



NEONATAL UNIT



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IMAGINE if you will...

BABY JOE

- Born at 27 weeks at RWH
- No anti-natal diagnosis
- Emergency C-section due to foetal distress
- Complications at birth & baby requiring resuscitation
- Upon stabilising baby is transferred to RCH Neonatal Unit



NEONATAL UNIT

The NICU stay is characterised by an environment that potentially hinders or alters normal infant development with frequent and prolonged exposure to multiple stressors such as painful and noxious stimuli including surgery, and other invasive procedures, periods of profound analgesia and sedation, and geographic and emotional isolation from parents and family.



NEONATAL ADMISSION

- The admission of an infant to neonatal intensive care has been acknowledged as a considerable source of parental anxiety (Miles and Holditch, 1997).
- Many factors are at play, including potentially unexpected pregnancy outcome, parent-infant separation, hospitalisation-related stressors, and the physical and behavioural characteristics of the infant. Uncertainty about the infant's condition and prognosis, and separation can result in parents feeling a loss of control, and the disruption of the attachment process (Miles et al., 1993).



The Use of Critical Incident Debriefing with parents with infants in the Neonatal Unit who have experience an unexpected traumatic event at/or shortly after delivery.....WHY?****



BACKGROUND

- Infant postnatal illness and/or maternal traumatic birth experience may be related to maternal PND and PTSD.
- Mothers with a traumatic birth experience report more difficulty coping with decision-making/processing of information in relation to a Neonatal admission.
- Little research on evidence based interventions to support mothers with unexpected traumatic event at/or shortly after delivery.
- PND and PTSD are likely to have a negative impact on mother-infant attachment, bonding and interaction.
- A Neonatal admission can have significant repercussions on the developing relationship between parents and baby.
- Enhanced interventions could be developed/implemented if clinicians were able to identify at risk mothers of PND/PTSD.
- The use of critical incident stress debriefing [CISD] is a well researched treatment model for trauma.



AIM OF STUDY

To trial the use of CISD to promote parental well being of Neonatal families and to facilitate the attachment relationship between parent/s and baby.

Anticipated benefits:

- ❖ Promote parental well being.
- ❖ To decrease the stress and trauma experienced by parents.
- ❖ Psychosocial education of parents
- ❖ Exploration and development of parents' relationship with baby.
- ❖ Engendering a sense of empowerment.



METHOD

- **A qualitative pilot study to determine the usefulness of CISD in preventing/reducing the psychological distress experienced by parents who have had a traumatic delivery experience alongside their baby's admission to a Neonatal Unit.**

Sample:-

- 15 mothers – 6 couples and 9 mothers without partners.
- Parents were selected according to their clinical presentation, they either self identified or identified via Neonatal staff.

Inclusion criteria breakdown:

- Unexpected deliveries resulting in Neonatal admission – N=7
- Traumatic/perceived traumatic event on Neonatal – N=3
- Traumatic event occurred after birth resulting in Neonatal admission – N=3
- Post withdrawal of intensive care discussion – N=2

Intervention Model:

- The Neonatal Social Worker met with each of the 9 mothers and 6 couples twice for up to 1 hour within the first 2 to 5 days of the Neonatal admission.
- Parent/s were seen in an interview room away from the bedside/baby.



Critical Incident Stress Debriefing Interview

<i>Introductory phase</i>	Introduction of concept of debriefing relating to delivery experience.
<i>Fact phase</i>	Parent/s narrative encouraged relating to what they saw, heard, smelt, felt and did.
<i>Thoughts phase</i>	Exploration of parent/s initial thoughts relating to event.
<i>Feelings phase</i>	Exploration of parent/s emotional responses to the event/narrative.
<i>Assessment phase</i>	Exploration of symptoms either physical/psychological relating to event/presentation.
<i>Education phase</i>	Psychosocial education of parent/s in relation to coping strategies and identifying triggers.



FINDINGS

- It was particularly pertinent for mothers, in particular, to have an opportunity to talk about their delivery experience, what their hopes/expectations had been and what their perceived reality was.
- It was evident that the parent/s had very vivid memories relating to nearly all bodily senses, these include sight, smell, sound and touch, when relaying their story.
- **CISD appeared to provide couples with an opportunity to hear the delivery experience from each others perspective and often a more complete narrative was formulated when both couples were involved.**
- It allowed the initial phases of some grief work to be performed in relation to the delivery trauma and associated losses following the admission.
- After two consecutive sessions, parent/s appeared to be more available to engage in the Neonatal admission of their baby in terms of decision making and meeting daily care needs of their baby.



IMPLICATIONS FOR PRACTICE

- Practical suggestions include assessing the risk of PTSD/PND in relation to birth trauma via screening tools for trauma stress symptoms.
- Further investigation/research is required in relation to the use of CISD when there has been a traumatic delivery.
- CISD likely to be most powerful in the Neonatal setting when used alongside things like kangaroo care [when appropriate], encouraging daily care contact, orientation to Neonatal, education relation to PTSD/PND.
- It is important to identify parents at risk of PTSD/PND when a Neonatal admission occurs.
- Psychosocial education of parents in relation to coping strategies, identifying triggers, risk factors/symptoms of PND/PTSD is paramount.
- Further research is needed into the impact of birth trauma and PTSD/PND and the possible question of co-morbidity.