Infant Mental Health (IMH) in the Intensive Care Unit: Considerations for the Infant, the Family and the Staff

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ABSTRACT

Infant mental health is an emerging evidence based field that enhances infant parent relationships and provides opportunities for early infant regulation that optimizes later social and emotional development. Infant mental health in intensive care settings is an approach that emphasizes the importance of helping manage stressful events for infants, parents, and staff, and supports early relationship development using reflective practice. Educational and experiential preparation for multidisciplinary IMH providers specific to work in infant intensive care is described.

Infant mental health (IMH) refers to the developing capacity for a child between birth and 3 years of age to experience, regulate, and express his or her emotions; form secure relationships with caregivers; master his or her environment; and learn within the context of family, community, and culture. As a foundation, infant mental health promotes the idea of optimal infant/child social and emotional development in the context of healthy relationships with caregivers. For a discussion of the foundational principles and practices in the field of infant mental health see Weatherston and Browne, this issue. Infant mental health in intensive care experience a number of threats to the establishment of secure and nurturing relationships, at the mercy of their hospital environment and often experience medical procedures and practices that result in altered social interactions and emotional resilience.

Infant mental health approaches emphasize exhibiting and supporting a reflective perspective in all exchanges, whether with infants, families, staff members or systems. Thus, the primary goal of infant mental health practice in an intensive care unit is to focus on the enhancement of nurturing relationships between the infant and their primary caregivers (typically their parents), and in doing so, support the professional staff in bringing a focus on practices and procedures that enhance opportunities for ongoing social and emotional development.

Examples of appropriate referrals for IMH providers in intensive care include:

• When there is a need for anticipatory guidance for parents regarding medical risk factors that may result in long hospitalization, witnessing of painful or stressful medical procedures and/or preparation for unexpected changes in their infant’s medical course;
• When families are doing well but wish to learn more about their babies’ emotional and social needs;
• When the parent demonstrates a need for someone to be a witness to their own or their infant’s suffering or for celebration of progress;
• When caregivers demonstrate that they are experiencing psychosocial stressors that currently interfere with nurturing/positive interactions with their infant;
• When there have been observed negative interactions between caregiver and infant;
• When caregiver expresses negative associations or perceptions about the infant;
• When the professional staff have concerns about their own interactions with parents that may cause distress.
Contributions of IMH in Intensive Care

The necessity for intensive care - whether neonatal, cardiac, or pediatric - has a significant effect on both babies and their caregivers. Those infants who are born preterm or with medical complexities are exposed to environmental and caregiving practices that are not only unexpected but also frequently disorganizing or even derailing in their expected developmental course. In addition, parents experience numerous unexpected stressful events and procedures (see other articles in this issue including Ashby & Bromberg, 2016; Ashby, Lakotas, & Scott, 2016; Del Fabbro & Cain, 2016; Hynan, 2016; McNeil, et al., 2016) resulting from high-risk pregnancy, delivery, and/or having their baby admitted to intensive care. The impact on the development of essential caregiving relationships is significant, and opportunities for the parent and infant to develop co-regulatory strategies to deal with the hospitalization are often limited. The effects of these altered experiences often result in less optimal regulation, a necessary foundation for ongoing development. Early regulatory issues have been seen to result in later cognitive and socio-emotional challenges, necessitating referrals to mental health services, as the infant grows into toddlerhood and preschool.

The advent of new technology, procedures, and interventions has improved the outcomes of babies from a medical standpoint. However, the neurodevelopmental and socio-emotional outcomes continue to be problematic as the early-hospitalized child grows, especially in the very and extremely low birth weight babies. Although there is a concerted interest in decreasing the rate of preterm birth, particularly in the United States, there has been only a gradual reduction across the United States. Evidence also reveals developmental challenges for infants who experience severe cardiac anomalies and intensive care after birth.

Extended stays in intensive care that result from improved technological and medical interventions and the ongoing high rate of preterm birth increase the likelihood that babies and families will experience environments that are overwhelmingly invasive from a sensory standpoint, as well as during stressful and potentially painful procedures. The literature is replete with documentation of the impact of the physical environmental on the hospitalized infant whose brain is developing at a faster rate than in any other age range. Especially, during the last few weeks of gestation, the cortical brain weight, sulci development, and neuronal activation increase significantly. During this critical time in brain development, infants who are hospitalized are exposed to the brain shaping that the intensive care environment provides.

Although many environmental changes to reduce the impact of light, sound, and activity near and in the baby’s bed have been instituted in intensive care over the past few decades, emphasis on the environmental contributions to the development of neonates and their families continue to be explored. Evidence based standards and recommendations have been promoted and serve to assist professionals in designing, renovating, and improving the environments in which infants and families live while in intensive care. Recent innovative design and family integrated practice provide more opportunities to not only protect the infant from intrusive environmental stimuli, but also provide opportunities for 24-hour family presence with their newborn. Single family room-designed intensive care units have recently been promoted as a shift from large, open rooms with multiple babies in them and research into the effect on both the infant’s developmental outcomes and the parental responses is ongoing. An emerging practice called “couplet care” keeping the mother, father, baby and often even siblings together for the entire intensive care experience is also on the horizon and will likely add to the focus on supporting early relationship development.

The infant mental health provider should recognize the efforts made by the intensive care unit to provide an appropriate sensory environment for babies and families, and support hospital efforts to design spaces where intimate, nurturing relationships can be experienced. Additionally, the IMH provider can assist and support the professional staff in identifying the impact of the caregiving environment on families, and then assist in communicating the effects, whether positive or challenging. With an emphasis on developmentally appropriate care during the sensitive periods when brain organization is rapidly progressing, some intensive care units have initiated a “neuroprotective” approach to caregiving. This approach emphasizes not only attention to the environment (termed a “healing environment”), but also emphasizes partnering with families, positioning & handling, safeguarding sleep, minimizing stress & pain, protecting skin, and optimizing nutrition.

The IMH provider should recognize the overlapping, yet synergistic effects of each area of “neuroprotection” in the context of the parents’ interactions, and encourage support for their efforts to promote their infant’s neurodevelopment in the context of their bodies, daily rhythms, and caregiving.

As medical professionals provide acute medical and nursing care, there are, of necessity, invasive assessment techniques (i.e. lumbar punctures, venipunctures, etc.), ongoing treatment procedures (i.e. thoracic tubes, surgeries and medication administration), as well as caregiving procedures that may disrupt the organization and/or sleep of the infant. In 1999 Peters (1999) reviewed publications up to that date that documented the frequency of handling of ill infants in intensive care. She reported a range of 2–60 caregiving procedures per hour during the intensive care hospitalization, a higher number for the smaller, younger infants, and found no decreases over the previous 15 years. Other more recent studies have also documented disruptions in infant sleep due to handling, procedures, and caregiving. Additionally, Smith and colleagues reported that in a typical hospitalization of babies in an intensive care unit, the number of invasive procedures is significantly correlated with brain size and function.

Although strategies for monitoring and ameliorating painful responses in infants have been developed and are in common use in intensive care units for infants, there is still controversy regarding the effectiveness and the best strategy for administration of assessment and treatment. For example, numerous pain assessments are available for use in intensive care with infants. However, in many hospitals, pain assessments on neonates are not routinely conducted or reported. Similarly, sucrose and other non-pharmacologic strategies prior to procedures have been studied as ways to reduce adverse responses in neonates undergoing painful events. However, there is ongoing controversy regarding dosage and use.

The IMH provider does not specifically assess or provide medication to ameliorate pain and stress, but understanding, interpreting and communicating about behavioral responses of infants to both parents and professional staff can lead to better management of stress and pain in neonates.

Of particular interest is the impact of the physical and caregiving environment during the hospitalization on the ability of the high risk and/or medically fragile baby to develop the capacity for appropriate and developmentally essential regulation of his or her sleeping, eating, and irritability. Those who demonstrate dysregulation in these areas very early on were more likely to go on to demonstrate cognitive and socio-emotional challenges as they grew into toddlerhood and preschool. The IMH provider can assist parents in intensive care to understand how to help with the infant’s regulation early on, emphasizing the organizing effects of the parent-infant relationship. As the infant continues to develop organization around these functional areas, the IMH provider can also be sure that referrals for continuing supports around these areas as the family transitions home.

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1. The primary caregiver(s) for most infants will be their parents. However, many babies will have grandparents, foster parents or others persons as primary caregivers. From this point in the article we will refer to all primary caregivers as parents, recognizing that the person who is responsible for being the primary caregiver may not be the infant’s biological parent.
The physiologic and behavioral impact on the infant who experiences repeated painful and stressful procedures is self-evident, but there is also an impact on the parent/primary caregiver who witnesses and/or administers the invasive procedures. Recent changes in policies in intensive care support the presence of parents/primary caregivers during the infant’s procedures in an attempt to provide opportunities for the parent to buffer the effects of the potentially painful and stressful events and to comfort the baby as he or she recovers. However, witnessing painful procedures that are done to their babies can have a lasting impact on the parent, who may or may not feel effective in buffering and comforting the experience for the baby. Moreover, with the increasing presence of families in intensive care resulting from implementing family centered/integrated care, they may be exposed to painful and stressful events that occur with other babies and families. Witnessed trauma such as seeing another baby dying, or being resuscitated, or seeing the family members of other children experiencing grief and/or stress can similarly affect the reactions of family members. The IMH provider cannot only support the staff in determining the family’s comfort in being present when adverse circumstances occur, but also gauge the staff member’s comfort with having parents present during stressful and/or painful procedures and offer support, clarification and debriefing with the parent if necessary. They can talk with the parent about how they experienced the stressful event, and what coping mechanisms they might use to manage any resulting adverse thoughts or feelings that might occur.

Role of the IMH provider

• Recognize and support efforts to create intensive care environments that support and facilitate relationship development between babies and their caregivers.
• Help intensive care professionals identify positive and negative environmental factors and address barriers that interfere with supporting nurturing relationships.
• Assist parents in understanding and supporting infant regulation through their relationship with their babies.
• Monitor infant regulation and parent coping strategies, and provide support and referrals as needed to optimize regulation both in intensive care and in home-based services.
• Support staff and families during stressful situations and help process the impact of the event after it occurs.
• Recognize the overlapping, yet synergistic effects of each area of “neuroprotection” in the context of the parents’ caregiving.

Role of the Infant Mental Health Provider

Education, Experience and Professional Recognition

Specialized training in IMH can be obtained through multiple avenues, depending on the basic education and experience that the individual brings to the work in intensive care. Typically, those with mental health degrees and licenses are well prepared to meet the general mental health needs of parents and families. However, as the field of infant mental health grows and obtains more substantive evidence for its benefits, focusing on appropriate education and experience of providers becomes increasingly necessary. Background education and experience should include specific relationship based approaches and reflective practice including reflective supervision and/or consultation. Given that the primary role of the IMH provider includes supporting parents to develop a strong foundation for regulatory relationships with their babies, they should also have a sound understanding of infant behavioral communication in order to facilitate the sensitive and reciprocal exchange in the dyad. Specific training is best obtained from programs such as the Newborn Individualized Developmental Care and Assessment Program (www.nidcap.org), the foundational Family and Infant Neurodevelopmental Education course (currently offered only in Europe), or the Newborn Behavioral Observation System.

Many professionals come to the field well prepared to treat mental health challenges, but benefit from additional training and experience in these more specific infant mental health areas. For many, a certification or endorsement beyond their basic training is beneficial. In the United States, there are several states that have developed an “endorsement” for the IMH work force, to ensure quality and ongoing professional development. For instance, Michigan’s Association for Infant Mental Health, a pioneer in formulating IMH Competencies and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® offers four different endorsement categories that are based on years of experience, education level, and clinical or research/academic tracks. Endorsement also involves a written exam to assure foundational knowledge of the workforce. Additionally, there is a requirement for having engaged in reflective supervision and/or consultation practices. To date, twenty-three states and other international countries have come together to form the Alliance for the Advancement of Infant Mental Health (http://mi-aimh.org/alliance/) as the umbrella organization. Further information can be obtained regarding endorsement in infant mental health at their website. States not in the Alliance have established their own criteria for education and experience to offer IMH services.

Centers or institutes throughout the country offer different models for achievement of infant mental health training. For instance, the Erickson Institute in Chicago, IL offers a certification program for a wide range of professionals, including child development specialists, health professionals, licensed mental health providers, and other professionals with related experience. Other graduate and post-doctoral programs that offer IMH training include the University of Minnesota, the Irving B. Harris Foundation funded Harris programs around the United States and in Israel, the University of Massachusetts, the University of California Davis, and Fielding Graduate University.

Responsibilities and Care Services

IMH providers maintain a supportive and reflective approach to all relationships and experiences in intensive care. The practice they embrace focuses on promotion of infant and family developmental progress and mental health, prevention of further dysregulation that may occur from time in the intensive care unit, intervention in situations where the threats to parent or infant mental health are real or perceived, and therapy to repair disordered relationships. They are acutely aware of their own responsibility to refer appropriately to other mental health services when mental health issues of parents and/or family members require more intensive treatment.

IMH providers demonstrate parallel process with staff and families, in that they strive to exemplify nurturing, safe relationships that then can be passed on to the families who provide nurturing and safe interactions with their infants. They work with individuals and groups to strengthen and support responses to a myriad of complex relationship issues that often occur in intensive care settings and that may be exacerbated by parental stress, infant stress, challenges to dyadic regulation, and complex family dynamics. They also work in concert with professional staff members to enhance relationships among infants, families, staff and systems.

In working from a reflective stance, the IMH provider strives to not only be reflective in his or her own practice, but to make opportunities for families and professionals to engage in reflective interactions and problem solving. Ultimately, the IMH provider holds the baby, the family and staff in mind, as they address the challenges and opportunities that life in an intensive care unit reveals.
Case Example

Jasmine is a 19-year-old new mother with a baby, Jojo, who was born at 34 weeks but had a number of complicating medical issues requiring surgery. Jojo is now recovering and growing, and the professional staff members anticipate that if all goes well, she will be going home in about 2 weeks. At first, Jasmine came to the unit on a regular basis in the mornings to care for and do kangaroo mother care with Jojo. The nurses were impressed with her sensitivity to Jojo’s needs. After about a week, the nurses noticed that Jasmine came to the unit later and later each day, and then in the evenings, sometimes as late as 11:30 PM, which was concerning to the nurses as they felt that Jasmine needed to be with Jojo much more. They alerted the social worker to their observations, after which she spoke with Jasmine about being with her baby more. She could not figure out why Jasmine was not coming in, as she had access to a private room near the hospital and was free to come and go as she pleased. In their frustration, the nurses called the people who managed the rooms and canceled Jasmine’s reservation. When she found out about the room cancellation, Jasmine said “I want to come in and see Jojo in the late evenings and then go dancing, so I sleep late in the mornings”. The social worker spoke with the person who oversaw the room and convinced her to allow Jasmine to keep the reservation while she worked to better understand what was happening.

The IMH provider was consulted to help with determining what Jasmine might be experiencing and to help the staff with their responses to this change in her behavior. The IMH provider began by setting a mutually agreeable time to meet with Jasmine, and met with her in her room, away from the unit. First she asked about Jasmine’s labor and delivery experience and what her impressions of Jojo were before she was hospitalized. She explored Jasmine’s reactions to her baby being in the unit and what it was like caring for him and doing kangaroo care. Jasmine described several impactful events. One day when she was doing kangaroo care with Jojo, a resuscitation was happening in the same room. On another occasion, she was there when a baby died. No one from the staff spoke with her about either of these events, and seemed to carry on as if nothing had happened. She said, “I was there and saw the baby and how the parents reacted when he died. None of the staff would though the conversation about how these events were being perceived as happening directly to her or her baby. Jasmine related that she was unwell while in the hospital and was free to come and go as she pleased. In their frustration, the nurses called the people who managed the rooms and canceled Jasmine’s reservation. When she found out about the room cancellation, Jasmine said “I want to come in and see Jojo in the late evenings and then go dancing, so I sleep late in the mornings”. The social worker spoke with the person who oversaw the room and convinced her to allow Jasmine to keep the reservation while she worked to better understand what was happening.

The IMH provider then gently helped Jasmine reflect on her past experiences and help the staff with their responses to this change in her behavior. The IMH provider began by setting a mutually agreeable time to meet with Jasmine, and met with her in her room, away from the unit. First she asked about Jasmine’s labor and delivery experience and what her impressions of Jojo were before she was hospitalized. She explored Jasmine’s reactions to her baby being in the unit and what it was like caring for him and doing kangaroo care. Jasmine described several impactful events. One day when she was doing kangaroo care with Jojo, a resuscitation was happening in the same room. On another occasion, she was there when a baby died. No one from the staff spoke with her about either of these events, and seemed to carry on as if nothing had happened. She said, “I was there and saw the baby and how the parents reacted when he died. None of the staff would talk about it, but everyone knew what had happened”.

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The IMH provider then sought permission from Jasmine to speak with the staff about what had occurred to change how much time she was spending with Jojo. She explored the events that unknowingly affected Jasmine’s presence with Jojo collaboratively with the nurses and other professional staff, allowing them to reflect upon the situations and arrive at their own conclusions about how the events had impacted Jasmine and Jojo’s relationship.

This case example demonstrates several core principles and approaches applied by IMH providers in working with fragile infant populations: create a holding environment; utilize a reflective stance without jumping to conclusions; use reflective questions to determine what is of concern; employ a parallel process of not judging the nurses so they will not judge the parents; emphasize the importance of the mother’s relationship with her baby; facilitate the mother’s ability to be with her baby; and support staff to support the parent who then can support the baby. These core principles and approaches serve as the foundation from which IMH work with fragile infant populations occurs in intensive care, home, and community settings.

Infant Needs for IMH Supports and Intervention

Approaches that have been developed to determine the behavioral responses of the infant have focused our attention on how the baby may be experiencing the environment, the procedures, and the caregiving. Als and colleagues have provided interdisciplinary, comprehensive training and consultation globally to assist professionals and parents in recognizing and interpreting the behavioral communication of infants (www.nidcap.org). Training in the Newborn Individualized Developmental Care and Assessment Program (NICDAP), provides the professional with insight into the experience of the baby during hospitalization, both what is supportive and regulating, as well as what is not supportive and disruptive to neurodevelopmental regulation. Additionally, the NICDAP approach emphasizes an inference of developmental goals of the infant, including what both professionals and parents can provide to enhance their organization. Thus, NICDAP inherently is relationship based and reflective. The elements of the NICDAP approach are consistent with the principles and practice of infant mental health. All infant mental health professionals who practice in intensive care units should be familiar with this program, and optimally, be trained to reliably use the NICDAP observational approach. Identification of the behavioral communication of the infant, as articulated in the NICDAP approach, assists the IMH provider to support the behavioral co-regulatory interactions between the parent and the infant, which, in turn, supports and promotes early relationship principles on which IMH is based. As the “gold standard” of individualized developmental caregiving, there are significant positive outcomes for medical, neurodevelopmental and socio-emotional effects both short and long term.

Another approach that has emphasized the importance of the early infant parent relationship and addresses the emotional connectivity of the dyad, with support from the family, is the Family Nurture Intervention (FNI). This approach provides early holding interactions between mother and the baby, emphasizing verbal and emotional exchange using soothing supports and kangaroo mother care as the medium for the intervention. Although at the present time, the FNI Program is primarily provided by neonatal nurses, it behooves infant mental health professionals in intensive care units to understand the principles, process, and evidence in order to support this emotionally significant relationship based approach. Published studies for FNI indicate significant positive effects on infant behavioral outcomes and brain organization. Mothers also benefit from this program, showing more optimal emotional connectivity with their infant and less postpartum depression.

Both the NICDAP and FNI approaches incorporate kangaroo care (also referred to as skin to skin care) as a primary strategy for promoting early co-regulatory relationships between the mother and her baby. Kangaroo care (KC) is a well-studied and promoted intervention for stabilization and nurturing approaches for typically developing and high risk newborns. KC and breastfeeding are known to have psychological effects. In this case, Jojo was born pre-term, which required ongoing IMH responses from the staff. Although Jojo did not experience a resuscitation in the NICU, her mother’s complex responses to the hospitalization and Kangaroo Care illustrate typical responses of a mother of a fragile infant.

2 Case example provided by Fernanda Sampaio de Carvalho, MSc, Clinical Psychologist-Psychotherapist, Infant Mental Health Specialist, Dept. Child and Adolescent Psychiatry, Sophia Children’s Hospital, Rotterdam, The Netherlands.
benefits, enhance the attachment relationship and reduce symptoms of depression (see Buchholz, Dunn, Watkins, & Bunik, 2016, this issue). Although infant mental health specialists do not themselves assist mothers with performing KC, their knowledge of the psychological and physiological benefits can help them encourage parents to engage in the practice and to advocate with the intensive care staff for increasing opportunities for parents to do so.

These exemplar programs seek to enhance infant regulation, parent regulation, and dyadic co-regulation and foster parent-infant relationships and interactions, all of which are consistent with the IMH field. It is incumbent upon IMH providers and specialists working with fragile infant populations to familiarize themselves and, ideally, seek training in using gold standard approaches and to support professionals who are using these programs so that optimal care can be achieved.

**Parental Needs for Infant Mental Health Support and Intervention**

Parents who unexpectedly find themselves in an intensive care unit after a high risk birth are known to experience a myriad of additional stressful events, from a physical perspective (i.e. a mother who has experienced a caesarean section) to an emotional perspective (i.e. adjustment to having a medically fragile infant) to an economic perspective (i.e. the added food, transportation, and related expenses associated with being in a hospital). Often the family home is at a distance from the hospital resulting in complicating factors including, but not limited to, transportation, child-care for siblings, and job responsibilities. The literature on parental stress of having a baby in intensive care describes the effects on cognitive, physical and functional processes. Often the cultural, spiritual and language resources that the family relies on for adapting to stressful events are not as available in a hospital setting as they would be in a more familiar community situation. Further, many intensive care units have limited resources for the parents’ comfort (such as showers, washer and dryers, food preparation facilities), or for intimate interactions among family members and their baby.

Parental presence in intensive care is essential for them to provide the unique parenting for their baby, and to develop their own secure relationship with their baby. The literature is convincing that at birth, the baby is prepared for intimate relationships with their mother and physiologically “primed” for attachment. At birth, the infant is able to recognize and respond to the unique odor of the mother’s body, taste of her milk, sound of her voice, and rhythm of her body movements (see entire issue of Browne and White (Eds.), Clinics in Perinatology, 2011). Opportunities for physically close and intimate exchanges provide for co-regulation between the mother and baby. Neurophysiologic and socio-emotional benefits of co-regulation for both the mother and the infant are well documented and need to be promoted whenever possible in intensive care. Settings that encourage parents to be present as often as possible without restriction for any reason, who include parents in medical “rounds”, and who provide parents with opportunities to engage in all caregiving offer optimal environments for early relationship development and, ultimately, more regulated infants and caregivers.

Recently, identification of parental resilience resources has been studied. Resilience resources can be recognized and capitalized upon so that parents and family members can better cope with the challenges of having an infant in the intensive care unit. They include a variety of strategies of coping, spiritual beliefs, personality traits, and social supports. The infant mental health provider who can identify, capitalize on and provide insight into parent resilience resources can not only support parental and family coping, but also assist professional staff in understanding how best to support the unique resilience that a family may utilize and benefit from.

Recent publications that identify the mental health supports that can and should be implemented for parents whose babies are in the neonatal intensive care unit have added significantly to a professional understanding of how health care systems address the significant mental health needs of parents in neonatal intensive care units. Infant mental health providers should not only support parents in their psychological adjustments and coping while their infant is under intensive care, but also advocate for appropriate resources and systems integration of mental health supports for families (see Ash and Williams, 2016 this issue).

Recent emphasis on maternal mental health issues resulting from a high risk pregnancy such as postpartum depression, anxiety and post-traumatic stress disorder (see Del Fabbro and Cain, 2016, this issue), has heightened awareness in the field of the importance of screening and support for mothers who exhibit or are at risk for mental health issues. In settings such as intensive care units there are opportunities for the infant mental health provider to provide standardized screening and assessment measures, and to provide intervention, always keeping in mind a relational approach. Although many infant mental health providers in intensive care units focus on supporting early relationship development using a reflective approach, they also screen and identify those parental mental health issues that need further referral to appropriate hospital based or community resources.

**Infant Mental Health and Intensive Care Unit Staff Support**

Professional staff who work in intensive care with babies and their families balance a high degree of technological and pharmacological knowledge and skill with interpersonal, cultural and psychological aspects of their job. Increasing complexity of medical care, the demands of staff assignments and responsibilities, combined with increasing needs to integrate families into the daily care routine make the workplace and work environment challenging for many staff members. Parents are increasingly included in rounds, during procedures, caregiving and shift change, making it difficult for staff to not only care for the baby, but also be responsive to parental needs and sometimes, demands. Some hospitals also include allowances for siblings to be with their families in the intensive care units, which often creates more demands on the professional staff’s time and responsibilities.

IMH providers can assist with interpretation of the parents’ need to be with their baby, while supporting the ongoing work of the staff, and assist in the development of a safe environment in which both parents and staff can function optimally. In doing so, parents can parent their infant while staff can provide medical and nursing interventions and procedures.

Additionally, nurses and doctors must often participate in invasive and hurtful but necessary procedures, or bear witness to infant death and the family’s related grieving. These aspects of care are often not recognized as witnessed trauma and in many hospitals there is little validation of the toll it takes on professional’s work and personal lives. It is often challenging for professionals to engage in conversations with others where their thoughts and emotions can feel safely exposed. The IMH provider can provide a safe and confidential haven for those professionals in order for them to be able to reflect on their own feelings of being overwhelmed, confused, or sad about what they are witnessing in their professional role (see Lorrain, this issue).

Opportunities for reflective stance and practice among professional staff in an intensive care unit can be challenging to find, as the demands of assignments and the episodic nature of the work often make it difficult to have a safe place in which to reflect on their work (see Tomlin, Deloian, & Wolleson, 2016, this issue). IMH providers must be present, consistently available, and trusted to hold feelings and conversations, even if they themselves are just bearing witness to professionals’ experiences. They must think carefully about their own and others’ behaviors to better understand the observed adult interactions and to assist parents and staff in interpreting and responding to the infant’s behaviors. By reflecting on their own interactions with babies and their families, IMH providers can better support parents and staff to function more reflectively themselves. By promoting parents’ and family members’ reflective functioning skills, professionals strengthen the parent-infant relationship. These reflective skills help parents to interact with their
infants in ways that further support the relationship, foster the development of co-regulation and self-regulation skills, and promote cognitive, physical, and social-emotional development.

A collaborative, coordinated effort among hospital and community professionals and families is necessary to appropriately assess and provide therapeutic intervention to support optimal parent-infant relationship development. Ultimately, fragile infants and their families can be optimally supported both in intensive care settings and after they transition home using re...


