

Paternal postpartum depression: How can nurses begin to help?

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ABSTRACT

Men's emotional health can be overlooked during their partner's pregnancy and throughout the first postpartum year. Postpartum depression, once expected only in new mothers, is now estimated to occur in 4–25% of new fathers as well. The incidence of paternal postpartum depression is greater in couples where maternal postpartum depression is also present. Paternal postpartum depression can be difficult to assess. New fathers may seem more angry and anxious than sad. And yet, depression is present. When left untreated, paternal postpartum depression limits men's capacity to provide emotional support to their partners and children. This article reviews the incidence and prevalence of paternal postpartum depression, comments on tools to measure the disorder, identifies paternal behaviors that may indicate depression, examines the effects of parental depression on families and discusses what nurses can do to begin to help.

KEYWORDS: nursing; paternal postpartum depression; sad dads; parental depression

INTRODUCTION

Traditionally, postpartum depression has been construed as a disorder of women. However, as many as one in four new fathers may also experience devastating depression following the birth of their new baby (Goodman, 2004; Madsen & Juhl, 2007; Paulson, Dauber, & Leiferman, 2006; Pinheiro et al., 2006; Ramchandani, Stein, Evans, & O'Connor, 2005). Adjusting to an infant impacts new fathers as well as new mothers. This article will review the incidence and prevalence of paternal postpartum depression, comment on tools to measure the disorder, identify paternal behaviors that may indicate depression, examine the effects of parental depression on families and discuss what nurses can do to begin to help.

INCIDENCE AND PREVALENCE OF PATERNAL POSTPARTUM DEPRESSION

The incidence or number of new cases of postpartum depression in men may be nearly half

as high as the percentage known to be occurring in women. Goodman's (2004) literature review spanned publications from 1980–2002 and was seminal in identifying that an increasing number of cases of paternal postpartum depression have been identified during the past few decades. During this period of time, a variety of different tools were used to determine that the incidence of paternal depression during the first year after childbirth ranged from 1.2–25.5% in community samples, and from 24–50% among men whose partners were experiencing postpartum depression. Maternal depression was identified as the strongest predictor of paternal depression during the postpartum period (Goodman, 2004).

The prevalence, or number of cases of a condition present in a population, continues to illustrate how a significant number of families remain affected. In England, Ramchandani et al. (2005) found that depressive symptoms were present in 10% of mothers and 4% of fathers 8 weeks

after childbirth. Ramchandani et al. (2005) used the Edinburgh Postnatal Depression Scale to measure depression. Initially developed for assessing maternal postpartum depression (Cox, Holden, & Sagovsky, 1987), the tool is increasingly being used with new fathers (Cox, 2005; Matthey, Barnett, Kavanagh, & Howie, 2001; Matthey, Barnett, Ungerer, & Waters, 2000).

In the US, Paulson et al. (2006) used a short form of the Centre for Epidemiologic Studies Depression Scale as a measurement instrument (Radloff, 1977). Paulson et al. (2006) concluded that 14% of mothers and 10% of fathers had moderate or severe depressive symptoms 9 months after childbirth.

In Brazil, Pinheiro et al. (2006) used an instrument for alcohol misuse, the Alcohol Use Disorders Identification Test AUDIT (Saunders, Aasland, Babor, De la Fuente, & Grant, 1993), and the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Pinheiro et al. (2006) determined that 26.3% of mothers and 11.9% of fathers scored above the threshold for depression 6–12 weeks after childbirth. They posited that paternal depression is significantly more prevalent when the woman is also depressed affecting up to 40% of men within that population.

In Denmark, Madsen and Juhl (2007) used the Edinburgh Postnatal Depression Scale and the Gotland Male Depression Scale (Zierau, Bille, Rutz, & Bech, 2002). The Edinburgh Postnatal Depression Scale established a paternal postpartum depression prevalence of 5.0% and the Gotland Male Depression Scale one of 3.4%. Results from an analysis combining the scales revealed that 7% of fathers were suffering from postpartum depression 6 weeks after childbirth. While Madsen and Juhl (2007) acknowledged that the Edinburgh Postnatal Depression Scale had been validated for men, they questioned whether the scale was sensitive to the unique symptoms of depression that men experience. The Gotland Male Depression Scale however, was specifically developed to improve the recognition of major

depression in males (Zierau et al., 2002). By using the two different scales, Madsen and Juhl (2007) included masculine appropriate manifestation of depression in their measurement.

In Australia, Bria, Pincombe, and Fedoruk's (2006) review of the incidence of paternal postpartum depression revealed that significant indicators exist to suggest that some fathers find pregnancy and the postnatal experience to be overwhelming and stressful. For these men, the added responsibility of providing for their family, adjusting to changes in lifestyle and experiencing role confusion were factors that contributed to a less than positive transition to fatherhood.

TOOLS TO MEASURE PATERNAL POSTPARTUM DEPRESSION

As the preceding discussion illustrated, researchers have used a variety of different measurement tools to understand paternal postpartum disorder. Reliable and valid tools such as the Edinburgh Postnatal Depression Scale, a short form of the Centre for Epidemiologic Studies Depression Scale, an instrument for alcohol misuse, the Alcohol Use Disorders Identification Test AUDIT, the Beck Depression Inventory and the Gotland Male Depression Scale all begin to offer insight into how new fathers may be feeling.

Nurses in practice may find some of these tools useful as well. The 10-question Edinburgh Postnatal Depression Scale (Cox et al., 1987) takes about 5 min to use, requires no specialized knowledge, has been used efficiently with new mothers for over two decades (Dennis, 2004; Downie et al., 2003; Eberhard-Gran, Eskild, Tambs, Opjordsmoen, & Samuelsen, 2001; Gibson, McKenzie-McHarg, Shakespeare, Price, & Gray, 2009; Murray & Cox, 1990; Pope, 2000) and is freely available on the internet. However, it is important to note that question nine, '*I have been so unhappy that I have been crying*' can be expected to be less applicable to fathers than to mothers. Testing the scale for reliability and validity with men, Matthey et al. (2001) determined that a significant number of fathers did not endorse crying

as a symptom of depression. These researchers recommended a lower cut-off score for fathers than for mothers.

Controversy over use of the Edinburgh Postnatal Depression Scale with women has centred on uncertainty related to cut-off scores (Cantwell & Smith, 2009). Cox et al. (1987), Cox (1994) and Cox and Holden (2003) identified that women who scored above a threshold of 12/13 were most likely to be suffering from a depressive illness of varying severity and recommended that a threshold of 9/10 might be appropriate if the scale was considered for routine use by primary care workers. Dennis (2004) suggested a cut-off score of over 9 to ensure sensitivity to depressive symptomatology. However, since the scale does not discriminate levels of depression, higher scores can also indicate distress and minor depression, or 'false positive' results. Similarly, lower scores can indicate that depression is not present when severe depression actually is present, or 'false negative' results (Guedeney, Fermanian, & Kumar, 2000). Clinical judgement must always take precedence over scores on any scale (Pope, 2000). Despite this controversy, the Edinburgh Postnatal Depression Scale continues to be used internationally as a screening tool for maternal postpartum depression (Affonso, Horowitz, & Mayberry, 2000; Beck, 2008; British Columbia Reproductive Care Program, 2003; Buist et al., 2002; Gaynes et al., 2005; Horowitz, 2006; Milgrom, Martin, & Negri, 1999 Registered Nurses' Association of Ontario, 2005; Scottish Intercollegiate Guidelines Network, 2002).

The short form of the Centre for Epidemiologic Studies Depression Scale (Radloff, 1977) also takes about 5 min to use, requires no specialized knowledge and is freely available on the internet. However, this scale was developed as a first-stage screening device to assess depression in community surveys in undiagnosed populations and is particularly useful for detecting depression in chronic disease conditions. The questions are not specific to the postpartum experience and a follow up interview is recommended (Rush et al., 2000).

An instrument for alcohol misuse, the Alcohol Use Disorders Identification Test AUDIT was designed to identify hazardous drinkers, or those who are at an early stage in their drinking and have not yet reached a level of harmful alcohol consumption (Saunders et al., 1993). The 10-question AUDIT also requires no specialized knowledge and is freely available on the internet. While the AUDIT is efficient in identifying new fathers at risk for encountering harm as a result of their drinking, and excessive alcohol consumption may be an indicator of paternal depression, the tool does not measure any other symptoms of depression.

The Beck Depression Inventory (Beck et al., 1961) has well established reliability and validity. Originally developed to assess depression in psychiatric settings, the tool has been revised several times since its introduction in 1961. Researchers using the instrument to measure maternal postpartum depression noted that usual aspects of postnatal life, such as lack of sleep, tiredness and weight changes can inflate depression scores and that mild or subclinical depression can be overlooked (Affonso et al., 2000; Milgrom et al., 1999). Specialized training is required and the tool is under copyright with the American Psychological Association so may not be used freely.

The newer Gotland Male Depression Scale (Zierau et al., 2002) uses 10 questions geared specifically towards masculine presentations of depression. Phrases such as 'stressed out,' 'burned out' and 'seeming pathetic to others' are used. The tool requires no specialized training and is freely available on the internet. Although reliability and validity studies are limited and the questions are not specific to the postpartum experience, the Gotland Male Depression Scale may be a valuable resource for nurses.

While tools such as the scales mentioned above begin to shed light on our emerging understanding of paternal postpartum depression, the current state of knowledge about this condition is limited. Scales designed to measure maternal postpartum depression (Edinburgh Postnatal

Depression Scale), depression in chronic conditions (short form of the Centre for Epidemiologic Studies Depression Scale) identify hazardous drinkers (Alcohol Use Disorders Identification Test), depression in psychiatric settings (Beck Depression Inventory) and major depression in males (Gotland Male Depression Scale) may not be appropriate screening instruments for paternal postpartum depression. Traditional scales such as these may be gender biased and neglect important symptoms present in depressed men (Diamond, 2004; Marcus, Young, Kerber, & Korstein, 2005; Salokangas, Vaahtera, Pacriev, Sohlman, & Lehtinen, 2002; Winkler, Pjrek, & Kasper, 2005). However, until measurement instruments are developed with specific psychometric properties for identifying depression in postpartum males, the scales offer nurses important direction for initiating assessment of new fathers.

PATERNAL BEHAVIORS THAT MAY INDICATE DEPRESSION

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) defines maternal postpartum depression as a major depressive episode with onset occurring within 4 weeks of delivery, depressed or sad mood, marked loss of interest in virtually all activities, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, diminished ability to think or concentrate, and recurrent thoughts of death (American Psychiatric Association, 2000). These symptoms as well as other behaviors may be present in depressed new fathers.

The onset of postpartum depression may be more insidious in men than in women. Paternal depression may be evident during pregnancy (Condon, Boyce, & Corkindale, 2004), particularly when spouses are depressed (Field et al., 2006; Morse, Buist, & Durkin, 2000). Coping with their partner's maternal postnatal depression can leave new fathers feeling overwhelmed,

isolated, stigmatized and frustrated (Davey, 2006). While paternal depression may decrease following childbirth, it can also recur and increase over the course of the first year, again, particularly when spouses are depressed (Bielawska-Batorowicz & Kossakowska-Petrychka, 2006; Dudley, Roy, Kelk, & Bernard, 2001; Goodman, 2008; Matthey et al., 2000; Paulson et al., 2006; Pollock, Amankwaa, & Amankwaa, 2005; Wang & Chen, 2005).

Depressed or sad mood may be less apparent in men (Cochran & Rabinowitz, 2000; Condon et al., 2004; Hausmann, Rutz, & Benke, 2008; Kilmartin, 2005; Marcus et al., 2005; Rutz, von Knorring, Pihlgren, Rihmer, & Walinder, 1995). Depressed men often change their social behavior. Withdrawal from social situations, indecisiveness, cynicism, and an irritable mood are identified as hallmark signs of depression in the adult male (Spector, 2006). Avoidance behavior, drinking, drug use, extra-marital affairs and partner violence can also be signs of male depression (Wexler, 2004, 2005). First occurrences of partner violence have been found to occur 2 months postpartum (Hedin, 2000). Men's affect may present more as anxious or angry than sad (Karp, 1996; Winkler et al., 2005). In the absence of consistent assessment criteria, symptoms of paternal postpartum depression can be misconstrued. For example, a new father's irritable mood may be attributed more to infant crying or feeling excluded from the mother-baby bond rather than to a symptom of depression (Kim & Swain, 2007). Similarly, spending extensive time at work away from the family may be perceived as a need to maintain the traditional male role of provider and breadwinner rather than as an avoidance behavior indicative of depression (Bria et al., 2006). Drinking, drug use, fighting, partner violence and extra-marital affairs may also be open to interpretations other than signs of depression. And yet, these behaviors can all reflect a mood of sadness.

Marked loss of interest in virtually all activities in both new mothers and fathers is difficult to

assess. Sleep and appetite disturbances, anergia or lack of energy and weight loss or gain can be misattributed to the normative changes of pregnancy and postpartum that can accompany a 24 h a day commitment to caring for a new baby (Lusskin, Pundiak, & Habib, 2007).

While maternal postpartum hormone changes are well documented, information about paternal hormone changes is less readily available. Kim and Swain (2007) posed five conjectures about paternal hormone fluctuation. First, they noted male testosterone levels decrease during a partner's pregnancy and postpartum period. Testosterone can decrease by as much as 33% during the first 3 weeks after birth (Storey, Walsh, Quinton, & Wynne-Edwards, 2000) and evening testosterone levels were lower in fathers than in controls (Berg & Wynne-Edwards, 2001). In healthy families, this lowered testosterone may be partially responsible for paternal behaviors such as responding with sympathy to babies' cries, establishing strong infant attachment, lower aggression and better concentration in parenting (Fleming, Corter, Stallings, & Steiner, 2002). But, Kim and Swain (2007) emphasize how a significant correlation exists between lower testosterone levels and depression. Second, Kim and Swain (2007) noted that male estrogen levels increase during the last month of a partner's pregnancy and the early postpartum period, a dysregulation not usually experienced. Higher levels of estrogen have been linked to fathers' experiences of couvade syndrome or pregnancy like symptoms such as nausea and weight gain (Storey et al., 2000). Third, Kim and Swain (2007) noted male cortisol levels decrease postpartum. Cortisol regulates physiological responses to stress. However, Berg and Wynne-Edwards (2001) also revealed that cortisol levels in new fathers increase during the week before the birth, and these researchers linked this increase with apprehension preceding the birth, a finding previously noted in male animals. Therefore, when the cortisol levels drop immediately following the birth, new fathers experience a further unusual dysregulation. Fourth, Kim

and Swain (2007) noted that male vasopressin levels decrease postpartum. Vasopressin affects the ability of the prefrontal cortex to plan and organize behavior. Lower vasopressin has been associated with lower male aggression towards other males (Young, 2009). Fifth, they noted that male prolactin levels usually increase during a partner's pregnancy and postpartum (Storey et al., 2000). But, if prolactin levels decrease instead of increase, a new father is prone to negative moods. Further study to substantiate these conjectures is warranted. However, a combination of lifestyle changes, increased estrogen and lower than usual levels of testosterone, cortisol, vasopressin and prolactin can influence paternal postpartum depression.

Assessing paternal postpartum depression is not easy. Nevertheless, it is critical for all nurses who have contact with new fathers to remain open to the notion that new fathers are predisposed to postpartum depression, particularly if their partner is afflicted. Delving deeper into understanding behaviors of withdrawing, indecisiveness, cynicism, avoiding, drinking, using drugs, fighting, partner violence, extra-marital affairs and feelings of heightened irritation will reveal important insights. Asking new fathers candidly if they are feeling depressed, anxious or angry can open the door to further exploration of these emotions. Considering conjectures that hormonal fluctuations can impact new fathers may help explain the condition. Creating opportunities for new fathers to use tools such as the Edinburgh Post Natal Depression Scale and the Gotland Male Depression Scale will also begin to shed light on their experiences.

EFFECTS OF PARENTAL DEPRESSION ON FAMILIES

Parents who are struggling with depression are not able to consistently care for their families. Maternal postpartum depression can significantly impact children's emotional, social and cognitive development (Murray & Cooper, 1997a, 1997b; Murray, Cooper, Wilson, & Romaniuk, 2003).

Mothers with postpartum depression may feel ambivalent, negative or disinterested in their children. Without experiencing bonding and attachment, depressed new mothers become disconnected and have difficulty responding to their infant's cues. Over time the infant becomes less positive in its responses (Feng, Shaw, & Skuban, 2007; Righetta-Veltema, Bousquet, & Manzano, 2003). Children of depressed mothers have been found to be more antisocial, neurotic, having more temper tantrums and being more difficult to control. They were less securely attached to their mothers and showed less sociability and sharing behaviors (Beck, 1998). Maternal postpartum depression can affect children later in their lives as well. Adolescents whose mothers experienced postpartum depression were found to have higher rates of depression themselves (Hammen & Brennan, 2003). They were prone to violent acts, exhibited tendencies towards oppositional and aggressive behaviors, achieved less than optimal academic success, continued to experience cognitive developmental problems, and were prone to having issues with low self-esteem (Johnson & Flake, 2007). Horowitz (2006) identified an overall maternal postpartum depression prevalence rate of 19.7% 2–4 weeks after delivery and called for adapting research-based screening approaches to clinical care. Current literature supports the assumption that paternal depression may exist in many of their partners as well and research-based screening tools for men are becoming available. As the following discussion of the impact paternal postpartum depression can have on families will emphasize, new fathers must also be included in postpartum depression screening initiatives.

When one or both parents are depressed, the couple may view their child somewhat negatively. When mothers are experiencing postpartum depression, both mothers and fathers may describe their child as having a difficult temperament or that the child is 'slow to warm up' (Di Blasio & Ionio, 2005; Edhborg, Seimyr, Lundh, & Widstrom, 2000). When both parents are depressed, they are twice as likely to rate their

children as below average or average and to perceive health problems in their children (LaRosa, Glascoe, & Macias, 2009).

Despite the impact depression has on couples, one well parent may compensate for a depressed parent (Paulson et al., 2006). Responsive care provided by the father can buffer a child from being negatively influenced by maternal depression (Edhborg et al., 2000). Fathers who are able and available to provide social support for their depressed partner appear to predict children's developmental success (Letourneau, Duffett-Leger, & Salmani, 2009).

The negative effects of depression on children are exacerbated when both parents are depressed. Having two depressed parents is associated with worse social and emotional adjustment than having only a depressed mother (Paulson et al., 2006). Having two depressed parents is also associated with undesirable parent health behaviours and fewer positive parent–infant interactions. Maternal and paternal depression each impacts positive parent–child enrichment activities such as reading, playing and singing (Paulson et al., 2006).

Independent of maternal postpartum depression, when new fathers are depressed, the effects on the family can be far-reaching. Fathers with symptoms of depression are twice as likely to have an infant who cries excessively at 2 months of age than fathers who are not depressed (van den Berg et al., 2009). Depression in fathers during the postpartum period was found to double the risk of behavioral and emotional problems in their children at 3 years of age (Ramchandani et al., 2005). Further, paternal postpartum depression in fathers was also significantly associated with psychiatric disorders in their children at 7 years of age, most notably, oppositional-defiant and conduct disorders (Ramchandani et al., 2008). Both of the Ramchandani studies revealed that boys seem particularly vulnerable to the effects of their fathers' depression. Fathers who are in poor mental health may not be able to provide emotional support to their partners and children. They may

not be able to function well at work, compounding the problem by creating financial stress.

Resources for helping depressed new fathers are often limited. Marital difficulties and the stress of responding to a new baby can make it difficult for couples to offer desperately needed support to one another. Healthy fathering role models were not present for many fathers in their own childhood. Social support may be inadequate and discussing emotional concerns may not seem acceptable. While postpartum therapy groups and classes are available for mothers, fathers may not feel welcome. Given the association between paternal postpartum depression and later child psychopathology, nurses have compelling reasons to consider ways to help promote mental health with this vulnerable aggregate.

WHAT CAN NURSES DO TO BEGIN TO HELP?

Few programs exist to address paternal postpartum depression and this gap in services needs to be urgently addressed. Guidelines for assessing new fathers' mental health may not yet be established, even in areas where midwives and other clinicians are directly involved with pregnancy and postpartum care. However, as trusted professionals, nurses from a variety of different practice areas can implement practical approaches to promote paternal mental health. Both professionally and personally, family members turn to nurses for advice when a new baby is expected and then arrives. Nurses in physicians' offices, early childbirth education, obstetrics, pediatrics, healthy child clinics and schools are all well positioned to initiate screening and outreach programs for new fathers, perhaps in conjunction with those already in place for new mothers. Advocating for the inclusion of information about paternal postpartum depression into existing programs will begin to stimulate awareness.

Nurses in other areas of practice can also increase public awareness of paternal postpartum

depression, provide education about agencies that offer counseling and initiate referrals. Nurses interact with grandparents, aunts, uncles, siblings and friends of expectant or new parents at work, socially and in our own families every day.

Increasing public awareness that a disorder exists, that it affects a significant number of families worldwide, that specific symptoms or behaviors can be expected and that there are tools to measure the disorder can be a powerful initial step in promoting mental health. Quantifying a disorder can begin to decrease the stigma that inevitably accompanies alterations in emotional health. Professional literature, such as the studies presented earlier in this paper, can be summarized and shared with interested individuals.

Waiting rooms in any physician's office or health care agency are opportune venues for displaying information about paternal postpartum depression. New mothers and fathers as well as those who are part of their lives can spend hours in wait areas. Similarly, bulletin boards in hospitals, outpatient clinics, community service buildings, day cares, recreation facilities and public libraries are prime locations for health teaching information. Permission to post material may be needed. Classrooms where childbirth education classes, baby care programs and parenting workshops are offered are also appropriate locations.

Online resources geared to the lay public that would be suitable to display in these venues are available on websites such as the Fatherhood Institute at <http://www.fatherhoodinstitute.org/> and Postpartum Men at www.postpartummen.com. The term 'sad dads' has emerged to describe paternal postpartum depression and can be used as a search term. Postpartum websites are beginning to include information for new fathers as well as new mothers. Reviewing these sites and then suggesting relevant links may be useful to those who interact with new parents.

Print resources such as a magazine or newsletter article in a plastic sleeve might be fitting

on a table display with other reading material. Oversize visual resources such as a poster can be impactful. Print resources can be readily constructed by reproducing information from websites. Often mental health agencies publish pamphlets that have no copyright restrictions and are provided free of cost. Print resources that can be carried out and that include specific contact information for counseling services are particularly valuable.

Student nurses attending practicum placements might be interested in creating mental health promotion materials targeting paternal postpartum depression. Students' assignments may invite them to become involved in agency activities and the idea of having their work viewed by members of the public can be appealing.

Tools such as the Edinburgh Postnatal Depression Scale and the Gotland Male Depression Scale can be presented as posters or handouts. Construction simply involves reproducing these self report scales, the instructions for completing them and the primary source citation identifying where they were first published. Once again, including accompanying information specifying contact information for counseling services is important.

Whenever possible, nurses are encouraged to discuss the results of a scale. When depression is present, an individual can be referred for help. In some cases, this may mean initiating the process by calling an agency to make an appointment rather than just making a suggestion to do so. It may mean writing a note to a physician that includes the completed and scored scale. In instances where suicidal thoughts are present and an individual seems to be a danger to himself or others, it may mean 'walking with' him to an agency or even an emergency room for immediate help.

Nurses may be most able to help new fathers devastated by postpartum depression when they plant seeds of awareness that the disorder exists, that the young man is not alone and that help is available. Schumacher, Zubaran, and White

(2008) called for more detailed assessments of fathers during the postpartum period, especially when their partners are also depressed. These detailed assessments must be framed from a deeper understanding of how men can express their feelings and how they feel about seeking help for emotional problems. Spector's (2006) review of fatherhood and depression underscored how therapy is effective when it can be initiated and continued, but research has repeatedly shown that men seek out counseling far less than women. So, sensitive and creative mental health promotion approaches, such as a poster of the Edinburgh Post Natal Depression Scale on a waiting room wall for one new father to fill out, may throw a private and non-threatening lifeline towards counseling to someone who desperately needs it.

CONCLUSION

Paternal postpartum depression is a very real and very serious problem for many new fathers and their families. Men whose partners are depressed are at greater risk and the disorder may be present in as many as 25% of the population. Tools such as the Edinburgh Postnatal Depression Scale and the Gotland Male Depression Scale have been used by researchers from different countries to measure paternal postpartum depression. Nurses can also use these tools efficiently in a variety of different practice settings as screening instruments.

Although the disorder is only now beginning to be defined and measured, sufficient evidence exists to warrant nurses' attention and concern. Paternal postpartum depression may be reflected in behaviors such as withdrawing, expressing irritation, cynicism, drinking, using drugs, fighting, partner violence and extra-marital affairs. New fathers who are depressed may present with symptoms of depression during their partner's pregnancy and throughout the first year postpartum. The presentation can be expected to be more insidious than the sudden onset usually seen in maternal postpartum depression. An affect of anxiety or anger may be more predominant than sadness.

The burden of these symptoms leaves new fathers with limited ability to offer emotional support to their partners and children. In turn, behavioral and emotional problems, even psychiatric disorders such as oppositional-defiant and conduct disorders, have been found to occur significantly more often among children whose fathers were depressed postpartum (Ramchandani et al., 2008).

Nurses can begin to help by implementing everyday strategies to increase public awareness of the disorder. Including information about paternal postpartum depression in existing programs geared to pre-natal and postpartum families is an important foundational step. Creative strategies to build on this foundation include summarizing professional literature and making tools such as the Edinburgh Postnatal Depression Scale and the Gotland Male Depression Scale available as program handouts or posters and pamphlets in wait areas. Other strategies include constructing visual aids from online resources for postpartum men's health and posting them on bulletin boards. Similarly, using print resources from local mental health agencies will offer valuable direction for initiating support and counseling services. Following up with new fathers or their family members about where to go for help with overcoming depression is critical. As nurses continue to learn about paternal postpartum depression and seek out ways to become involved in screening and treatment initiatives, more opportunities to reach out and help will emerge.

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