Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

Bereavement in children

Reviewing the impact of bereavement in children Richard Harrington and Lucy Harrison point out that many current assumptions are unproven (May 1999 *JRSM*, pp. 230–233). The assumption that a child would be equally disturbed by the death of a parent irrespective of which parent had died is not only unproven but often not even questioned. As a child I was aware that not all adults had the same importance for me. For instance, only one of my parents was able to help me when I was ill or really distressed. That parent was invaluable to me. The other parent could read a good story, and knew a lot of interesting things, but didn't understand how to comfort me. This kind of distinction seems to be true for many many people. Indeed, some describe their most significant adult as being not one of their parents at all. A grandparent, an uncle or aunt, a sibling, a teacher, a neighbour, a childminder or nanny have all been given this role by the child. Losing the truly significant person can be devastating; losing the not so significant person can be distressing. There is no immediate way of getting comfort when the comforter is gone; distress can be modified if the significant adult is there and able to give this comfort.

It seems to me that many studies of bereavement in children are essentially flawed because this has not been taken into account. Only the study of the loss of the significant adult can provide information about the impact of bereavement. Could it be that some of the reported ill-effects of bereavement counselling are the results of some counsellors' not realizing that the child had no sense of serious loss, since the dead parent had not been felt by the child as playing a significant part in the child's emotional life? Expecting the child to mourn in this case would be more likely to cause confusion than to help—for instance, by making the child feel guilty for not feeling stronger grief.

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A personal experience may be of interest. As my father was a colliery worker during the Second World War he was exempt from military service. To help the war effort and to provide us with our own milk supply he bought, in the spring of 1940, a nanny goat and kid. At 6 pm on my 10th birthday he milked the goat; later that evening he was called to the pit and in an accident he was burnt to death. The next morning I realized that, although I had only ever watched the process, the goat had to be milked at 8 am. I learnt then the valuable lesson that life goes on. By milking the goat that morning I was enabled to cope much more easily with many instances of bereavement.

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In the article by Richard Harrington and Lucy Harrison the general note of caution about the wholesale application of well-meaning, unreasoned interventions, which may do more harm than good is well taken. However, their specific assertion that bereavement counselling can harm children involves a leap of logic which is rather hard to follow, since it is based on a 30-year follow-up study published over 20 years ago which showed that counselling with *delinquents* increased the rate of *delinquency*. They did not mention the most recent and comprehensive research to date, the Harvard Child Bereavement Study, reported in *Children in Grief* by W Worden, published by Guilford, New York, in 1996. The study, which followed 125 children for two years after the death of a parent and used a matched control group of non-bereaved children, found that bereaved children were at greater risk of emotional and behavioural difficulties and that this effect was greater at two years after the death (21% compared with 6%).

Harrington and Harrison also failed to differentiate between the advice of a professional and over-enthusiastic counselling by those with little training. This confusion was maintained in the extensive news coverage which followed publication. The publicity could easily have conveyed, and perhaps might especially have done so to the anxious and upset carers of bereaved children, that it is a bad idea to seek any professional help for a child who has lost a parent.

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Richard Harrington and Lucy Harrison are right to urge caution before we offer interventions that may be harmful. However, lack of evidence for effectiveness is not the same as evidence for ineffectiveness.

Parents may not be aware of the extent to which bereavement affects their child. Silverman and Worden[1] found that 42% of the children in their study felt they had to act in a certain way for the sake of the surviving parent, and Black[2] likewise reported that children who lose one parent may shield the surviving parent from their distress. Much of the research conducted so far has relied on parent and teacher reports, and to establish the truth we need evidence from children themselves.

There are two particular dangers in this area—to lose objectivity by becoming over-sentimental; and to deny the

reality of children's experiences because of our own expectations.

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1 Silverman PR, Worden JW. Children's reactions to the death of a parent. In: Stroebe MS, Stroebe W, Hansson RO. *Handbook of Bereavement*. Cambridge: Cambridge University Press, 1993

2 Black D. Bereavement in childhood. *BMJ* 1988;**316**:931–3

Senile squalor syndrome

The case histories reported by Dr Joan Clark (May 1999 *JRSM*, pp. 138–140) highlight an increasingly important subject in view of our ageing population.

It is with trepidation that I write, having no qualifications in this field. However, my sister and I have lived for a large part of our lives with a relative diagnosed (late in life) as having Asperger's syndrome. I could not help wondering if this might possibly be the diagnosis in the first case described. There are so many points which tally exactly with our experiences: a person of average intelligence but who knew little of everyday affairs; her troubles seem to have been lifelong, suggesting a developmental problem; all her life was spent in the same house (with her parents as long as they lived); she was always known as an eccentric; nothing had been altered in the house and nothing repaired or replaced; she had never varied her diet; the piles of neatly stacked papers brought to mind the piles of tax returns, together with threats of prosecution, found in my relative's home (this is someone who had a college degree); once in residential accommodation she was happy to fit in with the routine way of living.

Of course the condition had not been described when this lady was a child. But if I am right in thinking that Asperger's syndrome might be the diagnosis, it is a good illustration of the fact that such people need to be recognized early. They cannot live safe or satisfactory lives without some support and supervision.

I feel that publicity needs to be given to this bewildering condition.

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Attention deficit hyperactivity disorder (ADHD)

If, as Dr Tucker suggests (May 1999 *JRSM*, pp. 217–219) ADHD is due to an inherited brain deficit involving the prefrontal cortex and the dopamine neurotransmitter system, it is surprising (in the light of Darwinian theory and of the condition's manifest disadvantages) that it affects so large a proportion of the male population; perhaps there have been compensating advantages that are not obvious to the twentieth century observer. In any case one cannot help worrying about the possible side-effects of long-term treatment with amphetamines both on the central nervous system and on the pulmonary circulation.

It is clear that the apparent hyperactivity displayed by children exhibiting this syndrome is due to their inability to focus and hold attention on one thing at a time, with a consequent butterfly-like behaviour as contrasted with that of the busy bee. It reminds one of the stage of excitement seen by anaesthetists as patients go under, and of the similar state some children get into at bedtime or when given phenobarbitone. Could it not be—even if there are long-term ill effects on cerebral development—that the syndrome is a response to our present-day child-rearing practices as a result of which few children get the undivided attention of an adult for long at a time or the opportunity to play in the self-absorbed state of mind described by Winnicott as requiring 'someone to be alone with'? We have no difficulty in attributing psychological disturbance to abnormalities of brain function; why not *vice versa*? Not every apparently innate disposition is genetically determined, and genes that are necessary for the exhibition of a trait are not necessarily sufficient.

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GDC's guidance on anaesthesia

Professor Strunin (June 1999 *JRSM*, pp. 326–327) is surely an experienced anaesthetist, as he is the President of the Royal College of Anaesthetists, but what does he know of general dental practice? He says 'It is interesting to note that, following the ruling of the GDC in November 1998, the number of general anaesthetics for dentistry in the UK has fallen by some 70%. To my knowledge no patient has been disadvantaged . . .'. Firstly, it is not interesting that the figures have dropped. It is inevitable if the conditions were imposed in a way that put most anaesthetic providers out of business over night. I'm surprised it wasn't 100%.

To get a protocol arranged with the local hospital has been difficult in some areas, impossible in others. Some trusts simply won't agree one. So lots of us have patients simply waiting for a general anaesthesia (GA) facility to re-emerge. When they do, as they will, you will see an upsurge again. I can't persuade all my GA patients to have sedation. With informed consent, they understand the difference and reject it. They are prepared to take the very small risk associated with dental GA. Perhaps Professor