Gravens By Design: Supporting Fathers in the NICU

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The NICU can be an incredibly stressful environment for both the infant and its parents. Unlike many traumatic events, the NICU experience can often feel like an ongoing trauma, with the stay often involving highs and lows, new diagnoses, changes in prognosis, multiple procedures, and a rollercoaster of emotions. This chronic stress directly impacts the brain and can cause challenges with memory, emotional regulation, hypersensitivity, weakened immune system, and mental health problems. (1) The NICU can also trigger trauma responses for parents with previous traumatic experiences. NICU triggers can include alarms, interaction with authority, loss of control, physical exposure of breast/chest for feeding, prior loss, or negative hospital experiences. When a parent is triggered, their stress response system is activated, causing them to go into fight, freeze, or flee mode. In the NICU setting, this may look like a family who rarely visits, parents who shut down and do not engage with the infant or ask questions to the medical team, or parents who appear to be overly aggressive or involved in infant care.

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When working with families in the NICU, it is essential to use a Trauma Informed Care lens to ensure that the families' behaviors are being viewed from a place of understanding rather than judgment. (2) Perinatal Mood and Anxiety Disorders (PMAD) can result from prolonged stress related to the trauma of the NICU experience. Both parents are susceptible to developing PMADs. Often, much of the attention from medical professionals, friends, and family is on the well-being of the infant and birthing parent; however, this article will focus on the father's experience.

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Paternal Depression:

Paternal Depression is often characterized by irritability, emotional detachment, withdrawal from the family, and increased substance use. (3) Research shows that 10-20% of fathers experience a diagnosable PMAD, with depression and anxiety being the most prevalent. (4) Paternal depression occurs in 10% of fathers and increases to 12% as children approach toddler age. (3, 5) For Headstart families, mostly minoritized, low socioeconomic families, the rate of paternal depression is 18%. (3, 5) Fathers are at increased risk for developing depression when the birthing parent experiences depression. (6) There is a known correlation between paternal depression and the father's use of corporal punishment, as well as emotional problems in the child at the age of 3. (7) Also, fathers with depression are less likely to read to their children, which is vital for future cognitive and language development. Black fathers' experience of depression is often complicated by racism and cultural norms, which often do not promote emotional expression or involve formal therapy or psychiatric medication. Fathers in the United Stated tend to have greater rates of depression than fathers internationally, which some contribute to the lack of adequate paternal leave.

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Paternal Anxiety:

Paternal anxiety is often related to worry about their child having adverse developmental outcomes. (7) It ranges from 4.1% to 16% prenatally but can range from 2.4% to 18% postnatally. (7) A systematic review of 43 papers showed that fathers experience anxiety at a rate much greater than depression, which is also true for the birthing parent. (7) Under the umbrella of anxiety is paternal postpartum Posttraumatic Stress Disorder (PTSD), which occurs at a rate of 33% for NICU fathers. This rate is slightly lower than for the birthing parent. However, fathers are likely to continue endorsing severe PTSD symptoms at six months postdelivery. For fathers, postpartum PTSD can look like avoidance or a protective need to be constantly present. Intrusive thoughts and increased irritability are also common symptoms. Fathers with a trauma history are at increased risk for developing postpartum PTSD. (1)

Screening:

Screening for PMADs is vital for both parents. Fathers are rarely screened for PMADs but are at equal risk. In 2018, the National Perinatal Association (NPA) released a position statement recommending that fathers be screened for PMADs at least twice during the perinatal period and at 2, 4, and 6-month pediatric visits. Pediatricians see the child and its parents multiple times within the first

year of life and are best positioned to detect maladjustment. (8) In one study, fathers assessed for PMADs in the pediatric setting screened positive at a rate of 4.4%, (9) which allowed for intervention that may not have otherwise been provided. The Edinburgh Postnatal Depression Scale is the standard assessment tool for PMADs. It is in 18 different languages, has ten questions, and assesses for anxiety, depression, and suicidality. When using with fathers, it is best to use a cutoff score of 5 or 6 to ensure detection of distress, as gender typical men are often less expressive about their feeling, and distress could go undetected if using the general 12 cutoff score. (10)

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It is important to remember that fathers are valuable members of the family system. During a NICU experience, they often take on much more responsibility than they are used to by ensuring that older children are cared for, chauffeuring the birthing parent during the first several weeks when they are unable to drive, being the liaison for medical updates with families and friends, cleaning the home, going back to work, all while trying to "be strong" or "hold it together" for their partner, all while experiencing their grief. This responsibility is a lot to manage and add to this stress. Fathers are often ignored or not addressed at the bedside or in family meetings, are less likely to be asked to hold or participate in infant care, and often witness intense scenes during the delivery. In order to care for the whole family, fathers' well-being must be a priority.

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