Indian J. Psychiat. (1984), 26(1), 79—81

THE ROLE OF A LIAISON PSYCHIATRIST IN A NEONATAL INTENSIVE CARE UNIT

ASHOKA PRASAD[1], M. R. C. P., M. R. C. Psych.

Over the last few years, we have witnessed a rapid growth in the number of neonatal Intensive Care Units in Britain. This has significantly reduced the mortality of low-birth weight infants.

However, it remains an established fact that it is these infants who are more likely to be represented in the population of battered babies and a significant number of these fail to thrive (Schmidt and Kempe, 1975; Pollit, 1973; Provence, 1974). It is not surprising, therefore, that we find a comparatively high incidence of behavioural difficulties in this population later on in life (Davies and Tizard, 1975).

The psychiatric dimension of this rapidly emerging speciality has largely been ignored. We can however note that paediatric practice in a neonatal unit does have a considerable psychiatric component which, if exercised judiciously, may combat further problems later on in the life.

ROLES FOR A PSYCHIATRIST

The first and foremost role of a psychiatrist in a neonatal setting is to assist parents in understanding the nature and significane of the premature birth. This could be seen as providing emotional support in the hour of need and serves to minimise distress considerably. Rosini et al. (1974), have contended in quite a convincing manner that parents of premature infants, who do receive support of this kind, behave more positively towards the infants.

Like all special settings, the staff in the neonatal unit remain in a constant state of tension, often very unclear of their own responses. This undoubtedly serves to undermine pateint care. The psychiatrist can play quite a useful role in assisting the staff to clarify their own responses. The analogy with a renal dialysis unit is easily discerned.

One of the major difficulties in any special setting is absence of, or very often distorted communication between the staff and the patient's relatives. But nowhere does it acquire greater significance than a neonatal intensive care unit where it is paramount to establish good communication between the parents and the staff. The psychiatrist could play a very useful role here in facilitating this communication and thereby lowering the anxieties of both parents and the staff.

The psychiatrist could also serve as a co-ordinator between different disciplines to ensure an optimal provision of care for the infant as well as the parents. Less obvious, but equally important is the role of a psychiatrist as a teacher and an investigator in these settings.

THE RESTRICTIONS IMPOSED BY THE SETTING :

The neonatal intensive care unit imposes certain important restrictions on the liaison psychiatrist. The first and foremost quality of a psychiatrist operating within this setting is an ample amount of patience and flexibility a general prerequisite of any liaison psychiatrist but especially so in a neonatal setting. It is necessary to be more flexible than usual

1. Research Psychiatrist, University of Leeds, U. K.

as he has to accomodate himself to the changing medical condition of the infant—the top priority.

Anxiety tolerance is a virtue of a Liasion psychiatrist in this setting. This serves to help him tolerate the emergence of an unexpected medical problem—a not very uncommon occurrence in this field.

Parents of premature infants usually have varying sources of information. They can get different messages from the nurses, the junior doctors and the consultants. Although the gist of the messages may be similar, the parents may find it difficult to extract it initially. The psychiatrist can help the parents with this dilemma.

Finally liaison psychiatrists in this setting have to face a problem familiar to every other psychiatrist hostility from the physicians, in this instance, the paediatricians. This may be a projection of the latter's inability to deal with his own repeated frustrations or it could be a reflection of the ignorance of the useful role a psychiatrist could play. This impediment, although universal, varies from setting to setting and in certain units could be a measure of a psychiatrist's reluctance to effectively liaise with the paediatricians.

PARENTAL REACTIONS TO THE NEONATAL UNIT EXPERIENCES

The wish for a perfect child is paramount in every mother's wishes. In almost every case, there is some discordance between the internalised image of the child that the mother has and the actual infant who is born. Healthy parent-child relationship is dependant upon coming to terms with this discordance. The birth of an imperfect child severely impedes this process of adjustment.

Benfield et al. (1976) in his classic study found that most parents whose infants had been admitted to neonatal units experienced grief reactions very similar to those whose infants did not survive the neonatal period. This is somewhat surprising as only some infants in the neonatal unit become severely damaged. Probably the very need to be in a neonatal unit serves as an implication that the child is imperfect thereby bringing about this reaction.

Kaplan and Mason (1960) have brilliantly described the stages of parental reactions to the birth of a sick infant. These stages could be very appropriately applied in the context of neonatal setting and are as follows—

(i) Anticipatory grief and depression,
(ii) Acceptance of the fact of the birth of a sick infant,
(iii) Resumption of relationship to the child.
(iv) Parent comes to see infant's special needs and comes to act upon that understanding.

Usually it is the second stage which is the most difficult and takes the longest time but it is totally dependant on the child's condition. During a period of crisis, parents may regress or become demanding and increasingly critical. It is then that they find it exceedingly difficult to deal with uncertainties and seek hope and reassurance.

STAFF REACTIONS TO THE NEONATAL UNIT EXPERIENCES

Caring for premature infants is a very stressful undertaking. The staff's sense of ommipotence is constantly threatened by any unexpected deterioration in the infant's conditon and this may affect the ability to provide optimal care.

Many professionals find it difficult to cope with parental inquiries and constant reassurance seeking behaviour. Others put on a false garb of confidence and may provide misleading information which may be very harmful in the long run.

Very often, the professional, constantly threatened by the infant becomes aware of destructive wishes towards the infant. This leads to massive guilt feelings within him and can pose a very major problem.

Some may try to project their own guilt feelings on to the others, especially their colleagues. In these situations, the psychiatrist is very often in a difficult situation, often the focus of all these bad feelings.

The psychiatrist can play a crucial role here and relieve the professionals of their anxieties by taking on the psychological care of the infant and the parents.

PARENT-STAFF COMMUNICATIONS

This is especially complicated in this setting as a parent has to deal with several staff members of different disciplines and different backgrounds thereby accounting for totally different predispositions.

Some staff members adopt a cautious line and are hesitant to reveal any information at all whilst the others feel that the parents should be made totally aware of the entire situation right down to the technical details.

It is difficult to adopt a definite and a rigid guideline in this regard as flexibility is the prime rule in this field. Eventually the decision would have to be made on the parental need and ability to digest and use whatever information is given to them and to avoid the emergence of excessive anxiety within them amounting to panic. It is important however to always keep in mind that the parents do expect a very clear and unambiguous statement unlikely to confuse them. They are more likely to seek reassurance from the most accessible member and it can solve a lot of problems if one staff member alone could be assigned for this specific purpose. A psychiatrist could play a very useful role in establishing useful channels of communication between the parents and the professionals.

The other point very often forgotten is that because of their anxieties, parents are likely to distort communications. Frequent meetings between professionals and parents can greatly help matters.

Thus the psychiatrist can play a very helpful role in the running of a neonatal unit. With the psychological aspect effectively handled, professionals would be able to work more efficiently. It is often wondered if the neonatologist himself can handle this without any psychiatric aid. Perhaps they could, and in many units they still do, but handling over the psychological care to the professional trained in that areas would not only be more desirable but would serve to minimise the stress that the neonatologist is already under in a very stress provoking situation. We are likely to see more and more liasion psychiatrists in the neonatal units in future.

REFERENCES

Benfield, D. G., Leib, S. A. and Reuter, J. (1976). New Engl. J. Med., 294, 975.

Davies, P. A. and Tizard, J. P. M. (1975). Dev. Med. Child Neurol., 17, 3.

Kaplan, D. M. and Mason, E. A. (1960). Am. J. Orthopsychiatry, 30, 539.

Pollitt, E. (1973). Am. J. Clin. Nutr., 26, 264.

Provence, S. (1974). In: The Child in his Family. (Ed.) Anthony, E. J. and Koupernick, C., John Wiley, New York, 157.

Robini, L. A., Hoswell, M. C., Jodres, I. D. (1974). Paediatrics., 53, 371.

Schmidt, B. D. and Kempe, H. C. (1975). Nelson's Text book of Paediatrics. (Ed.) Vaughan, V. C and McKay, R. J., W. B. Saunders Co., Philadelphia, 107.