To the Editor: My congratulations to Elizabeth Feldman on her sensitive and moving "Birth and Death: Through a Child's Eyes" (J Am Board Fam Pract 1999;12:344–5). Dr. Feldman's wonderfully insightful and reflective piece captures many of the life cycle issues that are so often not discussed in our society today. These values are those that we try to instill in our medical education programs for our medical students and residents as we attempt to teach them a normalizing perspective on important life cycle events. I have circulated this very moving piece to our faculty who are involved in early medical student education, and we are planning to use it for discussion and reflection in our life cycle discussions, particularly with issues of death and dying.

Dr. Feldman has provided us, in an articulate and sensitive manner, a framework with which to discuss these important issues. I will look forward to similar reflective pieces in your future journal articles.

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To the Editor: I found Elizabeth Feldman's article "Birth and Death: Through a Child's Eyes" (J Am Board Fam Pract 1999;12:344–5) extremely disturbing. Not only does this article not describe birth and death through a child's eyes - rather it details one adult's beliefs - but the author-mother herself is revealingly honest when she says: "I can draw no definite conclusions about the impact of these experiences on Hannah's psyche or her own future life choices."

Why then would a physician or a parent expose a child to experiences the impact of which is uncertain? The evidence from psychotherapy patients is that such experiences are often traumatic because the activities of adults are regularly misinterpreted by young children according to their own limited understanding. For example, observation of parental intercourse is usually experienced by the child as an assault on the mother. Children are routinely distressed by a parent's pain, physician or psychological - not to mention the sight of a parent bleeding - because they feel their own security threatened by such an event, often imagining that the parent will die. I have not seen evidence to suggest that the survival of the mother after childbirth makes the child any the less anxious about physical harm to the mother.

We know clinically that children of all ages are extremely sensitive to the condition of a parent who has, for example, a chronic painful illness. The younger the child, the more difficult the experience for the child to understand and tolerate. A mother groaning in pain during labor suggests that she is suffering, helpless, vulnerable, weak, and possibly not able to protect the child when she is frightened, because the mother is naturally preoccupied with coping with her own pain or other needs. Young children do not realize that this is not the case or at least that it is time-limited and not life-threatening.

It is furthermore disturbing that Dr. Feldman's admission of ignorance of the impact of these experiences does not dissuade her from a professional recommendation that "other children and families can benefit from these experiences."

Many are concerned about violence and sexuality in the media for precisely this reason. We should err on the side of caution when it comes to both raising children and making professional recommendations to our patients on the matter of child rearing. It is too easy to think that because we believe some approach worked with our own children, it will work for all children. We might be wrong, and we might have a blind spot precisely because we are dealing with our own families and our own narcissistic investment in our parenting abilities.

It is also a mistake to assume that because a child has no overt reaction to an event, the child has tolerated the event without trauma. There is a great deal of clinical evidence, for example from abuse victims, both adults and children, that denial and affect isolation can make a person look as though he or she is not reacting to an event. The impact, in fact, can be so troubling and overwhelming that it can cause a freezing of reactions, which superficially looks like an absence of difficulty. Later events then demonstrate the delayed impact. The tentative observations of her daughter's reactions ("birth *seems* to have been perceived as an emotionally intense, special event, . . . *not frightening or insurmountable*" [emphasis supplied]) are indication enough that as adults we should not subject children to our theories or experiments but only to the fruits of our carefully considered experience. We should have great concern and empathy for the fact that we are no longer children and must take a child's perspective, not our own.

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The above letter was referred to the author of the article in question, who offers the following reply.

To the Editor: I appreciate Dr. Shill's concern about traumatic experiences for children, but I would like to respond to several of his comments.

First, it concerns me that Dr. Shill would draw an analogy to violence or sexuality in the context of birth and death. Children who are present at births and deaths in nonthreatening, familiar surroundings do need advance preparation and the attention of loving, caring adults during these times. With proper preparation and explanations, children who have been present at births and deaths do not view the experiences as violent or sexualized. If caregivers are not frightened during these moments, they can enable even relatively young children to share the full moment without fear.

Perhaps we would be wise to address the emotions of adults during births or deaths in American culture. Many adults, perhaps including physicians, still experience these events as so traumatic that they might pass this attitude on to their children. Psychosocial research, however, indicates that if parents are not traumatized, children will not be traumatized. Certainly as family physicians, we are perfectly poised to change this emotional