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Paternal Perinatal Psychopathology and Stigma Related to NICU Admission

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Abstract

Stigma or the belief that mental health difficulties stem from a personal weakness, moral failing, or poor choices and will subject one to shame, embarrassment, scrutiny, victimization, oppression, and ostracization is a reason people choose to avoid, not to obtain or fully engage in mental health treatments despite their demonstrated effectiveness (Corrigan, 2004;Vogel et al., 2006). Gender differences have been found in experiences of stigma; for example, men were found to self-stigmatize to justify avoiding counseling to a greater degree than women (Judd et al., 2008). As such, stigma has been identified as a gender-salient variable that serves as a barrier to help-seeking that is proximal to attitudes toward counseling engagement (Vogel et al., 2011). Fathers of children born in the Neonatal Intensive Care Unit (NICU) are at increased risk of mental health problems throughout the perinatal period (Ireland, et al., 2016), and men, in general, may have increased susceptibility to self-stigma (Vogel, et al., 2007). Although NICU Dads have been shown to benefit from mental health support (Ocampo et al., 2021), there is a dearth of research related to their experiences with mental health treatments or the degree to which stigma is a barrier for them. Underutilization of treatment for this population unnecessarily maintains risks for fathers, partners, and children. The aim of this paper is to articulate the role of stigma and other barriers to paternal engagement in mental health supports and explore potential strategies for reducing stigma as a barrier to treatment for fathers of NICU babies.

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ABSTRACT

Stigma or the belief that mental health difficulties stem from a personal weakness, moral failing, or poor choices and will subject one to shame, embarrassment, scrutiny, victimization, oppression, and ostracization is a reason people choose to avoid, not to obtain or fully engage in mental health treatments despite their demonstrated effectiveness (Corrigan, 2004;Vogel et al., 2006). Gender differences have been found in experiences of stigma; for example, men were found to self-stigmatize to justify avoiding counseling to a greater degree than women (Judd et al., 2008). As such, stigma has been identified as a gender-salient variable that serves as a barrier to help-seeking that is proximal to attitudes toward counseling engagement (Vogel et al., 2011). Fathers of children born in the Neonatal Intensive Care Unit (NICU) are at increased risk of mental health problems throughout the perinatal period (Ireland, et al., 2016), and men, in general, may have increased susceptibility to self-stigma (Vogel, et al., 2007). Although NICU Dads have been shown to benefit from mental health support (Ocampo et al., 2021), there is a dearth of research related to their experiences with mental health treatments or the degree to which stigma is a barrier for them. Underutilization of treatment for this population unnecessarily maintains risks for fathers, partners, and children. The aim of this paper is to articulate the role of stigma and other barriers to paternal engagement in mental health supports and explore potential strategies for reducing stigma as a barrier to treatment for fathers of NICU babies.

Introduction

Parenthood is a life-changing event that can bring great joy and fulfillment for many, but it can also be a time of significant stress and challenge. While much attention has been paid to the mental health needs of new mothers, the mental health needs of fathers have been largely overlooked (Fisher et al., 2022). This is a significant oversight, as men are also vulnerable to a range of mental health challenges during the perinatal period, and poor mental health is known to have a negative impact on parenting behaviors and child development (Paulson, 2021). Men are also known to be especially impacted by the stigma of mental health (Vogel et al., 2007), and special consideration needs to be taken to understand how these manifest during the transition to fatherhood and the compounding effect on fathers impacted by the stress of the NICU. The dearth of literature on this topic should convey a sense of urgency in the field to develop psychotherapeutic interventions and support programs to serve this at-risk population (Ocampo et al., 2021). The known impacts of interventions on men's perinatal mental health and NICU specifically are promising (Ocampo et al., 2021), making it imperative to synthesize current knowledge about the experience of men with children in the NICU. The development and improvement of interventions specific to this special population can ensure, like mothers, fathers receive effective care and maintain their psychological health, so that they can effectively care for their infants and family. To inform intervention development, we conducted a survey for preliminary data on the frequency of paternal awareness of stigma and mental health symptoms during the time of a past NICU admission. This paper aims to highlight the importance of addressing the mental health needs of new fathers and recommends the integration of stigma-addressing strategies for intervention development.

Mental Health Stigma

Corrigan (2004) identified *stigma* as social-cognitive processes that elicit stereotypes or knowledge structures that the general public learns about a marked social group (Augoustinos et al., 1994; Esses, et al., 1994; Hilton & von Hippel, 1996; Judd & Park 1993; Krueger, 1996; Mullen, et al.,1996). Stereotypes about people with mental illness have been shown to include expectations of violence (e.g., "people with mental illness are dangerous), incompetence (e.g. they are incapable of independent living or real work), and blame (because of weak character, they are responsible for the onset and continuation of their disorders) (Brockington et al., 1993; Corrigan et al., 2000; Hamre, et al.,1994; Link et al., 1999). According to Corrigan (2004) stigma generates prejudice, beliefs, and attitudes involving an evaluative (generally negative) component (Allport, 1954; Eagly & Chaiken, 1993). These cognitive and affective responses (i.e., prejudice) lead to discrimination against mentally ill individuals (Crocker et al., 1998). Discrimination, negative action against an out-group, or exclusively positive action for the in-group, may appear as avoidance or not associating with people from the outgroup (e.g., employers not hiring or landlords not renting to mentally ill people) (Corrigan, 2004). As such, stigma motivates people to avoid the label of mental illness, including mental illness assumed present when individuals use mental health care.

Public stigma is what a naive public does to a stigmatized group when they endorse or perpetuate prejudice about that group (Corrigan, 2004). These actions harm people who are publicly labeled as mentally ill, as stereotype, prejudice, and discrimination serve to rob such individuals of important life opportunities (e.g., access to services, jobs, and housing) including opportunities to receive supports that could alleviate their pain. Studies have shown that public stereotypes and prejudice about mental illness have a deleterious impact on individuals obtaining and keeping good jobs (Bordieri & Drehmer, 1986; Farina & Felner, 1973; Farina et al., 1973;

Link 1982, 1987; Oshansky et al.,1960; Wahl, 1999; Webber & Orcutt, 1984), and leasing safe housing (Aviram & Segal, 1973; Farina et al., 1974; Hogan, 1985a, 1985b; Page 1977, 1983, 1995; Segal et al., 1980; Wahl, 1999). Public stigma has also been observed to have a negative impact on the general healthcare system. For example, people labeled as mentally ill are less likely to receive and benefit from the depth and breadth of available physical health care services, relative to peers without these illnesses (Desai et al., 2002; Druss & Rosenheck, 1997).

According to Corrigan's model conceptualizing stigma (2004), there are four cues from which the general public appears to infer about mental illnesses: psychiatric symptoms, social skills deficits, physical appearance, and labels (Corrigan, 2000; Penn & Martin, 1998). These cues elicit and maintain beliefs about people who are labeled as mentally ill (i.e., stereotypes and prejudice) and evoke discriminatory behaviors toward them. To avoid being labeled, people may deny their group status and not seek the institutions that mark them (i.e., mental health care). Indeed, research has shown that people with concealable stigmas often decide to avoid the harm of public stigma by concealing these identities (Corrigan & Matthews, 2003). Corrigan (2004) observed the label of mental illness can be obtained by association (e.g., a person observed coming out of a psychologist's office or talking to a mental health provider on the hospital unit may be assumed to be mentally ill) and can be obtained from others (e.g., a psychiatrist may inform others that an individual is mentally ill). As such, people with mental health concerns become motivated to avoid mental health providers to avoid the public stigma of mental illness and subsequent deleterious effects on their well-being.

Self-stigma is what the members of a stigmatized group may do to themselves as they internalize public stigma (Corrigan, 2004). Research has shown those who internalize public stigma about mental health disorders believe themselves to be less valued due to their psychiatric

difficulties (Link, 1987; Link & Phelan, 2001). Internalization of cultural stereotypes of mental illness (i.e., self-stigma) has been associated with diminished self-esteem, self-efficacy, and confidence in one's future (Corrigan, 1998; Holmes & River, 1998). Such negative emotional reactions towards oneself have been linked with self-prejudice (e.g., negative beliefs about oneself such as, "I am weak and unable to care for myself"), which may evoke self-discrimination, negative action against oneself as a member of the stigmatized out-group (e.g., not looking for a job due to belief that oneself is incompetent). For these reasons, those with mental health concerns may avoid the self-stigma of mental illness to protect themselves from the potential impact on their sense of self.

Healthcare Help-Seeking & Men's Disproportionate Experience with Stigma

Help-seeking attitudes (i.e., beliefs about seeking mental health care) are negatively impacted by self-stigma of mental illness, which represents the appraisal that seeking counseling would be threatening to one's self-worth. For those with high self-stigma of mental illness seeking counseling could be perceived as having an adverse impact on one's self-worth (Vogel et al., 2006). Indeed, self-stigma has been identified as an important barrier to initial decisions to seek information about mental health concerns and counseling, even for individuals with higher levels of distress (Lannin et al., 2016). Additionally, self-stigma has been shown to lower intention to seek counseling for specific problems (Brenner et al., 2020; Hammer & Vogel, 2013; Lannin et al., 2015; Pattyn et al., 2014) and decreased willingness to return for subsequent counseling sessions (Wade et al., 2011). Help-seeking self-stigma has also predicted decreased help-seeking behavior including lower rates of accessing online information about mental health and counseling services (Lannin et al., 2016), and decreased use of services over a two-year period (Seidman et al., 2019). Self-stigma of seeking help has also been positively associated with less

disclosure of distress and more negative attitudes toward help-seeking (Vogel et al., 2006), and self-stigma has been associated with anticipating greater risks and fewer benefits of seeking counseling (Vogel et al., 2007). Overall, the link between help seeking and self-stigma illustrates a negative impact on help-seeking attitudes and behaviors for those with high self-stigma.

Self-stigma appears to intersect with and be amplified by holding traditional masculinity ideologies (i.e., internalized belief structures dictating appropriate thoughts, feelings, and behaviors which are expected from men; Pleck, 1995). These ideologies, based largely on old-fashioned sexist beliefs about men (Levant & Richmond, 2016), promote stoicism and self-reliance and discourage men from asking for help (Addis & Mahalik, 2003; Vogel & Heath, 2016). Masculine gender role strain (MGRS) represents adherence to stereotypical masculine behaviors (Eisler & Blalock, 1991) to the point where violations of those behaviors are viewed as threatening and stressful (Eisler & Skidmore, 1987, Pleck, 1995). Numerous studies have found positive associations with self-stigma and restrictive, traditional expressions of masculinity or gender role strain (Vogel & Heath, 2016).

As a group, relative to their cis-gendered female counterparts, males have been found to hold greater self-stigma (Vogel et al., 2007) and to internalize public stigma about psychological help-seeking to a greater degree (Judd et al., 2006; Vogel et al., 2007). Gender differences are regularly identified in the maintenance of stigma beliefs and the perceived impact of stigma. given that the dominant gender role expectations for men include being able to be self-sufficient, independently solve one’s problems, being independent, and being in control of one’s emotions (Berger et al., 2005; Vogel et al., 2011). Results from the National Comorbidity Survey identified specific concerns about what others might think and wanting to solve problems on one's own as specific beliefs as dissuasive from treatment (Kessler et al., 2001). Overall, self-

stigma appears to be a gender-salient variable that affects male-identified individuals to a greater degree than their female counterparts.

Men have been found to underutilize mental health services due to self-stigma and the resulting shame and embarrassment they might feel toward themselves (e.g., to believe themselves "inferior" or "weak" for needing to seek help; Vogel et al., 2006). Schaub and Williams (2007) posited that willingness to seek counseling may be seen as a threat to men's sense of their masculine self, and as it may constitute an admission of weakness or a personal failure (Addis & Mahalik, 2003; Seidman et al., 2019; Tsan et al., 2011; Vogel et al., 2006). Men, relative to women, have also been found to underutilize counseling services due to less favorable attitudes regarding seeking professional help (Gonzalez et al., 2005).

In fact, researchers have shown self-stigma to fully mediate the relationship between perceptions of public stigma and help-seeking attitudes (Vogel et al., 2007) and men to self-stigmatize counseling to a greater degree than women (Judd et al., 2006). Men have also been shown to seek psychological services less frequently than women (Andrew et al., 2001; Eisenberg et al., 2012). In a help-seeking model developed by Vogel et al., (2011) the relationship between men's gender role conflict and attitudes toward seeking counseling was partially mediated by the self-stigma associated with seeking help.

Racial/ethnicity, gender identity differences and other intersectionalities (e.g., immigrant status and native language) lead to further disparities in mental health help-seeking due to stigma. Men from non-majority backgrounds seek and utilize psychological help even less frequently than white men (Chandra et al., 2009). Asian American, African American, and Latino American men have been shown to be less receptive to psychological help than European American men (Husaini et al., 1994; Shin 2002; Solberg et al., 1994; Whaley & Dubose, 2018).

African American men who adhere more to Black-centered notions of masculinity may also be in contexts in which stigmatization of mental health and treatment-seeking are more common, thus amplifying perceptions of public stigma and personal attitudes toward help-seeking. (Coleman-Kirumba et al., 2022). For example, among Nigerian Americans, higher Afrocentric spirituality was associated with more social (public) stigma of psychological help-seeking, further demonstrating the connection between Black cultural norms and perceptions of how others stigmatize help-seeking (Meniru & Schwartz, 2018).

Mental Health Stigma Impacting Transition to Fatherhood

Several authors have shown the transition to fatherhood to be a stressful and complex psycho-social adjustment, with physical and emotional demands that affect the mental health of fathers (Kim & Swain, 2007; Lara et al., 2010; Sheng et al., 2010; Singley & Edwards, 2015). Fathers in the perinatal period frequently report feeling neglected, pressured to adhere to gender expectations, and to repress feelings (Eddy et al., 2019). Additionally, men transitioning to fatherhood report experiencing gender role conflict (i.e., the pressure to adhere to socially sanctioned behaviors at the expense of devaluing the self and others) and role ambiguity which can lead to restrictive involvement with parenting and muted emotionality (O'Neil, 2015). Although men benefit from mental health services and other psychosocial supports during the perinatal period, fathers often do not receive the help they need (Hammer et al., 2013) and identification of and help-seeking for mental health problems is low in fathers (Call & Shafer, 2018).

For fathers, stigma around seeking help can be driven by a reluctance to feel or be seen as weak or vulnerable (Fischer et al., 2021). Indeed, a study of at-risk fathers found that appearing weak (i.e., fearing stigma) was perceived by participants as a significant barrier to help seeking

(Schuppan et al., 2019). Men in this study also reported believing that their role as a father was to demonstrate emotional, mental, and financial strength, and any indication that they were struggling would endanger their partner and family (Schuppan et al., 2019). Furthermore, fathers reported they were unlikely to seek help out of a desire to avoid difficult feelings (i.e., self-stigma) even if early mental health symptomatology was noticed. Such avoidance can lead to a building crisis point, when men would eventually seek help; but, this often occurred late in their illness trajectory (Schuppan et al., 2019). Some have hypothesized that appealing to men's role as fathers may reduce stigma and increase help-seeking behaviors as fathers more readily seek information and support to meet their need to understand their new parenting role (Schuppan, et al. 2019). In fact, Johnson et al., (2012), found that help-seeking was consistent with father's sense of masculinity when constructed as an active response to having exhausted one's internal resources.

Transition to Parenthood Stressors and Paternal Mental Health Problems

Decreased sleep and caring for an infant can wear on new fathers and increase stress associated with needing to be away from work more often, all of which can increase anxiety for dads. The relationship with one's partner changes in dramatic ways, requiring that the mother and father manage aspects of caring for themselves and their new baby alongside the psychosocial changes which commonly accompany new parenthood. Another study highlights associations of paternal stress from pregnancy onward on child problems, with greater influence on child internalizing than externalizing symptoms (Challacombe et al., 2023) Although the mechanisms of influence of paternal stress on child outcomes are not yet clear, they may include emotional or physical unavailability with the child, negative parenting style, relationship conflict, impact on maternal mental health or a combination of these (Challacombe et al., 2023). Previous

research has found that poor job quality, poor relationship quality, maternal distress and low parental self-efficacy contribute to father's perinatal mental distress (Giallo et al., 2013)

Impacts of Gender Role Conflict on Paternal Mental Health

New fathers struggle with gender role conflict, or men's experience of "rigid, sexist, or restrictive gender roles, learned during socialization, result in personal restriction, devaluation, or violation of others or self" (O'Neil, 1981). Fathers experiencing this type of conflict are likely to have difficulty engaging in behaviors such as caregiving, cooing, soothing, hugging, and playing with their infants—and sons in particular— because of deep-seated beliefs that these behaviors are feminine or "weak." (Singley & Edwards, 2015). Because men are commonly socialized to express "acceptable" masculine emotions such as anger and assertiveness, new fathers experiencing stress during the transition to fatherhood may channel their frustration by withdrawing from the child and/or partner, which can ultimately result in a decreased father-child attachment bond (Levant, 1995). Furthermore, fathers who experience difficulty juggling work-life balance demands in the perinatal period may opt to enact the traditional gender roles (i.e., focus on being the financial provider) to experience a sense of competence from increasing their time spent at work (Singley & Edwards, 2015). This imbalance results in decreased involvement with their babies, along with a concomitant increase in their partner's management of childcare responsibilities and a decrease in the father's sense of self-efficacy in caring for the child (Singley & Edwards, 2015).

Difficulties with Parenting Self-Efficacy and Paternal Mental Health

New fathers often question their ability to be a competent parent, and they may lack parenting self-efficacy beliefs due to a lack of caregiving experience (Coleman & Karraker, 1998). Social Cognitive Theory posits that self-efficacy for a certain behavior—for example,

caring for an infant—is one of the strongest determinants of whether or not a person will attempt a given behavior (Bandura, 1986). Research has shown that the more stress and marital dissatisfaction a new father experiences, the lower his paternal self-efficacy, which in turn reduces direct involvement with the infant (Murdock, 2013; Sevigny & Loutzenhiser, 2010). Furthermore, spousal/partner support in the form of "other-efficacy" or a belief that one's male partner's ability to parent an infant also likely informs a new father's self-efficacy (Singley & Edwards, 2015). Spousal support has been shown to predict enhanced psychological well-being, parental effectiveness, and coping in fathers (Aycan & Eskin, 2005). Although many mothers encourage fathers to be involved, one study found that the majority of women did not want their partners to be more involved with their children, even while 40% of fathers wanted to spend more time with their children than they currently were spending (Quinn & Staines, 1979).

Paternal Perinatal Mental Health Disorders

The perinatal period marks a time of increased mental health risk for fathers. Significant mental health symptoms are estimated to develop in 15-50% of fathers during the perinatal period (Holmberg, in press), and paternal perinatal psychopathology shows consistent and long-lasting, predominantly negative, impacts on child development and functioning. It is very common for mental distress and disorder to emerge from fathers' adjustment during pregnancy and through the first year after the birth of a child (Howard et al., 2014) and these interrelated mental health conditions are collectively referred to as Paternal - Perinatal Mental Health Disorders or P-PMHDs, formerly Perinatal Mood and Anxiety Disorders or PMADs (Moyer & Kinser, 2021). Depression and Generalized Anxiety Disorder are the most well-known P-PMHD disorders (Leiferman et al., 2021; Paulson & Bazemore, 2010). There is also evidence of increased rates of Panic Disorder, Post-Traumatic Stress Disorder, Obsessive-Compulsive

Disorder, alcohol and substance misuse, Bipolar Disorder, and death (e.g., by overdose, suicide) among fathers in the perinatal period (Amaral Tavares Pinheiro et al., 2011; Clemans-Cope et al., 2019; Coelho et al., 2014; Etheridge & Slade, 2017; Fisher, 2017; Hanley & Williams, 2020; Inglis et al., 2016; Richardson et al., 2021; Yoshida et al., 2005). Taken together P-PMHDs form a considerable public mental health concern that warrants further research to develop tailored interventions to meet the needs of fathers and their families.

Paternal Perinatal Mood Disorders

Estimates of paternal postpartum depression have varied from 1% to 26% within the United States (Goodman, 2004; Ramchandani et al., 2005). A meta-analysis of 43 studies from 16 countries estimated paternal depression rates between the first trimester and one year postpartum to be 10.4% (Paulson & Bazemore, 2010). In comparison with the 4.8% 12-month prevalence base rate of depression for men in the United States (Kessler et al., 2003), the findings of the meta-analysis provide additional support for the importance of attending to men's perinatal mental health needs. The Paulson and Bazemore (2010) meta-analysis revealed additional findings of interest. First, the incidence of postpartum depression for men was greatest between the initial three and six months of fatherhood, though the authors note that the small number of studies included in this analysis suggest the findings should be interpreted with caution. Still, previous studies have found that fathers tend to experience depressive symptoms more frequently prenatally as compared with postpartum (Boyce et al., 2007; Buist et al., 2003; Condon et al., 2004), implying the prenatal period was most stressful for men. Further research is needed to better understand the nature of prenatal depression and its course throughout the postpartum period among fathers.

Other Forms of Paternal Perinatal Psychopathology

Rates for other perinatal mood and anxiety disorders are difficult to obtain, though there have been a few studies to explore these. For example, a range of 0% to 4.7% has been found for paternal postpartum PTSD (Ayers et al., 2007; Bradley et al., 2008). For paternal postpartum anxiety, rates have varied from 4.4% to 9.7% (Bradley et al., 2008; Matthey et al., 2003). In a recent prevalence study of Obsessive Compulsive Disorder in fathers, authors found a prevalence of 3.4% in the third trimester and 1.8% in the postpartum period (Coelho et al., 2014). Finally, a study about depression and bipolar disorder (Pinheiro et al., 2011) suggests that depressive episodes were significantly associated with manic/hypomanic episodes for fathers during pregnancy and up to 12 months postdelivery. For example, among the 5% of fathers who were diagnosed as depressed during the prenatal period, 2.1% of them also experienced manic episodes, and 3.3% experienced hypomanic episodes.

Clearly much more research is needed to better understand the prevalence and comorbidity of these mental health disorders, and how they change over time during the perinatal period. Paternal mental health screening during pregnancy is necessary to identify and prevent depression from negatively impacting offspring functioning (Sweeney & Macbeth, 2016). Including both parents in this process should encourage the alleviation of the environmental mediators which dominate the negative association outlined within the review (Sweeney & Macbeth, 2016).

Risk Factors

There are several biological risk factors associated with fathers' mental health concerns during the perinatal period. Kim and Swain (2007) identified low testosterone, low estrogen, low cortisol, low vasopressin/oxytocin, and low prolactin level as biomarkers for paternal perinatal depression. Additionally, they found change in lifestyles, difficulty developing attachment with

infant, lack of a good role model and rewards, lack of social supports and network, changes in marital relationship, feeling excluded from mother-infant bonding, and maternal postpartum depression to be ecological risk factors associated with paternal mental health concerns during the perinatal period (Kim & Swain, 2007). Factors that further contribute to paternal perinatal mental distress include poor job quality, poor relationship quality, maternal distress, and low parental self-efficacy (Giallo et al., 2013). All biopsychosocial difficulties fathers experience which contribute to perinatal stress can be elevated in fathers of babies in the NICU, with compounded stress due to complications and, often, long-term stress associated with medical and developmental needs that lead to NICU admission.

Negative outcomes associated with paternal perinatal mental health problems

Paternal perinatal mental health problems have been linked to negative psychosocial outcomes for fathers themselves and to fathers' relationships with their partners. Antenatal anxiety and depression in fathers have been associated with postpartum parenting stress (Skjothaug et al., 2018), and paternal depression is linked to decreased marriage satisfaction (Davey et al., 2006).

Father's parenting behavior can also be negatively impacted by paternal perinatal mental health problems. For example, paternal depression is linked to decreased levels of paternal involvement (Garfield & Isacco, 2009) with negative impacts on parent-infant interactions (Séjourné et al.,2012). Relatedly, depressed fathers were also observed to be more withdrawn and less stimulating with their 3-month infants, (Ramchandani et al, 2013; Sethna et al., 2017), and fathers with anxiety symptoms can encourage less exploration and challenging than non-anxious controls in infants of 10-15 months (Moller et al., 2015).

Paternal perinatal mental health problems have been linked to negative psychosocial outcomes in children of fathers with P-PMHD's. Negative impacts on emotional and behavioral outcomes in children at 2 months-7.5 years (Sweeney & Macbeth, 2016), and infant's cognitive development (Séjourné et al.,2012) have been linked to the deleterious effects of P-PMHD's. Indeed, fathers' mental health may have a distinct impact on infant and child development (Cui et al., 2020; Sweeney & Macbeth, 2016), as depressed and withdrawn fathers have been associated with externalizing behavior problems in children at 1 year and cognitive development at 3 years (Ramchandani et al, 2013; Sethna et al., 2017). Fathers' postnatal depressive symptoms have also been associated with child emotional and behavioral problems at 3.5 years, and with a raised rate of conduct problems in boys (Ramchandani et al., 2005). Contextual mediators on the strength of the paternal depression-child development link included paternal negative expressiveness, hostility and involvement, and marital conflict (Sweeney & Macbeth, 2016). Notably, positive parenting and involvement by fathers have been shown to be associated with improved child outcomes (Shannon et al., 2002).

When a Hard Transition is Exacerbated by Having a Baby/Babies in the NICU

An infant's stay in the NICU can add complexity during a man's transition to fatherhood and lead to increased role ambiguity. NICU fathers have described feeling torn between competing responsibilities during their newborn's stay in the hospital, and conflicting priorities can be a daily occurrence (Logan & Dormire, 2018). Fathers have explained these needs to include needing to maintain the home front, taking care of older siblings, working regular jobs, and being a supporting presence in the hospital for their partners and their infants (Beck & Vo, 2020). The challenge of prioritizing responsibilities can be further complicated in the beginning when partners are still hospitalized; fathers face the dilemma of wanting to be in the NICU with their

newborns and wanting to be with their partners in their hospital rooms (Beck & Vo, 2020). Additionally, some fathers face the decision of saving their paternity leave until after their infants discharge from the NICU so they can be there to help their partners once everyone returns home.

NICU services often focus on mothers, assuming they will be primary caregivers, and fathers frequently feel they occupy a peripheral role (Beck & Vo, 2020). The lack of essential facilities and spaces for fathers in the NICU environment was described by parents as reinforcing the view of fathers as secondary to mothers (Serlachius et al., 2018). Mothers commented that fathers seemed out of place and uncomfortable in the NICU, despite being a critical source of support (Serlachius et al., 2018). Fathers often report feeling like the backbone of the family during this time - as the primary support person for their newborn, their partner, and any other children (Beck & Vo, 2020).

An infant's NICU hospitalization is often an unexpected experience (Beck & Vo, 2020; Hugill et al., 2013; Barton & Risko, 2021) that can result in significant stress for fathers. The stress can exacerbate role ambiguity and decrease participation in the infant's care. Stress, or the concept that environmental demands exceed an individual's adaptive capacity (Cohen et al., 2007), can be triggered in fathers impacted by the NICU due to demands of caregiving, financial provision, and relationship changes. Also, uncertainty around the infant's prognosis and survival and the unfamiliarity of the NICU environment can exacerbate stress. Health-related improvements and setbacks, as well as the fear of new complications, contribute to fathers' feelings of lack of control over their infant's wellbeing, and some fathers have described feeling disempowered in their role as a caregiver during their experiences in the NICU (Serlachius et al., 2018). Fears that they themselves might inadvertently hurt the baby when providing care can

contribute to fathers' experiences of low caregiver efficacy and may result in fathers approaching their infant apprehensively or opting to defer to their partners (Beck & Vo, 2020). However, fathers shared that the feeling of skin-to skin contact strengthened the bond and love between them and their infants (Logan & Dormire, 2018), and one father described Kangaroo care as a "sanctuary" where he was able to put aside stress (Olsson, et al., 2017) and actively participate in his infants care. This highlights the need for fathers to receive support related to caregiving and stress management during their infants NICU hospitalization.

Although fathers with babies in the NICU may benefit from increased supports, mental health stigma elicits behaviors that may impede fathers from receiving help. Articles focused on fathers' NICU experiences around their babies' hospitalization found that they tend to minimize their outward emotional response (i.e., restrictive emotionality; Tsan, 2011) to this traumatic experience, instead directing their energy toward supporting their female partner (Roque et al., 2017; Affleck & Tennen, 1991; Deeney et al., 2012; Hugill, et al., 2013). Similarly, NICU experiences appear to impact dads across cultures; moreover, fathers report they must stay strong for their families and some have opted not to share their fears, worries, or impatience with partners in an effort to protect them (Noergaard et al., 2017). This suggests that conformity to masculine gender roles may manifest as emotional repression (Eddy et al., 2019; O'Neil, 2015) in this way for fathers of NICU babies, and may contribute to gender role strain (Levant, 2016). NICU fathers describe their emotional responses as "silent emotion work" due to the need to avoid and hide their emotions (Hugill et al., 2013; Candelori et al., 2015). Sometimes NICU fathers redirect emotional distress by focusing on learning about the high-tech medical machinery in the hospital setting (Roque et al., 2017; Deeney et al., 2012).

Some fathers have wished there was a support group for them to share their feelings with other fathers without feeling the need to protect them (Beck & Vo, 2020). This highlights fathers' desire for environments that feel safe and supportive, where the challenges of NICU hospitalizations can be processed away from fears of stigmatizing labels. Indeed, several articles have highlighted an acute need to support fathers during and after the hospitalization period (Cyr-Alves et al., 2018; Shaw, et al., 2006; Fuller, 2017) due to the impact that the NICU experience has on fathers' mental health. However, fathers may be unlikely to seek professional or social support around their NICU experience in an effort to avoid the label of mental illness and the deleterious effects of public and self-stigma on one's sense of self-worth, especially during the complex transition to fatherhood that is characteristic of the NICU experience.

Rates of Paternal Perinatal Mental Health Problems Among NICU-Impacted Families

Research shows that NICU fathers, relative to their peers who do not have a baby with a condition necessitating an admission, have increased rates of Posttraumatic Stress Disorder (PTSD) (Binder et al., 2011), Acute Stress Disorder (ASD) (Shaw et al., 2006), generalized stress (Shaw et al., 2009), depression (Cyr-Alves et al., 2018), and anxiety (Philpott et al., 2019; Simmonds et al., 2015).

NICU Father PTSD, PTSS, and Acute Stress

Regarding paternal postpartum PTSD, 33% of fathers (versus 9% of mothers) met criteria for PTSD at 4-month follow-up post-discharge from the NICU (Shaw et al., 2009), and symptoms remained elevated at different time points (Binder et al., 2010). Factors associated with the development of PTSD at four weeks after newborn's admission to the NICU included history of mental health problems in the mother or father, extended family history of mental health problems, the number of concurrent stressors (Lefkowitz et al., 2010), change in relationship

status living arrangements, or job status, loss, personal or family health concerns, experience of a recent unrelated traumatic event, and legal problems (Roque et al., 2017).

Another study found significant predictors of post-traumatic stress symptom (PTSS) intensification in fathers including PTSS intensification in the child's mother, level of perceived stress, and emotion-oriented coping (Aftyka et al., 2020). Indeed, several studies have found fathers to be negatively affected by their partner's distress (Binder et al., 2011; Roque et al., 2017), and the NICU experience can exacerbate stress in fathers due to the expectation of simultaneously supporting the recovering mother and the medically fragile infant (Mackley et al., 2010). The most frequent trauma-related symptoms reported by NICU parents, in general, were hyperarousal, flashbacks related to their infants' birth and NICU admission, and avoidance of contact with the NICU (Shaw et al., 2006).

Around a quarter (i.e., 23-28%) of parents met criteria for Acute Stress Disorder after admission of the newborn to the NICU (Roque et al., 2017) and associated factors have been cited to be stress of parents, female sex, alteration in parental role and family cohesiveness, and parental coping style. The most frequently cited sources of stress for NICU parents in general were parental role adjustment and the infant's appearance. (Roque et al., 2017). Other sources of stress were the NICU environment (particularly sights and sounds), long length of stay in NICU, and communication difficulties with staff. (Roque et al., 2017). Salient factors that predicted stress of fathers were history of drug/alcohol abuse and transfer of partners during pregnancy due to complications (Roque et al., 2017). One study found disruptions in meaning systems, prolonged uncertainty, lack of control, and alterations in parental role expectations to be factors that contributed to trauma related symptoms in parents (Lasiuk et al., 2013).

Interventions Related to Paternal Perinatal Mental Health Problems

Studies investigating psychosocial interventions targeting caregiver mental health demonstrate various approaches that may benefit NICU-impacted fathers. However, a recent scoping review of perinatal interventions only identified one study that examines the psychosocial outcomes for fathers specifically (Ocampo et al., 2021), highlighting a significant gap in services for NICU-impacted families. Among NICU support programs that included fathers, several placed emphasis on caretaking and childrearing education for medically fragile infants (Ionio et al., 2016; Kadivar & Mozafarinia, 2013; Matricardi et al., 2013; Kardaş Ozdemir and Aldemar 2017). Most studies investigating education-based interventions either underrepresent or exclude fathers altogether (Ocampo et al., 2021).

Attending to Stigma When Developing Interventions for NICU Dads

Fathers of NICU infants are at an increased risk of psychological distress given the difficult, often traumatic, nature of having a child in the NICU. However, there are few existing interventions that focus solely on father's psychological needs within the NICU, and fathers often exhibit different symptoms than mothers who express their psychological distress (Ocampo et al., 2021). Even if early mental health symptomatology is noticed, fathers are unlikely to seek help out of a desire to avoid difficult feelings (i.e., self-stigma) and may eventually seek help late in their illness trajectory (Schuppan et al., 2019). Since stigma has been identified as a potential barrier to engaging fathers in NICU-associated interventions, this study sought to assess the degree to which fathers were aware of experiencing stigma barriers to engaging support and intervention programs in order to inform future program development.

Survey Methods

Through a university-approved protocol, an electronic survey was established using the Qualtrics software and secure server. Invitations to participate via the Qualtrics link were

distributed online and via social-media posts. To be eligible to participate, respondents needed to be at least 18 years of age and had experience being a father of a child or children in the NICU. All survey respondents were informed that information from the survey would be used to design father-focused programs and services, and that the survey took approximately 10 minutes to complete. Respondents were made aware that they could stop participation at any time, and all respondents voluntarily consented to participate in the survey study. Additionally, after completing the survey, respondents became eligible to enter to win one of four $25 Amazon gift cards via an optional link at the end of the survey.

While the full survey had participants respond to quantitative and qualitative self-report measures, only results from the participant Demographic section and the section titled, "Barriers to Seeking Support," were analyzed for this paper. This section used items related to expressions of mental health stigma to which fathers responded via 5-point Likert scale:

	Not True for Me / Not Applicable to My Experience	A Little True for ME	Somewhat True for Me	Very True for Me	Extremely True for Me
I needed to be strong for everyone else					
I needed to focus on work to care/provide for the family					
I find it difficult to tell people when I'm struggling					
I feared negative feedback or judgment from other people					
I was focused on others' (i.e., partner's, baby's/babies') needs					
I felt shame or badly about myself for needing help					

I feared what others would say about me if I reached out					
I didn't know how support could help me					
I didn't want people to think I was weak or lazy					
I felt like I just needed to "deal with it" or "get over it"					
I didn't know there were services for dads					
I didn't think services would help me					
I feared something might really be wrong with me and didn't want others to know					
Other: (please specify)					

In addition, specific demographic domains were assessed and included: self-report race/ethnicity, gender, current age, partnership status at the time of the NICU admission, length of NICU stay, and conditions necessitating NICU admission.

Results

In total, 150 eligible respondents completed the survey.

Sample Characteristics

The majority of respondents (73%) identified as White. 9% identified as Native American, Alaska Native, or Aboriginal, 7% identified as Black or African American, 6% identified as Asian, 4% identified as Native Hawaiian or other Pacific Islander, 1% identified as Multi-racial, and 1% identified as Other race. Additionally, most fathers who participated in the survey identified as men (95%, N = 142). Two respondents (1%) identified as non-binary, gender nonconforming, or genderqueer, one (0.6%) identified as other, and five (3%) preferred not to answer. Only 12% of respondents identified as 20-24 years old and none were younger than 19. List the other % of age brackets. The nature of co-parenting reported in the sample was predominantly characterized by traditional intimate partnerships: 78% of respondents identified as "Romantically Partnered, Living Together."

The length of NICU admission across the sample was well distributed. 3% of fathers' (N = 4) children stayed less than one day, 21% (N = 31) stayed 1 day to 6 days, 35% (N = 52) stayed 1 week to 2 weeks, 24% (N = 36) stayed 3 weeks to 4 weeks, 11% (N = 17) stayed 5 weeks to 6 weeks, and 6 % (N = 10) stayed 7 weeks or longer.

Most of the respondent's children were admitted to the NICU due to premature birth (48%, N = 72). NICU admission due to multiple birth (23%, N = 34) and traumatic birth resulting in infant health complications (21%, N = 32) were a similar portion of the sample. Only 2% (N = 3) of respondents' children were admitted to the NICU because baby/babies had a health condition, and 5% of respondents (N = 8) preferred not to answer.

Survey items were analyzed for degree of normality and univariate distributions. Correlations between questions were calculated as well as the Cronbach's alpha coefficient to determine the most parsimonious approach to the analysis.

Perceived Stigma

The fathers in the study reported barriers to accessing services due to stigma to a moderate degree. Individual item means ranged from 2.78 to 3.14. Both the individual stigma items and the stigma index (or average endorsement across the questions) were normally distributed, suggesting a wide range of experiences were reported, including difficulty disclosing, fear of judgement, shame, worry what others would say, concern of being labeled as weak or lazy, a preference to "deal with it" or "get over it," and fear that something was "really wrong." The interrelatedness of the stigma items, as indicated by a high alpha coefficient (i.e., 0.72) was greater than or equal to the conventional criteria of 0.70, suggesting that it represents a related construct or phenomenon. We created a stigma index by averaging the item responses and the resulting mean was 3.0 (standard deviation 0.74). Nearly all participating fathers (99%,

N = 148) endorsed at least one stigma item, suggesting that mental health stigma was a nearly universal phenomenon affecting fathers' access to support during their infants' NICU stay.

Implications for Future Research & Clinical Intervention Development

The findings from this survey highlight the need for further analysis to examine the relationship between perceived stigma and negative outcomes among fathers. It is important to note that the survey sample was limited in terms of diversity and age representation, potentially impacting the generalizability of these findings. Nevertheless, the results provide valuable insights into the prevalence of perceived stigma among fathers and its potential implications for support utilization and mental health outcomes.

Specifically, future research should explore the potential associations between perceived stigma and low receipt of support services, as well as its impact on maladaptive outcomes such as psychopathology. Given the interrelatedness of items on the survey questionnaire, these questions are well suited for this aim. Moreover, it is crucial to expand the sample to include greater diversity and ensure representation of younger fathers and fathers of diverse cultural backgrounds and gender identities to enhance the generalizability of findings.

Ocampo et al., (2021) borrow the Pediatric Preventative Health Model proposed by Kazak (2007) to organize types of interventions and programs using a three-tiered biopsychosocial approach that can address various levels of need for fathers in the NICU.

a. Universal Interventions

Universal interventions take public health approach that leverage peer support groups and low-to-no cost methods to support highly feasible, accessible, and easy to implement interventions such as NeoMates (Rackham & Morgan, 2017), and the PN System (Carty et al., 2018). These interventions may be especially beneficial for fathers who work full time and are

unable to attend sessions at the hospital. However, without licensed professionals, medical or psychological counseling may not be reliably disseminated.

b. Targeted Interventions

Targeted interventions are organized groups with curriculums uniquely created for NICU fathers, with the intention of reducing symptoms and increasing coping. They are best suited for fathers who endorse symptoms or are at elevated risk of developing symptoms, as measured by screening tools. Examples include father-focused psychotherapy groups (Thomson-Salo et al. 2017) and mindfulness-based groups (Petteys & Adoumie, 2018), relaxation and stress management groups (Fotiou et al., 2016), art therapy groups (Mouraidan et al., 2013), and empowerment and self-efficacy groups (Liu et al., 2010). Targeted interventions are best suited for fathers who are struggling with emotional dysregulation and have the potential to teach coping skills that can be utilized during hospitalization and thereafter. However, accessibility is limited and clinicians must be trained in the treatment protocol to deliver the intervention, reducing feasibility.

c. Clinical Interventions

Clinical interventions may be best reserved for fathers at highest risk of developing severe symptoms or who demonstrate an immediate need for support. Treatment approaches such as those proposed by Lakatos et al., (2019) provide significant benefits for fathers, as the individual nature allows for flexibility within the father's schedule. They also provide an individualized space for the father to work with a trained clinician on unique issues. However, such individualized interventions are difficult to scale and may not be financially prudent within a hospital setting.

Self-Stigma of Mental Illness and Perceptions of Help-Seeking and Screening

Given the prevalence of paternal perinatal mental health concerns, researchers have suggested introducing routine screening. Schuppan et al., (2019) investigated the acceptability of perinatal screening measures in male populations and found that routine screening is desired, however, acceptability is influenced by perceptions of its intention and possible outcomes. Label avoidance of mental illness and self-stigma (Corrigan, 2004) may also contribute to fathers' trepidations around mental health screening in the perinatal period and discourage NICU-impacted fathers' from seeking mental health support. Findings from Schuppan et al., (2019) suggest that barriers to men's perinatal help-seeking are likely to be minimized by increased awareness and normalization, as well as research to account for complexities raised by men's perceptions of health care services is warranted.

Conclusion

The survey findings underscore the prevalence of perceived stigma among fathers and its potential impact on support-seeking behavior and mental health outcomes. While the limitations of the sample's diversity and age representation should be acknowledged, these findings provide a foundation for future research to explore the relationship between perceived stigma and various outcomes for fathers who have children in the NICU. Addressing and mitigating the effects of perceived stigma can contribute to the well-being and support utilization of fathers, ultimately promoting positive parenting experiences and family dynamics.

DISCUSSION

Understanding the role mental health stigma plays in NICU-impacted fathers' access to mental health support during the perinatal period can help guide practitioners to meet the mental health needs of this population. This paper synthesized extant literature related to mental health

stigma, men's transition to fatherhood, and the experience of NICU fathers with pilot study results examining NICU fathers' experiences of mental health stigma.

The research highlighted mental health stigma as a significant barrier to accessing mental health support for men. Both public stigma of mental health (i.e., the resulting stereotypes, discrimination, and oppression of being labeled as mentally ill by others) and self-stigma (i.e., self-limiting thoughts, feelings, and behaviors that emerge from experiencing oneself as mentally ill) are shown to prevent individuals from accessing mental health care. This occurs when mental health stigma leads people who would benefit from mental health care to avoid treatment in hopes of avoiding the label of mental illness and the subsequent deleterious impacts of public- and self-stigma of mental health. Men in particular are vulnerable to mental health stigma due to the undermining effect it has on traditional masculine norms, such as the preference to handle problems on one's own, restrictive emotionality, and limited emotional expression between men. As such, cisgendered men are shown to have increased self-stigma of mental health and consequently seek mental health treatment less frequently than their cisgendered female counterparts.

The perinatal period marks a time of increased risk for mental health concerns among male-identified individuals when they become fathers, leaving them more vulnerable to decreased treatment seeking due to mental health stigma. Men navigating the transition to fatherhood can experience increased pressure to adhere to traditional masculine gender roles as they form their fatherhood identity. For men who experience mental health concerns around the birth of a child, stigma of mental illness can interfere with accessing mental health supports.

For fathers who have babies in the NICU, added stress and complications can result in fathers minimizing their own emotional needs and emotional expression, and focusing instead on

the needs of their partner and child. Although men who experience mental health concerns around their child's birth in the NICU may benefit from mental health supports, they may be increasingly motivated to avoid the label of mental illness to avoid any negative effects that mental health stigma may have on their already strained internal resources.

Findings from the pilot study suggest that NICU-impacted fathers' experiences of mental health stigma are universal and wide-ranging. Participants endorsed difficulty disclosing, fear of judgement, shame, worry what others would say, concern of being labeled as weak or lazy, a preference to "deal with it" or "get over it," and fear that something was "really wrong. As such, fathers' experiences reflect both fear of public-stigma and self-stigma.

With NICU-impacted fathers having so many competing responsibilities, stigma of mental illness is a removeable barrier that can decrease fathers' motivation to access mental health supports during their infant's NICU stay. Increased awareness and normalization of P-PMHDs and the increased risk that NICU-impacted fathers carry may serve to minimize stigma barriers. Psychosocial support for NICU fathers should also address the strain of simultaneously supporting their partner and child, encourage healthy emotional expression, and educate fathers on the unique signs and symptoms of psychological conditions such as ASD, PTSD, and postpartum depression in men. Furthermore**,** in order to be successful, psychological support for fathers in the NICU needs to be flexible with the other responsibilities often felt by fathers such as maintaining a job, providing for the family, and being a supportive figure.

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