

*Full-Length Article***Trauma Informed Care in the NICU: Implications for Parents and Staff**Mary Coughlin McNeil¹¹*Caring Essentials Collaborative, LLC, Boston, MA, United States of America***Abstract**

Neonatal intensive care has dramatically improved the survival of the tiniest infants born at the cusp of viability in addition to meeting the medical and surgical needs of infants born with an array of conditions that pose a life threat to the newborn. Despite advances in technology, however, neonatal intensive care unit (NICU) survivors experience a myriad of physical, behavioral and developmental challenges once they are discharged. Most recently a trauma-informed care paradigm [1] for neonatal intensive care has been introduced to mitigate and minimize many post NICU infant morbidities. It is clear, that trauma-informed care makes sense for the infant who finds them self in a life-threatening situation at birth, however, the implications for this paradigm extend beyond the infant.

The purpose of this paper is to examine the implications of a trauma-informed paradigm in the NICU for parents and clinicians.

Keywords: *Trauma, Parents, Staff, NICU*multilingual abstract | mmd.iammonline.com

“The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk on water without getting wet. This sort of denial is no small matter”[2]

Introduction

The concept of trauma and traumatic stress emerged in the field of mental health over forty years ago [3] and is a widespread public health concern. The paradigm of trauma-informed care acknowledges that trauma and traumatic stress overwhelm an individual’s ability to cope while simultaneously changing their biology with both short term and lifelong implications for health and wellbeing. The Substance Abuse and Mental Health Services Administration

(SAMHSA) was the first to implement a trauma-informed care framework. Acknowledging that a single definition of trauma underserves the complexities and nuances of the lived experience of trauma, SAMHSA conceptualizes trauma as an event or a series of events experienced by an individual as physically or emotionally harmful or life-threatening that results in lasting adverse effects on the individual’s health and wellness mentally, physically, socially, emotionally, and/or spiritually [4,5]. A trauma-informed approach then *realizes* the impact of trauma on the individual, *recognizes* signs and symptoms of trauma and *responds* by integrating knowledge about trauma and it’s adverse consequences into policies, procedures and practices to support the individual while actively *resisting re-traumatization* [4,5].

Trauma-informed Care in the NICU*The parents*

Trauma-informed care has recently been introduced as a biologically relevant paradigm for the neonatal intensive care unit (NICU) [6]. Infants who begin early life in the medicalized environment of the neonatal intensive care unit experience disruption to numerous fundamental expected

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experiences that are requisite for optimal human development primarily parental proximity and presence both physically and emotionally [7]. However, the trauma does not end there, parents of infants requiring intensive care are at a higher risk of experiencing mental health challenges as a result of their NICU encounter, to include depression, acute stress disorder, and post-traumatic stress disorder [8-10]. The percentage of NICU parents who met diagnostic criteria for Acute Stress Disorder (ASD) ranged between 24% to 28% [11-14]. In a systematic review investigating the traumatic stress response of parents of children diagnosed with serious illness, psychosocial factors rather than medical factors predicted the extent of parental distress [15]. Examples of psychosocial factors included previous experiences with stressful life events or trauma, parental perception of their infant's severity of illness, and parent trait anxiety and depressive symptoms contributed to their susceptibility of acute and posttraumatic stress symptoms [15].

Parental mental health plays a crucial role in optimizing infant developmental outcomes. As the infant needs parental contact for optimal physiological and psychoemotional development, the parents also need a meaningful relationship with their infant to establish their role identity as parents [1]. Trauma-informed, family centered care in the NICU is a commitment to protect and preserve the integrity of the family in crisis as well as mitigating the allostatic load of the at-risk infant in the NICU [16,17].

Becoming a family is a defining moment in human history, and how we show up to these critical moments define us!

NICU clinicians must be competent in recognizing signs and symptoms of emotional distress, postpartum depression, and acute stress disorder in parents and families to ensure that appropriate processes and referrals are in place to effectively support families through the trauma of NICU hospitalization [18]. However, this can only be accomplished by being fully present to the human needs of infant-family dyad which can often be a challenge in a technologically oriented environment with multiple competing priorities. Strategies to minimize parental emotional distress during NICU hospitalization emanate from our ability to be compassionate and empathize with the lived experience of other; to create human

connections and partnerships with the parent and family that translate into authentic healing intention [19].

Parents often struggle with their role identity, and the stress of parenting in the NICU has been correlated with clinically significant anxiety, fatigue, depression, and sleep disturbances [20,21].

Educating parents and providing opportunities for them to apply their new infant care knowledge in a controlled, simulated setting ensures infant safety and promotes parent confidence [22,23]. Competence and confidence in caring for their infant validates parental role identity, increases parental presence and participation in parent-exclusive activities, facilitates a safe discharge to home, and foster infant-parent attunement and attachment [22,24].

The physical layout of the NICU as well as the clinical routines impact parent access to, and participation in, the care of their critically ill infant [25,26]. Potentially, better practices in family-centered care include the full participation of parents in the care of their hospitalized infant which demands a global change in the culture and behavior of the interdisciplinary team to acknowledge the crucial role of the parent and family in the NICU [27-29].

The Staff

Bearing witness to the suffering of others underpins the work of neonatal intensive care. All disciplines should engage in healing relationships with patients and families during their time of potentially extreme vulnerability, sadness, and fear, "our consciousness, our intentionality, our presence, makes a difference for better or for worse" [30]. When clinicians are unable to be present or turn away from the lived reality of the patient, moral responsibility is abandoned, and quality care and patient safety are undermined [31,32].

Patients depend on and trust that health care professionals will ease their suffering and provide ethically sensitive care consistently and reliably. The clinician-patient relationship is a sacred trust and is the cornerstone of professional clinical practice [6].

Providing emotionally supportive tendering is an acknowledged and vital aspect of caring in the NICU but may be hindered by a deficit of knowledge about effective, emotionally supportive counseling strategies for NICU parents which is confounded by competing priorities in the

NICU's high-tech environment [33-35]. The work of neonatal professionals is both physically and emotionally demanding as well as morally and ethically challenging. Issues surrounding end-of-life care, futile aggressive care, potential patient harms, pain and suffering, depersonalization of patients, care and cost constraints, inadequate staffing, and working with incompetent colleagues have all been associated with moral distress (a precursor to clinician burnout) for nurses, physicians, and allied health professionals [37-44].

Self-care practices are those self-initiated routines and rituals aimed at restoring and rebalancing one's self off-duty and on-duty. On-duty self-care practices include developing professional autonomy, acknowledging colleagues, collaborating with the interprofessional team, and making sure you take your coffee and meal breaks [6]. Personal self-care practices include sleep, diet, and exercise, as well as self-compassion interventions (e.g., yoga, mindfulness meditation). For health care professionals, sleep and fatigue play a critical role in clinical performance, safety, vulnerability to psychological distress and burnout as well as increasing susceptibility to altered health outcomes (i.e., hypertension, coronary heart disease, metabolic syndrome, obesity, and motor vehicle accidents) [45-47].

Summary

Optimal Healing Environments 'make healing as important as curing' supporting self-care practices across internal, interpersonal, behavioral, and external domains for all who inhabit the space [48]. Adopting a trauma-informed paradigm for the NICU creates a healing milieu that *realizes* the widespread impact of trauma, *recognizes* its symptoms, *responds* by translating knowledge into practice, and actively *resists re-traumatization* for the infant, the parent and the professional! [5]

"At the heart of the work is caring, a desire to make a difference in the lives of others, to *be with* and bear witness to others—the authenticity of the caring relationship restores the clinician as well as the patient and must be protected, nurtured, respected, and honored at the individual and organizational level to diffuse and decrease the psychological and emotional distress associated with the complex world of neonatal intensive care" [6].

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