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REVIEW

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Interventions used to promote paternal mental health during the perinatal period: a scoping review

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Abstract

Following recent international calls to strengthen research on paternal perinatal mental health, interest in this area has increased. The present review aims to identify the key gaps within the emerging evidence base that warrant further investigation in the years ahead. This scoping review maps the available interventions for fathers and explores the potential role of psychological therapies in improving paternal mental health outcomes. This scoping review was conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses for Scoping Reviews (PRISMA-ScR) guidelines. A structured search of PubMed, CINAHL, and Medline was conducted from January 2005 to January 2025. The studies were screened using predefined inclusion and exclusion criteria. The search identified 446 records, of which 22 met the inclusion criteria. These studies, published between 2012 and 2025, were conducted across 15 countries and four continents. The findings suggest that several interventions are available to fathers, including digital interventions, couples and family-based approaches, group therapy, and individual Cognitive Behavioural Therapy (CBT). Several studies reported beneficial outcomes, particularly for group-based approaches and interventions incorporating CBT elements. However, the exact mechanisms of change and the long-term effects of group therapy and CBT for this population remain inconclusive. This review highlights the potential role of CBT and group therapy as promising interventions for paternal mental health. While the findings are encouraging, further randomised controlled trials (RCTs) are needed to assess the long-term effects of group-based interventions and CBT.

Keywords

Paternal perinatal depression (PPD); Paternal perinatal anxiety (PPA) fathers' wellbeing; Depression, anxiety, health disparities; Paternal perinatal mental health; Psychological interventions; Perinatal period; Scoping review

1. Introduction

1.1 Rationale

Parenting during the perinatal period is associated with an increased risk of developing depression in both mothers and fathers [1, 2]. The perinatal period encompasses pregnancy until the first year after birth National Institute for Health and Care Excellence (NICE) [3]. Maternal perinatal depression has been widely acknowledged as a major public health concern, affecting an estimated 10–20% of women globally [4]. This recognition has contributed to improved screening practices among healthcare professionals and, more recently, to greater access to treatment options [2].

In contrast, considerably less is known about paternal perinatal mental health [5]. However, increasing awareness in recent years has shed light on its prevalence. Fathers are at elevated risk of perinatal depression during this period, with prevalence estimates ranging from approximately 10% [6, 7] to as high as 25% [8], although the true prevalence may be higher due to limited screening practices and low rates of help-seeking among men [9, 10]. The World Health Organisation (WHO, 2022) [4] and National Institute for Health and Care Excellence (NICE, 2020) guidelines have highlighted the risks associated with untreated paternal perinatal mental health issues [3, 4]. Both organisations have called for further research to better understand its prevalence and to identify interventions to treat paternal perinatal depression. Despite its reported prevalence and the recent surge of attention, research on paternal mental health, including its underlying causes and potential interventions, remains limited [11].

Fathers' mental health problems can have far-reaching consequences, including economic strain from reduced productivity and impaired work performance [12, 13]. When left untreated, paternal mental health difficulties can disrupt family dynamics and intimate relationships, and may adversely affect children's behaviour, development, and mental health [14, 15].

These effects can extend to the father-child relationship, with approximately 62% of fathers reporting that their mental health challenges negatively affected their bond with their child [16].

Men experiencing perinatal depression face a heightened risk of suicide [17], which is consistent with broader epidemiological evidence showing that men are three times more likely to die by suicide than women [18]. Recent findings suggest that untreated paternal mental health difficulties may further increase this risk [11]. These concerns underscore the importance of recognising and addressing paternal mental health during the perinatal period.

Emerging research highlights that fathers' mental health during the perinatal period is shaped by a complex psychological transition to fatherhood, characterised by shifts in identity, relational dynamics, and societal expectations surrounding masculinity. Qualitative studies describe how fathers often negotiate new responsibilities that affect their sense of competence and connection to the infant, contributing to vulnerability to low mood, stress, or anxiety [19, 20]. In addition, broader sociocultural pressures for fathers to appear strong, emotionally restrained, and financially responsible may further inhibit the recognition and expression of distress, reinforcing patterns of under-reporting and reduced help-seeking [20, 21]. Meta-analytic evidence also shows that paternal depression and anxiety follow trajectories distinct from maternal patterns, suggesting unique underlying mechanisms and risk profiles that require dedicated investigation [7, 15]. These conceptual factors underscore the importance of developing father-inclusive approaches and interventions that recognise the specific psychosocial contexts shaping paternal mental health.

While maternal mental health frameworks might seem transferable, risk factors differ significantly. Maternal depression, marital distress, paternal stress, and anxiety are key contributors to fathers' perinatal mental health [15]. Symptom expression also varies. Women often present with internalised sadness, while men more frequently display irritability or anger, reflecting gendered social norms [22]. These differences further highlight the need for tailored approaches that address the distinct experiences of mothers and fathers during the perinatal period.

With regard to identifying paternal perinatal depression, there is currently no single, formally established set of diagnostic criteria. To date, only the Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaires-9 (PHQ-9) are commonly used questionnaires to identify men's symptoms [23]. This suggests that a more specialised screening tool may be necessary to capture the unique symptom profiles of men and fathers. While the EPDS questionnaire was not created with fathers in mind, it is the most widely used diagnostic tool for parental perinatal depression and has demonstrated strong validity and reliability [24].

This scoping review uses the term paternal perinatal mental health (PPMH) as an umbrella term referring to the spectrum of mental health difficulties experienced by fathers from pregnancy through to 12 months postpartum [25, 26]. Within this framework, particular attention is given to paternal perinatal depression (PPD) and paternal perinatal anxiety (PPA), as these are the most frequently reported conditions in the literature and the primary focus of existing intervention research [10, 27]. In the literature, perinatal typically refers to the period spanning pregnancy to the first year postpartum, whereas postnatal refers specifically to the period after birth; as terminology varies across studies, terms are reported as originally used.

This review focuses on fathers in the general population, typically heterosexual partners of mothers with healthy, full-term infants. Fathers of premature infants or those requiring neonatal intensive care (NICU) admission often experience distinct stressors associated with heightened levels of anxiety and psychological distress [28]. However, these specialised populations were outside the scope of this review due to their unique clinical context and the separate and well-established evidence base that exists for NICU-related mental health.

The World Health Organisation acknowledges the significance of addressing paternal perinatal mental health but also highlights the lack of specific recommendations for paternal PPA or PPD. Similarly, the NICE guidelines (2020) [3] emphasise the importance of perinatal mental health screening for all parents, including fathers. In particular, NICE guidelines emphasise screening fathers when mothers have diagnosed perinatal depression, as this is a well-documented trigger for fathers [29]. Both organisations call for further research to better understand the prevalence, impact, and effective interventions for fathers with PPD.

Cognitive Behavioural Therapy (CBT) has a strong and well-established evidence base for treating perinatal depression and anxiety in women [30], and its adaptability makes it a promising candidate for addressing paternal perinatal mental health. Reviews of psychological interventions highlight the effectiveness of CBT-based approaches for depression, anxiety, and trauma in the perinatal period [31], thereby providing a foundation for extending these methods to fathers. Emerging qualitative evidence shows that fathers often present with externalising symptoms, such as irritability, anger, and avoidance, which align well with CBT techniques targeting maladaptive thoughts and behaviours [32]. Taken together, these findings offer a strong theoretical and clinical rationale for examining CBT as a potential intervention for paternal perinatal depression and anxiety, particularly given fathers' historical underrepresentation in perinatal mental health research [33].

1.2 Objectives

This scoping review aims to identify gaps in the existing literature and to explore the effectiveness of the range of interventions used to address paternal mental health issues, with particular consideration given to the relevance of existing therapies (such as CBT) and the delivery modalities of these therapies (such as one-to-one; group or family-based formats) for the same population. The purpose of this scoping review was therefore to explore the mental health needs of fathers experiencing perinatal depression or anxiety and to map the range of interventions, including CBT-based approaches, that have been used to address these needs.

2. Methods

Although systematic reviews are considered the gold standard for evidence synthesis, they can be limited when evidence is sparse, heterogeneous or conceptually inconsistent [34, 35]. Recent systematic reviews on paternal perinatal mental health highlight these limitations, noting inconsistent methodology and a lack of robust intervention research [36, 37]. These findings support the rationale for conducting a scoping review, which enables a broad yet critical mapping of existing evidence and the identification of knowledge gaps in the field [38, 39]. A protocol was not registered for this scoping review, which is consistent with the exploratory and iterative nature of scoping review methodology [40].

2.1 Search strategy (eligibility criteria, information sources, search, selection of sources of evidence, data charting process, and data items)

A systematic literature search was conducted in three major databases: CINAHL, Medline, and PubMed. These databases were selected because they provide comprehensive coverage of nursing, medical, and health sciences research relevant to paternal perinatal mental health. PsycINFO and other psychology databases were not included, even though initially considered. While this may have excluded certain psychology-specific studies, previous work suggests that CINAHL + Medline + PubMed capture the majority of relevant perinatal mental health literature in scoping reviews, particularly when search terms incorporate psychological constructs [41, 42].

The inclusion of broad psychotherapy terms (*e.g.*, "therapy", "intervention", "treatment") alongside "CBT" ensured that the search captured a wide range of psychological interventions while remaining manageable and relevant to the therapeutic focus of this review. Preliminary testing of the search strategy in PubMed indicated that including "CBT" alongside broader psychotherapy terms (*e.g.*, "therapy", "intervention", "treatment") did not reduce the number of retrieved records. This suggests that the inclusion of CBT did not unduly narrow the search and that studies referencing psychological interventions commonly index CBT within their indexing terms. Details of search strategy are provided in **Supplementary Table 1**.

The review followed the PEO framework [43], which helped structure the search strategy around:

- Population: fathers/paternal figures.
- Exposure: perinatal or postpartum depression or anxiety.
- Outcome: psychological interventions including CBT, therapy, or mental health treatment.

Boolean operators were used to construct a transparent and comprehensive search strategy in line with PRISMA-ScR guidance (**Supplementary Table 2**). "OR" was applied within each PEO category to capture all relevant synonyms (*e.g.*, "postpartum depression", "perinatal anxiety"), ensuring sensitivity to the diverse terminology used in paternal mental health research. "AND" was used to link the PEO components, narrowing results to studies that addressed fathers, perinatal mental health, and interventions simultaneously. This structure balances breadth with specificity and is consistent with established guidance for rigorous scoping review searches [40, 43, 44].

The final search string was:

("postpartum depression" OR "perinatal depression" OR "postpartum anxiety" OR "perinatal anxiety") AND ("fathers" OR "paternal" OR "dad") AND ("Cognitive Behavioural Therapy" OR "CBT" OR "treatment" OR "interventions" OR "therap*").

This review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR; Tricco *et al.* [40], 2018). All steps, including the rationale for using a scoping review, eligibility criteria, search strategy, evidence charting, and synthesis process, were conducted in accordance with PRISMA-ScR guidance.

2.2 Screening and selection

The initial search returned 446 records from inception to January 2025. Results were uploaded to Rayyan, a literature management platform. Duplicates were removed, and studies were screened into "excluded", "maybe", or "included" categories. The researcher and supervisor independently reviewed the "included" and "maybe" categories, with disagreements resolved through discussion. A PRISMA (2009) [45] flow diagram (Fig. 1) illustrates the selection process. Inclusion and exclusion criteria are presented in **Supplementary Table 3**. This review did not intentionally include or exclude lesbian, gay, bisexual, transgender, and queer (LGBTQ+) parents; however, very few studies involving these populations were identified during screening, and those that did existed in substantially different psychosocial contexts. Consequently, these studies were not included in the synthesis, and the review focuses on fathers in the general population.

A 20-year publication limit was applied to ensure the review captured contemporary understandings of paternal perinatal mental health. Research conducted prior to the mid-2000s predates the emergence of recognised paternal screening tools, updated diagnostic criteria, and current models of coparenting and father involvement. For example, much of the foundational work on paternal perinatal depression, coparenting, and father-specific symptom profiles has been published since the early 2000s [26, 27]. Restricting the search to the past two decades, therefore, ensured relevance to modern clinical practice and reflects the period which paternal perinatal mental health began receiving systematic research attention.

2.3 Data charting process and data items

A data charting form was jointly developed by the two reviewers (authors of this article) to determine which keywords to extract. Both reviewers independently charted the data. The first author initially identified the articles, considering the agreed-upon inclusion and exclusion criteria. The first set of decisions was made based on the titles of the articles; the second was based on the content of the abstracts. Data charting was done iteratively. Both qualitative and quantitative articles involving interventions for fathers during the perinatal or postpartum stage, published in English, were included.

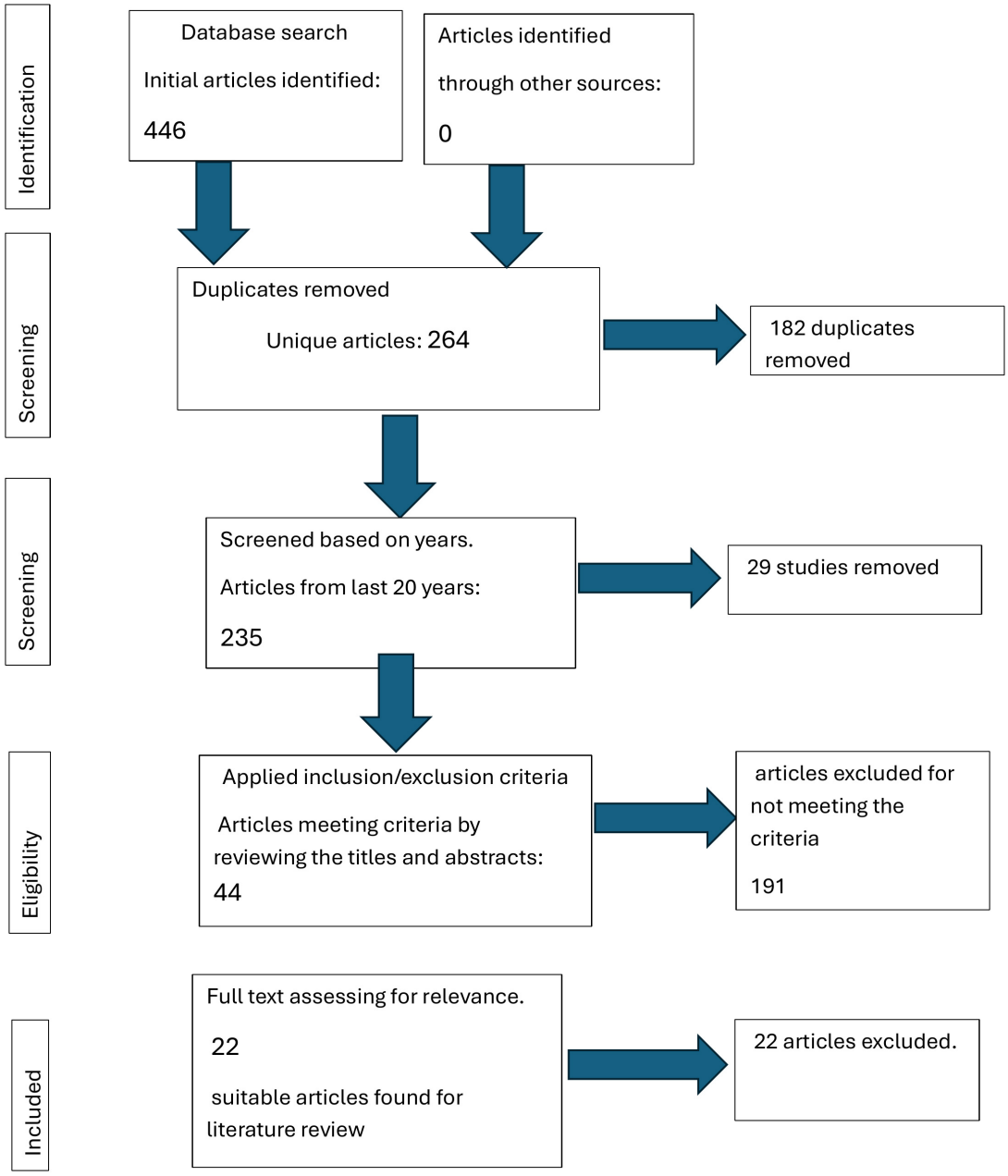

FIGURE 1. PRISMA flow diagram of study selection.

Even though all articles were written in English, the data were collected across the world. The final data charting table is provided as a supplementary file.

2.4 Data extraction and appraisal (critical appraisal of individual sources of evidence and synthesis of results)

All full-text articles were accessed via the University of Hertfordshire's online library. The final review included 22 key studies focusing on fathers and available interventions for paternal perinatal mental health. Critical appraisal was supported by the Joanna Briggs Institute (JBI) checklists, with the JBI Checklist for Randomised Controlled Trials, the JBI Checklist for Quasi-Experimental Studies, and the JBI Checklist for Qualitative Research [46] applied according to study design. Details of the appraisal process and individual study assessment was provided in **Supplementary Table 4** (Ref. [1, 11, 15, 20, 36, 37, 47–62]).

2.5 Data synthesis

Due to the heterogeneity in study design, populations, and outcome measures, findings were synthesised narratively, in accordance with scoping review methodology. A meta-analysis was neither feasible nor appropriate. Data synthesis considered individual article biases as well as groups of articles that are extracted. Systematic reviews, as well as quantitative and qualitative studies, have included JBI criteria used for the assessment of the quality of methodology in each article.

3. Results

This section presents the findings of the scoping review, based on the studies identified through the systematic search process. A total of 22 studies were included after applying the inclusion and exclusion criteria. The findings are presented in **Supplementary Table 5** (Ref. [1, 11, 15, 20, 36, 37, 47–62]), including study characteristics, types of interventions explored, and key themes relating to paternal mental health needs. The PRISMA flow diagram (Fig. 1) demonstrates how the studies were identified, screened, and selected for inclusion in this scoping review. It outlines the number of records retrieved, duplicates removed, studies screened, and the final number of articles included.

3.1 Characteristics of included studies

After reviewing the literature, the included studies were categorised into themes based on the interventions they utilised, following approaches used in previous systematic reviews, such as those by Goldstein *et al*. [37] (2019). See **Supplementary Table 5** for full details.

3.2 Themes identified

Two main themes emerged from the included studies: (1) barriers fathers face in accessing perinatal mental health support, and (2) interventions designed to address paternal depression and anxiety. The latter were further categorised into digital interventions, couples and family-based approaches, group interventions, and CBT-informed models.

3.3 What are the barriers to seeking support?

Before exploring the interventions for paternal PPD, it is important to acknowledge well-documented barriers for seeking support. One major obstacle is the lack of gender-sensitive diagnostic tools. Screening methods such as the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) [63] American Psychological Association (APA, 2013) and the EPDS [64] were originally designed to detect maternal symptoms, often overlooking male-specific manifestations of depression, including anger, substance misuse, and reduced problem-solving abilities [65] (APA, 2022). Furthermore, societal norms around masculinity contribute to men's reluctance to seek psychological help, with research consistently showing that men are less likely to access mental health support (Sagar-Ouriaghli *et al*. [66], 2019). These barriers highlight the need for more targeted interventions that address both the unique symptomology in fathers and the challenges they face in accessing mental health care.

Using interpretive phenomenological analysis (IPA), Pedersen *et al*. [20] (2021) identified key barriers including misconceptions about PPD, a lack of awareness, and stigma linked to masculine norms. Conversely, support from partners and health visitors facilitated help-seeking. The researchers adhered to Smith's IPA guidelines (2011) [67], ensuring robustness and validity. IPA offers a rich, in-depth understanding of experiences and contributes to new theoretical insights [68, 69] (Smith, Farr & Nizza, 2021). However, it carries the risk of researcher bias due to the researchers' central role in data interpretation (Galdas, 2017) [70]. These barriers, ranging from clinicians' challenges in identifying PPD to men's mental health beliefs, are well supported in the literature [7, 71].

3.4 What interventions are available?

Several interventions have been studied to address paternal mental health challenges. For the purposes of this scoping review, these interventions have been categorised into the following themes/chapters: group therapy, couples or family-based therapy, digital interventions, and Cognitive Behavioural Therapy (CBT).

3.5 Group therapies

Group-based interventions integrating CBT and parenting support show promise for fathers with PPD. Husain *et al.* [47] (2024) evaluated the "Learning through Play" (LTP) programme (Ashem, 2002), previously adapted for both maternal [72] (Husain *et al*. [73], 2021) and paternal depression [73–75]. The LTP + dads programme equips fathers with skills to engage in play to support children's physical, cognitive, and emotional development, particularly in disadvantaged families, with the hypothesis that it would also improve paternal mental health.

In a study conducted in Pakistan, Karachi, which used Randomised Control Trial (RCT) (n = 328), fathers were screened for depression and assessed using the Hamilton Depression Scale (Hamilton, 1960) [76], as well as measures of anxiety, intimate partner violence and quality of life. Children's development was measured with the (Ages and Stages Questionnaire) ASQ-2 [77] and ASQ-3 [78]. The 10-session, 3-month intervention combined parenting skills training, play therapy, and CBT, delivered by community mental health workers. Compared with controls, fathers in the intervention group showed greater improvements in depression, anxiety, parenting stress, intimate partner violence, and health-related quality of life; their children recorded significantly better social-emotional scores. Gains were maintained at four- and six-month follow-up, although longer-term effects remain unknown.

Limitations include unclear facilitator training in CBT, lack of detail on the delivery standard for Learning through Play (LTP), and potential measurement bias from clinician-administered scales such as the Hamilton Depression Rating Scale, which may not fully capture male symptomatology [76, 79]. As LTP combines play therapy, CBT and group work, the specific drivers of change remain uncertain and the "treatment as usual" group was not fully described and may have received minimal or no support, given the low-income setting. Results may not be generalisable to rural areas or fathers from higher socio-economic backgrounds.

When conducted properly, RCTs are considered the "gold standard" in clinical research [34, 35]. However, where the Treatment as Usual (TAU) group is not closely monitored, there is a potential for bias and confounding variables. The researchers themselves noted that the TAU group was not monitored for any variations in the standard of care, which

can lead to inconsistencies in the outcomes [80, 81]. The researchers in this study have, nonetheless, identified a combination that appears very effective. However, it is uncertain whether the group setting, the CBT components, or the family-style approach—either individually or together—contributed to the improvement in symptoms.

More broadly, group-based interventions may offer potential benefits for some fathers by providing opportunities for peer support and shared experiences, which have been associated with reduced feelings of isolation and increased normalisation of mental health difficulties. Evidence from men's mental health literature suggests that group settings can foster a sense of connection and mutual understanding, which may support more positive attitudes towards help-seeking [82–84]. However, the extent to which these processes translate to fathers experiencing paternal perinatal depression remains unclear. Many studies combine group formats with multiple therapeutic components, such as CBT and psychoeducation, making it difficult to isolate active mechanisms of change. In addition, the acceptability and impact of group-based approaches are likely to vary across individuals and contexts. As such, while group therapy may be a useful component of support for some fathers, further research is required to determine for whom, under what conditions, and through which mechanisms group-based interventions are most effective.

3.6 Couples or family-based approaches

Feinberg *et al.* [85] (2012) developed a conceptual framework for coparenting relationships, which includes four domains: childrearing agreement, division of labour, coparental support or undermining, and the joint management of family dynamics. Feinberg's ecological model suggests that depression in coparents may manifest through negative behaviours, such as anger, persistent complaining, and withdrawal from family interactions [85]. Using this as a foundation, Wells, Jeon, and Aronson (2023) then hypothesised whether there could be a link between coparenting challenges and paternal PPD [48]. They conducted a cross-lagged panel study of fathers of infants and toddlers in Sweden to examine bidirectional associations between paternal postpartum depression symptoms and coparenting quality [48].

The study recruited 429 fathers across two cohorts, with data collected during infancy (0–24 months) and again at 6- and 18-month intervals. Depressive symptoms were measured using the EPDS, and coparenting quality was assessed using the Brief Coparenting Relationship Scale (B-CRS) [64, 85]. The findings indicated supportive coparenting during early infancy was associated with lower paternal depressive symptoms at later time points, including during toddlerhood. In addition, the association between coparenting quality and depressive symptoms strengthened over time, suggesting that early coparenting experiences may have enduring implications for fathers' psychological well-being. Fathers who reported more positive coparenting relationships early in the parenting period were also more likely to maintain these patterns as their children grew, potentially contributing to sustained protection against depressive symptoms.

This study presents several strengths. Firstly, they identified a higher prevalence of paternal depression symptoms at 20% than previous estimates, and they also acknowledged the potential seasonal impact on depression prevalence, which can improve the interpretation of their findings. Building on this, a cross-lagged panel model design with controls for autoregressive effects and cross-sectional correlation can offer valuable insights into longitudinal data by capturing relationships overtime. However, due to the non-experimental nature of the study, causal inferences cannot be made [86]. These findings support the overall view that maternal well-being, paternal well-being, and coparenting dynamics can influence the prevalence of paternal perinatal depression [84]. Wells *et al.* [48] (2023) highlight the interconnected nature of parental mental health, suggesting that a holistic approach—including improved screening methods and consideration of contextual factors- may be beneficial in identifying and treating PPD more effectively [27].

Fletcher *et al.* [50] (2018) conducted an online couples-based RCT with 248 parents, who met the inclusion criteria. Participants were between the third trimester and six months postpartum, and were randomised into two groups based on EPDS scores. The control group included childcare information only. The intervention group was titled "baby steps and wellbeing", and participants took part in an interactive programme. Overall, they found that engagement was low, with only 37.3% of parents logging into the programme more than once. Of those who engaged, 53.6% were mothers and 20.9% were fathers. Between the two groups, they found that there was no difference between the intervention group for depression, quality of life, or social support. The Baby Steps and Wellbeing programme showed greater increases in self-efficacy for support provision, a smaller decline in relationship satisfaction, and mothers had a greater parenting self-efficacy gain than the fathers. No significant improvements were seen in perinatal distress, psychosocial quality of life, or social support between the two treatments. This is reported to be the first RCT to examine both mothers and fathers, and this research design ensures a high level of internal validity [86]. The intervention included interactive elements and goal setting. This design is, to an extent, aligned with general CBT principles of active engagement and behaviour change. However, due to the low engagement rates, it is not possible to draw meaningful conclusions regarding its efficacy.

Ngai *et al.* [51] (2020) investigated the effectiveness of a couple-based cognitive-behavioural intervention (CBI) for addressing postnatal depression among Chinese parents. Using a three-arm randomised controlled trial, the researchers compared a couples-based intervention and a mothers-only intervention with standard perinatal care as the control group. Results demonstrated significant reductions in depressive symptoms among mothers in the couple-based intervention at six weeks postpartum, while fathers in that group did not experience significant benefits. This suggest that couples-based approaches are beneficial for mothers rather than fathers.

The CBI sessions delivered to both the couple-based and mother-only groups included one three-hour group session and two follow-up calls with a midwife trained in CBT. Some evidence suggests that CBI/CBT can be effective in short, condensed formats, as these enhance accessibility and conve-

nience for patients [87]. However, brief interventions may not comprehensively address underlying issues, potentially leading to relapse [88]. Ngai *et al.* [51] (2020) highlighted the potential benefits of partner-inclusive approaches in reducing postnatal depressive symptoms among mothers by fostering mutual support and improved communication. However, the effect size was modest (Cohen's $d = 0.30$) and not sustained over longer follow-up periods, suggesting the need for booster sessions or more intensive interventions. The relatively brief intervention format—one antenatal session and two short telephone follow-ups may have limited its impact, particularly for fathers.

A key strength of this study is its rigorous design, incorporating a three-arm structure, blinded assessments, and a 12-month follow-up period, which suggests enhanced reliability [89]. However, limitations such as self-report measures and a sample primarily composed of educated, first-time parents reduce the generalisability of the findings. Overall, these findings align with previous research emphasising the importance of cognitive-behavioural skills in managing postpartum depressive symptoms and highlight the value of partner involvement in preventive interventions, particularly for mothers [30]. However, the modest effect sizes and lack of long-term benefits indicate a need for more robust and sustained interventions.

Like Ngai *et al*. [51] (2020), He Liping *et al*. [49] (2023) found that family or couples-based approaches may be more effective for mothers. In their overview of eight systematic reviews examining both preventative and therapeutic strategies to treat PPD using a family therapy approach, the findings suggest that integrating family support can lead to reductions in depressive symptoms among perinatal women. However, they found that taking a family approach does not lead to a reduction in symptoms for fathers. This suggests that there is currently limited evidence that family therapy improves paternal PPD outcomes. Additionally, the overall quality of the systematic reviews included was graded either "low" or "critically low" according to the Grading of Recommendations Assessment, Development and Evaluation GRADE tool [90].

Similarly, Letourneau *et al.* [62] (2012) conducted interviews with fathers whose partners had struggled with postpartum depression and found that they valued support from both professional and non-professional sources in coping with their partner's difficulties. They recommended that healthcare professionals actively involve fathers in family-centered interventions for postpartum depression, particularly when a mother screens positive. Likewise, Freitas & Fox (2015) argue that addressing paternal depression through family therapy could serve as a preventative measure, promoting overall family mental health and improving child development outcomes [53].

In a separate study, Ngai and Lam (2023) [52] using an RCT, explored first-time parents' perceptions of a couple-based Interpersonal Therapy (IPT) program and identified factors influencing its effectiveness through a process evaluation. The researchers utilised a satisfaction questionnaire to assess participants' views on the program's structure, process, and outcomes. Additionally, semi-structured interviews were conducted with 44 first-time parents who had completed the IPT program, and thematic analysis was used to interpret the qualitative data. The findings suggest that parents found couple-based IPT beneficial in several ways, including strengthening their relationships, managing emotional distress, and enhancing their confidence in parenting. Several key factors contributed to the program's successful implementation, including programme delivery by midwives, the use of interactive lesson formats, relevant content specifically tailored to first-time parents, and flexible scheduling and delivery methods that accommodated participants' needs.

While the adaptability of this approach enhances its potential for widespread implementation, the lack of outcome measures in this study limits the ability to assess the true effectiveness of IPT for postpartum depression. Without outcome measures, it is unclear whether the reported benefits, such as improved relationships and reduced emotional distress, translate into clinically significant reductions in postpartum depression.

Moreover, prior studies on IPT have demonstrated its efficacy in reducing perinatal depression among mothers when validated outcome measures were employed [91, 92]. The absence of such data in this study raises concerns about the validity of its conclusions, as self-reported satisfaction does not necessarily reflect actual symptom improvement [93]. Future research should incorporate standardised assessment tools to provide a clearer picture of IPT's effectiveness in treating postpartum depression in both mothers and fathers.

Couples-based interventions may improve coparenting and maternal mental health, but their impact on paternal perinatal depression is unclear. While strong coparenting has been associated with reduced PPD symptoms [48] (Wells, Jeon & Aronson, 2023), outcomes from joint interventions are mixed—some demonstrating improvements in self-efficacy and relationship satisfaction only (Ngai *et al*. [51], 2020), while others showing limited effects (Fletcher *et al*. [50], 2018). Low father engagement and modest results suggest a need for tailored, long-term approaches using validated measures.

3.7 Technology-based interventions

Digital interventions have gained traction as an accessible form of mental health support during the perinatal period, particularly for those who may face logistical barriers or stigma. Xie *et al.* [54] (2023) carried out a systematic review examining digital interventions designed for fathers in the perinatal period. Thirty-nine studies were included covering 29 interventions across 13 countries. 76% of the interventions were targeted at mothers, and only 26% of the studies focused exclusively on fathers. They found that although many studies reported positive results regarding feasibility and efficacy, the overall quality of the studies was moderate, and mixed findings regarding intervention effectiveness were noted.

The diversity of interventions across 13 countries suggests broad relevance across different settings, thereby increasing the generalisability of the findings [94] (Borelli *et al*. [95], 2020). The authors noted that the positive experiences reported in qualitative studies are important for understanding fathers' engagement and the acceptability of digital interventions [27] (Paulson & Bazemore, 2010).

The qualitative and mixed-method studies reported generally positive experiences, emphasising increased parenting confidence and normalisation of symptoms. Of the 18 efficacy-focused studies, 72% reported statistically significant intervention effects. The researchers concluded that while digital interventions could address accessibility for fathers, more targeted interventions are required to focus on father-specific needs. This review could be expanded to examine how these interventions could be integrated into existing healthcare systems or developed through partnerships between digital platforms and healthcare providers [95] (Alotaibi, Wilson & Traynor, 2025).

Following on from the work of Xie *et al.* [54] (2023), Iglesias *et al.* [55] (2024) carried out a meta-analysis and systematic review of RCTs exploring the effectiveness of online psychological interventions for fathers. The meta-analysis indicated a moderate effect size, suggesting that the interventions can be beneficial in preventing mental health difficulties in fathers in the perinatal period. The researchers emphasised that interventions that included components of CBT, psychoeducation and peer support were particularly effective. This is the first systematic review and meta-analysis to examine online interventions to prevent paternal PPD. The researchers restricted inclusion to RCTs. Meta-analyses and systematic reviews that include only RCTs provide the most reliable evidence for healthcare decision-making [96] (Williamson, Gamble, Altman and Hutton, 2015).

However, the authors acknowledged that some of the studies included had small sample sizes, and this can affect the generalisability of those findings [97] (Siddaway, Wood & Hedges, 2019). The overall risk of bias was high in most of the studies, and the strength of the evidence was low according to the GRADE methodology. Many of the studies included also did not use baseline screening of PPD. The lack of baseline identification creates ambiguity regarding the preventative effects of interventions. If PPD is not assessed prior to the intervention, it is impossible to ascertain whether the intervention successfully prevented the onset of PPD or if it was administered to individuals who were not at risk (Leach *et al.* [17], 2016). Only three of the seven studies offered a follow-up assessment. The follow-up periods were short, extending to a maximum of 24 weeks postpartum. Evidence indicates that the risk of PPD for fathers can extend from conception to one year postpartum [25] (Cameron, Sedov and Tomfohr-Madsen, 2016). This means that the overall preventative effects are uncertain.

Kaner, Cwikal & Segal-Engelchin (2023) examined an online group intervention for new fathers in Israel using a mixed-methods RCT with 122 participants assigned to intervention or control groups [56]. Measures included the EPDS and Israeli Marital Quality Scale (IMQS) [98], administered pre- and post-intervention, alongside thematic analysis of qualitative feedback. The six weekly 75-minute, semi-structured sessions covered topics such as identity formation, adjustment to parenthood, expectations versus reality in relationships, and collaborative parenting, with "Marriage Moments" homework between sessions [99].

Participants in the intervention reported greater feelings of normalcy, reduced loneliness, increased engagement as co-parents, and improved marital quality. EPDS data suggested that 25% met criteria for PPD [100] (Rao *et al.* [101], 2020), although the cut-off score and timing of assessments were not specified, limiting interpretation. While the mixed-methods RCT design is robust, generalisability is limited by the small, homogeneous sample of secular, educated Jewish Israeli fathers [101]. With only 25% scoring above the threshold for PPD and severity unreported, the sample may have been skewed toward mild distress, making it unclear whether the intervention benefits fathers with clinically significant PPD.

Self-selection bias is also possible, as participants recruited online may be more proactive in seeking support [102]. It remains uncertain whether improvements were due to the session content and homework assignments, or to the social support derived from the group. Future research should isolate active components and examine effectiveness for fathers with more severe PPD, who may require more individualised or pharmacological interventions [103].

In summary, digital interventions may offer a feasible and accessible form of support for fathers' mental health during the perinatal period, particularly by addressing practical barriers to engagement. While systematic reviews and a recent meta-analysis report small-to-moderate effects on paternal depressive symptoms, the overall quality of the evidence remains mixed [54, 55]. Many studies are limited by small sample sizes, heterogeneous outcome measures, short follow-up periods, and the absence of baseline screening for paternal perinatal depression, making it difficult to draw firm conclusions regarding effectiveness. Interventions that incorporate elements of CBT, psychoeducation, and peer support appear more acceptable and potentially beneficial than stand-alone digital approaches; however, further well-designed randomised controlled trials with longer follow-up periods are required before stronger claims can be made or widespread implementation can be recommended.

3.8 What role could cognitive behavioural therapy play in treating PPD/PPA?

Before proceeding, it is important to acknowledge that many of the studies reviewed so far have incorporated elements of CBT within the interventions and treatments offered [47, 50, 51]. Across several intervention types, CBT techniques were included as part of broader multicomponent programmes, reflecting their common use in contemporary perinatal mental healthcare.

CBT is a well-established and highly effective treatment for depression and various anxiety disorders and is more effective than antidepressant medication [104, 105]. NICE guidelines (2022) recommend CBT as a first-line of treatment for depression and anxiety, and it is often dubbed the gold standard of psychological treatment due to its extensive research base and effectiveness across diverse populations and conditions [106, 107]. Treatment for men can also be tailored by addressing cognitive distortions related to gender roles and societal expectations [108].

Several systematic reviews exploring the efficacy of different interventions for treating paternal depression and anxiety have been conducted (Goldstein *et al.* [37], 2019; Rominov *et*

al. [57], 2016, and Fisher *et al.* [11] 2022). A key distinction between the systematic reviews conducted by Goldstein *et al.* [37] (2019) and Rominov *et al.* [57] (2016) lies in their scope [57]. Goldstein *et al.* [37] centred their review on paternal perinatal depression and related interventions, whereas Rominov *et al.* [57] examined all available interventions targeting perinatal depression, anxiety, stress, and overall psychological functioning.

Goldstein *et al.* [37] (2019), in their systematic review of RCTs, explored the effectiveness of interventions for PPD. The interventions included psychoeducation for fathers, as well as approaches targeting co-parenting relationships and family dynamics. The review highlighted the lack of research in this area, with only six of the 14 studies offering interventions exclusively to fathers. Many of these studies did not require fathers to meet diagnostic thresholds for depression or anxiety, which may introduce selection bias; this suggests that the fathers in the studies may not have needed the interventions provided. RCTs provide the highest level of evidence due to their methodological rigor and higher reporting standards compared to observational studies [109, 110].

While this review has notable strengths, it also highlights the limited availability of interventions specifically for fathers. The researchers suggested that since maternal adaptations of CBT have proven effective and fathers responded positively to psychoeducation, there is potential for CBT to be adapted for treating PPD in fathers. Other systematic reviews have indicated that CBT, along with group therapy and digital interventions, could be beneficial for treating paternal perinatal depression, however, the limited research in this area prevents definitive conclusions [37].

Building on Goldstein *et al.* [37] (2019), Rodrigues *et al.* [36] (2022) conducted an updated integrative review, which included five newer studies. Their findings reaffirmed the scarcity of research, but they did identified five newer studies reporting positive paternal mental health outcomes. Significant improvements were seen in interventions with psychotherapy or counselling components, suggesting that therapeutic interventions specifically designed for perinatal men could help alleviate PPD symptoms. However, only two of the five new studies were RCTs, and neither included screening for depression or anxiety symptoms, which raises concerns about the clinical relevance and generalisability of these findings. Additionally, none of the RCTs included large sample sizes, indicating that adequately powered RCTs are needed before definitive conclusions can be drawn.

Similarly, O'Brien *et al.* [1] (2016) conducted an integrative review focused on treatment options for fathers and found that CBT, group work, and e-support were the most effective. They proposed that treatment should be tailored with a greater emphasis on stress management rather than emotional discussions, as men tend to respond better to goal-based, cognitive, and problem-solving strategies for managing mental health difficulties [111] (Proudfoot *et al*. [112], 2015). While integrative reviews offer a comprehensive overview of diverse literature, they also carry the risk of selection bias and subjective interpretation of findings (Whittemore & Knafl, 2005) [112]. Unlike systematic reviews, integrative reviews are also difficult to replicate.

Fisher *et al.* [11] (2022) conducted a systematic review of interventions targeting paternal perinatal anxiety (PPA), marking the first systematic review to focus on PPA. They found that no specific interventions targeted PPA, with all studies adopting a universal approach to treating fathers' anxiety. The review had a small evidence base, with the quality of studies being a concern. Furthermore, PPA outcomes were self-reported by participants, without clinical diagnostic interviews, and nine of the 12 studies compared interventions with TAU, without specifying the content of this care. The studies also focused exclusively on married fathers, limiting the generalisability of the findings.

The unique characteristics of the perinatal period have led to the creation of specialised CBT interventions for women experiencing perinatal depression [113, 114]. However, while CBT is not inherently gender-specific, current psychosocial interventions for fathers often fail to address the unique psychological and social challenges they face during this period. There remains a notable gap in interventions specifically designed to support fathers experiencing perinatal depression, particularly in the adaptation of CBT-based approaches to better reflect their experiences and needs [37, 57].

Using the Delphi technique, researchers have attempted to develop a CBT-based intervention for PPD by recruiting ten international experts [58]. The experts participated in an initial round of open-ended questions regarding potential components and targets of an intervention, followed by a second round to identify the most agreed-upon components. Despite maintaining the core Delphi methods, only two rounds were conducted, limiting opportunities for refining responses. The experts emphasised adapting CBT to a strength-based approach for treating PPD, with a focus on relationship changes, seeking social support, and stress management. However, the study lacked representation from fathers with lived experience on the expert panel, potentially missing valuable insights from the target population [36]. Moreover, no plans were made to evaluate the effectiveness of the proposed intervention.

In a recent case report, adapted CBT was found to be effective for a father experiencing symptoms of PPD [59]. The researchers followed Scarff's (2019) recommendations for symptom recognition using the PHQ-9 (Kroenke, Spitzer, & Williams, 2001) and adapted the treatment plan based on NICE (2020) guidelines [3, 29, 115]. The results showed significant improvements in the individual's depression, anger, and irritability. While promising, the case study has limitations, such as a lack of external validity and generalisability. Additionally, as it was uncontrolled, it cannot establish cause-and-effect relationships, and the possibility of natural recovery or a medication response remains undetermined [116]. This study suggests that CBT may be effective for fathers without requiring major adaptations.

Taking a qualitative, person-centred approach, Davenport & Swami (2022) reported on a father's lived experience of seeking support for perinatal mental health difficulties [60]. He described symptoms of inadequacy, isolation, and anxiety, and identified several barriers to help-seeking—particularly stigma, masculine norms, and a lack of awareness around paternal mental health. The researchers noted missed opportunities for support: a health visitor dismissed his concerns

with a joke, and a General Practitioner (GP) was unaware that fathers could experience perinatal mental health issues. With his partner's support, he was eventually referred to a family-centred psychotherapist. Although he did not feel fully recovered afterwards, a follow-up parenting course, combined with therapy, supported his overall recovery.

Despite the lack of generalisability, a narrative approach is appropriate in capturing the complexity of emotions and challenges faced by fathers during the perinatal period. Like many previous studies, the authors have emphasised the need for a more tailored intervention for fathers. In this study, it is not clear what the exact mechanisms of change were for the father.

Nawal *et al.* [61] (2024) examined the prevalence and impact of PPD, highlighting its underreporting and the resulting gaps in provider awareness and targeted support. The study found that PPD can strain family dynamics and hinder child development. Both IPT and CBT were noted as promising treatments. While advocating for a multifaceted approach that considers individual, relational, and environmental factors, the study lacked discussion of implementation barriers and long-term outcomes. Future research should explore how to embed paternal mental health support into routine care and reduce stigma around help-seeking.

In summary, CBT is a widely endorsed, evidence-based treatment for perinatal depression, with several studies demonstrating its effectiveness for mothers [117] (Pettman *et al.* [118], 2023). However, despite its theoretical suitability for the paternal population, the existing research highlights a critical gap in paternal PPD adaptations. Systematic and integrative reviews consistently highlight small sample sizes, inconsistent outcome measures, and the underrepresentation of fathers, all of which weaken the evidence base. While there appears to be promise for tailored approaches (Skilbeck *et al.* [59], 2023) the lack of large-scale RCT's continues to hinder progress. Future studies should focus on adapting CBT to fathers' unique challenges and integrating such interventions into perinatal or primary care.

4. Discussion

The findings of this review indicate that paternal perinatal mental health is a global issue, with studies conducted across more than 15 countries demonstrating consistent patterns in prevalence, symptom presentation, and unmet support needs. This geographical spread strengthens the generalisability of the findings and ensures they are not limited to a single cultural or healthcare context [42, 118]. Despite this international diversity, clear commonalities emerged: fathers experience significant psychological distress during the perinatal period yet remain under-recognised within routine care. Although a range of interventions has been trialled, including digital programmes, couple-based approaches, group therapy, and CBT-informed models the evidence base is limited by the scarcity of high-quality, father-specific RCTs. Collectively, these findings highlight the need for more rigorous and targeted interventions to support fathers during this period.

This review deployed a comprehensive search strategy. This can increase the likelihood of capturing a broad and representative sample of relevant research [42] (Levac, Colquhoud & O'Brien, 2010). The PRISMA methodological framework was utilised; this suggests a comprehensive and transparent search strategy that can be replicated, thereby increasing its reliability and strengthening methodological rigor [118] (Arksey & O'Malley, 2005). While the review used a comprehensive search strategy, only three databases were utilised. This may limit the scope of the review by missing relevant studies from psychology, social work, and non-English language studies. The exclusion of PsycINFO may have limited the retrieval of psychology-specific studies, and this is acknowledged as a limitation of the search strategy. This narrow focus may overlook grey literature or studies not indexed in these databases [41, 119].

To mitigate potential bias and ensure a rigorous and transparent study selection process, the researcher reviewed and shortlisted studies for inclusion using Rayyan, an Artificial Intelligence (AI)-assisted screening tool [120]. This process allowed for real-time discussion and ensured that all decisions were made collectively, in line with recommendations for minimising subjective bias in reviews [121] (Liberati *et al.* [122], 2009; Moher *et al.* [123], 2015). Any disagreements that arose during the review were resolved through open discussion, allowing consensus to be reached based on the predefined criteria rather than individual biases. This collaborative approach increases the consistency and transparency of the study selection process [123]. By utilising Rayyan and a dual-reviewer approach, the review aimed to enhance the objectivity and reliability of the study selection process, thereby strengthening the credibility and validity of the findings [97].

It has been over three years since the last systematic review exploring this area [36], underscoring the need for an updated review. This scoping review aimed to summarise findings from recent literature while identifying existing research gaps, which is essential for guiding future research efforts [124]. The objectives of this scoping review were met, as it provides an overview of recent findings in the field and offers updated insights into current research gaps. The findings of this research support the appropriateness of the methodology chosen. As there are few meaningful RCTs available, a scoping review is more appropriate for the aims of this study.

Another aim of this review was to explore the role CBT plays in treating fathers with perinatal mental health issues. There are promising results suggesting improvement among fathers receiving CBT-informed approaches, Husain *et al.* [47] (2025). However, the key limitation of these findings is that the fathers were also offered other treatments. Consequently, the mechanisms of change are difficult to isolate, making it unclear how much the CBT component contributed to the overall effect. One case study reported recovery in a father who received CBT for postnatal depression [59].

The available evidence on PPMH overwhelmingly focuses on heterosexual cisgender fathers. Studies involving same-sex fathers, transgender fathers, or non-binary parents remain extremely limited [125]. These existing studies highlight distinct pathways to parenthood shaped by adoption, assisted reproduction, minority stress, stigma, and barriers to perinatal care. These factors represent a separate set of determinants and

support needs that cannot be meaningfully integrated with the evidence base included in this review. To maintain methodological coherence and ensure comparability across studies, the review therefore focused on fathers in the general population, for whom most outcome measures have been developed and validated and for whom intervention approaches are still emerging. The lack of LGBTQ+ representation across the included studies highlights an important evidence gap and underscores the need for dedicated research exploring the perinatal mental health needs of LGBTQ+ parents, including the development of interventions that account for minority stress processes, diverse family structures, and differential access to care [126] (Moriarty & Willis, 2024).

While research increasingly recognises the diversity of families, including LGBTQ+ parents, the evidence base on perinatal mental health among same-sex fathers, transgender and non-binary parents remains limited and conceptually distinct from the literature on heterosexual father. Studies by Golombok and colleagues show that family relationship quality, rather than parental gender or sexual orientation, is the key predictor of child wellbeing [127, 128]. However, LGBTQ+ parents often navigate different pathways to parenthood and experience unique stressors.

Across the included studies, several common methodological biases were evident. Many interventions did not require fathers to meet baseline diagnostic criteria for depression or anxiety, introducing selection bias. A heavy reliance on self-report screening tools, rather than standardised diagnostic assessments, increased the risk of measurement bias. Samples were often small and drawn from homogenous, well-educated populations, limiting generalisability. Follow-up periods were short, making it difficult to determine long-term treatment effects. In several RCTs, the content of "treatment as usual" was poorly described, creating potential performance bias, and blinding procedures were rarely implemented. Furthermore, because many interventions combined CBT, psychoeducation, and group-based components, the mechanisms of change were difficult to isolate.

Although CBT is widely regarded as an effective and cost-efficient treatment for depression, the limited number of father-specific trials and the frequent use of adapted or multimodal interventions make it difficult to determine whether, and in what ways, CBT should be modified for fathers.

This review references studies that suggest fathers may benefit from a group therapy setting. Fathers who engaged in group therapy experienced enhanced emotional expression, reduced feelings of isolation, and improved coping skills [47]. Other studies have found that fathers who participated in face-to-face group support sessions reported a decrease in anxiety and depression symptoms, enhanced feelings of self-worth, and improvements in relationship quality [56]. These findings are supported by more general studies exploring the effectiveness of group therapy for men. Furthermore, in groups of men not experiencing perinatal-related issues, group therapy appears to offer essential support, reduce feelings of isolation, and enhance emotional resilience. Seidler *et al.* [9] (2018) highlight that connecting with peers allows men to discuss their struggles more openly and directly challenge traditional masculine norms.

This scoping review broadly met its aims by identifying a range of interventions targeting PPD, offering global perspectives across diverse healthcare contexts. It highlighted promising roles for CBT and group-based therapies, both face-to-face and online; however, few studies used CBT as a standalone intervention, making it difficult to isolate its specific effects. This review also underscored key gaps, including the need for more RCTs with larger sample sizes, clearer mechanisms of change, and long-term outcome data. While scoping reviews do not allow for firm conclusions, the findings offer a strong foundation for future research and practical development in this emerging area. Ultimately, this review supports the growing recognition that paternal mental health requires targeted, evidence-based support, and that CBT-informed approaches and group therapy hold promise, pending further investigation.

Scoping reviews provide breadth rather than depth, and because they include studies of varying methodological quality, the strength of conclusions is inherently limited, as is the case with existing systematic reviews [1].

Since the cut-off point for the primary search (January 2025), several notable studies have begun to emerge that reinforce and extend the findings of this review. For example, a recent RCT in Japan found that distributing a childbirth and parenting booklet to expectant fathers produced a reduced, but non-significant, risk of paternal postpartum depression [129]. Meanwhile, a feasibility study of an mHealth app designed for fathers' perinatal mental health demonstrated high acceptability and usability, signalling the potential of digital interventions for this population [130]. A third qualitative study from Tanzania reported that midwives recommend involving fathers more fully in postnatal care and developing father-specific supports, pointing to the need for culturally adapted models [131]. Finally, an RCT of coping strategies training during pregnancy for fathers showed promising reductions in postnatal depressive symptoms [132]. Collectively, these new studies highlight the growing momentum in father-inclusive perinatal mental health research, and they emphasise that intervention designs need to expand beyond maternal-focused models.

These developments support the central conclusions of this review: namely, that father-specific interventions are both emerging and necessary. That said, the fact that many of the studies remain feasibility trials, focus on support materials rather than full therapeutic protocols, or are located in specific geographical contexts underscores the continued gaps in robust, large-scale, treatment-based trials for fathers. Recognising the pace of research since January 2025 suggests that future reviews or updates may need to adopt a "living review" format to capture rapidly evolving evidence streams. Moreover, intervention designs should prioritise both digital and face-to-face formats, the inclusion of culturally diverse populations, and the use of clinically meaningful endpoints.

Although the included studies were conducted across diverse geographical and cultural contexts, most did not explicitly examine how cultural norms, religious beliefs, or faith-based community structures might influence fathers' experiences of perinatal mental health difficulties or their engagement with interventions. As a result, it is unclear whether findings relating to stigma, help-seeking, or group-based sup-

port can be generalised across different cultural or religious settings. This limitation reflects gaps in the primary literature rather than the scope of the present review. Future research would benefit from more explicit consideration of cultural and contextual factors when designing and evaluating interventions for paternal perinatal mental health.

5. Conclusion

In conclusion, this scoping review provides an overview of current research on paternal perinatal mental health, with particular attention to interventions and the potential role of cognitive behavioural therapy (CBT). Group-based approaches and CBT appear promising, although the evidence base remains limited.

In recent years, UK policy has begun to acknowledge the importance of involving fathers in perinatal mental health care. The National Health Service (NHS) Long Term Plan commits to offering mental health assessments and signposting to partners of women receiving specialist perinatal services, representing a shift toward more family-inclusive care [133]. However, despite these developments, fathers still have a dedicated or routine mental health pathway, and most national guidance remains centred on maternal care. This policy gap underscores the need for research that specifically addresses paternal perinatal mental health. Nevertheless, findings from this scoping review reinforce the role of recognition of needs for fathers' specific PPD interventions.

Future research should explore the long-term effects of group CBT, its practicality, and how it compares with other interventions (*e.g.*, IPT). Adapting programmes to fathers' specific needs, for example by including father-focused psychoeducation or peer-led group sessions, may improve engagement and outcomes. Greater consistency in outcome measures would also help to strengthen the evidence base and support the development of best practice in father-inclusive mental health care. Clinicians should consider adopting routine paternal screening and tailored interventions as standard practice to ensure fathers receive effective support when it is most needed.

AVAILABILITY OF DATA AND MATERIALS

Not applicable. No new datasets were generated or analysed in this study. All data supporting the findings are derived from previously published studies and are presented within the article.

AUTHOR CONTRIBUTIONS

MH—conducted the literature search and analysis; wrote the original draft of the manuscript. CE—provided supervision, methodological guidance, and critical revisions. Both authors contributed to editorial changes in the manuscript. Both authors read and approved the final manuscript. Both authors designed the research study.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This study is a scoping review of published literature and did not involve the collection of primary data from human participants. Therefore, ethical approval was not required. As this study did not involve human participants, informed consent was not applicable.

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CONFLICT OF INTEREST

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

SUPPLEMENTARY MATERIAL

Supplementary material associated with this article can be found, in the online version, at https://oss.jomh.org/files/article/2027619568162095104/attachment/Supplementary%20material.docx.

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