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LETTER

Prevalence of Paternal Prenatal Depression and Its Associated Factors in Saudi Arabia [Letter]

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Dear editor

Recently, with great curiosity, we have perused an original article titled "Prevalence of Paternal Prenatal Depression and Its Associated Factors in Saudi Arabia" by Younis et al.[1] This is a very interesting and valuable study because it focuses on a special group, namely expectant fathers. There are relatively few studies on paternal prenatal depression, especially in Arab countries (eg, Saudi Arabia, Yemen, Palestine, and Jordan, etc.) and China.[1,2] For example, traditional Chinese culture believes that fathers/men should be strong, resolute, masculine, and not fragile; thus, the topic of paternal prenatal depression has been rarely studied. This is an early or the first study to investigate the prevalence of and factors associated with paternal prenatal depression in Saudi Arabia, and even in the Middle East. It provides timely epidemiological data for understanding paternal prenatal depression in Saudi Arabia. Prenatal depression of fathers cannot be ignored, as it not only affects the health of fathers but also the well-being of their spouses and children.[3] Paying much attention to the mental health of expectant fathers, especially prenatal depression, and providing targeted psychological support and nursing care are the mission and responsibility of prenatal healthcare professionals.

This article was well written, with appropriate methods (eg, random sampling technique, using standard formula to calculate the sample size), and rich results. The authors considered relatively comprehensive factors related to paternal prenatal depression, such as demographic and psychosocial factors, as well as data about the family, wife, pregnancy and delivery, and job. Additionally, the authors conducted an in-depth discussion, fully compared their study findings with others performed in other countries and regions (eg, Germany, Canada, Brazil, USA, Japan, UK, Australia, Ethiopia, Egypt, Taiwan), and explained in detail the reasons for the discrepancies between research results.

There are several areas for improvement and further research directions in Younis's study, namely: (1) We suggest that the authors employ the following formula to calculate the sample size, which is faster and more convenient. When considering α=0.05, z_α=1.96, p = 0.318, δ=0.05, the sample size should be n = 1.96^2 * 0.318 * (1–0.318) / 0.05^2=334.

$$n = \frac{Z_\alpha^2 * P * (1 - P)}{\delta^2}$$

(2) There are several areas in the text where the data is incorrect: (a) Page 1085, line 6 in Results section, "69.7%" and "42.2%" are wrong, they should be "75.8%" and "43.2%". (b) Page 1086, the frequency for "Expected fetus gender" in Table 1 is incorrect. (3) Yi's study reported that BMI, self-efficacy, distress disclosure, and sleep quality may be associated with paternal prenatal depression.[2] We suggest that the authors consider incorporating these factors into the analysis in their future research. (4) Develop a prenatal depression scale/questionnaire targeting the expectant fathers, so as to reflect the real-world situation of the study subjects. (5) The authors can identify different change trajectories of paternal prenatal depression level through longitudinal study and growth mixture model, and provide a practical basis for targeting the timing of core interventions. (6) Conduct a long-term, large-scale cohort study to explore the impact of

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paternal prenatal depression on maternal postpartum outcomes, neonatal outcomes, and future growth and development of offspring.[4]

Disclosure

The authors report no conflicts of interest in this communication.

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