Infant Mental Health for Medically Fragile Babies in Intensive Care and Their Families

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Abstract
Infants who begin their lives in intensive care are impacted physically and socioemotionally for many months and years to come. Likewise, stressful experiences of caring for a baby hospitalized in intensive care have an impact on primary caregivers, typically the baby’s parents. Infant mental health (IMH) is an expanding, evidence-based field that emphasizes the importance of supporting early relationship development and optimal social and emotional outcomes through enhancing early relationships. Multidisciplinary IMH providers are uniquely prepared to support early relationship development between parents and infants, parents and intensive care professionals, and community mental health resources. As well-prepared and experienced IMH providers become available in intensive care units, babies, parents, and staff will benefit. This article addresses preparation, resources, and interventions that can be provided by IMH providers through case studies and examples for appropriate referrals in an intensive care setting.

Intensive care for hospitalized infants, whether neonatal, cardiac, or pediatric, and regardless of the length of hospitalization, has a significant effect on babies and their primary caregivers\(^1\), be they parents, grandparents, foster parents, or other friends and family. As illustrated in the three vignettes below, the combinations and permutations of factors leading up to and during an infant’s intensive care hospitalization include infant, parent, and environmental challenges that present in complex ways and impact relationship development and well-being.

Baby Lontel

Baby Lontel’s mother had been trying to get pregnant for several years and finally became pregnant after several miscarriages. She was ecstatic. When her early contractions started at 23 weeks, she was immediately hospitalized to keep Lontel from being born that early. When he was born at just 25 weeks, Baby Lontel was whisked off to the neonatal intensive care unit (NICU) where the professional staff used all of their strategies to keep him alive. He was put on a breathing machine, had several intravenous lines, and was placed in a bed that kept him warm and protected. His mother, Celena, was ill and unable to get to the NICU for an entire day. When she was finally wheeled across the hospital to see him, she saw a tiny, fragile son who didn’t really look like any baby she had ever seen. She was afraid to even touch him. The next 4 months were spent going to and from the hospital to be with him. After about 2 weeks, the nurse encouraged her to hold him, suggesting that she hold him on her chest for skin-to-skin contact, known as “kangaroo care.” When she held him, she couldn’t hold back the tears; it was a frightening, yet exhilarating experience. She had been afraid to even touch him because she was fearful that he would die. As a child, Celena had lost her little brother who was born premature, after her mother had gone into labor when her father kicked her mother in the stomach. Seeing her own son struggle to live brought visions of the domestic violence and memories of her brother’s struggle to breathe after he was born back to her in vivid color, as if she were re-experiencing the event all over again.

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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.
Baby Joey

Baby Joey was born 2 days after his due date, a bouncing 8 lbs, 11 oz, dark-headed, dimple-cheeked, perfectly formed boy. His mother, Sharon, had labored long, pushed him out, and grabbed him from the obstetrician as if she couldn’t wait to see him face to face, to breathe in his sweet baby smell, and to hold him as close as she possibly could. Her birth plan had been distributed to all the staff at the birth hospital with expectations that they would certainly do all they could to follow her requests: No ointment in his eyes at first so he could see her clearly, a delayed bath, a bassinet within her arms’ reach for the entire hospital stay, a golden hour when she and her partner, Jake, could take in their new role as Mommy and Daddy. Nobody expected that gorgeous boy to start to tremble, or that the intensive care nurse who came to check on him would swoop in and take him away from them. Or that he would be put in an incubator and have a big, restrictive arm board on the very hand that he used to suck on while still a fetus. For 2 days in the intensive care unit, his parents wanted the best for their boy, even when they didn’t get to be with him, to nurse him, to respond to his cries, to give him his first bath. His mother was devastated by the abrupt separation and by not knowing what was going on, wondering “Is he ok? Will he die? Why can’t I be with him every minute?”

Joey was not seriously ill, and will not remember that early separation or the painful procedures he endured. Sharon, on the other hand, continued for months and years to try to recover from the trauma of not knowing, not being in control, and not having the advantage of never being separated from her precious child during his first days of life.

Baby Cecile

Sandra knew the odds were against her for having a term delivery. The ultrasound showed a concerning heart problem that would require surgery right after the baby was born. For 2 months, Sandra, a single mother, worried for her unborn baby girl. She labored fast and delivered her sweet little girl 6 weeks early. Arriving by Caesarean section, baby Cecile was whisked away so that she could be stabilized before going to the operating room. For 6 long hospital weeks, her mother felt she was on a wild roller coaster ride. The baby had tubes, intravenous lines, and medicine pumps, and Sandra was anxious about disturbing all that medical equipment so she didn’t try to touch and hold her baby. She began to feel numb, disconnected, did not sleep more than 30 minutes at a time, and couldn’t hold back tears. Every surgery and procedure raised the potential for serious complications, poor outcomes, or death. She knew it was a possibility; it was written on the procedure permission form, plain as day. Sandra found herself angry at the baby for being sick, at the staff for not responding quickly enough to her calls, and at the doctors for always shifting their approaches and decisions. Sandra did the best she could to cope with each traumatic day, but felt the staff were avoiding her because she asked too many questions. When the day came for her to go home she had mixed feelings. Feelings of relief that the professional staff felt her baby was stable enough to go home; feelings that she was much less competent than the nurses and didn’t know if she would be able to cope, and feelings of anger that the baby had disrupted her entire life plan.

As early-hospitalized children grow up, they may demonstrate concerning neurodevelopmental and socio-emotional outcomes, especially for those babies born at very and extremely low birth weight.

Hospitalization of Infants in Intensive Care Settings

From a medical standpoint, new technology, procedures, and interventions have improved the outcomes of sick and early born babies. However, as early-hospitalized children grow up, they may demonstrate concerning neurodevelopmental and socio-emotional outcomes, especially for those babies born at very and extremely low birth weight (Anderson & Doyle, 2008; Boyd et al., 2013; Boyle et al., 2012; Jones, Champion, & Woodward, 2013; McNicholas et al., 2014; Treyvaud et al., 2013). In addition, diverse early experiences, in combination with decreased access to protective relationships, may result in fragile infants who possess less optimal regulation skills. Early regulatory issues often result in later cognitive and socio-emotional challenges, necessitating referrals to a variety of support services as the infant grows into their toddler and preschool years (Schmid, Schreier, Meyer, & Wolke, 2010; Winsper & Wolke, 2014).

As health professionals provide acute medical and nursing care, there are, of necessity, painful and stressful procedures such as blood draws, injections, and intravenous line placements, as well as ongoing treatment and caregiving procedures that may disrupt the organization or sleep of the infant. Historically, infants in intensive care experience up to 60 caregiving procedures per day during hospitalization, with even higher numbers reported for the smaller, younger infants (Peters, 1992). More recent studies have documented disruptions in infant sleep due to handling, procedures, and caregiving (Levy et al., 2016). In addition, Smith and colleagues reported that in a typical hospitalization of babies in a neonatal intensive care unit, the number of invasive procedures is related to brain development (Smith et al., 2011).
The frequent painful and stressful events that babies experience while hospitalized in intensive care can reasonably be considered unbuffered stressors that may ultimately result in toxic stress.

The field of infant mental health (IMH) has an emerging understanding of the effects of early stressful events on socio-emotional and physiological regulation and developmental outcomes in young children. They often experience long-term consequences of toxic stress (Shonkoff, 2016), which refers to stressful or neglectful experiences early in life that occur on an ongoing basis in the absence of buffering protection from a primary caregiver. The frequent painful and stressful events that babies experience while hospitalized in intensive care can reasonably be considered to be unbuffered stressors that may ultimately result in toxic stress. The impact of adverse experiences related to hospitalization in intensive care, intrusive sensory environments, and restricted ability of parents to serve as buffers make for a “perfect storm” that potentially compounds stressful responses in both babies and their parents.

Parents who find themselves in an intensive care unit after a high-risk birth are also known to experience a myriad of additional stressful events, from a physical perspective (e.g., a mother who has experienced a high-risk pregnancy or a Caesarean section), to an emotional perspective (e.g., adjustment to having a medically fragile infant), to an economic perspective (e.g., the added food, transportation, and related expenses associated with being in a hospital). Often the family home is at a distance from the hospital, which can cause a great number of complicating factors including, but not limited to, transportation, child-care for siblings, and job responsibilities. The cultural, spiritual, and language resources that the family relies on for adapting to stressful events may not be as readily available in a hospital setting as they would be in their own community. Further, many intensive care units have limited resources for the parents’ comfort (e.g., beds, showers, washer and dryers, and food preparation facilities), or for intimate interactions among family members and their baby (Brandon et al., 2011; Lasiuk, Comeau, & Newburn-Cook, 2013).

Babies who are hospitalized in intensive care and their primary caregivers experience a number of threats to the establishment of secure and nurturing relationships. They are at the mercy of their hospital environment, and the adults are frequently deterred from being able to comfort and parent their infant in ways that they would like to. The parents also often experience or observe medical procedures and practices that alter social interactions and deplete emotional resilience (Dingeman, Mitchell, Meyer, & Curley, 2007). Opportunities for the parents and babies to develop co-regulatory strategies to help deal with their situation are often limited, which significantly impacts the development of essential caregiving relationships. For example, the parents’ provision of skin-to-skin care not only helps the babies regulate their temperature, state, and other physiologic parameters, but at the same time, the parents benefit from both physiologic and psychological aspects of holding the infants. In addition, current or previously existing mental health concerns of the parents may surface in stressful hospital situations, requiring appropriate psychological and emotional evaluation and support for parents, infants, and, in many cases, staff.

**IMH in Intensive Care Settings**

The primary goal of IMH practice in an intensive care unit is to enhance nurturing relationships between the infants and their primary caregivers. In doing so, IMH practice also supports the professional staff by focusing on practices and procedures that promote ongoing social and emotional development. (See box Infant Mental Health Practice in Intensive Care)

### Infant Mental Health Practice in Intensive Care

The following are examples of infant mental health work with infants, parents, and staff in intensive care:

- Providing anticipatory guidance for parents regarding medical risk factors that may result in long hospitalization
- Supporting emotional well-being after witnessing painful or stressful medical procedures, preparing for unexpected changes in their infant’s medical course, or both
- Educating parents who wish guidance about their babies’ emotional and social needs
- Bearing witness and being an “interpreter” of a parents’ or infant’s suffering
- Participating in the celebration of an infant’s progress
- Assessing and intervening when psychosocial stressors interfere with nurturing or positive interactions with their infant
- Intervening when the provider or hospital staff have observed negative interactions between the parent and infant or when the parent expresses negative associations or perceptions about the baby
- Exploring, clarifying, and interpreting psychological and emotional aspects of situations when professional staff have concerns about their own interactions with parents that may cause distress
- Evaluating and providing appropriate psychological and emotional supports or appropriate referrals of parents with a current or prior mental health concern
- Consulting with professional staff on environmental, behavioral, and psychosocial well-being of infants, parents, and staff
- Taking a reflective stance in practice, consultation, and education
Mental Health Support for Infants, Parents, and Staff

The following is a description of IMH specialist involvement in each of the three families described previously. Infants, parents, and intensive care professionals benefit from the presence and involvement of an IMH specialist who can provide support, create a reflective space in which to understand family and staff concerns, and help focus on the developing relationship between infants and parents.

Baby Lontel

Celena’s nurse observed that she was hesitant to hold her baby. He was now stable enough to be held, and kangaroo care is known to be stabilizing for infants and beneficial for mothers. But in spite of the nurse’s reassurance, Celena still refused to hold him. The IMH specialist was in the hall, and the nurse asked her to step over and provide some guidance. The IMH specialist sat with Celena next to Lontel’s incubator and marveled at his efforts to get his hand to his mouth and console himself. She helped Celena to observe his efforts, gently “interpreting” what he was doing and how he was responding to Celena’s voice by turning his eyes toward her and changing his breathing. Upon hearing Celena’s story, listening carefully, and asking gentle questions about her previous losses, the IMH specialist realized that previous pregnancy losses and the death of her younger brother who was born prematurely were overshadowing Celena’s ability to see her own baby as capable and needing her tender care. The IMH specialist gently guided her to talk to Lontel and express her feelings of grief. After several sessions over the course of a few days, Celena was able to hold him intimately on her body. Both Lontel and Celena benefitted from this intimate embrace. He helped her with her emotional healing and, in turn, he benefitted from her body’s regulation.

Baby Joey

The staff members in the intensive care unit (ICU) could not understand the intensity of the distress in Joey’s mother and father. Clearly their baby had a minor illness that would not be considered life-threatening, and he was getting excellent care. They were stymied as to why Sharon was demanding to be in the ICU constantly rather than resting and recovering. They thought that perhaps the IMH provider might help these parents adjust to their current situation. The IMH provider met with the parents and asked them to describe the pregnancy, delivery, and their hopes and fears for their baby boy. She began to understand Joey’s parents’ need to have a close, intimate experience with their baby right after he was born. They related how hopes and dreams were for the mother to have her baby and, with trembling voices, described that they felt a part of them had been ripped from their arms with no explanation. The IMH professional and the parents then went to the intensive care unit to be with Joey and to see his robust behavior, including getting his free hand into his mouth and sucking vigorously. With Sharon and Jake’s permission, the IMH provider then related to the staff what she had learned from them. She helped the staff reflect on how this particular couple was affected by the intensive care unit practice of taking a baby away from parents without explanation and what the long-term implications for the family might be. As a result of Baby Joey’s parents’ story, and the staff’s ability to reflect on how it must have affected their experience, the policies were changed to have most of the evaluation tests done in the mother’s room, in the presence of the parents.

Baby Cecile

The intensive care unit was at full capacity and the staff was stretched thin. Baby Cecile was on the mend after two cardiac surgeries and was growing nicely. The primary care nurse was so concerned about Sandra, Cecile’s mother, that she contacted the IMH specialist to see if she could help the team understand the anger that Sandra was expressing not only to the staff, but also toward her infant. The nurse reported that Sandra was overheard saying to her baby, “You are messing with my life, I’m not sure I even want you.” The primary nurse also was concerned that Sandra became demanding when her requests were not answered quickly enough and that she had expressed anger over the doctors changing their approaches and decisions so frequently. Sandra had also asked the charge nurse to change her previous two primary nurses because they “weren’t good enough.” The primary nurse was concerned that Sandra was escalating her angry behavior and could possibly be a threat to her baby or the staff. The IMH specialist made a point to meet quickly with Sandra at Cecile’s bedside to explore what Sandra’s concerns were and to understand her coping mechanisms and social support from family and friends. She also performed some mental health assessments and, collaboratively with Sandra, developed a plan for communication and coping with her stress. Because the IMH specialist was concerned about the upcoming discharge to home, she explored possible resources for Sandra and Cecile’s through medical

Opportunities for physically close and intimate exchanges provide for co-regulation between the mother and baby.
home, community mental health services, early intervention, and public health nurses. Together with Sandra, the specialist developed a safety plan and promised to follow up with her both before and after discharge. She assured Sandra that she would continue to meet with her when Cecile had appointments in the cardiac clinics or returned for more surgeries.

**IMH Supports for the Infant and Parent in Intensive Care**

Parental presence in intensive care is essential. It allows parents to provide, as early as possible, their own parenting approaches that are regulatory, culturally relevant, and experience-based. Even if the baby is quite ill or early born, parents will be able to provide their own strategies and approaches to cherishing, nurturing, and buffering from stressful events, according to their own unique parenting style. In doing so, they will develop a secure, nurturing relationship with their baby (Hynan & Hall, 2015). The literature is compelling. At birth, the baby is prepared for an intimate relationship with their mother and physiologically “primed” for the attachment relationship. Immediately after delivery, 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 (Browne & White, 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 (Beeghly & Tronick, 2011; Boundy et al., 2016; Feldman, 2009; Feldman & Eidelman, 2003, 2006; Feldman, Weller, Sirola, & Eidelman, 2002; Ludington-Hoe, 2011) and need to be promoted whenever possible in intensive care.

As demonstrated in the vignettes, Celena’s own history of loss created anxiety and distress that made it hard for her to hold Lontel until she received the support and guidance from the IMH specialist. Baby Joey’s parents desperately wanted to be physically close to their son and were impacted greatly by the unexpected separation. The IMH specialist not only listened to and supported his parents during the stressful days, but also supported staff to reflect on how they might change policies to keep babies and parents together at all times. Sandra, Cecile’s mother, was angry and needed support and understanding—she needed to be held herself by the IMH specialist—in order to be ready to fully respond to her baby in a sensitive way. Parents who are encouraged to be present as often as possible without restriction for any reason, who are included in medical “rounds” where the attending physician discusses the infant’s care and progress, and who are given opportunities to engage in all caregiving experience offers optimal opportunities for early relationship development and a more regulated infant and mother (Hall et al., 2015; Hynan & Hall, 2015).

Recent emphasis on maternal mental health issues resulting from a high-risk pregnancy such as, for example, postpartum depression, anxiety and post-traumatic stress disorder (Del Fabbro & Cain, 2016; Montirosso, Fedeli, Del Prete, Calciolari, Borgatti, & Group, 2014), 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 IMH specialist to provide standardized screening and assessment measures, and to provide intervention, always keeping in mind a relational approach (Ashby, Scott, & Lakatos, 2016; Browne, Martinez, & Talmi, 2016). IMH providers in intensive care units focus on supporting early relationship development using a reflective approach, while simultaneously screening and identifying those parental mental health issues that need further referral to appropriate hospital or community resources. As babies and families transition to their home community, they may need further developmental and mental health support from medical home, early intervention, and public health resources. The transition from intensive care, where many professionals are available to answer questions and provide support, to a home situation where they are “on their own” can prove to uncover mental health challenges that were not apparent in the hospital and can be exacerbated by typical caregiving challenges such as lack of sleep, feeding difficulties, and few social support networks.

**Role of the IMH Provider**

In working with fragile infant populations, professionals from numerous disciplines can provide IMH supports and services to infants and their families.

**Education, Experience, and Training**

While educational background and experience may vary among IMH professionals, foundational knowledge in early childhood development, relationship-based approaches, and reflective practice are necessary. IMH professionals working with these populations benefit greatly from reflective supervision or consultation as they engage with the complexities of providing care and support to vulnerable infants and their families. A primary focus of the work centers on promoting positive, regulating relationships between infants and their caregivers, which also necessitates a solid understanding of infant behavioral...
communication in order to facilitate the sensitive and reciprocal interactions and exchanges that support optimal development.

Several programs provide training on fragile infant behavioral communication and supporting relationships between fragile infants and caregivers. Among these are the Newborn Individualized Developmental Care and Assessment Program (Als, 2009; Als et al., 2004; Als et al., 2003; Als et al., 1994; NIDCAP Federation International, 2016), the Family Nurture Intervention (Hane et al., 2015; Welch et al., 2012; Welch et al., 2013; Welch et al., 2014), the foundational Family and Infant Neurodevelopmental Education course (currently offered only in Europe), and the Newborn Behavioral Observation System (McManus & Nugent, 2014).

As families transition to their home in the community they may need ongoing programs that focus on mental health supports. Early intervention services are now focusing more on social and emotional assessment and intervention. The BABIES program provides training for early intervention and public health professionals for babies in home settings (Browne & Talmi, 2012; McNeil et al., 2016). Many elements of these programs are consistent with the principles and practice of IMH. IMH providers working in intensive care settings use these foundational programs to identify infant behavioral communication, support the co-regulatory interactions between the parent and the infant, and, ultimately, establish and promote healthy early relationship development. These established programs and recommendations are designed to enhance infant regulation, parent regulation, and dyadic co-regulation, and to foster parent-infant relationships and interactions, all of which are consistent within the IMH field. IMH providers and specialists working with fragile infant populations need to familiarize themselves and, ideally, seek training in using these gold standard approaches in supporting professionals who are using these programs so that optimal care can be achieved (Hali et al, 2015).

Although professionals from a wide range of disciplines and backgrounds have the opportunity to work as IMH specialists in intensive care settings, they may have training in traditional mental health service delivery. Additional training in IMH principles and practices can be beneficial (see Learn More for a selected number of programs and courses that offer educational opportunities in IMH). Certification, endorsement, or both are available from academic institutions, mental health associations, centers, and institutes throughout the country.

Responsibilities and Care Services

IMH providers use a reflective approach in developing relationships and promoting infant and family well-being in intensive care settings. (For further description of the IMH field and practice see Weatherston and Browne, 2016; Browne et al., 2016, Browne & Talmi, 2016). Their practice promotes infant and family developmental progress and mental health by increasing behavioral regulation and enhancing opportunities for co-regulatory and relationship-enhancing experiences. IMH providers may intervene during situations of real or perceived threats or traumatic events that occur to infants or their parents, and can provide therapy in cases of disrupted or disordered relationships. During hospitalization, IMH professionals are tasked with referring appropriately to other mental health services when mental health issues of parents or family members need further intensive treatment.

Using a reflective stance, IMH providers cultivate nurturing, supportive, and safe relationships with both families and staff. The parallel process ensures that the benefits of strong relationships and promoting infant and family well-being in intensive care settings.

Learn More

Selected Infant Mental Health Training Programs and Courses

Online Continuing Education Courses:

University of Minnesota, Center for Early Education & Development
http://www.cehd.umn.edu/ceed

Wayne State School of Social Work, Merrill Palmer Skillman Institute
http://mpei.wayne.edu/training/infant-health.php

Post-Graduate Certificate Programs in Infant and Early Childhood Mental Health

Portland State University Infant Toddler Mental Health Graduate Certificate Program
www.pdx.edu/ceed/infant-toddler-mental-health-graduate-certificate

University of South Florida Graduate Certificate in Infant Family Mental Health
www.usfspa.edu/infant-family-mental-health/

Barnard Center for Infant Mental Health and Development, University of Washington Graduate Certificate in Infant Mental Health
https://depts.washington.edu/chdd/ucedd/cimhd_3/3_cimhdm.html

University of Massachusetts Boston
https://www.umb.edu/academics/ccla/psychology/professional_development/infant-parent-mental-health

University of California Davis Extension
https://extension.ucdavis.edu/areas-study/health-sciences/napa-infant-parent-mental-health

Fielding Graduate University: fully online doctorate in infant and early childhood development with an emphasis on infant mental health and infants with disabilities. There are various concentrations available, including reflective practice/supervision.
www.fielding.edu/our-programs/school-of-leadership-studies/phd-infant-early-childhood-development

Post-Doctoral Fellowships:

Irving B. Harris Foundation-funded programs around the United States and in Israel

Other Online Courses Available for Training:

The Erickson Institute, Chicago, IL
www.erikson.edu/graduate-school/programs/online-infant-specialist-courses

The Parent Infant Centre and School of Infant Mental Health, London, UK
www.infantmentalhealth.com/school_new.htm?trk=profile_certification_title
relationships are transferred directly to babies through the nurturing and supportive interactions they experience. IMH providers may work with individual staff members or at the group level to identify and address the stressors and challenges that emerge in the context of intensive care settings. Providing support to professionals in intensive care settings creates an environment in which stressors and adversity factors including infant illness, complex family dynamics, parental well-being, and job demands are recognized to detract from healthy relationship development and interfere with optimal development. Enhancing relationships among infants, families, staff, and systems is a core function for IMH providers.

When IMH providers are reflective in their practice, they create opportunities for families and professionals to engage in a reflective manner during their interactions with others. The experience of being held in mind by the IMH provider becomes a conduit for stronger relationships among the baby, the family, and intensive care staff.

Conclusions

Infants who begin their lives in an intensive care unit often experience significant challenges in their early regulation and, subsequently, in their cognitive, social, and emotional development. Parents also experience multiple stressful events resulting from hospitalization of their infant that often are accentuated by their own history and current life circumstances. Intensive care hospitalization results in real and perceived threats to the early developing parent-infant relationship. IMH is an emerging field that emphasizes prevention, promotion, intervention, and treatment in support of early mental health and socio-emotional development using a relationship-based, reflective stance. The three families described in this article illustrate the importance of supporting strong parent-infant relationships beginning as early as possible, in particular if the baby is born early or with complex medical issues that result in hospitalization in an intensive care environment. IMH work in intensive care is multidisciplinary, focusing on support for infants, families, and staff. Training, experience, and appropriate recognition of expertise is essential for those who practice with medically fragile infants and their parents in intensive care and in the community after they are discharged home.

Acknowledgment

With thanks to the Alaska Association for Infant Mental Health, August, 2016, Cristina Ackerman, Lisa Hodges & Beth Routzahn, Editors.

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Ayelet Talmi, PhD, is an associate professor of psychiatry and pediatrics at the University of Colorado School of Medicine and director of integrated behavioral health in the Pediatric Mental Health Institute at Children’s Hospital Colorado. Dr. Talmi is the director of Project CLiMB, an integrated behavioral health services program in pediatric primary care. She is the co-director of the Irving Harris Program in Child Development and Infant Mental Health and the co-lead of the First 1,000 Days Initiative at Children’s Hospital Colorado. Her research and clinical interests focus on early childhood mental health in pediatric primary care settings and on systems of care for babies and young children with special health care needs. Dr. Talmi is a ZERO TO THREE Leaders for the 21st Century Graduate Fellow and a past president of the Colorado Association for Infant Mental Health.

References

A Guide for Supporting Parents With Newborns

Pathways to Positive Parenting: Helping Parents Nurture Healthy Development in the Earliest Months
Jolene Pearson

The first days, weeks, and months are critical for a baby’s development, but they can be overwhelming for new parents—and challenging for professionals who work with families of newborns.

This valuable handbook provides professionals with innovative teaching techniques that can be applied immediately in work supporting the development of positive parenting skills. Features additional information parent educators can use to support the newest parents in their programs. Topics include:

- Coping with crying
- Breastfeeding
- Strategies for safe sleep
- Managing postpartum depression
- The importance of tummy time

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