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Interdisciplinary Recommendations for Psychosocial Support of NICU Parents

Developed by

The Workgroup for Psychosocial Support of NICU Parents

(Convened by the National Perinatal Association)

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Recommendations for peer-to-peer support for NICU parents

1. Every parent of every baby admitted to a Special Care Nursery or NICU should be offered peer support from a “veteran” NICU parent mentor during their baby’s hospital stay. Ideally this would be a part of a NICU’s comprehensive family support program.
2. While in-person peer support during the baby’s hospital stay may be viewed as best practice, peer support can be offered to parents in a variety of different ways including email or phone support, group support, or through an online community support site for NICU families.
3. Peer support in any form is best started in the antepartum period when appropriate (as when mothers hospitalized during the antepartum period), continued through the baby’s NICU stay, as well as after baby’s discharge from the NICU. Having a consistent peer mentor throughout a NICU parent’s journey may be desirable.
4. Parents whose baby expires should be offered the opportunity to be paired with a bereavement mentor who has also experienced a neonatal loss.
5. Peer support is one element of a comprehensive family support program. Other elements should include:
 - a. An institutional and administrative champion for peer and family support;
 - b. A facilitator/coordinator which could be:
 - i. A hospital employee (psychologist, social worker, nurse, chaplain, physician),
 - ii. A trained parent and/or family support specialist,
 - iii. A former NICU parent or volunteer from one of the many non-profit peer-to-peer parent support organizations across the country;

- c. A menu of types of support available (individual and/or group in-person support, email, phone, and online support);
 - d. Parent education classes and written materials, as well as social activities;
 - e. Staff education to promote understanding of NICU families' psychosocial needs, family-centered care practices, and methods of communicating and providing support (see "Recommendations for enhancing psychosocial support of NICU parents through staff education and support," this document).
6. Any family support program that utilizes peer volunteers should provide training to the volunteers to ensure they are capable of carrying out the peer support role in a responsible and culturally sensitive way that is fully compliant with both HIPPA regulations and hospital policies.
 7. In NICUs without the resources to develop a local and comprehensive family support program of their own, parents should be referred to regional or national parent support organizations that have been evaluated by their NICU staff. Resources for parent support can be found at websites of the following organizations: the National Perinatal Association's Family Advocacy Network,¹ the Preemie Parent Alliance,² the March of Dimes,³ the Canadian Premature Babies Foundation,⁴ and the European Foundation for the Care of Newborn Infants.⁵
 8. Peer support organizations working with NICU families should consider offering support services to members of the baby's family including siblings, grandparents, and others, as needed and desired.

Recommendations for involving the family in developmental care of the NICU baby

A. Recommendations for supporting parents' roles as caregivers of their babies in the NICU:

1. Parents should be incorporated as full participatory, essential, healing partners within the NICU caregiving team. As partners within the medical team, parents should:
 - a. Assume the parental role through provision of hands-on care to their baby including early, frequent and prolonged skin-to-skin contact as is medically appropriate, with coaching, guidance and support from the NICU staff;
 - b. Participate in both medical rounds and nursing shift change reports;
 - c. Honor both HIPPA and safety concerns while in the NICU; and
 - d. Have full access and input to both written and electronic medical records.
2. Parents and family members should be supported to engage in developmentally appropriate care in order to become competent caregivers and advocates for the neuroprotection of their babies. Components of parent support should include guidance on how to:
 - a. Provide comfort and security through consistency of their presence for their baby whenever possible;
 - b. Understand the behavioral communication of their baby so as to best interpret and respond to the baby's needs;
 - c. Create and sustain a healing environment with respect to sensory exposures and experiences;

- d. Provide supportive positioning and handling for their baby, including supportive oral feeding experiences, skin-to-skin contact (kangaroo care) and infant touch;
- e. Collaborate with NICU staff to minimize their baby's stress and pain in the developmentally-unexpected environment of the NICU;
- f. Safeguard their baby's sleep, recognizing the importance of sleep to healing, growth and brain development;
- g. Optimize their baby's nutrition with breast milk and breastfeeding whenever possible; and
- h. Protect their baby's skin and its many functions, including its role as a conduit of neurosensory information to the brain.

B. Recommendations for staff participation in family-centered developmental care:

1. A culturally appropriate and warm welcome for families should accompany the admission of each NICU baby. Basic introductory resources written in the primary language should be provided and continued throughout their NICU stay. When parents are able to be with their baby, the following should be reviewed with them: hand hygiene practices, staff roles and simple explanations of equipment. However, *before* medical equipment is explained, the focus should be on promoting baby-parent interaction. Emphasis should be placed on the critical importance of the parents' presence to the short- and long-term outcomes of their babies, and parents should be assured of unlimited, around-the-clock information and access to their baby.
2. Staff should be educated on principles and methods of implementing family-centered developmental care, including the above topics in "supporting parents' roles" #2.
3. Staff communications with parents and families should be regular, understandable (free of medical jargon), personalized, consistent and carried out in a culturally proficient manner. The quality of staff communication with parents and families, as provided by every member of the care team, is key to ensure success of family-centered developmental care.

C. Recommendations for NICU policy to support family-centered developmental care:

1. A policy of unlimited, open access for parents should ensure around-the-clock information and access to their baby, including medical rounds and nursing shift changes. Parents should not be viewed or referred to as "visitors", but rather part of the care team.
2. Clear policies and procedures should promote the participation of parents' support system; including the baby's siblings, grandparents, extended family and parents' friends, recognizing the importance of their involvement to the family's well-being.
3. Support to the family should begin whenever maternal or fetal conditions and diagnoses are identified that could lead to a NICU stay. This support should include an antenatal consultation with the NICU healthcare team, including the developmental specialist or neonatal therapists (OT, PT, SLP), as well as an anticipatory lactation consultation.
4. Optimal family support in the NICU should include provision of:

- a. Tangible resources; such as a family lounge, sleeping rooms, showers, laundry, kitchen, computers, and a family room in which to practice caring for the baby prior to discharge. Learning materials about infant development and care practices should be created in understandable language and provided in either written or digital form (in the form of videos or apps), as parents may desire;
 - b. Psychosocial support for parents from every professional group providing care in the NICU including the neonatologists, nurse practitioners and nurses, social workers, psychologists, neonatal therapists/developmental specialists (OT, PT, SLP), lactation consultants, hospital chaplains, and the palliative care team;
 - c. Expanded family support inclusive of grandparents and siblings, as well as childcare while parents are caring for their baby in the NICU;
 - d. Peer-to-peer support (see also “Recommendations for peer-to-peer support for NICU parents,” this document); and
 - e. Referrals to resources within the community; such as mental health services, smoking cessation resources and services for parents who may have inadequate housing, transportation, food or clothing, as facilitated by the perinatal social worker or other staff members.
5. In the case of a baby’s death, an interdisciplinary palliative care and bereavement team should provide services to support the baby’s parents and extended family (see “Recommendations for palliative and bereavement care in the NICU,” this document).
 6. Preparing for the transition from the NICU to home should begin at the time of the baby’s admission (see “NICU discharge planning and beyond: recommendations for parent psychosocial support,” this document). Parents should be provided with:
 - a. Anticipatory guidance and education about criteria for discharge;
 - b. Education about Back-to-Sleep and Shaken Baby Syndrome and other issues related to baby’s safety;
 - c. Opportunities to develop competence and self-efficacy in the care practices needed for their baby at home;
 - d. Follow-up resources including referral appointments to appropriate care providers which may include home nursing visits, developmental care specialists (OT, PT, SLP) and breastfeeding support; and
 - e. An assessment of their social support system, their risk for postpartum depression or other emotional distress and the safety of their home environment as needed.
 7. Quality improvement projects on FCDC should become an integral part of the care provided.
 8. Hospital committee structure and NICU policy development should include family advocates as regular members.

Recommendations for mental health professionals in the NICU (NMHPs)

A. General recommendations:

1. All NICUs with 20 or more beds shall have at least one full-time masters' level social worker and one full-time or part-time doctoral level psychologist embedded in the NICU staff. NICUs should also consider having full-time or part time psychiatrists and psychiatric nurses on staff. Larger NICUs should have proportionally more NMHPs on staff.
2. All NICUs should provide at least one comfortable area for group discussions among parents (e.g., parent lounge) and one comfortable room per 20 beds for confidential discussions between NICU families and NMHPs.
3. The "Standards for Social Work Services in the NICU" of the National Association for Perinatal Social Workers (NAPSW) are endorsed, along with the NAPSW standards for social workers regarding postpartum depression and perinatal bereavement.
4. The roles of social work and psychology can overlap regarding activities such as counseling, screening, providing staff education and teaching parenting skills.
5. Procurement of benefits and services for families from outside agencies should continue to be one of the roles of social workers. Social workers, psychologists and psychiatric staff should have dedicated time to provide verbal therapeutic support to all parents and family members.
6. Roles of psychologists, psychiatric staff or advanced clinical social workers (when within the scope of their credentials) can include:
 - a. Conducting research in the following areas:
 - i. Use of assessment devices, test interpretation and outcome evaluation.
 - ii. Identifying risk for the development of psychological disorders in NICU parents.
 - iii. Parent-infant attachment and therapy.
 - iv. The effects of parental emotional distress on both the parent-child relationship, the parental couple and the long term outcomes of the child (both physical and emotional).
 - b. Providing the following clinical services for families:
 - i. Assessments, test interpretation, and outcome evaluation.
 - ii. Differential diagnoses of psychiatric disorders and recognition of sub-clinical symptoms.
 - iii. A variety of treatment approaches; including interpersonal therapy, short-term dynamic therapy, cognitive therapy, behavior therapy, couples and family therapy, mindfulness training and infant mental health.
 - c. Educating NICU staff about both the centrality of the parent dyad-infant relationship in all interactions and communicating with families who are a) guilt and shame-ridden, b) distressed and angry, c) possibly struggling with substance abuse, d) bereaved and e) coping with prior traumas and perinatal losses including multiple trials of assisted reproductive technology and miscarriages.
7. Social workers, psychiatric staff and psychologists who work in NICUs should provide support to staff as well as to families (see "Recommendations for enhancing psychosocial support of NICU parents through staff education and support," this document). Supporting roles include acting as liaisons between staff and families along with direct educational support by discussions of family dynamics and family/staff interactions. These discussions should occur in a

variety of settings including rounds, case conferences, faculty meetings, debriefing sessions, etc. Such support is necessary to minimize and ameliorate burnout, compassion fatigue and secondary traumatic stress. Pastoral care staff can also be instrumental in providing this support.

B. Recommendations for layered levels of emotional support for NICU parents and families:

1. The family-centered NICU environment should include an active peer-to-peer support organization, ideally with a position for a paid parent support coordinator embedded in the NICU staff.
2. All NMHPs should strive to meet with all parents/caregivers to screen and identify parents at high risk for emotional disorders and those who with sub-clinical symptoms. Clinical judgment and a consideration of other risk factors should determine the outcome of a screen.
3. All NICUs with at least 40 beds should have parent education groups with a therapeutic orientation, which meet at least once a week. These groups should be led by NMHPs and should supplement any group meetings conducted by the parent-to-parent group.
4. All NICUs should have resources within the NICU and affiliated hospital and for caring for the 20-30% (or higher) of NICU parents likely to experience a diagnosable mental disorder. All NICUs should also have referral mechanisms in place for treatment outside of the hospital by social workers, psychologists, psychiatric nurses and psychiatrists.
5. Utilizing the NICU's standards of confidentiality, NMHPs should strive to communicate the identified mental health needs of parents/caregivers with the obstetric care provider and the family's primary care provider, pediatrician and other care providers.

C. Recommendations for screening in the NICU for emotional distress:

1. NMHPs should strive to meet with all parents/primary care-givers within 1-3 days of admission to establish a working relationship, normalize emotional distress, and evaluate risk factors for all forms of emotional distress. Hynan *et al.*⁶ reported a table of replicated predictors of elevated scores for PPD and PTSD. Whenever possible NMHPs should utilize standardized measures for evaluation. There are many validated screens for PPD and PTSD.⁶
2. Screening should be done within the first week (both mothers and fathers).
3. NICU parent/caregivers should be re-screened later: a) whenever deemed important and b) within 48 hours prior to discharge (for NICU stays greater than 1 week).
4. Screening methods can include any of the following (in order of complexity):
 - a. Quick screens for depression (2 questions)⁷ and PTSD (4 questions),⁸
 - b. Validated PPD and PTSD questionnaires,⁹⁻¹⁶
 - c. Inventories, such as the Psychological Assessment Tool-NICU,¹⁷ and

- d. Interviews, such as the Clinical Interview for Premature Parents (CLIP).^{18,19}
5. Positive screens at a less complex level should be followed-up with more complex screens.
6. Screening should be incorporated into the NICU procedures as quality assurance.
7. Screening should only be implemented if there is psychological treatment available either within the NICU or through outside referral.
8. Screening for emotional distress should be offered to parents returning with their babies for developmental follow-up visits.

D. Recommendations for telemedicine support:

1. Telemedicine can be used for both screening and treatment, potentially increasing accessibility for families in low resource settings.
2. Telemedicine services shall be conducted in accordance with accepted standards for training, providers' credentials, confidentiality and HIPPA compliance, as developed (for example) by The American Telemedicine Association. Teletherapy and screening for NICU parents should follow the guidelines of the American Psychological Association.
3. Many NICU parents utilize social media from Internet sites for both information and emotional support. NICU staff should familiarize themselves with web-based support sites to guide parents to reliable sources.

E. Recommendations for antenatal screening and support:

1. When a NICU stay is anticipated, parent support coordinators and NMHPs should initiate a relationship with the family before the birth to provide both emotional support and prenatal screening for emotional distress.

Recommendations for Palliative and Bereavement Care in the NICU

A. General recommendations:

1. Parents who lose a baby before, during, or shortly after birth, or later in the NICU should be offered:
 - a. Anticipatory guidance regarding the grieving process, including how mothers and fathers, and other family members, may grieve differently. This anticipatory guidance should begin antenatally if a life-limiting diagnosis has been determined.
 - b. Participation in bereavement rituals, including those that meet their spiritual, religious and cultural preferences. These rituals that may include a variety of practices and items that will help them remember their baby, such as provision of hand prints and foot prints, photographs, etc. Smooth communication should be facilitated between parents and the staff of the NICU and obstetric units throughout the dying process; a Master's level perinatal social worker or other designated person can assist with this.

- c. Psychosocial support for all members of the family, including but not limited to grandparents and the baby's siblings.
 - d. Peer-to-peer support and/or referral to community or internet support organizations (see "Recommendations for peer-to-peer support for NICU parents," in this document).
 - e. Counseling and/or counseling resources regarding both the physical and psychological considerations of attempting another pregnancy.
 - f. Post-hospital follow-up in a variety of forms, including individual contact by a staff member at various time periods as well as a conference four to six weeks after the baby's death to review autopsy and other results that will help parents understand what happened to their baby.
2. When intensive care will not be provided, a collaborative, interdisciplinary approach should be used to provide palliative care including bereavement care to any family whose fetus or neonate is facing a life-limiting condition or imminent death.
 3. Physicians and nurse practitioners should follow the guidelines outlined by the American Academy of Pediatrics when engaging in discussions with parents about whether to initiate or continue intensive care for a baby who may not survive; neonatal nurses and perinatal social workers should be included in the decision-making process as well. Intensive care should be provided only if it is believed that the baby will benefit from it. The best interests of the baby should be the guiding standard.
 4. In cases where there are disagreements between parents and the healthcare team when making end-of-life decisions, particularly around the futility of further care for a baby, a Bioethics consult should be obtained and/or the case presented to the hospital Bioethics Committee.
 5. Parents whose babies with life-limiting conditions survive to hospital discharge should be offered both practical and psychosocial support to help them prepare for discharge, learn how to care for their baby, and cope with their baby at home, and/or they should be referred to a hospice with experience caring for infants. Their baby's PCP, neonatal specialist, or medical home, and any subspecialists involved in their baby's care, should be fully involved in making and carrying out home care plans and providing follow-up support.

B. Parents anticipating a perinatal loss should be offered:

1. An antenatal interdisciplinary conference to develop the following plans, which should be individualized according to parents' desires and cultural, spiritual and religious beliefs:
 - a. A birth plan, which should include parents' preferences regarding the conduct of labor, the circumstances surrounding delivery, and the care for baby and parents after the baby's birth;
 - b. A plan for the extent of resuscitation to be performed and whether to allow a natural death; and
 - c. A palliative care plan as indicated and desired when babies are not expected to survive. This should include parents' preferences on where the baby's care will be delivered, how nutrition will be provided, and how baby's pain and discomfort will be managed.

2. Encouragement to bond with their baby and to create memories throughout the pregnancy, whenever feasible, recognizing the barriers they may face in bonding.
3. Psychosocial support for all members of a family, including grandparents and the infant's siblings.
4. Both practical and psychosocial support to help them cope with their baby at home when infants with life-limiting conditions survive to hospital discharge.

C. Health system recommendations:

1. All health professionals that work with pregnant women, neonates and their families should receive education and demonstrate competence in palliative and bereavement care that is appropriate within their scope of practice, and training in how to communicate effectively and empathetically with families.
2. Policies for palliative care and bereavement practices in any part of a healthcare system should be in place and easily accessible to all staff, to ensure a standard of care for all families.
3. Palliative and bereavement care resources in the community or in other areas should be available to anyone who is providing care to a neonate and family facing a life-threatening condition or imminent death or has experienced a loss whether or not there is a palliative care team or program at a specific institution.
4. Hospitals should work in partnership with their local organ donation organizations to determine whether specific babies are eligible to become organ donors and to assess, in collaboration with the family, whether organ donation is the right choice for them.
5. Healthcare staff that provide palliative and/or bereavement care should receive psychosocial support and engage in self-care, to enable them to provide optimal care to the families they serve, as well as to prevent burnout, compassion fatigue or secondary traumatic stress. The perinatal social worker, NICU psychologist, or pastoral care staff can be instrumental in providing this support.

Recommendations for NICU discharge planning and beyond

A. Emotional support:

1. Parents should be involved in their baby's care in the NICU and this should be continued into the home as a crucial first step toward empowering and enabling their competence and confidence as caregivers.
2. Screening parents for emotional distress should be a high priority in the NICU along with providing parents access to resources, handouts and contact information for parent support organizations and mental health care providers.

3. All pre- and postnatal healthcare inpatient and outpatient settings should have staff trained to identify families at economic, social and psychological risk, as well as to provide the appropriate referrals.
4. Support for breastfeeding should be provided. To sustain breastmilk feeding from NICU admission through infancy, professionals should help parents develop pre- and post-discharge plans to overcome breastfeeding obstacles, to craft a breastmilk feeding plan, access breast pumps and gain support from their family.

B. Parenting education:

1. Hospitals need to have designated NICU staff to provide individualized training to prepare parents to assume the parenting role and feel capable of providing home medications, special feeds, changing tubes, ordering additional supplies and initiating cardiopulmonary resuscitation if needed.
2. Healthcare teams in NICU, outpatient and at-home visits should be skilled at observing and assessing parent-infant interactions so they can teach parents to respond to their baby's cues to support bonding.
3. One to two parents and/or members of the family should receive individualized teaching with checklists and outlines to cover all necessary care and education. Parents should be given a discharge folder or notebook that includes all teaching handouts, medication sheets, growth charts, supplies, follow-up appointment dates with phone contacts and a copy of the discharge summary.
4. The primary care provider and subspecialists involved in a baby's care should receive a copy of relevant information or be able to access it via the electronic medical record. High Risk Infant Follow-up (HRIF) clinics and home visitors (HV) should also be included in these communications.
5. To facilitate the transition process to home, a staff member from the primary care provider's office should meet with the family to gain familiarity with their needs and to establish a supportive relationship.
6. Parental teaching should be provided in a culturally and linguistically appropriate manner so that parents will be able to show competence in infant caregiving prior to transition to home. NICUs should establish policies that include members of the discharge team serving as "parent champions" to educate and guide the family through the maze of referrals and to pre-schedule initial appointments.

C. Medical Follow-up:

1. Transition planning involves NICU discharge (DC) preparation by teams beginning at admission and continuing beyond discharge. The team should identify the degree of medical, psychosocial, environmental and financial readiness of the infant-family unit.
2. A NICU point person needs to communicate information regarding parental emotional distress to alert other providers and assure documentation in the discharge plan.

3. The DC team should assist the parents with establishing post-discharge plans and referrals to lactation and feeding specialists, mental health providers, social workers, PCP, HRIF clinics, specialists, visiting nurses, and other community resources.
4. Healthcare teams in NICU and outpatient settings should observe evidence-based recommendations from literature reviews, policy statements and statewide quality improvement projects for pre- and post-discharge and follow-up during early childhood.

D. Home Visiting Services

1. During NICU admission, if a family is already involved with a home visiting program, their continued involvement should be encouraged. If peer mentors developed supportive relationships with families, it is desirable for them to continue their involvement after discharge, if both parties are willing. If not, home visits can be provided by NICU nurses or therapists, or other appropriate referrals can be made.
2. Nurses or others conducting home visits may augment other services by including screening for depression and anxiety and providing an additional level of emotional support to families via techniques such as 'listening visits.'

Recommendations for enhancing psychosocial support of NICU parents through staff education and support

A. Recommendations for staff education:

1. Staff education relating to the psychosocial needs of NICU families and methods of providing support to them should be provided to all NICU staff. "All NICU staff" refers to *all* disciplines that interact with NICU families on *any* level. Staff education should be provided during orientation and then periodically throughout the course of the year. Education of interdisciplinary groups should promote fruitful discussion and collaborative interaction.
2. Content of staff education should focus on:
 - a. Normal responses to infant hospitalization.
 - b. Perinatal mood and anxiety disorders (PMAD) in NICU parents.
 - c. Methods of improving and expanding implementation of family-centered developmental care, as described in "Recommendations for involving the family in developmental care of the NICU baby," this document.
 - d. Methods of delivering culturally effective care.
 - e. Self-care for staff, including management of work stresses; maintenance of work-life balance through giving attention to adequate nutrition, hydration, sleep and exercise; and management of life skills, including time management, budgetary management, and stress reduction.
 - f. Competent communication skills to better enable staff to meet the psychosocial needs of their patients and families, including providing tools in active listening, conflict resolution, the provision of support to parents during palliative and bereavement care, and particularly for physicians, performance of antenatal consultations especially those addressing patients at the edge of viability, and how to give "bad news."

3. A variety of methods are available to provide staff education, and each NICU should tailor their efforts to the size, composition, and needs of their staff, balanced with the hospital's available resources.
 - a. Simulation training (especially "standardized patients" and/or "role playing") is an effective method to incorporate into staff training.
 - b. A variety of other models of communication training can be utilized in staff education.
4. Ongoing education should be fully integrated into a variety of other platforms including case conferences, case debriefings, Morbidity & Mortality conferences, Ethics Rounds, daily medical rounds, etc.
5. It is critical that administrative leadership of the Neonatal Intensive Care Unit (both nursing and medical) provide support for staff education on many levels: with "buy in" and leadership, financial support, and providing paid time for staff to attend training sessions.

B. Recommendations for staff support:

- 1- Staff should support one other and respect each discipline's contribution. This may be accomplished in a variety of ways:
 - a. Psychologists, social workers and other mental health professionals should provide support to staff as well as to families; this may be accomplished through acting as liaisons between staff and families, and/or through discussions of family dynamics and family/staff interactions at a variety of case conferences, debriefing sessions, etc.
 - b. Pastoral care staff can be supportive in a variety of ways including involvement in one-on-one interactions, group experiences, and specific activities such as remembrance ceremonies.
 - c. Nurses can support each other through mentoring relationships, teamwork, team building activities, and nursing recognition activities.
 - d. Hospital or NICU-specific Ethics Committees and Palliative Care teams can help staff minimize the occurrence of moral distress, burnout and compassion fatigue through case discussions and debriefings. NICU staff should receive both initial and ongoing training and education in ethics, particularly related to engaging in shared decision-making with parents around withholding of life-sustaining treatment, withdrawal of life-sustaining treatment, end-of-life care, and palliative care.
- 2- Staff can be emotionally supported in a variety of ways, including:
 - a. Providing adequate opportunities for staff debriefing and processing of emotions after crisis events and difficult cases, including those that are ethically and morally challenging or involve the death of a patient.
 - b. Encouraging participation in bereavement interventions during and after provision of end-of-life care, such as conducting remembrance ceremonies and giving time to attend funerals.

- c. Ensuring an optimal physical environment in which to work, including one that conforms to standards for noise and lighting, and one in which communication and safety concerns of nursing staff are adequately addressed.
- 3- Nursing administration should provide support to nurses through provision of clear communication channels to access support from supervisors and through attention to best practices in staffing, including ensuring adequacy of staffing, provision of breaks as well as days off, and orientation and mentoring of new nurses.
- 4- Medical administrators should ensure adequate staffing of the NICU's medical team. The importance of physicians collaborating with other members of the NICU team should be emphasized and promoted.
- 5- Hospitals should provide support for staff that develop posttraumatic stress disorder or other psychological distress as needed, either through personal therapy or support groups, on-site counseling via employee assistance programs, pastoral care or other professional resources within the hospital. Employee wellness programs may also provide additional support through nutrition, art therapy, massage, group exercise, and/or stress reduction classes.

References

1. National Perinatal Association's Family Advocacy Network at www.nationalperinatal.org/fan.
2. Premie Parent Alliance at <http://preemieparentalliance.weebly.com/#/>.
3. The March of Dimes at www.shareyourstory.org.
4. The European Foundation for the Care of Newborn Infants at www.efcni.org
5. The Canadian Premature Babies Foundation at www.cpbfbpc.org.
6. Hynan M, Mounts K, Vanderbilt D. Screening parents of high-risk infants for emotional distress: rationale and recommendations. *J Perinatol* 2013; **33**(10): 748-753.
7. Gjerdingen D, Crow S, McGovern P, Miner M, Center B. Postpartum depression screening at well-child visits: validity of a 2-question screen and the PHQ-9. *Ann Fam Med* 2009; **7**(1): 63-70.
8. Prins A, Ouimette P, Kimerling, R, Cameron R, Hugelshofer D, Shaw-Hegwer J *et al*. The primary care PTSD screen (PC-PTSD): development and operating characteristics. *Prim Care Psychiatry* 2003; **9**(1): 9-14.
9. Beck A, Ward C, Mendelson M, Mock J, Erbaugh J. An inventory for measuring depression. *Arch Gen Psychiatry* 1961; **4**(6): 561-571.
10. Radloff L. The CES-D Scale: a self-report depression scale for research in the general population. *Appl Psychol Meas* 1977; **1**(3): 358-401.
11. Cox J, Holden J, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry* 1987; **150**(6): 782-786.
12. Eberhard-Gran M, Eskild A, Tambs K, Opjordsmoens S, Samuelsen S. Review of validation studies of the Edinburgh Postnatal Depression Scale. *Acta Psychiatr Scand* 2001; **104**(4): 243-249.
13. Beck C, Gable R. Postpartum Depression Screening Scale: development and psychometric testing. *Nurs Res* 2000; **49**(5): 272-282.
14. Davidson J, Book S, Colket J, Tupler L, Roth S, David D *et al*. Assessment of a new self-rating scale for post-traumatic stress disorder. *Psychol Med* 1997; **27**(1): 153-160.

15. Callahan J, Borja S, Hynan M. Modification of the Perinatal PTSD Questionnaire to enhance clinical utility. *J Perinatol* 2006; **26**(9): 533-539.
16. DeMier R, Hynan M, Harris H, Manniello R. Perinatal stressors as predictors of symptoms of posttraumatic stress in mothers of infants at high- risk. *J Perinatol* 1996; **16**(4): 276- 280.
17. Sampilo M, Lassen S, Belmont J, Parimi P. Development and validation of a psychosocial screening tool to identify high-risk families in the neonatal intensive care unit. The PAT-NICU. Poster presented at the annual conference of the Society of Pediatric Psychology: San Antonio, TX, USA, 2011.
18. Keren M, Feldman R, Eidelman AI, Sirota L, Lester B. Clinical interview for high-risk parents of premature infants (CLIP) as a predictor of early disruptions in the mother-infant relationship at the nursery. *Infant Mental Health J* 2003; **24**(2): 93–110.
19. Meyer E, Zeanah C, Boukydis C, Lester B. A clinical interview for parents of high-risk infants: concept and applications. *Infant Mental Health J* 1993; **14**(3): 192-207.

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