

# The Signal



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## Infant Massage

by *Tiffany Field, Ph.D.*

Infant massage is a common child care practice in many parts of the world, most especially Africa and Asia. For example, infants are massaged for several months of their life in Nigeria, Uganda, India, Bali, Fiji, New Guinea, New Zealand (the Maori), Venezuela and the Soviet Union (Auckett, 1981). In most of these countries the infant is given a massage with oil following the daily bath and prior to sleep time.

### *Infant Massage in the Western World*

Infant massage is only recently being discovered and researched in the Western World. In the United States, for example, massage therapy schools are beginning to teach infant massage, infant massage therapists have founded a national organization of approximately 4,000 therapists, and those therapists in turn are setting up institutes to teach parents infant massage. The techniques they use are based primarily on the teachings of two massage therapists who trained in India (Amelia Aukett who published a book on infant massage in 1981 and Vimala Schneider McClure who published a similar book on infant massage in 1989).

Although these infant massage training groups are located now in most parts of the United States, very little research has been conducted on the use of infant massage with healthy infants. Nonetheless, the infant massage training groups have anecdotally reported that massage: a) facilitates the parent-infant bonding process in the development of warm, positive relationships; b) reduces stress responses to painful procedures such as inoculations; c) reduces pain associated with teething and constipation; d) reduces colic; e) helps induce sleep; and f) makes parents "feel good" while they are massaging their infants. The infant massage therapy groups have also reported that several different kinds of infants with special needs appear to benefit from infant massage such as blind and deaf infants (becoming more aware of their bodies), quadraplegics and cerebral palsied infants, and preterm infants.

### *Massage Therapy with Preterm Infants*

Most of the data on the positive effects of infant massage come from studies on preterm infants. During the last two decades a number of investigators have researched the effects of massage therapy (earlier called tactile/kinesthetic stimulation) on the preterm newborn (Barnard & Bee, 1983; Rausch, 1981; Rice, 1975; Solkoff & Matuszuk, 1975; White & LaBarba, 1976). Generally the results published by these investigators have been positive. In a recent meta-analysis on 19 of these stimulation studies, Ottenbacher et al. (Ottenbacher, Mueller, Brandt, Heintzelman, Hojem & Sharp, 1987) estimated that 72% of infants receiving some form of tactile stimulation were affected positively. Most of these investigators reported greater weight gain and better performance on developmental tasks for the preterm infants receiving massage therapy. Interestingly, those who did not report significant weight gain have used a light stroking procedure which we have since found is aversive to babies, probably because it is experienced as a tickle stimulus. Those did show weight gain were providing more pressure, probably stimulating both tactile and pressure receptors.

One of the studies used in this meta-analysis was conducted in our lab starting in 1984. In that study we provided 40 preterm neonates 45 minutes of massage per day (in doses of 3 fifteen minute periods) for 10 days (Field, Schanberg, Scafidi, Bower, Vega-Lahr, Garcia, Nystrom & Kuhn, 1986). The infants averaged 31 weeks gestational age, 1280 grams birth weight and 20 days intensive

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care prior to the time of the study. They were recruited for the study when they had graduated from the "Grower Nursery" at a time when their primary agenda was to gain weight. The massage sessions comprised 3 five-minute phases. During the first and third phases, tactile stimulation was given. The newborn was placed in a prone position and given moderate pressure stroking of the head and face region, neck and shoulders, back, legs and arms for 5 one-minute segments.

The Swedish-like massage was given because, as already noted, infants preferred some degree of pressure probably, because the light stroking was experienced as a tickle stimulus. The middle phase (kinesthetic phase) involved flexing of the infants' limbs (moving them into flexion and then extension much like bicycling motions) while the infant was lying on his back.

The results of this study suggested that the massaged infants gained 47% more weight even though the groups did not differ in calorie intake; b) the massaged infants were awake and active a greater percentage of the observation time much to our surprise since we had expected that this would stimulate a soporific state and greater sleep time leading to weight gain via lesser energy expenditure and calories; c) the massaged infants showed better performance on the Brazelton Scale on habituation, orientation, motor activity and regulation of state behavior; d) the massaged infants were hospitalized 6 days less than the control infants yielding a hospital cost savings of approximately \$3,000 per infant.

Simultaneously, our collaborator Saul Schanberg was conducting studies with Cynthia Kuhn at Duke University on an animal model, removing the rat pups from their mother to investigate touch deprivation and attempting to attempt to simulate the mother's behavior to restore physiology and biochemistry of the rat pups to normal. In several studies they noted the fall in ornithine decarboxylase (ODC), a critical element of the protein

synthesis chain (Schanberg & Field, 1988). This decrease in ODC was noted in all body organs including heart, liver and brain and in all parts of the brain including cerebrum, cerebellum and brain stem, and these values returned to normal once the pups were stimulated.

A graduate student/animal caretaker observed rat mothers' nocturnal behavior and noted that they frequently tongue lick, pinch and carry around the rat pups. When they tried each of these maneuvers, only the tongue licking (simulated by a paint brush dipped in water and briskly stroked all over the body of the rat pup) restored these values to their normal level. More recently Schanberg and his colleagues discovered a growth gene that responds to tactile stimulation (an early immediate gene labeled C-FOS), suggesting genetic origins of this touch/growth relationship.

Realizing that an exploration of under-the-skin variables including physiology and biochemistry might suggest an underlying mechanism in the human model, we added physiological and biochemical measures to our next study. This study with preterm infants basically confirmed our previous data set. In this sample the stimulated infants showed a 21% greater daily weight gain, they were discharged 5 days earlier, they showed superior performance on the Brazelton Habituation items, and they showed fewer stress behaviors (mouthing, grimacing, and clenched fists) (Scafidi, Field, Schanberg, Bauer, Tucci, Roberts, Morrow & Kuhn, 1990). In addition, we noted that their catecholamines (norepinephrine, epinephrine) had increased across the stimulation period (Kuhn, Schanberg, Field, Symanski, Zimmerman, Scafidi & Roberts, 1991). Although these catecholamines typically increase following stress in the adult, suggesting that an increase is undesirable, an increase during the neonatal period would be considered desirable since there is a normal developmental increase following birth. Thus, the massage therapy apparently

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facilitated the normal developmental increase in these catecholamines in the stimulated preterm infants. In the interim we also discovered that their vagal activity increased during massage therapy sessions.

This observation plus the work of Uvnas-Moberg in Sweden led us to some ideas about underlying mechanisms. Uvnas-Moberg and her colleagues have reported that stimulating the intra-oral cavity of the newborn (and the breast of the mother) led to the increased release of gastrointestinal food absorption hormones such as gastrin and insulin (Uvnas-Moberg, Widstrom, Marchine & Windberg, 1987). It is conceivable that another form of tactile stimulation such as the massage therapy on different body parts would also lead to the release of gastrointestinal food absorption hormones probably stimulated by vagal activity. Thus, we are currently assaying glucose and insulin levels in the heelstick samples of preterm infants, and our preliminary data suggest that the massaged infants are showing elevated levels of both glucose and insulin.

### **Massaging Cocaine-Exposed Preterm Infants**

In the interim a relative newcomer to the NICU, the cocaine-exposed preterm infant provided us with another sample of infants that could presumably be helped by massage therapy. In this study the same type of massage was administered 3 times daily for a 10 day period with the hope that much the same effects would occur. The data suggested the following:

a) the massaged cocaine-exposed preterm infants had fewer postnatal complications and exhibited fewer stress behaviors during the 10 day period;

b) they had a 28% greater daily weight gain; and

3) they demonstrated more mature motor behavior on the Brazelton exam at the end of the 10 day period (Wheeden, Scafidi, Field, Ironson & Valdeon, in press).

### **Massaging HIV Exposed Neonates**

Still a more recent newcomer to the NICU are the HIV-exposed infants. Dr. Scafidi and our colleagues are currently investigating whether massage therapy also improves immune functioning in HIV-exposed newborns and whether massage therapy given by parents can improve the mental, motor, and social development of the infants as well as give the mothers a sense of worth and less guilt feelings for having transmitted this disease to their infants. We have noted very impressive compliance on the part of the HIV mothers; almost 100% com-



pliance in their administering 3 massages per day to their infants for the first 2 weeks of life. The data suggest the following: 1) greater weight gain for the massaged infants; 2) better performance on the orientation and motor clusters of the Brazelton scale; and 3) better performance on stress behavior scale including alert responsiveness, cost of attention, examiner persistence, state regulation, motor tone and excitability.

### **Depressed Mothers Massaging Their Infants**

Because we need a cost effective way to deliver massage therapy to infants and because parents as massage therapists may also benefit from giving massage and because the parent-infant relationship may improve, we are increasingly teaching parents to administer massage therapy in our studies. In a current study we are teaching depressed mothers to massage their infants to examine the effects of the massage therapy on the infants disorganized interaction behavior and their disturbed sleep patterns.

For this study we have asked the infant's primary caregiver to perform a 15 minute massage daily for a 2 week period. Preliminary results suggest the following: a) drowsiness and quiet sleep increased immediately following the massage, and activity decreased as might be expected; b) the infants' latency to sleep was shorter following the massage therapy study (by the end of the 2 week period the latency to sleep decreased from 22 to 9 minutes); c) the infants showed increased vocalizations, decreased restlessness and improved affect during mother-infant play interactions, and the mother's play behavior became more age-appropriate; d) the infants' fussiness decreased after the 2 week period; and e) the infants' depressed mothers perceived their "depressed" infants as being easier to soothe.

These data on decreased fussiness and more organized sleep suggested that we should conduct studies having parents massage their colicky infants and their infants with sleep disturbances. Thus, we are using the same model for those groups.

### **Grandparent Volunteers as Massage Therapists**

Another cost effective delivery of massage therapy is via grandparent volunteers. In an ongoing study grandparent volunteers are being trained to massage neglected and abused children in a shelter. The study is designed

to measure the effects of massage therapy on sexually and physically abused children living in a nearby shelter as well as the effects on the volunteer grandparents of their giving the massage. It is interesting that the other end of the age spectrum, the elderly, also experience failure to thrive, probably secondary to touch deprivation.

A recent survey indicated that medical staff using FTT as an admitting diagnosis documented that this was the diagnosis in 57% of acute care teaching hospitals (Campion, Berkman & Fulmer, 1986).

Clinical depression, on the other hand, is the most common psychiatric disorder among the elderly, with prevalence estimates between 5 and 26% (Copeland, Dewey, Wood, Searle, Davidson, & McWilliams, 1987; Gaylord & Zung, 1987). Depressive symptomatology in the elderly is similar to that in younger persons including anhedonia, poor concentration and feelings of hopelessness and worthlessness. On the other hand, complaints of ill-defined physical problems and memory impairments may be present in other elderly people while complaints of depressed mood or dysphoria may be absent (Post, 1982).

As is true of depression at other ages, one might expect effects on physiology including frequent night wakings, increased urinary cortisol levels and decreased levels of immunocompetence. These depression effects may readily contribute to the failure to thrive syndrome in the elderly as they do to infants who are depressed and fail-to-thrive. Pet therapy data suggest that volunteer grandparents may gain as much from giving a massage as from getting a massage (Grossberg & Alf, 1985).

In our study on training volunteer grandparents to give neglected and abused infants massage, the preliminary results suggest the following for the infants: a) drowsiness and quiet sleep increased and activity decreased following the massage; b) after one month of massage therapy, alertness and tracking behaviors increased; and

c) behavior observations suggested increased activity, sociability and soothability.

For the volunteer grandparent massage therapists a preliminary analysis of the data suggested that: a) the grandparent volunteers reported less anxiety and fewer depression symptoms and an improved mood after receiving the massage; b) their cortisol levels decreased; c) their lifestyle improved with more social contacts, fewer trips to the doctors office and fewer cups of coffee; and d) they reported improved self-esteem.

These effects appeared to be greater for the grandparents following a month of providing the infants with massage than they were following a month of receiving their own massages. These data suggest the power of massage therapy not only for the infants, but also for the adults who are massaging the infants, further enhancing the cost effectiveness of providing infants with massage therapy.

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# Clinical Use of Infant Massage in Italy

by Graziella Fava Vizziello

Some twenty years ago, Gabriella Arrigoni Ferresi, a Yoga, Shisatsu and Taoist massage instructor, began teaching infant massage to couples of parents attending prenatal classes in the city of Parma. Since then, infant massage gradually has spread throughout Italy, thanks in part to the work of professionals (especially rehabilitation therapists and midwives) chiefly committed to the cultural movement which supports the de-medicalization of child-birth and the return to a more "natural" life.

Many of these professionals have the Indian tradition as their model and have become specialists both through stages in Indian hospitals and following theories and courses advocated by Leboyer (1976), who has tried to adapt many features of Oriental experience to Western culture.

Leboyer (1976) has been concerned for many years about child welfare and has advocated for more optimal conditions in which children can be born non-violently, believing that this may enable them to thrive and be happy subsequently.

The massage, in this context, is proposed as one way of relating to the child. This emphasis in Italy on the wisdom of Oriental culture makes us forget the age-old roots infant massage has in Italian culture, with different oils (olive and Vaseline) being used, chiefly in the South to "protect" the baby's skin, a ritual often bringing together several women with small children from the same family.

Only later, in 1989, after various studies in the United States and on finding that some applications that were being tested in Italy aroused interest elsewhere, Benedetta Costa founded the Italian Association of Infant Massage (AIOMI) as a chapter of the Inter-

national Association of Infant Massage Instructors, an organization with its main center in Sweden. The Association's basic aims are to:

- ◆ introduce infant massage into routine child care with a view to encouraging harmonious development;
- ◆ train new infant massage instructors;
- ◆ ensure continuity or organization and training;
- ◆ collect data at national level on infant massage application methods and results.

Some 200 professionals (doctors, psychologists, rehabilitation therapists, nurses, social workers, and educators) belong to AIOMI. They have received training from the Association and have to inform it of their work.

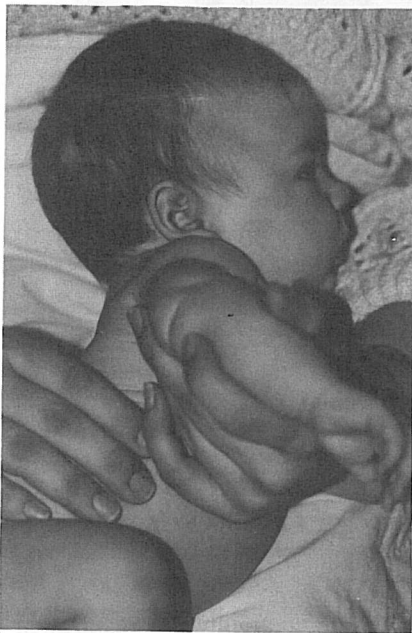
The massage therapy is patterned after that described by McClure Schneider (1989) and by Auckett (1981), although the Association is developing its own highly flexible, polymorphous method which can be adapted to suit differences among the children and parents to whom it is offered and to the type of service in which it is introduced.

Our interest has been particularly aroused by studies on hormonal mediators of the positive effects produced by the massage, since they seem to begin to bridge the gap between real and fantasmatic interactions, of which pleasure and pain are the main unexplored components.

## Objectives of Infant Massage

Mastella (1993) has summarized the objectives of infant massage as follows:

1. To offer the child additional proprioceptive stimuli on his skin,



muscles, and joints, giving him pleasant sensations, which help provide specific and general knowledge about his body.

2. To progressively relieve the child's body of muscular tension, easing activation of any damaged motor functions and at the same time, grant him a time of relaxation, especially in difficult situations.

3. To allow the mother figure to develop intimacy with her child's body, with a view to easing relations or in some cases as a basic, reassuring introduction to rehabilitation.

4. To enable the therapist to make first observations and an evaluation through contact with the child and mother/child couple prior to possible rehabilitation therapy.

### **Who Should Receive Therapy Massage?**

There are a number of potential infants who are believed to benefit from massage. These include:

1. Healthy newborns.
2. Premature infants hospitalized for long periods who are still in an incubator.
3. Newborn with problems of pre- or perinatal asphyxia who have required periods of hospitalization and/or have suspected neurological damage.

4. Infants with any form of illness.
5. Newborns and infants who are hospitalized following an operation or invasive treatment.
6. Newborns and infants with orthopedic malformations.
7. Infants with sensory deficits.
8. Down syndrome babies.
9. Infants with affective deprivation.
10. Cases of overtly difficult or disordered parent-child relationships.

### **How to Teach Massage**

Specific individual techniques may be outlined after observing the mother attending to her child. Sometimes, it may be advisable to try the experience out on the mother's body or part of her body to reassure her of its pleasant effects.

It is helpful for the mother to try out the massage at the same time as the therapist so as to reassure her about its correct performance.

The mother is generally told that there is not a right or wrong way to carry out the massage. The pleasure of touching and being touched is a reciprocal exchange of feelings, of which she will become aware after performing the massage a few times. In most cases, she will be the one to see what gives the child most pleasure and what she prefers doing, resulting in mutual pleasure-giving, which is an important goal.

### **Conditions Favoring Success**

#### **The Setting**

A warm, but not damp room is suggested, consistent with normal family habits. Generally speaking, the massage should be performed during moments of relaxation for mother and baby. A natural setting (seaside, beach, field, mountain) may provide the right conditions for carrying out the massage. Although it is not important that the child be on an empty stomach, it is more important that he or she is calm.

#### **Child's Posture**

The baby may lie on the mat in front of his mother on his back, tummy,

or side, depending on type of massage, and must always be naked, or in his mother's lap. It is an advantage to work on the floor, as this opens up the possibility of more natural conditions.

### **Mother's Posture**

The mother stands, kneels, or sits with her legs stretched out or cross-legged before her baby, according to whether she prefers to work on a table or on the floor.

### **The Holding Environment**

A steady rapport between mother and clinician is a necessary precondition in order to create a harmonious setting for the child and his body, thereby permitting sensations to be transmitted in a pleasant atmosphere for the mother/child couple.

The therapist acts as a vehicle of nonverbal communication between mother and child.

### **Applications to Specific Populations**

In recent years, massage also has been introduced as part of the comprehensive therapy for various special populations. These have included children born prematurely, infants with brain damage, infants who are recovering from surgery, or children or parents with psychiatric or relational disorders.

### **Premature Infants**

The first Neonatal Intensive Care Unit systematically and successfully to apply massage therapy, providing mini-courses for parents prior to discharging the child was the Gaslini Hospital in Genoa (Briganti, 1992). Soon, other neonatal intensive care nurseries in Turin, Milan, Bologna, Trieste, and Naples will provide massage therapy as an option for parents. Some of these also will provide support at home for mothers who have most difficulty in applying it.

Rather than type of massage, be it gentle or strong, the professionals are more concerned with respecting the



time taken by mother and child and their communications and suggestions, and they modify the massage, following child's requests or reactions.

The general tendency is to let the mother do the massage as soon as possible. However, in the case of very premature infants and ones who are hospitalized for long periods of time, therapists may perform the massage directly in view of its clearly positive results on infant recovery and development.

Typically, Neonatal Intensive Care Unit's place little emphasis on the baby's experience of pleasure. In fact, Italian Neonatal Intensive Care Unit's only recently have addressed the problem of preventing babies from feeling pain. Introducing the massage means forcing the entire staff to see the baby differently and enabling parents to see that their baby can be provided with less "alien" activities than ones involving machinery.

### Infants with Brain Damage

In addition to the Neonatal Intensive Care Units, infant massage is often also performed with children with neurological damage and with children who have undergone an operation. Attention is paid to postures preferred by children with suspected neurological damage. Where there are asymmetries, posture is corrected in the direction of the symmetry and the massage previously tried by the therapist performed in positions where the child keeps correct postural alignment.

In the case of extensor hypertonia, the massage is performed in a flat position, or after achieving a certain degree of flexion.

As for children with specific malformations such as clubfoot, clubhand, torticollis, massage is recommended before (and undoubtedly after) cast application, as it eases reintegration of the long blocked and forgotten limb.

In these cases, the first massage tends to be a general one, after which the malformed areas are subjected to more specific pressure, delicate pinching, and brushing.

### Post-operative Infants

Massage is important in children who have undergone surgery for a variety of reasons, not only on their scars and the areas surrounding the scars, but in the whole body with a view to returning overall harmony to a body broken by a painful, traumatic experience. Use of the massage as a starting point for motor rehabilitation or to reclaim the body of a child who has undergone an operation may activate new interactive fantasmatic processes which inevitably have effects on actual interactions (Stern, 1989).

### Parents with Psychiatric Disorders

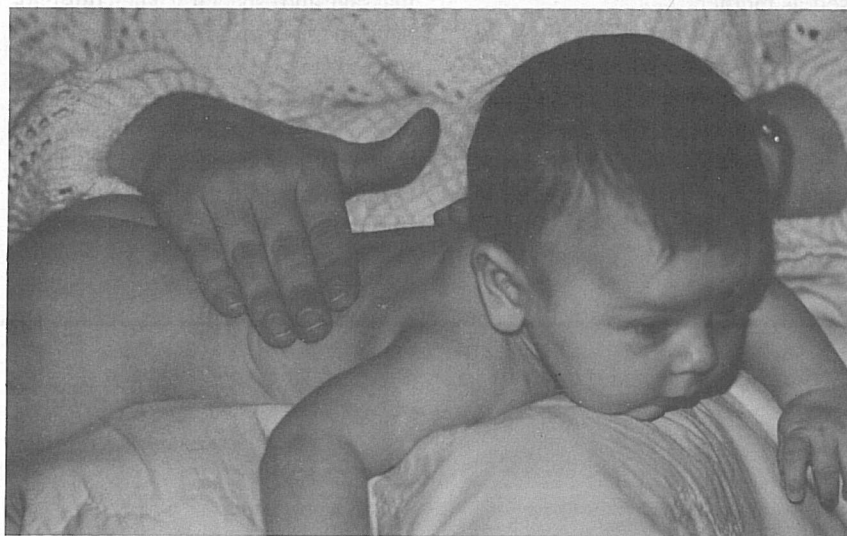
One application which is currently being explored is the use of massage therapy with disturbed parents experiencing severe psychiatric crises, especially with those who refuse any sort of

experimented teaching massage techniques to the mothers at highest risk for having children with poor outcomes.

### Mother-Child Prevention Groups

In the Family Guidance Clinic in Este/Montagnana, for example, a psychologist, Dr. M. Antonioli and a midwife, V. Rossetto, have set up regular groups of mothers (4-5) who get together to perform infant massage in the clinic during the puerperium and the child's first years of life. This enables mothers to share the experience, observe each other, and discuss any difficulties they may have with the two professionals.

De-medicalization of this space has meant that even mothers who have significant psychopathology and who are incapable of organizing representation of the child and of themselves as



psychotherapeutic relationship or other forms of psychiatric treatment (because they belong to disorganized or socially outcast families, because paranoid or obsessive ideas induce negative transference with regard to the services, because deeply depressive states prevent subjects from seeking help or positively investing any help offered).

In recent years, some Family Guidance Clinics which monitor families from early pregnancy, and some communities for teenage mothers with extremely adverse family histories, have

mothers, can be reached. These mothers are able to accept the suggestions of the other mothers in the group, or at least allow the midwife to come to their home to perform the infant massage as a relatively neutral intervention, after which they may return to the group or at any event, maintain relations with the services.

We have found this a particularly important use of infant massage. Family guidance clinics are present throughout Italy. We are constantly confronted with the fact that although the network

of so-called preventive services is free of charge, the most high-risk situations which really need intervention, often come to the attention of the services at the time of birth, after which they disappear, owing to their intrinsic difficulties and the type of communication that can be established, in which there is little room for verbal exchange (better known to those with psychodynamic psychotherapeutic training).

Infant massage has proved to be a tool that may facilitate the development of attachment since the mother is treated within her concrete relationship with the child. Often while testing the massage on herself and on her child, she discovers sensations which allow her to reactivate a more harmonious perceptual work than the one she is used to, thus enabling her to start a more positive construction process of herself as mother.

Moreover, if the therapist is able to provide a massage technique which gives the child pleasure without comparing it to the mother's failures, this will ease identification with the therapist and other mothers in the group at

times when she experiences feelings of profound inadequacy. In our brief experience, yet significant, moments of this kind have been enough to modify serious relational impasses or, for example, to bring an end to severe psychosomatic manifestations in the child.

Although most of these cases concern healthy children, clinicians must possess exceptional ability, as considerable knowledge is required on the limits had by each of these mothers and the family behind them. Exceeding these limits, becoming intrusive may once again mean breaking the fine thread holding family and services together, thus leaving child and parents even more on their own.

In most cases, massage becomes a part of daily bodily interaction between mother and child, and is worked through in a very individual way. Only a few mothers become very upset with massage and especially when this happens in the group, the therapist has some difficulties in order to help the mother to stop without feeling a failure. Usually parents don't ask when they should stop the massage, and the therapist doesn't indicate a termination point, either.

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## Stephen's Corner

### IN THE MARITIMES

My experience has always been with urban infants and children, more so these past years with those from the inner city. In its basics, I would like to feel, this background should translate to any setting. Still, I do not have a firm sense of what it would be like to work in a rural environment.

It was a wish to escape the constraints of my own city experience that pushed me to look around from the place I have spent the month of August during the last four summers. This is in New Brunswick, Canada, on the shore of the Bay of Fundy, where the towns are far apart. Except for a few small farms, the large expanses of land

are scrubby forests that were logged out years ago. Also, I have been curious about the Canadian system of medical care. Put in a more personal way, in a frightening fantasy I worry how I would survive if suddenly deposited in another system and place.

My beginning point in exploration was to ask Klaus Minde from Montreal to put me in touch with some child psychiatrists who practiced in the Maritimes. This first part was quite successful in that I got to meet many vivid people. Nevertheless, I became aware quickly that I would have to repeat my explorations many other summers before I had a firm sense of what were the mental health resources for young children in this part of Canada.

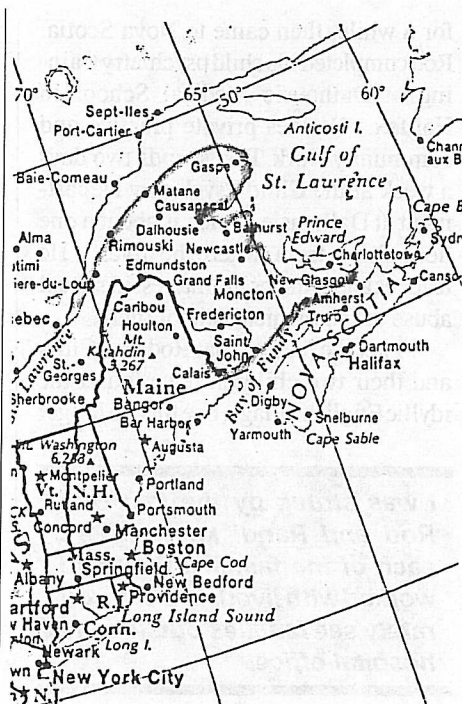
First of all, unless you have a map handy, a geography lesson is in order.



The Maritime Provinces consist of New Brunswick, Nova Scotia, and Prince Edward Island. Our interest here is in the first two. New Brunswick is a northern continuation of Maine that moves east as well. Nova Scotia is like a figure "7" attached at its upper left to New Brunswick and between is the Bay of Fundy where the tides are some of the highest in the world. Midway up the Fundy coast of Nova Scotia is a indentation which is called the Minas Basin. Its southern shore contains some of the richest farmland in the Maritimes. It is known popularly as Evangeline country, named after the Longfellow poem that begins, "This is the forest primeval...." It is from the village of Grand-Pre' that in 1755 the Acadians were driven out and subsequently scattered. "In the Acadian land, on the shores of the Basin of Minas, Distant, secluded, still, the little village of Grand-Pre'/Lay in the fruitful valley ...."

Rod Evans is a child psychiatrist who lives in Wolfville, which is several miles inland from Grand-Pre'. Because of its location and charm, it is a much frequented tourist area and as well is home to Acadia University. The possession of such a place usually gives a small rural town a special vitality and culture. I was put onto Rod through one of Klaus Minde's fellows who came from that area and felt he had pointed her in the direction of child psychiatry. Rod was enthusiastic about my visit and suggested that I meet with him in Kentville, ten miles south of Wolfville at the Regional Hospital, where he is the child psychiatry consultant.

Rod is a solid man in his early 40's who has the youthful animation and enthusiasm that I would like to believe is a special quality of child psychiatrists. I learned later that he plays lead guitar in one of the local rock bands. In our initial orientation to the other's way of life I learned that his catchment area is forty miles by forty miles and contains a population of 40,000, while mine is a triangle of a little over two miles high and midway a mile in width that is home for 150,000 people. History is alive up here, but not in the city



where I work. Still, it occurs to me that the name Harlem, the place in which I work, catches the old empire rivalries wherein one culture was pushed out by another, then the Dutch as the vanquished. We sit in Rod's office, which is in a small building that is part of the Kentville Regional Hospital complex.

I often feel it is an act of disloyalty to my own city hospital to find that attractive surroundings such as fresh paint and posters on the wall are agreeable. We are joined by Randi Robicheau, a social worker, who is the child psychiatry clinic coordinator. She is a slim dark-haired woman with an intense energy and restless curiosity which leads her to see the basic funniness of things. Her family is Armenian and her husband comes from a Dutch and Acadian background. I mention this only to catch that not only are there solid French and English pockets here, there is a diversity, as well. Randi is enthusiastic about the island down the coast, which one can reach by two ferries, where her husband's family live and where whales can be seen. Randi is a spirited promoter of maritime sights, a tour guide still excited by her own territory.

Except that drugs and AIDS have not as yet appeared, the issues for chil-

dren up here are much the same as what I am accustomed to in New York. The focus for assessment and treatment is on the family and the impact of family disorganization on children is as always crucial. Child abuse is a major issue and demands a close relationship with child welfare agencies and the court.

I brought up the question of infancy and young children. Rod said that they did not often see children in their clinic under the age of two or three years. My impression is that unless an organization goes hunting for infants they get lost. Randi's view is that there was not one friendly access to families with children under the age of three years. In the recent past, public health nurses used to visit every new infant, but this has been stopped. They mentioned a child that finally came to their attention at one year of age after languishing out in the country in deprivation, never having been given a name. When they both considered the issue of infants they realized that there was indeed a patchwork of services outside the mental health system. Nova Scotia is a poor Province and the area around them is wide-spread and rural, and the people parochial.

What Rod and Randi had to use were the existing community resources. One is the Valley Child Development Association, one of Nova Scotia's early intervention programs. This is a home-based program funded jointly through the Province and the community. It offers support, education, and coordination of services for families with children under three who are delayed or at risk because of birth history, medical, or environmental conditions. It appears similar to the U.S. Zero to Three programs and similar also in that it is here that infant mental health may or may not find a place, depending on the initiative of mental health professionals.

Other pieces of the patchwork are the pediatric services, a family support center sponsored by the department of health, and several members of the psychology department at Acadia College who have an interest in young

children. Let me say that I felt they had a good arrangement here and one that could thrive with the growing awareness of the emotional needs of infants.

Sitting in an office talking about programs brought out the similarities of our experiences, but it was the several hours ride around the countryside that highlighted the differences. The vista from the top of a small mountain displayed the miles of jagged coast line and the lush valleys with their orchards.

Abuse is a major interest for Rod, more specifically sexual abuse, and a vivid sense of it came from seeing where it resided. What I mean is that riding around with Rod and Randi the socio-economic aspects of abuse were striking. Even in an area of prosperous farms and scenic fishing villages with their piles of lobster pots at the dock, it took just a short drive down a back road to see rural poverty in the form of dilapidated cottages and disordered yards. Glib, but true enough, was the shabby isomorphism of family and surroundings. I was struck by the fact that Rod and Randi knew where each of the families they had worked with lived. In a city you rarely see families outside the hospital office. Randi had met with most of the difficult families in their home, the Maritime version of Selma Fraiberg's kitchen therapy. Since they both lived in the community every walk down a street led to a meeting with a patient, which could be rather sticky in that some had involved painful court work. At lunch, as I ate my oat bread and fish chowder, I listened as they planned with a quick ease an afternoon evaluation for the court -- which was one block from their clinic.

A personal sense that I could make it up here was boosted by dinner at Rod's large Victorian home on a lovely tree-lined street. It was described by Chris, his wife, as a typical Nova Scotia meal -- salmon, scallops, corn and potatoes. She had made a trifle for dessert. Both Rod and Chris are from England, she from Liverpool and he from Wales. He attended medical school in Sheffield and took his psychiatry training there. After marriage, they lived in Australia

for a while, then came to Nova Scotia. Rod completed his child psychiatry training at Dalhousie Medical School in Halifax. Besides private practice and community work, Rod spends two days a week at the Child Psychiatry Department at Dalhousie, which is about a one hour drive from where he lives. He teaches and pursues his interest in sexual abuse at the medical school there.

I get the feeling that Rod and Chris and their two children have found the idyllic English village, one that no longer

***I was struck by the fact that Rod and Randi knew where each of the families they had worked with lived. In a city you rarely see families outside the hospital office.***

exists in England. Chris laughs as she describes her mother's visits, her locking the doors always -- never done in Wolfville -- which annoys the children because they cannot get in after school.

In this era of urgent health care reform, I comment that the Canadian system seems to be the model we in the United States look to, a comment that Rod thinks is very funny because he believes the British system is much admired here. The British, in turn, feel the American system is the best. No one is ever happy or ever will be -- except that Rod may just have found contentment.

Back to geography. Let us sail over the Bay of Fundy and then into its uppermost west corner to the city of Moncton where Bobbie Ross practices.

Bobbie attended medical school at Dalhousie and trained in child psychiatry in Ontario when Klaus Minde was there. She is spending the summer at her cottage in Shediac, which is 30 minutes above Moncton. She advises me to bring a swimming suit, but I pay no attention because the water where I vacation would not allow you to stand it for ten seconds. I find that when I get there the place is advertised as having the warmest swimming north of Virginia. This is the Northumberland Strait, the body of water separating Nova Scotia

and New Brunswick from Prince Edward Island and for some reason gets the gulfstream.

I sit on the beach and take in the many shades of green and blue in the beautiful shallow bay as Bobbie describes her professional life here and watches her three children who range in age from just one to five years. Bobbie possesses the proper determined animation of her profession but also a striking prettiness. I assume she was contestant for prom queen when in high school. My listening was at first concrete, in that although she was answering my questions I was missing the main point. She feels that the very young child in trouble such as failure to thrive or suffering neglect is more apt to be picked up by pediatricians or the Department of Health or community service organizations. I think about this and decide that if there are to be further articles I need to expand my interest to these other areas. Also, after hearing Bobbie describe her several seasons of adventures in pediatrics in northern Newfoundland and Labrador, I decide that I want to move explorations up north.

As she talks, Emily, her one-year-old, plays at her feet with some thick sea weed, delighting in pulling it apart and tossing it. This is a classic baby, plump and hearty, whose large blue eyes both look you over and merrily greet you. Upon her own urge she nuzzles her mother and Bobbie deftly breast-feeds her.

Bobbie shares an office with her husband David, who is in family practice. They both try to keep their work week modest so as to have time for their small children. She felt that a particular protection and positive point in this region was the extended family. This is true for her family, with grandparents, uncles, and aunts nearby.

Suddenly, she has to go down to the beach to mediate a dispute involving the throwing of mud and so leaves Emily with my wife and myself. Emily is a good sport about this for a moment but then starts to protest loudly. She calms quickly when her mother returns. Later, I watch David as he grills salmon steaks



in the backyard of their beach cottage and listen as he tells me about a meeting he attended where Berry Brazelton chastised psychiatrists for putting enormous energy into their professional activities but not paying much attention to their own children. Essentially he believes that good mental health begins at home. They both were delighted to hear this, especially since they believed it already. Bobbie went on to say that she was just finishing up a years maternity leave. She had been determined to take this time but it had been very hard to get away. During this year she had maintained some contact with her patients and had kept in touch with the literature, especially psychopharmacology which is of special interest to her. She was enthusiastic about her teaching and research plans for next year. Now, we were sitting at a table out back. Emily, who sat next to me, mushed spaghetti into her mouth and also seemed to like carrots so I slipped her some of mine.

It was then that I caught onto what was important in this talk with Bobbie. I had been pressing her about generalizations concerning health delivery for young children, but often a specific instance best captures the essence of things. I thought of the most apparent observation to be made at a WAIMH meeting and also at other organizations that focus on young children. Most of the participants are women, and the number of infants in backpacks, snugglies, and strollers is considerable. In this exploration of Canadian infant mental health I had gotten beyond programs and had met one real baby, one whose life was thriving in this setting and system -- Emily.

#### **Editor's Note:**

*Dr. Stephen Bennett is Chief of Child Psychiatry at Harlem Hospital and Assistant Professor of Clinical Psychiatry at Columbia University. He has been a baby watcher for many years. At present, he straddles the ivory tower concerns of academe and the pressing real world problems of the inner city. His column is a regular feature of this newsletter.*



## **President's Perspective**

*Joy D. Osofsky*

In this President's column, I will continue my efforts to inform the membership about Regional Meetings that are held around the world and offer my perspective as President about some of the important new developments. Our latest WAIMH Regional Meeting was a joint one with the International Association for Child and Adolescent Psychiatry (IACAPAP) and the International Society for Adolescent Psychiatry (ISAP) held in Punta del Este, Uruguay, November 24-28, 1993. The theme of the meeting was "Change and Development: The Infant, the Child, and the Adolescent in the XXI Century" organized with great energy, enthusiasm, and skill by Miguel Cherro Aguerre. Thanks to Cherro and his



*Conference organizer, Miguel Cherro Aguerre*

wife Natalie's extraordinary efforts the meeting had an excellent mix of clinical and scientific presentations as well as warm collegial sharing. Cherro went out of his way to attend to both professional and personal aspects of the meeting and for this, we are most appreciative.

WAIPAD and now WAIMH meetings in South America have always been special in ways somewhat different from those held in other parts of the world. Over the past 6 years, initiated under Bob Emde's Presidency and con-

tinuing since then, colleagues from North America, Europe, and Japan have built special relationships with our South American colleagues that have included not only sharing ideas, but also consulting on the development of research and clinical programs addressing concerns with both low and high risk infants and families. Colleagues from Argentina (organized by Miguel Hoffmann), Brazil (organized by Salvador Celia) and Uruguay (organized by Miguel Cherro Aguerre) have come together in building their own special relationships and opportunities for sharing work and programs. The Punta del Este meeting represented a special coming together since it involved not only the cooperation across countries in South America but also cooperation among international organizations.

The meeting covered research and clinical material ranging from the prenatal period through adolescence, reflective of the interests of the three international organizations. There was much diversity in the types of presentations including courses, symposia, workshops, papers, and plenary sessions. WAIMH Executives participating included Bob Emde, Yvon Gauthier, Antoine Guedeney, Miguel Hoffmann, Hisako Watanabe, Charley Zeanah and myself. Alicia Lieberman (from San Francisco and Paraguay) was invited to join the WAIMH group at the meeting. The consecutive translation for the meeting was excellent as two of the main translators were a pediatrician and a child psychiatrist. It was a unique experience at times when the translators would get involved with the material we were presenting as well as translating it for others.

The weather played an active part in our Punta del Este meeting. Living in a region of the United States where hurricanes are common, when we woke up one morning with the banging resulting from strong winds and rain, I concluded that we were either experiencing a weak hurricane or a strong tropical storm. However, the meeting went on--as did the extraordinary hospitality. Miguel Hoffmann, our Treasurer, and his family from Buenos Aires entertained WAIMH colleagues and about 50 other people in his Punta del Este home with no electricity! (We also conducted our second Executive Committee meeting by candlelight.)

The best story, however, was told by Yvon Gauthier. While delivering one of his talks, his videotape became stuck in the machine and had to be extracted with a screwdriver. As they were competing this process, all of the electricity in the building went out. As he was continuing his lecture in the dark at the request of the audience, the interpreter knocked over a glass of water that spilled all over his lap! Yvon reported that it was such an unusual

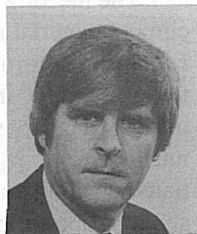


L-R: Miguel Hoffmann, Bob Emde, Joy Osofsky, Yvon Gauthier, Antoine Guedeney, Phillippe Jeammet (ISAP), Alain Bagonnier (ISAP), Donald Cohen (IACAPAP)

series of events that he laughed throughout feeling like he was caught in a "Charlie Chaplin" movie!

A final personal note. Those of us from North America, and perhaps other parts of the world as well, have much to learn from our friends and colleagues in South America about relationships and sharing. There is a level of genuine warmth, acceptance, and welcoming that seems to characterize people from this

region of the world that I have rarely experienced elsewhere. Despite their many problems, economic and otherwise, they know how to gain the best of life through sharing, valuing relationships and having fun--often with wonderful music. We have much to gain by sharing and learning from these experiences.



## From the Red Cedar

**Hiram E. Fitzgerald**  
*Executive Director*

There are many individuals who hold membership in WAIMH who also hold membership in a WAIMH Affiliate. Others belong only to WAIMH and there are some Affiliates who have members who do not belong to WAIMH. There continues to be much confusion about the distinction between Affiliate membership and WAIMH membership. So in my report from the central office for this issue of *The Signal*, I will try to clarify the situation.

Individuals who join WAIMH are entitled to all of the benefits of WAIMH membership. These include a substantial reduction in the cost of the *Infant Mental Health Journal*, quarterly issues the *The Signal* (newsletter), access to the WAIMH Video Library on Infant Mental Health, reduced registration fees for workshops, regional conferences, world congresses, video rentals and any other activity that would be accessible by the general public. Membership does

have its privileges. Some individuals join WAIMH and do not wish to subscribe to the *Infant Mental Health Journal*. They receive all benefits, except the subscription. I believe that all of this is rather straightforward. Now is when it gets a little tricky.

Many individuals live in an area that has an Affiliate organization. There are two options available to these individuals. Option 1 is to join the local Affiliate and join WAIMH. These individuals would receive the benefits of both the local organization and WAIMH. The WAIMH by-laws stipulate that each Affiliate must have a minimum of 10 members who belong to WAIMH. For very small Affiliates the requirement holds that a minimum of 10 individuals must have membership in WAIMH (and their local Affiliate). However, if the number ever falls below 10, the Affiliate should contact the Executive Director,



who will immediately set things in motion to help to rebuild and revitalize the Affiliate. **Keep in mind that the only way that an individual can receive a subscription to the *Infant Mental Health Journal* at the member price is to have membership in WAIMH.** Membership in the Affiliate does not qualify an individual for WAIMH benefits unless the individual also has membership in WAIMH. To summarize:

- ◆ WAIMH Membership Only. All benefits of membership.
- ◆ WAIMH and Affiliate Membership. All benefits of both organizations.
- ◆ Affiliate Membership Only. Benefits of Affiliate membership, but no WAIMH benefits.
- ◆ Affiliates must have a minimum of 10 WAIMH members who also belong to the Affiliate.

Affiliates may elect to collect both their own dues as well as that of WAIMH and then send WAIMH membership and subscription fees in one mailing. This is quite acceptable, actually preferred. However, we also can process WAIMH memberships regardless of the individual's Affiliate status. Many of WAIMH's members do not belong to an Affiliate, many do. One of the major benefits for Affiliate membership is that

members of affiliates are generally held together by a set of local issues; that is, their interdisciplinary focus is bound to the local geopolitical base that either is or is not in support of the shared mission. Others are held together because they find great value in sharing clinical information, participating in clinical study groups, or participating in a reading study group. Other examples could be generated I'm sure. WAIMH's focus is the world, its that simple. WAIMH provides training, education, advocacy, etc. worldwide by its own sponsored activities, and by **supporting the activities of Affiliates by helping them to access master clinicians for presentors at Affiliate conferences and training programs.** WAIMH also will co-sponsor regional conferences/training programs. For information about co-sponsorship interested individuals contact any of the following: an appropriate WAIMH Regional Vice-President, the President, or the Executive Director. WAIMH must have a role in any meeting that is advertized as having WAIMH co-sponsorship. I hope that this clarifies the relationship between WAIMH and a WAIMH Affiliate. If there continue to be questions, please contact the central office and I will answer your questions as best I can. Finally, I just want to make it quite clear

that it is not necessary for an individual to belong to an Affiliate in order to be a member of WAIMH.

The **Beacon Club** is off to a flying start with five individual members. In addition, Clinical Psychology Publishing Company, the publisher of the *Infant Mental Health Journal*, is donating 10 subscriptions to an international consortium that provides scientific journal subscriptions to third world countries and the countries of the former Soviet Union. So we will have an annual base of 15 subscriptions heading abroad to help bring infant mental health knowledge to our many colleagues in countries where financial resources are limited. Want to joint the effort? Why not make a 1994 commitment to support this outreach effort and underwrite a WAIMH membership and journal subscription. We will publish a list annually of all Beacon Club members and the recipients of the donated memberships. Remember, you must renew your Beacon Club memberships annually if you want subscription to continue to be sent abroad.

My very best wishes to everyone who celebrates religious holidays during December, as well as to members whose holidays occur at other times during the year. Joy and Peace to you all.

## A WAIMH Study Group Report

### Specificity of Psychoanalytical Work with Parents and Infants:

#### Origins:

The idea for study groups was Serge Lebovici's. The goal of such groups is to discuss important topics between world congresses in order to provide program committees with relevant issues for discussion at the congresses.

The goal of the study group on Specificity of Psychoanalytic Work with Parents and Infants was to enhance our ability to teach psychoanalytically oriented techniques, and to improve our

sensibility to various situations. Obviously, and happily, psychoanalysts are not the only professionals in the field of infant psychiatry and infant mental health. Many different approaches are possible for parents and infants. We, as analysts, believe in the value of psychoanalytical theory as a firm basis for intervention with parents and infants. But what is the specificity of psychoanalytical work in such a

setting? To answer this issue, Serge Lebovici, Bernard Golse, Michele Maury and I asked a few well-known clinicians to participate in a study group: Bertrand Cramer (Geneva); Dilys Daws, principal child therapist at the Tavistock clinic (London); Rosine Debray, professor of psychology, full member of the French Psychoanalytical Society and the French Psychosomatic Institute (Paris); Pr. Michel Soulé, also a full member of the French Psychoanalytical Society; and Dr. Anette Watillon-Naveau, full member of the Belgian Psychoanalytical Society, and of the Association de Psychoanalyse de l'enfant.

Dr. Alice Doumic-Girard, a

pioneer in the field of parent-infant psychotherapy, joined the group for the first sessions. After the Chicago congress, Dr. Nicole Guedeney, head of a parent-infant program in Paris, joined the group, along with Martine Morales-Huet, psychoanalyst and psychologist. Tobie Nathan and Dr. Marie-Rose Moro were also invited for their work with migrant parents and infants. Dr. Francisco Palacio-Espasa, working in Geneva with Bertrand Cramer also joined the group then.

The group went into a first "gathering" period, meeting twice a year in Paris, beginning in February of 1992. Paris was considered more convenient for everyone. We have tried from the beginning to have meetings on the same weekends as the Study Group on Infant Observation headed by Bernard Golse. Peter Fonagy is a permanent guest of our group. The two study groups share their conclusions and look forward to having a common meeting in 1994.

Each member of the group first presented the core of his or her beliefs about what is specific in the work with parents and infants. Each member summarized his or her personal approach, and the results of personal experience. Infancy plays a very important part in psychoanalytic theory, at least as a theory of the beginnings of mental life. But psychoanalysts working everyday with parents and infants are rare. It is important to remark that most of the members of the group have had pediatric experience.

### **Presentations:**

*Serge Lebovici* is a pioneer in the field of infant mental health. He has gathered an extensive experience of therapeutic consultations. He showed how identification to the child and to the parents can lead to the recognition of the different themes of the "fantasmic interaction", with special emphasis on the process of transgenerational transmission of these themes.

*Bertrand Cramer* drew attention to the main conflictual theme between mother and child and demonstrated how

this theme is present in the first minutes of the consultation. He then follows the trail, helping its elaboration and establishing links with the mother's or parents' past. His research shows a much greater activity of the therapist in such a setting, compared with conventional therapy. The presence of the baby enables the making of "hic et nunc" links between the intrapsychic conflict of the mother and its expression in the mother-child interaction or the "specific interactive sequence" under the eyes of the therapist, thus somehow showing him the way to the core of the conflict. Most of his patients are referred by pediatricians for evaluation. Cramer has been working on the feasibility of brief and focalized parent-infant therapy.

*Dilys Daws* sees families and infants with sleep, feeding, crying, or "bonding" problems, at the Tavistock clinic and in a well-baby clinic in London. She insists on the necessity for psychoanalytically based work to take in and reflect on what parents tell her, so that an integrative and understanding process beginning in her mind can then take place in theirs. Practical matters are discussed extensively, but little, if any, advice is given. The meetings are dramatic, packed with information and emotions. The analyst has to be able to accept the initial chaos, to receive and identify projections, thus helping the integrative process in the parents to take place again.

*Rosine Debray* insists, along with D. Days, D. Cramer and S. Lebovici on the preventive impact of parent-infant therapy in the very specific and sensitive period of the first year following birth. The main aspects of the infantile neurosis are then stirred up again by the presence of the baby, and are much more obvious than in a conventional setting. Therapeutic consultations can lead to impressive changes. However, Debray believes that therapy should aim at a long term involvement each time this is possible. She emphasizes the need for the parent-infant therapist to have an explicit theory for the infant's physical symptoms, in order to be able to make an evaluation of the level of

responses the infant is able to make in the interaction. She emphasizes the need to take in the economic perspective in psychoanalysis, especially when applied to parent-infant situations.

*Anette Watillon-Naveau* has acquired great experience in parent-infant consultation and therapy. As does Serge Lebovici, she insists on the impact of such experience on adult analysis. As a trained supervisor in infant observation, she is interested in the therapeutic aspects of this technique, along with the general issues of therapist formation.

*Michel Soule* has extensive experience with clinical situations that can be traumatic for infant and families such as prematurity, medically assisted procreation, antenatal diagnosis, still-birth, or after sudden infant death.

### **Evolution of the group:**

The group held a first colloquium, with one hundred invited professionals, February 5, 1992, in Paris. The theme was "Treated Infant, Observed Infant", and each study group had half of the day. A special issue of *Devenir* will appear in January, 1994, about this meeting. The meeting created considerable interest, since it is a bit unusual in France to see experts in a field having what the diplomats call a "frank discussion" about their differences, and even more interesting, the possible reasons for their differences.

It became obvious that the differences between the therapeutic strategies are related to differences of etiology, differences in personal styles, and differences in the situations of the infants and their families. The group has met regularly since. We are now working on the first consultation, to understand our process of making choices and how we respond to what is exposed to us. We intend to make the same kind of analysis for a session on parent-infant therapy. We also plan to have one of us presenting a videotaped first consultation with a new methodology, in order to understand what the consultant was driven to do, more or less consciously.



### ***Relations with other groups:***

We are in contact with the "American Group" which meets on the same basis (Eleanor Galenson, Alicia Liebermann, Paulina Kernberg, and Stephen Seligmann, who serves as secretary). The two groups exchange reports on their meetings via the secretaries and through our personal contacts. We presented a symposium in Chicago, which was successfully attended, and intend to continue our exchanges in Lahti, with more audience participation. The two groups could, for example, react to a videotaped interaction

that was prepared and translated prior to the congress. A common meeting is planned with the Study Group on Infant Observation. The theme will be the therapeutic applications of observation.

The study group is very interested in receiving reactions and suggestions. Our goal is to improve the efficiency of applied psychoanalysis in different situations where infants and parents are in trouble. We want to improve our sensibility to different contexts and cultures, to enhance our technical skills, and our instructional methods and techniques.

—Antoine Guedeney, M.D.

Interested readers can contact Dr. Guedeney at:

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## **Pregnancy Following Perinatal Loss:**

### ***An Intervention Program for Parents***

by: *Joan Alar, M.P.H., M.S.*  
*Care Thorwick, R.N.*

The death of a baby creates a unique type of bereavement, with particularly severe, long-lasting and complicated consequences for parents. Parents who have lost a baby during the perinatal period bring special needs to a subsequent pregnancy as they attempt to work through the interwoven tasks of grieving their loss and bonding to the new pregnancy/baby.

It is difficult to establish accurately the number of neonatal deaths that occur annually. It is equally difficult to measure the occurrence of other experiences that can create feeling of loss such as the birth of a child with disabilities, a premature birth, spontaneous or elective abortion, or giving up a child for adoption. In addition, advances in reproductive endocrinology and perinatal medicine make it possible for many couples who previously were infertile to conceive and for couples with multiple losses to carry pregnancies to viability. All of these issues will affect a subsequent pregnancy.

Current research primarily deals with parental grief when loss occurs. Support services based on this research have been established to assist parents in birth and post-partum adaptation. Other than retrospective studies, little research has been done on parental reactions in a pregnancy after a perinatal loss (Zeanah, 1989). Therefore, few programs are available to parents in these subsequent pregnancies. In addition, little is known regarding what their specific needs might be.

For the past eight years, Abbott Northwestern Hospital has had a special childbirth preparation class for parents experiencing a pregnancy after a loss. This class led to the development five years ago of a weekly family support group dealing specifically with the issues they face. We used what we learned from families who have been brave enough and strong enough to deal with the pain of their loss as the foundation of our multi-faceted program.

Most professionals have no idea of what these families are going through. Many, unfortunately, may cause emo-

tional damage because of their lack of understanding. These families have needs during pregnancy, labor and birth, and their post-partum experience that are different from other families. The merger of two theoretical frameworks - one dealing with grief/loss and the other with attachment - is the foundation on which we developed Abbott Northwestern Hospital's Pregnancy After Loss Program.

Research shows that some parents exhibit detached responses during pregnancy, focus excessively on negative outcomes, and have intense anxiety regardless of how long after the loss the pregnancy occurs (Phipps, 1985; Davis, Steward, & Harmon, 1989).

What we have seen clinically in our program validates these findings. These themes are so common that we look at these stages as the normal developmental process of preparing for parenting after a loss (Alar, 1992). When families come into the program, they are searching for others who understand that, though a child of theirs has died, they were parents once and, indeed, still are. As one parent said, "My baby died, but I am still a mom." In our work with families with previous loss, the focus of the pregnancy is to validate the parenting experience they had. Efforts also are made to help them find a place in their family for the baby who died (Theut, 1992). We guide them in learning to

trust the behavior patterns of the baby they are carrying to give them the reassurance they need (Alar & Thorwick, 1993). As they learn to know this baby, they begin to attach and learn to trust their bodies again as they prepare for birth and parenting.

Our program is designed to empower parents to understand their loss, to recognize and affirm that their fears and anxieties are normal given their history, and to support them in attaching to their new baby while continuing to love the baby who died. The program's goal is to provide families with a sense of how the child who died and the new baby fit together in their lives. Parents find healing in seeing their grief and anxiety put into a normal framework.

Abbott's Northwestern's Pregnancy After Loss Program consists of:

- ◆ a booklet written by parents on the emotional issues of pregnancy after loss
- ◆ one to one consultation
- ◆ a weekly support group
- ◆ phone consultation with parents who have previously participated in the program
- ◆ a birth preparation class
- ◆ a post-partum mothers' group

For more information on the program or to order the program booklet, please call Joann O'Leary at (612) 863-4427 or write to her at:

Abbott Northwestern Hospital 11602  
800 East 28th Street  
Minneapolis, MN 55407-3799

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**Editor's Note:** Joann O'Leary, M.P.H., M.S. is a Parent-Infant Specialist at Abbott Northwestern Hospital and President of the Minnesota Association for Infant Mental Health. A forthcoming issue of the *Infant Mental Health Journal* will be devoted to "Perinatal Loss and Infant Mental Health."

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