Fragile Infant Forums for Implementation of IFCDC Standards: Key Cornerstone of the IFCDC Standards: Infant Mental Health

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Infant and family-centered developmental care (IFCDC) includes several guiding principles, one of which is the application of Infant Mental Health (IMH) to practice in intensive care. The emerging knowledge base of IMH clearly shows how early experiences affect babies' social and emotional well-being and should be a major consideration in all caregiving. Within the field of IMH, the constructs of *regulation, relationships, and reflection* guide thinking about the optimal environment of care on 1) the baby's organization/regulation, 2) the baby's ability to be an active interactor, 3) the primary role of the m(other) on the baby's organization, and 4) optimizing neurodevelopment. See Figure 1. Engaging in a reflective stance regarding the impact of care on the baby's and family's experience individual experience assists the professional in implementing the principles included in IFCDC practice. (1) IMH considerations are vital in the conceptual model of how IFCDC should be implemented in intensive care. (2, 3, 4)

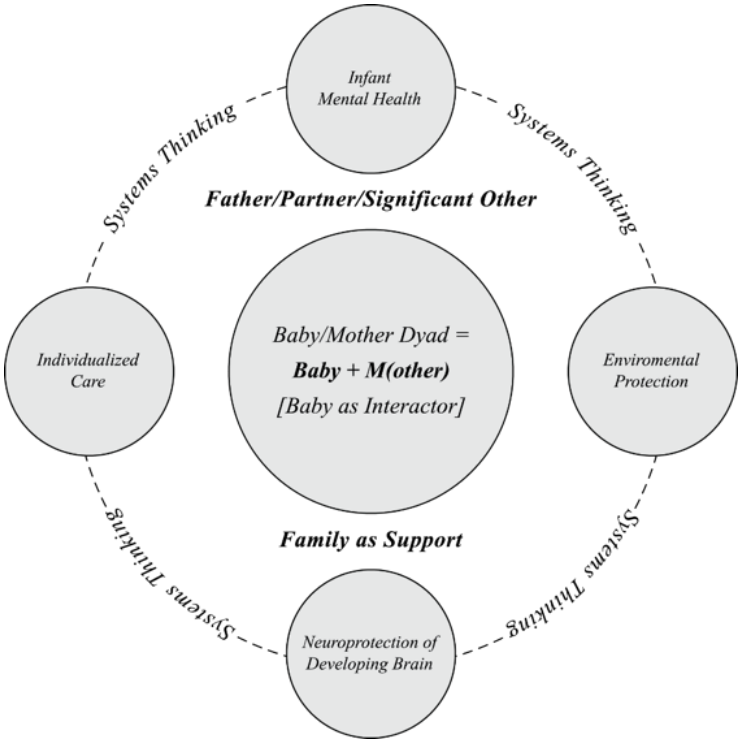

Figure 1

IMH is becoming more relevant to babies and young children's social and emotional development. Intensive care professionals must understand and implement strategies to enhance rather than detract from optimal developmental outcomes. (5, 6) Implementation of appropriate IMH approaches should be provided in the context of the baby's family, the family's cultural and social orientation, and their caregiving preferences.

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Historical aspects of IMH

IMH is now considered an essential consideration for robust infant and child development. Its roots come from a shift in focus from more adult-oriented psychodynamic approaches to seeing the baby and young child as unique within their caregiving relationships. Early studies by Selma Fraiberg (7), Donald Winnicott (8, 9), and Claire Britton (Winnicott) (10) recognized the impact of early childhood traumatic events as well as disturbed relationships

as affecting the young child's mental health and behavior. Interventions developed by those early investigators focused on understanding the infant and young child's world, beliefs, and fears. They recognized that as the child is dependent on others for both physical and emotional growth, a sensitive, nurturing relationship with the primary caregiver is essential for optimal outcomes.

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More recent emphases on early childhood social and emotional development have resulted in theoretical and practical foundations for IMH assessment, prevention, and intervention. Accumulating scientific evidence has pointed to the neurobehavioral and social, and emotional impact of early experiences and the protective nature of nurturing early relationships. (11, 12)

Defining IMH and its primary principles

IMH is typically defined as "the young child's capacity to experience, regulate and express emotions, form close and secure relationships and explore the environment and learn. These capacities are best accomplished in the caregiving environment, including family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development". (13)

The field of IMH is "represented by multidisciplinary professionals of inquiry, practice, and policy concerned with alleviating suffering and enhancing the social and emotional competence of young children" (14), page 6. The guiding principles of IMH include the following:

- Infant-caregiver relationships are the primary focus of assessment and intervention
- IMH is a strengths-based discipline
- Caregivers' past and current experiences influence their relationship with their baby/child.
- As the field strives to delineate, establish, and sustain positive development for infants and young children, intervention should not only alleviate suffering in the short term but also attend to future development through nurturing relationships.

Prevention, Promotion, and Treatment: Three Levels of Intervention:

Primary IMH goals include promoting emotional well-being in young children and their families, reducing risk factors, and preventing and/or ameliorating emotional problems. Three levels of approaches describe awareness of what is necessary to support emotional well-being and the intensity of appropriate approaches to meet the goal of that particular level. The first level relates to all babies and children and addresses preventive services, including ensuring early nurturing relationships and environments for all babies and children within the context of their family's culturally relevant parenting practices. The second level includes promoting emotional well-being by helping to reduce identified risk factors and includes more focused and nuanced approaches to enhance the child's regulation and relationships within the context of their caregiver(s). The third level indicates that babies, children, and their families have mental health or behavioral issues that need specific treatment. Many evidence-based interventions are now available when significant intervention is necessary.

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Application of these three levels of intervention to intensive care assumes that professionals and hospital systems should provide care that prevents long-term social and emotional distress. (15) It assumes that all hospitalized babies and children will have safe, responsive, and nurturing care primarily provided by their family members and that the environments in which they receive care will be non-threatening and age-appropriate. Policies and procedures that minimize separation from their primary caregiver and strategies to minimize the effects of invasive procedures may be included in this level of prevention. Examples might be assuring comfortable accommodations for families to be with their baby; unrestricted access to be with their baby; assuring that painful procedures are minimized and/or that they have appropriate analgesia for painful and/or stressful procedures.

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The level of promotion, however, is likely to apply to most babies and infants in intensive care. Due to the nature of the unfamiliar hospital setting, potentially overwhelming sensory environments, separation from their family, and invasive caregiving procedures by non-primary caregivers are likely. These situations are also likely to be emergent and fast-paced, with little consideration of the potential for the baby to experience stressful and overwhelming traumatic events. Careful assessment of the baby's behavioral reaction to caregiving and their ability to use the help of the primary caregiver to regulate their responses appropriately is necessary. Specific strategies should be implemented to promote regulation and to assure positive interactions and relationships with their primary caregiver. At this level, the family members may also need significant support to interact positively with their baby. Examples of situations like these might be when babies have been in traumatic accidents and need immediate clinical approaches in order to provide stabilization. Another example might be if the

parent is separated from the baby for procedures and unable to regulate their behavior due to the cause of the baby's hospitalization. Application of infant and family-centered developmental care standards, competencies, and best practices guide how best to address many of these issues and thus promote more optimal immediate and long-term behavioral and developmental outcomes. https://nicudesign.nd.edu/nicu-care-standards/. (2, 3)

Treatment at the third level typically results from concerns of the professional staff or parent that the behavior of the baby and/or family is outside the expectations of the baby's age or condition. It also involves concerns about the parents' reactions to the intensive care situation. Examples include babies who cannot calm down and are irritable, regardless of typical calming strategies or those who become listless and "tuned out" and do not seem to be processing their experience appropriately for their age. Additional examples include parents needing third-level intervention when they exhibit extreme withdrawal, uncontrolled crying, anxiety, or difficulty managing their behavior. Mental health concerns should be addressed by a well-trained IMH professional with both baby and adult experience. Recommendations for mental health resources for parents are detailed in the Psychosocial Program Standards for NICU parents. (16, 17)

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What about the baby?

A typical question in IMH practice, particularly if interventions seem to be more focused on the caregivers or the system itself, is: "*What about the baby?".* Much mental health supports focus on the mental health of the parent/caregiver rather than understanding the baby's experience. When starting with the baby, it is easy to understand that they focus on intervention and guidance for the caregiving environment. (6, 18) Understanding the subtle nuances of behavior and reactivity of the baby guides an understanding of their development and capacity for relationship, which further guides intervention. (6, 19, 20, 21) This allows for reflection on the baby's experience and what they need for regulation and support for relationship development. Keeping the baby in mind throughout the hospitalization and providing opportunities to support the primary caregiver to reflect on the baby's experience is a critical intervention strategy in IMH. (18)

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Key elements for IMH practice in intensive care

The application of IMH practice highlights the necessity of addressing essential components of *regulation, relationships, and reflective practice*. (1) These three complementary practices are best visualized in Figure 2.

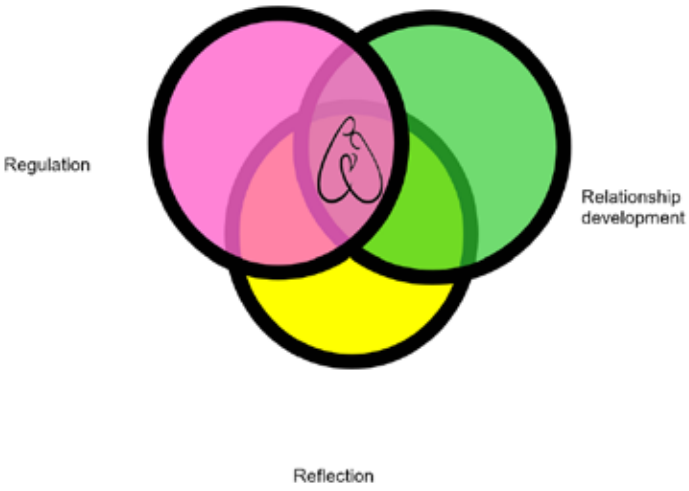

Figure 2

"Regulation" applies to the baby's ability to regulate their behavior with the support of the primary caregiver, typically the m(other). In utero, the fetus is provided regulation through the mother's body and physiology. For typical births, the m(other's) body continues to promote the regulatory environment for the baby's physiology, arousal, sleep states, and motor behaviors. For babies in intensive care, equipment, medication, and caregiving interventions often become the regulating or dysregulating environment as most babies are separated from the m(other), even if briefly. IMH practices, therefore, should focus on ensuring that the m(other) is physically and emotionally available as constantly as possible, and until that occurs, provision of support for regulation of the baby's behavior and physiology is essential.

Another essential aspect of IMH practice includes the provision of a nurturing environment that lays a foundation for *sound relationship development*. All social and emotional development begins in infancy and depends on the baby's feeling safe and secure and that the familiar m(other) can meet their needs and respond to their distress. Providing opportunities for close, intimate, and supportive face-to-face interactions with familiar caregivers continues the familiarity with the mother's body after birth and allows for feelings of safety and regulated behavior. Studies have shown that promoting emotional exchanges between the baby and the mother has both short- and long-term benefits. (22, 23, 24) As relationships are a two-way street, understanding and supporting the primary caregiver's ability to provide a nurturing exchange can also be a focus of IMH intervention. As primary caregivers have their background and stressful experiences, including being in intensive care and having potential mental health issues, providing physical, psychosocial, and emotional support is imperative. (17)

Reflecting on the baby's and caregiver's experience provides a foundation for both best practices and sensitizing professional staff to the potential challenges to the baby's regulatory capacity and relationship development. Studies of parental reflective capacity clearly indicate that the child's mental health can be significantly and positively impacted when the parent can reflect on the child's experience. Reflection leads to insight and sensitivity to what the baby's world may be like enhancing individualized caregiving. Reflection and a reflective stance are robust and evidence-based practices that can enhance professional interactions and evaluate the success of their interventions on the dyad. Reflective practice

in a busy, intensive care unit is challenging if not practiced regularly and valued by the unit leadership. Providing education and opportunities for reflection individually or in groups can benefit the professional and the professional's practice with babies and their families. (1, 6)

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Conclusion:

Applying IMH principles and practices in scientific and clinical settings allows for robust inquiry and practice. IMH definition, principles, scientific inquiry, and clinical application can be used in caring for all babies and families, including those whose lives begin in intensive care. (1, 5, 15) As a vital component of the IFCDC standards, competencies, and best practices for babies and families intensive care, IMH plays a significant complementary role. Application to intensive care should contribute to optimal outcomes for high-risk babies and their families. IMH approaches should be infused into all levels of care in hospital settings, particularly in intensive care, prevention, promotion, and treatment. The practice of IMH in intensive care should represent the key elements in support of physiologic and behavioral regulation, sound relationships with primary caregivers, and a reflective approach to caregiving.

References:

1. Browne JV. Infant mental health in intensive care: Laying a foundation for social, emotional and mental health outcomes through regulation, relationships and reflection. Journal of Neonatal Nursing. 2021;27(1):33-9.
2. Jaeger CB, Browne JV. The Science. In: Kenner C, McGrath JM, editors. Developmental Care of Newborns and Infants: A Guide for Health Professionals. Third ed: Wolters Kluwer; 2023. p. 1-17.
3. Jaeger CB, Browne JV. The infant and family-centered developmental care standards for babies in intensive care and their families. In: Kenner C, McGrath JM, editors. Developmental Care of Newborns and Infants: A Guide for Health Professionals. Philadelphia: Wolters Kluwer; 2023. p. 18-34.
4. Browne JV, Jaeger CB, Kenner C. Executive summary: standards, competencies, and recommended best practices for infant- and family-centered developmental care in the intensive care unit. Journal of perinatology: official journal of the California Perinatal Association. 2020;40(Suppl 1):5-10.
5. Givrad S, Hartzell G, Scala M. Promoting infant mental health in the neonatal intensive care unit (NICU): A review of nurturing factors and interventions for NICU infant-parent relationships. Early human development. 2021;154:105281.
6. Talmi A, Browne JV. Regulation, Relationships and Reflection: Developmental care in the NICU. In: Dempsey AG, Cole JCM, Saxton SN, editors. Behavioral Health Services with High-Risk Infants and Families: Meeting the Needs of Patients, Families, and Providers in Fetal, Neonatol Intensive Care Unit and Neonatal Follow-up Settings. New York: New York: Oxford University Press; 2022. p. 359-74.
7. Fraiberg S. The Magic years: Understanding and Handling the Problems of Early Childhood: Simon and Schuster; 1996. 303 p.
8. Winnicott DW. Primitive emotional development. Int J Psychoanal. 1945;26(3-4):137-43.
9. Winnicott DW. Babies and their Mothers. Reading, Massachusetts: Addison Wesley Publishind Co 1992.
10. Kanter J. The untold story of Clare and Donald Winnicott: How social work influenced modern psychoanalysis. Clinical Social Work Journal. 2000;28(3):245-61.
11. Shonkoff JP, Phillips DA, Committee on Integrating the Science of Early Childhood Development boC, Youth and Families. From Neurons to Neighborhoods: The Science of Early Childhood Development. New York National Academies Press; 2000. 612 p.
12. De Haan M, Gunnar MR. Handbook of developmental social neuroscience: Guilford Press; 2009.
13. Three Zt. Definition of infant mental health [www.zerotothree.org.]. Arlington, VA,: Zero to Three; 2001
14. Zeanah CH. Infant Mental Health: The Science of Early Experience. In: Zeanah CH, editor. Handbook of Infant Mental Health Fourth Edition. New York: New York: The Guilford Press; 2019. p. 5-24.
15. Browne JV, Talmi A. Reflections on infant mental health practice, policy, settings, and systems for fragile infants and their families from prenatal and intensive care through the transition home and to community. Newborn and Infant Nursing Reviews. 2016;4(16):255-7.
16. Hynan MT, Hall SL. Psychosocial program standards for NICU parents. Journal of perinatology: official journal of the California Perinatal Association. 2015;35 Suppl 1:S1-4.
17. Talmi A, Harmon RJ. Relationships between preterm infants and their parents. Zero to Three. 2003;24(2):13-20.
18. Weatherston D, Browne JV. What is Infant Mental Health and why is it important for high-risk infants and their families? Newborn and Infant Nursing Reviews. 2016.
19. Als H. Reading the premature infant. In: Goldson E, editor. Nurturing the premature infant: developmental interventions in the neonatal intensive care nursery. New York: Oxford University Press; 1999. p. 18-85.
20. Als H, Butler S, Kosta S, McAnulty G. The Assessment of Preterm Infants' Behavior (APIB): furthering the understanding and measurement of neurodevelopmental competence in preterm and full-term infants. Mental retardation and developmental disabilities research reviews. 2005;11(1):94-102.
21. Als H, Duffy FH. The Behavior of the Premature Infant. In: Brazelton TB, Lester BM, editors. New Approaches to Developmental Screening of Infants. New York, NY: Elsevier Science Publishing Co., Inc.; 1983. p. 153-73.
22. Welch MG, Myers MM. Advances in family-based interven-

tions in the neonatal ICU. Curr Opin Pediatr. 2016;28(2):163-9.

23. Bergman NJ, Ludwig RJ, Westrup B, Welch MG. Nurture-science versus neuroscience: A case for rethinking perinatal mother-infant behaviors and relationship. Birth Defects Res. 2019;111(15):1110-27.

24. Porges SW, Davila MI, Lewis GF, Kolacz J, Okonmah-Obazee S, Hane AA, et al. Autonomic regulation of preterm infants is enhanced by Family Nurture Intervention. Developmental psychobiology. 2019;61(6):942-52.

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