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Research report

Couple comorbidity and correlates of postnatal depressive symptoms in mothers and fathers in the first two weeks following delivery

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ABSTRACT

Background: Postnatal depression affects a significant number of parents; however, its co-occurrence in mothers and fathers has not been studied extensively. Identifying predictors and correlates of postnatal depressive symptoms can help develop effective interventions.
Methods: Questionnaires on several socio-demographic and psychosocial factors were administered to 276 couples within two weeks after birth. Depressive symptoms in mothers and fathers were assessed using the Edinburgh Postnatal Depression Scale (EPDS). After calculating the correlation coefficient between mothers and fathers' EPDS scores, univariate and multivariate linear regression analyses were performed to identify significant correlates of postnatal depressive symptoms in mothers and fathers.
Results: Prevalence of maternal and paternal postnatal depressive symptoms was 15.9% (EPDS > 12) and 5.4% (EPDS > 10), respectively. There was a moderate positive correlation between mothers and fathers' EPDS scores ($r=.30$, $p<.001$). Multivariate analyses indicated that parental stress was the strongest predictor for maternal and paternal postnatal depressive symptoms. Pregnancy- and birth-related distress and partners' EPDS scores were also associated with depressive symptoms in both parents. Relationship satisfaction was only inversely related with fathers' EPDS scores, while mothers' EPDS scores were additionally associated with critical life events, history of childhood violence, and birth-related physiological complaints.
Limitations: Since information about participation rates (those who declined) is unavailable, we cannot rule out sampling bias. Further, some psychosocial factors were assessed using single items.
Conclusion: Since co-occurrence of depressive symptoms in mothers and fathers is high, developing and evaluating postnatal depression interventions for couples may be beneficial. Interventions to reduce parenting stress may help prevent parental postnatal depression.

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1. Introduction

The transition into parenthood involves major life changes (Pinquart and Teubert, 2010), requiring adaptations that can result in increased vulnerability to mental health problems like depression (Cox et al., 1993; Vesga-López et al., 2008). The mean prevalence rate of postpartum depression in women is considered to range 10–15% in Western countries (Gavin et al., 2005; O'Hara and Swain, 1996; Wisner et al., 2013). However, as Halbreich and Karkun (2006) point out, this estimate of prevalence might not be representative, since there is considerable cross-cultural variation. In their review of 143 studies reporting prevalence of postpartum depression in 40 countries, rates ranged from 0% to over 50%. Beyond cultural influences, the differences in reported prevalence might also be related to study characteristics such as sample selection, time of assessment (O'Hara et al., 1990) or measures of depressive symptoms, with self-report screening questionnaires usually yielding higher prevalence rates than diagnoses with structured interviews. In Germany, Reck et al. (2008) found a 6.1% prevalence for postnatal depressive disorder according to DSM-IV criteria and a prevalence of 8.7% based on EPDS scores (caseness criterion: EPDS scores > 12) within the first three months postpartum in a community sample.

While previous research on postpartum mental health has strongly focused on women, there is growing awareness that men

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can be affected by postpartum depression (Bradley and Slade, 2011; Goodman, 2004; Wynter et al., 2013). Prevalence estimates of paternal postpartum depression vary widely and are often found to be lower than those for mothers (Matthey et al., 2000). A meta-analysis of 43 studies on paternal pre- and postnatal depression found an overall prevalence rate of 10.4% (heterogeneous), with significantly higher post- rather than prenatal rates (Paulson and Bazemore, 2010). Gawlik et al. (2014) recently reported a prevalence of 7.8% for elevated postnatal depressive symptoms in fathers (EPDS cut-off score >9) within 4–6 weeks postpartum in a German community sample.

It is still debated whether depression with pre- and postnatal onset is similar to depression occurring outside this timeframe (O'Hara and McCabe, 2013; Pereira et al., 2014; Riecher-Rössler and Hofecker-Fallahpour, 2003). However, Vliegen et al. (2014) concluded that in studies with community samples, about one third of the mothers who meet postnatal depression criteria and about half of the mothers in clinical samples experienced depression throughout and after the first postnatal year, indicating that although most mothers recover from postnatal depression, it is chronic in a substantial number of women. According to O'Hara and McCabe (2013), depression leads to personal suffering and functional impairment, irrespective of its onset. Within the postpartum period, parents have to care for a young infant and depressive symptoms can have serious implications for early mother–child interactions (Murray and Cooper, 1996) and maternal child care behaviors (Field, 2010). Depressive symptoms in the early postnatal period have been linked to impaired bonding in longitudinal studies (e.g., O'Higgins et al. (2013); Ohoka et al. (2014)). Research also shows that maternal postpartum depression is linked to adverse cognitive and emotional development in children (Avan et al. 2010; Beck, 1998; Fihrer et al., 2009; Murray et al. 2011; Santos et al., 2014; Sutter-Dallay et al., 2011; Verbeek et al., 2012).

Although the impact of paternal postnatal depressive symptoms on child outcomes has previously received less attention, the recent growing body of evidence demonstrates an independent negative impact on child development (Smith et al., 2013). For example, Paulson et al. (2006) found that self-reported depressive symptoms were inversely related with both mothers and fathers' positive parenting activities. In a large population-based longitudinal study, Ramchandani et al. (2005, 2008) found that even after controlling for maternal depressive symptoms and fathers' depressive symptoms occurring outside the postpartum period, elevated postnatal paternal depressive symptoms were associated with adverse emotional and behavioral outcomes in their children.

Furthermore, postnatal depression is also associated with higher community care costs for both mothers (Petrou et al., 2002) and fathers (Edoka et al., 2011). Postnatal depression often remains undetected in primary care settings (Anding et al., 2015; Buist et al., 2007; Coates et al., 2004; Morris-Rush et al., 2003), and therefore prevents the delivery of support and treatment for affected parents. Research on correlates and predictors of postpartum depressive symptoms may contribute to early identification for high-risk parents and help develop effective interventions. To date, several correlates and predictors of postnatal depressive symptoms in mothers and fathers have been identified. For example, Beck (2001) identified the following 13 significant predictors for maternal postpartum depression: prenatal depression and anxiety, self-esteem, child-care stress, life stress, social support, marital relationship, history of depression, infant temperament, maternity blues, marital status, socioeconomic status, and unwanted/unplanned pregnancy. Yim et al. (2015) classified research on psychosocial predictors of postpartum depression into studies on "stress" and "interpersonal factors." The former included episodic stressors like stressful life events and daily hassles; and chronic stressors like parenting stress, perceived stress, and chronic strain. Regarding interpersonal factors, the following were relevant: martial relationship status, social support, relationship quality, relationship conflict and violence, and adult attachment style. Recent studies have also found that childhood abuse is significantly related to postnatal depression in women (Plaza et al., 2012).

The empirical base for correlates and predictors for postnatal depression in fathers is comparatively weaker. In a recent literature review, Wee et al. (2011) found that having a partner with depression, low marital satisfaction, and low social support were the most common correlates of postnatal depression in fathers. However, predictors and correlates for mothers and fathers are seldom concurrently investigated in the same sample.

The co-occurrence of postnatal depression in mothers and fathers has not been studied extensively. Studies reporting depressive symptoms in both parents often find mothers and fathers' depression scores to be correlated (Dudley et al., 2001; Matthey et al., 2000; Paulson and Bazemore, 2010).

Since research has often focused on a limited set of potential predictors and/or correlates, or exclusively on either mothers or fathers, our aim was to investigate correlates and the cross-sectional couple comorbidity of depressive symptoms in mothers and fathers in the early postpartum period. Potential correlates were explored using a multivariate approach and included socio-demographics as well as psychosocial risks such as episodic and chronic stressors, and interpersonal resources like social support and partnership satisfaction.

2. Methods

2.1. Design and sample

A total of 317 mothers (mean age: 28.83 years, $SD=5.22$) and 276 fathers (mean age: 32.18, $SD=6.21$) filled out questionnaires as part of a longitudinal study, designed to investigate the effects of prolonged as opposed to standard midwifery care (for details see Anding et al. (2013) and Anding et al. (2015)). For the purpose of this study, we used questionnaire data from mothers and fathers, assessed within the first two weeks subsequent to delivery (first wave data collection) for a secondary data analysis. This time of assessment was originally chosen to represent a baseline measurement at the beginning of the midwifery postnatal care interval. Data was collected from November 2010 to October 2012 in Bavaria and Rhineland-Palatinate, Germany. Mothers and fathers were recruited by their midwives, who participated in the German Midwife Prevention Study and provided them with oral and written information about the study. Participating midwives were instructed to approach families for study participation according to the inclusion criteria. Inclusion criteria for mothers were being at least 18 years old (full legal age) and having public health insurance (Allgemeine Ortskrankenkassen, AOK) as well as sufficient German language ability to fill out the study questionnaires. Mothers who gave birth to multiples were excluded since multiple births was considered a special situation and a risk factor for greater parental postnatal stress (e.g., Sheard et al. (2007) and Thorpe et al. (1991)). Out of the 240 midwifes who originally registered for study participation, only 104 midwives (mean age: 40.33 years, *SD:* 9.06) finally participated in the study. Since the originally estimated sample size and recruitment rates were not reached, reasons for study drop out were investigated in a subsample of 73 midwifes in the middle of 2011 via short telephone interviews. The main reason for study drop out according to the midwives was that not enough of their clients were insured with the AOK, which was an inclusion criterion for study participation.

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