



“Who is that masked man?”

Jeffrey R. Alberts, PhD
Indiana University, NFI Science Committee, Associate Editor for Science

Target article: Cyr-Alves, H., Macken, L. and Hyrkas, K. (2018) Stress and Symptom of Depression in Fathers of Infants Admitted to the NICU, *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 47: 146-157.

In 1933, *The Lone Ranger* was a favorite on U.S. radios. In 1946, the show debuted on the new medium of television and became a cultural icon in the States. The Lone Ranger character was a mysterious, heroic cowboy. He wore a black mask and did good with humble anonymity. At the end of each episode, after a successful, selfless exploit, as our hero rode off on his white steed with his trusted Indian companion, grateful townspeople would ask, “Who is that masked man?”

There seems to be an emerging realization that fathers of babies in the NICU are Lone Rangers. They are little known, but heroic. Babies hold center stage in the NICU, often with a mom that becomes known, understood, and integrated into the daily routines. The dad is more likely to be off stage, in the wings, and kind of mysterious. In my experience, fathers of babies in the NICU are often “hard to read”. It is as if they are behind a mask. Who is that masked man?

Cyr-Alves, Macken, and Hyrkas (2018) describe our woeful state of knowledge about fathers of babies in the NICU. There is little systematic information. So they turned to a 51-bed NICU study site in the northeast of the U.S., where they probed into phenomena of stress and depression among NICU fathers. They studied 104 dads, beginning with their infants’ admission to the NICU (Time (T) 1), then 3 weeks later (T2), again at discharge (T3), and finally 2 months after discharge (T4).

At each of the four time points, trained staff administered two, oft-used questionnaires. The specific tools used were the Parental Stress Scale (PPS), an 18-item, self-report questionnaire, and the 10-item Edinburgh Postnatal Depression Scale (EPDS), also a self-report questionnaire. Because each father was tested at each time point, the data describe stability and change over time for each subject and, thus comprises a *longitudinal study*. This was practically the first of its kind.

The PSS expresses level of stress with a composite score that can range from 18 -90. In the hands of previous researchers, a score of 43 or more was indicative of “high” level of stress. In the present study, the average stress levels reported by the NICU fathers was a moderate, 32. Statistically, there was no overall change in reported stress levels from T1 and T4, but the authors dug more deeply into the numbers and found that significantly more fathers scored as highly stressed (above 43) at T1 and at T4, suggesting that circumstances surrounding admission to the NICU and when the baby is settling into the home, can bring notable challenges.

The researchers sought to measure the incidence of depression

in NICU fathers and assayed for symptoms with the EPDS. Fathers in the present study consistently produced low average scores, suggesting no depressive symptoms. Again, the authors looked more deeply into the results by asking about the frequency of depressive symptoms – for this can get lost if we look only at averages. They found that 41% of the fathers reported minor signs at T1; 16% showed major symptoms at that time.

Amid the statistical metrics in this paper, “Chronbach’s α ” was used and this ominous-sounding term might need explanation. Chronbach’s α represents the degree to which there is internal consistency between different tests or test items. The idea is that such consistency indicates that the tests are measuring the same construct, implying reliability and accuracy. According to conventions guiding interpretation of such scores, Chronbach’s α in the present study scores indicated “satisfactory” internal consistency.

In all, this thoughtfully-designed and well-reported investigation identified only modest representations of stress and few symptoms of serious depression. I think one can detect some surprise in the authors, which I found comforting, because I was shocked. The stress and depression scores do not correspond to the severity of the babies’ condition or to the realities of the impact of having a newborn requiring intensive care. Why might this be?

The authors considered a range of possible explanations, including a subject population lacking diversity, unknown psychological status of each father before the baby’s hospitalization. They acknowledge that self-reports are susceptible to modifications shaped by social expectations. For these or other reasons, these tests were not sensitive to reflect fathers’ experiences or were incompatible with the dads’ abilities to report their condition.

I believe that this is an important and valuable research report. Although the findings were mostly ‘negative’, meaning they didn’t reveal big effects, this is not failure. The research question is not *whether* NICU dads are stressed or get depressed, it is *how* do we recognize and measure the important elements that comprise the fathers’ stressed and depressed conditions? These are vital matters of well-being, also important to the health of the mother, the strength of the parental bonds, and to the development of the infant.

Once more sensitive measurements are identified, it will be advantageous to incorporate a control group to learn more about the tests and, importantly, to learn more about how NICU fathers differ from new fathers with healthy babies. Do they show

more or different kinds of stress or depression? How much more? Carefully constructed, matched sample controls will someday be a useful part of a serious, systematic analysis of these important questions. When these fathers are better understood, it will be possible to develop and validate interventions and protections for them. More and different populations must be included. There is much to be learned about fathers in different cultures and different health care systems.

We are at a most fundamental, basic starting place. We are just beginning to ask, what is behind that mask? What is hurt and what is intact? What can we provide to facilitate his fatherhood and through the derived benefits to mother, buttress a loving family that will help a sick baby recover and travel on a healthy developmental path?

The Gold Standard for Excellence in Newborn Individualized Developmental Care

Model of the NIDCAP Nursery: From Self-Assessment to NIDCAP Nursery Certification

(Deborah Buehler, PhD, Sandra Kosta, BA, Heidelise Als, PhD, September 2018)

The figure graphically describes the relationship of training and support opportunities to nursery change from conventional care to consistently well-integrated NIDCAP care. It depicts the roles and relationships of newborn nursery components and the support opportunities offered to nursery professionals and staff engaged in this change process.

The infant and family are depicted at the nursery's core, cared for by the professionals and staff within the nursery and hospital. The hospital is understood as part of a greater community, a community from which infants and families come and to which they hope to return. The core of the figure shows the infant-parent relationship as it moves from one of infant isolation from the parents (Conventional Care; bottom) to one of full emotional and physical integration of infant and parents (NIDCAP Care; top) within the nursery.

Model of the NIDCAP Nursery

Highly Attuned NIDCAP Care - Nursery Certification

PROCESS of NIDCAP CARE IMPLEMENTATION

Consistently Well-Integrated NIDCAP Care

Variable NIDCAP Care

NIDCAP Beginnings

Conventional Care

Nursery Self-Assessment: Identification of Strengths & Challenges

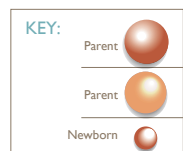
SUPPORTS FOR NURSERY CHANGE

Continued Mentorship for Self-Assessment, Reflection, Education and Training

NIDCAP & APiB Training for Core Teams and Nursery Assessment Review

Introductory/ Foundational Education (e.g., NFI Nursery Foundation Education, FINE, and other NFI-Endorsed Conferences & Courses) for all Professionals & Staff

Interdisciplinary (incl. Parents) Goal Setting and Planning



D. Buehler, S. Kosta, H. Als



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