An Intuitive Approach to Understanding Infant Death

William H. Kautz

Abstract: The sudden, unexpected, and unexplained death of a healthy infant in its first year of life (nominally 2 to12 months) is surely one of the most tragic human experiences a parent can undergo. The shock of loss is commonly accompanied by extreme sorrow, grief, feelings of guilt, and the emergence of unanswerable questions on how such an event could possibly have occurred. Forty years of medical research to find the cause of Sudden Infant Death Syndrome (SIDS) have found neither the cause of the phenomenon nor a means of predicting or preventing it—only a long list of secondary, unlikely, and non-causal "risk factors" which offer no consolation to parents, no answers to their questions, and no substantial and trustworthy guidelines for action.

A novel investigation at the Center for Applied Intuition (CAI) utilized a systematic method of *consensual intuitive inquiry* to answer these questions. It sought to generate an explanation for the cause of SIDS and suggest how the disorder may best be handled by the parents and associated family members. A dozen "expert intuitives," whose skills had been verified for acquiring entirely new and correct knowledge in other areas, explained that a very young infant is sufficiently conscious to be able to choose "at will" whether to continue its life or leave it—its own kind of suicide, just as adults may do. As the life force withdraws, the body succumbs to its weakest physical condition, which in the case of SIDS is not medically detectable.

Modern medical science possesses no means for investigating subjective information sources such as intuition, or even for testing whether proposed explanations are right or wrong. It has therefore disregarded non-physical approaches to understanding SIDS. However, corroboration of the intuitive findings is available from psychological sources. They show clearly that perinatal infants possess an active consciousness capable of sensation, memory, and some degree of choice, thereby adding credibility to the intuitive information.

SIDS can be seen as a natural occurrence, not a physical disorder or a medical disease and not a direct result of parental action or inaction. The usual grief, guilt, and confusion of the parents, while certainly understandable, arise from a misconception of the life process itself, which includes the possibility of premature death for infants just as it does for adults. These typical but mistaken responses by parents may be dispelled when they can achieve a fuller understanding and acceptance of the central place of loss and death in human life. The

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infant has the same choice as its parents to leave life at any time. The parents' love for their child is no less genuine by this revised understanding, though it applies more to the infant's consciousness, than to its body which can indeed be lost. Herein lies the meaning and the fundamental lesson parents may learn from losing a child to SIDS or any form of infant death.

Keywords: sudden infant death syndrome (SIDS), sudden unexplained infant death, crib death, cot death, intuition

In our way, we conform as best we can to the rest of nature. The obituary pages tell us of the news that we are dying away, while the announcements of births, in finer print, off at the side of the page, inform us of our replacements. ... The vast mortality, involving something over 50 million us each year [sic], takes place in relative secrecy.
(Lewis Thomas)

All things are in process, rising and returning. Plants come to blossom, only to return to the root. … We go down into death for refreshment.
(Lao Tse)

This paper focuses on infants who die unexpectedly in their first year of life, usually in the range of two to six months. They may do so for several readily recognizable reasons—accidents, poisoning, diseases, homicide—but they may also die for no apparent reason at all even though they are completely healthy. This mysterious event, so tragic for the parents, is called *Sudden Infant Death Syndrome* (SIDS). It is actually a misnomer because a syndrome is a collection of symptoms whereas SIDS is characterized by a total lack of symptoms.

In contrast to Western parents, consider a pregnant mother in a primitive village who has already lost two babies. She regards these deaths as "normal" and accepts the possibility of similar risk in her next birth (Jind, 2003). She is no less sad but she does not demand explanations and accountability as do we Westerners today. Does she understand something the rest of us would do well to remember?

Part I
Background on SIDS

All medicine wants is pain to cure.
(Rumi)

Any loss of a loved one through death can be difficult, but infant death is typically the most catastrophic and tragic for parents. This subject, obviously a sensitive one for those exposed to the experience, is usually greatest for the mother, for she grew the child within herself, gave birth to it, provided primary care during its first months and came to love it—

only to lose it. Father, family members, and siblings can also be strongly affected (Anon 2, 2013).

But why does this sudden and unexplained infant death occur? Even after many decades the question remains unanswered. Coroners, registrars, and medical researchers have an obvious interest in the cause of the death. Those directly affected wonder about the cause but are occupied with the shock of the loss and how to support one another through its consequences. For many young parents it is the first occasion when they must confront the intrusion of the specter of death into their daily lives.

Several decades ago it was not unusual for poorly informed police, relatives, friends, spouse, or disturbed sibling to accuse a SIDS mother (or babysitter) of gross negligence, even murder, for which she was sometimes sent to prison (Batt, 2004). We are well beyond such harsh action today. But even when ample sympathy and support are given the resultant grief can trigger lasting depression and disturb family relationships for years (Boyle, Vance, Naiman, & Thearle, 1996; Mitchell et al., 1992; Rosof, 1995). In the face of the many unknowns small irregularities can trigger the imagination, suspicions, and fears. Misunderstandings can easily lead to anger, accusations, disruptions, unrelated crises, and divorce. Those affected often talk of fate, destiny, bad luck, loss of faith, doubts about life itself, and the desperate need to "just grin and bear it." Unfounded beliefs and the attitude of victimhood they sometimes induce are an added burden, as the absence of a ready explanation for their loss amplifies the self-assumed guilt, especially by the mother, who naturally assumes, "I must have done something wrong." She does not even know whether the child died peacefully or in pain.

On the other hand, a more positive outlook can initiate a personal inquiry to try to understand what meaning the event might hold for those affected. While the questions of meaning and purpose may not be easy to answer, they are fundamental and underlie all more mundane issues. The child died even before it had a reasonable chance to live! What could possibly be the human purpose in such a premature departure? What human value lies in parents' losing that which they most love? Is human life really so arbitrary and unfair?

It seems that nothing can be offered the parents beyond sympathy for their loss and its consequential residues of sorrow, emptiness, grief, and often loneliness, anger, seeming failure, and guilt. Religious counsel can be reassuring but it usually comes up short: "It is God's will," and "such things must be accepted as a part of life" and "the child has gone home"—not necessarily wrong but of limited help for most bereaved parents. Religion is commonly regarded as society's standard bearer for moral

behavior. Its judgments typically connote sin, wrongdoing, and offense to God, and these only add to the guilt when no specific wrong can be cited.

It is common for SIDS mothers to be initially afraid of becoming pregnant again, though they usually recover from this fear within a year and go on to have more children. The incidence of SIDS is only slightly higher among subsequent siblings; the effect appears to be a family artifact not causally related to their first loss (Keens, 1998).

Less obvious but especially relevant, most modern persons today live with an unacknowledged fear of death, if not their own then that of someone on whom they depend. This fear may be quite separate from the actual or possible fear of losing their child. They do not like to think about death and do not discuss it openly, despite the obvious fact that it is an inherent, natural, and unavoidable part of every human life, including their own. This denial of death has a major impact on how one lives his daily life, (Becker, 1997, Levine, 1982) and it can certainly affect how one approaches an infant death. The shock of a death can provide an opportunity to reexamine one's views on death (and life) and bring them up to date. We will return to this examination later.

Medical Science to the Rescue

We have a cultural heritage now that we can fix anything we don't like, even death. So to die suddenly is a nightmare. We believe that sudden death is the worst possible fate.
(Stephen Jenkinson)

In today's industrialized world it was expected that science, in the form of medicine, should be the appropriate social institution to step forward and try to unravel the mystery of SIDS. After all, science is our society's principal means for exploring unknowns about the world and finding useful answers. Medicine is science's trusted and responsible arm for explaining dysfunctions of the human body.

The basic phenomenological data on SIDS, before interpretation and analysis are undertaken, are simple indeed. The death occurs during sleep, almost always at night, with no advance warning, no signs of struggle, and no immediately detectable precondition, abnormality, or irregularity to which it might be attributed. After it occurs the death scene is routinely examined to try to rule out homicide; the infant's medical history is reviewed to look for any preconditions; the parents are interviewed to detect any relevant personal issues; and the family setting is usually assessed to discover any social or cultural irregularities. Finally, an autopsy of the body is performed to try to find anything unusual that might account for the unexpected death. If a physical defect is detected, the death is not classified as SIDS, of course.

With so little to build upon, direct medical research on SIDS has been difficult and not very productive. The only option was to conduct *epidemiological* studies in which large numbers of SIDS death reports are compared against a parallel collection of reports on living infants in the same area and time period. Sophisticated statistical analyses were employed to try to detect even tiny differences between the two groups. A dozen such studies, some of them very large, began in the mid-1970s. They sought to discover any particular and unique physiological, environmental, societal, or cultural conditions under which SIDS was occurring.

Unfortunately, no clear, meaningful, and useful pattern emerged from these attempts. Every SIDS case was essentially the same and apparently "normal." Many small differences turned up but none was sufficiently strong and consistent to provide a satisfying explanation for the cause of SIDS or to enable prediction, prevention or any kind of "cure." This lack of useful findings was a disappointment and major setback for medical research. Uncertainties and speculations followed, and they did nothing for parents except provide more for them to worry over.

After this first wave of negative results the public recognition of SIDS improved throughout the industrialized world. SIDS is still broadly regarded as a mysterious tragedy. The public response to it is now uniformly sympathetic, even in the absence of understanding and with little hope for future resolution. As medical science further advanced more childhood diseases were found which could be excluded from SIDS so it became better defined. The incidence dropped to its present level—less than 1% of live births in the U.S., though it is still the leading "cause" of infant death after accidents. (The announced rates for other countries vary and many are not known accurately.)

Infant death may occur at other times with different names: before birth (miscarriage or spontaneous abortion), during birth (stillbirth) and when the child is older, vital, and healthy. It is interesting that the unexpected death rate stays about the same, 1%, throughout the human lifespan, from birth to near death, over all ages and stages of life (up until old age, when it cannot be readily measured). It is clear that neither adults nor infants are being favored. Are we missing something important here by assuming that SIDS is exceptional in life?

Defining SIDS

SIDS cannot be just a modern phenomenon for it has surely been occurring among the entire earth's population for millennia. The first medical reports appeared in the 1800's. SIDS was officially recognized as a definable cause of death in the Western world about 1960 and by the

World Health Organization (WHO) in 1979 (Beckwith, 1973; Russell-Jones, 1985). Even today, however, there is ambiguity about exactly what allows an infant death to be classified as "unexplained." Who can or cannot explain it, and who has the right to speak with authority on what it is and what not? While autopsies of SIDS infants have long been required by law in the U.S. and in several Western countries, and the physiological data are abundant, the detailed findings are very varied and complex and they reveal no obvious pattern.

This imprecision produces confusion among parents, as explained above, but it also prevails among caregivers, physicians, and medical researchers. By gathering all unexplained deaths together we don't even know if they are all the same, aside from the obvious consequence that the child ultimately dies. Before proceeding further we need to define better what constitutes a so-called SIDS death.

The usual practice when an infant (or anyone) dies is to attribute the death to the most readily recognizable medical irregularity that could possibly relate to it. This "cause of death" is recorded on the death certificate by the attending physician, and is subject to change by the pathologist who performs the autopsy. If nothing new is discovered the record is changed to "unexplained infant death" or SIDS. Unfortunately, these determinations are often subjective, incomplete, and barely symptomatic. They depend upon the examiners' experience and skills and tend to be only loosely related to the official criteria in use at the time, which are themselves changing (Timmermans, 2007). Although standardized guidelines for conducting thorough case investigations have been developed these guidelines have not been uniformly adopted across the more than 2,000 US medical examiners and coroner jurisdictions (Bajanowski, 2007; Berry, 1992).

In any case, medical classification of a death as SIDS is always by exclusion. It is not a specific physical symptom or abnormality but only the absence of it, so there is much space for misinterpretation and guessing. Even a runny nose or upset stomach can be cited as the cause of death, thereby excluding it as SIDS (Jones & Weston, 1976). Conversely, the death could easily have arisen from an inconspicuous virus, trace-level food poisoning, a magnesium deficiency, or dozens of influences beyond those readily detectable, in which cases it would not be correct to classify it as SIDS.

The accuracy of the older epidemiological data is therefore poor and cannot be fully trusted. These studies must be continually updated (CDC, 2015).

Risk Factors

Causal explanations are oversimplifications. This is what makes them useful. Searching for correlations is a terrible way of dealing with the primary subject of much modern research. The causes that matter are still nowhere to be found.
(Jonah Lehrer)

Most of the physiological differences detected during the early epidemiological comparisons showed just a few percent difference, not statistically significant, let alone indicative of a cause. Among non-physical factors the largest variation in SIDS frequency was a 50% higher rate for male infants. Others showed a seasonal, racial, or cultural dependency. About ten of those which scored highest were further investigated with more cases, tighter protocols, and wider geographical areas. Still, none emerged that was strong enough to be cited as the cause of SIDS or to be useful for prediction (Beckwith, 1973; Naeye, 1976; Valdes-DaPena, 1980). For example, a comprehensive and carefully conducted epidemiological study of 757 SIDS deaths in the U.S., conducted for the National Institute of Child Health and Human Development (NICHHD), concluded that "none of the dozens of risk factors investigated in the study was found to be strong enough to explain the syndrome, or to enable prediction or prevention of SIDS in vulnerable infants" (Hoffman, Damus, Hillman, & Krongrad, 1988, p. 4). The author's Center for Applied Intuition conducted its own epidemiological study in the mid-1970s on all documented SIDS cases (917) in Alameda County, California over a 16-year period, along with a comparable group of live controls. It confirmed all of the physiological and family risk factors identified in studies up to that date and added one more: a weekly periodicity in the deaths, peaking on Friday and Saturday nights. Other research reports verified this weekend increase and associated it with low birth weight (Gould, Qin, Marks, & Chavez, 2003; Malloy & Freeman, 2003, 2005; Platt & Pharoah, 2003). Since nature seems to contain no weekly cycles, this discovery threw new suspicion on parental habits, such as absence from home, transfer of care to a babysitter, or drinking alcohol.

As the defining criteria for SIDS were tightened over time the epidemiological data became somewhat more reliable. Small differences also emerged in the non-physiological categories, such as age of mother, use of prenatal care, premature birth, low birth weight, and race. In the U.S. the frequency was found to be significantly higher among those belonging to certain ethnic minority groups: African Americans, American Indians, and Hispanics; and lower among East Asian populations, a variation that suggested differing cultural practices in diet or child raising. SIDS deaths in the U.S., Canada, and Britain showed a somewhat higher frequency among twins, young mothers, and non-breastfed infants;

in disadvantaged, uneducated, and impoverished communities; families with poor nutritional habits; those receiving less than normal prenatal care; and those who use drugs, drink, or smoke habitually.

These findings, still not strong and definitive, came to be called "risk factors," a medical term that refers to a statistical risk of possible association and merits further study. It is *not* an identified cause and does *not* imply that a child exhibiting this factor is at greater risk of succumbing to SIDS. But this ambiguity in the meaning of "risk" took root in the public perception of SIDS to signal a real danger, and it led to further confusion among parents who are anxious to protect their infants. Alcohol use by parents during pregnancy, at birth, or after birth was directly implied in a British study of SIDS (Blair et al., 2009) and again in Australia and the US (O'Leary, 2013). A review of early studies also revealed a smoking risk, both apart from and near the sleeping infant (Scragg et al., 1993).

The term "risk factor" has now become a catch-all for the entire collection of still unproven speculations on the cause of SIDS, and little more than this. The attempt to unravel these dozens of factors is an almost impossible task because of their strong interdependence (some depending on others), their uncertain nature and their connection with so many stages of physical and psychological functioning. Many are surely associated with an aftereffect of dying rather than a cause of death, since these two sources are so hard to distinguish. Most of medicine's forty years of SIDS research has been consumed with this complex unraveling.

Media announcements, supported by statements from physicians and researchers, while surely intended to be informative and hopeful, are often reported enthusiastically as "breakthroughs" that would soon allow this "disease" to be prevented—even when there is no reasonable basis for such optimism. SIDS parent organizations are kept busy reeducating new parents and the public about the continuing state of ignorance of the cause of SIDS, and that future progress in understanding, prevention and prediction cannot reasonably be expected.

An Abortive Attempt at Prevention

We do not enjoy this world everlastingly, only briefly, for our life is like the warming of oneself in the sun.
(Ancient Aztec prayer)

Since the mid-1990's additional risk factors, still uncertain, have continued to accumulate (Ball & Volpe, 2013; Colson et al., 2009; Duncan et al., 2010; Leach et al., 1999; Leduc et al., 2004**,** Overpeck et al., 2002; Porter, 2013; Shapiro-Mendoza, Tomashek, Anderson, & Wingo, 2006; Task Force, 2011). One source cited neural anomalies near the top of the spinal cord as an occasional precursor to SIDS, and added that important

work on this defect was in progress at a medical laboratory in Cleveland, Ohio. This irregularity was subsequently reported from the Cleveland Clinic for infants suspected to be at high risk of SIDS, (Naeye 1976; Orlowsky, Nodar, & Lonsdale, 1979) and later from other laboratories (Duncan et al., 2010; Kinney, 2009; NICHHD, 2006; Paterson et al., 2006). Like several other risk factors, this one does not distinguish between a pre-SIDS vulnerability and a true cause, though both could eventually be relevant to SIDS prevention.

The latest speculations have focused on infant sleeping with parents, infant lying on its stomach, too many blankets, very young mother, too little breastfeeding, and parents smoking nearby (Anon 1, 2008; Burnett, 2013; Malloy, 2013; Malloy & Eschbach, 2007; Platt & Pharoah, 2003; Scragg et al., 1993; Task Force, 2000, 2005, 2011) In 1992 the National Institute for Child Health and Human Development (NICHHD) gathered some of these factors, along with a few well-known recommendations which made good health sense for any infant, at risk for SIDS or not, and packaged them into a set of "Safe-to-Sleep" recommendations. This prescription was somewhat exaggerated since none of the factors had been shown to be effective for either prevention or prediction, and they were certainly not causal to SIDS. Most were largely speculative or palliative actions which concerned parents could safely take to feel they were doing something positive to protect their babies. This program was gradually promoted throughout the U.S. and Western countries and widely adopted by young parents.

By 2000 the SIDS rate had dropped by about half. Authorities were quick to claim that their program was effective for preventing SIDS but doubts soon began to arise. Autopsies had become more thorough and the criteria for classifying infant deaths had further tightened over this same period, so the number of *reported* SIDS deaths dropped significantly (Malloy & MacDorman, 2005). Many deaths that previously would have been classified as SIDS are now attributed to other sleep-related causes (AAP Policy, 2005; Moon, 2016). One medical report concluded, "It is unclear which risk reduction messages have contributed towards this continued fall in rates" (Blair et al., 2009). The chairman of the task force on SIDS at the Center for Disease Control (CDC) said, "A lot of us are concerned that the rate (of SIDS) isn't decreasing significantly but that a lot of it is just code shifting" (Kattwinkel, Hauck, Moon, Malloy, & Williger, 2006, p. 6). In fact there has been no change in the SIDS rate in the US since 2005. It is doubtful that the "Safe-to-Sleep" program had any direct impact on actual prevention of SIDS. Safe-to-Sleep is not so safe after all (Trachtenberg, 2012).

The Safe-to-Sleep program and its ten recommendations continue to be promoted and practiced today. Recent changes have made them

somewhat more realistic as associations or indicators, though firm evidence that they are being effective at prevention is still lacking (Moon, 2011, 2016; NICHD, 2015; Dagur et al., 2015). Moreover, it is suspected that they are not reaching far enough into the communities mentioned above which are deemed to be at highest risk of SIDS.

A careful analysis of the dozens of proposed risk factors—one analyst says 70—has led to a three-risk model, based on the assumption that SIDS deaths are triggered by a combination of risks in disparate categories: developmental deficiencies during early growth, intrinsic vulnerability, and strictly external triggers. Five of these factors have emerged to be more credible candidates for SIDS: parental smoking near infants, co-sleeping with mother, night-long belly sleeping, absence of skin-to-skin contact, and non-breastfeeding. Current research is focusing on these. The first three are correlated with race and culture and may also be indicators of congenital heart conditions and arrhythmia, both possibly relevant to SIDS vulnerability.

The Safe-to-Sleep program cannot be said to be a failure since it may be contributing to infant health generally. It induces parents to pay closer attention to their infants and may be stimulating the use of well-known child healthcare practices under the threat of child loss. The program has also shifted medical attention further away from a purely physical approach to SIDS and toward socio-cultural and racial factors. These have been noted for many years by social workers, who visit SIDS homes and offer help to grieving parents. Their journals report on the positive effects of co-sleeping, long breastfeeding, close bonding, skin-to-skin care, and strong emotional attachment (Anon 3, n.d.; Friedlander & Shaw, 1975; Kitzman et al., 1997; Price, 2007) and most are recommended by parenting organizations. Their observations are not often medically noticed because of their subjective, immeasurable, and anecdotal nature, so they have received little attention from physicians who prefer to work with more precise data. Modern medicine still remains the primary field to which the public turns as the prime authority on all SIDS matters, yet it is only partially qualified in this responsible role.

It must be remembered that the official considerations are based almost entirely upon modern medicine's physically based and therefore limited approach to SIDS. While psychological and social factors continue to be acknowledged, they play only a secondary role as potential causes or contributing agents and their relevance to SIDS has not yet been well explored. Psycho-spiritual factors, including the "state of mind" of the infant itself, have not even been acknowledged, though they could be approached through (transpersonal) psychology. This serious omission should be taken into account by parents and others who are most concerned about SIDS, before the proposed recommendations are assessed and applied.

A more complete medical recognition of these non-physical factors could open the door to exploring them as possible influences and indicators, not only for SIDS but on child development in general. Herein may lie the greatest hope for progress in both the medical and public understanding of SIDS. These factors are part of the nearly invisible complex of mental processes which underlie human health, both psychologically and spiritually. They merit much closer attention.

Part II
Intuition

This term [intuition] does not denote something contrary to reason, but something outside the province of reason.
(C.G. Jung)

Going Beyond the Body

Eventually it became clear in medicine that our emotions, attitudes, and thoughts profoundly affect our bodies, sometimes to the degree of life or death. Mind-body effects were soon recognized to have positive as well as negative impacts on the body.
Physicians are getting used to mind-body medicine.
(Dossey, 1999)

When the available means at hand, including scientific studies, experiments, epidemiology, careful observations, and the accumulation of personal experiences prove to be insufficient for discovering something still not known then another resource must be called upon.

Why has this shift of emphasis to the non-physical been so difficult and slow in manifesting? To answer this question one must understand that modern medicine, despite its great advances in health and healing over the last hundred years, is still a *materialistic* sub-discipline of science. It tends to regard all human deviations from normality as *physical pathology*—an illness, a virus, a breakdown in an organ, or some bodily function not working right. Moreover, it considers that its task is to "fix" the disorder by restoring what it considers to be normal physical health through drugs, surgery, or other physical treatment. We can all be grateful for its fantastic accomplishments in this direction but it is not the full picture.

With every passing decade medicine has been confronted by more and more disorders whose primary cause obviously rests not in the body or brain but within consciousness itself: stress, unacknowledged fears, destructive habits, unresolved emotions, blatant disinterest, denial, and poorly chosen lifestyles and diets, etc. The majority of these mental

patterns lead indirectly to physical diseases, either by reducing the body's natural immunity to invading organisms, distorting body chemistry, or disturbing some other physical function whose origin remains inconspicuous to the myopic medical eye.

It is not difficult to identify the underlying source of this limitation: The discipline and practice of medicine does not include consciousness as part of its territory, competence, or responsibility (Dossey, 1999; Timmermans & Angell, 2001). We are gradually learning in this century that healing from many illnesses must be achieved first in the consciousness that created them, rather than in the body which is only reacting to the mind. This observation may be challenging for a medical mind to accept but it is no longer in doubt.

Could "premature" death be one such presumed pathology? Is consciousness playing a role in SIDS? Is there a mental defect to which the body is reacting by dying? Could there be an invisible physical defect which the mind is trying to heal? If consciousness is really in control, how is it working to allow or produce SIDS in particular? If so, what kind of healing of SIDS is possible and appropriate? Could the infant itself be somehow playing a part in its own demise?

These questions have not yet been addressed let alone answered. Medicine's purely physical approach to SIDS has shifted attention away from *why* the infant died to *how* it died. This serious bias has obscured attention from the mental, cultural, and perhaps spiritual factors that appear to be involved in SIDS but remain unexplored and unknown.

We must remember that when physicians say "the cause of SIDS is unknown," they are making only a medical statement, and a physically based, incomplete, and presumptive judgment at that. It is obvious by now that they have been looking in the wrong place for an explanation for SIDS. Any one of the several socio-cultural and psychological factors cited above, or another not yet discovered, could provide the clue to understanding the infant's external or internal susceptibility which leads to its eventual death. Our work has just begun.

Another Way of Knowing

The leading candidate for filling this gap is *intuition*, the human faculty by which new information can be received into consciousness *apart* from sensual perception, memory, and rational thought. This innate capacity is not widely understood, nor is it often acknowledged or deliberately employed as a source of new knowledge. Some persons do not even know that intuition exists despite abundant evidence to the contrary (Palmer, 1998; Radin, 1997; Vaughan, 1979). For many scientists and rationally inclined psychologists it is considered a leftover from the past, long since left behind in their professions as a superstition and a "taboo." Intuition is actually an essential component of ordinary thought, though

the rational mind is typically and incorrectly given credit for its contributions.

The widespread ignorance about intuition calls for some explanation here to explain just what it is, what are its salient features and properties, and how it is able to go beyond familiar means of generating knowledge to help solve human problems that rely upon the generation of new knowledge for their advances.

Intuition is popularly and ambiguously regarded as a flash of insight, a gut feeling, a hunch, perhaps a "psychic hit" or an unconscious reasoning process. A much older tradition bespeaks of it as an innate and fundamental attribute of consciousness, a kind of "direct knowing" capacity which everyone possesses. Intuitive knowing was well-known in ancient Greece (as *nous*, from which the words *noetic* and *gnostic* are derived) and in non-Western cultures everywhere. Early religions do not contain philosophies in the modern, Western intellectual sense, for they relied instead upon direct experience, mystical insight, and a close association with the natural world when they evolved their world views.

Intuition persisted as an underlying quality and a natural practice up until the scientific revolution in the 16th and 17th centuries. It did not then totally disappear but took second place to the empirical, sense-based, rational, and materialistic values and methods of modern science, which replaced intuition as the preferred means for learning about the world and its human occupants. It is not surprising, therefore, that intuition has not been a favored topic for acceptance within science, which allies it with discarded past beliefs and considers it much too unreliable for rational investigation and reliable use. Today intuitive knowing is disdained by science, barely mentioned in psychology textbooks, and not a subject of systematic study by mainstream psychiatry.

While this exclusion is historically understandable, it is now partially justified because the *metaphysical assumptions* on which all modern science is based insist on objectivity, measurability, repeatability, and certain presumptions about causality, mainly reductionism. None of these properties is satisfied by familiar subjective phenomena such as imagination, creativity, perception, and intuition (Barrow & Tipler, 1988; Harman & Clark, 1994; Popper, 1959; Sperry, 1987). All science can do with an acclaimed intuitive event is to verify whether it actually occurred and if it might be explained according to its limited objective criteria. Until the 20th century it has been reluctant to do even this much. Science could also utilize intuitive information in a hypothetical fashion, as a source of ideas, which it does occasionally. However, it is not qualified to investigate or explain the intuitive process so long as it holds to its restrictive assumptions.

On the other hand, several decades of research in *parapsychology* have firmly verified that intuition really exists as a human mental capacity. This work has shown that many kinds of specific information, not accessible by ordinary means, not predictable in any real sense and not already known by any living person can be obtained through the direct-knowing intuitive process (Palmer, 1998; Mishlove, 1975; Vaughan, 1979; Radin, 1997; Targ & Puthoff, 1977/2005). Moreover, the individuals who have manifested this capacity most strongly as "intuitives" (or under other names) are not exceptional in any other way. This observation suggests that intuitive capacity is not supernatural but belongs to everyone. It seems to require only a willingness and suitable stimulus to function as a generator of entirely new information and knowledge.

The value of intuitive knowing is recognizable today through its applications in artistic creativity, occasionally in scientific subfields and business, in human interactions generally and in psychotherapy, which can hardly function without it. These more conspicuous applications are just a beginning.

Recent attempts are seeking to explain intuition further within the latest models of *consciousness* (still a vague concept). An explanation within science itself is still lacking and may be fundamentally impossible until science's assumptions are loosened. Freud had no use for intuition but his follower Carl Gustav Jung considered it to be one of four fundamental psychological "functions," along with thinking, sensing, and feeling (Jung, 1976). The popular Myers-Briggs personality test utilizes these four functions to create sixteen psychological types (Myers, 1995). Intuition as a "direct knowing" capacity has always been an integral part of Eastern philosophy, which regards it as the most significant means by which humans gain new knowledge **(**Blavatsky, 1887).

Like other recent discoveries which provide direct access to the unconscious, intuition can now be recognized as able to provide a fluid and direct flow of information from the natural world as we know it. The most systematic explorations of intuition are taking place within humanistic and transpersonal psychologies. While neither has yet won broad acceptance, they are playing a central role in re-growing the entire field of psychology from a sounder and broader base through inclusion of intuitive knowing as a major constituent (Aurobindo,1993; Kelly & Kelly, 2009; Kelly, Crabtree, & Marshall, 2015; Palmer, 1998; Vaughan, 1979; Walsh & Vaughan 1993). At the very least intuition can already be seen as a creative tool which science and several other fields could employ to their strong advantage.

The Center for Applied Intuition

An extensive research program by this author's organization (The Center for Applied Intuition [CAI]) in the late 1970s and through the

1980s confirmed that intuition, as defined above, is a genuine mental faculty, learnable, virtually universal, and it may be deliberately drawn upon to elicit highly specific, totally new, and accurate information of the inquirer's choosing. Again, the intuitives who did so were not exceptional in any way other than having developed this innate faculty into a refined and usable skill. These early information-based findings using intuition presaged a broad range of unique discoveries and potential applications.

CAI collaborated with about ten "expert intuitives" to create a systematic method of *consensual intuitive inquiry*. It then applied this method in exemplary fashion in several knowledge dependent fields and specialties: geophysics, archeology, ancient history, nutritional science, linguistics, nuclear technology, personal counseling, business, medical and psychiatric problems, and others. The more factual portions were tested whenever possible by comparing them for accuracy with independent findings made by others and published in scientific journals during the following 20 to 30 years (Grof & Kautz, 2010; Kautz, 2005, 2012, 2015a, 2015b, 2016a).

The consistency of the information received from different individual intuitives was near perfect. The level of confirmation with external sources was high and the error rate was very low—it appeared to have arisen only from vagueness in the questioning. Not all of the intuitive information could be externally verified in this way since some of the intuitive findings had never been obtained by independent means, so comparisons were not always possible. Some portions were not verifiable by their very nature: too personal or historically lost. Many would have been too expensive and time consuming to be verified by ourselves. Still, those portions which were formally verified are more than enough to render credible the unverifiable portions over a wide range of subject matter (Kautz, 2016b).

We may conclude that intuition inquiry is a practical tool capable of enhancing human endeavors that depend for their success upon the generation of new information, knowledge, and understanding. This broad coverage extends from science and its several branches to the social sciences, humanities, liberal arts, various practical areas such as political science and commerce, and even the attainment of personal knowledge for individual enhancement.

Questions still remain about who can best learn and perform intuitive perception, any inherent limitations (apparently very few) on the kinds of information that can be obtained, and especially how intuition works within the mind. These same questions arise with other human capabilities such as reasoning, creativity, learning, communication and speech. Man has learned to utilize all of them effectively even though he does not understand the brain processes involved or how they function

within the mind. Similarly, while waiting for acceptable explanations of intuition in scientific, psychological or familiar terms, we are free to make use of it—thus, "applied intuition."

Part III
Intuitive Inquiry on Infant Death

Coming to terms with existential questions of identity, meaning and purpose in life are crucial to mental health.
(Frances Vaughan)

In the late 1970s CAI became aware of sudden infant death as an unsolved human problem to which intuition inquiry might be able to contribute. After due preparation we applied our newly developed method to try to find a solution to this mystery. The focus was on SIDS rather than infant death in general, though it soon evolved that almost all of the findings applied equally to both. The questions to be posed to the expert intuitives arose out of several months of interaction with a group of parents, midwives, birth advocates, and a few physicians who were trying to understand better the outstanding problems in female fertility, pregnancy, and childbirth, including infant death.

The questions on infant death were addressed independently to twelve participating intuitives, most of them expert, in inquiry sessions in 1977 to 1979. (Grateful thanks are due the several participating intuitives, whose initials are cited in brackets in the following sections: [AA] Aron Abrahamsen, [AAA] Anne Armstrong, [GB] Gabrielle Blackburn, [LB] Lynn Burgett, [SF] Sandra Freeman, [LH] Lenora Huett, [DR] Deborah Reynolds, [SR] Shirley Rogers, [BR] Barbara Rowan, [KR] Kevin Ryerson, [JR] Jane Roberts and [PR] Pat Rodegast. [The last two participated only indirectly.])

This inquiry made fewer underlying assumptions than the medical approach in order to permit a broader and less constrained range of answers. Agreeing responses were collected into the consensus presented below.

Let it be understood that in conducting this investigation our prime focus was to explore new ideas and perspectives on infant death. We were not regarding the study as just another academic exercise or a scientific or psychic experiment. As the main inquirer I was fully respectful of the pain, confusion, helplessness, and grief of SIDS parents and families. They were co-inquirers with me, so we could learn together what might be done to alleviate the suffering which almost always accompanies the loss of a child.

Just as with all intuitive inquiries, the intuitives themselves were neutral "channels." Their personal background and interests were not relevant to the subject matter. None had had prior training or education

in medical physiology or other aspects of child death, and none had lost a child to SIDS or claimed significant past experience in the subject. A few may have had incidental exposure, but this background was not relied upon or further explained to them during the inquiries. They did no more than respond to the questions posed to them, obviously drawing upon a higher source of knowledge than what they had already acquired.

The dozens of inquiry sessions generated a wealth of detailed information. It was duly recorded and typed into transcripts for comparison and analysis. The intuitives' responses to the main questions provided a strong consensus. Individual intuitives sometimes contributed additional insights on particular matters or offered details about particular families.

When quoting the intuitives responses here we include only representative examples from the consensus, not the voluminous and highly repetitive report. These examples should not be taken as predictions, proven facts, or evidence from an experiment. Rather, they are a collection of ideas and perspectives for further examination, possibly as hypotheses and later for verification. They were certainly a positive inspiration to those who had generated the original questions.

The Cause of SIDS

Human beings have an idea they are very fond of: that we die in old age.
This is just an idea.
(Katagiri Roshi)

The intuitive consensus indicated first of all that the general cause of SIDS—in fact, *any* infant death—may be regarded on two levels: the *physical*, meaning the body, and the *non-physical* or mental. Both are valid views, they said, but no explanation of the cause of SIDS is possible at the physical level:

- There is not one isolated cause of crib death. [BR]
- Every case is different. No case is typical. [AAA]
- Anybody is susceptible to this peculiar set of events. It is not a virus, not a disease, or an illness. The nervous system triggers this, but SIDS is not a response for it is not a nervous disease. I look through the body, at the heart, the liver, the kidneys and all the different parts. They all fade together. [LH]
- It's not coming out of a physical defect. [SR]

We have immediately a direct contradiction with the stance of medical science, which had been assuming from the start that there must be a common *physical* cause of SIDS to be discovered.

The intuitives went on to explain that when a SIDS infant dies, its life force, vital energy, or consciousness simply withdraws from its physical body. The body then collapses from whatever essential physical function happens to be the weakest. If it already has an illness, even a minor one not normally fatal, it may succumb to it. Otherwise a small vulnerability, even a readily avoidable "accident" from which it would normally react and recover, serves in its place. An autopsy may reveal this or another weakness, or an inconspicuous irregularity in normal daily health, or it may reveal nothing unusual at all. If an infant is inclined to die it apparently finds a way to do so.

This non-physical cause of death *precedes* the physical failure and leads to it — not the other way around. The physiological aspect of death, including heart stoppage and cessation of breath, is an *after-effect* and not its cause. Withdrawal of consciousness is the basic cause of SIDS and overrides all physical candidate explanations, at least until we can learn *why* the infant withdrew its consciousness and initiated the physical dying process.

The intuitives went on to explain that in this early stage of life the infant simply "knows" when it is time to go, just as the elderly sometimes testify on their death-beds. They also say it is easier for an infant to leave life than an adult because it has entered its body only relatively recently and is still partly attached to the pre-birth realm from which it came, whatever that might be. Since its body is still young and immature it has fewer physical symptoms to account for the death, hence the greater mystery.

A voluntary exit?

> *There is no such thing as accidental death.*
> *All souls are self-determining and self-creating every minute of the day.*
> *They choose their own life and death.*
> (Rodegast [Emanuael] & Stanton)

A SIDS death appears to observers to be a random event. Is it also random from the infant's "perspective"? Or is there a *reason* for it? The infant possesses enough of a consciousness to be able to *make choices* in response to an internal reason. When it "wills" to leave life, it simply "chooses" to do so.

The possible reasons for its departure are many and they tend to vary with the individual. The intuitives say that the soul or consciousness almost always enters the body at birth or a few moments after, though a loose and intermittent connection with the fetus may occur for weeks or months before then.

- Many of these children are coming into life without the background of experience with bodies that others have had. They need to learn rapidly what bodies are all about. Sometimes it's too fast for them. [DF]
- Sometimes a soul comes in just to touch base with reality — most commonly if it has [recently] undergone a violent death and is still hanging onto the physical world. [AA]
- The soul is not "trying" to leave the body. It is simply ... a calling back, to realize it made a wrong decision. It's just a natural consequence. [GB]
- The soul decides to leave because unfavorable conditions have happened after it has entered. [AAA] (See box below)
- [The death] may be because the entity has learned in another manner what this lifetime was to provide. … Or because the parents have chosen to study death and the entity is coming in to create a body and then die so they [the parents] can examine their beliefs about death. [LB]

An interesting case illustrates one way in which SIDS can occur. CAI conferred with a mother about a year after she lost her baby girl. We offered her the opportunity to consult an expert intuitive to try to learn what happened from the girl's point of view and she agreed.

In the session the intuitive [AAA], who was given only the mother's name and address, provided details about mother and child and then reported that the girl had come into this family to have a strong interaction with the father. It was to be a special relationship and a main focus of the girl's life. During the pregnancy, however, he became jealous of the shift of his wife's attention to the forthcoming child, was moody and upset and began to drink heavily. By the time of the birth he was well on his way to becoming an alcoholic. The baby girl, who had lost the main motivation for her new life, left at four months of age.

The mother confirmed from her own experience the main details in the intuitive's report: her feeling about the girl's impending connection with her father, his jealousy, his moodiness, and his drinking. His alcoholism grew after the loss and the marriage soon broke up.

A SIDS infant's withdrawal from its body is therefore "voluntary" from its own perspective. We cannot say it is making a rational decision as an adult might do before a suicide — but neither is it merely reacting to physiological or environmental stimuli like an animal. It is responding to a shift in its own consciousness, one which *triggers* the separation from its body. The departure is indeed an infantile form of suicide.

Do Newborns have an Active Consciousness?

Most people come to dying informed by a whole sequence of fears, issues, associations, and traumas, not one of which they [deliberately] chose. All are culturally driven, not psychological, inherited, or purely religious.
(Stephen Jenkinson)

This non-physical explanation for SIDS affirms first of all that a newborn infant actually *has* an active consciousness capable of making a life-and-death decision. Can a recently born infant really be so aware*?*

To answer this question we can only go back and ask how we originally acquired the notion that a newborn lacks conscious awareness. This can only be an assumption or speculation, not a fact derived from direct experience or by empirical observation, since we have no way to observe the internal workings of the infant's consciousness or to communicate with it. Although more recent research has been able to document evidence that newborns are aware and conscious (Chamberlain, 2013), this assumption could only have arisen from a societal belief that originated in the early development of modern medicine, which allows only physical explanations. This belief presumed that human consciousness can arise only out of a developed brain, the only organ presumed at the time to be capable of perception and awareness. This belief was never an established fact (Kuhn, 1962; Latour 1987).

Most of medicine today still operates under this same tacit and unproven presumption, which is undoubtedly a prevailing belief among many physicians. This profession is therefore not qualified to claim that perinatal consciousness does *not* exist. It can only say that if it does it is not part of the large collection of confirmed medical knowledge already extant. We already know that this collection excludes almost all mental activity and is very incomplete as a description of the overall human condition. Evidence that infant consciousness could exist outside of medical knowledge is just waiting to be discovered. There is ample evidence that it actually does exist, as we shall soon see.

Traditional psychology has tried to go further on this question but it follows science too closely and operates under much the same misassumption. It prefers brain explanations and disallows mind-based hypotheses for most recognized psychological processes, including both the source and the nature of human consciousness. It is not able to offer a verified model or explanation for perinatal consciousness. Transpersonal psychology has found empirical evidence that consciousness actually exists both prenatally and postnatally, at least for some infants and probably for all, and for at least a minimal degree of operating awareness.

The new intuitive information does not contradict existing physiological and psychological knowledge about infant consciousness but only certain prevalent assumptions and beliefs about it. The intuitive

claim on the nonphysical cause of SIDS must be accepted as plausible in the face of medicine's and psychology's present ignorance of a cause, and their inability to show that the intuitive claim is incorrect.

An infant may not be able to *"think"* in an adult sense, but it is still credible that it has a consciousness capable of making certain kinds of choices. The evidence is actually stronger than this.

Recovering from Infant Death

"Don't grieve. Anything you lose comes around again in another form."
(Rumi)

When a child dies from SIDS, what specific and practical counsel can be offered to help the parents adjust to their loss, deal with the common emotional reactions to it, and perhaps learn something of lasting value from their experience? Answers to these questions depend strongly upon individual beliefs and expectations, and therefore upon what one is willing to hear, accept, and act upon. Still, the intuitives' counsel is much the same for almost all SIDS parents during the first months after the infant's departure. It is fairly obvious but worth delineating:

- The parents need to understand the *fairness* of what has happened to them—that they are not being discriminated against. [AAA]
- Help them to understand that they have fulfilled their part. When they have been released from the burden of their sorrow, they in turn must take their place to help others, even as they have been helped. [LH]
- When someone you love dies, let them go into the next step of their evolution. Give them a hearty "bon voyage" and offer comfort to others like yourself. Then enjoy a grand celebration and go about the business of your own lives [Rodegast (Emanuael) & Stanton, 1985].

Bring them together with other parents ... [so they may] channel their psychological states into socially constructive labors. Restructure their desire for further births. [KR]

And from other sources:

You can reconcile yourself to feelings of loss by identifying with that which is not lost when all else is lost; namely, the consciousness that informs the body and all things.
(Joseph Campbell)

The task is one of finding meaning at the end of life. Nothing you hold dear lasts, you know. And life is not just your lifespan.
(Stephen Jenkinson)

Some of the SIDS mothers encountered during this study had already committed themselves to helping other SIDS parents deal with their loss, just as advised. Some did so by joining organized parent groups, now in most large cities in the US and Britain, which systematically contact every new SIDS parent to offer support as conversation, information, and direct assistance. Psychotherapists, health practitioners, and ministers also provide grief and guilt counseling, which can be especially helpful when these professionals have themselves already had a direct experience with loss. Still, enduring the sadness and grief of loss is inherently a solitary process. The fragmented melange of different cultures in the U.S.'s highly materialistic society is, unfortunately, not so well equipped to provide this kind of intimate support as are interdependent and earth-based Asian cultures, for instance (Klass, Silverman, & Nickman, 1996).

Part IV
Confirmation of Intuitive Findings

Every theory, however majestic, has hidden assumptions, which are open to challenge, and indeed, in time, will make it necessary to replace.
(Jacob Bronowski)

Is Verification Possible?

It is clear that medicine and science are not able to provide solid evidence that a newborn infant has a consciousness and can choose to leave its body at will, since neither has the means for exploring human unconscious, as explained above. Religious authorities are willing to take a position on this matter, but they do not agree with one another and the results do not enjoy wide acceptance. Contemporary psychology acknowledges the existence of an unconscious mind, though it has little understanding of it except as a presumed source of human behavior which cannot be otherwise accounted for. Even transpersonal psychology cannot deal directly with the matter because it lacks sufficient data and is limited by its available methods. All attempted explanations are only fragmentary and partial.

The only ultimate possibility for validating the intuitive findings is by distinct individuals, on the basis of their own individual criteria, just as for intuitive knowing itself. While this option may have no superior for personal truth, it is of no use for the collective knowledge we seek. We are forced to conclude that a socially acceptable means of formal verification of the SIDS mystery does not exist (Kautz, 2016b). Our intuitive

discoveries on infant death are therefore not "provable" and must left to a potential future application of intuition, with whatever benefits may be gleaned from the following fragments of supportive evidence.

Pre-birth Memories

Birth memories indicate that babies have an identity of their own.
Their parents don't give it to them.
They act mindfully and build experience around a central core of self.
(David Chamberlain)

Almost all adults have long since forgotten their own perinatal state of mind. We have no reason to accept or reject outright the intuitive claim that we once possessed a live, working consciousness at our birth and just before and after. If it occurred we can imagine that it would be similar to the kind of a reverie, dream, or contemplation familiar to us as adults, but this can only be a guess.

Nevertheless, some exemplary individuals claim they can enter this dream-like state of reverie at will, and are able to report afterwards what they experienced. Hundreds of such examples speak of an ethereal quality, profound clarity and peace, timelessness and spacelessness, the complete absence of fear, sometimes ecstasy, and a feeling of unity with everyone and everything. These phenomena occur at all ages, apparently independent of the health or illness of the body and unrelated to the physical event that appears to have triggered it. These examples show that at least some humans possess this capacity to withdraw from waking consciousness and enter a non-ordinary state of mind. A few claim to remember experiences while growing in the womb, during birth, or shortly after, thereby providing a link to the perinatal mind we have forgotten (Kelly & Kelly, 2009).

Victims of serious accidents and very old persons occasionally report a similar perceptive state as they approach closely to the doorway of death.

This includes the near-death experience (NDE), which occurs when the heart stops, clinical signs vanish, and the body "dies," only to bounce back to life after a few minutes or longer (*days* later in a few validated cases). These persons sometimes report verifiable perceptions of their environment, such as nearby conversations and much more, which they experienced while they were "out" (Alexander, 2012; Greyson, 1993; Moorjani, 2012; Ring, 1980, 1984).

Maternal dialogue with the mind of a prenatal infant is actually quite common. Pregnant women often feel they are in intimate touch with their unborn infants and talk to them (Dougherty, 1990; Hallett, 2002; Verny & Kelly, 1981). Two intuitives said they had previously experienced such conversations with their own or other prenatal infants. A simple experiment with three pregnant women in their third trimester confirmed that such communication is at least possible. The most unusual information they reported, allegedly from the unborn infant, was found later to be factually correct, unique, and meaningful to the mother.

We therefore have a credible basis for hypothesizing that this kind of mind-to-mind dialogue may be a real, built-in human capacity which begins very early in human development. If this kind of direct communication could be refined into a skill and taught to mothers and practiced, it would surely provide them with a supportive and rewarding connection with their infants.

But the case for perinatal awareness is much stronger than this speculation(Riley, 1988).

Prenatal Consciousness is Alive and Well

Specific evidence for prenatal consciousness has been discovered in several transpersonal studies reported over recent decades. It includes convincing examples of young children who described unusual experiences during gestation which were verified after birth by the mother: physical abuse, birth complications (caesarean, inverted birth, long duration, etc.), emotional upsets, moments of exceptional contact, and music heard by both mother and infant (Chamberlain 1998, 2013; DeCasper & Fifer, 1980; Dougherty, 1990; Hallett, 2002; Kraus & Borbani, 1972; Odent, 1984/1994; Tomatis, 1991; Verny & Kelly, 1981; Verny & Weintraub, 1991; Whitwell, 1999). Two recent reports provide cases in which even maternal voice quality, nursery rhymes, vowel sounds, and songs heard during the third trimester were retained and recognized by the infant a few months after birth (Partanen et al., 2013; Moon, Lagercrantz, & Kuhl, 2013). These accounts show that some children were sensitive to certain kinds of events taking place both within and without the womb and were retained and later recalled as memories. The prenatal mind apparently

has the capacity to be receptive and remember its uterine and adjacent environment to at least this limited extent.

Evidence of a different sort arose in carefully gathered data collected over decades by Dr. Ian Stevenson, M.D. and his successor Dr. Jim Tucker, M.D. on past-life recall by young children (Stevenson 1966/1974, 1987; Tucker, 2005). Evidence for reincarnation is abundant, but it almost always applies only to adults. In dozens of these cases children described the specific living conditions of another child, whom they claimed to be themselves, from a nearby village who died shortly before they were born. Their stories were confirmed by Stevenson in impressive detail through actual visits to the identified village families and interviews with the families. He presented these cases as evidence for *reincarnation* of the child's consciousness, and it is difficult to interpret the data otherwise. They show again that the prenatal and perinatal mind can remember (that is, place into memory) external events before it was born, remember (retain) them, and remember (recall) them later as a young child in another body.

Extensive research on non-ordinary states of consciousness has been conducted by psychiatrist, Dr. Stanislav Grof, with the aid of consciousness expanding techniques such as holotropic breathwork and psychedelic substances. His sixty years of experiments provide what is undoubtedly the strongest confirmation that early memories are retained and carried into adulthood for all stages of gestational and perinatal growth, from embryonic to postnatal and older. They include prior incarnations, precognition, moments of merged identity with others, feelings of cosmic unity, timelessness, oceanic ecstasy, and verifiable and specific traumatic events such as attempted abortion, drugs, gynecological exams, sexual intercourse, forceps assisted and inverted births, cruel treatment of mother, loud sounds, as well as the mother's depression or anxiety, aggression, and emotional stress. When traumatic these memories can be responsible for various physical and mental disorders, and they are sometimes healed spontaneously when the original trauma is recalled and re-experienced. These memories normally remain unconscious unless released. They turn out to be highly formative in establishing character, personal traits, a sense of security, and a primordial personal identity. Such early wounds are not ordinarily amenable to conventional psychiatric diagnosis and treatment but Grof found that they are real and valid (Grof, 1985, 2006, 2010; Grof & Grof, 2010).

There can no longer be any reasonable doubt that the infantile mind is alive and active behind what can be readily observed. The extent of its sensitivity, memory, reasoning capacity, and degree of awareness are not

yet fully known, but it is clear that all four of these features are functioning in some form from well before birth and until much later.

The intuitive claims on the existence and activities of perinatal consciousness are well substantiated based on evidence from these sources. They are almost certainly a natural attribute of *every* infant, whether a candidate for SIDS or not.

Possibilities for Prediction and Prevention

There's no separate, indivisible, specific point of death, ... even in the case of a sudden accident. ... Your consciousness may withdraw from your body slowly or quickly, according to many variables.
(Jane Roberts/Seth)

The consensus suggested (in a parallel childbirth inquiry) that if the infant is entering human life with uncertainty, and if this uncertainty could somehow be anticipated, either intuitively or by a physiological signal, then it may be possible to *persuade* it to stay around instead of leaving.

- Talk to the child, make yourself a close friend of the child. Speak positively to the soul, saying, "You don't need to leave." [AA]

The intuitives proposed several physiological indicators for infants which could easily be detected by electronic monitoring devices and thereby signal a warning. The parents could then intervene in the dying process and give the infant an opportunity to "change its mind." However, they explained (as is already known) that such sensitive devices are inherently unreliable. They must be tuned to each individual body and frequent false alarms can be expected at times when the infant is not intending to leave. They are therefore not feasible as a practical means for detecting an imminent SIDS. The official recommendation is unqualified: Home cardio–respiratory monitoring should not be prescribed to prevent SIDS (AAP Policy, 2003; Silvestri, 2009; Strehle et al., 2012).

Not a Good Idea Anyway

In our death-phobic culture you will someday die on the receiving end of treatment to prevent you from dying, even after it's past time to die. … More time means more drugs, more symptoms, more side-effects. It has no resemblance to what we bargained for when we came into life.
(Stephen Jenkinson)

If parents could somehow detect a SIDS death in advance, should they try to persuade the infant to stay around? It is not immediately obvious that they should.

The situation might be compared with trying to convince a confused teenager not to leave home or an elderly patient not to die. Such urging can be a fitting act of love and caring when the recipient is just waiting for a sincere invitation to stay. It can also be driven by the mother's or caregiver's clinging — "please don't leave me!"— or a father's misplaced sense of duty to try to "save a life" when that life is trying to end. How can a parent decide?

Cultural pressures can make this decision difficult. Western social values tend to honor emotional attachment and they hold that any sacrifice, effort, and expense to keep a person *alive* is justified as the most caring action one can take. This forced "saving of life" occurs regularly in hospitals where the well-trained staff provides the dying person with abundant drugs, treatments, life-preserving care, and other amenities — and never mind his stated wishes. To be sure those approaching death are often senile, confused, feeling helpless, or in pain. They tend to be compliant, too weak to object (Campbell & Black, 2013; O'Reilly 2013).

It is becoming more and more difficult these days to leave physical life when one chooses to do so. Loud voices from both science and religion take their positions on the issue and modern man has no broadly accepted social principle to guide him on such occasions. Since most caregivers are unable to grasp the notion of a prenatal will and consciousness, they steer a safe course by trying to preserve the physical body. This practice is not categorically wrong, of course, for it is sometimes perfectly appropriate. But in other cases it is a misinformed or even selfish act, just the opposite of what the patient has chosen.

This same error can occur for euthanasia, also a controversial social issue these days without publicly accepted guidelines (Weigel, 2010; Kadampa, 2012), and presumably for abortion of a prenatal infant as well since the child is not able to communicate its wishes.

Most to the point, we are reminded by the consensus that it is the *consciousness* of the infant, not its physical body, that is the primary life to be nurtured. Moreover, it cannot be "saved" from death since it does not die. It resides in the body as a guest, and comes and goes as it chooses at every stage of the body's existence — including the prenatal. This is much the same privilege we allow the adults whom we most love, is it not? We make decisions for them only when they are not competent to ask for help.

As an infant's temporary caregivers in this life we are required only to provide love and nurturance while it is present and try to be sensitive to its unspoken wishes. In the absence of clear and certain communication it may be wiser to deliberately avoid all external interference. Persuasion

can then be set aside, the ethical issues vanish, and the infant can be given full freedom to make its independent decision to stay or leave. Again, this option must also exist for euthanasia and voluntary death at any age.

Further Use of Intuition for SIDS

Parents can certainly benefit greatly through development of their own intuitive faculties, just as anyone can, and perhaps more so in relationship with children because parent-child communication is such an essential part of raising healthy children.

Intuitive inquiry offers a means of gaining increased understanding of SIDS for medical research, for psychosocial programs, for gaining insights into prenatal and perinatal consciousness, and for assisting bereaved parents. After all, expert intuitives have direct access to these prenatal and perinatal states and to the minds of the infants who experience them. They may also be willing to identify infants contemplating their death yet willing to be persuaded to change their minds. Suitably qualified intuitives can serve for all of these purposes.

Special unresolved problems could also benefit from intuitive insights: why an unhealthy or deprived family environment is associated with high SIDS frequency, how a prenatal or perinatal infant is affected by loss of a parent, why male infants are at greater risk of SIDS, and what a SIDS infant can expect to experience after it dies (is it the same as an adult suicide?).

Part V
Summary

A woman with babe said, speak to us of children. And he said: 'Your children are not your children. They are the sons and daughters of life's longing for itself. They come to you, but not from you. Though they are with you, they belong not to you.
(Kahlil Gibran)

Medical Background

The uncomplicated circumstances surrounding sudden infant death (SIDS) provide no clues to its cause, prediction, or prevention. Forty years of medical research, including thousands of autopsies and several large epidemiological studies, have generated many non-causal "risk factors," most of them physiological, but have contributed almost nothing toward an understanding of this perceived tragedy except what it is *not*. A well-intended government program for reducing SIDS risk, based on some of these factors, along with common-sense child health practices, has been

promoted widely since 1992 but it has not helped to reduce the frequency of SIDS nor allowed advance detection or prevention.

About ten of these factors show that SIDS is associated with unhealthy parental habits (drinking, smoking, drugs), substandard living conditions, inadequate prenatal and postnatal care, poor nutrition, certain cultural and racial practices, and sleeping irregularities. None is strong enough to be indicative by itself, but a combination may be at least a predictor of SIDS. Collectively they point away from medicine's purely physical approach and toward the psychological, psychosocial, or spiritual causes that appear to be playing the determining role in SIDS.

Intuitive Findings

Consensual intuitive inquiry is a proven method of utilizing a team of highly skilled intuitive individuals to provide knowledge on problems that can benefit from totally new and accurate information not accessible through science or other familiar means of knowledge generation. Such an inquiry on the mystery of SIDS explained that the disorder *has no physical cause* but is the result of the infant's "choice," from its own consciousness, to exit life, and for its own reasons. To do so the infant simply withdraws from the physical body which then succumbs to its physically weakest part. The tragedy of SIDS arises not from the loss itself but from the parent's lack of understanding of this subtle but crucial aspect of human life. It includes the possibility of the early death of their infant at any time, just as for adults. SIDS must be seen as a *natural* occurrence. It is not the direct and immediate result of parental action, though there may be a vulnerability due to long-term negligence or inaction.

Evidence in support of these intuitive insights lies in

- the inability of medical research to explain the SIDS phenomenon
- psychological confirmation that perinatal infants are independent identities and possess various sensitivities and memories, with their own kind of consciousness
- the well-recognized fact that many gestating and postnatal mothers are in close psycho-spiritual contact with their infants, often accessing verifiable details
- the statistic that the frequency of unexplained human death remains about the same (1%) throughout the lifespan, thus indicating that spontaneous infant death is not unusual but is to be expected.

The intuitive findings do not contradict the results of medical research and its associated epidemiological data, though they differ substantially

in the interpretation of these results and data and the negative conclusions medical science has drawn from them.

Part VI
Implications

Both the medical and the intuitive findings, each in their own way, support a positive course of action which SIDS parents (and those fearful of SIDS) may pursue on their own. It can help them deal with the common aftereffects of their loss (anxiety, grief, guilt, doubt, loneliness, etc.), accept it as a natural and necessary part of their lives, and find solace, peace, and understanding. Most important, it can lead them to find personal *meaning* in the event so they may understand the great potential benefit which the seeming tragedy is offering them.

This matter of *meaning* is not just an intellectual topic for debate by philosophers, analysis by psychologists, or a religious matter for clerical judgment. It is rather a very personal *spiritual* issue which the death has compelled into attention. It is fundamental to individual and collective human experience and a part of everyman's ongoing search to comprehend his own life, including his death and whatever may lay beyond it. This understanding is so basic and crucial to a full appreciation of being human that it is sometimes necessary for those who have been resisting it to experience a major loss in order to bring it home.

Birth and death are not about possessing and not possessing, about gaining and losing, or about attachment to superficial needs. They are parts of a vibrant whole in which every change is purposeful and instructive. When seen from this broader perspective the birth-death polarity becomes a platform out of which deeper understanding may emerge. This is a gain which transcends all lesser difficulties. The loss of a child is never necessary to achieve this gain nor is it inherently tragic for there are much less painful, more conscious, and voluntary ways to attain this precious piece of knowing. When such a loss occurs, then it is time to pause, identify the opportunity being invited, and begin the effort to find a way to understand and accept it. This is very much a solo task.

Medicine's contribution has been primarily by default through its long and thorough, but fruitless, search for a physical cause for SIDS and its inability to predict or prevent SIDS death from occurring. It has found that several psychological and psycho-social factors are relevant, and these may enable an "explanation" of how a SIDS death arises or takes place once initiated. This approach, if pursued in future medical and societal research, may also identify inherent and developmental vulnerabilities in infants at risk. While still not causal these efforts could lead eventually to psychosocial steps to correct long-term behavioral patterns among SIDS parents who appear to be attracting SIDS infants into their lives.

The Challenge

The primary challenge to parents from intuitive sources is first to recognize that a prenatal or perinatal infant, being a distinct human being, has a natural right to make its own decisions about when to enter and leave life — just as do adults. While its choices may be influenced by family, society, and the external environment, it is solely responsible for its own departure. Attempts to prevent its demise by external intervention can only fail if the child has chosen to withdraw.

Second, the task of the parents, as its temporary custodians, is to avoid regarding it as their "possession" and using it as a vehicle for meeting their emotional needs. They are called upon to listen carefully and intuitively to its ongoing special interests and particular needs and respond to them. They will also do well to prepare in advance to accept their child's possible departure, in case it should choose to do so — and without guilt or blame.

While sorrow, separation, and grief are natural to human life, the typical human reaction to them is not. Death, too, is a natural and necessary part of life, not an enemy to be feared or opposed. The greatest tragedy of SIDS lies not in the loss itself but in the misinterpretation of the death as an unusual, unnatural happening and a threat to the parents.

I can hardly believe that this tiny death, over whose head we look every day we wake, is still such a threat to us and so much trouble. I cannot take his growls seriously.
(Rainer Maria Rilke)

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