Peer Reviewed

Mental Health Services for Caregivers of Premature Infants

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Introduction:

Globally, there are approximately 15 million preterm births annually (1), with almost 400,000 occurring in the U.S. The increase in preterm newborns continues to be a public health challenge. Preterm births, defined as birth before 37 weeks, continue to be the leading cause of morbidity and mortality (2). The focus of infant research is the reduction of preterm births, although the number of overall preterm births has not decreased. In 2021, the Centers for Disease Control and Prevention (CDC) reported that preterm births rose by 4%, with one in ten pregnancies classified as preterm (3). Moreover, when considering racial, ethnic, and social disparities, preterm births remain stagnant as Black Women account for 14.4% of all births, 50% higher than both White and Hispanic births (3).

Twenty percent of pregnant women will experience some form of adverse mental health outcome while caring for their babies (4). Along with preterm birth outcomes, there is considerable concern for the mental health and wellness of pregnant persons. The physical health of the infant and pregnant person is often prioritized in healthcare settings at the expense of the pregnant person's current and long-term mental well-being. With the current maternal mortality rate at 32.9 per 100,000 births and infant mortality at 5.4 per 1,000 per live births, it is not surprising that imminent health needs are paramount (3). Moreover, for minority populations, infant mortality remains the highest at 69.9 for Blacks and 28.0 for Hispanics (3). Although evidence supports health disparity in prematurity and mortality rates, both the physical and mental health concerns must be prioritized in maternal child health.

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Mental Health Needs of Caregivers:

Caregivers of premature newborns are more vulnerable to adverse mental health outcomes. These pregnant persons often suffer from anxiety, postpartum depression, post-traumatic stress disorder, and obsessive-compulsive disorder (4, 5). If not assessed and targeted early in the perinatal period, the mother/infant bonding period is compromised (5, 6). In addition, the cognitive development of newborns is compromised when pregnant persons suffer from mental/behavioral health challenges (5). Maternal mental/behavioral health challenges impact the entire family system. Maternal mental health challenges can pervasively impact the system, including the marital relationship, other children, and extended family (7).

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Caregivers of premature infants have higher levels of stress and have unmet needs. In a study, pregnant persons reported that their mental health needs were not effectively addressed (1). Mental health services are identified as taking place during the antepartum period and consisting only of postpartum depression screens (1). There are opportunities to assess and screen significantly earlier in the perinatal period, allowing customized, comprehensive mental health treatment and services.

Unique Needs of Women of Color:

The preterm birth rate for Black women is 50% higher compared to both White and Hispanic pregnant persons (3). The premature birth rate for Black women is attributed to long-standing racial discrimination (2, 8). Though the risk of mental health issues is high for all pregnant persons who give birth to premature newborns, studies have shown that women of color, particu-

larly Black women, are at higher risk (8). Black women do not receive adequate mental health services that are culturally sensitive. Healthcare policies and practices must focus on cultural biases and racism. Black pregnant persons report feeling invisible and misunderstood by providers and hospital staff. The "one size fits all '' health care model undercuts the multiple socio-cultural layers that affect Black pregnant persons (8). These types of experiences worsen mental health outcomes. More research is needed to explore the health care and mental health care needs of Black pregnant persons.

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Reflections of a Mother:

As a woman of color who gave birth to late preterm (35 weeks) twins during COVID-19, I can attest to the necessity of ongoing dialogue around mental health services for mothers. Though my children were fortunate not to have any major medical complications, both my genetics specialist and obstetrician used each perinatal appointment to prepare me for the possibility of a newborn intensive care unit (NICU) admission due to premature birth. Though I was given adequate information regarding the best and worst scenarios concerning the health outcomes of my twins, my anxiety increased with mood swings fluctuating from anxious to depressed with constant, ongoing hypervigilance. These mental health needs were not addressed. I was clear that being a woman of color placed me at higher, elevated health risks and adverse maternal health outcomes; however, I was not aware or prepared for the mental health toll during and after my pregnancy.

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Interactions with healthcare providers were not ideal and further contributed to mental health challenges. Though I would voice my desire to carry my pregnancy to at least 35 weeks, I was told it was impossible due to my dynamic cervix. Early in my second trimester, I requested to be placed on bed rest; however, I was told I "was fine." Since my husband was not permitted to attend my appointments due to COVID-19 health regulations, I requested that he attend virtually via Facetime. This request was met with resistance even though his support would have benefited my mental health. My husband would try to discuss my mental health challenges and voice his own concerns, but his concerns were also ignored.

These instances often made me feel alone and that I had no autonomy over my pregnancy or my body. The lack of cultural sensitivity I encountered only heightened my fear and frustration. I, too, felt unheard, particularly when advocating for the mental health services I needed. Moreover, the lack of provider engagement after giving birth and at discharge left me anxious and concerned about my ability to effectively parent premature infant twins who were both under five pounds.

Conclusion:

The patient and health care provider relationship holds a vital key to shifting maternal mental health care services. Researchers propose using collaborative models when discussing mental health interventions to alleviate maternal stress (5). Furthermore, a host of perinatal mental health screening can detect other perinatal conditions outside of depression. Ongoing maternal health care assessments and interventions should not be limited to the hospital setting or discharge. Instead, the discharge plan should include follow-up reassessments and interventions to promote the continuity of care and progress.

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As premature births continue to remain on the rise, adequate maternal mental health interventions are vital to the healthy development of newborns and serve an essential role in supporting pregnant persons during the perinatal period. When supporting the mental health of persons of color, health providers are tasked to create meaningful bonds for pregnant persons by listening, validating concerns and fears, and encouraging full family support. To help decrease stigma and increase mental health awareness, culturally relevant community education about perinatal mental health concerns and their impact on the perinatal postpartum (9).

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Disclosures: *There are no reported disclosures.*

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