

## CHILDREN'S DISTURBED REACTIONS TO THE DEATH OF A SIBLING\*

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*Children's disturbed reactions to the death of a sibling are reported. A wide range of enduring symptoms and distortions of character structure stemming from sibling death reactions are reviewed and determinants of the nature of sibling death reactions are noted.*

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THE PURPOSE of this paper is to explore one portion of a relatively neglected territory in the domain of child development and psychopathology, that of children's reactions to death. Our culture's avoidant attitudes toward the realities of death<sup>17, 37, 40</sup> have until recently been too fully reflected in the sparsity of scientific investigations into attitudes toward and reactions to death. But in the

last decade the study of death and dying,<sup>4, 16, 39</sup> and particularly of children's profound reactions to the death of a parent, have received increasing empirical and theoretical attention.<sup>9, 10, 18, 19, 28, 31, 34, 35</sup> By contrast, the investigation of children's reactions to the death of *siblings* remains in an early stage. We have barely progressed beyond the time when lengthy, intensive psychiatric case stud-

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The paper stems from a broader investigation, "The Mourning and Familial Loss Project," supported by The Grant Foundation, Inc., and deals with 58 children, ages two and one-half to 14, who had experienced the death of a sibling. The children were seen mainly at children's outpatient and inpatient psychiatric settings: The major sources of data were intensive outpatient psychotherapy records, outpatient evaluations (referral materials, developmental histories, psychological tests, psychiatric interview), and in 11 cases the full materials from prolonged inpatient treatment. The project's case material comes primarily from Children's Psychiatric Hospital, the Mental Hygiene Clinic and the Counseling Division, University of Michigan; Hawthorn Center; Ypsilanti Family Service; Huron Valley Child Guidance Clinic; plus a few much appreciated case reports from private practice. Once again we wish to thank the many staff members of the above agencies who so willingly shared their case material with us. Similarly, our thanks to Drs. Stuart M. Finch, Andrew S. Watson and Anna S. Elonen for their helpful comments and suggestions.

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ies could note in a passing sentence that "one of the patient's siblings died when he was four" and omit any further reference to the event's meanings to the patient. Similarly, current studies showing a sharp awareness of the complex reactions of parents to the death of a child may omit any mention of the impact of the death upon other family members.

But there are now brief mentions of the effects of a sibling's death in a number of specific cases in the literature (to be noted later); three studies assessing the comparative incidence of early sibling deaths among a variety of clinical and control groups<sup>8, 28, 33</sup>; and a recent case study partly focused on a sibling loss.<sup>21</sup> Stimulated by some striking case material and tangential findings of a previous investigation,<sup>13</sup> this study was undertaken in part to fill in the outline gradually sketched by these papers. Our growing case material soon served to demonstrate the limitations of perhaps the one notion of any currency about the import of sibling death, namely, the concept that the primary if not exclusive pathological impact of a sibling's death upon the surviving child is one of guilt over rivalry-bred hostile wishes which, through the early omnipotence of thought, are seen as having been fulfilled by and responsible for the sibling's death.<sup>32, 33</sup>

The importance of multiple-based sibling tensions, rivalries and hostilities are visible to the most naive clinical observation, emerging vividly even in research investigations employing such minimal disguise as single standardized interviews

with children asked rather directly about sibling attitudes and grievances.<sup>20</sup> The import such dynamics have for personality development cannot be overemphasized. But as the following case material indicates, we must proceed far beyond the perception—which would not do justice even to the psychoanalysis of the 1920s—of a child's siblings as almost exclusively representing rivals, sexual temptations or objects for Oedipal displacements, and a sibling's death as primarily, if not exclusively, producing guilt reactions.

After attempting to expand such conceptions, we will briefly note the preventive implications of some of our findings. And in a later study the data on children's reactions to a sibling's death will be reviewed in terms of prevalent theories of object loss and mourning. For, as Pollock<sup>27</sup> has noted, and as our data appear to indicate, the process of bereavement in such a context may show striking differences from other contexts of loss and bereavement (for example, the loss of a parent or a spouse, or parents' loss of a child), thus broadening and differentiating current concepts of mourning.

What follows, then, is a listing of varied forms of disturbed reactions by children to the death of a sibling.\* The children whose cases are noted here were all psychiatric patients, and in each there was clear evidence that some—though by no means all—of the major symptoms and character distortions were substantially related to the death of the sibling. The individual forms of reac-

\*Given the nature of the data—collected in good part from closed files of materials ranging from outpatient evaluations to years of intensive inpatient treatment, with cases seen in various clinical settings each with its own emphases and orientation—it was often not comparable from case to case. As such, quantification in a number of instances would be futile if not misleading. Instead, where the data permitted, we have simply noted approximate percentages of the children in the sample who evinced a particular, disturbed reaction.

tions are by no means mutually exclusive; in most of the children studied, a number of such reactions were intertwined. It is only for the sake of clarity and simplicity of presentation that the material sequentially focuses upon single dimensions of the surviving child's response. Obviously the cases are far more complex, the sources of disturbance numerous and difficult to disentangle, and each child's reactions in some ways unique. Nevertheless, we have cited only cases where reactions crystallized along fairly clear dimensions of personality development and disturbance. Omitted are such observations of more unsettled, immediate responses to a sibling's death as Cobb<sup>15</sup> succinctly described: appetite loss, dazed states, incessant talk about the death. Also omitted are many enduring symptoms we encountered that were originally precipitated by the sibling death, for example, nightmares, speech disturbances, enuresis, antisocial acting out, severe anxiety states.

Some exclusions are to be noted: We have reserved for discussion elsewhere children's often deep, if not immediately evident, reactions to their mother's stillbirths and miscarriages.<sup>14</sup> Nor will we deal with the even more complicated cases of infanticide in which one or more children survived a parent's attack while other siblings were killed. Initially we had also thought to exclude cases where the dead sibling died *before* the sibling we studied was born, but some of these cases share in so many ways the specific problems seen in our primary group of children that they are included.\*

#### THE DISTURBED REACTIONS

##### *Guilt reactions and their vicissitudes.*

We found, of course, a heavy accent on guilt-laden reactions. In approximately half our cases, guilt was rawly, directly present. So, too, was trembling, crying and sadness upon mention of the sibling's death, with the guilt still consciously active five years or more after the sibling's death. Such children felt responsible for the death, sporadically insisted it was all their fault, felt they should have died too, or should have died *instead* of the dead sibling. They insisted they should enjoy nothing, and deserved only the worst. Some had suicidal thoughts and impulses, said they deserved to die, wanted to die—this also being motivated by a wish to join the dead sibling. They mulled over and over the nasty things they had thought, felt, said or done to the dead sibling, and became all the guiltier. They also tried to recall the good things they had done, the ways they had protected the dead sibling, and so on. The guilt was variously handled by each child in accord with his unique personality structure, with reactions including depressive withdrawal, accident-prone behavior, punishment-seeking, constant provocative testing, exhibitionistic use of guilt and grief, massive projection of superego accusations and many forms of acting out. The consequent deterioration in these children's functioning, especially in school, provided them further grounds for insisting they were rotten and worthless.

The sibling deaths among the cases studied ranged widely from chronic or sudden illnesses—leukemia, asphyxia-

\*The death of a child's close friend, neighbor, cousin, or the like, was found capable of producing disturbances in important ways similar to those reported here. "Loss" of siblings due to war-induced separations, splitting up of siblings when transferred to foster homes, and long-term institutionalization of a mentally defective or psychotic sibling also obviously have great emotional significance for a child, and demand active working through.

tion, heart conditions, severe infections—through car accidents, drownings, burning to death, accidental shootings, severe beatings and murder. The remaining siblings' actual involvement in or "responsibility" for the death of their siblings similarly ranged widely. In at least one-third of those cases in which one or more remaining siblings had, in a sense, been significantly responsible for the death, the findings were striking. The child's parents often clearly would *not allow* the remaining sibling to talk about the event. They rushed in with heavy repeated reassurances, quickly labeled it all an accident, and cut off any possibility of the child's telling them what he told (in some instances pathetically, eagerly told) us later—that it wasn't a total accident, that they had been mad at the sib at the time, partly wanted him hurt or "dead," and intentionally did what they did. The suppression of the child's need to confess his role in the incident appeared multiterminated. Parents understandably, if wrongly, felt or were professionally advised that allowing the child to talk about the incident would only upset him more and make it linger on in his and everyone's mind. The parents were fearful of being swamped by even further affects beyond those already overwhelming them, fearing not only their own intense grief but their repressed or suppressed rage at the child. Lastly, they needed desperately to avoid the open assessment of blame, for each parent was struggling with his own self-accusations. It was particularly this latter element that consistently kept the specific details of events surrounding the death remarkably vague in even the most important respects. One cannot help but conclude from these records that the

clinicians later involved in these cases too often joined in this preconscious pact not to explore even the simplest details about the death.

The child's death typically stimulates an avalanche of superego accusations and overt blaming, which in turn undergo marked transformations. Generally, the remaining children and each parent, in some way and to some degree, blame themselves. Alternately they blame each other, and often, needing to maintain positive images of and relationships with each other, they try defensively *not* to blame each other. Frequently a major solution is found that permits the anger and blame assignment so vital to object-loss reactions to occur without disrupting much-needed family relationships. This solution consists of placing the blame well outside the family circle onto neighbors, car drivers, lifeguards, doctors, or "the hospital." While this worked well for some families, with about 15 per cent of our group the oscillating superego introjections and projections quickly wreaked havoc: Mothers sought divorces; a father denounced his wife for her responsibility in the death and abandoned his family forever; a girl ran away from home insisting her mother was a murderess; a boy killed his father whom he held at fault in his little brother's death (the autopsy had established otherwise). Nor does the blaming end there. Grandparents and other relatives also pointed accusing fingers, and in three cases neighbors called in the police much as has been occasionally reported in the pediatric literature on sudden, unexpected death in infants.<sup>2</sup>

Where either the realities or the aggressive fantasies surrounding the death left the remaining sibling struggling with

intense guilt, the child typically grew extremely fearful of losing control of his anger and experienced himself as a monster and potential killer. He attempted various identifications which all cried out that he was in no way aggressive or capable of such behavior, generally withdrew and perceived situations in which he might do *anything* wrong as reverberating of the past wrongdoing, the "killing." In all but one of the instances in which the child had actually been an aggressive participant in his sibling's death, the child's parents, siblings or peers reinforced this reaction. They viewed the child as always latently dangerous, shrank back from him and never fully trusted him. As if this were not tragic burden enough for a child to carry, he often took upon himself even further guilt stemming from additional family reactions to his sibling's death, for example, his father's desertion, his mother's miscarriage or hospitalization.

Beyond immediate blaming reactions, in some cases one or both parents continued to maintain explicit or unconscious attitudes of blame toward a surviving child, with constant hostility and guilt-inducement toward the child and minimal love for him. The child was never conceded the possibility of "making it up." As one parent put it, "I guess we bore him a grudge."

In slightly less than one-quarter of our cases, guilt regarding the sibling's death was essentially *imposed* by the parents, but not by blaming a child for his sibling's death. Rather, it was that the child had shown no regret, no sadness, no grief at the loss of his sibling, perhaps blithely going off to play or eagerly using the dramatic news of the death to grab his playmates' interest. His parents, distressed at the child's lack

of "proper sentiment," sharply rebuked the child and made him feel guilty over his apparent lack of grief. This was even more intense in a few instances in which the parents were horrified, then enraged by a child's outspoken happiness at being rid of his sibling. We originally considered such reports to be mostly retrospective distortions; we assumed this alleged "guilt over lack of grief" was primarily a displacement of guilts, guilts basically derived from the child's fantasied responsibility for his sibling's death. It appears to be that in some cases, but such guilt-induction over lack of grief clearly can exist powerfully in its own right.

Far rarer forms of guilt imposition were also encountered, for instance, in the referral of a three-year-old girl by her mother, who stated that the girl had become severely disturbed, tortured with self-accusations since her involvement in a farm accident in which she was held responsible for her sister's death. Clinical observation revealed, rather, an essentially normal, well-functioning three-year-old—in no way corresponding to her mother's description of a nightmare-ridden, nail-biting, depressed, agitated, self-accusing little girl. The evaluation revealed, instead, a mother who had entirely projected her own guilty, tormented reaction to her child's death onto this child, then vicariously sought treatment for her.

*Distorted concepts of illness and death.* Apart from such vicissitudes of guilt reactions, the siblings of the dead child often had quite confused, distorted concepts of illness, death, and the relationship between illness and death. The normal child's developmentally evolving concepts of death have received atten-

tion elsewhere,<sup>3,23</sup> as have some pathological distortions of such concepts.<sup>13</sup> These children, who had long been treated to conventional saws about people not dying until they were very old, struggled with the clear contradiction to this of their sibling's death, and its corresponding undermining of their confidence in adults' pronouncements. A few simply solved it temporarily by saying "you can't die 'til you're at least nine" (the dead sibling's age). Others swung back and forth, wanting to continue to believe they couldn't die until very old but having to deny the sharpest of realities to do so. They emerged with such confusions as, you die because you're small, you die young only at night, only girls die and the like. The lesson taken by almost one-third of the children was that growing up, growing older, meant you would die: Partial or total defensive regressions toward passive-dependent infantilism followed. A sample of one preschooler's concerns: His dead sister was in heaven, heaven was up in the sky, birds flew in the sky, would the birds eat his sister? And one hardly need elaborate upon how utterly distorted a young child's concept of his sibling's death was when he observed (or heard fragments of) attempts at emergency respiration, tracheotomies and so on. Here, the surviving child's ghastly fantasies centered not around illness but upon adult murderers killing a struggling child.

Children's distorted concepts of illness, still too little recognized by parents and pediatricians, were heavily present in those children whose siblings died due to illness. The children lived with frighteningly concrete disease notions, for example, that coughs, colds, "high temperatures" and bruises led to death. Thus, death was constantly imminent.

Notions combining old parental urgings and cautionary tales about sleep, food, wearing galoshes, running about barefoot and the like, were elaborated into causes of illness and death (for example, "he didn't eat his vegetables"), and other more primary process fusions of concepts of food, germs and death were also present.

*Disturbed attitudes toward doctors, hospitals and religion.* In the majority of such cases, the surviving children's fears of doctors were greatly heightened. Doctors were perceived as impotent in the face of illness and closely associated with illness and death, if not themselves seen as somehow responsible. Hospitals were even more terrifying, and going to a hospital was equated with death. This response by the children was not an isolated one: Often the parents distrusted and blamed doctors or hospitals, and later some remained reluctant to let their other children be hospitalized for necessary medical procedures.

Almost as strong was the child's confusion about God's portrayal as benevolent. Many of the children simply remained puzzled as to how and why their loved and loving God would have killed or at best "taken away" their sibling. Some needed constant reassurance that God didn't really go around hurting people. A few others, awed by the concrete, inches-away demonstration of their Lord's power, spoke of fearing or even hating God as their sibling's "murderer."

*Death phobias.* Looming large in virtually all of the children's responses was an intense fear of death. A few children responded with such omnipotent attitudes and statements as "I can't die," and, "I couldn't be killed," but their defensiveness was transparent and their

fears constantly broke through. Most prominent in these fears were talion fantasies and identifications with the dead sib: The children were often convinced not only that they, too, would die, but that they would die either at precisely the same age or from the same cause or under the same circumstances as the dead sibling. The children, of course, had a generally heightened awareness and fear of death, feeling it could strike at any moment, and at his other siblings or parents as well as himself. Notions of their parents' invulnerability, all-powerfulness and especially of their parents' strength as protectors, came crashing.

But it should be clear, the children's death phobias were not solely the product of talion fantasies and identification with the dead sibling. As noted by others,<sup>5, 13, 22, 26</sup> a typical parental response to a child's death was fearful overprotectiveness of the remaining children. Normal parental concerns were intensified to extreme proportions, leading to restrictiveness, overprotection and infantilization. The parents' phobic vigilance, and the extremely dependent, phobia-breeding relationship into which the remaining child was often pressed, tended to heighten further the child's death phobia. Thus restricted from so many basic growth experiences, these children were generally immature, passive-dependent and fearful, feeling small, inadequate and vulnerable in an ever dangerous world. These parental attitudes sometimes focused primarily on just one child, for example, "the only girl we have left," and often were combined with open favoritism toward and indulgence of that child. The child was rarely punished or properly controlled; the other siblings were not permitted to interfere or even hold their own with this

child, as the parents quite consciously tried to make up for past guilt-festered behavior toward the dead child through this living child. The child became quite aware of his special role and used it to the hilt.

*Comparisons, identification and "mis-identification."* Previous mention was made of these children's identifications with the dead child, in the sense that they believed they would die much as their siblings had. In addition, in approximately 40 per cent of the cases there were either immediate, prolonged or "anniversary" hysterical identifications with the dead child's prominent symptoms. These included hysterical pains, convulsivelike states, severe asthmatic attacks (the first occurring immediately after a sibling died in such an attack), and apparent almost total motor paralysis, which indeed nearly did lead to death. In such cases, awareness of the identification element in the symptoms was crucial to the medical diagnosis.

Identification, or as John Benjamin wisely calls it, "mis-identification," played another major role with roughly one-fifth of the children in our group. As some children are specifically conceived to replace a dead child,<sup>13</sup> these children were unconsciously mis-identified with the dead sibling, becoming the parents' open "substitute" for him. In a few stunning cases, parents even changed the *living* child's name to that of the dead child, while in other cases newly born children were given the dead child's exact name or his name slightly changed. The dead child's identity was further imposed upon the sibling by the parents' (and at times the community's) continual open identification of the two—their looks, posture, way of talking—and by

the parents' expectations and demands upon the replacement being based on the idealized image of the dead child. All of this severely warped the "replacement's" identity formation. The parents' relationship with the substitute child, was, in brief, almost totally dominated by their image of the dead child. The children, of course, could not possibly replace the dead child for their grief-stricken parents. They found this strange task of being yet not being the dead child hopeless, resented it, were resented by their parents for not fulfilling it, and were aware of their parents' basic wish that *they*, not the dead sibling, had died.

Consistently unfavorable comparisons between the surviving children and their dead siblings occurred in almost one-half of our cases, both in these replacement cases and in many others.<sup>7, 25</sup> The comparisons were relentless, often quite open, even in parents who were aware of how damaging this was. Comparisons could extend over any and all areas of behavior, but were particularly focused upon school performance. The surviving child initially wondered if he could measure up. He tried to compete with his dead rival, but even his best efforts went for naught, given the hyperidealization of his dead sibling. Soon such children gave up, at times joining in the idealization of the dead sibling, at times unconsciously engaging in vengeful school failures.

*Disturbances in cognitive functioning.* In a manner distinctly different from the poor school performance in some of the above cases, other children, 15 per cent of all cases, revealed major distortions of cognitive functioning related to the death of their sibling. These otherwise intellectually intact children displayed profound cognitive distortions in which

occurred unbelievable encapsulated "ignorance," fluctuating pseudo stupidity, seeming lack of knowledge of the child's own age, reversals and distortions of concepts of old and young. General "not knowing" or particular areas of ignorance, and especially specific disability in concepts of time and causality seemed unconsciously vital to these children; these deficits appeared traceable to denial mechanisms surrounding the sibling's death (its causes, its relation to age, and so on).

*Impact of changes in the family structure.* A child's death also had both direct and indirect effects upon his remaining siblings by its disruption of internal balances of interrelated roles and functions in the family structure—in brief, by shifts required in the "family dynamics."<sup>1, 38</sup> The remaining siblings directly lost, for instance, a playmate, a companion, an older brother who "ran interference" for his younger sib, a protector, a scapegoat, a baby whom a four-year-old girl needed to mother, an ally against a fierce borderline psychotic mother, a younger sister who could be actively dominated and controlled in order to master a mother's sadistic controlling behavior, and the like. But the indirect effects of the loss could be even more encompassing. Some fathers who strongly needed a son and lost their only son began (and succeeded in) masculinizing their daughters. Needs to infantilize a child after a baby's death interfered with a surviving preadolescent son's struggle for independence; a mother's need to act out vicariously through a daughter's tempestuous rebelliousness, blocked by the daughter's death, sought expression through a remaining daughter, previously the family's "good girl." A family of four that had existed con-



tentedly but precariously on a preconscious arrangement in which each parent virtually owned one of their two children, burst assunder upon the death of one child and its shattering of the bargain. Similarly, when veiled counter-Oedipal involvements of a father with his only daughter were ended by her death, he turned in an unmistakably erotic manner to his youngest son. In these and far more complicated ways did a child's death rebound upon his siblings through realignments of the family dynamics.

*Impact of parental mourning.* In at least one-fourth of the cases, the primary impact of the sibling death seemed less specific in nature and more diffuse in its effects. Here the primary impact consisted of the parents' profound grief reactions and prolonged mourning. Thus, the mothers, a few of whom required brief hospitalization, were generally severely withdrawn, preoccupied and depressed. They unendingly reworked the details of the child's death, blamed themselves as well as others for the death, alternately assured themselves they loved the child and guiltily accused themselves of past harshness with the dead child and all manner of shortcomings as mothers. Findings such as severe anxiety states, insomnia, nightmares, incessant talk about the death and the dead child, auditory hallucinations of the dead child and rage-filled agitation were not uncommon. Amidst these reactions, mothers were often completely incapable of providing any love for, or even attention to, the remaining siblings, and could barely stumble through the simplest household chores. Our lesser data upon the fathers' reactions indicated that for the most part, in accord with our culture's role prescriptions for men, the fathers were more overtly calm, stoic and

effectively functioning. But they also tended to let themselves cry when no one could witness it, were dazed, preoccupied and heartsick, all the while overtly "intact," hearing little of what was said to them, constantly forgetting things, muted to automaton behavior.

Another damaging element may be added when the child's death occurs after prolonged illness and hospitalizations. In such cases the heightened disturbance in the face of sudden death is avoided, and gradual anticipatory mourning may take place, but other strains upon the family members are exaggerated. Major contributions to mental health have been made by those who have vividly aided our understanding of the impact of hospitalization upon children: the separation from parents, the strange new surroundings and people, completely different routines, traumatic medical procedures and so on.<sup>11,30</sup> As a consequence of such influences, some pediatric wards have extended visiting hours, allowed a mother to move right into the hospital with her child, or worked out programs of active parental participation in hospital care of the ill child.<sup>6,24</sup> While this is of immense help to the hospitalized child, and probably vitally necessary to hold down otherwise spiraling guilt in the mothers of dying children, we found as did Cobb<sup>15</sup> that it can also do striking damage to the dying child's siblings. During such times they become essentially motherless, their mother not only being emotionally drained by her ordeal, but often having little actual time left for the other children (the more so if the hospital is at any distance). In her absence, the children are often left with neighbors, or even distributed among relatives for prolonged periods. The remaining children

often lose not just their mother's love and concern but her very physical presence. When available at all she is rushed, burdened, sapped and irritable, and, should the children complain, they are likely to draw a hasty, guilt-inducing retort. Illness, too, may come to be seen as the only route to the mother—but far more crucial is her physical or psychological absence and almost inevitably disturbed state. And as the children then turn to their father they find little emotional support, for he is bereft of his wife, has heavily increased responsibilities, and is struggling to suppress his own anguish.

#### CONCLUSIONS

Reviewing the clinical data, the determinants of children's response to the death of a sibling were found to include: the nature of the death; the age and characteristics of the child who died; the child's degree of actual involvement in his sibling's death; the child's pre-existing relationship to the dead sibling; the immediate impact of the death upon the parents; the parents' handling of the initial reactions of the surviving child; the reactions of the community; the death's impact upon the family structure; the availability to the child and the parents of various "substitutes"; the parents' enduring reactions to the child's death; major concurrent stresses upon the child and his family; and the developmental level of the surviving child at the time of the death, including not only psychosexual development, but ego development with particular emphasis upon cognitive capacity to understand death. The effects upon the child obviously are not static, undergoing constant developmental transformation and evolution.

Clearly, these data require related investigations into the factors differentiating relatively successful integrations of sibling losses versus pathological consequences akin to those depicted here. Such investigations, complementing further clinical study of the psychopathology of "sibling death" patients, will be of particular preventive value. We are, of course, committed to the preventive application of the findings from these sibling death cases, and are much encouraged, even excited, by the preventive opportunities therein. For in all child deaths, professional people (namely, pediatricians and ministers) of potentially immense preventive-therapeutic assistance are almost automatically involved—an impressive contrast with many other equally needy but relatively inaccessible subclinical or "in crisis" groups.

Our optimism, though, remains restrained by this study's demonstration that the problems involved are *not* simply those of a surviving child's unrealistic, inappropriate guilt or fear of death. Rather, as seen in the cases described here, the complex pathological distortions involved in children's disturbed reactions to the death of a sibling include such areas as affect, cognition, belief systems, superego functioning and object relationships. The distortions are not merely intrapsychic, they are inevitably intertwined with and partially products of the dynamics and structure of the family. In fact, they may significantly involve the extended family or the child's peers, or even his general neighborhood and community. They include not only profound immediate reactions, the least of which often are physical and psychological symptoms, but tendencies to-

ward enduring symptom formation and distortions of character structure.\*

Accordingly, the preventive task is a large one, and preventive efforts in such cases must necessarily be comprehensive. Recently, pediatric workers have wisely insisted that in child deaths the physician's responsibility is not alone to the dying child but to the entire family unit.<sup>12,24</sup> Others have reminded us that "family unit" includes the dead child's siblings as well as his parents.<sup>29,36</sup> A full preventive-therapeutic approach to the dead child's siblings, integrated with assistance to the grieving parents, remains to be carefully spelled out. But recognition of the need for such efforts represents a major step toward preventing what we elsewhere called the senseless arithmetic of adding newly warped lives to the one already tragically ended.

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