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A Nurse-Based Model of Psychosocial Support for Emotionally Distressed Mothers of Newborns in the NICU

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ABSTRACT

Mothers whose newborns are hospitalized in the NICU are frequently emotionally distressed, particularly early in the hospitalization. The Family-Centered Developmental Care philosophy, widely adopted by NICUs, calls for an expanded focus on the well-being of the entire family. In this article, we describe an innovative, nurse-delivered program for emotionally distressed mothers of newborns in the NICU that includes screening and an empirically supported counseling approach: Listening Visits.

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Depression and anxiety symptoms are prevalent among mothers of newborns hospitalized in the NICU. However, emotional distress is often not identified, and even when it is detected, mothers are not always able to access support. In alignment with the philosophy of Family Centered Developmental Care (FCDC; Gooding et al., 2011), which is widely adopted by NICU professionals, nurses are well positioned to identify distress through screening and to provide an empirically supported intervention called Listening Visits (LV) for those in need of such support. We describe how this nurse-based model of psychosocial care was implemented within the context of a program of applied research and suggest how this model might eventually be implemented into routine clinical care within the NICU environment.

Background and Significance

Emotional Distress in Mothers of Hospitalized Newborns

The hospitalization of a newborn in a NICU is often stressful and may result in clinically significant levels of emotional distress among mothers. Focusing on the immediate postpartum period when a newborn is first hospitalized, two groups of researchers found that elevated anxiety and depression symptoms were prevalent in mothers (Holditch-Davis et al., 2015; Segre, McCabe, Chuffo-Siewert, & O'Hara, 2014). From their results, a third group of investigators suggested that these elevated depression and anxiety symptoms can be severe. Specifically, they found that early in the newborn hospitalization period, 35% of mothers reported symptoms that met the diagnostic criteria for Acute Distress Disorder (Lefkowitz, Baxt, & Evans, 2010). In addition, they found that 33% of these mothers experienced suicidal thoughts compared with 14% of perinatal women in the general population who report such ideation (Lindahl, Pearson, & Colpe, 2005). Moreover, the depression symptoms can endure. In one longitudinal assessment of mothers whose newborns were hospitalized in the NICU, researchers found that without treatment, at just over 1 year after the birth, 21% ($n = 102$) still reported clinically significant levels of depression symptoms (Miles, Holditch-Davis, Schwartz, & Scher, 2007). Finally, in studies that included a comparison group of mothers of nonhospitalized, term newborns, researchers found that mothers of hospitalized newborns reported significantly more clinically significant symptoms of anxiety and depression (Brandon et al., 2011; Vanderbilt, Bushley, Young, & Frank, 2009).

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Current NICU Psychosocial Care

In the NICU, standard care includes maternal depression screening with as-needed referrals to mental health professionals, usually without follow-up. In suboptimum care, depression symptoms are not assessed, perhaps because emphasis is placed on the hospitalized newborn. Even when clinically significant depression symptoms are identified, barriers such as social stigma and cost (Dennis & Chung-Lee, 2006) prevent most perinatal women from receiving treatment (Marcus, Flynn, Blow, & Barry, 2003). Because mothers are often busy visiting their newborns in the NICU, lack of time may be an additional barrier to seeking care.

In two small trials, researchers evaluated interventions for emotionally distressed mothers of hospitalized newborns and reported significant reduction of depression symptoms when treatment was delivered by a psychologist (Jotzo & Poets, 2005) or a care manager (Meyer et al., 1994). Although such interventions are valuable, the social stigma sometimes associated with seeing a mental health professional may prevent some mothers from accessing this form of care. In one model of care, FCDC, the entire family is emphasized, not just the infant (Gooding et al., 2011). The expansion of a nurse's role in the NICU to include screening for emotional distress and providing support adds a tangible means to implement this philosophy.

Many integrated models have been developed for selected health care systems, but the United Kingdom provides a unique example of postpartum services. As part of the United Kingdom's universal health surveillance, all new mothers receive home visits within the first 10 days after birth from a public health nurse, called a *health visitor* (Holden, 1996). During this routine care, health visitors attend to the psychological well-being of the mother.

The UK Model of Integrated Psychosocial Care

In the early 1980s, a British nurse/psychiatrist team developed The Edinburgh Postnatal Depression Screening Scale (EPDS), a 10-item scale used to assess depression symptoms (Cox, Holden, & Sagovsky, 1987). Today, the EPDS is used by clinicians and researchers worldwide to screen for depression symptoms in women of childbearing age (Cox, Holden, & Henshaw, 2014). In addition, this nurse/psychiatrist team also developed and validated LV, a first-line depression treatment approach expressly for use by health visitors (Holden, Sagovsky, & Cox, 1989). The LV intervention consists of six 50-minute sessions delivered by a nurse who has completed LV training and has a bachelor's degree or greater. Key components of LV, which are described fully elsewhere (Chuffo Siewert, Cline, & Segre, 2015), include active listening and collaborative problem solving. These techniques are used to gather a genuine understanding of a woman's experiences and perspective in the postpartum period. The LV intervention is nondirective, so the focus of each session is decided by the woman herself, not the nurse. In general, a single LV session includes a greeting, debriefing about the previous visit, updates on present issues, discussion of current concerns, a summary, and scheduling the next visit or concluding the visits (Chuffo Siewert et al., 2015).

In the United Kingdom, considerable empirical support garnered through several randomized controlled trials (Cooper, Murray, Wilson, & Romaniuk, 2003; Holden et al., 1989; Morrell et al., 2009; Wickberg & Hwang, 1996) prompted the National Institute of Clinical Excellence to recommend LV as an evidence-based treatment for mild to moderate postnatal depression (British Psychological Society, 2007). In a program of research directed by the second author, LV was imported to the Midwestern United States and proved to be a feasible way to deliver a first-line depression treatment approach to low-income mothers who receive home visiting services (Segre, Stasik, O'Hara, & Arndt, 2010). Subsequently, this group of researchers conducted a randomized controlled trial and found that LV significantly reduced depression and improved perceived quality of life compared with home visiting services or routine prenatal services (Segre, Brock, & O'Hara, 2015).

LV in the NICU: Implementation and Evaluation

The novel idea to implement LV in the NICU was proposed by the first author, an advanced practice NICU nurse who recognized that the emotional needs of mothers of hospitalized

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