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PREVENTION OF POSTPARTUM DEPRESSION IN PARTNERS

SPECIALE RAPPORT

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Abstract

Partners can during the transition to parenthood be understood as a system under stress. Focusing on one of the partners is not ideal as partner-related factors are associated with postpartum depression. With postpartum depression being a huge risk for the wellbeing of the partners and the baby, both partners should be included in preventative interventions to ensure best possible outcome for the families.

The aim of this review is to synthesize the literature on preventative interventions targeting postpartum depression on both partners.

Databases were systematically searched to identify both qualitative and quantitative literature describing interventions designed to prevent postnatal depression in both partners. Ten studies met the inclusion criteria. Several themes were identified using a thematic approach, here all articles were concerned with prevalence of postnatal depression and educational interventions. Eight articles mentioned risk factors and predictors, and eight were concerned with protective factors. The variability of the studies makes it impossible and irrelevant to evaluate on overall effectiveness of the interventions. The only general conclusion to be made regarding effectiveness is that none of the interventions has reported or concluded significant effective measures of preventing postpartum depression in both partners. The aim was simply to explore the current status of interventions to prevent postnatal depression amongst partners. The review highlights a need for further research on the development of new interventions aiming to prevent postpartum depression in both partners which are accessible for health professionals to implement – as well as future research on the effectiveness of partner inclusive interventions versus interventions only including one partner.

This thesis also contains an intervention for professionals on prevention on postpartum depression in partners based on the findings in the systematic review. This is an easy to implement step-by-step guide with handout material for the participants.

Additionally, the thesis includes material on strategies for partner prevention for perinatal depression and anxiety, which has been translated and modified to fit the Danish context.

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1. Introductory

Postpartum depression is a huge risk for new families, as it can impact the current and future situation and development of the parents and the baby. Between the first trimester of pregnancy and until one year postpartum up to 23.8% of women and 10.4% of men suffer from depression (Paulson & Bazemore, 2010). Postnatal depression is stigmatizing and for many a taboo as the negative feelings are not appropriate for what is anticipated to be one of the happiest times in one's life. This leads to parents hiding their suffering and symptoms, and they might be reluctant to seeking help. Obviously, professionals have a hard time diagnosing postnatal depression because the lack of help-seeking behavior and unwillingness to disclose their feelings postpartum. The prevalence rates are high, but most likely this is underdiagnosed in practice and many go untreated.

My 9th semester project was a systematic review on interventions for paternal postnatal depression. I was surprised by the interrelatedness between mothers' and fathers' depressive symptomology. If mother is depressed postpartum there is up to 50% risk that the father also suffers from depression (Goodman 2004). Also, I discovered that postpartum depression can be detected in both parents already during pregnancy (Madsen, 2017). Therefore, it is relevant to investigate possible preventative interventions targeting both partners – as this should be the most cost- and resource-effective for society and the families. This leads to the following research question:

"Which preventative interventions for postpartum depression targeting both partners can be identified in the current literature? And how effective are they?"

Unfortunately, in psychology and when it comes to mental illness there is not much focus on preventative efforts as resources are mostly distributed to treatment. Somatic illness is viewed in a different way, where preventative efforts are prioritized as it is commonly known it is cheaper to prevent than to treat. Since this was possibly my last chance to spend one semester on researching something preventative, I wanted to focus my resources on something which I found relevant and useful. Hopefully this could lead to something of value for clinical practice instead of the creation of yet another thesis for the university bank of never downloaded dissertations.

The papers disposition is structured with the review as the theoretical framework creating the foundation for the rest of the material. The thesis consists of three main sections: The

Systematic Review; The Intervention for Professionals; and The Translation of Preventative Guidelines. The discussions are integrated in the three sections to make the paper more reader friendly as the discussions are linked to and relevant for each of the specific topics.

First, the literature is reviewed to identify preventative material for both partners, aiming to answer my research question: *"Which preventative interventions for postpartum depression targeting both partners can be identified in the current literature? And how effective are they?"*. Surprisingly, the material was scare and only few interventions to prevent postnatal depression in both partners existed. Knowing that postnatal depression can be predicted and prevented left me even more interested in the topic.

Secondly, an intervention was created on prevention of postnatal depression in partners as previous Systematic Reviews and this current review identified a need for an intervention for professionals with transparent material which is easy to implement in a clinical setting. The intervention was designed based on the reviewed articles. The product is a practical step-by-step guide to help prevent perinatal depression and anxiety in partners along with hand-outs for the parents. The intervention is made for professionals with different professions and levels as it is not common that psychologists are hired to educate in antenatal sessions; therefore, it is very descriptive and practical. The group of professionals could be midwives; pediatricians; psychologists; or other professionals working with antenatal sessions - as the intervention is suggested to be used as a supplement to the existing antenatal programs.

Third, after becoming aware there are no interventions to prevent postpartum depression in both partners available in Danish, I decided to translate some preventative guidelines from English to Danish. I discussed my research topic with a Danish midwife and she strongly agreed that some educational material based on recent research is much needed to help the soon to be parents and the professionals as they do not have much information to guide them.

1.1 Limitations

The focus in this dissertation is to identify interventions to prevent postnatal depression in both partners - and find out how effective the interventions are. In order to answer these questions an integrative systematic review was found to be the most relevant solution. In order to synthesize; review and to identify relevant literature some limitations has been made by establishing specific exclusion and inclusion criteria in order to synthesize, review and inclusion of relevant literature. For a more detailed description of this process see Addendum 1 *"Search Protocol & Process Description"*

Only academic papers and reports, both qualitative and quantitative which are written in English, Swedish, Norwegian or Danish have been reviewed. The review does not include study protocols; pilot studies; research designs or articles regarding cost-effectiveness of interventions. Interventions are limited to all types of interventions and treatment e.g. therapy and programs aiming to prevent postnatal depression for both partners. The participants in the studies were limited to partners and couples but included same-sex couples and unmarried couples.

The paper does not include other physical or mental issues than peri- and postnatal depression. Also studies with unclear diagnosis, comorbidity, substance use, smoking or concerned with alcohol-, drug- or substance-use, partner violence, infertility, breastfeeding, or specific childbirth outcomes, birth or fertility complications, pre-term infants, adoption, infants with illnesses, birth defects or abnormalities are not included.

Since the review and other literature reviews demonstrated a need for transparent interventions which can be implemented in a clinical setting I decided, that instead of only submitting the systematic review and process and study description as the final academic product, I wanted to utilize the opportunity to of creating what was found missing. Therefore, the next step was to design a preventative intervention for professionals which could be used in practice. The limitation here is time and resources; therefore, the intervention is created based on the interventions and studies reviewed and read by a colleague to help assess the quality and weather the intervention was found easy to implement and transparent. The intervention is not further tested or assessed.

Due to the Covid-19 pandemic there were several limitations to consider. Face-to-face interviews and interventions should be avoided, both from an ethical point of view - but also due to the practical circumstances of antenatal sessions being canceled due to restrictions from the Health Authorities. Other practical limitations due to the pandemic were the closing of libraries and Aalborg University was closed for physical attendance and meetings with supervisors were conducted online.

1.2 Method

The rationale behind making an integrative systematic review can be found in the nature of the research question: "Which preventative interventions for postpartum depression targeting both partners can be identified in the current literature? And how effective are they?". In order to find what exists in the literature it is essential to review this in a systematic way to

ensure that relevant material is identified and included. The reason for including qualitative and quantitative literature is that both types of studies are relevant to answer the research question. Another argument for doing a review is that the evidence hierarchy for academic research place systematic reviews on top as the highest evidence of research.

Since the studies and interventions included in the review were homogenous and incomparable it was not possible to create a meta-analysis.

A reason for choosing a theoretical approach where only literature is treated, was due to the Covid-19 pandemic. This is simply was not the time to meet with expectant or new parents for observations or interviews to instigate the effectiveness of interventions.

The methods used in the three parts of the thesis are briefly described and discussed in the specific sections. The systematic review has a thorough search protocol and process description accounting for all steps of the process for transparency and possible replication (Addendum 1 & 2)

2. A Systematic Review of Preventative Interventions Targeting Postpartum Depression in Both Partners

2.1 Introduction

The transition to parenthood is for many a very stressful life event. This period is critical due to the consequences that peri- and postnatal depression can have for the partners, the infant and the family. It is therefore relevant to focus on preventative efforts targeting both partners.

According to previous reviews, there are potential benefits of partner-inclusive interventions. The review and meta-analysis by Pilkington, Milne, Cairns, Lewis, & Whelan (2015) investigated modifiable partner factors associated with perinatal depression and anxiety, suggesting that including partners is relevant as couple-related factors may reduce the risk of peri- and postnatal anxiety and depression. Other existing reviews were concerned with prevention and treating women's postpartum depression using partner-inclusive interventions (Alves, Martins, Fonseca, Canavarro & Pereira, 2018) and interventions targeting paternal mental health in the perinatal period (Rominov, Pilkington, Giallo & Whelan, 2016). The review by Pilkington, Whelan, & Milne (2015) analyzed peer-reviewed articles on preventative interventions for perinatal depressive and anxiety symptoms with interventions

addressing partner support or couple relationship. The name of the review is: "*A review of partner-inclusive interventions for preventing postnatal depression and anxiety*", but the review was not focused on both partners being included in the intervention. Only interventions targeting couple relationship factors were included. Interventions which might have included partners in the intervention but did not have a couple relationship focus were not analyzed further than mentioning there was no data on partner's attendance nor on the influence on changes in mothers' symptoms due to partners' participation in interventions (Pilkington, Whelan & Milne 2015, & Alves et al. 2018). Alves et al. (2018) argue how the review did not provide specified details about the partners' real attendance and found the partners' participation in the interventions were described scarcely. They argue that information about the content of sessions delivered to partners needs to be addressed "in order to inform clinical practice for evidence-based goals and the content of the interventions" (Alves et al., 2018). Pilkington, Whelan & Milne (2015) exclusively addressed the content related to couple relationship in peer-review articles and their criteria were: "Interventions were eligible for inclusion if they aimed to facilitate partner support or strengthen the couple relationship, and included perinatal depression or anxiety as an outcome variable." This current systematic review aims to present literature, quantitative and qualitative, which is addressing preventative interventions for postpartum depression for both partners, and to deliver information on the content of the sessions delivered to the partners to inform on content of interventions to inform clinical practice. The research question for the present systematic review was formed based on knowledge from previous systematic reviews: *"Which preventative interventions for postpartum depression targeting both partners can be identified in the current literature? And how effective are they?"*

2.2 Method

The method is described briefly here but a more detailed description for replication is presented in the review protocols (Addendum 1 & 2).

2.2.1 Search Procedure

The systematic search was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA guidelines) (Moher, Liberati, Tetzlaff, & Altman, 2009). A Search Protocol (Addendum 2) and a Study Protocol and Process Description (Addendum 1) was developed to guide the underlying steps of the review process. The search protocol was registered with PROSPERO, database of systematic reviews under registration number: CRD42020208745 (http://www.crd.york.ac.uk/prospero).

Databases searches were performed on PsychNet, PubMed, Scopus, EBSCOhost / CINAHL and Cochrane Library to include studies publish up until September 14th & 15th 2020. Search words were generated by investigating terminologies from relevant literature. Online dictionaries were utilized to identify synonyms. Additionally, Index Terms, Thesaurus Terms and MeSH terms were identified in the various databases. The following search words were divided into four blocks; ("Postnatal Depression" OR "Postpartum Depression" OR "Postnatal Dysphoria" OR "Puerperal Depression" OR "Perinatal Depression") and (Parent* OR Paternal* OR Partner* OR Spouse* OR Couple* OR Famil*) and (*Intervention* OR *Therap* OR *Treatment* OR *Education* OR *training*) and (Prevent*).

2.2.2 Selection Criteria

The articles were identified first by screening abstract and title and if required by reading the full text. The inclusion criteria were: a) Participants: Partners and couples – same sex couples and unmarried couples were also included; b) academic papers both qualitative and quantitative; and c) interventions: treatments, therapy, programs and other interventions for both partners aiming to prevent postnatal depression. The exclusion criteria were: a) Other physical or mental problems/issues than postnatal depression; b) articles not in English, Swedish, Norwegian or Danish; and c) articles focusing exclusively on maternal depression d) Articles focusing exclusively on fathers' depression; e) study protocols, research designs, Systematic Reviews, Pilot Studies, Non-academic journals and reports; f) articles regarding cost and cost-effectiveness of interventions; f) articles not addressing preventative interventions; g) studies with unclear diagnosis, comorbidity or substance use; and h) interventions targeted exclusively at smoking, alcohol, drug or substance use, partner violence, infertility, breastfeeding, specific childbirth outcomes, birth or fertility complications, pre-term infants, adoption, infants with illnesses, birth defects or abnormalities.

2.2.3 Data Extraction and Assessment of Quality

The full text articles (n =49) were read and eligibility was determined using the predefined exclusion and inclusion criteria, which were noted for extra transparency (Addendum 3). The review was made by one author and therefore comparison of discrepancies, cross-checking and discussion hereof was not possible—therefore a process description was also developed for transparency. The Critical Appraisals Skills Programme (CASP) and the JBI Critical Appraisal Checklists (JBI) were utilized to assess quality of included literature. The results are enclosed for transparency (Addendum 4; 5; 6; 7; 8; 9; 10; 11; 12; and 13).

2.3 Results

The results of the systematic literature search are shown in the Flow Chart, figure 1, according to the PRISMA guidelines (Moher et al., 2009).

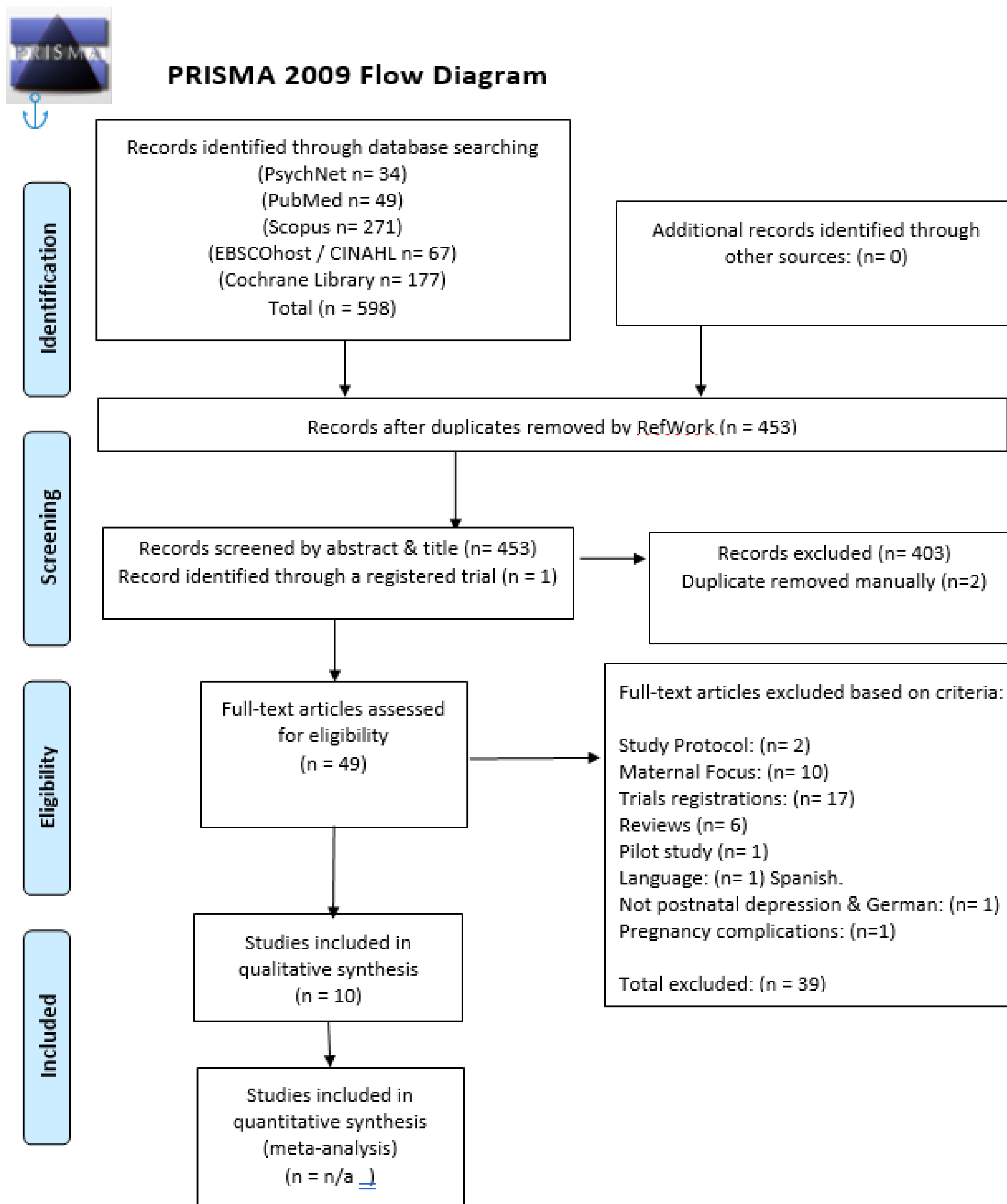


Figure 1: Flow diagram.

10 articles published between 1985 and 2020 were identified on the topic: Preventative interventions for peri- and postnatal depression for partners. Table 1a & 1b illuminates the study characteristics of the ten studies.

Reference	Main Discipline. Year. Country.	Sample	Study Design	Control type	Partner Participation & Intervention Format	Depressive Symptoms Scale	Prevention timing	Number of specific intervention sessions	Intervention content
Cussiono, M., Zaccagini, M., Callerame, C., Civilotti, C., Di Fini, G., Veglia, F., (2016). Postnatal depression and prevention: the role of partners. Minerva Psichiatrica 2016 March;57(1):1-9. https://www.minervamedica.it/en/journals/minerva-psichiatrica/article.php?cod=R17Y2016N01A0001	Psychology. 2016. Italy.	(n= 181) pregnant women and their partners.	Randomized controlled trial	Control group (n= 66) participating in standard antenatal sessions was proposed participation in research with the sole compilation of filling in some questionnaires. Experimental group (n=115).	Total. Group and booklet for experimental group	Mothers: EPDS & EPDS-P. Fathers: EPDS	Antenatal and interview 10 months postpartum	1 session and a booklet	During the standard antenatal classes the experimental group participated in a special intervention sessions providing accurate information on postpartum discomforts in order for the parents to recognize symptoms and request information and support if needed. The couples in the experimental group were given a booklet about postpartum depression and also participated in a meeting ten months postpartum with administration of the Parent Development Interview.
Kayoko Ishii, Aya Goto, Kazuyo Watanabe, Hiroshi Tsutomi, Mie Sasaki, Hiromi Komiya & Seiji Yasumura (2020) Characteristics and changes in the mental health indicators of expecting parents in a couple-based parenting support program in Japan, Health Care for Women International, 41:3, 330-344, DOI: 10.1080/07399332.2019.1643350	Midwifery & Health Care. 2020. Japan.	(n=100) couples	Quasi-experimental non-randomized study at three sites	None	Total. Group.	Mothers: EPDS. Fathers: N/A.	Antenatal and 6 weeks postpartum a self-administered questionnaires was mailed to the couples.	One 2-hour session	The Empathy Session by Matthey et al. (2004) was adapted to the Japanese setting. It is a 3-step program in a 2-hour session: 1) First activity participants complete a "checklist of concerns during pregnancy" and then there is a group discussion in a group of same gender peers and final a discussion with own partner. Then couples participate in a small-group discussion talking about a "difficult day" scenario of a tried mother taking care of a crying baby when the father returns home at night; 2) Completion of a checklist on sharing child-rearing roles, which is mailed to the parents one week after step 1; and 3) Completion of an additional checklist assessing each other's understanding and condition, which is mailed 6 weeks after delivery.
Kusuma, R., Keliat, B. A., Afiyanti, Y., & Martha, E. (2019). The Ratu's model: A prevention model of postpartum depression. Enfermería Clínica, 29, 70-73. doi:10.1016/j.enfcli.2018.11.023	Nursing. 2019. Indonesia.	(n=108) pregnant women in the second trimester week 20-27.	Quasi-experiment	Divided into an intervention group (n= 54) and the control group receiving standard care only (n =54)	Unclear if fathers participated total or partial. Group.	Mothers: EPDS. Father: N/A.	Ante- and postnatal	Three 50-60 min sessions delivered every 9 days over the course of 27 days	The Ratu's model is based on Roy Adaption Model and involves four main components 1) education to enhance stimulus of pregnant women; 2) education to enhance coping mechanism; 3) education to enhance adaptive behavioral response; and 4) education to enhance social support of the husband.
Locicero, A. K., Weiss, D. M., & Issokson, D. (1997). Postpartum depression: Proposal for prevention through an integrated care and support network. Applied and Preventive Psychology, 6(4), 169-178. doi:10.1016/s0962-1849(97)80006-6	Psychology. 1997. USA.	N/A	Suggests a model for care and support	N/A	N/A. Model.	N/A	N/A	N/A	The proposed model of networks includes a wide range of services and resources available to meet the needs of childbearing families, such as sensitive perinatal and pediatric health care, prenatal and postpartum exercise classes, home-visiting services, parenting education and family support programs, and breast-feeding support. Additional services for families with special childbearing needs include mother-baby psychiatric units, Depression after Delivery (a mutual support group), pregnancy loss groups, and post cesarean support.
Matthey, S., Kavanagh, D. J., Howie, P., Barnett, B., & Charles, M. (2004). Prevention of postnatal distress or depression: An evaluation of an intervention at preparation for parenthood classes. Journal of Affective Disorders, 79(1-3), 113-126. doi:10.1016/s0165-0327(02)00362-2	Psychology & Psychiatry. 2004. Australia	(n = 268) couples expecting their fist baby who attended the evening "Preparation for Parenthood" program (Standard fee AUS$ 40)	Randomized controlled trial	A 3x3 between subjects randomised control design was utilised. The two factors were condition and self-esteem. Preparation for Parenthood programs were randomly allocated to one of three conditions: usual service ('control'), experimental ('empathy'), or non-specific control ('baby-play').	Total. Group	Mothers: EPDS. Fathers: CES-D.	Antenatal	1	Couples in all three conditions recieved six routine antanatal session. Experimental group participated in one special session "The Empathy Condition", which provided information on both partners' postpartum concerns and presented strategies to help these issues along with talking through a stressful typical day postpartum scenario. Postsession mailouts were sent to remind of information given in the intervention session.

Table 1a

Reference	Main Discipline. Year. Country.	Sample	Study Design	Control type	Partner Participation & Intervention Format	Depressive Symptoms Scale	Prevention timing	Number of specific intervention sessions	Intervention content
Ngai, F., Wong, P., Chung, K., Chau, P., & Hui, P. (2019). Effect of couple-based cognitive behavioral intervention on prevention of postnatal depression: Multisite randomized controlled trial. BJOG: An International Journal of Obstetrics & Gynecology, 127(4), 500-507. doi:10.1111/1471-0528.15862	Obstetrics and Gynecology, Social Work and Social Administration, Psychiatry & School of Nursing. 2019. Hong Kong.	(n=388) low-risk childbearing couples.	Multisite randomized controlled trial (Antenatal clinics at three regional public hospitals).	Childbearing couples were randomly allocated to couple-based CBI (n = 134), women-alone CBI (n = 124) or control (n = 130). Comparison of couple-based cognitive behavioral intervention (CBI) for postnatal depression with CBI delivered to women alone and control (standard perinatal care).	Total. Group.	Mothers: EPDS. Fathers: EPDS	Antennal session and two 30 min phone sessions 2 and 4 weeks postpartum	One 3-hour antenatal group session with a midwife and two 30-min follow-up sessions on the telephone within the first month after delivery	The CBI program co covers: (1) an overview of stressors in the postnatal period and the signs and symptoms of postnatal depression; (2) cognitive restructuring techniques for modifying and challenging irrational thinking and negative thoughts that were depressogenic in the postnatal (3) problem-solving, goal-setting, and decision-making skills to manage common neonatal problems; and (4) communication skills training to improve interpersonal relationships. 2 and 4 weeks postpartum the intervention was reinforced with 30 min individual structured phone sessions.
O'hara, M. W. (1985). Depression and marital adjustment during pregnancy and after delivery. The American Journal of Family Therapy, 13(4), 49-55. doi:10.1080/01926188508251276	Psychology. 1985. USA.	N= 51 couples were recruited in the second trimester	Correlation Study	N/A	Total. Individual	Mothers: BDI & clinical assessment of depression symptoms. Fathers: BDI.	Ante- and postnatal	Suggesting family therapy	Study is assessing correlation between father' and mothers' measuring depression symptoms (BDI), marital satisfaction level (DAS) and postnatal partners support (PPSQ). O'hara is suggesting and discussing family therapy as an intervention
Pilkington, P. D., Rominov, H., Milne, L. C., Giallo, R., & Whelan, T. A. (2016). Partners to Parents:development of an online intervention for enhancing partner support and preventing perinatal depression and anxiety. Advances in Mental Health, 15(1), 42-57. doi:10.1080/18387357.2016.1173517	Psychology. 2016. Australia.	N= 12 participants (5 men & 7 women).	Usability Study of Website	N/A	N/A. Individual	N/A.	Expecting or parenting an infant under 2 years old.	One 30 min usability testing session	Partners to Parents website- a website promoting partner support to prevent postnatal depression and anxiety (http://www.partnerstoparents.org)
Pilkington, P., Milne, L., Cairns, K., & Whelan, T. (2016). Enhancing reciprocal partner support to prevent perinatal depression and anxiety: A Delphi consensus study. BMC Psychiatry, 16(1). doi:10.1186/s12888-016-0721-0	Psychology. 2016. Australia/International panel members	(n= 60) Two panels of experts in perinatal mental health. 39 professionals min 5 years of expertise with postpartum depression and anxiety & 21 consumers with lived postpartum experience	Delphi Consensus Study	Three rounds of assesment of items with a consumer panel and an expert panel. The items were assessed online in three rounds. Items which were not endorsed by 70-79% of both panels as Important or Essential were re-rated in round two and the expert panel could add items which were assessed in round three.	N/A. Booklet for both partners	N/A.	Ante- and postnatal	Booklet	214 guidelines on how partners can support each other to reduce each other's risk of developing perinatal depression or anxiety - on the following themes: supporting each other through pregnancy and childbirth, communication, conflict, division of labor, practical support, emotional support, emotional closeness, sexual satisfaction, using alcohol and drugs, becoming a parent, encouraging self-care, developing acceptance, help-seeking.
Sanaati, F., Charandabi, S. M., Eslamlo, H. F., & Mirghafourvand, M. (2018). A randomized controlled trial on the effect of lifestyle education for Iranian women and their husbands on post-partum anxiety and depression. Health Education Research, 33(5), 416-428. doi:10.1093/her/cyy026	Nursing and Midwifery. 2018. Iran	(n=189) literate, non-depressed pregnant women with a gestational age of 24–28 weeks and some of their husbands.	Randomized single-blinded controlled trial. The outcome assessor was blinded by using coded data for intervention groups.	Participants were allocated in three groups of 63 women in each group; 1) dyad-group of women & husbands both receiving life-style based education on postpartum anxiety and depression 2) women only receiving the intervention 3) control group women receiving only routine care	Partial. Separate gender groups.	Mothers: EPDS. Fathers: N/A.	Antenatal sessions and Postnatal phone counselling	Mothers: 4 sessions 60-90 min. One 10 min phone session weekly between session and postpartum. Fathers: 1 session 60-90 min. Two phone sessions. Training Booklet.	The content of the training booklet included the anatomy and physiology of genital organs and pregnancy, sleep hygiene, nutrition, pregnancy exercises, sexual matters etc. The sessions provided education on how to improve sleep: such as abstaining from certain foods before bed as well as ways to improve nutritional status and to overcome common digestive problems, such as heartburn and constipation during pregnancy as well as healthy sports during pregnancy and healthy marital relations during pregnancy and after childbirth. The participants recieved a contact number in order to ask the researcher further questions.

Table 1b

2.3.1 Themes in the literature

In order to identify the major themes across the articles a thematic approach was utilized to select relevant themes based on prevalence. First a template of themes was made after all articles were read full text. Secondly the articles were read again whilst noting down specifics or copying paragraphs under each theme (Addendum 14). The identified themes which occurred in more than 50% of the articles were:

- Postnatal depression prevalence (n=10)
- Educational interventions (n= 10)
- Risk factors and predictors (n= 8)
- Protective factors (n= 8) S*ubtheme: Social support vs. postnatal depression (n=7)*
- Symptoms of parents experiencing postnatal depression (n= 6)
- Risk for children of parents suffering from postnatal depression (n= 7)
- Link between father & mother's postnatal depressions (n= 5).
- High drop-out rates or difficulty finding participants (n= 5)
- Delivery methods of intervention needs to be considered (n=6)
- Most research has a maternal focus (n= 6)
- Suggest the need for further research (n= 6)
- Suggest the need for partner interventions (n=5)

Only the four major themes which appeared in a minimum of 80% of the articles are included in this review: Postnatal depression prevalence (n=10), Educational interventions (n= 10), Risk Factors & Predictors (n= 8) and Protective Factors (n= 8) including the subtheme: Social support vs. postnatal depression (n=7). Some elements will be used in the discussion and the remainder will be discussed further in my master thesis which is the framework for this review.

2.3.2 Postnatal Depression Prevalence (n=10)

Prevalence rates were identified in all ten articles. In the earliest, O'hara (1985) reports how postpartum depression is affecting about 12% of women after delivery and back then only few data existed on men's depression related to parenthood. O'hara found the prevalence of depression to be decreasing during pregnancy and postpartum for both men and women. 13,7% of men and 29,7 % of women during second trimester, 10,4% of men and 14,9% of women at third trimester and 7,8% of men and 18% women at six weeks postpartum. The

measure was self-report on Becks Depression Inventory (BDI) as the Edinburgh Postnatal Depression Scale (EPDS) was created in 1987 (Cox, Holden& Sagovsky 1987). The study reports lower rates of depression than previous studies which was attributed to the participants completing BDI more often which could lead to artificially lowering the score because of an overfamiliarity with the instrument. 31 years later Cussiono, Zaccagini, Callerame, Civilotti, Di Fini & Veglia, (2016) reported similar rates using the EPDS. The prevalence was also decreasing from pregnancy to postpartum; with 21.8% of mothers during pregnancy to 17.8% postpartum; and for fathers 9.5% during pregnancy and 6.1% after childbirth.

Locicero, Weiss, & Issokson (1997) reports that between 10-20% of new mothers suffered from postpartum depression within the three months after giving birth. The same prevalence rate was reported in the study by Matthey, S., Kavanagh, D. J., Howie, P., Barnett, B., & Charles, M (2004) using a source from 1996 (O'Hara and Swain, 1996). The study also included an estimate that if the postnatal depression is left untreated between 30-50% of the women will remain depressed one year postpartum. Locicero et al.(1997) highlighted it was problematic to rapport these statistics as there was no universally accepted definition of postpartum depression. The American Psychiatric Association's DSM-IV (1994) did not have any specific diagnosis for disorders related to pregnancy or postpartum period even though a lot of research and clinical literature existed on the subject.

Pilkington, Rominov, Milne, Giallo, & Whelan (2016) and Pilkington, Milne, Cairns, & Whelan (2016) refer to a meta-analysis which indicate the combined prevalence of maternal depression during pregnancy is 18.4% and up to 19.2% of women have a depressive episode during the first three months postpartum (Gavin et al., 2005 if Pilkington, Milne, Cairns, & Whelan, 2016). Ngai, F., Wong, P., Chung, K., Chau, P., & Hui, P. (2019); Pilkington, Milne, Cairns & Whelan (2016) & Pilkington, Rominov, Milne, Giallo, & Whelan (2016) refer to the same meta-analysis by Paulson & Bazemore (2010) which included 43 studies across 16 countries and reported that 23.8% women and 10.4% men suffer from depression between the first trimester and 1 year postpartum. The peak period prevalence for paternal depression was 25.6% at 3-6 months postpartum. Pilkington, Milne, Cairns & Whelan (2016) argue that the prevalence is most likely underreported due to some new parents' reluctance to disclose their mood problems.

Sanaati, Charandabi, Eslamlo, & Mirghafourvand (2018) address that depression during pregnancy or peri-partum is the most common complication of childbirth and argue that it is the second leading cause of disability in women of reproductive age. Kusuma, Keliat, Afiyanti & Martha. (2019) agree that depression is one of the most common psychological problems experienced by women postpartum.

2.3.2.1 Cultural differences

Sanaati et al. (2018) report a prevalence between 10-15% worldwide and clarified that there is a higher prevalence in Arab women in low and middle-income countries such as Iran (25.3%) and Turkey (28.9%) compared to countries like USA which can be attributed to the social and economic conditions. Kusuma et al. (2019) report that the prevalence of postpartum depression in women in Indonesia is estimated up to 20% and argue that postpartum depression should be limited to 1% prevalence.

Kayoko Ishii, Aya Goto, Kazuyo Watanabe, Hiroshi Tsutomi, Mie Sasaki, Hiromi Komiya & Seiji Yasumura (2020) also report a prevalence of maternal depression symptoms among their participants at 20.0%, which is much higher than the Japanese national average from 2013 which is low compared to the other prevalence rates mentioned (8.4%) and 2001 (13.4%) reported by the Japanese Ministry of Health, Labor and Welfare. They authors point to the limitation of the small sample size (n= 60 couples) and speculates if the program attracted more couples with high risk of parenting difficulty than average.

2.3.2.2 Fathers

Five studies do not mention the prevalence rate for men, Sanaati et al. (2018), Kayoko et al. (2020), Kusuma et al., (2019), Locicero, Weiss, & Issokson (1997) & Matthey et al. (2020).

Matthey et al. (2004) mention that maternal depression has been linked to elevated rates of depression amongst fathers and refers to a previous study by Matthey et al. (2000) without mentioning any prevalence rates for fathers. The study measured fathers' depression with The Centre for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977 if Matthey et al., 2004). At 6 weeks postpartum the low esteem fathers scored significantly higher on the CES-D measure than high esteem fathers (mean scores 8.1 and 4.9, respectively; $P < 0.05$), no significant interaction was obtained at any other measure. The found their intervention showed no effect on rates of caseness neither for fathers nor mothers, but women and men with low self-esteem had the poorest adjustment at 6 weeks postpartum.

In the studies by Sanaati et al. (2018), Kayoko et al. (2020), Kusuma et al., (2019) the effect of intervention on EPDS scores were only measured on the mothers. Cussiono et al. (2013), measured EPDS score on the 63 partners who participated in the study and found EPDS >10 in 9,5% of fathers during pregnancy and 6,5% of fathers after pregnancy – the article does not report the difference from control group to experimental group, only the total measure for all fathers.

2.3.3 Educational interventions (n=10)

All 10 included articles were addressing educational interventions or included educational elements. Matthey et al. (2004), created an intervention called "The Empathy condition" in their study of couples in Australia. The same intervention was used by Ishii et al. (2019) in a modified version to make it applicable to Japanese culture. The Empathy Session is an intervention consisting of one session focusing on psychosocial issues related to becoming first-time parents. The first focus was to increase couples' awareness of psychosocial concerns related to pregnancy and postpartum and to consider practical strategies to reduce parents' distress at home with the baby. Here possible postpartum concerns were first discussed in separate gender groups and afterwards the issues were discussed by the couple. Second focus was to enhance problem-solving skills by discussing some hypothetical scenarios on a stressful situation for women and men early postpartum. The researchers provided the participants solutions to those scenarios that other parents had found useful. The intervention was reinforced through mailouts sent shortly after the session and again 1-2 weeks after birth. Matthey et al. (2004), found the intervention effective for first-time mothers who antepartum reported low-self-esteem in reducing postpartum distress at 6 weeks postpartum. The low self-esteem women in the intervention group had significantly lower EPDS scores than low self-esteem women in the control group [$F(1,55) = 12.36$, $P < 0.01$]. The effectiveness of the intervention was argued to be related to the fathers' increased level of awareness on how the mothers' experienced the early postpartum weeks as the intervention group were found significantly more aware than those in the control group ($t = -2.05$, $df = 184$, $P < 0.05$). Ishii et al. (2019), found that changes in paternal empathy ($\beta = -0.26$) and maternal EPDS score during pregnancy before intervention ($\beta = 0.41$) were significantly associated with maternal postpartum EPDS score in a multivariable analysis. The authors argue that these results indicate that paternal involvement and long-term support from antenatal phase is essential for prevention of MPD.

In the study by Cussiono et al. (2016), a control group (n=66) was following the regular antenatal classes and the experimental group (n=115) participated in the same classes, but had one special session providing information on postpartum discomforts in order to recognize signals and request information and support if needed. The couples in the experimental group were also given an informational booklet about postnatal depression. Both groups were assessed during last trimester of pregnancy and again during first trimester after delivery. In addition, the couples in the experimental group were asked to participate in a meeting ten months after delivery with the administration of the Parent Development Interview (PDI) to assess the quality of parental description of representation of their child and about their relationship. EPDS score were slightly higher in the experimental group than the control group at both measures (24,6% vs 17,5% antepartum and 19,7 vs 15 % postpartum). The only significant difference between experimental and control group was the average higher EPDS-P score, which were higher in the experimental group ($t= 2.74$, $p<0,01$). The authors argue that greater awareness about effects of depressive symptoms on themselves, the other, the child and the couple can be promoted through understanding and support in partners. The study found that the most welcomed form of support was represented by the information received in the course they took part (prenatal 32,7% N=33, postnatal 27,7%, N=28) which was followed by emotional support (prenatal 16,8%, N=17; postpartum 13,9%, N=14). The authors also state that literature identifies psychoeducation about discomforts of having a baby and how to manage this as being the most effective intervention type in order to develop more realistic expectations on pregnancy, childbirth and parenthood.

The study by Ngai et al. (2019) adapted a couple-based Cognitive Behavioral Intervention (CBI) from a local Chinese developed postnatal depression manual. The CBI program was one 3-hour antenatal group session and two telephone follow-up sessions of 30 minutes at two and four weeks postpartum. The group session consists of four elements: 1) Overview of stressors, signs and symptoms of postnatal depression; 2) Techniques for cognitive restructuring techniques to modify and challenge negative or irrational thinking which are tending to cause postnatal depression; 3) Utilization of skills such as problem-solving, goal setting and decision-making to manage common problems related to newborn babies; 4) Training of communication to improve interpersonal relationships. The findings showed that skills in problem-solving, identifying and modifying negative thoughts and development of effective communication was particularly useful for the participants receiving couples-based CBI in order to manage the transition to parenthood. The study showed that couple-based

CBI was more effective in reducing the incidence of postnatal depression among Chinese mothers in the early postpartum than CBI delivered to mothers only and standard perinatal care.

The randomized controlled trial by Sanaati et al. (2018), investigated the effect of lifestyle education for Iranian women and their husbands on postpartum anxiety and depression. The lifestyle-based training during pregnancy included the following topics: sleep hygiene, nutrition, physical activity and exercise, self-image and sexual matters. The mothers (n=189) were evenly divided into a lifestyle dyad-group and a lifestyle women-only group which both received the intervention and a control group receiving only standard care. The intervention groups received four 60- to 90-min sessions with 7-day interval during pregnancy in weeks 24–28 in group sizes ranging from 3-15. One educational session was provided for the husbands from the dyad-group (n= 63) in group sizes ranging from 15–25 participants. The last 30 min of each session was dedicated to discussion, questions and answers. A training booklet was given to mothers in the two intervention groups and the dyad-group was instructed to read it with their husbands. The booklet included educational training about the anatomy and physiology of genital organs and pregnancy, sleep hygiene, nutrition, pregnancy exercises, sexual matters etc. Significant reductions on mothers' postnatal depression scores were found in both intervention groups. Furthermore, significant reductions were observed in postnatal depression, state anxiety and trait anxiety scores in the lifestyle education–dyad group compared with the lifestyle education–women only group. The results indicated that lifestyle-based training may be helpful in reducing depression scores for mothers alone but even more when both partners receive the CBI.

Pilkington, Milne, Cairns, & Whelan (2016) argue that regular antenatal classes focus on childbirth and do not adequately prepare the couples for the emotional adjustments related to becoming parents. They believe that in order to effectively improve partner support and couple's awareness in order to promote earlier and increased help-seeking the interventions need to provide couples with specific guidance and recommendations. The New Delphi study resulted in 214 recommendations on how partners can support each other. The recommendations were endorsed by at least 80% of both panels as being important or essential in reducing the risk of perinatal depression and anxiety. The main categories of the recommendations were: becoming a parent, supporting each other through pregnancy and childbirth, communication, conflict, division of labor, practical support, emotional support,

emotional closeness, sexual satisfaction, using alcohol and drugs, encouraging self-care, developing acceptance and help-seeking.

Pilkington, Rominov, Milne, Giallo, & Whelan (2016) created an information-based website "Partners to Parents" specifically to prevent perinatal depression and anxiety by empowering reciprocal partner to support without professional intervention. The study was on usability testing and aiming to gather information on the perceived quality and to improve design and functionality. In general, the participants had positive feedback to the content and appreciated the inclusion of fathers, simple design and personalization. The following changes were made due to feedback from participants in the study: Simplifying language and content structure, enhance graphic design and navigability, increased number of images, new material to increase engagement and interactivity, Search Engine Optimization to make the site easier to access. The authors argue that the website has several potential advantages due to its inexpensive to maintain and accessibility. The Partners to Parents intervention is supported by research evidence which the parents in the usability study noted was important for credibility. The website is extending the existing partner-inclusive interventions which tends to focus on maternal childbirth by taking a preventative approach and including both the fathers and same-sex partners. The intervention is the first theory and evidence-informed online intervention aiming to prevent perinatal mental illness which is directed towards both men and women (inclusive of same-sex couples) which targets both anxiety and depression during the antenatal and postnatal period.

O'hara (1985) created a study to assess the relationship between husbands' and wives' depressive symptoms, and between husbands' and wives' martial satisfaction during pregnancy and postpartum - as there previous had been done limited research on the topic. O'hara argue that postpartum a couple can be viewed as a system under stress and therefore equal attention should be paid to both of their needs. He suggests that high-risk couples should be referred by the obstetrician to a family therapist for a consultation (short-term therapy). Family therapy can be used as a preventative strategy by including the extended family members in preparation for childbirth and childcare which could reduce emotional distress for the partners and prevent relationship problems. If family is unavailable, then close friends could be included in this type of preventative family therapy. Family members would be encouraged to identify and help with the tasks most suited for them. The examples in the study are that the grandmother and mother can advise on preparation for labor and early childcare. The male family members with children can provide reassurance and help for the

father by establishing clear expectations regarding tasks of fathering infants. Family members can provide help with household tasks and childcare, so the couple occasionally can have some time to themselves. O'hara argues that this type of intervention can increase cohesion of the family's social network.

The article by Locicero, Weiss, & Issokson (1997) is proposing a model for prevention of postpartum depression in an American context called "Integrated Care and Support Network". The model is emphasizing collaboration among all providers, services and resources to meet the needs of childbearing families. The model of the network mentions educational elements such as; childbirth and childcare education and sensitive perinatal education, nutritional education, parenting education, prenatal/postpartum exercise classes, psychoeducation, breast-feeding support, empowering childbirth education and baby care classes. The authors point out how these elements exist in many communities as free-standing entities and the idea is to create and integrated network which easily accessible for families.

The study by Kusuma et al. (2019) state that health care services in Indonesia has not yet managed implement integrated prenatal care based on the Roy Adaptation Model, which also prioritizes nutrition to prevent postpartum depression. The Ratu's model was developed based on the Roy Adaption Model. It involves four main components - education in order to enhance stimulus of pregnant women, coping mechanism, adaptive behavioral response and social support from the husband. The intervention consisted of education provided to pregnant women and their husbands. The sessions were delivered 3 times; every 9 days during a 27-day period. Each session lasted 50-60 minutes. Post intervention there were three visits to the participants to monitor the results of the education provided. The authors conclude that nutrition and the correct intake of carbs, protein, minerals, vitamins and antioxidants may help preventing postpartum depression and that psychoeducation and counseling during the period of pregnancy may reduce the incidence of depression peri- and postnatal.

2.3.4 Risk factors & Predictors (n= 8)

Eight of ten articles are concerned with risk factors or predictors for postnatal depression.

Eight articles present some of the risk factors identified to be relevant. Kusuma et al. (2019) & Sanaati (2018) argue that the causes of postnatal depression are still unknown, but risk factors can be identified. Locicero et al. (1997), Kusuma et al. (2019), Cussiono et al. (2016),

Ishii et al. (2019) & Sanaati et al. (2018) all highlight how the risk of postpartum depression is multifactorial with involvement of demographic socioeconomic, psychosocial, social and hormonal factors. O'hara (1985) argue that the risk of postnatal depression is increased if having a history of depression / postpartum depression, a history of depression in first degree relatives, or having high levels of stressful life events during or after birth, lack of support, dissatisfaction with marital relationship, marital discord or psychopathology in either partner. Sanaati et al. (2018), Kusuma et al. (2019) & Cussiono et al. (2016) agree that predictors can be history of mental disorder during pregnancy, stressful life events, poor marital relationship and lack of social support. Cussiono et al. (2016) adds the lack of information about birth & pregnancy as a risk factor.

O'hara (1985) found that women's perception of martial relationship and support from spouse are related to peri- and post-natal depression, this claim is backed by Locicero et al. (1997). Ishii et al. (2019) argue that the lack of support from partners and marital dissatisfaction are strong predictors of postpartum depression. Pilkington, Milne, Cairns, & Whelan (2016) were also concerned with risk factors related to partner support and identified inter-partner conflict as being a significant risk factor due to lack of communication, support and closeness. In addition to lack of social support and recent life stress, the study by Locicero et al. (1997) expands this topic and lists many risk factors: social isolation; disharmony in the primary relationship; adverse economic conditions; difficult birth experiences; vulnerability to depression; difficult infant temperament; adverse reactions to biochemical & hormonal shifts; lack of culturally determined rituals, support, and recognition of the mother. They use an Ecological Frame Work and argue how the factors contributing to postpartum depression are likely to interact which increase the risk of postpartum depression i.e. financial problems may contribute to marital disharmony and a job change can result in a move which can contribute to social isolation. They point out there is no such things as a primary cause it is the interactions of causal factors such as: biological, psychodynamic, cognitive, developmental and life events – they should be seen as interrelated cause there can be several of each type of factors simultaneously which interact with other factors. Ishii et al. (2019) also argue how risk factors are not only psychological but can also be socioeconomic and relate to poverty, employment and social support.

Matthey et al. (2004) found that self-esteem is a severe risk factor during transition to parenthood as it is a necessity to learn new skills at a very rapid rate. There is an immediate feedback when the woman appears unsuccessful in learning new skills, for instance baby will

cry when hungry if food is not readily available. Women with low self-esteem might interpret such feedback with reflection on own incompetence and might interpret comments from others as criticism of abilities as parents which will increase the experienced stress which can result in an onset depression. Sanaati et al. (2018) also briefly mention low self-esteem as common risk factor and suggest that those who do not wish to participate in treatment or who drop out tend to be more vulnerable to postpartum depression. The authors elaborate that those who do not wish to accept routine antenatal care are also more likely to be women who has additional risk factors for postpartum depression.

Kusuma et al. (2019) is the only study with a large focus on the physiological changes which are occurring during pregnancy, labor and/or postnatal as being risk factors. They mention nutritional deficiencies, metabolic disorder, anemia, hormonal changes, fatty acid changes and obstetric-related complications. This Indonesian study also differs by pointing out some other factors: unhealthy lifestyle such as smoking, consuming alcohol and drugs for recreational purpose, past failure in marriage, domestic violence, mood disorder during period of menstruation, age of the pregnant women, educational degree, working status, the number of children, the norms and cultural perspectives in the society.

2.3.5 Protective factors (n= 8)

Majority of the risk factors mentioned above are linked to the protective factors. Cussiono et al. (2016) mention optimism and high self-esteem as protective factors and Matthey et al. (2004) elaborates how high self-esteem is likely lead to setting more realistic expectations of oneself. High self-esteem parents are less likely to interpret comments from others as criticism of competences. Additionally, the feedback of an unsettled child is likely to be accepted as something normal or the child just being difficult rather than internalizing it as being inadequate in the new role.

Sanaati et al. (2018) found that providing lifestyle-based interventions to both parents and to mothers alone is helpful in reducing depression scores during pregnancy and postpartum, it was found more effective when both parents received the intervention. Sleep-training for both parents during last trimester reduce postnatal depression scores more than training mothers alone (Kempler, Sharpe & Bartlett, 2012 if. Sanaati et al., 2018). A clinical trial reported increased quality of life especially in the area of mental health in pregnant mothers' which husbands participated in physiologic childbirth classes (Dehcheshmeh, Salehian & Parvin, 2014 if Sanaati et al., 2018). Physical activity was mentioned as a protective factor by

Pilkington, Milne, Cairns, & Whelan (2016) and Sanaati et al. (2018). Physical activity is argued to improve mental health, improve self-image and self-confidence - and to prevent and treat mild to moderate depression and is suggested as an alternative to psychopharmaceuticals.

Cussiono et al. (2016) mention protective factors such as satisfactory and stable marital relationship also O'hare (1985) found that husbands' marital satisfaction was the major contributor in accounting for variance in women's satisfaction with levels of support from husbands ($F(1,48) = 4.99$, $p < .05$) and state that men who are more satisfied with their marriage were more likely to provide the level of support which their wife perceived as being appropriate.

2.3.5.1 Partner Support & Social Support

Seven articles mention partner support and social support as protective factors (Cussiono et al., 2016, Matthey et al., 2004, Ngai et al., 2019, Pilkington, Milne, Cairns, & Whelan, 2016, O'hare, 1985, Locicero et al., 1997 and Sanaati et al., 2018). Matthey et al. (2004) highlight that the importance of partner support to prevent postpartum depression has been well documented and Pilkington, Rominov, Milne, Giallo, & Whelan (2016) specifies that evidence "demonstrates that supportive relationships facilitate an individual's capacity to adjust to significant life events, such as the birth of a child, by buffering the associated stress". They point to several studies which demonstrates that partner support and relationship satisfactory are two of the strongest predictors against perinatal depression and anxiety (Beck, 1996, 2001; Pilkington, Milne, et al., 2015; Robertson, Grace, Wallington, & Stewart, 2004 in Pilkington, Rominov, Milne, Giallo, & Whelan, 2016) also Pilkington, Milne, Cairns, & Whelan (2016) refer to longitudinal research by Don & Mickleson (2004) which suggest the link between maternal and paternal postpartum depression is mediated by partner support and relationship satisfaction and claim that partner support is an established modifiable factor and is key target for prevention interventions for perinatal depression and anxiety. They highlight how their panels widely endorse item related to how partners can encourage each other to take care of themselves physically and mentally and promote a satisfaction with sexual relationship. Evidence shows that incongruence between expectations and reality of parenthood is common amongst men and women experiencing postpartum depression. The authors suggest how accepting a flexible attitude towards pressure of early parenthood might protect against postpartum depression, here the highly endorsed items were for instance: "Partners should try to enjoy their family rather than feel that they are missing

out on the old days". Positive communication, emotional closeness, emotional support and minimizing conflict are protective factors related to postnatal depression and anxiety which partners can potentially help modify. Parents who feel they have control over their risk of perinatal depression are less likely to develop symptoms and therefore it is relevant to provide expectant parents information on specific actions they can take to increase sense of empowerment and interpersonal agency to prevent perinatal depression. Cussiono et al. (2016) pinpoints that support in childbirth in practical and emotional terms seems to be one of the most important factors and that support from partners is widely recognized as being essential.

The study by Ngai et al. (2019) found the participation of fathers was found to make a significant contribution to reduction of postnatal depression among mothers. Fathers' involvement is believed to provide support to their partners which helps reduce stressors and difficulties encountered postpartum. They argue that interventions based on cognitive behavioral approaches are found effective in preventing postnatal depression and refer to the study by Matthey et al. (2004) which focused on problem-solving amongst partners and reduced parents' depressive symptoms six weeks postpartum. Matthey et al (2004) did not find that increased partner awareness resulted in higher perceived emotional support, they claim this could be due to having reached the ceiling effect as all the women reported exceptionally high perceived emotional support (75% of more satisfied). This could be attributed to the fact that the participants already had paid for and attended perinatal classes together, which demonstrates a higher level of support at baseline level.

On the contrary Sanaati et al. (2018) refer to the Cochrane review by Dennis & Dowswell (2013) of 28 trials involving almost 17,000 women, which concluded that none of the studies addressed the husband as the most important source of social support for the mothers in the interventions. Although Pilkington, Milne, Cairns, & Whelan (2016) established that partner support protects against perinatal mood problems, the authors mention a lack of research on how other people in the parents' social network can be supportive. Their panel members were reluctant to endorse items on help-seeking from friends and family yet 100% of both the professional and consumer panel endorsed the guideline: "Partners should discuss and consider what supports they will draw on when they become parents".

O'hara (1985) noted that men should be encouraged to be more supportive during and after delivery in order to prevent perinatal depression. He highlights the need to encourage couples

to receive support from close family, which is supported by Cussiono et al. (2016) who argue that good availability of social support counteracts the effects of risk factors. Ngai et al. (2019) support this notion that support from family members during the postpartum period helps mother's adaption and lower the risk of postnatal depression. Cussiono et al. (2016) found their data agreed with the literature that the important supporters are usually identified as the parents, partners and friends. Their study showed that the women identified as depressed postpartum reported a significantly lower mean score on both perceived support from the partner and perceived global support.

Locicero et al (1997) highlight the need to look at interplay between individual and support systems on various levels such as individual, family, community and societal by adapting an ecological model of human development. Anthropologists have suggested that there is less postpartum depression in cultures with more collective ethic which supports a structured prescribed postpartum period (Harkness, 1987; Stern & Kruckman, 1983 if Locicero et al., 1997). They argue that the lack of universal traditions, practices and rituals postpartum can lead to conflicting expectations on parenthood and caregiving. Conflicting advice to American families from different systems makes them uncertain on what to expect and how to handle the challenges of parenthood, they use examples such as whether to pick up a crying baby at night, letting the baby sleep in the parents' room and breastfeeding exclusively.

2.4 Discussion

All ten interventions reported on prevalence and had educational focus in their preventative interventions. Eight reported on risks and predictors and eight mentioned preventative factors. Issues related prevalence rates, the different focus in the interventions and risk- and protective factors are discussed.

2.4.1 Prevalence

When discussing prevalence, it is necessary to discuss the fact that there are differences in how researchers define postpartum depression. Locicero et al. (1997) argued that is a problem to rapport these figures due to a lack of a universally accepted definition of postpartum depression. When the study by O'hare was executed in 1985 there were no measures or diagnosis for postnatal depression. "Major Depressive Disorder with postpartum onset" was only recognized in the publication of the DSM-IV in 1994, but no special diagnosis for disorders related to pregnancy for postnatally existed. In DSM-5 the diagnosis of depression

during the postpartum period still utilizes the onset specifier format. However, the specifier has changed it is now titled "with peripartum onset" which is defined as the most recent episode occurring during pregnancy as well as in the four weeks following delivery (Segre & Davis, 2013) and ICD-10 has the onset period up to 6 weeks (Lægehåndbogen, 2019). The period of four weeks is according to the included studies not sufficient as parents can suffer for longer. The review by Paulson & Bazemore (2010) reported the peak in prevalence to be at 3-6 months postpartum, which is not accounted for in some studies using the diagnostic criteria. Clinical work often accepts periods until 3-6 months postpartum (Videbech, 2019).

The averages of the prevalence found in this review are 21.2% of women and 10.33% of men during pregnancy; 17.75% of women and 6.95% of men postpartum. Combined over pregnancy and postnatal rates the average reported is 19.48 of women and 8.65 of men. This is close to what was reported by Paulson & Bazemore (2010) in the meta-analysis that 23.8% women and 10.4% men suffer from depression between the first trimester and 1 year postpartum. This number is although much higher than the prevalence rates found on the Danish Patient Handbook, which states a prevalence rate of 6% in mothers with postpartum depression which is unfortunately based on one single Danish study (Videbech, 2019), Rigshospitalet estimates a prevalence of 10-14 % of women and 7-10 % of fathers (Svenstrup, 2017). Sanaati et al (2018) and Kusuma et al. (2019) agrees with Videbech (2019), that the prevalence is highly related to the level of maternity care and the prevalence is therefore lower in industrialized countries. Pilkington, Milne, Cairns & Whelan (2016) discuss that the rates are underreported due to parents' reluctance to disclose their mood problem, according to Videbech (2019) the diagnosis is underreported due to underdiagnosis by health personnel. Parents reluctance to share their mood problems and the health professionals underdiagnosis of postnatal depression is a very bad combination. Knowing the relatedness between mothers' and fathers' depression and the damaging impact it can have on the entire family this should be something which should not be underdiagnosed. Help seeking behavior should also be encouraged by help professionals to try to prevent stigma, or even better preventative efforts should be made to reduce the prevalence rates as this is the most cost effective and also gives the new family the best premises without having to suffer consequences of postpartum depression.

2.4.1.1. Fathers

It is problematic how only 50% of the studies mention prevalence rates for fathers' postnatal depression when they have fathers included in the intervention. Not including fathers is a

known concern in recent research, and six of the included articles address the issue that majority of studies and interventions are focusing on maternal mental health during pregnancy and postpartum (Cussiono et al., 2016; Ishii et al., 2019; Pilkington, Milne, Cairns, & Whelan, 2016; Pilkington, Rominov, Milne, Giallo, & Whelan, 2016; & Ngai et al., 2019). Several previous reviews also mention the issue of a research foci mainly on maternal postnatal depression (Rominov, Pilkington, Giallo & Whelan, 2016 and Alves et al., 2018). Matthey et al. (2004) & Ngai et al. (2019) argue that there has been developed various psycho-social interventions to help prevent postnatal depression in women, but very few preventative intervention addresses paternal depression, which was also the finding in this review.

The studies by Sanaati et al. (2018); Kayoko et al. (2020) and Kusuma et al., (2019) do not measure or report the interventions effect on the fathers but only on the mothers, which is interesting as they are focusing on partner-inclusive interventions to some extent by having the father partaking in the intervention. Cussiono et al. (2016) did measures for the fathers but only the EPDS score for the fathers as a single group during and after pregnancy. They did not report any measures on difference from control group to experimental group and no conclusion was made if the intervention was helpful to the fathers, only that the fathers in the experimental group rated the mothers higher on EPDS-P scores and gained knowledge on mothers' symptoms compared to the fathers in the control group. Matthey et al. (2004), write that they measured fathers' depression using CES-D at six weeks postpartum and six months postpartum but only report the mean CES-D scores for 6 weeks postpartum measure where the fathers with low self-esteem fathers scored significantly higher than the high self-esteem fathers and mention that there was no significant at other measure, without reporting these other measures like the do for the groups of mothers. The authors make a brief conclusion that the intervention did not show effects on rates of caseness; meaning the intervention was not effective in lowering postpartum depression symptoms generally as to the standardized diagnostic criteria. They could conclude that women and men with low self-esteem had the poorest adjustment at 6 weeks postpartum.

Pilkington, Milne, Cairns, & Whelan (2016) argue that fathers' postnatal depressive symptoms are often not recognized by healthcare professionals and this limits the fathers' capacity to support their partners. They stress while the fathers' involvement in parenting is increasing the focus is stuck on the mothers' well-being and that fathers' peri- and postnatal mood problems needs recognition as the partners' mental health correlates and partner

support is essential to prevent peri- and postnatal depression. Ishii et al. (2019) argue that there is sparse evidence for educational interventions to improve couples' relationships, but participants in postnatal classes are interested in learning about changes in relationships postnatally and how to deal with such changes (Entsieh & Hallstrom, 2016; in Ishii et al., 2019).

2.4.2 Educational Interventions

Some differences appear in the ways of providing and thinking about what relevant education is to prevent postnatal depression, especially two studies differ in content. The study by Kusuma et al (2019) from Indonesia includes education on such as nutrition, smoking and drug use during pregnancy and the study by Sanaati et al (2019) from Iran included a focus of anatomy and physiology of genital organs and pregnancy, nutrition, pregnancy exercises and sexual matters. It is possible that they differ because they are made to be used by midwives in a context where there is limited or no access to preparation for parenthood classes and antenatal care. The remainder of studies are less concerned with educating on physiological matters, presumable because it is more common knowledge, or this information is being given in a different context. Instead, these studies have a psycho-educational and cognitive-behavioral focused, providing education on coping-strategies, support networks, help-seeking behavior, communication, problem-solving etc. The two Australian studies by Pilkington et al. (2016) take a modern approach by incorporating same-sex partners, unmarried partners and other family structures than the traditional man & women. They made the interventions more neutral by referring to just partner, partners and the childbearing mother. Something which should be considered by all parental programs, maternal/paternal care informational material and interventions in order to includes and embrace all family types. Some of the more atypical family structures are most likely already under additional pressure to societal norms and stigma and therefore it seems relevant not only to be partner-inclusive but also aim to be all-family-types-inclusive.

The literature suggests that the important supporters are usually identified as parents, partners and friends. It is therefore interesting that Pilkington, Milne, Cairns, & Whelan (2016) found that panel members were reluctant to endorse items on help-seeking from friends and family. All interventions focus on partner support as being essential, but little attention is being paid to extended family as supporter. The authors argue that it is understudied how other people in the social network can be supportive. O'hara (1985) stress that support from partners and family is essential in preventing postpartum depression and included the extended family to

support and guide in order to prevent postnatal depression. He also suggested that incorporating family can increase the cohesion of the family's social network. The literature points to the need for studies on who are considered supportive, how, when and why. The beneficial support networks for the partners are of course individual due to social relationships and status. Still some general knowledge on other supporters than partners during the transition to parenthood can possible be helpful in order to present ideas for expecting parents on who to ask for support and help and what to ask for.

A general disadvantage of the studies is the brief description of the interventions without many details, also Alves et al. (2018) addressed this issue in their review. The interventions are not created as manuals which are easily implemented, more focus has been giving on testing effectiveness than providing material which is usable in other contexts or could be tested by others to verify effects or see if there is a difference in effect in another population. The study by Locicero et al. (1997) is not testing effects but is made to encourage change on practices on a higher societal and political plan in USA, which is also important but extremely hard to apply. The "Empathy Session" made by Matthey at al. (2004) and used by Ishii et al (2019) also provides a good overview of the intervention and implementation when combining the two articles; but is not set up for easy implementation with the resources available. Only the study by Pilkington, Milne, Cairns, & Whelan (2016) is providing the full intervention with all details and material available. They encourage others to use their material when crediting the source and distributing the material non-profit. By making the material and resources available for others to study and replicate it is possible to keep building on interventions to make new and improved interventions to assess instead of having to start from scratch.

2.4.3 Risk Factors

Majority of the articles suggest risk factors such as: previous mood disorders including depressed mood during pregnancy, previous episodes of depression, lack of partner support, low self-esteem and marital dissatisfaction. Majority of the articles are focusing on the interventions effect on mothers EPDS scores and has a maternal focus and few mention risk factors which are specific for fathers. Sanaati et al. (2018) argue that the risk is even higher for women who drop out or who are unwilling to participating in routine antenatal care or treatment as they are more likely to suffer from postpartum depression and have additional risk factors. This stress the need for preventative efforts during pregnancy. The high-risk group is already reluctant to participate in activities such as antenatal and treatment which

predicts higher risk for postpartum depression and with no antenatal care and limited contact with health providers the depression is more likely to remain untreated which can have severe consequences for the new families. Despite knowing that mothers' unwilling to attend places them in a high risk group, makes it interesting how none of the articles are concerned with fathers' who are not willing to participate in health care sessions or interventions or who drop out – and especially the relevant fact that many men cannot attend the classes due to their work schedule. Pilkington, Milne, Cairns, & Whelan (2016) found it surprising that their panels members did not endorse any items relating to both mothers and fathers attending antenatal appointments or classes. They argue that attendance by both partners might not seem relevant as to prevent perinatal depression. Another possibility mentioned is reluctance to endorse these guidelines due to the current status with antenatal classes and health service focusing on maternal mental health and how these classes are commonly only attended by the mother. The authors highlight the need to investigate alternative formats and timings so both partners can attend, as fathers are often limited in participation due to work commitment. The same article also mention that fathers report that the potential for fathers to develop postnatal depression symptoms is not often recognized by health care professionals and yet neither the panel of consumers whom have experienced peri- or postnatal depression nor the professional panel working with peri- and postnatal depression endorsed the item related to the importance of fathers participating in antenatal appointments or classes. It is rather straightforward that when the father by default do not attend antenatal classes or health care appointments due to a maternal focus or due to the common understanding this is most commonly only the mother attending or because of work commitments they will experience that health professionals do not recognize fathers' depressive symptoms - simply because they are in limited contact with health professionals antenatal and with the professionals focusing on mothers' mental wellbeing. Knowing the risk is higher when withdrawing from antenatal classes and care, it is most likely even harder to discover fathers' depressive symptoms when it is socially acceptable that they just do not attend, they do not even have to be reluctant or unwilling – they are already excused.

2.4.4 Protective Factors

Majority of the studies accept partner support, social support and relationship satisfactory as being essential in order to prevent postpartum depression. Most of the interventions are aiming to improve these factors as a prevention strategy. Also, the fact that having expectation of parenthood meeting the reality is a protective factor should be obvious – if we

know what to expect, we can prepare mentally and practically. This should be fairly easy to educate on, by letting parents know how it is like to become parents. Locicero et al (1997) points to the societal problem that most parents are taking care of their infants without any additional support due to the belief that this is a task the parents should handle without help from others. O'hare (1985) argued that it is ideal to involve the extended family members as the primary ones, in order to educate on transition to parenthood and to guide to the right expectations and let family members express which practical tasks they could help with after childbirth. Locicero et al. (2017) also argued that parents are exposed to conflicting advice from various sources which creates uncertainty and even conflicting expectations. Pilkington, Milne, Cairns, & Whelan (2016) argue how a person who feels in control of risks for perinatal depression is less likely to develop symptoms and by informing expectant parents on actions they can take to prevent depression can help increase their sense of empowerment and agency. Health care providers should therefore try to help the partners with valid and helpful advice, but without overwhelming the new parents. Providing support is important - but providing the right type of valid support is essential.

Although seven of the included articles mention partner support as being essential in prevention postnatal depression, some important considerations are still unaccounted for. None of the studies included in the review could conclude that their interventions were effective in reducing depressive symptoms for both partners. Three of the articles were not assessing depression rates at all due to the type of study and intervention (Pilkington, Milne, Cairns, & Whelan, 2016; Pilkington, Rominov, Milne, Giallo, & Whelan, 2016; and Locicero et al., 1997). Three articles only provide measures for the mothers' depressive symptoms (Sanaati et al, 2018, Kusuma et al., 2019; and Ishii et al., 2019). Sanaati et al. (2018) found their intervention effective on reducing mothers' depressive symptoms but did not assess fathers, although they refer to their previous study in which they conclude the lifestyle education to be effective in fathers (Charandabi, Mirghafourvand & Sanaati, 2017). In the study by Kusuma et al. (2019) the husbands participated in part of the intervention by receiving education, but the study had a maternal focus and was only assessing mothers' depressive symptoms. The study by Ishii et al. (2019) used the intervention designed by Matthey at al. (2004), where the fathers also received the interventions. Ishii et al. (2019) were concerned with maternal mental health and paternal empathy and therefore only assessed the depressive symptomology amongst the mothers. Cussiono et al. (2016) reported the prevalence of fathers' depressive symptoms at two measures, but the study failed to report

or measure the effect of intervention and difference between control group and experimental group on fathers' depressive symptoms. Instead the study was concerned with interventions effect on mothers EPDS scores and the fathers filled in the EPDS-P on mothers' symptoms.

Only two studies did measure the interventions effect on both partners, but none found the interventions significantly reduced depressive symptoms for fathers. Ngai et al. (2019) found that depressive symptoms were significantly improved in the couples-group than in the mothers-only group, but there was no significant effect among fathers at any measure. Similar findings were reported by Matthey et al. (2004). Depressive symptoms were significantly improved at 6 weeks postpartum for mothers in the low self-esteem group only, but there were no significant main or interaction effects for men at either time point, except from the men with low self-esteem were reporting poorer adjustment.

It is interesting that fathers' participation in partner-inclusive interventions helps reduce mothers' depressive symptoms, but no significant effects were found for the fathers. Judging by the content of the reviewed interventions it can be argued that there is still a larger maternal focus even when designing partner-inclusive interventions, this is shown both in the tendency to only assessing the mothers but also in the content of the interventions which is not demonstrating an equal partner focus on lowering risks of postpartum depression in both parents. The interventions seem to prepare fathers to be able to assess and support the mothers in order to lower her depressive symptoms – more than they aim for mothers to assess fathers' depressive symptoms and educating on support for fathers.

2.4.5 Directions for Future Research

The fact that no interventions in this review were found effective in preventing postnatal depression in both partners does not mean it is not a research area of importance. The literature suggests there is a link between mothers' and fathers' postnatal depression so there is a good reason to focus on preventative efforts targeting both parents. The research on the topic is still scarce. In order to create effective interventions more studies which provide transparency of interventions is essential; so they can be replicated or amended in order to test effectivity. The Cochrane review of 28 trials by Dennis & Dowswell (2013) found no studies stating that the husbands were the most important sources of social support. Still, there is a societal consensus that partners are the most important sources of support postpartum. Further research should investigate the effectiveness of different sources of support and try to identify which combinations of supports create the most effective support

networks. Cussiono et al., (2016) mention that the important supporters are identified throughout literature as being the parents, partners and friends. Also, O'hare (1985) and Ngai et al. (2019) argue that support from family members postpartum can help the couples adapt to the new parenting role and lower the risks of postnatal depression. Pilkington, Milne, Cairns, & Whelan (2016) argue that there is a lack of research on how other people in the network can be supportive. Further research is needed to create new interventions and to investigate effects of preventative interventions. Research should also assess who and how other people in the family network can be supportive in order to prevent postnatal depression in both partners.

Further research is needed on this topic in order to develop and test more interventions incorporating educational strategies to prevent the risk factors and to enhance the protective factors with an equal focus on both parents in order to create interventions which can possible be found effective for both partners. The need includes development and assessment of new psychological treatment interventions for both partners that include structured and transparent programs which can be published in order to implement such in existing child preparation programs in a beneficial, easy and cost-effective way.

2.4.6 Limitations

The limitations of the study include how the review is made by one author, and only one person assessed all articles against inclusion and exclusion criteria. The results were therefore not compared, nor were discrepancies discussed. In order to make this process as transparent as possible the inclusion and exclusion criteria is noted on all articles in a summary (Addendum 3). To assess the quality the review two separate checklists were used. The CASP appraisal form for Systematic Reviews (Addendum 15) and the PRISMA checklist (Addendum 16) were filled out as assessment tools. On the PRISMA checklist there were a few limitations due to the nature of an integrative review including both qualitative and quantitative literature. With the homogenous articles included in the review it was not meaningful nor possible to conduct a metanalysis, as the research results are not comparable.

2.4.7 Clinical Implications

Special attention should be given to the partners who drop out or are unwilling to participate in the routine antenatal care or treatments as this group is more likely to suffer from

postpartum depression (Sanaati et al., 2018). Additional efforts should be made to reach, assess and help these parents and families that go “under the radar”.

Fathers report that their depressive symptoms are not often recognized by health care professionals. This is possibly related to fathers not participating in antenatal consults due to work commitments and that majority of interventions has a maternal focus so it is socially understood that only the mothers should attend. Increased efforts should be made to get both partners to attend health care appointments in order to assess the couples’ relationship, partner support, self-esteem and to identify symptoms in order to prevent or diagnose and treat peri- and postnatal depression amongst both partners. Fathers’ depressive symptoms can differ from the mothers’ depressive symptoms: examples are anger, avoiding being home, burying oneself in work or hobbies, alcohol or drug consumption amongst other. It is therefore essential to assess if there are abnormal mood or behavioral changes in either parent. It is also important knowledge that postnatal depression is most likely underdiagnosed since parents can be reluctant to disclosure mood problems during the transition to parenthood and additionally health professionals can be reluctant to give these diagnosis (Pilkington, Milne, Cairns, & Whelan, 2016).

Another clinical implication is that the diagnostic criteria with onset specifiers of 6 weeks in ICD-10 and 4 weeks in DSM-5 are not matching the clinical work which often accepts periods of up to 3-6 months postpartum (Videbech, 2019), nor the more current research in the field—here a systematic review and meta-analysis report peak prevalence at 3-6 months postpartum (Paulson & Bazemore, 2010). It is estimated that if postnatal depression is left untreated between 30-50% of cases will remain depressed one year postpartum (Matthey et al., 2004).

2.5 Conclusion

Across the existing literature ten articles on prevention of peri- and postnatal depression in both partners were found. The articles point towards elements of education, mainly psychoeducation, as being essential in preventing peri- and postnatal depression. The interventions vary in type and focus, as they are created to different populations in different countries and made by different type of professionals such as midwives, psychiatrists, psychologists and other health providers who have different objectives and aims. Although the interventions varied, all were universal prevention strategies and had an educational focus in order to improve partner support. The limited amount of interventions and the diversity in

the type makes it difficult to evaluate their effectiveness overall. There were three of the included articles which did not assess depression rates due to study type (Pilkington, Milne, Cairns, & Whelan, 2016; Pilkington, Rominov, Milne, Giallo, & Whelan, 2016 and Locicero et al., 1997). Three other articles provide measures only for the mothers' depressive symptoms, not for fathers (Sanaati et al., 2018; Kususma et al., 2019 and Ishii et al., 2019). One study reported the prevalence of all the participating fathers' depressive symptoms as a group at two measures, but only assessed the effect of intervention on mothers not on fathers (Cussiono et al., 2016). The final two studies reported on the interventions effect for both partners but none of these were concluded to be effective in lowering depressive symptoms in both partners (Ngai et al., 2019 and Matthey et al., 2004).

Peri- and postnatal programs occur as part of regular maternal care programs in many settings worldwide; yet there are a limited number of programs that specifically include interventions for prevention of postnatal depression and even fewer which address both parents' mental health. In this review none of the articles found the intervention to be significantly effective in preventing depressive symptomology in both partners. The literature acknowledges the value of having supportive partner and address that both partners should be targeted in the interventions due to the interrelatedness between mothers' and fathers' postnatal depression. In 1985 O'hara argued how the partners should be viewed as a system under stress and equal attention should be provided to both in order to prevent postpartum depression. Researchers tend to agree on this idea, but in reality, it is not yet the case in the current studies as they still lean towards a maternal focus even when described as partner inclusive. The knowledge of interrelatedness between mothers' and fathers' depressive symptomology combined with the long-term consequences of postnatal depression for the entire family stresses the need of a change in focus of interventions from mainly mothers to being genuinely partner inclusive.

2.5.1 Funding & Conflict of Interest

This article was a part of a master thesis, and no funding was received, and no conflict of interest is declared.

3. Intervention for Professionals

3.1 Background and method

In the following section the background and rationale of creating an intervention for professionals on prevention of postnatal depression is discussed. Finally, the method is explained to provide information and transparency.

3.1.1 Rationale

No easy-to-implement interventions for professionals on prevention of postnatal depression in partners were identified in the literature. The same conclusion was made in the review by Alves et al. (2018), who addressed the need for transparent and thorough information about the specific content of the sessions delivered to the partners. They argue this is needed to implement the interventions into clinical practice and to research the evidence. Since focus is often on treatment of mood problems rather than prevention, normative ethics would suggest that the most relevant and useful angle to this thesis would be to try to create and design an intervention which is easy to implement in a clinical setting and could benefit many expectant partners. The material in this intervention is based on the studies and interventions, which were identified in the systematic review.

Since the intervention is created for use in a clinical setting as a guide or manual it is very explanatory in each single step. This type of manual is not the most exciting material for the readers not aiming to host antenatal sessions, yet it is important start producing more material written in a language where it is useful to other disciplines. Often the antenatal sessions are not facilitated by psychologists so the material should be detailed enough to be implemented by nurses, midwives and other groups of professionals with limited theoretical knowledge on the topic. The very descriptive and thorough material is also essential to overcome the issue of interventions not being transparent and fully described for them to be replicated and assessed in other settings.

3.1.2 Identifying the Aims

The articles and interventions were reviewed to identified aims, which could be found important to cover in the session in order to help the partners, 1) set realistic expectations to the transition to parenthood; 2) increase the partners' knowledge about symptoms of postpartum depression to help identify these in themselves and their partner to promote early help-seeking behavior; 3) enable the partners to find strategies to reduce distress for the partner who is at home with the baby; 4) identify helpful and unhelpful supports and talk

about the resources in their network for support and practical help; 5) enhance problem-solving skills; 6) training of problem-solving skills; 7) provide techniques to modify and challenge negative or irrational thinking and to normalize postpartum feelings of stress, isolation, doubt and low self-esteem/confidence; 8) improve communication skills; 9) give the partners opportunity to ask questions or raise concerns; and 10) provide the partners with a booklet on how partners can help prevent postpartum depression and anxiety.

3.1.3 Information Categories

In order to be able to identify relevant information for the intervention the ten aims were deducted into these five major categories of information; 1) realistic expectations / psychosocial concerns; 2) reduce distress and help the primary caregiver; 3) enhance problem-solving skills; goal setting; and decision making regarding baby; 4) modify negative/irrational thoughts; normalize postpartum feelings of stress; isolation; doubt; and low confidence; and 5) improve communication.

3.1.4 Material

In order to provide the best possible and most relevant information the seven articles from the main disciplines of psychology or psychiatry in the Systematic Review were utilized. Two interventions were not found to be easily applied in an antenatal session; one is a model addressing societal changes in an American context (Locicero et al., 1997); and the other intervention was a usability study of the "Partners to Parents website" (Pilkington, Rominov, Milne, Giallo & Whelan, 2016). The five remaining articles makes the foundation of the intervention (Ngai, et al., 2019; O'hare, 1985; Cussiono et al., 2016; and Matthey at al., 2004, Pilkington, Milne, Cairns, & Whelan, 2016). The study by Ishii et al. (2019) is from the main disciplines of midwifery and health care but since it is based on the psychosocial intervention created by Matthey et al. (2004) it is included to supplement the information regarding "The Empathy Session".

Three of the reviewed interventions consisted of one antenatal sessions between 1 – 3 hours with educational focus and different types of postpartum follow-ups from interviews, mail and phone sessions (Matthey et al., 2004; Ngai et al., 2019 and Ishii et al., 2019). The study by O'hare et al. (1985) suggested family therapy for the new parents to get realistic expectations on parenthood and support and practical help from extended family and friends. The last psychological intervention is a booklet containing guidelines on how partners can

prevent perinatal depression and anxiety amongst partners (Pilkington, Milne, Cairns, & Whelan, 2016).

The articles were reviewed to identify specific actions or assignments provided in the interventions to prevent postnatal depression. Unfortunately, there was not much material accessible on specific actions to reduce postnatal depression in partners. In order to provide the facilitators of this intervention with valid and relevant content on how to prevent postnatal depression the guidelines from the consensus study by Pilkington, Milne, Cairns, & Whelan (2016) were utilized as main source of information. The 214 guidelines on actions partners can take to prevent postnatal depression by Pilkington, Milne, Cairns & Whelan (2016) were assessed and grouped within the five major categories of information, as mentioned above. The categories and the division of the guidelines can be viewed in Addendum 18.

3.1.5 Ten Components of the Intervention

The ten aims identified in the section "Identifying the Aims" were transformed into ten components (or steps). These are a combination of the methods used in the existing interventions. An overview of the components accounting for the antenatal session which covers all the aims are listed below; including information on where the structure, idea and material came from. The full intervention is presented as a step-by-step guide in the section *The Intervention "Prevention of Postnatal Depression in Partners"*.

1) education and awareness on psychosocial concerns related to pregnancy and postpartum.

This is important or essential and is part of all the interventions (Ngai, et al., 2019; Ishii, et al., 2019; Pilkington et al., 2016; Cussiono et al., 2016; Matthey at al., 2004; Sanaati et al., 2018; and Kusuma et al., 2019). Information from the systematic review and the guidelines by Pilkington, Milne, Cairns, & Whelan (2016) makes the basis for the educational section. The information is presented by the facilitator.

2) overview of stressors, signs and symptoms of postnatal depression.

Also, the education of symptomatology is part of most the educational sessions to some extend (Ngai, et al., 2019; Ishii, et al., 2019; Pilkington et al., 2016; Cussiono et al., 2016; Matthey at al., 2004; Sanaati et al., 2018; and Kusuma et al., 2019). The lists created from material by Black Dog Institute (2013), Beyondblue (2015); and How is Dad going? (2015) in Pilkington, Milne, Cairns, & Whelan (2016) and supplemented by information from the Systematic Review. The information on hormonal and biochemical changes is from recent

research by Frøkjær (2020). This is presented by the facilitator to the participants as a presentation. Alternatively, the facilitator can print out the lists and ask the partners to read it together and highlight possible warning signs for themselves and their partner, which enables both partners to consider symptoms and risks.

3) strategies to reduce distress among partners when at home with the baby.

This component is based on information found in the guidelines by Pilkington, Milne, Cairns, & Whelan (2016) and the aims raised by Matthey et al., (2004) "(i) to increase the couple's understanding of each other's concerns, especially postpartum concerns; (ii) to enable the couples to identify helpful and unhelpful behaviors if either found new parenthood stressful". Firstly, this component consists of a same-gender small group discussion, where participants brainstorm and note things or behavior which is helpful in relieving distress in the partner who is pregnant - and the partner staying at home with the baby on maternal or paternal leave. Secondly, the suggestions are supplemented by the facilitator by suggestions found important to prevent perinatal depression and anxiety by Pilkington, Milne, Cairns, & Whelan (2016). The partners are asked to identify and discuss suggestions which are relevant for their situation.

4) identify supports and practical helping-network.

Partner and social support were mentioned in majority of the reviewed articles as being essential to prevent postnatal depression (Cussiono et al., 2016, Matthey et al., 2004, Ngai et al., 2019, Pilkington, Milne, Cairns, & Whelan, 2016, O'hare, 1985, Locicero et al., 1997 and Sanaati et al., 2018). This component is mainly based on the suggestions on Family Therapy by O'hare (1985), which was basically encouragement to engage family members or close friends to support; prepare; and help during the transition to parenthood and postpartum. Firstly, in this intervention the partners are asked to identify and draw their support network and to consider who, how, where and when these specifically can assist. Secondly, the couple should discuss which services they would consider outsourcing according to their needs and financial situation. Third, the couple should discuss these suggestions and create consensus on supports. Fourth, the partners are encouraged to talk to their identified supports to engage them and get their opinion on how they can and would like to assist. This is also considered a way for the partners to start communicating needs and expectations and to prime and promote help-seeking behavior.

5) enhance problem-solving skills, goal setting and decision-making regarding common issues related to caring for a newborn.

This component is part of the interventions by Ngai et al. (2019) and Matthey et al. (2004), unfortunately no information was provided on the specific way this was done in the session.

In this intervention the guidelines by Pilkington, Milne, Cairns, & Whelan (2016) were utilized as material. First, the partners are asked to discuss and provide compatible and realistic answers to questions on their fears, hopes, expectations and roles related to becoming parents. Secondly, the partners are asked to fill out a "do or don't" form on problem-solving scenarios. The problem-solving scenarios are rated as being essential in order to prevent perinatal depression and anxiety in the study by Pilkington, Milne, Cairns, & Whelan (2016). In order to make the task a bit fun and engaging some of the scenarios have been reversed, e.g. "Do not trust your own knowledge and understanding of your baby – instead let others pressure you and make sure you adapt to their expectations (e.g. parents, in-laws, colleagues, family, friends)", which is obviously wrong but important to consider if feeling insecure as a new parent.

6) training of problem-solving;

This component is part of the "Empathy Session" by Matthey at al., 2004, with their aim "(iii) to provide participants with strategies other couples have found helpful when parenthood has been stressful". They provided two scenarios of a stressful day postpartum, which were first discussed in same-gender groups and afterwards discussed as a couple. Finally, the facilitator provided strategies which other couples found helpful.

In this intervention, firstly, the two hypothetical scenarios on a very stressful situation early postpartum are discussed in small same-gender groups. Secondly, the groups are asked to provide suggestions and there is a solution in the material which the facilitator can provide. The small twist is, that the two scenarios are the same situation viewed from two different perspectives; the partner who has been at home all day with a crying baby with a partner who comes home late and unengaged – and the partner who comes home exhausted after a long and stressful day at work to a messy home with the partner sitting on the sofa still in pajama with a sleeping baby.

7) Techniques to modify and challenge negative or irrational thinking which are tending to cause postnatal depression.

Ngai, et al. (2019) used a cognitive behavioral intervention for couples, and this component of teaching cognitive restructuring techniques was part of their intervention. No information was provided on how this step was done in the session, so the material for this intervention is new. A simple model for cognitive restructuring was created to challenge negative or irrational thoughts, the model is inspired by Ackerman (2020). An example is shown, and the model is provided to the participants and they are asked to fill it out and answer a few of the questions thoroughly to get an idea on how these thoughts can be challenged if or when they occur.

Matthey et al. (2004) included the aim "(iv) to normalize any feelings of stress, isolation, or lack of confidence that may be experienced postpartum". This is included in this component with a brief presentation of feelings which are uncomfortable but commonly experienced in the transition to parenthood. Such as new parents might feel stressed, fatigued, isolated, doubtful or have low self-esteem and/or low confidence.

8) improve communication skills.

This is component is part of several interventions (Cussiono et al., 2016; Matthey et al., 2004; Ngai et al., 2019; Pilkington, Milne, Cairns, & Whelan, 2016; and Sanaati et al., 2018). Only the prevention strategies by Pilkington, Milne, Cairns, & Whelan (2016) provide suggestions on how this can be done. Information on communication is readily part of several previous components, this step is therefore a brief educational talk on how to improve communicational skills. This is compromised to a short section in order to avoid insulting anyone's intelligence as most people know how to communicate – it mainly when things get hot or they feel pressured that they forget their communication skills.

9) options for participants to ask questions or raise concerns. This is the normal courtesy step of providing time for questions and answers before ending the session.

10) provide a booklet/material for the partners on preventative strategies, symptoms of postnatal depression and a list of useful contacts.

3.1.6 Limitations

Since there was only one author working on this intervention some assistance was needed to ensure the material was useful for other professionals without prior work experience with postnatal depression. One of my psychologist colleagues, who has not been working with postnatal depression and who has not attended any antenatal sessions, was very helpful and

read through the material and helped comment where more information was needed and what was not easy to understand or implement. This was done to ensure the intervention is understandable and easy to implement for other professionals. The material was edited to accommodate these suggestions. Since the intervention is part of a master thesis with specific restriction in duration and volume of the project the intervention has not been tested. It is a product which is created to fill the gap as no other transparent and easy-to-implement interventions were identified in the Systematic Review. Hopefully it can be assessed and modified in future research.

3.2 Measures

In order to assess the intervention and the participants' depressive symptomology some measures are suggested in the following sections.

3.2.1 Measures Suggested Antenatal and Postpartum

These three easy and quick to administrate Likert type self-report questionnaires can be filled out by the participants prior to the intervention and postpartum. Make sure to decide on when, why and how the participants should be assessed. If any participants are suffering from depression according to these measures, they should be referred to the general practitioner for clinical assessment.

- Edinburgh Postnatal Depression Scale, EPDS. 10 questions with 4 options. (Cox, Holden & Sagovsky, 1987)
- Gotland Scale of male depression: 13 questions with 4 options.
- The masculine depression scale: 20 questions with 5 options, 10 questions can be taken out to shorten the process.

A questionnaire which contains elements from the three measures listed above is available in Danish. The questionnaire is used and suggested by Rigshospitalet. The link is provided in the literature list (Madsen, S.A in www.sundmand.dk).

3.2.2 Additional Possible Measures

Depending on the group of participants and time available these measures can be used to assess low self-esteem or support.

- Coopersmith Self-Esteem Inventory (Coopersmith, 1984) women and men.
- Significant Others Scale (Power et al., 1988).

- Postpartum Social Support Questionnaire: 50 questions designed to measure social support received postpartum

3.3 Preventative Intervention for Postnatal Depressions for Partners – Antenatal Session

The following material is a suggestion to how to host an antenatal session to help educate and prevent peripartum depression and anxiety amongst both partners. The intervention contains suggestions for how to assess the interventions quality and usefulness along with a step-by-step guide to building an educational session, which is easy to implement as supplement to the basic antenatal sessions provided. The material also suggests ideas on how to do follow-ups and evaluation of the intervention.

The intervention is based on "The Empathy condition" by Matthey et al., 2004 and the studies by Ngai et al., 2019 and Cussiono et al., 2019 with material from the guidelines to prevent perinatal depression and anxiety by Pilkington, Milne, Cairns, & Whelan (2016). The studies and interventions are combined to create a more complete and transparent intervention, which is easy to implement in a clinical group setting as part of the existing antenatal programs.

3.3.1 Single Session vs. Multiple Sessions

The literature reports difficulties in recruitment, delivery and drop-outs with several sessions. All the psychological interventions identified in the literature was using one single antenatal session to educate the partners about symptoms and help-seeking behavior for postnatal depression. Ngai et al. (2019) hosted a single 3-hour session. Matthey at al. (2004) and Ishii et al. (2014) used the same intervention with a single 2-hour session and Cussiono et al. (2016) also did one single session. All interventions were delivered as part of a longer antenatal preparation program for partners.

The proposed program is one session with a focus on psychosocial issues related to the transition to parenthood. The session should last around 3 hours depending on available resources and preferably as part of the existing antenatal programs as this is considered a supplement only about peri- and postpartum depression. Another possible solution is to divide the material into two 90-minute sessions or even three 60-minutes sessions, depending on the options available and the best strategic implementation to include the material as part of the standard antenatal program.

I suggest the following 3-hour format or as mentioned above, that the material is divided into several shorter sessions. Read the material and make the adjustments you find relevant according to your audience, resources, and your personal style.

3.3.2 Guide and Program

In this section the practical steps of the intervention are presented in a suggested program format. It consists of 12 components: 10 in the antenatal session, which are linked to the aims listed in "Identifying the Aims" and one component is one for follow-up and one is evaluation.

Before start: Hand out printed material (Addendum 17) including an overview of the program including breaks; see suggestion below. Make sure you receive the needed contact information if you intend to do any post-intervention measures, follow-ups or evaluation.

Present a brief introductory of facilitator(s) and present the program. Make sure the participants know that what is talked about during the session should be kept confidential (5 min).

1. Education and awareness on psychosocial concerns related to pregnancy and postpartum (10 minutes)
2. Overview of stressors, signs and symptoms of postnatal depression (15 minutes)
3. Strategies to reduce distress among partners when at home with the baby: First discussed in gender groups. Then add suggestions from this material and ask the partners to discuss possible strategies. (25 minutes)
   Break. 10 min
4. Identify supports and practical helping-network. Who can help with which tasks – how and when? First, an example is provided by the facilitator. Secondly, the couple identify their support network (20 minutes)
5. Enhance problem-solving skills, goal setting and decision-making regarding common issues related to caring for a newborn (30 minutes)
   Break. 10 min
6. Training of problem-solving. Discuss two hypothetical scenarios on a very stressful situation postpartum for both women and men early. Ask the group about solutions and possible solutions are provided by researchers (20 minutes)
7. Techniques to modify and challenge negative or irrational thinking which are tending to cause postnatal depression (cognitive restructuring techniques) (15 minutes)

8. Improve communication skills (10 minutes)
9. Questions (5 minutes)
10. Suggest they read the booklet. Material by Pilkington, P.D., Milne, L.C., Cairns, K., & Whelan, T. (2015). *Supporting your partner when you have a baby* [Brochure]. Melbourne, Australia: Partners to Parents (5 minutes),

    Goodnight and thank you.

11. Follow-up visit or phone session 2/6 weeks after delivery / due date.
12. 10 months postpartum evaluation of intervention perhaps online.

3.4 The Intervention "Prevention of Postnatal Depression in Partners"

In the following you will access the intervention, which is very descriptive and detailed as it is thought as a manual for several types of professionals conducting antenatal sessions. It is important you read the material and the handouts thorough and feel confident with it before presenting it to your group. The headings explain the subject and aim of the specific step you are going to start. The material has *Practical Information* for the facilitator on what to do in the specific step. This is highlighted in the text in *italic*.

3.4.1. Education and Awareness on Psychosocial Concerns Related to Pregnancy and Postpartum.

Practical: Read the below material and present the knowledge about the transition to parenthood to the parents in your own style. Preferably without just reading it aloud.

The transition to parenthood is a very stressful life event. Having unrealistic expectation to having a baby is linked to an increased risk of perinatal depression and anxiety (Pilkington, Milne, Cairns, & Whelan, 2016). It is essential to gain information on how it is like to become a parent by asking various family members or friends with children how their experience was (O'hare, 1985). Having had this talk to relatives and friends also makes it easier to talk about this later if or when things get tough.

Becoming a parent is mentally and physically challenging. You are no longer just a couple; you are a family. You are parents and your little baby is depended on you. Therefore, there is a natural change in division of time, attention and care. Your life will change dramatically. Being mentally and practically prepared can help make this transition easier. One day you might find it difficult to find 5 minutes to shower or get dressed because baby is feeling restless – while the next day your baby takes a two-hour nap and you have time to take care

of yourself or even catch up on sleep. It is therefore hard to plan things. Taking a relaxed and flexible perspective on things might help. Keep in mind it is a limited period of your life. Help each other and consider yourselves as a team who needs to help and support each other for best rates of success. Adapting the dual approach of "preparing for the worst and hoping for the best" can be beneficial.

Practical: Copy these preventative guidelines and make a presentation and talk about the items.

In order to prevent perinatal depression and anxiety partners should be aware that:

- Pregnancy is a powerful and life-changing experience for both mothers and fathers.
- Hormonal changes will affect the child-bearing mother's mood and energy levels
- The partner does not go through the physical changes of pregnancy and giving birth and might only start adjusting to parenthood when the baby is born.
- Even though childbirth is a natural process the child-bearing mother will need support.
- It is normal to experience a wide range of range of emotions during pregnancy and the following year.
- When the baby arrives, the focus shifts from self and partner-care to mostly baby-care and caring for a baby may place additional stress on the relationship.
- Most couples find the transition to parenthood challenging
- Both partners should be at home for at least the first week or two after the birth
- The daily routines will change.
- Existing supports and friendships can change when you become parents
- It is important that both partners learn about the changes in roles, responsibilities, and relationships that occur after birth

Sex

- Pregnancy, birth, and parenting can affect sexual health and intimacy
- Many mothers will have less interest in sex in the later stages of pregnancy and the months following birth due to hormonal changes and the way they feel about their body

- Your sex life is likely to change during pregnancy and following childbirth and may not return to normal for a year or more and may be different to "pre-baby" but not necessarily worse
- If the birth was traumatic, it may impact the sexual relationship and even if the birth wasn't traumatic, it may impact the sexual relationship.
- Pregnancy, birth and parenting can affect sexual health and intimacy due to the physical recovery after childbirth, lifestyle changes after the birth, and changes in body image
- Partners should be aware that their partner may feel rejected or unwanted if they are not interested in sex, but less interest in sex does not mean that your partner is no longer interested in you or attracted to you.
- If partners lose interest in sex, they should explore different types of intimacy, such as cuddling or hand holding
- It is important to communicate what you want and how you feel about sex

3.4.2. Overview of Stressors, Signs and Symptoms of Postnatal Depression

Practical: Deliver the information below to the participants, preferably without just reading aloud.

Symptoms of depression and anxiety are common among new parents. Prevalence rates are up to 23.8% of women and 10.4% of men who suffer from depression between the first trimester and 1 year postpartum (Paulson & Bazemore, 2010). If mother suffers from depression between 24-50% of the fathers also experience perinatal depression (Goodman 2004). Anxiety and depression symptoms are often occurring at the same time and if untreated it can impact pregnancy, the baby and the level of care for the baby. Be aware of the difference between the common baby blues and depression. Because this birth of a baby is expected to be a happy time it is often hard to recognize depression or admit not feeling happy when expected. Many parents are reluctance to disclose their mood problems and do not get the help needed as the professionals don’t recognize the symptoms. Postnatal depression is therefore most likely underdiagnosed. It is important to know the warning signs, risk factors and symptoms so you can seek help early. Drug and alcohol use can mask perinatal depression and anxiety.

Practical: Copy the material below onto a presentation and read for the group. Alternatively print out the lists and ask the partners to read it together and highlight possible warning signs for themselves and their partner - this gets both partners to consider symptoms and risks.

Symptoms of perinatal depression

• Low mood and/or feeling numb most of the day, nearly every day

• Feeling inadequate and/or excessive guilt

• Loss of interest in things that you would normally enjoy

• Being unable to fall asleep or get back to sleep or sleeping excessively

• Not eating or over-eating

• Feeling unmotivated and unable to cope with the daily routine

• Withdrawing from friends and family

• Not looking after yourself properly

• Decreased energy and feeling exhausted

• Having trouble concentrating, making decisions, or remembering things

• Having thoughts about harming yourself or the baby, ending your life, or wanting to escape

Source: beyondblue. (2015) in Pilkington, Milne, Cairns, & Whelan (2016).

Symptoms of perinatal anxiety

• Anxiety or fear that interrupts your thoughts and interferes with daily tasks

• Panic attacks - outbursts of extreme fear and panic that are overwhelming and feel uncontrollable

• Anxiety and persistent worries that keep coming into your mind

• Constantly feeling irritable, restless or 'on edge'

• Having tense muscles, a 'tight' chest and heart palpitations

• Finding it difficult to relax and/or taking a long time to fall asleep at night

• Anxiety or fear that stops you going out with your baby

• Anxiety or fear that leads you to check on your baby constantly

• Fear for the baby and/or fear of being alone with the baby or the baby being unsettled

Source: beyondblue. (2015) in Pilkington, Milne, Cairns, & Whelan (2016).

Symptoms more typical of fathers

These are symptoms which are more typical to fathers and fathers can also get depressed when their partner is not.

• Tiredness, headaches and pain

• Irritability, anxiety and anger

• Changes in appetite

• Feelings of being overwhelmed, out of control, and unable to cope

• Increased risk tasking

• Changes to sleep patterns, especially a lack of sleep

• Feeling isolated and disconnected

• Withdrawal from intimate relationships and from family, friends and community life

• Increased hours at work

• Increased alcohol or drug use

Source: How Is Dad Going? (2015) in Pilkington, Milne, Cairns, & Whelan (2016).

Risk factors

These are some of the risk factors for perinatal depression and anxiety. People are individuals and respond different to stressors and triggers, so if you have some of these risk factors it does not mean you necessarily get depressed.

• Personal or family history of mental health problems or current mental health problems

• Pregnancy, labor or delivery complications

• Perinatal loss, e.g., miscarriage, stillbirth or termination

• Current or history of physical, psychological, or sexual abuse

• Anxious or perfectionist personality

• Lack of support from family and friends

• Stressful life events (e.g., moving to a new house)

• Continuing lack of sleep or rest

• Unplanned pregnancy

• Having multiples (e.g. twins or triplets)

• Severe baby blues after the birth

• Premature baby

• Difficulties with breastfeeding

• A baby that is difficult to settle

• Partner experiencing perinatal depression or anxiety

Unsatisfaction with relationship or partner, e.g. experiencing problems in communication or conflicts; or a lack of support, help, acknowledgement or closeness.

Unrealistic expectations or lack of knowledge on how parenthood is like

Lack of knowledge or information regarding pregnancy, birth, labor and the first time with baby – which can cause uncertainty; low self-esteem or low confidence.

Low self-esteem

Hormonal or biochemical factors (e.g. hypothyroidism or fluctuating levels of estrogen steroid hormone)

Sources: Adapted from beyondblue (2015) in Pilkington, Milne, Cairns, & Whelan (2016); Kjær, *unpub.*; and Frøkjær, 2020.

3.4.3 Strategies to Reduce Distress Among Partners. First Discussed in Gender Groups. Then Discussed as a Couple.

Practical: Read the text below to create an introductory about reducing distress amongst partners.

Partners can prepare for the time with their baby and reduce distress by identifying and discussing how to deal with potential sources of stress before the baby is born, this could be relationship or financial issues. The partner who is pregnant or staying home with the baby is most often the parent who experience the most dramatic and intrusive changes in everyday life, therefore it is essential to talk about how the other partner can provide relief and support.

3.a Strategies to help and support your partner

Practical: Ask the participants to find assignment 3.a in their handouts (Addendum 17). Make groups of maximum 5 participants of same gender and ask them to think of and write down suggestions on what can be done to help relief distress in the partner who is pregnant - and the partner staying at home with the baby on maternal or paternal leave. Ask each group to present their two best suggestions. The suggestions can be typed in a quiz/brainstorm tool and be shown on a big screen to make it more interactive, there are a variety of free online tools. If the technology is not available in your facility the participants can write their suggestions on a black/whiteboard or on pieces of paper and hang with tape for the participants to display.

3.b: Discuss and identify the relevant strategies

Practical: Copy the suggestions mentioned below onto a presentation. Show the presentation while the participants also can see the results from assignment 3.a. Ask the partners to read and identify relevant strategies together which they find useful to their situation (from the suggestions from 3.a and the material below).

Presentation of strategies to prevent perinatal anxiety and stress in partners

- Encourage the child-bearing mother to rest, particularly if she is having a difficult pregnancy
- Support breastfeeding mother and make sure they are hydrated and getting enough sleep
- Help provide a healthy diet with some quick and easy meal options in order to cope with less sleep and recovering from birth or breast-feeding

- Plan, share and agree on the division of chores
- Agree who will go back to the regular job and when
- Re-negotiate the division of chores when needed
- Encourage the partner who is not at home with the baby to be involved with the baby. This will help boost their confidence and build a stronger relationship with your child. Give them space to do so without watching over them.
- The partner at home with your baby might feel trapped at home all day and may feel resentful
- The partner attending work should try to be realistic about what time they can be home. And try to get home on time.
- Provide practical support so the primary caregiver can focus on resting and feeding the baby for the first six weeks postpartum or until the primary caregiver feels recovered or able to take on more duties.
- Identify tasks you can make part of your routine, e.g. bathing your baby or cooking dinner
- Ask your partner which type of practical help they would like
- Help rather than getting angry if your partner finds it hard to cope with everyday chores
- Discuss it with your partner if you are nervous or unsure about providing practical support
- Acknowledge your partners help and support
- Provide breaks to the primary caregiver which they can count on, e.g., take the baby out for a walk, so your partner can do something they find pleasurable (e.g., a warm bath or reading a book)
- Arrange so the primary caregiver has some leisure time at least once a week
- Help with the baby if your partner is getting upset or flustered
- If you have older children, you can arrange taking turns on caring for that baby so the other partner can spend some time with the older siblings without the baby.
- Help the primary caregiver
- Tactfully limit visitors and set boundaries if a partner is overwhelmed. Make sure visitors do not outstay their welcome or turn up at inconvenient hours. Consider having a word, phrase or excuse to use if visitors are overwhelming.
- Nurturing each other enables you to nurture the baby

- Let each other know you are there for each other and do what you can to strengthen your connection
- Be patient and understanding
- Show your partner appreciation and love (e.g. give massages, make their favorite meal or get them flowers)
- Commit to and enjoy some quality alone time. This might be a luxury you previously have taken for granted.
- Consider how you might get to do enjoyable activities together, perhaps things you liked doing before you had the baby
- Encourage each other to be physically active or exercise either individually or together
- Encourage each other to sleep when needed
- Help each other to get out and get some fresh air.
- Get outdoors together with the baby as much as possible.
- If your partner is resistant to going out then think of activities, they can do at home to give them a break from parenting, e.g. watching a movie or reading a book.
- If the mother is admitted to a mother-baby unit, the partner should make the most of visitation hours to maintain contact with the family
- Reassure each other it is okay if you are not interested in sex. This is normal.
- Ask which level of support the mother would like during childbirth (e.g., massage, acupressure, reassurance, verbal encouragement) but be flexible on the day.

3.4.4. Identify Support and Practical Helping Network

Practical: Read the information below and present the topic to your participants in your own style.

Family members and close friends can help the new parents with childbirth preparation and childcare as stress relief. It is therefore important that the parents have identified the people who can help; how they can help and when they can help. Help-seeking behavior might not be considered at first as most parents are convinced, they need to manage everything singlehanded (Locicero et al., 1995) – when before the saying was "it takes a village".

Family members or close friends can provide help with household tasks and childcare. This is a way for the couple to occasionally get some time to themselves without the baby and a way to create cohesion of the family's social network (O'hare, 1985).

To help prevent perinatal depression and anxiety it is recommended that during pregnancy the partners should identify people who will help them following childbirth and discuss and consider what supports they wish to draw on when they become parents, e.g. family. They should accept support from people they both feel comfortable inviting into their home and/or helping taking care of their child. Ongoing the partners should discuss if the extended family is being intrusive or supportive. It is also recommended that partners make and agree on strategies for seeking help as this can help the family to seeking help when needed (e.g., we call his mother if we need help cooking, we call my sister if we need to catch up on sleep).

During the first weeks after delivery both partners should arrange to be at home if possible. If one partner works away from home a good support network is essential. Partners should also discuss and agree on which practical help with home duties (such as gardening, cleaning and cooking); childcare and other support the primary caregiver can get if the other partner is unable to help, e.g. hire a cleaner 2 hours twice a week, order grocery delivery and have his/her mother help babysit every afternoon for an hour.

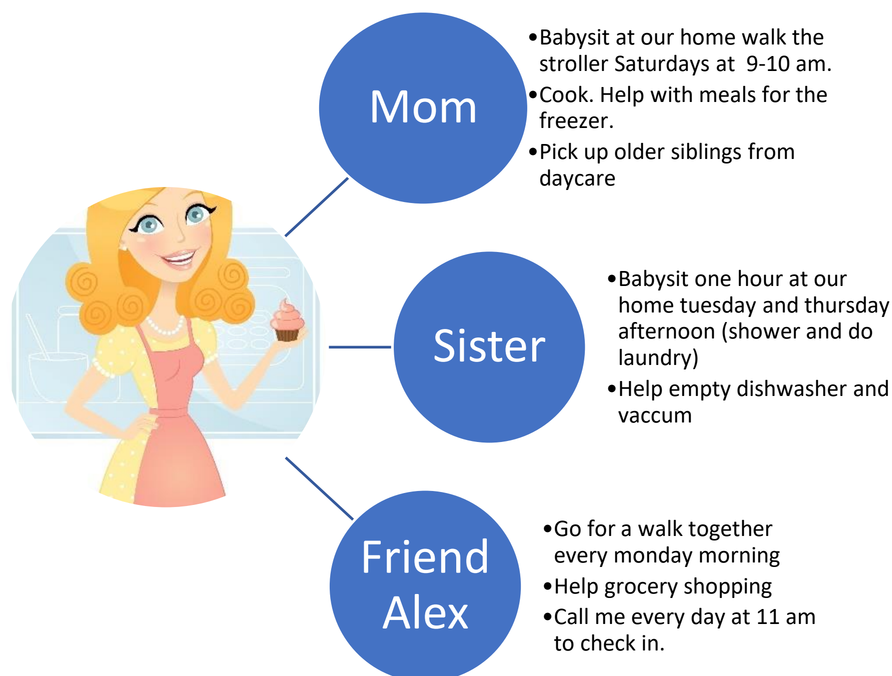
4.a: Your support network

Practical: Ask the participants to turn to assignment 4.a in their handouts (Addendum 17). Take them through the five steps below, one at a time.

1. *Draw a network of possible sources of help and support on a black/white board or show the example below with a mother's network. Explain that every family is unique – if no family is available then suggest considering friends or services providers for help (cleaner, babysitter, grocery delivery). Ask the partners to draw their main support network together.*
2. *Identify what the people or service providers can help with and when. Ask partners to identify what their family and friends could, should and would help with. Many new grandparents, aunts and uncles hope for a close relationship with the new family, so asking them to help can also be doing them a favor to let them take part in your daily life.*
3. *Ask the participants to discuss which services they would consider outsourcing according to their needs and financial situation. They can note the possibilities below*

their network map. For example: grocery delivery, laundry service, cleaners, babysitters, gardening, take-away or meal delivery.

4. *Ask the partners to discuss this network model together for a few minutes to create consensus. E.g. do both partners agree to the mother-in-law moving into the guestroom the first month? Are both partners okay with friends helping with gardening? And so on.*
5. *Encourage the parents to show or talk to the people who they considered supports or practical helpers to engage them and get their opinion on possible tasks, places and times they can help during pregnancy and postpartum. Maybe the plan they make now is not ideal for the support, but this is a way to start communicating about expectations and needs – and promote help-seeking behavior.*



Example from Addendum 17 - *Handouts to Participants in Antenatal Session*.

3.4.5. Enhance Problem-Solving Skills, Goal Setting and Decision-making Regarding Common Issues Related to Caring for a Newborn.

Practical: Read the text below and present for your participants.

When becoming parents, it is a good idea to think about which sort of partner and parent you want to be and think of ways you can achieve this. Discuss your fears, hopes and roles related to becoming a parent prior to the birth of this baby. When communicating your expectations on parenting try to ensure these are compatible and realistic. Unrealistic expectations can

cause problems in your relationship, for instance thinking you will have the same time available for work and leisure as before the baby was born.

Note that several services are available to help with the challenging aspects of parenting, e.g. Maternal Child Health Nurses, Parenting Centers, Baby Sleep Clinics, various hotlines.

5.a: *Practical: Ask the partners to find assignment 5.a in the handouts (Addendum 17). The questions listed below, which are also in the handouts, are identified as relevant to prevent perinatal depression. Ask the partners to discuss the questions and to note their answers on the lines provided below each question.*

Discuss with your partner. Be realistic and make sure your expectations are compatible and review your priorities and expectations after the birth of your baby.

Which sort of partner and parent do you want to be – and how can you achieve this? Be aware you bring separate pasts experiences, ideas and hopes to your new family – how can you combine these?

Discuss your parental roles? Consider your own childhoods and discuss how this might influence what you do and say as a parent e.g., if you partner was not parented warmly themselves, they may need encouragement to spend time with their baby.

My fears and hopes related to becoming a parent are?

What is important to each of you and how can the needs be met? E.g. affection, financial security, time together as a family.

After the birth of your baby you should discuss any differences in parenting. That way you can ensure that both parents are happy with how the infant is being parented or work on compatible ways of parenting.

5.b: Problem-solving.

Practical: Ask the participants to find assignment 5.b in their handouts (Addendum 17). Explain that these problem-solving scenarios are rated as being essential in order to prevent perinatal depression and anxiety. Some answers might seem obvious but nonetheless important. Ask the couple to categorize these problem-solving scenarios as "do and don't" by writing + (do) and – (do not) at the items. See your correct answers below.

Take a break if your tempers are too hot and return to communicating when you are calmer. You can say something like "I want to listen to you. I know this is important, but I'm having a hard time because we're so mad at each other. Can we take a break and talk about it later?"	+
Let fights continue overnight	-
Judge each other, e.g. thinking in terms of who is right and who is wrong, or thinking of their partner as the enemy or "the one with the problem"	-
Seek professional help if you have difficulties resolving relationship problems	+
Review progress when problem solving by discussing what worked well, what didn't work and what you should change	+
You can always pre-empt or fix everything that goes wrong	-
Take turns when problem solving	+
Do not hear the positive in what your partner is saying when problem solving	-
Avoid jumping to conclusions when problem solving	+
Try to force the other partner to change when problem solving	-
Parents always do things the same way	-
Different experiences can be good for your baby	+
Do not trust your own knowledge and understanding of your baby – instead let others pressure you and make sure you adapt to their expectations (e.g. parents, in-laws, colleagues, family, friends)	-
Suppressing your thoughts and feelings can cause your partner to feel shut out	+
Be willing to continually explore and adapt – as what works one day may not work the next	+
Conflict is a natural part of relationships	+
It is best to raise problems in front of other people (e.g. at the supermarket or at a dinner party) or when you are hungry, tired or had a bad day	-
Engage in problem solving together by identifying the problem, brainstorming solutions, choosing a solution, evaluating the solution, and making a follow-up action plan	+
When problem solving you should not take responsibility for your own behavior and the impact of it	-
Try not to bottle-up your feelings as it makes it more likely they come out the wrong way, for instance during an argument which is not ideal.	+

Good management of conflict will benefit your relationship and your child/children	+
Do not try to resolve small conflicts. Instead let them escalate into major rifts	-
Learn and become aware of your own and your partners warning signs that they are getting overwhelmed, e.g. raised voice, clenched jaw, door slamming, irritability, indecisiveness	+

3.4.6. Training of Problem-Solving

6.a *Practical: Ask the participants to find assignment 6.a in their handouts and return to the small same-gender groups as previous. Ask the groups to discuss the two hypothetical scenarios on a very stressful situation early postpartum. Afterwards ask if any groups will volunteer to share their suggestions. The facilitator can also read the solution listed below or provide another possible solution.*

1) Partner B arrives home after work - exhausted, hungry and tired after a very stressful day with arguments with the boss. Partner B is completely drained and needs some time to relax before engaging with the family. The house is a total mess and dinner is not prepared. Partner A has been at home all day with the baby. Partner A is sitting on the sofa still in pajamas with the TV turned on with a sleeping baby. <u>What does Partner B do or say?</u>

2) Partner A is feeling exhausted after a rough day with an unsettled baby who wanted to feed all day and was crying every time, he/she was not being held. Partner A is starving after not having time to eat all day but sits quietly in the sofa afraid to wake up the baby who is finally sleeping in his/her arms. Partner B comes home an hour late from work without notifying the family. Instead of offering to take the baby or prepare dinner Partner B just sits down on the sofa, put his/her feet up and watch TV. <u>What does Partner A do or say?</u>

6.b. *Practical: Below you find possible solutions for the two stressful scenarios above. First, ask the participants if anyone wants to share their suggestion. Afterwards read the text below and present it to the participants.*

The two situations could be the same situation from two different perspectives. Instead of blaming or being annoyed with your partner it is a better approach to be relaxed and understanding as you cannot know what your partner has been dealing with.

Make sure you don't end up in the trap of making it a game of who is having the hardest time "you have only been to work, at least you ate lunch. I have not eaten all day" or "you just sit at home with the baby, I have to be at work at 7 am to make money"; this is not helpful and it is not a competition of feeling worst – it is a competition to make each other feel the best possible.

Act like a team – help each other through and keep in mind the better you both feel the better for your baby. Keep in mind it is temporary as the baby grows and gets more independent.

In both scenarios the partner could say: "it looks like you've had a rough day. I also had a rough day at work/with a crying baby. I will order a pizza for delivery. Let us sit and relax watching a movie together and eat pizza while the baby is sleeping. The mess isn't going anywhere so let us deal with that tomorrow and go to bed early. Great job mom/dad".

3.4.7. Techniques to Modify and Challenge Negative or Irrational Thinking Which are Tending to Cause Postnatal Depression (Cognitive Restructuring Techniques)

7.a: Modify and challenge negative or irrational thinking.

Practical: Ask your participants to find assignment 7.a in the handouts (Addendum 17). Read the information and show the example in the model below. The example in their handouts is blank for them to fill in. Ask the participants to individually think of (or write down) one negative thought they have about becoming parents – ask them to select maybe 3 or 4 questions for the thought and provide in-depth responses rather than answering many questions

When you identify some negative or irrational thoughts you can explore where they come from and why you started believing it. Identifying that this thought is destructive or even harmful you can challenge the thought and possibly defuse it (Larsson, Hooper, Osborne, Bennett, & McHugh, 2015).

An expecting parent fears that he/she will become a horrible parent. He/she feels bad and has negative thoughts and low self-esteem. Instead of accepting this faulty belief he/she thinks about what evidence there is which makes him/her subject to becoming a "horrible parent". It is just a negative feeling he/she has about themselves as no facts are supporting the thought. It is up to you to become a good parent. Knowing this is an irrational fear can make it easier to actively work on becoming a good parent instead of just accepting the thought of being a horrible parent.

Thought to be challenged: I am going to be a horrible parent

Evidence supporting the thought

My parents were horrible

Evidence against the thought

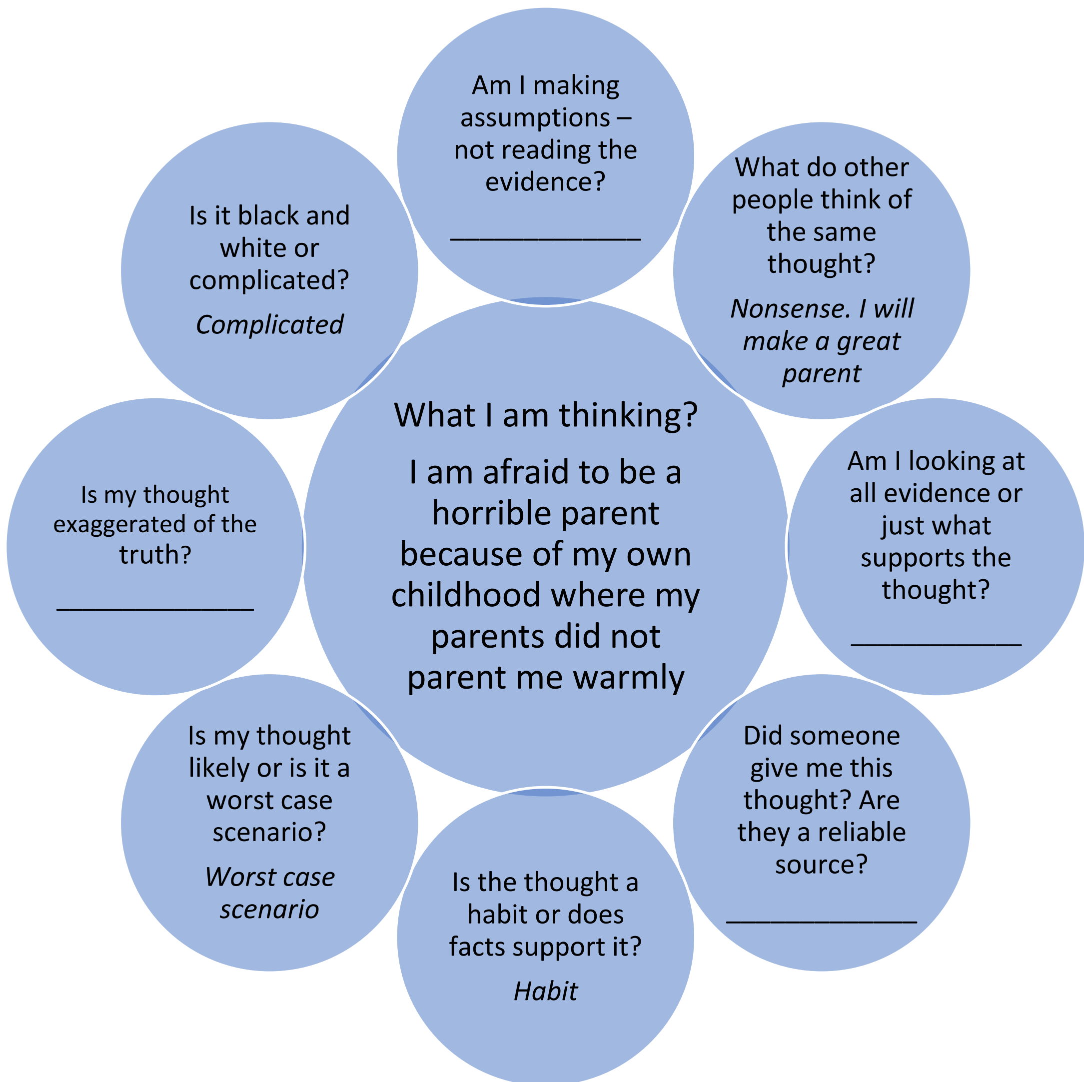
I am not my parents

I am good with children

Other people say I will make a great parent

I have never tried it before

Is the thought based on facts or feeling? *Feeling*



Model inspired by Ackerman (2020)

7.b: Normalization of feelings related to parenthood.

Practical: Read the text below to your participants and show the pointers on a presentation.

It is normal that new parents feel stressed, fatigued, isolated, doubting and having low self-esteem and/or low confidence. Even when things are progressing normally pregnancy and parenthood can put stress on you, your partner and immediate family (Matthey et al., 2004 and Pilkington, Milne, Cairns, & Whelan, 2016).

The stressful parenthood

- Having a baby can involve loss and grief, such as loss of freedom, work, identity, financial independence and social contacts. Having these feelings or feeling stressed doesn't mean you are failing your baby.
- It is common to experience an increase in arguments and tension during pregnancy and postpartum.
- Acceptance is an attitude which can reduce the stress and challenges of working together to raise children. Acceptance also create a healthier, happier and positive environment for the family
- When things get tough keep in mind it is temporary – your baby will begin to sleep more, eat less often and it will get easier to take them out of the house.
- Enjoy your family rather than feel you are missing out on the old days
- Learning about changes and challenges in the transition to parenthood may help you recognize and respond to the difficult situations but will not protect you against them.
- Even if you have a supportive relationship you might experience difficulties during the transition to parenthood
- You may be vulnerable and competent during different developmental stages of your child's life, e.g. some fathers feel they are more competent when the child is a toddler.
- Your attitude towards your partners parenting affects their confidence in caring for the infant

3.4.8. Improve Communication Skills

Practical: Read the information below and present to your participants.

Talk together daily: Open communication will strengthen your relationship. Babies develop well if their parents can relate to each other with respect and affection. Complement each

other's parenting and support each other by letting your partner know you are there for them. Share your concerns, thoughts and feelings and listen to each other's concerns in a respectful and non-judging way. Talking is a major part of resolving problems or conflicts. It can be very hard to talk about painful or negative thoughts, try to validate each other's thoughts, experiences and worries in a caring way.

Actively listening: Stop what you are doing and show you are giving your full attention. Use body language to show you are listening, for instance by having eye contact and sit in a relaxed position. Wait until the other has finished speaking before offering your opinion or suggestions.

When raising problems: Stay on your own lane. You do not control how your partner feels or behaves but you can explain how their actions make you feel. Try not to imply your partner is always wrong, avoid saying "You always ..." or "You never ...". Use I statements, e.g. "You don't make any time for us anymore" vs. "I feel sad cause we spend less time together". Express your needs without criticizing each other: "You slept all night and I have gone days without sleep" vs. "I am really tired; can you take the baby duty for a few hours so I can catch up on sleep".

Do not blame each other is you have problems communicating as a couple. Instead seek professional help as communication is an essential skill when parenting.

3.4.9. Questions

Practical: Encourage the participants to ask questions or raise concerns.

3.4.10. Provide a Booklet / Material

Practical: In English you can provide the material by Pilkington, P.D., Milne, L.C., Cairns, K., & Whelan, T. (2015). Supporting your partner when you have a baby [Brochure]. Melbourne, Australia: Partners to Parents. The brochure is a summary of some of the things presented in this educational session, so the participants can read it at home or look up symptoms or prevention strategies. The booklet can also be found helpful to provide education to people in the support network and can be handed to relatives or friends if one of the partners are experiencing perinatal depression or anxiety. A Danish translation and modification of the brochure is available in this paper in section 4.0 *Translation of Preventative Guidelines.*

It is a good idea is to add a list of relevant contacts for your local area, e.g. suicide hotline, emergency numbers, midwives, parenting hotlines and others. You can also translate the booklet into the suitable language for non-profit purposes when following the criteria mentioned for reprinting and copyrights.

3.4.11. Follow-up Visit or Phone Follow-Up Session after Delivery

Practical: Meet or call the participants as you have agreed upon, for instance two or six weeks after delivery / due date. Be polite and ask if it is a convenient time or schedule another possible time. Do relevant assessment if you are doing measures, e.g. EPDS. If you sense that any of the participants might be depressed ask them to contact their general practitioner or other health professionals. Remind them about the booklet for references and contacts.

3.4.12. Postpartum Evaluation of Intervention

If possible, ask the parents to evaluate the interventions perhaps 10 months postpartum. For instance, by sending them a brief online questionnaire and thanking for their participation and time. This can be done by asking a few questions to be rated on a Likert Scale. See example below.

I found the session about perinatal depression and anxiety helpful. (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.

I found the session about perinatal and anxiety to be too long. (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.

The information provided in the sessions was relevant. (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.

The facilitator was engaging the audience when teaching. (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.

The booklet provided was helpful (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.

The follow up visit / call was helpful. (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.

Additional comments:

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4. Translation of Preventative Guidelines

Since no material was identified in Danish on how to prevent postpartum depression in partners, the guidelines created by Pilkington, Milne, Cairns, & Whelan (2016) were translated to Danish for them to be helpful locally in a clinical setting.

The guidelines should not be written in an academic language for professionals but should be easy to read and understand for majority of expectant partners. I teamed up with my brother who is not afraid of correcting me when I am wrong and was willing to take on the task of translating the 214 items. My brother works with IT and is a parent himself. Furthermore, he is a good translator as he has been living abroad for 8 years and is in an international relationship - so English is considered his second language and Danish is his mother-tongue.

First, guidelines were translated by one person from English to Danish and afterwards e-mailed to a second party. Secondly, the translation was assessed by the second party and returned by e-mailed with edits, accept or comments. Third, these answers were evaluated and either accepted or returned to the second party again. Finally, all the translations were accepted and agreed upon by the second party.

Since the process was via e-mail the translations are easily verified and the process is totally transparent, see Addendum 19 - "*Translation of Guidelines English to Danish*" to view the full process.

The guidelines were used as basis for the translation of the brochure by Pilkington, P.D., Milne, L.C., Cairns, K., & Whelan, T. (2015), which was modified to fit a Danish context and updated with a few additional pointers from the systematic review. Also, an overview of important Danish contacts, hot-lines and resources was created. To ensure the quality of the material two psychologist colleagues read the material independently and provided comments, suggestions and edits.

4.1 Støt din partner, når I skal være forældre.

Tips til mental sundhed i forbindelse med forældreskab.

Let læselig information og forslag til hvordan du og din partner kan minimere risikoen for symptomer på depression og angst under graviditet og efter fødsel.

Anbefalingerne er baseret på international forskning. Anbefalingerne er blevet udvalgt som de vigtigste for at forebygge fødselsdepression og fødselsrelateret angst af et ekspertpanel af klinikere og forskere som har arbejdet mindst 5 år med mental sundhed under graviditet og efter fødsel, samt et panel bestående af pårørende og mennesker, som selv har haft fødselsrelateret angst eller depression (Pilkington, Milne, Cairns & Whelan, 2015).

Anbefalingerne er formuleret så alle typer par inkluderes, f.eks. par af samme køn. Hver familie er unik og alle forslagene er måske ikke relevante for jer, så brug de råd som passer til jeres situation. Sidst i materialet findes en oversigt over kontaktoplysninger til forskellige typer hjælp, rådgivning og støtte.

4.2 At blive forældre

Mange par finder overgangen til forældreskab udfordrende. Perioden fra graviditet og et år efter fødsel kan vække mange blandede følelser. Selv når det forløber normalt, kan det være en stressfuld periode, både for dig, din partner og den nærmeste familie. At få et barn kan både vække følelser af sorg og tab, f.eks. tab af arbejdsidentitet, frihed og social kontakt. At tage sig af et barn kan også sætte parforholdet under pres. Når babyen er født, flyttes fokus naturligt fra omsorg af partneren og sig selv til fokus på babyen.

4.2.1 Håb, frygt og forventninger

At lære og blive bevidst om udfordringer og vanskeligheder ved at blive forældre beskytter ikke nødvendigvis mod udfordringerne, men det kan hjælpe med at genkende og reagere på dem, hvis de opstår. Før babyen bliver født, kan partnere forsøge at identificere og tale om håndtering af potentielle kilder til stress, såsom parforholdsproblemer eller økonomiske

vanskeligheder. Diskutér dine håb, forventninger og rollerne som forældre med din partner. Forsøg at finde ud af, hvad der er vigtigt for hver af jer, og diskutér hvordan behovene kan opfyldes. Det kan være emner som at være social og tale med andre, nærhed/omsorg, sjov, sikkerhed, økonomisk stabilitet, tid sammen som familie og så videre. Tænk over hvilken type forælder og partner du ønsker at være, og hvordan du kan blive det. Tal med din partner om dine forventninger til at blive forælder og prøv at sikre, at forventningerne er realistiske og mulige. Vær opmærksom på at urealistiske forventninger kan skabe afstand i forholdet; for eksempel er det urealistisk at tænke: ”Jeg har samme tid til rådighed for arbejde og fritidsaktiviteter, som før babyen blev født”.

4.2.3 Tænk tilbage på egen barndom

Du og din partner har forskellige tidligere erfaringer, idéer og håb for den nye familie, og det kan være svært at kombinere disse. Tænk tilbage på din egen barndom og diskuter hvordan din opvækst måske kan påvirke, hvad du siger og gør som forælder. Hvis en partner for eksempel ikke havde en omsorgsfuld opvækst, kan der være behov for ekstra opmuntring til at bruge tid med jeres baby.

4.2.4 Tilpasning til forældrerollen

Efter fødslen kan det være hjælpsomt at genoverveje dine prioriteter og forventninger sammen med din partner. Find tid til at tale om håb, frygt og rollerne som forældre. Vær villige til løbende at udforske og tilpasse jer, da hvad der fungerer én dag, måske ikke fungerer den følgende dag. Du kan føle dig både kompetent og sårbar i forskellige stadier af dit barns liv. Husk, at uanset hvor svært det er, så er situationen midlertidig. Din baby vil begynde at sove mere, spise mindre hyppigt og det bliver lettere at komme ud af huset sammen med barnet. Forsøg at nyde din familie fremfor at føle, at du går glip af de gode gamle dage.

Det kan være hjælpsomt at udvikle en accepterende attitude overfor hinanden, barnet og den nye hverdag, så man kan åbne op og gøre plads til svære følelser og oplevelser. Accept giver et sundere, gladere og mere positivt miljø for hele familien, hvilket kan reducere stress og udfordringer med at samarbejde om at opfostre børn.

4.2.5 Graviditet og fødsel

Graviditet er en kraftfuld og livsændrende oplevelse for mødre og fædre. Opfordrer din partner til at hvile sig, især hvis hun gennemgår en svær graviditet. Det er en god idé at tale om en fødselsplan og intentionerne for fødslen på forhånd. Fortæl din partner hvordan du

føler om fødslen. Den gravide partner bør også tale med sin partner om, hvem der skal være til stede under fødslen. Selvom en fødsel er en naturlig proces, bør du ikke tænke at den gravide kan klare sig uden støtte. At skulle føde et barn kan være angstprovokerende. Partnere kan give støtte ved at give massage, opmuntring og beroligelse. Diskutér på forhånd, hvilken grad af støtte du ønsker, men vær begge klar til at være fleksible på dagen. Hvis din partner bliver indlagt på hospitalet med jeres baby, så forsøg at få mest muligt ud af besøgstiderne for at opretholde kontakten og nærhed med hende og jeres baby.

4.2.6 Tal om fødselsoplevelsen

Forældrenes oplevelser af graviditet, fødsel og tidlig forældreskab kan være meget forskellige. Vær opmærksom på, at modsat den gravide mor, så oplever partneren ikke de fysiske ændringer under graviditeten og efter fødslen. Derfor begynder partneren måske først at justere sig til forældrerollen, efter babyen er blevet født. Hormonelle ændringer påvirker den gravide mors humør og energiniveau, og en grad af stress og udmattelse er normalt efter fødslen. Du og din partner kan have stærke følelser om fødslen og behov for at tale om oplevelsen, så tal med din partner om jeres forskellige oplevelser af fødslen. Hvis fødslen var traumatisk, så kan den påvirke jeres seksuelle forhold. Det kan også øge risikoen for at udvikle fødselsrelateret depression og angst. Hvis du oplever en traumatisk fødsel og ikke føler du har det godt efterfølgende, bør du søge professionel hjælp.

4.2.7 Sex og intimitet

Selvom fødslen ikke var traumatisk, så kan det påvirke jeres seksuelle forhold. Jeres sexliv kan ændre sig under graviditeten og efter fødslen og bliver måske ikke normalt før efter et år eller mere. Jeres seksuelle helbred og intimitet kan blive påvirket af forskellige ting som fysisk helingsproces, livstilsændringer og ændring af kropsopfattelse. Mange gravide har mindre interesse i sex i de sidste stadier af graviditeten og i månederne efter fødslen grundet hormonelle forandringer samt måden, de tænker om deres krop på.

Du kan føle dig afvist eller uønsket, hvis din partner ikke viser interesse i sex. Mindre interesse i sex betyder ikke at din partner ikke længere er interesseret i dig eller føler sig tiltrukket af dig. Udforsk forskellige typer intimitet, som for eksempel kram, knus og at holde i hånden. Jeres sexliv er måske anderledes, efter I bliver forældre, men ikke nødvendigvis værre. Sørg for at forsikre din partner om, at det er okay hvis han/hun ikke er interesseret i sex. Tal med din partner om, hvad du ønsker og føler om sex. Det er vigtigt at være klar over,

at hvis din partner føler sig nedtrykt og har mistet interesse i sex, så kan det være tegn på en depression.

4.3 Vise kærlighed og accept

At tage sig af en baby udelukker ikke, at I som partnere kan tage jer af hinanden. Gør hvad I kan for at styrke relationen til hinanden under graviditeten og efter. Lad din partner vide, at du holder af ham/hende. Gør ting for at vise din kærlighed og påskønnelse, såsom at købe/plukke blomster, lave en kop te/kaffe eller give massage.

4.3.1 Finde tid til hinanden

Efter fødslen er det vigtigt at arrangere kvalitetstid med sin partner, hvor du måske før tog dette for givet. Arrangér nogle aktiviteter, som I begge nyder. Prioriter stille-tid, som I kan tilbringe sammen, mens jeres baby sover, også selvom det kun er i 10 minutter. Tænk over, hvad I plejede at kunne lide at lave, før I fik barn og overvej, hvordan I kan begynde at lave de aktiviteter sammen igen. Forsøg at komme udenfor i den friske luft sammen med jeres baby så meget som muligt. Hvis din partner er tilbageholden med at tage ud af huset, så find på ting som I kan lave sammen i hjemmet, som giver jer en pause fra forældrerollen, f.eks. at spille brætspil eller se en film.

4.3.2 Vise din anerkendelse og værdsættelse

Lad din partner vide, at du er der for ham/hende og forsøg at være tålmodig og forstående. Din partners selvtillid er måske mere skrøbelig efter jeres baby er født. Ros din partners forældreevner ved at give specifikke eksempler, f.eks. ”Jeg elsker hvordan du smiler til vores baby”. Anerkend din partners tanker, oplevelser og bekymringer, f.eks., ”Jeg kan se, hvor hårdt det er for dig. Det ville være hårdt for alle”, ”Du har haft så meget at lave på det seneste”. Lad din partner vide, at han/hun ikke svigter jeres baby eller dig, hvis han/hun føler sig stresset. Lad også din partner vide, hvis du føler, at du har brug for mere anerkendelse, værdsættelse, ros og opmuntring fra ham/hende.

4.4 Tips til at forbedre kommunikationen

4.4.1 Kunsten at lytte

Spædbørn udvikles godt hvis deres forældre er respektfulde og kærlige overfor hinanden. At tale sammen er en stor del af at løse problemer og konflikter. Åben kommunikation vil styrke jeres forhold. Del dine bekymringer, tanker og følelser med din partner. Spørg din partner hvordan deres dag har været og hvordan de har det, fremfor kun at fokusere på jeres baby. Eksempelvis ”Hvad var godt ved din dag?”, ”Hvad var ikke så godt?”. Lyt til din partners

bekymringer, selv hvis du føler du hører det samme blive gentaget om og om igen. Bed dem om at forklare eller uddybe, hvis du ikke forstår hvad der bliver sagt. Når din partner ønsker at tale, så søger de ikke nødvendigvis råd, måske har de bare et behov for at tale om tingene. Undgå at drage forhastede konklusioner. Lyt aktivt for at hjælpe hinanden med at føle jer anerkendt og støttet ved at:

- Stoppe med hvad du laver for at vise, at du giver din fulde opmærksomhed.
- Bruge kropssprog til at vise, at du aktivt lytter, f.eks. ved at bevare øjenkontakt og sidde i en afslappet position.
- Vente med at tilkendegive eller tilbyde dine meninger og forslag, til din partner er færdig med at tale.

4.4.2 At tale om svære emner og smertefulde følelser.

Det kan være svært at finde ord når man skal tale om smertefulde eller negative tanker. Opfordr din partner til at tale ærligt om de ting, de kæmper med. Vær forsigtig med ikke at nedgøre deres bekymringer, når du forsøger at berolige din partner, f.eks. fremfor at sige at noget ikke er et problem, så kan man sige: ”Jeg vil være her til at hjælpe dig med det” eller ”Jeg kan forstå, det virkelig bekymrer dig, men jeg tror, vi kan klare den sammen”. Tal åbent om dine følelser og læg ikke låg på følelserne, da det så er mere sandsynligt at de bliver udtrykt forkert, som f.eks. under et skænderi. Italesæt dine behov direkte fremfor at tænke, at din partner kan læse dine tanker. Hvis du undertrykker dine tanker og følelser, kan det resultere i, at din partner føler sig afvist eller ekskluderet.

Professionel assistance er tilgængelig hvis I har behov for hjælp med at kommunikere effektivt (f.eks. en parterapeut eller en psykolog).

4.5 Konflikthåndtering

Uenighed og konflikter er en naturlig del af parforhold. Det er normalt for par at opleve flere konflikter og mere anspændthed under graviditet og efter fødsel. At håndtere et skænderi eller en konflikt konstruktivt vil gavne jeres barn/børn. Man kan ikke altid afværge eller løse ting som går galt. Prøv at løse de små konflikter, før de eskalerer.

4.5.1 Udtryk dine bekymringer respektfuldt

Bliv enige om at tale om problemerne på at godt sted og tidspunkt, når der ikke er konkurrerende behov, f.eks. når jeres barn/børn er kommet i seng. Hvis din partner ikke ønsker at tale om problemet når det først bliver adresseret, så aftal et andet tidspunkt at tale

om det. Undgå at lade diskussioner og skænderier fortsætte natten over og dermed ødelægge nattesøvnen. Forsøg at forklare dine behov uden at kritisere din partner. Overvej hvad du siger og hvordan det siges, da det kan påvirke hvordan din partner svarer. Prøv at bruge "Jeg-udtalelser"; f.eks. fremfor at sige: "Du har aldrig tid til os mere", kan man sige: "Jeg føler mig ensom, når vi har mindre tid sammen".

Beskriv, hvad der er årsag til dine bekymringer uden at forklare, hvorfor du tænker det sker; f.eks. fremfor at sige: "Du sidder bare og ser TV, mens jeg bliver nødt til at lave aftensmad og se efter børnene", kan man sige: "Jeg synes, det er lettere at lave aftensmad, når børnene er underholdt. Kan du bruge lidt tid med dem?". Undgå ord eller sætninger, som antyder, at din partner altid tager fejl eller ikke forsøger, f.eks. "Du gør/siger altid…" eller "Du gør ikke/siger aldrig…". Tag ansvar for din egen adfærd og konsekvenserne heraf.

4.5.2 Problemløsning som et team

Engagér jer i problemløsning sammen ved at følge disse trin:

1. Identificér problemet
2. Brainstorm løsningsforslag
3. Vælg en løsning
4. Evaluér løsningen
5. Lav en opfølgningsplan

Når I problemløser bør I skiftes til at tale. Fokusér på emnet frem for at afspore samtalen ved at adressere andre problemer eller bekymringer. Forsøg at lytte til det positive i, hvad din partner siger. Prøv at forstå din partners synspunkt, selv hvis du er uenig, f.eks. "Jeg kan forstå hvorfor du er sur over, at jeg inviterede mine forældre over i weekenden uden at tale med dig først". Tilbyd forslag eller eksempler frem for at diktere, hvad din partner skal gøre eller forsøge på at presse dem til at ændre sig. Tænk over jeres fremskridt i at problemløse ved at diskutere, hvad der virkede, hvad der ikke virkede, og hvad I bør ændre.

4.5.3. Undgå at være kritisk

Undgå at kalde hinanden navne, f.eks. "Du er dum!". Lav ikke uhensigtsmæssige sammenligninger med andre forældre. Forsøg at undgå at dømme din partner, f.eks. ved at tænke på hvem har ret, og hvem tager fejl. Eller ved at tænke på din partner som fjenden eller "den med problemet". Undgå at kritisere din partners krop eller forlange, at de taber sig. Hvis du føler dig kritiseret af din partner, så giv dem feedback på, hvordan du føler, f.eks.: "Når du gør/siger, så føler jeg…". Vær opmærksom på forskellen mellem at være kritisk og

angribende, f.eks. kan kritik blive sagt og hørt som velmenende og konstruktivt, hvorimod et angreb er sårende.

Det er en god idé at blive bevidst om egne og din partners advarselstegn på, at I er ved at blive frustrerede, f.eks. bider tænderne sammen, hæver stemmen, smækker med døren, irritation, ubeslutsomhed. Tag en timeout hvis jeres temperament bliver for højt og genoptag kommunikationen, når I er mere rolige. F.eks. kan partneren sige: "Jeg vil gerne høre hvad du siger. Jeg ved det er vigtigt, men det er svært når vi er så sure/vrede på hinanden. Kan vi tage en pause og tale om det senere?". Søg professionel hjælp, hvis I har svært ved at løse problemer i jeres parforhold.

4.6 At dele om arbejdsopgaverne

Jeres daglige rutiner vil ændres, efter I bliver forældre. Det kan være hjælpsomt at planlægge og fordele arbejdsopgaver, aftale hvem som gør hvad, inden babyen bliver født. Tal om, hvordan barslen fordeles, og hvem der tager babyen om natten. Vær villige til at genforhandle fordelingen af arbejdsopgaver efter behov. Diskutér hvordan den primære omsorgsperson bliver støttet og hjulpet med babyen samt husholdningspligter, hvis den anden forælder ikke kan hjælpe (f.eks. ansætte rengøringshjælp, hvis økonomien tillader).

Arrangér så I begge kan være hjemme i mindst den første uge eller to efter fødslen. Forsøg at dele de huslige pligter. Forsøg at hjælpe den primære omsorgsperson, så de kan fokusere på at hvile og give barnet mad de første seks uger efter fødslen, eller indtil de føler sig i stand til at varetage flere opgaver.

Den primære omsorgsperson bør sige hvis de har behov for hjælp ved specifikt at sige hvad de har behov for, f.eks. i stedet for at sige: "Jeg føler mig overvældet og har brug for hjælp herhjemme", så spørg: "Vil du venligst ordne vasketøjet for mig denne uge? Jeg føler mig så overvældet". Husk at anerkende din partners hjælp med praktiske opgaver.

4.6.1 Giv den primære omsorgsperson pauser

Forsøg at arrangere ting, så den primære omsorgsperson har fritid mindst en gang om ugen. Giv den primære omsorgsperson rigtige pauser ved at gøre ting såsom at tage babyen med ud at gå. Hjælp den primære omsorgsperson med at få tid væk fra babyen til at gøre noget, de finder behageligt eller rart (f.eks. en massage eller et varmt bad). Forsøg at hjælpe frem for at blive irriteret, når den primære omsorgsperson har det svært med at klare daglige pligter. Hjælp med babyen, hvis din partner er ved at blive oprevet eller gå i panik.

4.6.2 Vær involveret i børnepasningen

Hvis du er den primære omsorgsperson, så opmuntr din partner til at involvere sig i babyen og giv dem plads til at gøre det uden at overvåge dem, da det vil styrke deres selvtillid og hjælpe dem med at opbygge et stærkt forhold til jeres barn. Din attitude over for din partners måde at være forælder på påvirker, hvor selvsikre de føler sig i at drage omsorg for jeres baby. Acceptér, at I måske gør tingene forskelligt, og at disse forskellige oplevelser kan være gode for jeres barn. Diskutér jeres forskelle i opdragelse og omsorg for at sikre, at I begge er glade for den måde, jeres barn vokser op på.

4.7 Sundhed

4.7.1 Ernæring

At spise sundt vil hjælpe jer til at klare mindre søvn samt at komme jer efter fødslen samt opnå optimal amning. Overvej hurtige og lette måltider, som indeholder fedtfattigt kød, fuldkorn, fedtfattige mejeriprodukter, frisk frugt og grøntsager. Vælg sunde snacks (f.eks. frugt, fedtfattig yoghurt, rå nødder og kerner, fuldkornskiks) frem for stærkt forarbejdede fødevarer såsom kiks, kage og chokolader. Har du symptomer på angst, er det en god idé at reducere indtaget af stimulanser såsom kaffe, te, cola og energidrikke, da de kan forværre symptomerne.

4.7.2 Søvn

Hjælp hinanden til at få nok søvn. Opfordr din partner til at sove, når der er behov og mulighed.

4.7.3 Træning

Opfordr din partner til at være fysisk aktiv, enten individuelt eller sammen med dig. Hjælp din partner til at komme ud og få noget frisk luft.

4.7.4 Amning

Hvis din partner ammer, så støt hende ved at sørge for at hun får nok væske og så meget søvn som muligt.

4.7.5 Alkohol og stoffer

Der er mange udfordringer når du bliver forælder, og det kan være fristende at indtage alkohol eller stoffer for at overskue det. Alkohol og stoffer får dig måske til at have det bedre i kort tid, men de kan føre til ekstra problemer. Indtagelse af alkohol og stoffer under graviditeten kan være farligt for barnet. Forbrug af alkohol eller stoffer efter fødslen øger

risikoen for fødselsrelateret angst og depression. Søg hjælp, hvis du eller din partner måske har et for højt indtag af alkohol eller stoffer; der er sundere måder at håndtere svære ting/situationer på end med alkohol og stoffer.

4.8 Søg hjælp hos familie og venner

Eksisterende kontakter og venskaber kan blive ændret, når I bliver forældre. Under graviditeten bør I forsøge at identificere mennesker, som I ønsker støtte/hjælp fra efter fødslen. Diskutér og overvej, hvilke hjælpere I ønsker at trække på når I bliver forældre. Et godt støttenetværk er særligt vigtigt, hvis én af jer arbejder væk hjemmefra (f.eks. rejsearbejde). Det kan hjælpe jer med at søge hjælp, når det bliver svært, hvis I på forhånd har talt om strategier for at søge hjælp med forskellige problemer i forhold til at blive forældre (f.eks. ”Vi ringer til din mor, hvis vi får behov for hjælp med rengøring”, ”Vi ringer til sundhedsplejersken, hvis vi får behov for hjælp med søvn”, ”Vi tager over til vores vens hus og overnatter, hvis vi har behov for at indhente noget søvn”).

Søg og tag imod støtte/hjælp fra dem, I føler jer trygge ved at invitere ind i jeres hjem og hjælpe med jeres barn. Overvej at søge og tage imod støtte fra familien, hvis det er hensigtsmæssigt i jeres tilfælde. Vær opmærksom på pres og forventninger fra andre (f.eks. forældre, svigerforældre, familie, kollegaer) og stol på jeres egen viden og forståelse af jeres baby. I bør diskutere og forhandle, hvem I finder hjælpsomme/støttende og hvem I finder påtrængende/belastende. Hvis du føler dig overvældet, så begræns besøg og lave klare rammer for besøg på en ordentlig måde, så gæster ikke bliver for længe eller kommer på ubelejlige tidspunkter. Overvej at finde et ord/sætning/undskyldning I kan bruge, hvis gæster bliver for overvældende, f.eks. at I hjælpes ad med at skifte baby of dermed for mulighed for at tale alene om, hvad I gør for at afbryde besøget.

4.9 Hvordan kan jeg vide om min partner har en fødselsdepression eller angst?

Fordi fødslen af jeres baby er ventet, og det er forventet at være en glædelig tid, så er det ofte svært at genkende depression eller angst symptomer. Hold øje med tilbagetrækning eller ændring i humøret hos hinanden. Fædre skjuler oftere deres fødselsrelaterede depression. Vær opmærksom på de symptomer på depression, som er mere typiske for fædre. Hvis sin partner opfører sig anderledes end normalt, kan det være tegn på, at de har behov for hjælp til at justere sig til forældrerollen.

Hvis du bemærker, at din partner ser ulykkelig ud eller udtrykker negative følelser, bør I tale om emnet på en omsorgsfuld og ikke-fordømmende måde, f.eks. ”Jeg har bemærket, at du

virker meget nedtrykt på det seneste, - hvordan har du det med ting/dig selv/ babyen/ forældrerollen?". Brug opfølgende spørgsmål for at finde ud af, hvordan din partner har det, f.eks. "Hvordan har du det?" Og hvis de siger noget, såsom: "Jeg er træt, men har det fint", så spørg: "Men hvordan har du det egentligt?".

4.9.1 Hvordan kan du hjælpe din partner med at håndtere sin angst?

Hvis din partner oplever problemer med angst, så hjælp dem med at opdele opgaver i mindre trin, så selvom de føler, det er en udfordring, er de selvsikre på at de kan klare opgaven. Hjælp din partner ved ikke at lade angsten overtage, f.eks. ved at forsøge ikke at følge urimelige regler såsom at skifte alt sit rene tøj, inden man kommer ind i huset. Din partner kan have bekymringer, som de ikke tænker er berettigede, men de er ikke desto mindre virkelige for din partner. Forsøg at undgå at reagere på din partners frygt med forbavselse eller undren.

4.10 Hvad er fødselsdepression og fødselsrelateret angst?

Fødselsdepression og fødselsrelateret angst er typer af depression og angst, som udvikler sig under graviditet eller efter fødslen, det er vigtigt at vide, at både fødselsdepression og fødselsrelateret angst rammer både mænd og kvinder.

4.10.1 Fødselsdepression

Til trods for at de diagnostiske kriterier beskriver fødselsdepression til at være i perioden fra graviditet og indtil 6 uger efter fødslen, så kan fødselsdepression opleves fra graviditet og op til et år efter fødslen.

Fødselsdepression er anderledes end en tudetur efter fødslen, som også kaldes "baby blues" eller 3-dages-tudeturen. Cirka 50-80% af kvinder oplever en tudetur mellem den tredje og tiende dag efter fødslen. I denne periode er kvinder måske lettere til tårer end normalt og føler sig overvældede. Disse følelser forsvinder oftest i løbet af et par dage. Fødselsdepression varer oftest mindst to uger, og symptomerne påvirker evnen til at varetage almindelige dagligdags aktiviteter.

4.10.1.1 Symptomer på fødselsdepression

Symptomer på fødselsdepression kan være meget forskellige og derfor være svært at identificere. Der er typisk forskel på mødres og fædres symptomer. Det kan f.eks. variere fra søvnløshed til at sove dagene væk – og fra isolerende adfærd til en udadreagerende, aggressiv

og irritabel adfærd. Søg derfor altid professionel hjælp, hvis du er i tvivl om, hvorvidt du eller din partner oplever følgende symptomer:

- Nedtrykt humør og/eller følelse af ligegyldighed det meste af dagen, næsten hver dag
- Følelsen af at være utilstrækkelig og/eller skyldbetonet
- Tab af interesse for ting, man normalt nyder
- Har svært ved at falde i søvn eller sover ekstremt meget
- Spiser ikke eller overspiser
- Føler sig umotiveret og ude af stand til at klare de daglige rutiner
- Trækker sig fra venner og familie
- Tager sig ikke ordentligt af sig selv
- Mindsket energi og føler sig udmattet
- Oplever koncentrationsbesvær og/eller glemsomhed og/eller har svært ved at træffe beslutninger
- Har tanker om at skade sig selv, babyen, at tage sit eget liv eller at slippe væk/stikke af

Kilde: beyondblue (2015).

4.10.2 Fødselsrelateret angst

Fødselsrelateret angst er tilstedeværelsen af alvorlige længerevarende angst symptomer under graviditet og op til et år efter fødslen. Angsten er voldsom nok til at gøre det vanskeligt at håndtere den almindelige hverdag og forårsager ofte problemer i relationen til familie og venner.

4.10.2.1 Symptomer på fødselsrelateret angst

- Angst eller frygt, som forstyrrer tanker og daglige gøremål.
- Panikangst – udbrud af ekstrem frygt og panik, som føles overvældende og ukontrollerbart
- Angst og vedvarende bekymringer, som bliver ved med at forstyrre
- Konstant følelse af irritation, urolighed eller af at have ”dårlige nerver”
- Anspændthed i muskler, følelse af det strammer i brystkassen samt hjertebanken.
- Svært ved at slappe af og/eller tager lang tid at falde i søvn
- Angst eller frygt, som forhindrer dig i at gå udenfor med din baby
- Angst eller frygt, som får dig til at se til/tjekke din baby konstant
- Frygt for babyen og/eller frygt for at være alene med babyen

- Frygt for, at babyen græder eller er urolig

Kilde: Beyondblue (2015).

4.10.3 Symptomer som er mere typiske hos fædre

- Træthed, hovedpine og smerte
- Irritabilitet, angst og vrede
- Ændret appetit
- Følelsen af at være overvældet, at have mistet kontrollen og ude af stand til at håndtere situationen
- Tager øgede risici (f.eks. ved bilkørsel eller øget gambling)
- Ændring i søvnmønster, særligt søvnmangel
- Føler sig isoleret og distanceret eller undgår social aktivitet
- Trækker sig fra intime forhold og fra familie, venner og fritidsaktiviteter
- Øget antal timer væk fra hjemmet, f.eks. på arbejdet
- Øget forbrug af alkohol eller stoffer

(How Is Dad Going?, 2015).

4.10.4 Risikofaktorer for fødselsdepression og fødselsrelateret angst

Risikofaktorer er karakteristika eller oplevelser, som øger sandsynligheden, for at nogen udvikler en sygdom. Forskere har identificeret de følgende risikofaktorer for fødselsdepression og fødselsrelateret angst. Hvis du har en eller flere af disse faktorer, betyder det ikke at du nødvendigvis udvikler en fødselsdepression eller fødselsrelateret angst. Alle mennesker er unikke og reagerer på forskellige begivenheder forskelligt. Hermed følger liste af risikofaktorer:

- Psykisk sygdom i familien eller personligt
- Problemer under graviditet, under fødslen eller efter fødslen
- Spædbarnsdød, f.eks. abort, dødfødsel eller afsluttet graviditet
- Har oplevet fysiske, psykiske eller seksuelle overgreb
- Ængstelig eller perfektionistisk personlighed
- Manglende støtte og hjælp fra familie og venner

- Stressfulde livsbegivenheder (f.eks. flytning, økonomiske problemer, afskedigelse, dødsfald af nærtstående)
- Længerevarende mangel på søvn og hvile
- Uplanlagt graviditet
- Venter eller har flerlinger (f.eks. tvillinger eller trillinger)
- Voldsom tudetur/gråd efter fødsel (baby blues)
- Præmatur baby (for tidligt født baby)
- Problemer med amning
- En baby som er urolig, temperamentsfuld eller græder meget (f.eks. kolik)
- Partner oplever fødselsdepression og eller angst
- Utilfredshed med parforholdet eller partner, f.eks. oplever manglende støtte, hjælp, anerkendelse og nærhed/nærvær, dårlig kommunikation, konflikter
- Urealistiske forventninger eller manglende viden om, hvordan det er at blive forældre
- Mangel på viden og information om graviditet, fødsel og den første tid med baby, hvilket skaber usikkerhed
- Lav selvtillid
- Hormonelle og biokemiske faktorer (f.eks. lavt stofskifte og svingninger i kønshormonet estradiol)

(Black Dog Institute, 2013; Beyondblue, 2015; Kjær, *unpub.*; and Frøkjær, 2020)

4.11 Søg hjælp

Hvis du er bekymret for, om din partner oplever en fødselsdepression eller angst, så tilbyd at tage med dem til lægen eller at mødes med sundhedsplejersken sammen. Søg professionel hjælp, da det hjælper på dit helbred og din babys og parforholdets udvikling. Depression er ikke frivilligt eller noget, man blot kan slukke for. Ubehandlet angst kan påvirke graviditeten og din baby - søg derfor hjælp så tidligt som muligt.

4.11.1 Hvad hvis min partner tøver med at søge hjælp?

Der er normalt for mange med depression og angst ikke at erkende, at de har brug for hjælp eller støtte. Derfor afviser de måske dem, som tilbyder hjælp. Din partner undgår måske at søge hjælp på grund af forskellige bekymringer. Måske skammer din partner sig eller er flov over at have en depression eller angst. Måske har din partner svært ved at erkende, at de har det svært/dårligt, eller at deres tilstand kan være skadelig for babyen. Hvis din partner afviser

at tage til egen læge, så kan du kontakte din læge eller sundhedsplejerske for råd og vejledning om hvad du kan gøre for at hjælpe din partner. Der findes forskellige kommunale tilbud for familier som er påvirket af fødselsdepression og angst - spørg derfor fagpersoner om hjælp til at guide jer til den rette type hjælp i netop jeres situation.

4.11.2 Hvad gør du hvis du, din partner eller jeres baby risikerer at tage skade?

Tag din partner seriøst, hvis hun eller han taler om ikke at ønske at leve eller om at gøre skade på sig selv. Én måde, du kan gøre dette på, er ved at lade din partner vide, at du forstår, at disse følelser er ægte og alvorlige for dem, uanset hvor slemme eller ufornuftige de lyder. Søg professionel hjælp med det samme hvis:

Din partner har tanker om selvmord eller at skade sig selv, dig eller babyen.

Din partner opfører sig unormalt eller bizart, f.eks. hvis de er ekstremt tilbagetrukket, frygtfulde eller de ser eller hører noget, andre ikke kan.

Kontakt nogen, som kan hjælpe på tidspunktet - det kan være egen læge, sundhedsplejersken, lægevagten, psykiatrisk skadestue eller ring 112 hvis situationen er kritisk.

Hvis du er bekymret for din partners mentale helbred, så er det okay at risikere en kortvarig konflikt med dem, ved at søge hjælp for dem, især hvis du eller babyen er i risiko for at tage skade.

4.12 Vigtige kontaktpersoner

Der er mange som står klar til at hjælpe dig, hvis det er svært, men det kan virke uoverskueligt for dem, som har det psykisk dårligt. Husk, at ved akut hjælp skal du have fat i alarmcentralen på 112. Er der tale om noget ikke-akut, kan du kontakte egen læge, lægevagten, sundhedsplejersken, din jordemoder eller nogle af de mange muligheder for hjælp og rådgivning. Listen herunder er ikke udtømmende, men et forsøg på at gøre det lettere at få den relevante og hurtige hjælp.

***Akut hjælp**. Ring: 112*

Egen læge (notér selv): ____

Lægevagten, når egen læge har lukket. Hverdage kl. 16.00 - 08.00 og lørdag, søn- og helligdage hele døgnet.

Region Hovedstadens akuttelefon: 1813.

Region Midtjylland. Tlf: 70113131

Region Nordjylland. Tlf: 70150300

Region Sjælland. Tlf: 70150700

Region Syddanmark. Tlf: 70110707

Patienter på Ærø. Tlf: 63523090

Jordemoder (notér selv):____

Sundhedsplejerske (notér selv):____

Fødegangen (notér selv):____

Psykisk helbred

Psykiatrisk skadestue. Ved akut brug for hjælp på grund af psykisk sygdom. Find din lokale afdeling: www.borger.dk/sundhed-og-sygdom/Alarm-112-laegevagt-og-skadestuer/Psykiatriske-skadestuer

Livsliniens telefonrådgivning. Rådgivning ved mildere selvmordstanker. Telefon: 70 201 201, alle årets dage fra kl. 11-05.

Psykiatrifondens rådgivning. Rådgivning til mennesker med psykiske sygdomme og problemer, personer i krise, deres pårørende, og fagfolk. Rådgivningen er gratis, anonym og fagligt funderet. Telefon: 3925 2525 www.psykiatrifonden.dk/faa-hjaelp/ring.aspx

DepressionsLinien. En anonym samtalelinje for mennesker med depression, bipolar lidelse (maniodepressiv) og deres pårørende. Linjen passes af frivillige i DepressionsForeningen. Telefon: 33 12 47 74. Åben mandag – fredag kl. 19-21, undtagen helligdage.

Voldsramte (fysisk og psykisk)

Lev uden vold. Døgn hotline, telefon: 1888. https://levudenvold.dk/for-fagfolk/krisecentre-og-andre-raadgivningstilbud/ Obs: På siden findes lister over krisecentre for mænd og kvinder samt andre rådgivningstilbud.

Dannerhus. Fortrolig gratis rådgivning og hjælp til voldsudsatte (fysisk og psykisk vold). Telefon: 33 33 00 47. https://danner.dk/ring-for-hjaelp-og-raad

Mandecentret (for mænd). Gratis praktisk rådgivning og personlig sparring. Parforholds-problemer eller -ophør. Juridisk rådgivning, f.eks. om samvær med dine børn. Hjælp ved højt konfliktniveau, fysisk eller psykisk vold. Telefon: 70 11 62 63. Mail: info@mandecentret.dk.

Rådgivning af forskellig karakter

Kontakt din **kommune** for forældrerådgivning eller undersøg de mange muligheder for råd og vejledning. Få mere information om råd og hjælp, se den generelle oversigt her fra borger.dk her: https://www.borger.dk/familie-og-boern/Brug-for-raad-og-hjaelp/Familieraadgivning-og-akut-hjaelp Herunder er et lille udpluk af de mange muligheder for gratis vejledning:

ForældreTelefonen. Rådgivning til alle forældre og pårørende, der har spørgsmål, som omhandler børn. Åbningstider: Mandag, torsdag og fredag: 9.00 – 17.00. Tirsdag og onsdag: 9.00 – 21.00. Lørdag: Lukket. Søndag: 15.00 – 21.00. Tlf.: 35 55 55 57 https://bornsvilkar.dk/det-goer-vi/foraeldretelefonen/

Mødrehjælpen. Rådgivning og vejledning til gravide og børnefamilier, både mor og far, i sårbare og udsatte situationer. Åbningstider: Mandag & tirsdag: 9.00-14.00. Onsdag: 12.30-15.00. Torsdag: 9.00-16.30. Fredag: 9.00-11.30. Telefon: 33 45 86 00 https://moedrehjaelpen.dk/holdepunkt/ring-til-os/

Foreningen Far. Tilbyder rådgivning og viden om børn og fædre. For både mødre, fædre og børn. https://foreningenfar.dk/rådgivning

KFUM forældrerådgivning. Rådgivningen tilbyder gratis, børnefaglig og anonym rådgivning til alle familier, både til store og små spørgsmål. Send en SMS til 22 49 68 23 for at chatte, svartid indenfor 24 timer på hverdage. Bag tasterne sidder en erfaren og uafhængig rådgiver som er uddannet psykolog, der har erfaring med at rådgive om og til børn, unge, voksne og familier. https://www.kfumsoc.dk/gratis-raadgivning/familieraadgivning

Forældrerådgivningen. Rådgiver forældre eller pårørende, der har spørgsmål vedrørende børn og skole. Alle skoledage 10-14; tlf. 70 25 24 68. Mailrådgivning skriv til foraeldreraadgivningen@skole-foraeldre.dk. www.foraeldreraadgivningen.dk

FOLAs Forældrerådgivning. Rådgivning for forældre og andre pårørende, der oplever, at de og deres børn har problemer i institutionen (dagpleje, vuggestue, børnehave, skole, SFO, fritids- eller ungdomsklub) kan få anonym rådgivning. Mandag, tirsdag, torsdag og fredag kl. 9:30 -13:30. Telefonnummer: 73 70 73 79. www.FOLA.dk

5 Conclusion

The aim of the literature review was to answer the research question: "Which preventative interventions for postpartum depression targeting both partners can be identified in the current literature? - And how effective are they?". The simple answer was that only ten articles were identified in the current literature, which were concerned with prevention of postnatal depression in partners. Only eight articles were interventions aiming to prevent postnatal depression (Matthey et al., 2004; Ngai, et al., 2019; Ishii, et al., 2019, Pilkington, Milne, Cairns, & Whelan, 2016; Pilkington, Rominov, Milne, Giallo, & Whelan, 2016; Kusuma et al., 2019: Cussiono, et al., 2016; and Sanaati, et al., 2018) and one suggested a societal model for intervention (Locicero et al., 1995) and the last article only suggested family therapy as an intervention (O'hare, 1985). Pilkington et al. (2016) made two promising interventions a website "partners to parents?" and a PDF with guidelines for prevention of partners' postnatal depressive and anxiety symptomology - but no results of the effectiveness was measured or mentioned. Only two studies reported on the interventions effect for both partners (Ngai et al., 2019 and Matthey et al., 2004). No interventions were found effective in treating postnatal depression in both partners, yet the intervention by Matthey et al. (2004) argued their intervention "The Empathy Session" was effective in lowering postpartum depression in low-self-esteem women and men.

An intervention was designed, as literature revealed a need for transparent and easy-to-implement interventions for clinical use in order to help prevent postpartum depression in partners. The intervention is not tested but is a suggestion on how an antenatal session educating on how to prevent postnatal depression could be structured with an easy step-by-

step guide and hand-outs for the participants. The material can be used for non-profit purposes if sources are credited.

Finally, one translation and modification of the preventative intervention for partners created by Pilkington, Milne, Cairns, & Whelan (2016) based on their Delphi Consensus Study was made. The material was translated from English to Danish and modified to fit a Danish context. An overview with relevant contacts of resources who can assist if partners are feeling depressed postpartum was also created. This material can also be used for non-profit purposes if sources are credited.

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7 Addendums

Addendum 1 - *Search Protocol & Process Description*

Addendum 2 - *AUB Search Protocol*

Addendum 3 - *Inclusion and Exclusion Criteria All Fulltext Articles*

Addendum 4 - *CASP Checklist Cussiono et al. 2016*

Addendum 5 - *CASP Checklist Pilkington, Rominov, Milne, Giallo, & Whelan 2016*

Addendum 6 - *CASP Checklist Sanaati et al 2018*

Addendum 7 - *CASP Checklist Locicero et al. 1997*

Addendum 8 - *CASP Checklist Ngai et al., 2019*

Addendum 9 - *CASP Checklist Matthey et al. 2004*

Addendum 10 - *JBI Critical Appraisal Checklist Pilkington, Milne, Cairns, & Whelan (2016)*

Addendum 11 - *JBI Critical Appraisal Checklist Kusuma et al 2019*

Addendum 12 - *JBI Critical Appraisal Checklist O'hare 1985*

Addendum 13 - *JBI Critical Appraisal Checklist Ishii et al. 2019*

Addendum 14 - *Themes*

Addendum 15 - *CASP Systematic Review Assessment*)

Addendum 16 - *PRISMA 2009 Systematic Review Assessment Checklist*

Addendum 17 - *Handouts to Participants in Antenatal Session*

Addendum 18 - *Themes for the Intervention for Professionals*

Addendum 19 - *Translation of Guidelines English to Danish*