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* An article explaining the need for family-centered care in the NICU and after discharge. Explains preterm outcomes and how holistic care, including complimentary medicine, is important in improving outcomes for premature infants.

How Family Centered Care affects Preterm Infants (including Late-Preterms) and their Families

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Family-centered care (FCC) has been an integral part of the NICU for nearly two decades. Although the format in which FCC is implemented may vary from unit to unit, the goals remain the same: enhancing the attachment between the infant and family which improves the long-term physical, emotional, and psychological outcome of the preterm infant.¹ Box 1 lists evidence-based reasons why we need FCC. Box 2 lists evidence-based benefits for parents of FCC. Looking at FCC from a broader perspective gives neonatal caregivers more meaning as to the need for constant vigilance in the implementation of FCC.

Outcome Research

“Don’t worry, they will catch up by about two years old.” “Just take them home and treat them like a normal baby.” These are common phrases used by nurses as parents are preparing to leave the NICU. Outcome research, however, has shown that these phrases are no longer appropriate, even for the 32-36 week preterm infant. Preemie outcomes are complex and interwoven. Even as adults, former preterm infants show long-term effects from their prematurity ranging from lower academic achievement (fewer graduate from high school and fewer go on to college), to subnormal height, to a higher incidence of neurosensory impairment. Formerly preterm adult males report significantly more thought problems and females significantly more anxious and depressed behaviors. The good news is that adult (former preemies) have consistently fewer delinquent behaviors such as alcohol and drug use and lower rates of pregnancy at 20 years of age.²⁻⁴

It is important for all NICU caregivers to educate themselves on preterm outcome research. Long-term assessments most often begin around 9 months and continue through 27 years of age. A meta-analysis done by Aarnpidsse-Moens, et al reviewed 35 studies (published between 1998-2008) on neurobehavioral outcomes of very preterm and/or VLBW infants (≤ 33 weeks’ gestation and/or ≤ 1500 grams). Included studies required a case-controlled design, mean age at assessment of at least five years of age, and each study had to report data on academic achievement, and/or behavioral problems, and/or executive function.⁵ Executive function is a

term describing the brain function that controls planning, cognitive flexibility, abstract thinking, and behavior change.⁶

The analyzed data showed consistently significant sequelae of poor academic achievement, behavioral problems, and diminished executive function among preterm infants. Math, reading, and spelling were significantly poorer in VLBW children. Behaviorally, preterm infants have a higher incidence of attention problems and they often demonstrate internalizing behaviors such as anxiety and

depression. Verbal fluency, working memory, and cognitive flexibility were significantly worse in former preemies. These adverse outcomes persisted into young adulthood and were inversely related to birth weight and gestation age.⁵

Sequelae in the extremely low birth weight infant (ELBW, <1000 grams and ≤ 26 weeks) is even more prevalent. Research shows that 1/3 to 1/5 of all ELBW infants will have at least one major disability (i.e., impaired mental development, cerebral palsy, blindness, or deafness). Impaired mental disability is the most frequent. Approximately half of all ELBW children will have one or more subtle neurodevelopmental disabilities. These children often score significantly lower than children who were term newborns in cognitive ability, educational progress, and behavioral problems. Cystic periventricular leukomalacia, congenital malformation and severe intraventricular hemorrhage were most often correlated with a severe disability, but not necessary for the presence of subtle disabilities.⁷⁻⁹ Even without major impairments, adults (formerly ELBW preterms) tend to be more cautious, shy, less extraverted, and more risk averse than their term peers.¹⁰

Caregivers (obstetric and neonatal) often believe that if a preterm can “make it” to 32 weeks gestation, they are more likely to be free of any long-term sequelae. Research has shown that although they carry less risk for developing significant problems later in life, they are still at risk for some impaired functioning. Van Baar, et al¹¹ reported that a cohort of eight year old formerly preterm infants (32 and 36 weeks gestation) showed cognitive and emotional difficulties. Seven point seven percent (7.7%) of this cohort attended special education classes, twice the rate of the general population. Nineteen percent (19%) of the preterm vs. 17% of the general population experienced grade retention and there was a 3 point deficit in IQ. These preterm children needed more time to finish a task and had more behavioral problems, especially internalizing their feelings and more attention deficit/hyperactivity disorder.¹¹

Several other recent studies show abnormal “brain” outcomes in late preterm infants. A prospective study of the reasons for mechanical ventilation in 1011 late preterm (> 34 weeks gestation) found that respiratory distress syndrome (RDS) was the most common reason for needing ventilator support.^{11a} This same study found that 9% of these late preterms suffered long-term neurologic complications.^{11a}

Another recent study found that late preterms admitted to the NICU have the same risk as very preterm infants of requiring interventional therapies at 12 months corrected age (CA).¹² A total of 30% of these late preterms qualified for services: 1) 28% for physical therapy, 2) 16% occupational therapy, 3) 10% speech therapy and 4) 6% special education.¹² Morse, et al¹³ compared the early school-age outcomes of late preterms compared to term infants. They found that the late preterms had a higher risk than the term infants for: 1) developmental delay (36%), 2) suspension in kindergarten (19%), 3) 10% to 13% more disability in pre-kindergarten at 3-4 years of age, exceptional student education, and retention in kindergarten.¹³

Other research has shown a variety of long-term problems that often go unrecognized. Strong evidence has associated prematurity to autism spectrum disorders.^{14,15} A cross-sectional study of 126 preterm infants born with a mean age of 27 weeks and 34 term control subjects showed that the exercise capacity of the preterm group was approximately half of the control group.¹⁶ Kilbride, et al¹⁷ demonstrated in a cohort of 25 ELBW preemies, at age 3 and/or 5 years old, that the ELBW children were lighter, shorter, had smaller head circumferences, and lower IQ's than their full-term siblings. Hovi, et al¹⁸ measured blood glucose and insulin concentrations in 150 adults (who were low birth weight at birth) and found that this cohort had higher indexes of insulin resistance, glucose intolerance, and higher blood pressure than those born at term.

Reading outcomes research can be overwhelming, but imagine dealing with these issues either as a former preemie or as a parent or family member facing these sometimes daunting problems on a daily basis. An international, internet preemie parent support group called *Premature Baby, Premie Child* (www.comeunity.com/premature/preemie-child/) offers support through daily conversations from parents of preterms, often discussing the trials of life as or with a former preemie. To gain better insight as to the daily needs of former preterm infants and their families, an informal survey asked what the outcome research really means in daily life. Although the list of issues for both parents and former preterms listed in Box 3 is long and intimidating for professional caregivers to read, imagine the challenge these pose for daily living! Some professional caregivers have voiced despair and question their work. Instead of questioning your work with preterms, use this information as an opportunity to understand how extremely important each task you do with each preemie can make a lifetime imprint that may worsen or modify long-term outcomes.

What influences preemie outcomes?

For years health professionals believed that outcomes were based solely in biological insults. However, we now know that outcomes are based in biological impact, genetic potential, and environmental experience.

Biologically, we know that a preterms with insults such as periventricular leukomalacia (PVL), intraventricular hemorrhage (IVH), and necrotizing enterocolitis

(NEC) have an increased risk of poorer outcomes.¹⁹ We also know that babies who are small for gestational age (SGA) are more at risk.²⁰ The most obvious trend in outcomes research is that the smaller the preterm and earlier the gestation, the higher the risk of problems. From a purely physical perspective it is clear what biological impacts influence outcomes.

Genetics also determines outcome. For decades scientists believed that it was only our genetic make-up that shaped our health status throughout life: if we developed anxiety, depression, heart disease, diabetes, etc. it was due to our genetic formatting. From a wide range of studies, we now know “that human development is a product of the effect of the experience on the unfolding of the genetic potential”.²¹ Genetically, an individual may inherently be prone to a certain problem or disease, but it is our environment that determines whether or not the individual will develop it. Likewise an individual preterm infant may or may not have the genetic potential for learning disabilities or anxiety and depression. Someone who has a genetic potential for a certain problem is at a higher risk than another who does not have a genetic propensity, but genetics is not the sole determining factor. In determining preterm outcomes, it is, in part, the infant’s experience(s) in the NICU that also influence development.

To understand environmental influences on outcomes, it is critical to appreciate infant brain development. An infant’s brain doubles in size in the first year of life. Neuropathways and new synaptic connections are rapidly establishing themselves. These neuropathways develop in response to experiences in every moment of life. Positive experiences promote healthy, “normal” brain wave patterns. Even a momentary stressful experience creates a stress response pathway via neuronal connections in the brain, which creates a specific cascade of hormonal responses in the body. Repeated stressful experiences create a brain structure where a reactive response is the norm. In other words, a baby who often feels stress, anxiety, and fear as an infant can establish these neuronal connections as well as hormonal responses, so they are intrinsically “normal” and part of their typical response throughout life.²¹ Understanding the experiential influence on brain development found in sound research, we can no longer believe that babies do not remember. Although neonates do not have the verbal language available to create an explicit memory, their brain circuitry remembers and expresses itself later in abnormal reactions and outcomes.

The importance of the parent infant relationship.

In healthy, term infants parents regulate the environment and any stressful events for the infant through bonding and attachment. This dance of attachment between mother (and sometimes the father) and the baby creates a blueprint for the infant’s future well-being including his or her brain development, nervous system regulation, self-esteem, intelligence, ability to manage stress, sense of security, and social behavior.²² The infant uses the mother’s mature brain to organize and respond to his or her own experiences.^{21,23} During stressful experiences, it is the

mother (and father) who help the baby calm down and find internal regulation and hormonal homeostasis after stress, establishing optimal neuronal brain circuitry.²⁴

Unfortunately, in the NICU, parents are often unable to help their infant regulate stress, particularly in the beginning of the hospital stay. They may not be present during the stressful event, unable to touch or hold the baby if they are present, or even so distressed themselves that their own homeostasis is challenged. It is common for mothers in the NICU to experience many emotions including anxiety, guilt and depression. Symptoms of acute stress disorder and post-traumatic stress disorder (PTSD) occur in up to 25% of mothers and fathers in the NICU and can continue to be present even 2-3 years later.²⁵⁻²⁷ Empiric evidence shows that maternal psychological distress can negatively influence VLBW outcomes. The reverse is also true, maternal sensitivity and warmth moderate long-term adverse outcomes such as attention deficits, hyperactivity and internalizing problems.^{28,29}

Improving preterm infant outcomes: a multi-dimensional approach

At the 2010 International Conference on Pediatric Psychological Trauma in Infants and Young Children from Illness, Injury and Medical Intervention, Dr. Zeev Kain suggests improving outcomes needs a multi-dimensional approach including pharmaceutical relief for pain, developmental care, family-centered care, and complimentary and alternative therapies.²⁸ Improvement requires the doctor, nurse, and allied health professionals to address every aspect of the dynamic experience of the physiologically and psychologically fragile infant.

Pharmacotherapy

One way we can improve outcomes is through pain management. Unfortunately, the outdated and incorrect perception that “babies don’t feel pain” continues to permeate the belief system of many neonatal careproviders in Levels I-II and III care. The fetus, preterm, and term infant, beginning somewhere around 20 weeks gestation, has the ability to feel pain. Painful procedures experienced by the neonate can challenge their physiologic stability having immediate and long-lasting effects on brain development. These effects can affect self-regulation, sensorimotor function, sleep/wake cycles, memory encoding, and learning as they become children and adults.^{28,30}

An epidemiological study done by Carbajal, et al³¹ examined the management of painful procedures done on 430 neonates during their first 14 days of admission in the NICU. Neonates experienced 60,969 first-attempt procedures, with 42,413 (69.6%) painful and 18,556 (30.4%) stressful. Each infant had an average of 115 procedures during the study period, 16 per day of hospitalization. Over seventy-nine percent (79.2%) of these procedures were performed without specific analgesia and 34.2% were performed while the infant was receiving other, nonspecific pain infusions for other reasons. The long-term impact of these experiences on the growing brain is remarkable.³¹

Grunau, et al³² demonstrated that stress systems in preterm infants may be altered beyond the NICU due to early exposure to painful procedures. In a study of 54 preterm infants born 32 weeks or less it was found that the salivary cortisol levels (increased cortisol is an indicator of a stress response) were significantly higher at 8 months of age than the term control group. They concluded that procedural pain was a key component in the resetting of basal physiological regulation in preterm infants. Previous studies have shown that morphine helped normalize behavioral and cardiac reactivity to pain, however this study did not show that morphine helped or hindered stress responses at 8 months of age.³²

Sufficient research shows that sucrose is a simple and effective tool for reducing procedural pain such as heel sticks and venipuncture.³³ Non-nutritive sucking and swaddling the infant can be helpful as well.³⁴ It is extremely important to remember that preterm infants feel pain and stress throughout their daily routine of care and handling. Pain relief in the form of analgesia or less invasive comfort techniques for the neonate should always be foremost in the minds of professional careproviders in Level I-II or III units.

Developmental care

The NICU is a very stressful environment. Living in this environment for days, weeks, or months has a profound effect on the infant's neurodevelopment. Unfortunately, decades of neonatal care occurred before an understanding of this environmental impact was even considered or studied. Thankfully we have access to sound, scientific and conscientious programs for implementing developmental care in the NICU.

The foundation for developmental care is a change from task-oriented to a relationship-based model of care. It is imperative for nurses (and all careproviders) to realize that the approach they use when caring for a preterm infant has a dramatic effect on the infant's long-term (for a lifetime) neurodevelopmental, psychological, and behavioral outcome. There is ample empirical evidence to show that NIDCAP®-based developmental care improves brain function and reduces medical and long-term morbidities in the premature infant.³⁵ A study of thirty (28-32 week) preterm infants used EEG's, MRI's and behavioral assessments at 2 weeks and 9 months. At 9 months' corrected age the NIDCAP® group showed consistently better brain function and more mature brain fiber structure as well as significant improvement in neurobehavioral performance in the mental developmental index (MDI) and the psychomotor developmental index (PDI) and improved scores in emotional regulation and motor quality.³⁶ Another important outcome finding of this study was that not only brain function, but brain structure, was changed by participation in the NIDCAP^(R) program.³⁶

Relationship-based care means attention to all caregiving actions from softly closing the portholes on the incubator to constant monitoring of the physiological and

behavior stress cues of the infant and responding to those cues appropriately. The neonatal nurse is an advocate and “substitute parent” in helping the infant tolerate and reorganize each and every circumstance of the day. In the words of Dr. Allan Schore, a highly regarded neuroscientist and psychiatrist whose life’s work is focused on infant brain development states, “A nurse that is attending only to the biological needs and not the emotional needs of an infant may be creating more stress for the infant which is similar to that of a parent’s flat affect interaction”.²⁸

Family Centered Care

Included in the developmental-care framework is family-centered care (FCC). The ultimate goal of FCC is to empower parents to be and become parents in the intimidating and challenging journey of having their newborn in the NICU. Through all of the frightening machinery, foreign medical language, and overwhelming site of their sick infant, parents must learn to love and care for their baby. Creating a holistic environment for the infant and family requires: 1) establishing a trusting relationship with optimal communication between parents and the health care team, 2) involving parents in the care and decision-making for their infant(s), 3) facilitating parent-infant attachment, 4) giving emotional support to the family, and 5) preparing the family for life at home. A FCC model of care that supports the implementation of these ideas throughout the hospital stay is possible with caregiver attitudes that promote FCC, FCC protocols and practices in the NICU.¹

One of the areas of FCC that can be lost or forgotten is the emotional support of parents. The earlier discussion on parent-infant attachment helps to understand the importance of a healthy bond between the mother (and father) and the baby’s brain and nervous system. Unfortunately, the bonding process can be challenging for many reasons. Preterm infants do not socially engage as do term infants. The preterm infant is often more irritable, less active, alert, and responsive and often has gaze aversion when compared to the term infant. This lack of responsivity creates a parental reaction of anxiety and fear ----parents often worry that something is wrong with their baby and/or their ability to parent. When a mother or father

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feels psychological distress (e.g., anxiety, depression and/or posttraumatic stress) from the overwhelming experience of the NICU, their ability to connect, support and parent their infant is limited. Research has shown that maternal anxiety in the NICU has long-lasting effects: 1) less sensitivity and less structure while interacting with the infant (at 24 months CA) and 2) the infant was less likely to involve their mothers in their play at 24 months of age.^{37,38}

There are currently two evidence-based programs to help parents with psychological distress and improve interaction between the parent and infant. The

Cues and Cares Trial teaches mothers to use cognitive and behavioral strategies to reduce their own stress as well as teaching them to recognize infant states and behaviors and how to interact with sensitivity to their infant.³⁹ The Creating Opportunities for Parent Empowerment (COPE) program used a randomized control trial (RCT) to show that implementing an educational-behavioral based program early in the NICU stay enhances parent-infant interaction. COPE educates parents in infant needs and how parents can participate in the infant's care. Results showed that mothers enrolled in the COPE program had significantly: 1) less stress in the NICU, 2) less depression and anxiety at 2 months' CA (than the comparison mothers) and 3) reduced infant length of stay by 3.8 days.⁴⁰

One powerful tool that promotes parent infant attachment is skin-to-skin or kangaroo care (KC). Benefits of KC include: 1) diminishes pain from heel sticks⁴¹, 2) improved maternal affect, touch, and adaptation to infant cues, 3) less maternal depression and seeing their infants as less abnormal and, 4) more alertness and less gaze aversion in infants receiving KC. At 3 months and 6 months mothers and fathers were more sensitive and infants scored higher on developmental indexes.⁴²

Complimentary and Alternative Therapies

There is minimal research on complimentary and alternative therapies (CAM) in the NICU. There may, however, be some benefits in helping infants and families relax and augment physiologic stability. Preliminary research shows that music may improve physiological and behavioral parameters of the preterm infant.⁴³ Infant massage reduces stress responses, enhances behavioral organization of premature infants and decreases depression and anxiety of mothers.⁴⁴⁻⁴⁶ Therapeutic touch, Reiki, craniosacral therapy and other energetic healing modalities need further evaluation as to their benefits.

After discharge parents often have to weave through the maze of doctor visits, physical therapy, occupational therapy and speech therapies for weeks, months or even years. Often times parents find road blocks in healing some or many of the issues that their child faces because "western medicine" is not always complete in the healing process. Parents are often afraid to look further than traditional medicine for help. If parents are "given permission" by someone they trust in the NICU to seek CAM modalities, they will feel more comfortable trying nontraditional methods. Acupuncture, acupressure, chiropractic, massage, and other holistic modalities have been found to improve immune system function, sleep, and attitudes and behaviors in children.⁴⁷ Advise parents to ask their doctor, therapists, and/or other parents for referrals. Educating parents about outcomes, teaching them to be their child's advocate, and encouraging them to research CAM therapies empowers parents in assisting in the care of their child with chronic needs.

Conclusion

When looking at family-centered care from the needs of the parent, one may feel like it is a daunting task to properly care for the preterm infant. When doing any task in the NICU, keep in mind the primary goal is your caring and healing intention with every touch, skill, and/or procedure. The immediate goal is to meet the emergent needs of the infant at that moment, but the long-term goal/intent is to find a loving, caring, and supportive relationship within each and every contact you make. Giving an infant and family the best possible outcomes---physiologic, psychologic, developmental, emotional and social--- using all aspects of your knowledge of evidence-based practice is why providers work with premature infants and their families.

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Box 1: Evidence-Based Benefits of Family Centered Care (FCC)

- Shorter length in hospital stay
- Fewer readmissions
- Enhances breastfeeding outcomes
- Reduces parental stress
- Increases parental confidence after discharge
- Improves family satisfaction with the health care experience
- Increases staff satisfaction

Box 2: Evidence-Based Benefits for Parents of Family Centered Care

- Creates a positive experience for the infant and family
- Creates a more holistic, natural environment
- Affects and improves outcomes for the infant
- Promotes and facilitates the mother and father in “falling in love” with their baby: bonding and attachment, the very fiber of their relationship

Box 3: Issues Identified as Important in the Daily Lives of Former Preterms and their Families

Abnormal sensory issues

Hypersensitivity to sounds

Hypersensitivity to smell

Does not like certain textures on hands, feet, and mouth

Abnormal tolerance or intolerance to pain

Do not like bathing or brushing their teeth

Learning disabilities

Doing poorly on tests and/or homework

Difficulty with telling time and using money

Often behind in classes, grades

Problems planning tasks or thinking sequentially

Literal minded and baffled by abstract thinking and humor

Poor memory

Lower IQ

Social challenges

Loners

Do not understand social cues

Difficulty making friends

Can be aggressive/compulsive
Can be made fun of or have feelings of being left out

Mental health

Problems with motivation
Obsessive, compulsive behaviors, need structure, routines
Deficient language, talk incessantly
Anxiety and/or depression
Lack of empathy, emotionally distant
Attachment problems
Abnormal/unusual fears (being alone, going to the bathroom)
Low self-esteem

Balance and visual-spatial issues

Often have difficulty competing in sports
Late to ride bikes, skate boards, etc.
Poor depth perception
Poor fine motor skills and coordination problems
Poor tone, clumsy

Physical problems

Tooth enamel issues
Frequent/chronic illness
Asthma
Diabetes
Constipation
Poor growth
Tire easily
Late toilet training
Poor immune system
More frequent problems with acute and chronic reflux

Feeding problems

Very picky eaters
Food refusal and/or battles over food
Having to create two foods at one sitting
Odd behaviors around food such as breaking food into tiny pieces and then shoving them all into his/her mouth
Oral aversions, strong gag reflex

Side Bars:

“A baby who cannot find his mother—and thus himself—within her gaze, is drastically handicapped in the complex developmental task of putting together a ‘self.’” Dr. Allan Schore

Reference: Axness M: When the joy of mother is missing – An organic perspective on postpartum depression Journal of Prenatal and Perinatal Psychology and Health 2007; 21(4):315-19.

“Repetitive neonatal pain →cortical and hippocampal cell loss →altered preattentitional processes in the brainstem →sensorimotor gating imbalances →Attention Deficit Disorder (ADD) →poor memory encoding →“hidden” learning disabilities →poor cognitive outcomes.” (Dr. Anand slide at Pediatric Trauma Conference)

CAM In the NICU

Therapeutic touch (TT): TT is a form of energetic healing where the practitioner (most often nurses) run their hands over the body’s energetic field or “aura” to balance the energy fields. Studies suggest that TT can help wound healing, reduce pain, and promote relaxation.

Reiki: Reiki is a Japanese energetic healing technique used for stress reduction and relaxation. It is a fairly simple technique that nurses can easily learn. The practitioner uses a “laying on of hands” technique to shift energy in the body.

Craniosacral therapy (CST): CST is a therapy most often used by osteopaths, massage therapists, naturopaths, chiropractors, and occupational therapists. The practitioner tunes into the craniosacral system and uses their hands to gently work with the spine, skull, cranial sutures, diaphragms, and fascia. CST eases restricted nerve passages, optimizes movement of cerebrospinal fluid, and helps restore misaligned bones to their proper position.

After the NICU

Acupuncture and Acupressure: Chinese medicine has been tested over thousands of years. Their theory is that energy runs through meridians in the body just as blood runs through veins and arteries. Acupuncture and acupressure uses either tiny needles or massage to open and redirect blocked energy within the meridians that can cause illness. Acupressure is more commonly used on infants, needles are used when the child can be still.

Chiropractic Care (CC): CC focuses on disorders of the musculoskeletal and nervous system. Correcting these imbalances can have a profound impact on general health issues.

Classical Homeopathy (CH): CH is a system of medicine that is based on the theory of like treating like, the same basic principle used in antidotes and vaccinations. After careful examination and research of one’s symptoms, a tiny amount of a natural substance is given which strengthens the body and supports healing. It’s a unique form of medicine that can be a strong foundation for long-term healing.

Energy Psychology (EP): Energy psychology uses energetic healing techniques to help release stressful and traumatic experiences. Talk therapy is helping for the cognitive understanding of issues, but EP helps the individual let go of the experience on a deeper level. EP techniques include Emotional Freedom Technique (EFT) and Eye movement Desensitization and Reprocessing (EMDR).

Brain Balancing: Brain Balancing Centers believe that many academic, behavioral, emotional and neurological disorders are due to one of the hemispheres of the brain working less efficiently than the other. The brain balancing program allows for a rebalancing program that gives proper stimulation to particular circuits of the brain through certain tasks and exercises.

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Bio:

Dianne spent over 17 years working as a neonatal intensive care nurse. She received her masters of Science in Psychiatric/Mental Health Nursing from the University of Colorado Health Science Center in Denver and has trained in a variety of alternative healing modalities. Dianne is the co-author of "Your Premature Baby and Child: Helpful Answers and Advice for Parents" (Berkley, 1999). She is the mother of a premature infant, born 3 1/2 months early who is now 17 years old. As a national speaker and a member of many local and national organizations, she works with medical professionals and parents advocating to further incorporate a parent perspective and family needs into the care of the pre-term infant and child, both in the NICU and at home. Dianne has a private practice in the Denver area working with all ages of clients, helping them with the long-term effects of early life experiences.

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