

# The Signal



Vol. 4, No. 2

Newsletter of the World Association for Infant Mental Health

April—June 1996

## The Parentless Child in the Hospital: A View from Turkey

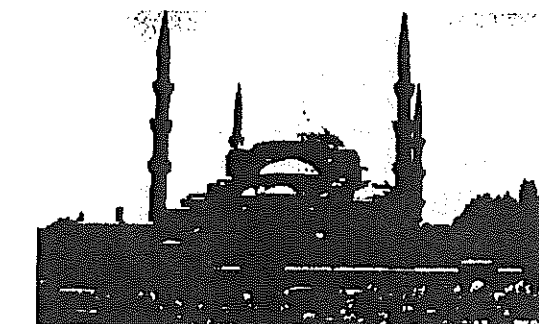
Ilgi Ozturk Ertem, MD

Turkey is known as a bridge between the east and the west, an ancient land of beauty where many civilizations have left marks, a culture that inherited diverse elements from its historical antecedents and an old nation that is striving to find a new identity within the modern world.

I have recently returned back to my country after a four year stay in the United States at the Department of Pediatrics and Child Study Center at Yale University School of Medicine. There, I completed a fellowship in developmental and behavioral pediatrics, my primary area of interest being the development and psychosocial problems of infants and young children. Now, as a junior faculty member at the departments of pediatrics and child psychiatry at Ankara University School of Medicine, I am working to help establish a psychosocial and developmental perspective in pediatrics and an infant mental health unit within child psychiatry.

The concept of infant mental health is fairly new in Turkey. Even so, at the first national conference on infant mental health which was held in Ankara in February 1996, many local clinicians and researchers presented their own work with infants and families. Charley Zeanah came as a guest speaker and spent a week with us. I believe his unspoken mission was to support us all in the work that we do and to challenge us with new thoughts and ideas. One of the challenges he put forth for me was to write this article for *The Signal* about the "Parentless Child in the Hospital."

The readers of *The Signal*, I am sure, do not need this article to remind them that the hospitalized infant or child should not be separated from his or her family. Many writers studies, dating from the dramatic work of Spitz (1945) and the Robertsons (Robertson, 1953; 1958a; 1958b; 1962; Robertson and Robertson, 1989), have addressed the effects of hospitalization on children and the reactions of parents (Brody & Klein, 1980; Knaf, Cavallari & Dixon, 1988; Roskies, Bedard, Gavreau-Guibault, & LaFortune, 1975; Thompson, 1985).



Cavallari & Dixon, 1988; Roskies, Bedard, Gavreau-Guibault, & LaFortune, 1975; Thompson, 1985).

Karen Waymen's recent article on implications of chaos science for children in the hospital published in the January-March issue of *The Signal*, reminded me that the current discussion for many hospitals in the West is how to deliver family-centered care in hospitals (Waymen, 1996). I believe this discussion is universally relevant.

At a time, however, when infant mental health workers in some countries are discussing family centered care in hospitals, it may be helpful to know what lies at the heart of the struggles of other countries at a more basic level. If a likert scale were developed to describe 'how much' a health delivery system is oriented towards care that is family centered, I believe that the hospital practice of not allowing parents to be with their children during hospitalization would lie at

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the bottom of the scale.

This practice may not seem relevant for many hospitals in the world today. As indicated however by a study in England, it has been relevant even in developed countries at least until recently (Consumers Association, 1980). This study found that in most hospitals in England, parents were not permitted to stay over night with their hospitalized infants. I fear that current hospital regulations elsewhere in the world, as is the case in many hospitals in Turkey, may not permit parents to remain with their children when they are hospitalized. The purpose of this article is therefore to draw attention to this phenomenon, to discuss the reasons behind such regulations in our country and to share my thoughts on possible solutions to the problem. My hope would be to find out from the readers of *The Signal* their experiences with similar situations and their suggestions for worldwide solutions.

I completed medical school and pediatric residency in Turkey. During most of this time I worked and trained in hospitals where mothers were permitted to stay in the hospital with their children. My initial recollection of experiencing a parentless child in the hospital was as a sixth year medical student. I remember a three year old girl with leukemia whose parents were not allowed to stay in the hospital with her. Each day after evening rounds when the ward turned quiet this 3 year old girl would go to the bathroom to wash her socks saying her mother had told her to take good care of her socks and to keep them clean. Although nursing staff offered to do this chore for her, she resisted. It appeared that this was her special time to be with the thought of her mother who could not be physically there with her.

My second recollection is during my pediatric residency rotation on the infectious diseases ward of the largest and most prestigious teaching children's hospital in Turkey. There, to this day, parents are not permitted

to stay with their children and visitation is very limited. The infectious diseases ward allowed no visitation. Parents dropped their children in and picked them up at the end of therapy, often several weeks later.

The windows of this ward overlooked an indoor corridor. During visiting hours parents lined up on this corridor. I remember parents and children touching and kissing through the fly-netting of these windows. The cries of these children sounded different from other cries like those of pain or hunger, they sounded filled with despair. These children cried most during visitation hours when they saw or heard their parents. At other times they rarely vocalized.

Recently, in order to refresh my memories for this article, I visited this university hospital where parents are permitted only if the child meets certain criteria, such as being very ill or needing constant supervision. This hospital is the largest teaching children's hospital in Turkey. It is recognized both nationally and internationally as being a hospital with modern technologies, contemporary clinical practice and dedication to pediatric research. On the infant ward there were about 15 infants and toddlers. Only two had parents at their bedside. Those who were not so ill that they could move were tied to their beds from their hands and feet. The resident who was my guide told me that this way they were safe and that they would not pull out their intravenous lines. Not one of them was crying.

My effort as I try to paint these pictures is not to convince those who are already convinced. The traumatic nature of such a separation for infants and young children and for parents is well recognized. Nevertheless, these pictures may serve to help us in understanding that despite the suffering that is bitterly obvious attempts to alleviate this suffering have been few. Identifying the reasons for the paucity and failure of such corrective attempts will be the

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key in finding solutions that will bring forth change.

In order to gain further insight into the phenomenon of the parentless child in the hospital, I interviewed parents who remained with their children during hospitalization, parents who were not permitted to remain during hospitalization, parents who experienced both policies, medical staff who worked in hospitals where parents were allowed to stay with their children and those who worked in hospitals where parents were not allowed to stay. Medical staff interviewed included pediatric nurses, residents, senior teaching staff, child development specialists who have similar functions as child life workers, child psychiatrists, clinical psychologists working in hospitals and chairpersons of departments of pediatrics who in Turkey also function as directors of hospitals. The heads of the Bureau for Inpatient Services and that of the Maternal Child Health Bureau of the Ministry of Health were also interviewed. As a result of these interviews I have formulated 5 factors operating as causes in the phenomenon of the parentless child in the hospital: historical, educational, economic-political, cultural and emotional.

I will analyze each factor separately although it appears that these factors are continuously interacting thus causing a sturdy backbone for "no change." Later, I will discuss possible solutions in light of this analysis.

#### **Historical factors:**

Since the earliest physicians who cared for pediatric patients were internists who also cared for adults, the model for caring for the 'little adult' was adopted from that for the adult. Typically the health care for the adult did not include the family. During the nineteenth and early twentieth centuries most health care institutions for the care of adults and children in Europe and the Middle

East were designed as large scale "sanatoriums" where the family had to leave their patients for treatment or custodial care.

Although today hospitals with modern facilities have replaced the old fashioned sanatoriums, wards for adults have not changed their admission policies. Visitation is limited and unless the room is a private one, there is often no room and no permission for a family member or friend to accompany the patient.

An example of this policy in adult medicine that is very relevant to infant mental health occurs on the obstetric wards. In hospitals, women deliver without the presence of a partner, and visitation even by the father is often very limited during the postpartum period. Children have not been the only age group that have been "patients-alone" in the hospitals in Turkey as this practice has historically prevailed for patients of all ages.

Also of historical interest is that founders of pediatrics in our country mostly trained in the West in the 1940's and 50's and brought back with them the subspecialties of pediatrics. The major pediatric hospitals in Turkey that were built around this time therefore were modeled after hospitals in the West, particularly those in the United States. Much of the terminology that is used today remains from those days. Rules and regulations such as calls once every other night for residents are also remnants of earlier practice in the United States. The founders of pediatrics stated that where they were trained in hospitals in Europe and in the US, parents were not permitted to stay with their children during hospitalization. They followed these models to establish the pediatric tradition in Turkey and this has not changed over time.

Unfortunately, the models adopted from adult medicine and from earlier pediatric medicine of the West have not been the appropriate ones for the mental health of children and parents. Even so, don't many prac-

tices that start at out problematic in time change for the better? The following factors may help us understand why change has not occurred for the parentless child in the hospital in Turkey.

#### **Educational factors**

During the 20th century, medical education and practice in Turkey have been oriented towards the biological model. The biopsychosocial model is talked about and taught, but in the minds of the medical profession it remains at best at the level of theoretical knowledge. Medical practice largely focuses on curing illness. Mental health and developmental concepts generally are taught only in adult and child psychiatry. Typically, these specialties cover teachings on mental illness and do not place emphasis on the psychological needs of the physically ill person without a mental illness. The pediatric teaching programs are no exception to the rule.

Pediatricians are involved in curing the biological disease. The pediatric discipline teaches little about child development or the psychosocial aspects of illness and health care. A professor of pediatric cardiology pointed out: "We give the medication. We forget that there is an emotional component to health." Furthermore, the psychosocial components of disorders such as malnutrition or asthma are rarely taken into consideration during treatment. As a result, it is not surprising to find that a child with severe malnutrition is hospitalized for months without the presence of the parent. The reasons for not permitting parents to remain in the hospital with their children therefore comes not only from the past but also from ignorance of the importance of having parents available to their children.

#### **Economic and political factors**

Turkey spends about 3% of its annual budget on health care. Hospi-

tal conditions suffer from having to depend on this small expenditure. The typical ward on a pediatric unit is comprised of rooms with three to six beds for infants and children alike. There is literally no space for the parent. In hospitals where the parent or other caretaker is permitted to stay, this person will be staying oftentimes for days on a chair at the bedside of the child. A senior pediatric resident reflected on her experience with such situations: "In our hospital, parents are not allowed to stay with their children. If you ask me, of course, I believe that parents should be there. Sometimes we make exceptions to the rule. If the child has terminal illness for example, we let the parent stay. The picture that follows is unbearable. This parent sleeps and lives on a chair. I cannot bear it. If conditions allowed it, of course I would want parents to stay."

Is there not enough money to remodel the existing pediatric wards? An answer comes from the attending physician at our hospital: "The rooms had three beds. We took out one. We separated the room into two with a glass wall and door. We painted the glass and made curtains. We made two rooms from one and we put in a couch for each mother. This is very inexpensive to do. Often times, you can find donations to do it. At the end you have fewer beds. This is, however, financially for the profit of the hospital since the parent is also charged to stay. Health insurance through the government covers this expense. These rooms for parent and child are constantly demanded by the parents."

Some opposition comes from the medical staff of the university hospital at the other corner of Ankara: "We could not do away with any of our beds. It would not be possible first of all because we cannot stop serving the public, and secondly we cannot risk compromising the education of our pediatric trainees by having fewer beds. There will be no change of policy in this hospital, it simply would

not work." This tertiary center has funds for highly technical and modern medical equipment and treatment facilities, and not all hospital beds are fully occupied at a given time. It thus appears that there may be room and money to remodel and change, but hospital policy still does not allow parents to remain with their children.

To remodel large wards into rooms able to accommodate a parent and child can be costly. Solutions some hospitals have found are remodeling the wards inexpensively with loss of some beds, allowing a 'chair' for all parents, or installing pull-out or bunk beds for caretakers. It is evident from these examples that the financial limitations of hospitals in Turkey and the policy to serve more patients are identified as important contributors to the parentless child in the hospital; however, the fact that there are hospitals with similar historical, educational, economic and political barriers that have moved ahead to solve this problem indicates other factors are operating to keep parents out of pediatric hospitals.

#### **Cultural factors:**

There is a tremendous gap between the educational levels, life styles and thinking of the urban and the rural parts of our country. Differences between the everyday life of different socioeconomic groups are striking. At one end of Ankara you can see women doing washing outdoors with hand pumped water, and on the other side of town they are shopping at a huge and luxurious mall. Although the income of physicians is low, which places them solidly within the middle class, their way of life differs considerably from the populations they serve. The words of one senior resident exemplifies how the gap between different socio-cultural groups affects hospital policies: "I would want them to stay with their children, but I can't bear it under these circumstances. They bring all sorts of food into the wards, they don't know

how to wash their hands, they don't understand what you tell them." Although these comments come from hospitals where parents are not permitted in the wards, it is interesting to note that physicians and nurses in hospitals where parents remain have seen the other side of the coin: "It is our job to teach them about prevention of disease. Letting the parent remain in the hospital with the child is one very effective way to teach concepts such as nutrition or sanitation."

Another important cultural phenomenon arises when it comes to fathers staying in the hospital. Traditionally it is the mother who is the primary caretaker of the child. Although many fathers or other men in the family may wish to stay with the child in order to allow for the mother to rest and attend to her children who may be at home, conservative customs do not allow a mix of men and women caretakers to share the same wards.

So far I have attempted to cover the cultural phenomena operating within the medical system that keeps parents and children separate during hospitalization. There is another contributory element. If we can assume that all change within a society led by democracy is brought about by public opinion, we will need to address the issue of why the opinion of the parents has not brought about a change in the medical system. A quick answer is that public opinion has brought about very little change in any area of the medical system in our country so far. A more specific answer lies in the cultural characteristic of the doctor-patient relationship. In our society, a more passive, dependent and almost magical expectation of the physician and a total submission to his authority is the prevailing patient attitude. (Ozturk & Yorukoglu, 1976). There may be also something specific to separation from infants and children that deserves attention. Working at the well child clinic, I have noted over and over

again that issues of separation from the infant are rarely considered in depth by even educated parents.

As the primary caretaker, often the mother, resumes work, the infant is dropped off to a babysitter or child care center with very little if any warm-up period. The belief is that the baby "will get used to it more easily if separation happens suddenly." Many child care centers also encourage this type of hurried separation.

Other examples of abrupt separation are when infants are given to grandparents to spend the summer or winter and then are taken back by the parents. Is it that separation is considered so traumatic that it has to happen suddenly? Or is separation from the parent not considered an issue for the infant?

Although I cannot answer these questions, I wonder whether this factor may be operating in keeping parents from rebelling against hospital practices that separate them from their children. Support for this hypothesis was found when interviewing mothers in the hospital about being separated from their infants during their hospitalization. The mother of a 12 month old said: 'I hurt like a fire was inside of me. I dreamt of her every night. I did not think she would mind it so much since she is so little.' It was also interesting to find that mothers placed emphasis on their physical, caretaking role rather than their emotional role. 'Who could look after her like I do, who could feed her, she will not eat, how could they change all these diapers, it is not possible.' Although there are no cross-cultural studies to indicate different patterns of separation for our population, other clinicians working with families also share these anecdotal impressions.

### **Emotional factors**

To hospitalize a child with his parent introduces multiple psychological elements to the medical care of the child. The biological model of care is not useful in dealing with the compli-

cated reactions that the parent develops during hospitalization. In situations where this is the only model that is familiar to the medical staff, friction and at times collusion between parents and staff may be inevitable. A professor of pediatrics in a university hospital where children remain without their parents stated: "Parents, of course, should be with their children. However, there are many examples where parents may sabotage the medical care of their child. We have all had parents say to us that they don't want an intravenous line in or that they don't want a lumbar punc-

infant ward at our hospital: 'When there is no parent, you don't have to see the eyes that await at the door as you try to draw blood from the child. You don't have to feel a failure when you fail to put an i.v. in at the first try.' The child life worker on the infant ward at our hospital sheds further light on this phenomenon: 'There are infants who come from the orphanage for treatment on the ward. I feel sorry for them, of course. But to see them does not break my heart as much as the infants whose parents cry as they learn about a severe medical condition that their infants will be



ture done. Sometimes it works better to have parents away." The elimination of the parent from the ward eliminates this problem.

A last year pediatric resident becoming increasingly angry at a mother stated: "They should be thrown out of this ward; that is when we'll know that we are doing our job." Pediatric medical staff rarely regard dealing with the thoughts and feelings of the parent as their job. Even when they do, since they are not guided and supported in doing this job, anger and frustration with this aspect of the job can easily be projected on to the parents.

I believe, however, that there is a far deeper issue that operates in keeping eyes and ears closed to the cries of the parentless child in the hospital and the cries of his or her parents. An example for this is given by the attending physician on the

facing all their lives. I can't help but think of my own 12 month old when that happens."

It is the presence of the parent that makes the child, the infant in particular, totally human. It is the presence of the parent that reminds the medical staff that they are just as human as their patients and that illness can happen to them and to their children. It becomes much harder to work in an atmosphere where you yourself feel vulnerable to illness and where you feel that your child is vulnerable to the same illnesses that you are trying so hard to cure and at times failing to cure. Especially when one is inadequately equipped with the knowledge, experience and support for dealing with such an emotional burden, it is much easier to avoid it.

Therefore, could it be that a reason for the parentless child in the hospital is not just one of tradition or



ignorance or finances or cultural beliefs and attitudes, but also one of avoidance?

### **How Do We Let Parents In?**

At the university hospital where I work a number of clinicians are joining forces to address this problem. The group includes two child development specialists, a psychologist, the attending physician of the infant ward, the chairman of pediatrics and myself. Reflecting on the strengths of the same causal factors that I have identified above, our past, education, economic circumstances, cultural and emotional upbringing, enables us to

example where the demand generated by parents and the good will of the attending physician and chairman have brought change in the hospital policy. The same demand has not led to a change at the remaining four hospitals in Ankara, and many more in the country.

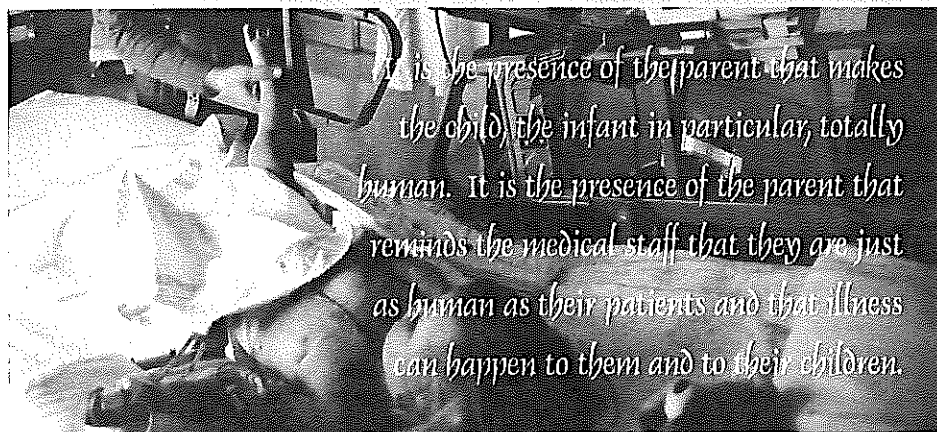
Another example comes from a relatively new university hospital in Istanbul. There, during the course of the establishment of the pediatric department the chairman of pediatrics, Dr. Basaran, stated that his policy would be to allow the mother or a female caretaker to be present during the hospital stay of each child. He gave two reasons for this policy: 1) he

### **Addressing Barriers of Tradition**

Although historically medical practices have kept parents distant during the hospitalization of their child, in Turkey we have a strong tradition of keeping the family together, especially in times of crisis. We need to build on the belief in this tradition. In order to break the historical effect of the models that have been adopted from adult medicine and medical practice during the early 20th century in the west, new models need to be introduced and supported. It has been interesting to find that during all of my interviews with medical directors in preparation of this article, I have been asked about hospital practices in the United States. Medical staff are interested in finding out whether their policies are up to date and meeting modern standards.

It is our plan to introduce and support the model of family centered care wherever possible. We believe that the policy of enabling parents to remain in the hospital with their children needs to be introduced as a first step in accomplishing this model. Otherwise for a very long time the parent may not be able to move further than the "chair."

At this point, work on this aspect of the problem has been through workshops and presentations. Together with the three child life workers at our hospital we have conducted a workshop titled "The Infant in the Hospital" at the first national conference on infant mental health. We brought together parents, the chairman of pediatrics at our hospital, and the chairman of child psychiatry. It appears that this workshop helped to solidify the hospital practice of keeping the child with his caretaker at our hospital. After this workshop, the child life worker for the infant ward got something that she had not directly asked for, namely, a promise from the chairman that the playroom for the infants will be enlarged and renovated. We plan to carry this workshop to pediatric meetings and to work to



notice the potential for change and resources for solutions.

Before discussing the actions we have planned so far, I would like to describe the process of change that has led infant wards at two university hospitals in Turkey to allow parents to remain with their children. The attending physician of the infant ward tells the story of the hospital in Ankara where I work: "I was tired of seeing mothers live on this one chair for days, at times for weeks. I was tired of having parents beg me to stay on chairs next to their child. It was their right they were begging me for. I talked to the chairman so that I could throw away a few beds and remodel this ward. If I had the money, I would make it a much better place for children and families." This is an

believed that the presence of the caretaker was emotionally important to the child during hospitalization and that separation would be hazardous, and 2) he did not believe that his department was staffed adequately to meet the physical care of the children. He said that over the past ten years, since the establishment of the wards, he has not changed this policy, and it has worked well.

These two examples show us that the policy of not letting parents remain with their children can change if the administering medical staff wish it to change. Since this is the key to inducing such a change we have directed efforts accordingly. I would like to outline our action plan according to the five causal factors that I have identified above.

create more effective formats for presentation and discussion.

We are now in the planning phase of conducting a survey with the purposes of identifying the psychosocial support provided to hospitalized children within all hospitals in Turkey. The information gathered will include whether or not parents are permitted to remain with their children during hospitalization, the living facilities that are available to children and parents during this hospitalization, the presence of mental health professionals such as child development specialists, psychologists, or social workers within pediatric wards and the presence of play facilities. The survey will be sent to the directors and chairpersons of all hospitals serving children in Turkey. We hope that as a by-product this survey may induce a self-appraisal with respect to the issues that it addresses.

### ***Addressing Educational Barriers***

Even if medical education has failed to teach the detrimental effects of separating children from their parents, or the usefulness in keeping them together, our tradition teaches us that parents should be with their children at all times. We need to build on this tradition and to bring it to the pediatric arena. Medical, and in particular, pediatric education needs to include teaching of child development and psychosocial issues. One format we have found useful is discussion of cases in small groups. Cases of children with severe malnutrition and developmental delay have been perfect examples with which to start a discussion on the child's development, his interaction with the parent, and his relationships with different people. For these cases, the role of the parent in the illness and treatment has been undeniable. Through these examples it has been possible to talk about the virtues of enabling parents to stay with their children and also the difficulties of such practice for medical staff. We hope to continue such case confer-

ences and perhaps to carry them to larger scale pediatric gatherings.

### ***Addressing Economical and Political Barriers***

Even where the economic situation does not enable rapid change within the medical system, in Turkey there is a saying "you make something from nothing." People find a way to pay for hospitalization, to solve problems of insurance, and to be with their children. Extended family and sometimes the whole village may help. For hospitals also the saying holds true. Medical staff find donations, and feel that just as new and expensive equipment is being purchased for the hospital, so could funds be found for the remodeling of the wards to accommodate parents.

In order to tackle the economic and political difficulties collaboration with the Ministry of Health will be very important. The majority of hospitals in Turkey are run by the government. In these "government hospitals," the ministry of health determines the staffing but hospital policies are left to each hospital administration. The ministry has had pilot projects in supporting changes in hospital policies. One example has been the Baby Friendly Hospital Project, a worldwide campaign led by UNICEF and carried on by the Maternal Child Health Bureau in Turkey that promotes rooming-in during the postpartum period. Another such project works to change restricted visitation hours by the friends and family of the patients to an "any time, any day" format. Both projects are identified by the Ministry of Health as being extremely successful. It appears that when a government hospital is ready to bring parents in, there will be support from the ministry. The responsible officers have also expressed interest in designing pilot projects related to this issue.

Another important issue is the coverage of hospital expenses

incurred by the parent who stays in the hospital with her child. Approximately 70% of the population in Turkey, has health insurance. Most of this is provided through the state. If the responsible physician during a hospitalization of the child reports that the parent needs to stay with the child in the hospital, the expenses of the parent are also covered through this insurance. How to meet the expenses of the 30% who do not have coverage still remains as an important problem. Its solution will need to involve advocacy groups and the Ministry of Health.

### ***Addressing Cultural and Emotional Barriers***

Even if the medical staff are inadequately equipped to carry the emotional burden of caring for families, it is also true that in these times in Turkey, the medical profession offers little beyond the emotional fulfillment of the profession. Physicians live on satisfaction from treatments they give and the relationships they form with their patients. If they could experience the gratification of working with the whole family and enabling the family to fully support the child during illness, I believe that the parentless child in the hospital would cease to be a problem.

Our action plan addressing the cultural and emotional issues has been to work directly through relationships. Continuing clinical work on the infant ward will be key in keeping in touch with the issues that arise for infants and families who are hospitalized as well as the dynamics of the ward.

My own work presently includes case consultations and supporting the child development specialist Canan Gül Gök in her work with hospitalized infants and their families. Ms. Gök is the major source of support for parents who spend many weeks in the hospital, especially for those mothers whose homes are located away from Ankara. She works closely with these mothers and infants in order to reduce

the ill effects of hospitalization as much as possible.

She has a very small playroom, but it is a busy place. Parents come in for one toy after the other and infants seek refuge in the colorful, joyful atmosphere of the room after a painful procedure. One mother stated "this playroom is the only place where I remember that my baby is a baby and not a patient." Our collaboration has been key in teaching me about issues during the hospital stay of infants and toddlers. Her close contact with clinicians who work with infants in the hospital has generated collaboration in the work. For instance, some of the nursing staff are beginning to show interest in talking about mental health issues related to some of the infants on the ward. During all these discussions the importance of the presence of the mother with the infant is highlighted. The support of the attending physician Dr. Suskan, and the chairman Dr. Cin, makes the infant ward a safe haven for us. Apart from clinical work at our hospital we are currently identifying other clinicians in the country who are advocating for the parentless child in the hospital or who may be potential advocates.

One such person, Dr. Ufuk Beyazova, is a professor of pediatrics at the third university hospital in Ankara and a long-standing advocate for children in Turkey. Although current policy in his hospital does not permit parents to stay with their children during hospitalization, Dr. Beyazova is working to institute a new policy for when the hospital moves to its new building in 1997. We are also working together to design a study examining the effects of a policy change on families receiving care from this hospital and on the medical staff. We believe that if medical staff feels pride in working in a hospital where parents are permitted to be with their infants and children and if we succeed in carrying this pride backed up with research to the national pediatric arena, other hospitals may follow.

To increase demand for hospitalizing children with their parent(s), an increase in public awareness that such practice is important for the mental and physical health of children of all ages and for the well-being of families is needed. Society must understand not only the detrimental consequences of separation during hospitalization but also the pain that children and families endure during this separation. The quickest and most effective way to do this is to use the media, in Turkey, particularly the radio and television. This is not difficult to do in Turkey, but I worry about the consequences of such an approach. There are families in which a child has been hospitalized alone and there are many situations in which the parent has no alternative. Great caution and sensitivity need to be exercised when using the media to highlight the problem.

Over the last few decades, there has been a tremendous improvement in the medical care of the ill child in Turkey. The care of the psychosocial needs of the child is slower to improve. The field of pediatrics in Turkey, the medical approach to ill children in many hospitals meets Western standards in many respects. Now is the time to rapidly bring "family standards" into hospitals. Even when both parents and other family members of all infants and children who are hospitalized are permitted to be with their children at all hospitals in Turkey, there is still much work that needs to be done related to their mental health needs. Hospitals need to be physically arranged so that they can accommodate families, the cost of stay for the parent needs to be covered through all insurance plans. However, perhaps even more importantly than these concrete changes, there needs to be a change in medical thinking. The biopsychosocial model and family centered care needs to be taught and practiced throughout the medical profession. Particularly for the pediatrician, there needs to be a shift

in emphasis from the illness of the child to the child in the context of the family. Pediatric staff who deal with children in the hospital need to feel more comfortable in experiencing the pain of feeling vulnerable to illness and of being helpless to cure the suffering of the child and the parent. There will need to be positions for non-medical, mental health professionals to work in hospitals side by side with medical staff. All of these changes are necessary so that the psychological needs of the children, the family and the hospital staff can be mutually met. This will take time.

At times, an international movement brings forth more rapid change. An example is the "Baby Friendly Hospital" campaign led by UNICEF. Through the efforts of this campaign hospitals throughout the world, including many in Turkey, have changed policies of separating the mother and the child during the postpartum period. Hospitals making this shift have "earned" the honor of becoming a "Baby Friendly Hospital." I wonder if a similar campaign could be led for children of all ages who are hospitalized. I wonder whether WAIMH may take an initiative in starting such a campaign as the "Family Friendly Hospital." Could hospitals earn the first step in becoming a "Family Friendly Hospital" by rendering obsolete the phenomenon of the parentless child in the hospital and letting families in?

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#### Editor's Note:

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## Stephen's Corner

*Stephen Bennett*

#### To the Editor:

Dr. Stephen Bennett and I were good friends during the nearly fourteen years we worked together closely at Harlem Hospital Center. Considering the loud noise that sometimes was generated between us, many would not have known that we were a great source of comfort to each other. I can truthfully say that I, as Head of the Department of Psychiatry, gave him many directives and that I cannot think of a single one he obeyed exactly. Seldom have I known anyone quite as oppositional, and I am certain that he made the same assessment of me. We had much in common including a love of working with children, a life-saving sense of humor,

a serious interest in human history and affairs, and the habit of coming to work promptly at 8:00 o'clock in the morning. An example of our sense of humor might be the observation that he and I both thought that next year things at Harlem would be better.

Shortly after arriving at Harlem in 1982, I assigned a group of residents a set of readings from the book by Dr. Stanley Greenspan on his interventions for promoting the emotional development of infants (*Psychopathology and Adaptation in Infancy and Early Childhood*, 1981). When he learned of this, he suggested our first serious conversation. For me it was a pleasant surprise to learn that our Dr. Bennett was a founder and a world leader in the new field of infant

psychiatry. Over the years he brought many leaders in that field to our department to give lectures and seminars on mother-infant interaction and on the way a child learns to think and to become a person.

Once, I made the mistake of asking him to help me solve a major problem which involved several other clinical departments as well as our own. We arranged a series of meetings with key people from those different departments. During the meetings there was so much loud talking and hurling of insults back and forth that at the end of most meetings I had to remind him that he was a psychiatrist. Together we made many enemies; one person even threatened to sue Dr. Bennett for defamation of character. In spite of all this, on still another occasion, when I was involved in resolving a controversy within our own department, Dr. Bennett confidentially advised me that I should be more diplomatic in my approach to certain people.

Dr. Bennett's competence and warm good humor will indeed be missed, but he gave so much of himself to us and enriched our lives in

so many ways that he will be with us always. Let me cite a personal example: following one of our conversations he suggested that I read one of the classics which I had always planned to do when I could find the time. One of the best homework assignments anyone ever gave me was this book: "The Varieties of Religious Experience," written by William James, first published in 1902. You can do honor to his memory by reading that great book.

James L. Curtis, MD  
Director, Dept. of Psychiatry  
Harlem Hospital Center  
Clinical Professor of Psychiatry  
College of Physicians and  
Surgeons of Columbia University

To the Editor,

Ten years ago our paths met, Dr. Stephen Lamar Bennett and I, when I became his secretary in the Division of Child and Adolescent Psychiatry at Harlem Hospital Center. Our working relationship was good, as I respected him even though he was low-key in all his undertakings. I saw behind the facade, a learned gentleman who still craved more knowledge in his chosen vocation. I made a decision to move on to greener pastures within the Department of Psychiatry, and even though Dr. Bennett did not like that, we remained friends. He oftentimes came by my desk, and we made small talk. He knew of my journalistic pursuits, and he became my mentor, always encouraging me to continue writing, always mentioning personalities I could interview. One of those he told me to interview (which I did) was Retired General Colin L. Powell. During all those times, he never neglected to ask in sotto voce, "Why don't you come back to Child Psychiatry?" We had a strong bond.

Dr. Bennett's last visit and words to me were, "I am going on vacation. We have a home in New Brunswick and we will be going there. I will be gone for a month." But, the grim

reaper had other plans for our Dr. Bennett because on August 14, 1995, he snatched him from us forever. I never use the words "untimely death" because it is not for me to know whether it was time or not.

The essence of Dr. Bennett's life is that he was a quiet, private, sincere, caring individual whose simple demeanor belied his academic brilliance. As I pay tribute to this memory, I choose to use the motto of the City of London, England: DOMINE, DIRIGENOS (LORD, DIRECT US).

Barbara M. Simpson  
Department of Psychiatry  
Harlem Hospital Center

To the Editor:

The sudden, unexpected death of Steven Bennett last summer has taken one of the most esteemed infant psychiatrists in North America from us.

Steven, long time director and leader of child psychiatry at the Harlem Hospital in New York City, was a most unusual man. He was a psychoanalyst, yet worked with families who were often severely deprived and troubled. He worked within a typical inner city hospital environment, yet would assemble students and faculty in his department's yellow clinkered meeting room to hear Daniel Stern or Berry Brazelton talk about intricate feelings or communication patterns of parents and their babies. In his clinics, he often listened to tales of violence and abuse, yet was able to give back understanding, hope and the persuasive message that there was a developing internal world in each baby and that we had the power to change that world for the better.

For all his outstanding abilities, Steven was a very unassuming man who had no need to impress others. This quality allowed him to listen and learn from all he came in contact with. His observations and musings in "Steven's Corner," eagerly awaited by

the readers of this newsletter, showed this characteristic most clearly. In each column, the reader felt that Steven was speaking to him or her in person because we did not only learn something about a particular infant program or an interesting person within the field of infant development, but also about some of Steven's likes and dislikes and his ability to place issues into an academic context. Thus, he might cheerfully report on a developmentalist who did not believe in treating infants and their families, yet formulate this opinion in such a way that even the most committed infant therapist would understand and empathize.

Steven's love of dialogue and discussion, in my opinion, contributed to a significant degree to his synthesizing ability. When he visited us in Montreal about two years ago, he arrived in a dreadful state suffering from the flu and had to be put to bed. However, he revived rapidly when on the same evening ten colleagues of widely varying ages from our two local universities met to share their ideas on infancy and politics in English and French. His questions, thoughtful yet provocative, made everyone feel that they had learned something that evening about each other, about Steven, and about themselves.

We all will miss Steven and his "Corner" a great deal. His writings helped us to connect with each other as professionals treating infants and their families and reminded us of our common goals. However, each baby we try to understand in our clinical work will also rekindle some memory of the visions and hopes Steven talked about—and so Steven's corner will continue.

Klaus Minde, MD, FRCP  
Professor of Psychiatry and Pediatrics  
Head, Division of Child Psychiatry  
McGill University

To the Editor,

Steve was gifted clinician and dedicated leader in advancing what was best on behalf of children and their families. His positive attitude and sunny disposition in the midst of difficult problems was an inspiration to many. He had a remarkable knack for identifying and encouraging strengths in others, and his enthusiasm was infectious. His friendship and wisdom will be missed by many in WAIMH and elsewhere.

Robert N. Emde, M.D.  
Senior Scientific and International  
Advisor for WAIMH  
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University of Colorado Health  
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To the Editor:

I learned with much regret the sudden death of Stephen Bennett. I met him only once when he visited Montreal last year, but I always read his column in *The Signal* with much pleasure. He was able to convey the essence of his meetings with colleagues involved in infant mental health, and thus give us a fascinating picture of the varied facets of our field. It will be a great loss for us all.

Yvon Gauthier, M.D.  
President-Elect, WAIMH  
Hospital Sainte-Justine  
Montreal, Quebec

To the Editor,

I am moved to learn of the sudden death of Stephen Bennett. Although I never met with him, his chronicle, "Stephen's Corner," would be the first I would go to in the letter, *The Signal*. It was marvelously written. The humor and modesty could not hide the vast culture and the deep interest towards the other's way of thinking and doing.

I intended to ask him for an interview in *Devenir*, as I believe he

was among the best people to give French readers a landscape of American and Canadian child and infant psychiatry. Stephen's death is very much a major loss for WAIMH.

Antoine Guedeney, M.D.  
Program Co-Chair, WAIMH 6th  
World Congress  
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*Editor's Note:*

*When I was a resident in child psychiatry, I was nurturing an interest in the evocative power of babies. I noticed that parents developed the most remarkable attributions about their young children, sometimes quite positive and other times quite alarming. During this time, I ran across a paper by Stephen Bennett of Columbia University on nurses attributions of newborns. This Dr. Bennett, it seemed, had gone to the newborn nursery, sat down, and paid attention to what went on between nurses and babies. In particular, he was struck by the border babies, who spent several months in the nursery awaiting adoption. The nurses it turned out, developed elaborate fantasies about the babies: one I remember was lover boy whose weekend conquests the nurses would elaborate on Mondays. This was exciting stuff for a "wannabe" researcher interested in parents' fantasies.*

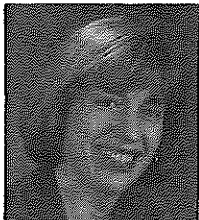
*Not too long afterwards, I read a chapter on infancy in a book on child development (long since lost to my bookshelf), also written by Stephen Bennett. Here, I encountered a delicious example of Steve's wry humor as he talked about the plight faced by the student of development in trying to plow through issues of Child Development or the Psychoanalytic Study of the Child. He had a remarkable way of connecting with the reader, even in the midst of an academic text, and I appreciated his*

*validation of both the excitement and the drudgery involved in the study of development.*

*Years later, I actually got to know Steve through WAIMH and the American Academy of Child Psychiatry, and I felt as if I were befriending one of my heroes. He invited me to visit his group at Harlem once, and there I experienced first hand, the specialness of that place for him. It was after that visit that I got the idea of having him write a column for this newsletter. At the time, I envisioned that it would be a column of "Tales from the Trenches," with clinical vignettes filtered through his keen and thoughtful sights. He seemed pleased that I told him to have fun with it.*

*What emerged was "Stephen's Corner" (so dubbed by Melanie Smith), a delightful depiction of some of the characters of our field, known and unknown, engaging and irascible, assuming and unassuming, but all embraced by him for their individuality. What strikes me now, as I think back over the columns, was that Steve had a novelist's eye for sizing people up and conveying their essence in a paragraph or a phrase. I loved the way he approached controversy through the extreme views of others, as if understanding not only the arguments but also the people who made them, might help decide how he (and we) felt about an issue. I also appreciated the sweep of his gaze, from the landscape on the way to an interview, to the inscapes of Gerard Manley Hopkins, to the look of love exchanged between a boy with autism and his mother in Steve's clinic.*

*Steve seemed to accept the world as a deeply flawed, but ultimately hopeful place in which the efforts of some might be useful to the troubles of others (fully aware that not everyone would agree). On our journey through the flaws and the troubles, I think he would add that some very interesting, funny and occasionally beautiful things happen. I miss him.*



## President's Perspective

Joy D. Osafsky

As my four years as President of WAIMH are coming to an end, it is a time to reflect on both the past and the future. It has been an especially exciting time both professionally and personally serving as President of WAIMH and traveling to many parts of the world "spreading the message" about WAIMH, the mental health and prevention needs of infants and families, and about how we can make a difference through our international organization. I learned a great deal in my travels and, following the perspective of my immediate past-president, Serge Lebovici that our real growth and strength lies in regional activities, became even more firmly committed than when I began.

As for the future of WAIMH, I see three main directions.

### **Expansion of affiliate activities**

In the four years of my Presidency there has been much growth in affiliate activity with new affiliates being formed every year. Many groups from far-reaching regions of the world have come together as official affiliates of WAIMH. I have been involved, together with our Executive Director, Hi Fitzgerald, in encouraging the official affiliates that have formed in France, St. Petersburg, Russia, German-speaking countries in Europe, United Kingdom, and The Netherlands. In the United States, two new affiliates have formed—in Kansas and Louisiana. In addition to the official affiliates, there is continuing interest among groups and individuals in other regions in forming

affiliates. Discussions are ongoing in Portugal, the Baltic countries, Japan, Italy, Russia and various countries in South America especially Argentina, Brazil, and Uruguay.

The affiliate groups plan activities in their regions suited to their needs and the desires of their members. For example, in France, study groups have been a very important part of regional activities. In South America, the regional activities include a joint meeting among international organizations concerned with similar issues for infants, children, adolescents and their families. WAIMH encourages the diversity and variety of composition and activities of regional groups. We will try to facilitate these endeavors as much as we can to help the local regions grow and develop. Several of the older and larger regional groups, for example, the Nordic group in Europe and the Texas and Michigan groups in the United States, continue to grow and thrive through their regional members. We welcome the suggestions of the membership about ways to facilitate and encourage this growth of our organization.

### **Growth in communication**

Another major area of growth and expansion that occurred during the years of my Presidency is in communications. We now have a thriving journal, an excellent newsletter, communication links via the Internet through E-mail, a list-serve and a Home page on the World Wide Web, and a growing and thriving lending library at our main office in East

Lansing, Michigan where publications, videotapes and other materials will be available for our members.

Over the past few years, the *Infant Mental Health Journal* has become a major publication medium for work in the field of infant mental health. In the Spring of 1996, it was bought by John Wiley and Sons, a major publishing company in the United States with important international connections. The acquisition of the IMHJ by Wiley will allow for the journal to expand and grow and to be distributed to a greater world-wide audience. We have already been discussing the addition of two new sections to the journal, one devoted to "Clinical Perspectives" and the other to covering "Book Reviews." As Editor of the *Infant Mental Health Journal*, I will be appointing Associate Editors to oversee and develop these two new sections.

The *Signal*, the official Newsletter of WAIMH, under the very able editorship of Charley Zeanah, has developed into a first rate publication that provides a way of communicating in a less formal fashion. I envision the *Signal* continuing to grow and expand and to include more reports on the activities of our affiliate groups. I know Charley Zeanah has fresh ideas to increase our ability to share information across the many countries represented in our organization.

Our ability to communicate using the latest means is being enhanced by the work of Hi Fitzgerald, Melanie Smith and their assistants at the main WAIMH office in East Lansing, Michigan. They have been working actively over the past year and will continue using the Internet to reach our membership across its wide geographic diversity. In addition, they have been setting up a comprehensive library with both publications and videotapes to be available for distribution and sale. I expect that these aspects of communication will continue to grow and develop in the

next few years allowing us all to be closer together across great distances.

### ***Collaboration with national and international groups that share similar interests and goals***

I hope that we will see other changes in WAIMH representing an evolution of practices just emerging during the past four years. The needs of infants and families world-wide are very great, and the international organizations truly concerned about these issues few. I hope to see many more joint efforts by different national and international groups working together toward common goals. This collaboration could take several forms. First, we could hold joint regional meetings—as we have already done in some parts of the world—to share our individual ideas

and to see where we may have similar goals. Second, we could present some of our ideas—as we also already have done—as part of meetings of groups that share some, but not all of our interests. Third, we could collaborate better on joint projects of mutual interest. Such collaboration may be particularly important to achieve international goals related to the rights and needs of children. One such effort took place during my Presidency when WAIMH, IACAPAP (International Association for Child and Adolescent Psychiatry and Allied Professions), and ISAP (International Society for Adolescent Psychiatry) jointly supported the United Nations resolution on the rights of children. Many more efforts are needed, however, particularly in the public policy arena. I hope that WAIMH will become more involved with

international groups concerned with infants and children such as WHO, UNICEF, and the United Nations and will work with them to develop proposals and plans for policy in these areas.

I will continue to work actively with Yvon Gauthier, the incoming WAIMH President and the new WAIMH Executive Committee elected at the 6th World Congress in these and other areas defined to be important by the new Executive Committee and the membership. I and other members of the Executive Committee welcome your comments and suggestions. I can be reached at Department of Psychiatry, Louisiana State University Medical Center, 1542 Tulane Avenue, New Orleans, LA. 70112 or by fax (504) 568-6246 or e-mail JDOPS@UNO.EDU. I look forward to hearing from you.

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## **MORE TRAINING PROGRAMS**

We continue to add to our data base of information about worldwide training programs in infancy. WAIMH member Michael Scheeringa has provided the following information about infant psychiatry programs in the United States. For more information on other programs, see *The Signal*, April—June 1995.

Brown University  
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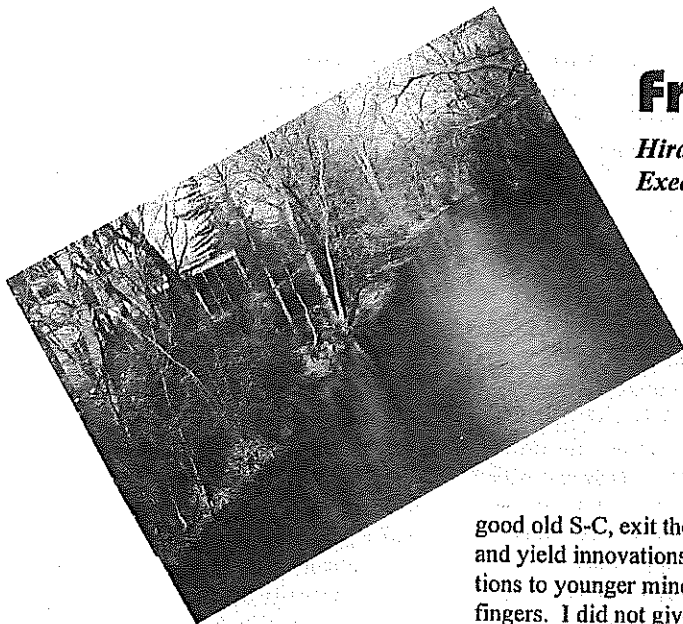
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*(continued on page 16)*



## From the Red Cedar

*Hiram E. Fitzgerald*  
Executive Director

First, to subscribe you must type:  
listserve@msu.edu

Then, you must type:  
subscribe waimh@msu.edu (your  
first name/last name)

For example, if I was subscribing I  
would type:

Listserve@msu.edu  
subscribe waimh@msu.edu hiram/  
fitzgerald

### **WAIMH on the WEB**

When I graduated from high school my parents presented me with a blue-grey Smith-Corona typewriter. That electric wonder produced college term papers, occasionally in French, letters to friends and family, and all of my personal correspondence. In graduate school my trusted S-C added journal articles and research reports to its repertoire, and during the first 13 years of my professorial life at Michigan State University, it produced many scientific articles, review articles, and books. Many evenings it had a dual function, serving as a pillow for a weary workaholic striving to earn tenure and promotion. During the late 1970's my graduate students kept pressuring me to bring both my psychophysiology laboratory and my office into the computer age. So in 1981 a Digital Equipment Corporation computer became "command central" for the laboratory and a Zenith computer replaced old S-C in my office. After my nth failure to properly save Wordstar files (one day in May losing nearly one-third of a manuscript) I was ready to revive my

good old S-C, exit the computer age, and yield innovations in communications to younger minds and more able fingers. I did not give up old S-C to join the computer age without a major struggle. But join it I did and wow, what results. All of the promised advantages for word processing and statistical analysis came true. And with e-mail the ability to communicate with colleagues began to reduce weeks and months to hours and days. In the early part of this year, WAIMH established its first communication network with LIST SERVE. List serve is an e-mail bulletin board posting service. Subscribers (there is no fee, just a registration requirement) can post their thoughts and questions on infant mental health for all other subscribers to read and respond to. Major international discussions can take place, debates held, and consensus positions achieved (or not) via the open channel LIST SERVE. I am delighted to announce that Peter Scheer (Austria, and a member of the newly established German Speaking Affiliate) has volunteered to take responsibility for sparking discussion and debate on the LIST SERVE about a variety of topics. But bear in mind that anyone can access this communication network—it is free and open. To access LIST SERVE you must do the following:

In July, WAIMH officially took the next step in electronic communications by establishing its own WEB page. Check it out. Currently it contains information about the Board of Directors (Executive Committee), Affiliates, Membership (names, address, and phone numbers), and a list of videotape rentals available (unfortunately at the present time, only in the American standard versions). Soon we will add information about training and educational programs, and other information related to infant development, infant mental health, family development, and other topics that are important for WAIMH's members. Help shape the content of the Web page by sending your suggestions via e-mail (LIST SERVE), FAX, letter, or phone to the Central Office. In the meantime, here is how you access WAIMH on the WEB:

<http://www.msu.edu/user/waimh>

In retrospect, it is painfully clear that there were many things that faithful S-C could not do. However, I have yet to fall asleep nestled on top of a computer—and yes, I still own S-C.



*Joann O'Leary, MPH, MS*  
*Reviewed by Sherryl Scott Heller,*  
*MS*

Perinatal loss has received increasing attention in the medical literature. For example, hospital practices have been altered to humanize the experience, and obstetricians and pediatricians have been encouraged to address loss directly with families. Still, it is not uncommon for mental health professionals to work with families for whom perinatal loss is directly or indirectly related to other clinical problems. One of the most common issues encountered by parents concern children born following the loss. Parents may struggle with many important questions: Deciding how soon to become pregnant, fear of failure, withholding attachment from the new baby until it is "safe," worrying about reproductive integrity, attaching to the new baby while simultaneously mourning the lost baby, impact of different mourning styles in the couple, increased anxieties about parenting, overprotectiveness and preciousness of the new baby, etc.

The "After Loss: Journey of the Next Pregnancy" video was created to increase health care providers' awareness of the uniqueness of a pregnancy after loss and its clinical issues in order to sensitize their interventions. It was also intended as a tool to help families undergoing the next pregnancy to recognize that they are not alone in their experiences and feelings.

The video is introduced by Michael Trout, MS, a specialist with the Pregnancy After Loss Program. At the start of the video he reviews some of the issues families struggle with after experiencing a perinatal loss and subsequent pregnancy. Following his brief introduction families who are at different stages of a subsequent

## After Loss: Journey of the Next Pregnancy



pregnancy discuss some of the difficulties they faced. Couples who are pregnant, who have recently given birth, and who have toddlers share their experiences as they struggled to find a place for both their grief and attachment. Intermingled with these interviews health care workers discuss some of the issues they encounter with families working through a subsequent pregnancy.

Many points made by the narrator or health care providers are elaborated upon by parents. For example, the importance of separating the two experiences of loss and pregnancy, yet giving them both a place in one's life

is stressed by Joann O'Leary, MPH, MS another specialist with the program. Parents describe how difficult yet necessary it is to give both separate the two. Parents also comment on the various forms of anxiety they experienced and how they managed that anxiety. This is followed up with interviews of health care providers who stress how medical technology can help decrease parents anxiety and the importance of parents allowing themselves to express their needs to their doctor.

This video covered many of the dilemmas that couples struggle with as they work through their grief and anxiety. The inclusion of parents discussing their experiences and struggles after the loss and into the next pregnancy highlights the intensity and importance of various issues. The insensitivity of well-meaning family and friends, the difference between spouses in the manner which they deal with the loss and pregnancy, and the permanency of the loss are a few of the issues in which individuals currently struggling with resolving their loss and celebrating their pregnancy address.

One concern is the inclusion of a live birth on the video. This is worrisome in that couples who have experienced such a painful birth experience and also such a strong desire to experience a successful birth may be distressed by this scene.

Overall, the Pregnancy After Loss Program succinctly and competently addressed the issues these families face. The material is presented in a gentle and supportive manner, and the inclusion of parents at the various stages of the next pregnancy is all the more poignant. This is a tape that every health care worker involved with pregnant women should view, and it is a must see for any couple experiencing the next pregnancy.

(continued from page 13)

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4940 Children's Place  
St. Louis, MO 63110

**WORLD ASSOCIATION FOR INFANT MENTAL HEALTH**  
Institute for Children, Youth & Families  
Kellogg Center, Suite 27  
Michigan State University  
East Lansing, MI 48824-1022

Tel: (517) 432-3793  
Fax: (517) 432-3694



**Poem: Advice to Professionals  
Who Must Conference Cases**

In the last issue of *The Signal*, we  
printed a poem by Janice Fialka.  
Anyone wanting to reprint her poem  
or to arrange speaking engagements  
can contact her directly: Janice  
Fialka, 10474 Lasalle Boulevard,  
Huntington Woods, MI 48070 USA.  
Tel: (810) 546-4870.

**Affiliate Activities**

November 1, 1996. 13th Annual  
Conference of the Illinois Association  
for Infant Mental Health. Illinois  
Institute of Technology. Matthew  
Melmed, Director of Zero to Three.  
*In the Best Interests of the Child:  
Policy Issues.*

**Call for Papers**

International Conference,  
Jerusalem, Israel, July 6—10, 1997.  
"Pediatrics in the Community—  
2000." Deadline for 150-250 word  
abstract is February 1, 1997. Contact:  
ISAS International Seminars, PO Box  
34001, Jerusalem 91340, Israel. Tel:  
972-2-652-0574, Fax: 972-2-652-  
0558. email: isas@netvision.net.il

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