Gogineni & Newmark, 2010; Letourneau et al., 2012;; Ramchandani et al., 2011; Yiong Wee et al., 2011). This final stressor, relationship quality, has been identified as one of the most significant challenges facing men in the postpartum period and has been described as one of the strongest risk factors for PPMD and PAD for men (Foli, South & Lim, 2014; Gawlik et al., 2014; Gogineni & Newmark, 2010). Letourneau et al. (2012) have articulated that unresolved relationship issues may be a better predictor of poor child outcomes than maternal depression on its own.

Additionally, a father may end up as caregiver when their partner is ill, this contributes to the problem fatigue and increased family responsibility. There is a 24-50% risk that fathers will experience symptoms when a partner is also ill (Letourneau et al., 2012). The persistence of unrecognized or untreated maternal PPMD or PAD can increase paternal stress and the possibility of symptoms in the father. Fathers have reported feeling isolated, overwhelmed, stigmatized, confused and concerned for their spouse/ partner (Goodman, 2008).

Gender Specific Symptoms

The relationship between parental stress and depressive symptoms is evident for both men and women (Mothander & Moe, 2010). The gender differences lie in timing of the illness and the resulting symptoms or behaviors. Women and men experience feelings of anxiety and depression at different times during the perinatal period. Women are more likely to have higher anxiety than men in the 3rd trimester and around childbirth. Men are more likely to have higher anxiety at 3 months postpartum (Figueiredo & Conde, 2011). Men are more likely than women to engage in destructive behaviors such as the use of alcohol, drugs, have angry outbursts or take unnecessary risks such as reckless driving or extramarital relationships (Gogineni & Newmark, 2010).

Tools and Measurements for PPMD and PAD in Fathers

The Edinburg Post Natal Depression Screen has been shown to have reasonable sensitivity and specificity when utilized with fathers (Edmondson et al., 2010).

Researchers have recommended using a cut off of 5, 8 or 10 or more for paternal depression and anxiety (Edmondson et al., 2010; Figueiredo & Conde, 2011; Gawlik et al., 2014). Some researchers have used a combination of the EPDS and other scales, such as the State/Trait Anxiety Inventory (STAI) and the Parenting Stress Index (PSI-SF), the Dyadic Adjustment Scale (DAS) and the Beck Depression Inventory, and the CES-D to detect paternal depression or anxiety (Gawlik et al., 2014; Goodman, 2008; Mothander & Moe, 2010; Paulson & Brazemore, 2010; Ramchandani et al., 2011)

Conclusion

Best practice suggests that fathers should be screened for PPMD and PAD if a mother has an EPDS score of 12 or more (Letourneau et al., 2012). Paulson and Brazemore (2010) have recommended a screening rubric where depression in one parent would prompt clinical attention for the other parent. Considering the risk factors and the economic cost of paternal PPMD and PAD it can be concluded that a holistic family focused approach, where individual relationship issues are addressed, may be the most effective and cost sensitive method of treating families (Edoka, Petrou & Ramchandani, 2011; Gogineni & Newmark, 2010; Goodman, 2008; Letourneau et al., 2012; Luoma et al., 2013; Paulson & Brazemore, 2010).

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