BRIDGING THEORIES OF GRIEF SINCE KUBLER-ROSS, PART II:

Postmodern Grief Concepts and Perinatal Loss

by Judith L. M. McCoyd, PhD

The 2017 Fall FORUM published Part I of “Bridging Theories of Grief since Kubler-Ross: Traditional Grief Theories and Perinatal Loss.” Part I explained why theory is important for guiding our interventions, reviewed earlier stage-and-task theories of grief and asserted that we need to stay up-to-date with the evolution of grief theory.

In Part II, we discuss post-modern concepts that are no longer one-size-fits-all, nor grand theories about how grief works. Rather, these are varied concepts that inform the way we now think about grief and how social workers tailor assessment and intervention to the griever’s needs. These individualized, non-cookie-cutter approaches allow for cultural variation, individual idiosyncrasies and respect for varied rhythms of grief. This allows social workers to adhere to our Code of Ethics, which values individuality and the dignity and worth of all humans, and to avoid trying to push a one-size-fits-all approach on a grieving individual.

Postmodern Grief Concepts

Disciplining or policing Grief

It comes as no surprise to perinatal social workers that society (by way of a person’s mother-in-law, neighbor or other contact) often gives grievers the message that they have been grieving too long. Foote & Frank coined this process “disciplining of grief” (1999), while Walter called it “policing grief” (2000), noting that some of the stage theories had contributed to the problem: “These people had received counseling and read umpteen books on bereavement, yet nowhere had they received permission to find a place for their dead. Everywhere, the message they heard was ‘Let go. Leave behind. Move on.’” [Walter, 2000, p. 106]. This concept sets the stage for one of the revolutionary post-modern theories that overturned the conventional wisdom on “accepting” or “letting go,” namely “continuing bonds” [Klass, Nickman & Silver, 1996].

Continuing bonds

Calling it revolutionary may seem like hyperbole now, but in the 1970’s through the early 90’s, perinatal social workers who encouraged clients and patients to continue to memorialize their fetal and neonatal sons and daughters were castigated (I can tell you stories of my own!). When Klass, Silverman and Nickman (1996) put their disparate research findings together and proclaimed, “Rather than letting go, they [the bereaved] seemed to be continuing the relationship.” [1996, xviii] This observation upended grief theory as it was then understood. All of a sudden, we perinatal social workers were “allowed” to encourage “the bereaved [to] remain involved and connected to the deceased, and actively construct an inner representation of the deceased that is part of the normal grieving process.” [Klass et al., 1996, p. 16]. In the book’s Introduction, these researchers noted:

The book challenges the idea that the purpose of grief is to sever the bonds with the deceased in order for the survivor to be free to make new attachments and to construct a new identity. … [T]he constant message of these contributions is that the resolution of grief involves continuing bonds that survivors maintain with the deceased and that these continuing bonds can be a healthy part of the survivor’s on-going life. [1996, p. 22]

Notably, this approach supports our understanding of the cultural role in grieving. Mexican “Day of the Dead” celebrations and Buddhist worship at shrines of deceased loved ones provide rituals that foster continued bonds. Japanese ancestor worship (Shinto and Buddhist) also reflects continuing bonds with the deceased [Valentine, 2010]. So we embrace cultural diversity instead of forcing grievers into Western models when we acknowledge that many grief processes include continuing bonds rather than “closures”—another word that has no place in the perinatal social worker lexicon [Berns, 2011]. Even so, that does not mean we must

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Happy new year! As we enter 2018 we should reflect on our personal and professional accomplishments in 2017. What were your contributions to family and career? Did you accomplish your personal and professional goals? If not, what progress did you make toward those goals? This status check is important for self-insight and growth.

NAPSW had a lot to be proud of in 2017. In March—National Professional Social Work Month—we began our first membership recruitment campaign. This campaign was very successful, resulting in a significant increase in membership. Through Stepping for Preemies and Night-Out at the Seattle conference, NAPSW raised money to support scholarships and other activities.

In 2017 NAPSW continued to increase its advocacy and policy efforts. NAPSW signed several legislative petitions protecting and defending the rights of pregnant, incarcerated women. We also signed numerous letters and petitions for perinatal healthcare improvements: human milk, health care reform, Medicaid/CHIP, respiratory syncytial virus (RSV), and childhood lead poisoning, to name a few.

We have accomplished a lot this past year and it is now important to look forward. In 2018 NAPSW plans to build on its accomplishments and continue to grow. We are planning another recruitment campaign for the month of March and plans are underway for an amazing annual conference in Long Beach, California. Members should have received the save-the-date (May 2-5) information for this upcoming conference. With money raised in 2017 we will award scholarships and donate to a Long Beach NICU family support program. We will once again conduct Stepping for Preemies fundraising during the 2018 conference and will officially launch the campaign shortly afterwards.

NAPSW has made great strides in sharing cutting-edge information with members through our social networking channels (Twitter, Facebook, and LinkedIn). We will continues to grow in our ability to leverage technology in order to further the mission of our organization and keep members connected and informed throughout the months ahead. We will be looking for member feedback to help revise and update NAPSW’s strategic plan.

It is important that we get the word out to members and, in turn, they participate and support all of these important initiatives. As part of your goals for 2018, strengthen your commitment, support and give back to NAPSW. There are many ways to give back. You can sign-up to participate on a committee, run for a leadership position with the board of directors, consider being a regional/state representative, or make a financial contribution. Please consider making a monetary contribution through the donations tab on our website, at your conference registration or with your membership renewal. I have mentioned just a few ways that you can get involved and contribute to NAPSW. I hope you take advantage of these opportunities in 2018.

A special thank you to those members who continue to support NAPSW each year, to members involved in committee work and to those who serve as NAPSW officers and regional and state representatives. Our organization will always need the support and involvement of its members to uplift the lives of women, children, families and our fellow social workers.

Sincerely,

JaNeen Cross, DSW, MBA, LCSW-C LICSW
Come to the 2018 NAPSW Conference in Long Beach, California

Time flies. It’s already January and the 42nd Annual NAPSW Conference, May 2-5, is less than four months away! The Conference Committee, #NAPSW2018, is currently reviewing abstracts submitted for presentation at the Conference. We are excited that perinatal social workers from across North America have submitted abstracts and are eager to share their experience with colleagues. We want to thank everyone who took the time to submit an abstract/proposal this year and to encourage others to consider submitting proposals for future conferences.

NAPSW conferences are known for the quality of education provided to attendees. This year’s conference committee is excited to continue that tradition and make 2018 a year to remember! We have a variety of topics, such as substance abuse, birth tourism and grief and loss, plus information about various innovative programs across America.

We are excited that Melissa Bird, PhD, has agreed to be one of our speakers! Talking with her by phone, I felt and heard her passion for our profession, for reproductive justice and for feminism. After our conversation, I felt motivated and inspired. This is the way we want attendees to feel at the end of our Long Beach conference. Therefore, we have asked Dr. Bird to wrap things up with a passionate, forceful and “unapologetic” session.

Long Beach is friendly to walkers. The Renaissance Hotel is at the corner of Ocean Boulevard and Pine Street, known for its restaurants, bars and entertainment. You won’t have to go far for delicious food, great views and amazing people. For our “Night Out” we will be spending the evening with Spirit Cruises on the Pacific Ocean. We haven’t finalized all the details just yet; but be prepared for a night that includes unlimited margaritas, music, great views and amazing company!

Southern California is known for its “perfect” weather: while some say it is a beach day every day, it can get somewhat chilly. The first week of May in Long Beach is typically in the 70’s during the day and in the high 50’s at night. We recommend bringing a sweatshirt.

If you have any questions, please feel free to email conference chairs: Tiffany Hanff, LCSW at TR.Hanff@GMail.com and Karina Ousley, LCSW at KOusley@CHOC.org.

SAVE THE DATE: MAY 2-5, 2018

NAPSW Conference
Scholarships for 2018

A much anticipated and long held goal of NAPSW is now finally a reality. NAPSW is pleased to offer scholarships, which will cover the registration fee ($285.00) for the upcoming 2018 annual conference in Long Beach CA, “Shining the Light on Perinatal Social Work,” May 2-5. We are able to offer a few scholarships through funding from the Silent Auction organized by the 2017 Portland OR conference committee and from our summer 2017 Stepping for Preemies program.

Important details to note:

- Any NAPSW member with active membership may apply.
- The conference scholarship application is available on our website: www.napsw.org.
- All recipients are required to moderate at least 1 session during the conference.
- If you are applying for a scholarship, please do not pay the conference registration fee until you have been notified of the application decision.
- Scholarships are not transferrable between members.
- If you receive a scholarship and then cannot attend the conference, please let the committee know as soon as possible so it reassign the scholarship to another applicant.

The deadline for submitting applications is March 1, 2018. Please email completed applications to Debby Segi-Kovach at Dsegiko1@jhmi.edu by March 1, 2018. Decisions for the scholarships will be made by March 15, 2018 and you will be notified by email.
Postmodern Grief Concepts

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push continuing bonds if a client/patient does not feel this is helpful. Yet, many of us have adopted practices such as memory building, memory boxes and looking at photographs that help families with their continuing bonds.

Relearning the world

Thomas Attig says grievers must relearn the world (2001), while Janoff-Bulman (1992) asserts they must revise their assumptive world (1988). Essentially, this refers to the process the bereaved must go through of learning to live in a world that has fundamentally changed as a result of the loss of their loved one. All the assumptions they had prior to the death have likely been violated. Perinatal social work reveals the need to revise assumptions. For example, women assume that once they get past the 12-week mark of a pregnancy, they will not have a miscarriage [but some do]; that once one finally gets pregnant after IVF, that a baby will be born healthy (not always); or that their children will outlive them [often not the case in the venues where we work]. We know how precarious assumptions about reproduction and childbearing are, yet the women and couples we work with have not had their assumptions similarly challenged until they have that first loss and lose their innocence with it. In mourning losses, grievers must rethink their assumptions about the world and truly relearn how to live in the world that has changed for them forever.

Dual Process Model (DPM)

Stroebe and Schut [1999] developed a straightforward and elegant theory that meets the criteria for a postmodern grief theory as it is not prescriptive and can be tailored to individual grievers. Stroebe and Schut [1999, 2010] postulate that grievers oscillate (go back and forth) between Loss Orientation [LO] and Restoration Orientation [RO]. The bereaved person usually starts by spending more time experiencing the grief actively and focusing on the loss (Loss Orientation), and gradually starts to spend more and more time moving toward building a new life [RO]. Both processes are necessary and we can share this with grievers who believe they must stay in sadness mode or try to push their way forward. We must help them recognize that both processes are part of life from the moment of a loss until one has moved into life again more fully.

Ruminating on the loss (a typical aspect of early Loss Orientation) is often portrayed as important to grief work (Bonanno, 2009). However, Stroebe and colleagues (2007) developed the Dual Process Model [DPM] to show how excessive rumination about one’s loss and a sense that one can never recover actually harms the grief healing process. Stroebe and Schut (2010) assert that DPM can be used as an assessment tool [How much of the bereaved’s time is spent in each orientation? How does the proportion gradually change toward more RO?] as well as intervention guidance [the counselor can help grievers move into whichever orientation the griever might be avoiding].

Dual Process Model [DPM] incorporates revision of the assumptive world: The death of a loved one violates the assumption that the world is a fair and just place and requires grievers to revise and re-learn assumptions about the way the world works. This happens during RO as grievers work to understand what their assumptions were and to relearn the world. By doing so, grievers typically find some meaning in the call to move forward in life.

Meaning-making

"Meaning-making" is a postmodern grief concept identified with Robert Neimeyer in the current world of grief theory, though originally part of Viktor Frankl’s work in “Man’s Search for Meaning” (1984/1946). Drawing also from narrative therapy concepts, Neimeyer asserts:

Bereaved people often seek safe contexts in which they can tell (and retell) their stories of loss, hoping that therapists can hear to hear what others cannot, validating their pain as real without resorting to simple reassurance. Ultimately, they search for ways of assimilating the multiple meanings of loss into the overarching story of their lives, an effort that professionals can support through careful listening, guided reflection, and a variety of narrative means for fostering fresh perspectives on their losses for themselves and others. (Neimeyer, 1998, 2001)

Although perinatal social workers cannot “make meaning” for their clients, our work naturally involves the processes that help bereaved parents to work toward this goal. Davis, Wortman, Lehman & Silver (2000) believe only about half of all mourners make meaning. However, social workers can facilitate this process by helping the bereaved to understand: (1) the risks of staying stuck in their grief; (2) how to use the counselor as a “container” during the early phases of intense grief; (3) the benefits of using rituals and traditions that have meaning and comfort for them; (4) how to move ruminations/obsessions into a flowing narrative rather than a recurrent thought; and (5) how to set attainable goals that allow grievers to make choices and sense accomplishment. Working to help people continually tell their evolving stories helps them create meanings over time.

Disenfranchised grief

Yet another useful postmodern concept is Doka’s conceptualization of “disenfranchised grief” meaning grief that is not recognized and supported by others. Many forms of perinatal loss, especially infertility and miscarriage/stillbirth fit this description. Doka (2002) recognized that responses to grief are based on social expectations: when the loss or the grief does not meet the norms for grief in the griever’s culture, support is not available. Doka defined five categories of disenfranchised grief: (1) the relationship is not recognized, such as gay
and lesbian relationships, extramarital relationships and other relationships that lack social sanction; [2] the loss is not acknowledged by societal norms as a “legitimate” loss, as when abortion, relinquishing a child for adoption, or miscarriage/stillbirth are not viewed as worthy of sympathy; [3] the griever is excluded as is often the case for siblings and grandparents of neonates who die in NICU’s; [4] the circumstances of death cause stigma or embarrassment, such as when a person dies of AIDS, drug overdose or in other ways that are viewed as the result of moral failures; and [5] grief is expressed in non-socially sanctioned ways, as when a griever is deemed either too expressive, or not expressive enough (reminiscent of policing of grief discussed above).

Disenfranchised grief means that grieving individuals do not receive the sympathy and social support that would be optimal for processing their grief. Indeed, that pain is often exacerbated by social isolation or lack of support. Our intervention in perinatal realms often provides validation of the event as a loss and normalizes the grief response so that the griever can move through the loss without the complications that may occur if their experience is not validated. Validation of miscarriage and stillbirth has been a major part of our work in perinatal settings.

**Ambiguous and non-finite (or chronic) grief**

A final concept from the postmodern grief theory world is Boss’ (1999) concept of “ambiguous loss” also called “frozen grief.” In ambiguous loss, the lost entity is:

- **Physically present but psychologically absent**—the typical example is the individual with Alzheimer’s disease or brain injury; another example is the neonate diagnosed with Grade IV cranial bleeds or significant brain injury that threatens life; or
- **Physically absent but psychologically present**—such as when someone is kidnapped or missing in action during a war and, possibly, when a mother remains in a birth hospital but her infant has been transferred to a children’s hospital.

It is particularly hard to process this type of loss because the loss has not fully happened. Without a death [in the first case; it seems cruel to grieve as if a death has occurred; in the second case, grieving removes the hope of return. Boss identifies the following challenges:

- Adjustment to the loss cannot occur as it is uncertain what one is supposed to adjust to;
- Rituals are not available or there are few social supports; and
- Nothing feels rational when nothing is clear or rational; the ambiguity is seemingly unending.

The uncertainty drags on and there is little ability for resolution and no end in sight. In many ways, our micro-preemies with their long NICU stays represent a type of ambiguous loss—it is unclear whether they will live and go home, yet one will not mourn them as parents are pleased the infant’s little body continues to function at all. These losses also confuse support people who do not know whether to express joy about the birth, or sympathy about the critical nature of the neonate’s health. Because there is not a death, people lack social support. Life becomes incomprehensible (unpredictable and utterly different from what one planned). A key to managing ambiguous loss is to focus on the relational, according to Boss and colleagues (2011, p.165). They suggest that support groups are efficacious with griever such as these. Group members share a similar experience of confusing loss over a protracted period.

Chronic sorrow (sometimes referred to as non-finite grief) is similar in that it is also a “living loss” (as in ambiguous grief). This type of grief tends to be “permanent, periodic, and progressive in nature” (Boss et al., 2011, p. 165) and is characteristic of parents whose children are born with (or contract) disorders that affect their development and ability to participate in typical society. With each milestone similarly aged other children achieve, the parent sees how their own child was unable to complete that milestone and the grief lives on. Both of these types of grief require coping for long periods of time, challenging a griever’s capacity to cope.

**Interventions**

All of the above-described concepts can be shared with clients and patients to help them understand the expectations and challenges of grief. The most important intervention is to listen respectfully, closely and with compassion and empathy as grievers tell their stories. Even so, some models exist (aside from the task-based models described in Bridging Theories of Grief, Part I). These postmodern models involve what the helping person (perinatal social worker) can do, rather than prescribe what the griever should do. Boss, Roos and Harris (2011) suggest the following steps for work with those experiencing ambiguous or chronic loss: [1] name and validate the loss; [2] help the client find meaning in their new role; [3] address trauma when it is present; [4] temper client mastery, by which they mean moderating the mourner’s expectations to have control of, or overcome the situation; [5] help the griever reconstruct identity; [6] normalize ambivalence, recognizing that
We can help our bereaved patients understand that some losses are not death losses, that many losses are disenfranchised, that continuing bonds and meaning-making are useful processes, and that both loss and restoration orientations are part of the grieving process.

Having both love and dislike for the person (in this case the baby who is not the idealized baby they wanted) is normal; (6) revise attachment; (7) help the client discover new hope; and (8) identify resources for support. Social workers can easily apply these steps to many forms of perinatal grief.

Lloyd (2002) suggests areas for exploration after a death loss. The focus of the work is to explore (1) attitudes towards death and dying from psychological, sociological and philosophical/religious perspectives; (2) the bereaved’s constructions of life; and (3) the processes of adjustment to the world without the lost entity. Each area of exploration involves paying attention to how the bereaved is redefining their roles, rebuilding their identities, negotiating transitions, surviving trauma and maintaining morale.

Finally, yours truly (McCoyd, 1987) developed a model of the Five V’s many years ago when I was supervising new social work students in the NICU and on the antepartum floor. The Five V’s are: Validating, Valuing, Verifying, Ventilating and being Visionary. Validating works to ameliorate disenfranchised loss and validates the griever’s experience. Our task is to help the bereaved identify areas where they may not feel permitted to grieve, and to recognize and validate their right to mourn. When a pregnancy has not been revealed, or it is not far along, the bereaved parents may not have others who are even aware of the loss, much less acknowledge and support them in their loss. Helping women and couples to recognize their right and need to mourn is a critical first step to facilitating the healing process.

Valuing and Verifying are the concrete parts of Validating. By recognizing the value of the lost entity, we can validate the griever’s right to mourn. We explicitly send the message that the pregnancy/baby was of value to the bereaved parent (or even that the notion of the idealized baby was of value and can be mourned) and that there is worth to what was lost. When we help the bereaved parent address all aspects of what was valued, we acknowledge the importance of who or what was lost. Verifying involves assisting the bereaved to gather tangible mementos and/or engage in rituals that “make real” the loss. Memory boxes with footprints, handprints, locks of hair and pictures are useful to parents’ own grieving, and can also be used to enlist support from family and friends and to assert the baby’s presence in the world.

Ventilating is something with which social workers are very familiar. Ventilation does not always require tears, but encourages the bereaved to talk about the loss with authenticity and consistent affect and content. In pregnancy loss, gender stereotypes of mothers mourning with tears and fathers with rigid control often hold true, but not always. In my practice, mothers often are emotionally expressive until the due date; at that point, partners suddenly start to express anger, sadness, and irritation. Partners seem to have “stayed strong” for the mother and once her emotion has run its course, the partners begin to express their emotions. Ventilating may create the narratives that lead to meaning-making. Continuing to explore how loss has affected the griever’s life will promote ventilation in useful ways. Even so, a few choice questions are useful. Overall, the social worker needs to remain quiet and provide support without platitudes or trite phrases that interrupt the griever’s ventilation of thoughts, feelings and reflections.

Finally, Being Visionary is often part of the ending process, but can happen at any point in the process. This entails helping the mourner to consider future events and identify dates, events and feelings that might intensify grief feelings (also referred to as Sudden Temporary Upsurges of Grief [STUG]). (Rando, 1993) In Being Visionary, lessons learned from other mourners about their STUG reactions help clients anticipate and prepare for them. In perinatal losses, the due date for a lost pregnancy often revives feelings of grief, as do sisters’ and friends’ showers and successful births. Helping the perinatally bereaved to anticipate those moments helps to defuse the surprise on top of the grief. Warnings about how future pregnancies may be fraught with anxiety and reminders of the loss can help inoculate women and help them manage anxiety.

**Conclusion**

Grief theory has evolved dramatically since Kubler-Ross and we perinatal social workers need to be familiar with the new developments in order to provide competent and compassionate care. We can help our bereaved patients understand that some losses are not death losses, that many losses are disenfranchised, that continuing bonds and meaning-making are useful processes, and that both loss and restoration orientations are part of the grieving process. Incorporating these ideas into our practice will go far to serve families as they cope with perinatal losses of all types.
References


Women offenders are a fast-growing population in the American criminal justice system (NRCJIW, 2016). The increase in incarceration rates for women is not a result of increased criminal activity by women. Instead, the increase is a direct result of state and national drug sentencing policies, which disproportionately affect women in poor and marginalized communities, particularly women of color (NRCJIW, 2016). Since 1980, the number of women in US prisons has grown more than 700%. The US Department of Justice reported that 110,000 women were incarcerated in 2015 (USDOJ, 2016). Approximately 5-10% of women entering the prison system each year are pregnant (Liptak, 2006), resulting in approximately 2000 babies born each year to incarcerated mothers.

Challenges for Incarcerated Women during Pregnancy

Although bringing a baby into the world is a joyous and miraculous occasion, it can be difficult and comes with risks—even in the best of circumstances. In prison expectant mothers face additional physical, psychological and emotional challenges. Attendees of the 2017 National Association of Perinatal Social Worker’s Conference had the opportunity to hear about these challenges first-hand from Lanetta Garner. Lanetta gave birth to her youngest son while incarcerated at Oregon’s only women’s prison, Coffee Creek Correctional Facility. Lanetta’s experiences were similar to those faced by many expectant mothers in US prisons.

In most prisons in the US, expectant mothers are not provided with additional meals or allowed specialized nutrition allowances (Roth, 2010). Moreover, they are not guaranteed work restrictions. Several previously incarcerated mothers interviewed for this article reported slipping and falling while working in a prison kitchen.

Another challenge is the lack of transparency regarding health care policies that govern the services provided to incarcerated women and their babies. There are no national policies mandating a particular set of standards. In circumstances where standards have been developed and recommended by medical professionals, adherence to the standards is often voluntary and not enforced (Roth, 2010). The lack of clear standards can have lifelong impacts for mothers and their babies. For example, even though it increases the risk of falling, there is a widespread practice in US prisons of shackling the feet of pregnant women when they are transported to and from medical appointments (Ocen, 2012). In addition, several studies have documented that women’s requests to see a medical professional are routinely denied or delayed by corrections officers and other prison staff (Roth, 2010). Denying or delaying medical services is not only cruel, but can have fatal consequences.

Challenges for Incarcerated Women during Childbirth

The challenges faced by mothers do not stop when they arrive at the hospital for delivery. It is not uncommon for women to be handcuffed and/or shackled to the hospital bed before, during and after delivery. In some cases the restraints prohibit mothers from sitting, bending or moving into appropriate positions for labor. In addition, the imposition of handcuffs poses a threat to mothers and their babies if there is a need to move the mother quickly into surgery due to an unexpected medical emergency (Ocen, 2012).

Restraints also impede maternal breastfeeding, bonding and attachment with their infant in the limited time they have together post-delivery. Women interviewed for this article reported having on average 24-36 hours with their baby before leaving the hospital to return to prison. One mother reported coming back to her hospital room after a brief trip to the bathroom to find her baby gone. She
said that the corrections officer told her that he asked the nurse to take the baby back to the nursery to wait for a family member to pick him up because he didn’t want the mom to get “hysterical” when saying goodbye to her baby.

**Challenges for Mothers Returning to Prison after Delivery**

Once women return to prison, the challenges oftentimes continue. Mothers report that they have little social or emotional support to help them cope with separation from their baby. The lack of social and emotional support can hinder their ability to parent in the future (Wismont, 2010). In addition, even in situations where a family member is allowed and able to bring the baby for visits, it can sometimes take weeks or even months to process the necessary paperwork. Many prisons restrict the amount of physical contact a mother can have with her baby during visits, making bonding and attachment difficult. The multitude of barriers placed between a mother and her baby, interfering with her ability adequately to care for her baby before, during and after delivery, can be staggering.

**Innovative Support Programs for Incarcerated Mothers and Their Families**

Although the challenges are plentiful, bright spots do exist for some incarcerated mothers. For example, at the 2017 NAPSW Conference, Lanetta shared her experience with the Family Preservation Project (FPP). FPP, a program operated by the YWCA of greater Portland, is a holistic family support program at Coffee Creek Correctional Facility. The program supports women and their children in a variety of ways. FPP provides ongoing, meaningful, supervised visitation between mothers and their children and guidance and coaching that helps mothers learn healthy ways to interact with their children. In addition, the program provides intensive case management through family interventions, transition support, adult education and parenting support.

Attendees at the 2017 NAPSW conference were provided with a glimpse into the benefits of the FPP program through the award-winning documentary *Mothering Inside*, by Brian Lindstrom. *Mothering Inside* follows women and children participating in FPP over the course of a year. The film provides powerful stories about the importance of the bond between mothers and their children.

Other innovative programs across the country also provide hope for incarcerated mothers and their children. At least 11 states currently have prison nursery programs [NRCJW, 2016]. The programs allow babies (usually up to 18 months) to live with their mothers in a specialized unit within the prison. Mothers and babies receive intensive services and specialized support. Several states are also piloting alternative sentencing programs that allow mothers and fathers to stay in the community with their child under strict supervision by a probation officer. Head Start and Girl Scouts both offer variations of their programs for incarcerated mothers and their children.

Advocates for women and children have made progress in promoting policy changes to support incarcerated parents and their children. To find out more about Mothering Inside and the Family Preservation Project, you can check out their website at [www.ywcapdx.org/what-we-do/family-preservation-project](http://www.ywcapdx.org/what-we-do/family-preservation-project). To learn more about the experiences of incarcerated mothers and children, including ways to help, please go to the National Women’s Law Center report on incarcerated mothers at [www.nwlc.org/sites/default/files/pdfs/mothersbehindbars2010.pdf](http://www.nwlc.org/sites/default/files/pdfs/mothersbehindbars2010.pdf). For more information about the Bill of Rights of Incarcerated Children, visit [www.sfcipp.org](http://www.sfcipp.org).

**References**


FETAL PROGRAMMING:
The Impact of Stress on the Developing Fetus and Implications for Effective Intervention

by Sherri L. Alderman, MD, MPH, IMH-E Policy & Clinical, FAAP Developmental Behavioral Pediatrician

How we care for our children is how, at last, we take charge of our own destiny.”
—Laurence Frank, 1939

Introduction
The field of neuroscience and brain development is a rapidly growing area of research, policy, and practices. In this process, we are gaining a broader and deeper understanding of how human brain development is impacted by biology, the social and physical environment, and health and development. Each domain interacts with and is influenced by the other: health and development by biology through neuroscience; biology by the social and physical environment through epigenetics; and health and development by the social and physical environment (Shonkoff and Garner, 2012). When considering ways of optimizing brain development, it is prudent to think about each of these aspects of influence on the developing brain.

Much attention has been focused, rightly so, on the first three years after birth. An infant’s brain will more than double in mass before his or her first birthday. The child’s brain reaches 90% of its adult size by three years of age. The developing brain is exquisitely sensitive and responsive to its environment. The infant’s brain is the most undifferentiated organ in the body. Those first three years of brain development after birth are a period of great potential. That potential is also a vulnerability. The quality of the environment and relationships that an infant and toddler experiences will set into motion the quality of the child’s social, emotional and cognitive development, and will impact health, productivity, and success over the lifespan.

What is less well recognized is the brain growth that occurs during pregnancy. A tremendous amount of brain growth has already happened by the time of birth. A newborn’s brain is 10% of their body weight compared to adults’ brains that are only 2%. Brain development during pregnancy is equally if not more sensitive to environment as after birth. This influence of environment on the developing fetus’s brain is called “fetal programming.”

Neuroscience of Brain Development
Brain development involves four core principles:
1. Genetics and environmental influences (including epigenetics)
2. Sequential and hierarchical development
3. Experience-dependent neurodevelopment
4. “Sensitive periods” of brain growth, (Perry, 2002; National Research Council & Institute of Medicine, 2000)

Genetics, environmental influences and epigenetics
Inherited genetic information certainly plays a role in brain development. Research is discovering more and more the significant role that epigenetics plays in brain development as well. Genetic information must be decoded and expressed in order to fully function in the development and growth of all aspects of the body. If a gene is modified and expression is inhibited, then the gene does not have an influence. Toxic stress can result in inhibited gene expression. This process is call “epigenetics.” Some mechanisms that are protective of the adverse impact of stress on the body are impaired by epigenetics. In short, stress begets stress in these uncontrolled situations. Without repair, that modification can be transmitted to the next generation.

Sequential and Hierarchical Development
Brain growth happens in a sequential order beginning with the brain stem, then the mid-brain and limbic system, and finally the neocortex. Evidence of development of the brain stem happens very early in fetal development. Presence of the heartbeat controlled in the brain stem is one example. The limbic system, site of emotions, develops before the neocortex. The neocortex is the last part of the brain to develop. The prefrontal cortex, one part of the neocortex, is not fully developed until around 25 years of age. Brain development is also hierarchical. Through the process of development of neuropathways and integration, some parts of the brain have capacity to influence other parts. For example, the prefrontal cortex when connected to the limbic system through neuropathways can influence the degree of emotional expression. This is sometimes referred to as “top-down” control. This hierarchical function of the brain provides potential for controlling behavior. This is discussed further below.

Experience-dependent neurodevelopment
There are parts of the brain that develop only if life experiences stimulate their development. An example is language acquisition. A baby’s brain
has full potential to learn and speak all of the sounds in all languages around the globe. When that window of potential closes is a topic of discussion but likely begins around six months. A baby holds the capacity to learn and speak the sounds that he or she experiences in the environment. Parts of the brain responsible for learning language depend on exposure to the language to develop. Without exposure, that potential is lost. Certainly, it is possible to learn other languages later in life. It is harder, though, and imperfect. Also, learning a second language is founded on the experience of having learned a first language.

**Sensitive periods**
The sequential growth of the brain has sensitive periods during which growth is optimal. That period of sensitivity is an opportunity for development in an experience rich environment and a highly vulnerable time. If the environment does not provide the experience that the developing child needs to cultivate learning and brain development, the window of opportunity closes. Repair can promote learning outside the window of opportunity. However, repair takes greater human and financial resources to be successful. The younger the child, the greater the brain plasticity to repair and the less it takes in resources to repair.

**Neuroanatomy and neurochemistry**
Two areas of the limbic system of particular interest in social and emotional development and learning are the amygdala and hippocampus. The amygdala is where emotions originate and are stored. Without even thinking about it, the amygdala will react to environmental experiences by sending out hormones along neural pathways. For example, the highly intense emotion, fear, activates the amygdala. The amygdala then sends signals throughout the body in preparation for the “flight, fight, or freeze” response. This survival response is important in times of danger. This response is rapid and not thought out. It is sometimes referred to as “go on automatic” or “hot circuit.”

The hippocampus, another part of the limbic system, is a place in the brain where factual, learned information is stored. The active process of storing new information and retrieving learned information can be blocked by the amygdala. This occurs when a person is emotionally activated. Again, in a moment of danger, this is helpful at better assuring a rapid response to get oneself out of harm’s way. When, however, a person becomes chronically emotionally activated, learning is impaired.

The prefrontal cortex is the last to develop and mature. The prefrontal cortex is the thoughtful part of the brain. When we think about what we wish to do or how we wish to respond to a situation, we are using our prefrontal cortex. A healthy, fully developed prefrontal cortex can signal to the amygdala to not respond or “go on automatic.” This pathway is sometimes referred to as the “cool circuit.”

The brain communicates with the rest of the body through the hypothalamic-pituitary-adrenal (APA) axis. Through a cascade of neurochemical events, the hypothalamus deep in the brain sends out neurochemical signals to the pituitary gland also within the brain. The pituitary, in turn, releases hormones into the blood stream. The adrenal gland, a gland sitting on top of the kidneys, is one target. Under times of stress, when that specific hormone reaches the adrenal gland, it signals the adrenal gland to release the stress hormone, cortisol. Cortisol travels via the blood stream throughout the body. Cortisol is responsible for preparing the body for the fight-flight-freeze response. For instance, cortisol triggers the liver to release glucose. Glucose is an energy source for muscles. Muscles then have the power to act. In the instance where survival is at stake, it is very important that the body quickly readies itself for mobilizing power. Cortisol also has an effect on the brain. It promotes the “go on automatic” pathway by blocking the neuropathway between the prefrontal cortex and the amygdala and blocks activation of the hippocampus. This stress response is designed to provide a rapid life-saving bodily response to danger. Cortisol requires two or more hours to be cleared from the blood. Cortisol levels will not return to baseline until both the release of cortisol ends and the already released cortisol has been metabolized.

Another hormone, adrenaline, is also released during times of acute stress and sense of danger. Adrenaline has multiple effects in the body including increasing the blood flow to muscles, again, for increased capacity for power and strength. Adrenaline also signals the amygdala. This promotes laying down implicit memories in the amygdala. Implicit memories are sensory-laden information stored unconsciously in the amygdala. Implicit memory prompts future amygdala action in similar situations. “Learned” sense of danger and life-saving responses in the form of implicit memory help assure survival of the species.

When a person experiences chronic stress or frightening moments repeatedly, hormonal effects on the brain adversely impact brain architecture. This is termed “toxic stress.” This is particularly true during times of rapid brain growth. Prolonged exposure to cortisol will enhance growth of the amygdala (hypertrophy) and inhibit prefrontal cortex growth (hypoplasia). Adrenaline will enhance the laying down of implicit memories of those frightful moments in the amygdala.
and program it for future responses. Over time, the amygdala becomes primed to react quickly and robustly. A mere isolated sensory feature of a previous adverse experience can activate the amygdala even when that sensory experience is in a new context. People talking about an adverse experience will often describe it in sensory terms. The experience for them is tagged by a smell, a sound, a color, or some other feature that they remember as their experience. An ability to talk about an adverse experience is a developmentally advanced skill. More typically, that feature and a person’s understanding of their reaction is hard to describe in words. Instead, a person’s brain will be triggered by their implicit memory in a totally new and perhaps even non-threatening context. The result is an initiation of the cascade of hormonal responses and an uninhibited fight-flight-freeze reaction. Research suggests that this neurochemical pattern is set into motion even before birth.

**Fetal Programming**

Brain development begins very early in pregnancy and is exquisitely sensitive and responsive to the uterine environment. Fetal programming is the result of the influences of environment on the developing brain's architecture during gestation that creates persistent consequences of health and disease risk (Barker, 1998; Glover et al., 2014). The working hypothesis is that the developing fetus is preparing for the environment into which they will be born and, as such, will increase the chance of survival. For instance, if a mother is in a stressful environment during pregnancy, the fetus will develop hypervigilance and capacity to be aware of danger.

There are protections that shield the developing fetus from elevated levels of cortisol in the mother's blood. Within the placenta, an enzyme, 11-dehydrocorticosterone dehydrogenase (11-HSD2) metabolizes the mother's cortisol to the inactive form, cortisone, before it reaches the fetus. In short, the balance between maternal levels of cortisol and enzyme capacity to metabolize is protective of the fetus to high levels of cortisol. However, this protective mechanism can be over-taxed in two ways: (1) high levels of cortisol and (2) enzyme down-regulation (Davis and Thompson, 2014; Glover et al., 2014).

When the mother's cortisol levels are extremely high, the demand for metabolizing the cortisol exceeds the capacity of the enzyme to do so. As a result, cortisol passes through the placenta and into the fetus' blood stream. Two instances when this can happen are: (a) during the third trimester of a healthy pregnancy and (b) when mother experiences high stress.

During a normal, healthy pregnancy, cortisol levels rise two to five fold from the first to the third trimester. Toward the end of the pregnancy, mother's high cortisol levels exceed the metabolizing ability of the enzyme and mother's cortisol reaches the fetus. In this instance, the cortisol serves to prepare the fetus for delivery by promoting lung development and shifting fetal development from growth to maturation. By 40 weeks gestation, the fetus is prepared for life outside the womb.

If, however, maternal cortisol levels are elevated anytime during the pregnancy, cortisol can impact fetal growth and disrupt brain architecture. During the first 20 weeks of the pregnancy, fetal brain development is exquisitely sensitive to environment, including cortisol levels. A mother's experience of chronic stress will adversely impact fetal growth through the mechanism described above and will prime the fetal brain to be more reactive to environmental stress.

Finally, a process of enzyme down-regulation can also result in fetal exposure to elevated maternal cortisol. A mother’s elevated cortisol levels can impede production of 11-HSD2. With reduced quantities of the enzyme, mother’s cortisol passes through the placenta and into the developing fetus’ blood.

Fetal exposure to abnormally high levels of cortisol during pregnancy can result in altered brain architecture, amygdala hyper-responsiveness, shortened gestation (premature birth), and stunted fetal growth (in utero growth restriction or small for gestational age).

Research provides evidence that exposure to abnormally high levels of cortisol during pregnancy can result in detrimental fetal outcomes. Davis and colleagues measured babies' cortisol response to the newborn heel stick for newborn metabolic blood tests. The assumption was that all the babies were subjected to the same pain. What they found was that those babies whose mothers had high levels of measured cortisol during the pregnancy and reported stress, anxiety, or depression showed higher cortisol response to the heel stick and longer recovery to quiet state 24 hours after birth (Davis, et al., 2011). This suggests that newborns are already programmed differently and maternal stress levels during pregnancy are associated with higher reactivity and prolonged recovery to noxious stimulus.

Another study looked at six-month-old babies using functional MRI. For this study, mothers were asked to complete a questionnaire that assessed degree of spousal conflict in the home. Physical conflict was screened out and not included in the study. Babies were brought to the laboratory to nap in the functional MRI (fMRI). While they napped, they heard unintelligible angry voices through headsets. Results showed that inter-parental conflict correlated with heightened brain activity in sensory processing areas of the brain. The degree of brain activity in those sensory processing areas of the brain increased with increasing reports of conflict in the home (Graham, 2013).

Other studies have shown associations between maternal stress during pregnancy and negative emotional reactivity in six month olds (Nolvi, et al., 2016), higher pre-stress cortisol levels in 14-19 month olds (O’Connor, et al., 2013), delayed cognitive development and increased fearfulness in 14-19 month olds (Bergman, et al., 2017), higher internalizing symptoms in five year olds (Howland, et al., 2016), and internalizing problems in six to nine year old girls (Kim, et al., 2016). Pregnancy anxiety is particularly impactful for infants. Pregnancy anxiety is defined as a negative emotional state tied to worries about the health and well-being of one’s baby, the impending childbirth, of hospital and healthcare experiences, birth and
postpartum, and parenting or maternal role (Guardino, et al., 2014). Pregnancy anxiety has been linked to preterm birth (Rini, et al., 1999; Roesch, et al., 2004; Kramer, et al., 2009), infant attention regulation at three to nine months after birth (Huizink, et al., 2002), cognitive and motor delay at eight months (Huizink, et al., 2003), and reduced gray matter volume at six to nine months after birth (Buss, et al., 2010). Risk factors for pregnancy anxiety include:
- Low self-esteem
- Low perceived control of important outcomes
- Pessimistic about one's future
- Lack of social supports (including with baby's father)
- Low income
- First pregnancy (Rini, et al., 1999; Gurung, et al., 2005)

Early identification and supports for mothers and fathers with associated risk factors for pregnancy anxiety through programs, such as home visiting, could reduce pregnancy anxiety and improve child outcomes.

Studies suggest that stress and elevated cortisol levels during pregnancy have an adverse effect on babies' brain architecture, predisposing them to challenges with social, emotion, and cognitive development beginning at a very young age. What is commonly referred to as “temperament” may be behavioral evidence of fetal programming that began during pregnancy. Knowledge of the dynamic brain growth that happens after birth and the opportunity for repair especially during the first two years after birth logically makes the case for approaches effective at repair of difficult “temperaments” in infancy and early childhood. This work, especially when focused on dyadic work supporting child-caregiver relationships, has potential for reversing the adverse outcomes of fetal programming that occurred during pregnancy.

**Approaches to Intervention**

Using an ecological model for child well-being, we can support optimal child outcomes on multiple levels.

**Early intervention for optimal fetal development**

The fetus benefits from nurturing for optimal physical, developmental and mental health. Strategies that target the developing fetus include prenatal comprehensive screening and services. Screening for social determinants of health, mother's and father's adverse childhood experiences, and mental health can identify concerns early and provide supports to address those concerns. For parents/caregivers with high risk factors for adverse outcomes, early postnatal referral to habilitative, developmental, and dyadic services can intervene at a time of dynamic infant brain development and promote development of secure attachment. Secure attachment is the foundation for engaged caregiving, delight in parenting, healthy social and emotional development, academic success, and lifelong health, gratifying relationships, and productivity.

**Addressing a parent’s adverse childhood experiences**

The fetus inherits genetic information from the parents. Also, through a process called epigenetics, the environment influences which genes are expressed, which are not, and which genes are modified, resulting in different functionality when expressed. Optimizing healing and minimizing risk reduce the adverse impact that epigenetics can have on development and increase the probability for optimal child outcomes. This is important work calling for an increase in the professional workforce available to address such issues and general public awareness of the impact adverse childhood experiences (ACEs) have when carried into adulthood without repair. Creating a culture of recognition of the wide prevalence of ACEs, reducing the stigmatism of victims of ACEs, and promoting a shift from an attitude of “what you did” to “what happened to you” will have a long-range benefit for children, families, communities, and society. It will reduce the sense of shame, validate a person's feelings, break the cycle of transgenerational transmission of the consequences of ACEs, and start the process of rebuilding a new, healthier life for ourselves and the lives of our children.

**Maternal and paternal support factors**

Maternal factors and paternal factors contribute to child outcomes. As with early identification of risk factors, promoting healthy dyadic relationships for all parents can begin in pregnancy. All parents benefit from parental supports. Supports may include:
- Financial supports for families to maintain economic stability
- Early detection of mental health and substance abuse issues and timely, effective implementation of treatment
- Home visiting services with mental health consultation for home visitors (Mind the Baby model)
- Identification of opportunities for social networking
Ininclude:ports that optimize child well-being and increase accountability for promoting their child's optimal development.

External family support

There are numerous opportunities to mobilize extended supports and grow family strengths. Strategies that match the needs and challenges of each family in a culturally responsive way and utilize and reinforce family strengths best assures an optimal fit of services for each family and equitable allocation of resources to address that need. Building on family strengths is respectful, builds confidence in parents, reduces stress, and creates opportunity for each parent to be the best parent they wish to be.

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External family support

There are numerous opportunities to mobilize extended supports and increase accountability for promoting a healthy pregnancy and optimal child outcomes. External family supports that optimize child well-being include:

- Attention and resources to assure safe, stable housing, healthy home environment
- Access to healthful nutrition, food security, and education on maintaining a healthy diet
- Access to healthcare and healthcare insurance
- Active welcoming and involvement of father and extended family
- Paid parental leave for a time period consistent with research findings on infant brain development and secure attachment
- Affordable, high quality child care
- Services to heal consequences of trauma history and ACEs
- Recognition and support of resilience

- Resources and information on methods of child rearing that are culturally responsive
- Community public health support

Communities have a determining influence on child outcomes. Social capital within a community is the currency of exchange that provides opportunities for supporting optimal child outcomes. Ways that communities support healthy child outcomes include:

- Provide safe water and clean air
- Provide affordable, healthy housing options for families
- Create and maintain safe neighborhoods and green spaces that are infant and family friendly
- Provide community social gathering sites for social networking that are infant and family friendly
- Policies and practices that provide equitable allocation of resources to support parenting
- Coordinated, multidisciplinary system of pediatric and adult healthcare that is culturally responsive
- Promote and allocate resources for routine developmental, social, emotional, and mental health screening for infants, children, and their caregivers
- Early identification of developmental delays, expeditious developmental evaluation, and implementation of appropriate services to address needs
- Tools, resources, and expertise to engage families across the early childhood behavioral continuum
- Provision of preventive and habilitative services for high risk populations
- Culturally responsive early learning settings (childcare, preschools) and community-based healthcare systems
- Shared value for innovative, flexible, and culturally responsive models of child rearing
- Initiatives and services that are trauma-informed
- Affordable, high quality childcare and preschools
- Strategically located and welcoming neighborhood libraries
- Active clergy and spiritual community involvement

- Development of a skillful early childhood workforce and appropriate compensation
- Organizations that operate as a trauma-informed workplace
- Community resilience identification, ongoing supports, and continuity
- Revamped media that respects the vulnerability of developing minds

Acute events and disease

Acute natural and human disasters and disease adversely impact early childhood development and can disrupt child-parent relationships. Preparedness and special resources for very young children and their caregivers can reduce the impact of adversity. Ways that reduce the consequences of adverse events include:

- Strong public health infrastructure and system appropriately resourced through financial and human resource allocation
- Community and family preparedness
- Rapid response to disaster or epidemic
- Child- and family-friendly response including workforce and emergency accommodations
- Restorative physical, mental, and community health
- Operative restoration of workforce mental health
- Restoration of community resilience and social capital

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Conclusion

Brain development is highly influenced by environment—beginning with the prenatal environment. Maternal stress and anxiety during pregnancy are associated with infant and child dysregulation, cognitive delay, and mental issues. Many genetic, epigenetic, family, and community level infrastructure and services can support parents and promote optimal child outcomes and well-being. Community social capital and family resilience are promoted through strategies that focus on optimal perinatal and early childhood brain development and child well-being. Here is truly the best place to start taking charge of our own destiny.


References


NAPSW 2018 Award for Excellence

NAPSW established the Award for Excellence in Perinatal Social Work in 1988 to recognize a member for “outstanding clinical achievement in the field of perinatal social work.” In 2002 the board of directors voted to include consideration of service to NAPSW.

Please take a few moments to recognize and nominate a fellow NAPSW colleague. Nominations are welcome from the general membership through FEBRUARY 16, 2018. The nomination form is now available at www.napsw.org. Please email completed nomination forms to Debby Segi-Kovach (dsegiko1@jhmi.edu).

The NAPSW Board of Directors will choose the final award recipient by secret ballot and the award will be announced at the 2018 Annual Conference in Long Beach, CA.
In “The Panic Virus” Steve Mnookin explores the origins and development of the anti-vaccine movement. He focuses on fears that childhood vaccination is a cause of autism. The book presents a detailed and easy-to-read look at the faulty research and reasoning behind that conclusion.

The author describes the ways misinformation and false rumors about vaccines and autism have spread and the impact of this phenomenon on individuals, families, and communities. The book is engaging and includes many personal stories along with the historical context that helps readers understand how some families made the decision not to vaccinate.

Mnookin reports he became interested in the subject when he was at a dinner party and heard the guests discussing the issue as if deciding to vaccinate was a decision based on beliefs instead of scientific fact. He heard parents saying things such as, “It just doesn’t feel right to me to inject my child with so many things at such a young age.” He writes, “Like many reporters, my first instinct was, ‘Oh, a juicy story about how the pharmaceutical industry and the government are conspiring!’” He thought he would uncover a group of parents and activists working against very powerful interests. However, he found the opposite was true: there is no data to support the claims that vaccinations cause autism. There is much data, however, showing how imperative vaccinations are to prevent outbreaks of harmful illnesses and death.

In “The Panic Virus” Mnookin shows how people come to believe and promote false claims. He attributes the anti-vaccine movement to panic-driven parents, sensation-hungry media, and PR-challenged health authorities. With 24-hour news coverage and Internet search engines, our culture has leaned away from scientific research and facts for our information and leaned toward intuition, personal beliefs and opinions. Mnookin gives examples of news organizations reporting on a claim with no research to back it up. Yet, just because it is on the news or in print, people come to believe it is a legitimate issue. He tells the stories of individuals infected with diseases long thought to be defeated and parents who thought they were doing the right thing by not vaccinating their children. In some cases, these children died from diseases that could have been easily prevented with vaccination.

While debunking the myth that vaccinations may cause autism, Mnookin shows great compassion for parents who are raising a child with autism. He describes the loneliness and anguish parents feel and why they are so desperate to identify a culprit.

“The Panic Virus” is a book I would recommend to perinatal social workers and to anyone about to become a parent or whose children are approaching vaccination age. Mnookin’s thorough research on the subject of vaccination makes it clear that there really is no debate on this issue: scientific and medical research findings all verify the fact that vaccinations do not cause autism. In contrast, the author makes the case that parents who reject vaccines for fear of autism are “casualties of a war built on lies.”

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Mother Nature challenges NAPSW members

In 2016 and 2017 weather-related disasters seemed ubiquitous—three massive hurricanes, prolonged wildfires across large areas, and even severe thunderstorms. What happened and how did perinatal social workers respond? Were disaster response plans adequate? Or do such plans need to be tweaked to reflect lessons from recent events? We wanted to hear individual stories from our perinatal colleagues across the US and Canada. Here’s what we learned:

**Eastern North Carolina (Nina Beech)**

Hurricane Matthew was a category 5 Atlantic hurricane that reached the shores of North Carolina in September 2016. Although the storm weakened as it traveled up the coast, it triggered flooding responsible for the deaths of 31 people, displacement of many thousands of people and billions of dollars in damages. One social worker was unable to travel to work due to the flooding and, therefore, unable to assist her employer with the disaster response. Fortunately, the workplace had a disaster response plan in place and services continued as planned. The recovery timeline was 6 months. In the aftermath of this flood, additional mandatory disaster response training was implemented. In addition to missing time at work, this perinatal professional learned to be “more mindful of the reports of the inclement weather” and to stock a “minimum of 2 weeks’ worth of non-perishables and drinking water.”

**Charlottesville, Virginia (Will Crowder)**

In the South, any significant snow accumulation can be disastrous and require an immediate response. In Virginia recently, a snowfall of 24 inches created a major challenge for typical healthcare operations, limiting the staff’s ability to travel to work and parents’ ability to visit their hospitalized children. A local hospital with a long established emergency preparedness plan and team focused their efforts on getting staff to the hospital and discharging patients, who were medically ready to go home or transition to a lesser level of care. Every discipline has an assigned role and the hospital provides emergency preparedness training to all staff. In the event of an actual disaster, a command center manage operations and determines when the hospital can return to business as usual.

**Corpus Christi, Texas (Jennifer Vasquez)**

Hurricane Harvey made landfall on the Central Texas coast near Corpus Christi, as a Category 4 storm in August 2017. The National Hurricane Center warned of catastrophic flooding from the storm surge and torrential rains. The eye of the storm swept ashore with 130-mile-per-hour winds. While workers and first responders followed the existing disaster response, for one person, the role described for social workers was “vague” and in need of further definition. The hurricane resulted in the evacuation of infants and separation of parents and infants. It directly affected many hospital employees. This perinatal social worker stayed at the hospital for 48 hours during the hurricane—a stressful experience as she worried about her own family at home. While the hospital attempted to get back to normal 72 hours after landfall, this was unsuccessful; most departments were functioning “as normal as possible” about 96 hours after Harvey’s disastrous hit.

**Medford, Oregon (Stacie Westbrook)**

Wildfires in Oregon are frequent during summer months. The 2017 fire season was consistent with a trend toward increases in the number and duration of wildfires. Families can be displaced from their homes and many times they are worried about other family members and animals near the fires. Healthcare facilities are not typically located in proximity to potential wildfires, but when fires do occur, smoke and ash particles travel great distances and contribute to dangerous air quality for large geographical areas.

**St. Louis, Missouri (Corliss Burton)**

In the Midwest, natural disasters can be in the form of tornados, storms, and floods. One social worker’s experience over many years has been that disasters come and go fairly quickly and that recovery time is typically short. She recalled one disaster in which the health center where she worked closed for one day and two other occasions where they lost electricity for seven days, but each time the hospital was able to rely on backup generator power. While their community health center has an established disaster response plan, much of the current focus for staff training is in workplace violence rather than natural disaster planning.

**All hands on deck!**

As we head into 2018, preparation for unusual events in the healthcare workplace—whether natural or man-made—is crucial to our success as perinatal social workers.
NEW MEMBER SPOTLIGHT

NAPSW Welcomes Jenise Katalina

Jenise Katalina lives in Springfield, Massachusetts where she works in a local community organization serving families with young children. Forty percent of the population Springfield (3rd largest city in the state) live in poverty.

Jenise earned the MSW degree at Springfield College. Her career has included over six years as a supervisor and coordinator for home visiting services that support families prenatally through their child’s kindergarten year. In addition, she has assisted in the development of a local family center offering support groups, parent workshops and activities that promote parent-child interaction. This family center offers programs of interest to the community under the direction of a parent advisory board.

Jenise is certified in multiple models for supporting parents and families, including “Train the Trainer in Cultural Humility” and “Strengthening Families Protective Factors.” She currently serves in a leadership capacity in many community-based coalitions, including the Springfield Department of Health and Human Services Maternal Child Health Commission and the Hampden County Perinatal Support Coalition. In the spring of 2016 Jenise joined the Mother-Woman Perinatal Support Group team. As a trainer, she provides education to providers on perinatal mood disorders and how to support families using a culturally humble lens.

Jenise says, “I love hearing new ideas from our families and being creative about developing programs beneficial to them. … My passion is to provide a community impact approach to supporting families by reducing health disparities and promoting racial equity. I hope to educate and support community providers in breaking down the stigma and barriers to providing support to families of various cultural backgrounds struggling with perinatal mood disorders.”

Jenise is the mother of two children. Whenever possible she enjoys traveling. As a new member of NAPSW

NAPSW Welcomes Kelli Weber

We are excited to welcome Kelli Weber from Chicago. Kelli joined NAPSW this past year at the annual conference, which was the first one she had attended. Originally from the metro-Detroit area, Kelli received her BSW from Wayne State University and her MSW from Michigan State University. She has a certificate in Infant Mental Health from the Erikson Institute and a Masters in Health Administration from DePaul University. Kelli currently works as a Social Work Clinical Coordinator at Ann & Robert H. Lurie Children’s Hospital in Chicago. She is one of two social workers in their 44 bed NICU. Her social work administrative duties include coordinating the Medical Social Work Internship Program and lead for a team of 10 social workers.

Please join NAPSW in welcoming Kelli and learning a little more about her in her own words. “I felt ‘at home’ with all of you and was inspired by those that have been working in this field for many years. I look forward to collaborating on important issues—advocating at the macro level, sharing clinical interventions, and promoting reflective practice so we all feel sustained in this work. I am incredibly passionate about the perinatal period and am thankful I can integrate my specialty in infant mental health with my clinical work. I love the flexibility of providing psychotherapeutic supports for longer admissions, while also addressing immediate crises, and offering NICU staff support. I have been working on our NICU for 4 years and seeing NICU graduates thrive helps sustain me in this challenging role. In addition, coordinating the student program and supervising my social work team promotes my own professional growth. My team includes cardiac, GI/liver, kidney, and pediatric surgery social workers—services many of our NICU graduates are followed by. It is incredibly rewarding to see our patients and families make progress along
Jenise Katalina continued

Jenise looks forward to connecting with other community social workers supporting parents and families through the perinatal period.

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Kelli Weber continued

with my team members expanding their own clinical skills.

“My biggest challenges likely parallel most perinatal social workers. While I truly love holding multiple roles, I frequently don’t have the time needed to do all aspects of my job as thoroughly as I’d like. When we have a very high census I don’t have the time to provide quality, dedicated psychotherapy to parents. Like most regions, Chicago is severely limited in mental health services—especially for Medicaid recipients. Frequently I am unable to make a solid referral for therapy and recognize my limitations in providing that support in-house. In addition, many of our families are facing significant social stressors that we can’t easily address during their NICU stay. As a social worker I feel really helpless in ensuring a family is set up for success when realistically there are no programs to address a family’s inadequate housing, transportation barriers, and community violence issues.

“The perinatal setting allows me to integrate both the clinical and macro level areas I am passionate about. Early intervention and preventive programing is critical for children’s success. In the NICU I am able to integrate trauma informed models, like Child Parent Psychotherapy, to promote parent-child attachment and mitigate Perinatal Mood Disorders. On a macro level, I am interested in reproductive health care, particularly in terms of quality, access and affordability. Working directly with mothers and infants affords me the opportunity to advocate for this vulnerable group in an informed manner.

“Before working on the NICU I was the overnight Emergency Department Social Worker for two years. In that role I completed child abuse psychosocial assessments and psychiatric evaluations. Prior to that I provided homebased Child Parent Psychotherapy with homeless young mothers and children. I also was a foster care case worker and worked in residential treatment for a few years. My firsthand experience as a foster care worker has been essential in navigating DCFS involved cases in the NICU. I developed my passion for young parents while doing home based therapy. From that experience I have a better understanding of the specific community stressors many of our families’ experience.

“The training I received in Infant Mental Health through the Erikson Institute provided a solid knowledge of infant development, perinatal mood disorders, parent-child attachment, and reflective practice. Integrating reflective practice in my own clinical work, with social work colleagues, and the NICU team is integral in being sustained in this challenging work. I am passionate about providing quality, wraparound, early intervention supports for our NICU families. This includes screening and treatment for perinatal mood disorders, trauma informed clinical interventions, and concrete supports to mitigate non-adherence issues. We often say ‘our NICU grows our hospital population’ as most of our long-term chronic patients spent time in our NICU. With that, it is imperative we provide a quality, supportive environment for these families as they enter their long medical journeys. It is rewarding to see the strides our families make and I am thankful to be a part of their journey.”

In her free time Kelli is an avid runner, including qualifying for and running the Boston Marathon in 2017. During races she likes to dedicate each mile to a NICU baby and use them as inspiration to run harder. She loves to hike and travel, and in 2017 Kelli and her husband hiked to Mt. Everest Base Camp in Nepal! Kelli also loves to cook, bake, and have a nice dinner at home with a good bottle of vino!

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Innovative Programs Research Grant

The National Association of Perinatal Social Workers invites applications for the Innovation Programs Research Grant. This grant provides seed money for perinatal social workers to fund special programs or research efforts that would otherwise be unfunded through their agency or place of employment. The purpose of this program is to:

- Assist social workers in funding new programs designed to identify or meet the needs of their client population;
- Encourage the translation of evidence-based findings to practice through the development of novel or unique interventions; and
- Encourage the evaluation of best practices through research projects designed to inform practice.

Interested applicants should submit a 3-5 page proposal that includes the following elements:

- Discussion of how the proposed project contributes to the objectives of NAPSW
- Description of the need for this research and the population served
- Description of the program implementation or research plan, including:
  - Aims
  - How aims will be carried out (specific plan)
  - Outcomes, including evaluation of outcomes or benchmarks
  - Time line
- Budget
- Agency letter of support

This program is open to social workers of any level currently practicing in a perinatal field, as well as full-time students currently enrolled in an accredited social work graduate or undergraduate degree program with a research agenda that directly relates to perinatal social work. Applicants will receive a one-time funding award in the amount of $1,000.00 and are expected to submit a poster presentation of their outcomes or research findings at the NAPSW annual conference the year following the award. A two-page summary of findings should accompany the poster presentation. Award recipients are expected to maintain membership in NAPSW for the year in which funding is provided.

Please submit proposals via email to Lisa Baker (lisabakerbdb@gmail.com) no later than Friday, February 9, 2018. Proposals will be reviewed by a committee.

NAPSW Nominations

At the 2018 NAPSW annual conference in Long Beach CA, we will select candidates to fill the following positions:

Vice-President
Treasurer
Nominating Committee member
5 members of the Board of Directors

Nominations are now open and must be received by the nominating committee (no later than February 1, 2018. Send nominations to Corliss Burton at corlissburton7@gmail.com).

Please consider nominating yourself or other NAPSW members for these positions. Candidates for the Board of Directors’ positions need to be members in good standing for one year prior to running for the Board. Candidates for officer positions [Vice-President, Treasurer, and Nominating Committee] need to have served at least one term on the Board of Directors.

Again, PLEASE send names of people you think will serve our organization well! Including yourself! We LOVE self-nominees because they have already said “yes” to running for a position.

If you have further questions, please contact the nominating committee directly.

Nominating Committee Chair – Corliss Burton corlissburton7@gmail.com
Committee Member – Mary Denato marydenato31@gmail.com
Committee Member – Tiffany Hanff tr.hanff@gmail.com