

sons charged with surveillance are not skilled and trained in infant cardiopulmonary resuscitation and other pertinent matters. Nurses and nurse practitioners and other health care providers in the SIDS context risk incurring civil liability unless they are adequately trained to take the proper action in the event of an episode. Physicians in rural areas should consider sending the infant to an appropriate hospital if facilities are not available locally. But home monitoring may be appropriate* where the persons involved in the surveillance are adequately trained.

*The question whether to prescribe an electronic monitor in appropriate situations is sometimes complicated unfortunately by the question whether such a monitor is covered by the pertinent insurance carrier. This is frequently a matter of insurance contract law and beyond the scope of my remarks here. Some suggest coverage turns on whether a specific expense is treatment of a condition or prophylactic care. I find this distinction unhelpful in the SIDS context.

The physician's duty in this context seems to me to have been summed up succinctly by Dr. Kelly, et al., in a recent article.

We conclude that infants who have experienced near-miss SIDS are at great risk of recurrent apnea, hypoxia, and sudden death. Most deaths can be prevented by supervised home monitoring of respirations and appropriate intervention by parents trained in resuscitation.*

In closing, I must say I do not know whether the civil liability problem in the SIDS context is an immediate one or merely a cloud on the horizon. It could be neither and the problem can be avoided permanently by continuing medical education programs such as this to ensure that physicians and other health care providers in Virginia remain abreast of the latest developments in medicine.

Thank you.

*61 *Pediatrics* at 514 (April 1978).

The Grief Reaction

ELOISE HAUN, M.D., *Clinical Assistant Professor of Psychiatry, Medical College of Virginia, Health Sciences Division of Virginia Commonwealth University, Richmond, Virginia*

For most parents the death of their infant is the first serious crisis in their lives. This event is regarded by all young parents as more stressful than previous deaths in the family, divorce, separation, alcoholism, or suicide. The infant death may be the first death in the family. The grief reaction is not stereotyped; it is as varied as the individuals experiencing it and the families of which they are a part. Several patterns of grief will be treated here.

One of the features of the grief reaction is reminiscing. Old people who die have a history. There are photographs, objects that are meaningful, shoes, dresses, suits and ties are left be-

hind. There are memories. A 3-month-old infant doesn't have a lot of memories associated with it. It may have a little toy or blanket. The process of internal bargaining is lost in the SIDS death. There are limited experiences and a lack of time associated with the death. Rationalization of the death is difficult because there was no recognizable cause. There is no opportunity to speculate or predict what might have been.

This leads us to the subject of guilt which has been mentioned before many times; the guilt of the parents and let us not neglect the physician. I would like to introduce the thought

that the physician might also feel grief and this should not be left out of this process. The guilt extends to family and friends. The neighbors tend to remove themselves from the parents. They don't know what to say and if they say something, it comes out wrong. The families may take offense, and in their sorrow, they may be difficult to work with and the neighbors may turn away. There is confusion among the neighbors as to what to do. There is always the lurking suspicion of child abuse and neglect. It never really goes away, regardless of what the facts are. The family is usually the resource to which the parents of the deceased child turn. It is the safest and most familiar resource, perhaps the most comfortable. However, what is happening to the American family? Is it home down on the farm or in the same old house? No, it is dispersed. We have a fragmentation of the American family and therefore a dissipation of that much needed resource. There is also the possibility of exacerbating previous psychiatric difficulties at the time of grief. Marital problems that existed prior to the infant's death are certainly amplified at the time of death. The entire extended family reacts with predictable patterns established years before the crisis. The family may be a great source of secrecy, denial, blame, ostracism, and other reactions. Among family members where there had been competition, this past hostility is revived and reinforced by the guilt.

Family also includes siblings. The siblings may be denied access to their parents because the mother and father are busy talking to the pathologist, their attorney, pediatrician, and funeral director. The little ones are left at home with a great void. The children do react. The parents are in shock or severely depressed and unable to communicate. Perhaps they are irritable. Three fourths of all siblings of a dead baby are symptomatic. Nightmares, insomnia, enuresis, syncope, and school failure and discipline problems are recorded. Children under 5 years old regard death as temporary. It is a reversible concept. There is always the fantasy that the baby is asleep or will come back. It is not a final phenomenon. Between the ages of 5 and 10 years, children have some magical thinking about death. They contrive a cause; someone or something is responsible in their mind. It is important to know that children older than 10 regard death as inevitable, irreversible

and final. These children can and should be included with the adults in sharing reactions and information.

Little children are fearful that the same thing will happen to them. There are two components to this fear. One is that if the baby died, they too could die, especially if they are under 10. They must understand that infants are the only ones who die like this; that this will not happen to them. A little child often has rich fantasies which help him or her cope with stress. These fantasies are useful and needed and it is better to let the child have them and for the family to intervene in a supportive way than to belittle them. As long as the small child can avoid the terror of expecting to die, he or she can indulge in fantasy. In the interim, brief disturbances are very common. There is a little prayer, "If I should die before I wake, I pray the Lord my soul to take," that has persisted for generations. Even without trauma children have believed that they could die in their sleep.

A second component of the fear of dying is that a young child often implicates himself or herself as contributing to or being the cause of the infant's death. Rivalry may have existed, in fact, it always does. The young child 5 to 10 years old may have wished that the infant would die. I hear this frequently in my practice. Children can say this to me because I promise I won't tell anyone else. Such a wish, if it comes true, is indicative of magical powers too frightening to tolerate. In a magical reference the person having successfully willed the infant's death must also die as punishment for the evil wish. Fear of going to sleep occurs because the child feels he or she will die as the infant died. Some children may have touched the baby or taken the bottle or blanket on the fatal day. Guilt will often occur, manifest by behavior, because the guilt itself is unspeakable. Behavioral problems are the first sign that the child needs to have more time to talk about this.

Subsequent children of SIDS death parents are targets of overprotection, anxiety, and indulgence. Sterility and spontaneous abortion are also higher in these parents. Having a replacement child is another mistake. No child can be replaced. One of the psychiatric complications of a replacement child is identity confusion. He or she asks, "Who am I? What is my significance in this family? Am I Jane, John, Tom or Jim? What is expected of me?" Survival

guilt ensues. "I lived and she died. I shouldn't be alive." Chronic depression with suicidal inclinations and resentment with its behavioral equivalents can occur.

Fathers tend to withdraw to work or pursuits outside the home. Separation and divorce are not uncommon. The young mother is abandoned emotionally by her husband and left with the responsibility for caring for the siblings. Postpartum hormonal equilibrium is often not yet established. A physiologic vulnerability exists which further accentuates the emotional reaction. The mother will "hear the baby cry" or make formula. Concentration and memory are impaired, leading to accidents in the home and possibly younger children getting injured because the mother wasn't thinking. More guilt arises. Lactation persists and the let-down reflex with flow of milk occurs at the thought or suggestion of the deceased infant. Lactation is a big problem for nursing mothers whose baby has died. Sleep disturbance occurs, too, and without sleep one doesn't cope very well anyway, so it's a vicious circle. Insomnia and nightmares can be helped with a mild sedative for a few days.

But drugs do not cure grief; they complicate and prolong it. One of the biggest problems I have is the pressure applied to prescribe medication for grief. This should be resisted, but the physician may be required to devote more time to emotional support.

Families often go away for a few weeks after the funeral of a deceased infant, but returning home is difficult. Sixty percent of families move away six months to two years after the funeral. With every subsequent loss or bereavement the memory of the infant is revived or referred to. Anniversary syndromes develop; Mother's Day, or the birthday of the infant, becomes unhappy.

I would like to share a poem written by a mother 14 years after the event. This appeared in *Pediatrics*, April 1979, and is called:

The Tenth of July*

It was so many years ago
When you left us.
Why you died
No longer matters.
But the when remains
And serves, one more time, as a memorial
To remembering.
Today is very like that day long past
Clear and cool and out of season

For the midst of Summer.

It stirs the memory so carefully submerged

Until today.

And it matters.

Because you were.

My mind does not mourn yesterday.

It mourns today.

The images that pass before my eyes

Do not recall the infant son

But see you running through my house

A teenage child in search of food and gym shoes and
maybe me.

I do not mourn you for what you were,

But for what can't be

The unfinished life we didn't share.

The very briefness of that life

Has reached this day and makes me pause and know

I miss you.

I remember my first SIDS death. I was a resident in Pediatrics and pregnant at the time. The clinic was about to close and the nurse was sending people away who came late. One lady protested. I was very tired, but I examined her baby. It was a well baby. The next day the ER staff said "Hey, there were three guys in here with black suits, white shirts and black ties looking for a pregnant lady doctor who examined a baby late in the Well Baby Clinic and it died suddenly." I never knew why the baby died.

Currently, I am a child psychiatrist and inevitably, in the course of history taking, I look for a dead baby. It comes up very often and the grief and mourning process goes on. It has been resolved incompletely. Often I see an alive child years later who is affected by it—a surviving twin, or a near-miss, or a child adopted to replace the dead baby. That history is very relevant and many times the whole box of tissue is gone in the course of history taking. It is worth looking for that dead baby because if it is there, its memory persists.

In conclusion, I present more questions. What happens emotionally to the infant at risk? I wonder what effect the monitor has in the home and what effect it has on a baby. I wonder what effect a monitor has on a sibling. I don't know. I wonder what can be said about physicians' anxiety about litigation, regardless of their feelings for caring for people. The emotional ramifications of SIDS are far-reaching. The grief reaction and its attendant components affect the quality of life. We have only begun to study and respond to the serious and emotional sequelae of SIDS.

* Reprinted with permission from *Pediatrics* (63:615, 1979).