For some years now, it has been recognised that men can also suffer from depression related to becoming a parent.¹ This disorder, usually called postnatal depression, was previously regarded as something only women could suffer from and has been linked to female biological functions, hormones and the bodily process of giving birth. The phenomenon has also been linked to motherhood per se. Usually, however, postnatal/postpartum depression in mothers is now defined as a measurable non-psychotic mental disorder linked to the adjustment of becoming a parent and building attachment with an infant.

Perinatal depression, as measured by the Edinburgh Postnatal Depression Scale (EPDS)(see Table 1), affects 10–14% of women.² This mental disturbance in women and men has usually been observed after birth, which is why it is often referred to as postnatal or postpartum depression. Several recent studies³ have discovered that it is possible to detect these afflictions in both men and women as early as during pregnancy, which is why the term perinatal depression is used here.

Because perinatal depression arises from having to adjust to the onset of parenthood, men can also be affected by this disturbance, of course, which is an important new perspective that has emerged in contemporary approaches to fatherhood. Increasing numbers of men attending the births of their children and participating in the child-rearing process may enhance men’s awareness of the mental and emotional wellbeing of their family and themselves. This may also sensitise men and heighten their awareness of their own physical and mental health – not least their perinatal mental health – and prompt them to seek help.

Furthermore, the importance of raising an awareness of men’s perinatal depression has been emphasised by research that has found paternal depression also has a specific, detrimental effect on the early behavioural and emotional development of children.⁵,⁶,⁷

Table 1. Short versions of the screening instruments used for diagnosing paternal perinatal depression. Edinburgh Postnatal Depression Scale (EPDS)

<table>
<thead>
<tr>
<th>EPDS² ('traditional' depression)</th>
<th>The Gotland scale³ ('male' depression)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Unable to laugh or see funny side of things</td>
<td>• Lower stress threshold/more stressed</td>
</tr>
<tr>
<td>• Cannot look forward with enjoyment to things</td>
<td>• Aggressive, acting out, difficulty with self-control</td>
</tr>
<tr>
<td>• Blamed myself unnecessarily when things went wrong</td>
<td>• Burnout and emptiness</td>
</tr>
<tr>
<td>• Have been anxious or worried for no good reason</td>
<td>• Unexplainable fatigue</td>
</tr>
<tr>
<td>• Have felt scared or panicky for no good reason</td>
<td>• Irritable, restless and frustrated</td>
</tr>
<tr>
<td>• Felt things have been getting on top of me</td>
<td>• Difficulty in making everyday decisions</td>
</tr>
<tr>
<td>• Have been so unhappy that I have had difficulty sleeping</td>
<td>• Sleeping problems too much/too little/restless/difficulty in falling asleep/waking early</td>
</tr>
<tr>
<td>• Have felt sad or miserable</td>
<td>• Feelings of unrest/anxiety/discomfort, especially in the morning</td>
</tr>
<tr>
<td>• Cried because I was unhappy</td>
<td>• Excessive consumption of alcohol and pills and/or hyperactive/works hard and is restless, jogs, etc</td>
</tr>
<tr>
<td>• Had thoughts of hurting myself</td>
<td>• Behavior changed so you are difficult to deal with</td>
</tr>
<tr>
<td>• Lower stress threshold/more stressed</td>
<td>• Feel yourself or others regard you as gloomy, negative</td>
</tr>
<tr>
<td>• Aggressive, acting out, difficulty with self-control</td>
<td>• Feel yourself or others see you as self-pitying, complaining</td>
</tr>
<tr>
<td>• Burnout and emptiness</td>
<td>• Family tendencies to abuse, depression, suicide</td>
</tr>
</tbody>
</table>

Prevalence of perinatal depression in men
Meta-analyses of studies⁸ report rates of 7–10% of men suffering from perinatal mood disorders. To determine whether these studies detect all men who are afflicted with
this disorder, it is important to explore whether the assessment instruments used are suitable for all men.

Recently, several studies claimed that men might exhibit different symptoms of depression and other mental disturbances than women and, thus, different symptoms of perinatal depression. Men often exhibit symptoms that are not usually connected with depression or psychological disorders at all. Depression is usually defined as a passive, inward reaction with elements of self-criticism and feelings of guilt. However, studies have shown that bouts of anger, affective rigidity, self-criticism and substance abuse are symptoms often seen in men suffering from depression. From the Gotland Study, Rutz et al. suggest the existence of male-specific symptoms. This research led to the development of the Gotland Male Depression Scale (GMDS) (see Table 1), which lists some of the symptoms or states of mind more often seen in men that are quite different from those traditionally associated with depression, such as:

- acting out, aggressiveness
- low impulse control
- anger attacks
- irritability
- tendency to blame others and to be implacable
- low stress threshold
- restlessness
- risky, socially unacceptable behaviour
- substance abuse, especially alcohol.

Other researchers in the field have focused on additional specific reactions and state-patterns (see Box 1) that, together with those mentioned above from the Gotland Study, are seen more often in men than in women. These include:

- withdrawal from relationships
- over-involvement with work
- denial of pain
- rigid demands for autonomy.

When such states as ‘acting-out’, substance abuse and/or withdrawal symptoms are predominant, a man’s suffering is not identified in many instances and, therefore, their depression remains untreated.

### The Copenhagen studies

To determine whether it is necessary to include such ‘male-specific’ symptoms in order to detect all men with this disorder, the Fatherhood Research Programme in Copenhagen conducted a screening programme that included both the traditional symptoms of depression and the male-specific symptoms.

The screening instruments used were the EPDS and the GMDS, which both parents were requested to fill in. The screening programme was run in 22 municipalities and at 30 GPs, including a total of 7757 screenings of men (42%) and women (58%) during the period from four months before the birth of their child until two months after the birth.

The study found that among parents-to-be, 11% of the women and 8% of the men risked suffering from perinatal depression, while among parents two months after the birth of their child, 8% of mothers and 6% of the fathers were at risk.

Furthermore, the study showed that 23.5%, almost one-quarter, of the men included were identified as suffering from depression only when the ‘male-specific’ depression-symptom scales were used.

### Treatment of men with perinatal depression

There is not currently any national UK guidance relating specifically to the treatment of depression in men during the perinatal period. Instead, the NICE guideline for the treatment of adult depression is a useful guide to follow in the majority of cases; which would include exercise, dietary change and scheduling of activities in mild cases of paternal perinatal depression; and psychological and pharmacological treatments as alternatives (or together) in more severe cases.

However, the treatment of paternal perinatal depression should first approach this suffering as a relational disturbance that is rooted in the father’s own upbringing, constituting itself in relations as a parenthood disturbance that also influences their partner and relations in future, namely by having impact on the child’s development. As a result, counselling and psychotherapy is recommended as first choice of treatment, and this can be as individual, group or family therapy.

In addition, therapy should engage with ‘male specific’ mental states, because many men in their upbringing – and in the cultural and societal expectations of masculinity – are confronted with and have psychologically internalised an ambivalence between autonomy and freedom on the one hand, and closeness and attachment on the other. This ambivalence becomes sharpened in male mental states during the process of being a parent, and it is a vital issue in perinatal depression in men. This is often displayed in a man’s tendency to withdraw himself from relationships in the hope that he will find relief in distancing himself from close family. It also appears in many men’s wanting to get away from agony, sometimes by alcohol abuse, irrational actions, etc. Finally, this also appears in some men’s tendencies to act out in angry outbursts, violence, or different abuse.

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**Box 1. Special issues in treatment for men with perinatal depression**

- Withdrawal from close relationships
- Anger and acting out states of mind
- Tendencies to quickly get away from agony
- Ambivalence between autonomy and closeness
Besides the mainstream psychotherapy that builds upon psychodynamic, mentalising, narrative, or cognitive methods it is useful to also include the above mentioned topics in a treatment model suited for men with perinatal depression.

Discussion
Research seems to support the claim that there are gender-related differences in the symptoms of perinatal depression, and that it is necessary to include ‘male-specific’ symptoms in detecting men with perinatal depression and probably also other forms of depression. Nearly one-quarter of the fathers at risk of perinatal depression are only detected if the GMDS is included in the screening instrument. At the same time, it is important to mention that some, but significantly fewer, women also display ‘male-specific’ symptoms and some mothers, but fewer with perinatal depression, are detected only when ‘male-specific’ symptoms are included.

These results might be important in efforts to reduce under-diagnosing and thereby under-treatment of poor mental health in men. Fathers’ perinatal depression account for a pronounced part of the undetected mental problems in men. By using adequate assessment tools deemed suitable for diagnosing male-specific symptoms, more men with mental health problems will be detected and hopefully get treated.

Conclusion
Heightening awareness and honing skills to detect men with mood disorders related to parenthood will require training of healthcare staff at maternity wards. The professionals in these wards need to become sensitive to gender-related conditions and the psychological state of fathers in order to identify and help those suffering from perinatal depression. There is a need to improve our understanding of gendered dimensions to mental health disorders, the provision of mental health services and the behaviour of the men themselves. There is also a need to develop treatment approaches that target men more specifically.

Creating good physical and emotional conditions for a father’s participation in preparation, delivery and life with a newborn child can be an important way to strengthen father-infant attachment and thus increase a father’s general participation in child-rearing and sharing responsibility with the mother. The whole family will benefit from this.

Declaration of interests: none declared

References