Some Psychiatric Sequelae to Crib Death

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Sudden, unexplained infant deaths present acute problems in adaptation for the remaining members of affected families. A constellation of events is described here in which an older sibling of preschool age is present during the mother's discovery of the crib death. Scapegoating of the surviving child by the mother arises out of the compelling need to reduce her anxiety and guilt. This observation has special significance for the type of therapeutic intervention used.

And this woman's child died in the night because she overlay it . . . .
And the king said: Divide the living child in two . . . .

—Kings 3: 19, 25

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ver the past two decades the syndrome of sudden infant death or crib death, known since antiquity, has come under vigorous scrutiny for an understanding of possible etiologic factors. Before the careful use of necropsies was instituted in the investigation of cases of unexplained deaths, sudden infant deaths were most commonly blamed on mechanical suffocation from pillows, blankets, or "overlaying" adults. The lack of significant pathologic evidence in the majority of cases brought the asphyxiation theory into serious question. In its place, several hypotheses were advanced; among the more significant were respiratory infection (1), antigen hypersensitivity (2), parathyroid malfunctioning (3), cervical spine injury (4), and cardiac arrhythmias or conduction disturbances (5).

A return to the asphyxia theory was proposed by Shaw (6), who noted that about 30 percent of infants are unable to breathe through the mouth as a substitute for the preferred nasal route when this is obstructed by a mild respiratory infection. Epidemiologic factors, such as unfavorable weather (7, 8), reduced exposure to sunlight (9), and poverty (10), were also implicated in a relationship to the incidence of this syndrome. In her review of the literature, Valdes-Dapena (11) cited Spils as seeing a need for examining the place of emotional deprivation in unexplained sudden deaths of infants. Asch (12) noted the possible relationship of crib deaths to postpartum depression in the mother. In the absence of a more precise understanding of crib death, the syndrome is now viewed as being due to the interaction of several factors, all of which must be present to bring about a lethal condition (13, 14).

About 50 percent of all deaths that occur between the age of 20 days and the end of the first year of life are ascribed to this syndrome. Characteristically, a child who is found dead or moribund in his crib was thought to be healthy, or so mildly ill with an upper respiratory infection as to make the possibility of death quite remote. The immediate parental reaction to the discovery of the dead or dying infant is generally one of acute grief, disbelief, rage, guilt, and projection of blame (15). Furthermore, unexplained infant deaths invite inquiry into possible child abuse, thus eliciting fear and resentment commingled with more classical grief reactions. Because parents are burdened by the felt responsibility for the child's death, dissemination of information about sudden infant death syndrome has been considered an important effort in preventive psychiatry through the alleviation of self-accusation and gratuitous guilt (16, 17).

The discovery of the dead or moribund infant by the mother is a trauma that is often shared with an older child who may become the immediate target for the distraught mother's initial actions. A number of such children were brought by their mothers to a

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child guidance clinic in a community mental health center because they were reported to have behavior problems. What stood out in each case was the long-term effect of the mother’s panicked accusations against the dead child’s sibling at the time of the catastrophe. The implication or outright accusation that the sibling was the agent of death had been vocally and behaviorally communicated by the mother upon the discovery of the crib death. Subsequently, both mother and child were locked into a relationship marred by fearful doubt, hostile dependency, and guilt. The mother’s shaken confidence in her parenting role, as much as the child’s symptoms, prompted these self-referrals.

Case Reports

Case 1. The mother of a four-and-a-half-year-old boy applied for help in the Children and Youth Division 11 months after the Christmas Day crib death of a six-week-old girl. Her son was moody and destructive and suffered from nightmares. He voiced the conviction frequently that all baby girls die. There were no siblings, but the mother, who was again pregnant, was hoping for a daughter.

On the morning of the infant’s death the boy had followed his mother, who was checking on the baby. He had climbed up the outside of the crib for a closer look when the mother became aware of the cyanotic, lifeless body of the infant, who was lying face down. In an action that she described as hysterical, she threw her son against the wall and questioned him about “hitting” the baby. After this brief attack on the boy, the mother remained inconsolable for days without overtly persisting in the belief, however, that her son had contributed to the death. Nevertheless, no one comforted the boy during the mourning period. Eventually he was told that God wanted the baby in heaven. Whenever his parents left him on subsequent occasions, he worried that they were “going to heaven.”

Although the mother had been assured by her physician that having allowed the baby to cry for an hour the morning of the death had nothing to do with the demise, she felt guilty nonetheless. Her husband, after a brief personal mourning period, did not wish to discuss the death again. The boy took his cue from the father but was overheard to say to age-mates that his “sister had a hole in her head” and that his father and he, not his mother, had found her dead.

Although the boy was not taken to the funeral, his parents included him eventually in trips to the cemetery. He was observed to kick at small gravestones and accompanied this action by commenting disparagingly, “crib death.” His development subsequent to the death of the sibling turned him from a happy and outgoing child to a quiet, brooding one.

Upon examination he was initially expressionless, inhibited, lacking in curiosity, and unable to acknowledge feelings. A return visit made him less apprehensive. He quoted his mother as saying that his dead sister had a hole in her head but said that he had not seen it. Admittedly, he still had “bad dreams” about the episode.

Case 2. The 23-year-old mother of a four-and-a-half-year-old girl requested help for her daughter, who she said was “sneaky, spiteful, moody, and irritable.” Moreover, the child had sleep problems, particularly nightmares about a younger sister who had unexpectedly died the year previously at age six months.

According to the mother she had awakened, after sleeping late, to find the older girl scattering Christmas presents around the living room. After spanking her for this behavior, she checked on the sleeping infant, only to find her limp “like a rag doll.” There was some evidence that the older girl had been in the room earlier to apply a hair-setting gel to the baby’s scalp in order to make her hair curl. The mother thought that the infant had been fed this material and angrily spanked the presumed offender.

Although the baby was promptly hospitalized, she died the following day. The mother was informed that the cause of death was crib death, which she found difficult to comprehend.

After the mother left with the baby for the hospital, the older child remained behind with a neighbor. She was not seen by her mother for four days.

The mother had been divorced soon after the birth of the older girl, presumably because the father had been rejecting and abusive toward his pregnant wife. The second child was the issue of a nonlegal union. When the mother was pregnant with this child, she took an overdose of aspirin upon discovering her lover’s infidelity. The daughter awoke from sleep just as the mother was taken to the hospital by ambulance. From the second day of the mother’s hospitalization, however, the little girl was permitted to visit her. For some time afterwards, she had difficulty separating from her mother and would frequently admonish her: “Don’t forget to come back.”

According to her history, the child had reached all developmental milestones early or well within accepted limits. She had spoken of “her baby” when the mother brought the infant home, had evidently enjoyed her little sister, and had helped in her care. Since the age of one year she had been placed in a supervised family day-care home while the mother worked to support them.

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After the sister's death, she talked of dreaming about going to God's house, where she saw the baby and learned that God was going to give the baby back. At the same time she spoke vehemently of hating angels and God for taking her sister away.

On examination, the girl was found to be an attractive and verbal child who separated easily from her mother. Behaviorally, she tended to be impulsively attention-seeking. With frustration, she became scattered and whiny. The sister's death was referred to matter-of-factly and without elaboration, except that she stressed that death meant being "buried in the ground."

Case J. The young mother of a five-and-a-half-year-old girl born out of wedlock first came to the attention of a Children and Youth Division worker assigned to a neighborhood health center one and one half years prior to the request for a psychiatric examination of the daughter. The occasion had been the crib death of a six-month-old male infant, to which the mother had reacted by throwing the daughter out of the house. Since both children shared the same bed, the mother was convinced that the daughter "overlay" the baby and was therefore responsible for the death. One of the health assistants of the neighborhood health center kept the child in her home until the mother was able to accept her back. Periods followed when the mother could not tolerate the girl. On each occasion, the child was brought into the home of the health assistant, where she remained for several days at a time. However, other brief placements had already occurred before the crib death.

Because the mother still registered anger with the daughter about the death of the infant boy, especially as the girl grew generally more resistive to the mother, the referral to the Children and Youth Division was arranged for the family unit. The child's behavior in kindergarten was also a problem, because of poor attentiveness and uncooperativeness with the teacher. The school's complaints led the mother to beat the girl and to question her own capacity as a nurturant person. In some ways, she looked upon the daughter as an adult. For example, if the mother was not feeling well, the girl was accustomed to look after her, cleaning the house and preparing meals. While the mother was at work, the child called her frequently each afternoon to check on her whereabouts. She also confided to the mother that the next baby should be older than she, so that the sibling could accompany her to school and play with her.

On psychiatric examination she appeared to be a controlling child who constantly needed approval from adults by all manner of attention-getting and manipulative behavior. The deceased brother was hastily dismissed with a reference to "crib death," as if the associated feelings were forbidden for discussion.

Discussion

The suddenness of crib death does not allow parents to prepare themselves psychologically for the loss of the child. This is most often true of the mother who is the first to discover the baby's lifeless body when she was unaware of any significant sign of illness. She is prone to react with considerable anguish. Such an immediate reaction of alarm and terror communicates the need for urgent help, the dreadful recognition of the loss, and the frightened concern with responsibility for the death in the absence of an otherwise satisfactory explanation.

It is this last factor which fuels the irrational behavior so well described in the biblical story of the two women upon whom King Solomon conferred his wise judgment. The woman whose infant had died, and who had taken another woman's child as a substitute, was willing to accept the king's decision to cut the living child in half rather than let go of the desperate denial of her infant's death. Ancient folklore and conventional wisdom assign blame to the mother for the infant death. Since young mothers are bound to have conflicted feelings about the helpless infant or to worry about their maternal adequacy, the unexpected and unexplained death lays bare these ambivalent feelings and doubts with respect to their role. Fathers, on the other hand, being less involved in infant care, are not as vulnerable to the psychic hazard of questioning their role in sudden infant death. When blame and guilt cannot be tolerated by the parent who discovers a crib death, one way out may be found through the use of projection, with the focus on the conveniently available older child.

Older children are known to harbor strongly ambivalent feelings toward newborn siblings. Therefore, they can easily be seen in the mind of the distraught mother as having acted on their negative feelings toward the baby, even to the point of bringing about its sudden death. If the older child is present when the dead or moribund infant is found—evidence links him to a prior presence—he is in danger of being quickly implicated in the explanation for the death.

It is true that in the midst of experiencing acute grief, few parents are capable of empathic understanding of their children (18). The violence accompanying the grief reaction

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in these cases, however, suggests that the loss of control over rage conveys the judgment that the mother believes to be her due for having failed the dead child. Whatever prior exasperation she may have experienced with the scapegoated child now is validated in a moment of terrifying uncertainty and in an instant of accusatory rage. In verbally and physically violating the older child, she quite literally invites punitive controls for herself.

The consequences of such an act upon the mother and the surviving child exact considerable psychic distress for both. Obsessive rumination about determining the older child’s whereabouts and activities at the time of the crib death may dominate the mother’s thinking, as exemplified in cases 1 and 2, or banishment of the child from the home is relied upon as a safeguard between them, as occurred in cases 2 and 3. In each instance, the child who was identified as the death-dealing agent at a very traumatic moment for the mother continues thereafter to live under the shadow of shared guilt.

Quite characteristically, the first anniversary of the death arouses many of the more dormant feelings in the mother, e.g., her grief over the loss of the infant and her despair over having wronged the older child. Part of a restitutioinal effort may become expressed in her desire for help with the child, who need not present serious overt pathology. The usual symptomatology matches the mother’s defensive coping style. If she has been inconsistent or has avoided the child, the latter is prone to become a behavior problem, whereas over-concern elicits neurotic traits.

The children can acknowledge that a sibling has died, but the memory of having been accused of the death is not reported by them spontaneously. The observation that the immature ego copes with unbuffered psychic trauma by denial holds true in these situations (19). Realistically, the young child is in no position to question a parent’s irrational or threatening behavior; he therefore foresees future coexistence as occurring only if he pretends the assault never happened. Of course, the anxieties that have been unleashed are not well bound by the defense of denial, so that some clinical symptoms inevitably appear to arouse further parental guilt.

Discussion with the parents, and most significantly with the mother, about facing some of the shared unhappiness with the child can alleviate the tensions between them. Usually, the mother needs help in accepting her feelings toward the child by being well received herself. A “child guidance” approach serves this function with minimal threat to the mother because she need not be viewed as the primary patient. She is met as a parent who seeks to discharge her responsibilities in behalf of her family by requesting professional help for the child and for her role as a mother (20). Counseling with parents or brief collateral therapy aimed at clarifying the enigmatic nature of crib death and the associated dynamics of guilt, with its propensity for fixing blame, can alleviate a potentially serious estrangement between parent and child. This process also assists the work of mourning, so often incomplete for both mother and child, under circumstances more propitious for mutual understanding and empathy.

REFERENCES


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Changing the Journal’s Volume Year

Since some confusion has resulted from the Journal’s current practice of beginning a new volume year in July, it was suggested that a change be made so that the Journal’s volume year coincides with the calendar year. The Editorial Board has decided, and the APA Board of Trustees has approved, that the change be made in January 1973. Volume 129 will be the short volume (July–December 1972), and Volume 130 will begin with January 1973.