HANDLING THE EMOTIONAL IMPACT OF THE BEREAVEMENT HOME VISIT

How do you describe your SIDS bereavement visits with your family and friends? Like most of us, you probably don't. Discussing death often makes people uncomfortable. If most people do not even want to think about delving into the details of infant death, what does this say about how hard it is to actually conduct the visit?

In order to take care of ourselves, we need to start with some validation regarding our grief, just like we do for the bereaved family during a home visit. Yes, a home visit can make us sad! And if you have children yourself, or expect to, add to the sadness the threat of losing someone you love. Perhaps you have grieved an infant death yourself: the home visit can bring it back as if it were yesterday.

Using defenses to keep yourself aloof will be as counterproductive as being too emotionally involved. It's normal to feel emotionally affected by these home visits. Explore what kind of permission you have given yourself to experience these feelings and to express them. A home visit can be a heart-wrenching occasion. You may be the only person who has used the baby's name or allowed the parent or parents the opportunity to discuss the death. The pictures come out, the tears; you start to get a lump in your throat yourself. Now ask yourself: Who do I want to be? Do I want to be a person who isn't touched by a story, or does my own emotional reaction reaffirm that I went into a helping profession because I care about people and about their suffering? Do I trust myself emotionally to be sad because I know that I'll be "okay" afterwards?

Another way to look at it is that we have some control of our perceptions of what we experience. Sometimes all it takes is a little re-labeling, "Yes, this affected me, but I am not going to call this handling it poorly, I'm going to call this proud to be a caring and empathetic person."

On the other hand, it is also okay not to react to a home visit. Perhaps you wonder why only some cases seem so difficult or why you never have an emotional reaction. The answer is that our own vulnerabilities, attachments, and personalities resonate to certain situations and not to others. The only caution is that if we don't react because our defenses are raised to prevent it, we're not going to be free to be supportive to the grieving family. Guaranteed, this is where the insensitive mistakes come from. If you find yourself working hard to keep from "getting too close," talk it over with someone you feel is a good professional model.

You may feel that you actually mourn. It is important to realize that we do not grieve for or have an attachment to this particular human being who died. But there are losses for us (e.g., trust that the world is a safe place). This can produce a very uncomfortable existential crisis, and it is important to process your feelings with a trusted source of support. We have learned to encourage families to let themselves mourn. Don't deny yourself the same when it is needed.

Being confident that we can be helpful and having a clear sense of purpose are two important factors in keeping a positive orientation to our work. In most cases, bereaved family members are aided in their grief work by the opportunity to retell their story, to feel someone cares, to be allowed to cry and vent their deep anguish.

Caring for ourselves while working with death and loss is an ongoing need. This means it is important to find or create the supports you need. Don't do visits when you know you'll be alone. Plan for them when you can debrief with someone afterwards. Get together occasionally with other SIDS nurses and share how you deal with these issues.

You are doing a difficult task that most people would not touch and that is emotionally and professionally demanding. Reach around and pat yourself on the back. We need to feel proud of our work, and ourselves, to perform at the fullest potential.

Adapted with permission from "Taking a Culturally Sensitive Approach to Fetal-Infant Mortality Review" by Dan Timmel, LCSW. NIFMR Action Update/Spring 1993.

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