

will lessen in time. While people need privacy and time to grieve on their own, most mothers sooner or later feel an urge to talk repeatedly about the baby and what happened until they have worked through their grief; fathers on the other hand often try to repress their emotions, sometimes to the extent of refusing to talk about it in the family. Parents may need help in understanding that different people mourn in different ways but can also be encouraged to talk to each other. A good cry together can often release pent up emotions. Parents often have unrealistic expectations of how soon they will recover. In the experience of the Foundation for the Study of Infant Deaths, intense grief is likely to last for 2 to 4 months, and while most parents have come to terms with their loss after a year, anniversaries of the baby's birth and death are moments of renewed grief.

Abnormal grief: This may show itself in avoidance of mourning, prolonged grief or a delayed reaction where parents appear to be coping very well initially but break down later. Bereavement may revive memories of previous loss or emotional crisis which was inadequately resolved, and the help of a social worker, psychiatrist or clergyman may be necessary.

Siblings: Overwhelmed by their own grief, parents may be grateful for practical help with their other children as well as guidance on how to cope with their emotional needs and how to explain the death to them. Parents are likely to panic at the slightest illness in surviving children and need a lot of reassurance that they are not at risk.

Future children: Almost all parents fear that the tragedy may repeat itself with a subsequent child and seek reassurance that neither a hereditary nor a genetic factor is involved. Some parents fear they are going to be advised not to have another child, others are worried they will not conceive again. While some parents are ready to start another child immediately – 'I personally think only another baby can help ease the big void that one feels inside' – others need time until they feel ready to have a child whom they can consider as a new personality and not a replacement: 'I am hesitant to have another baby at the moment – I feel it would be an insult to D. I don't think we could ever replace him.' The Foundation's leaflet 'Your Next Child' is designed to help parents with their anxieties in caring for a subsequent child. An accompanying card gives guidance on 'When to Consult a Doctor about your Baby', which could be of use to all mothers of new babies.

Mutual support: Many parents derive great comfort from realizing they are not alone in their tragedy and by talking with other similarly bereaved parents. This can be arranged through the Foundation for the Study of Infant Deaths,

whose leaflet 'Information for the Parents of a Child who has died suddenly and unexpectedly in Infancy' which tries to answer the questions parents most frequently ask, is also of great help to parents, their relatives and members of the caring professions involved.

Dr Dora Black
(*Edgware General Hospital,*
Edgware, Middlesex,
HA8 0AD)

What Happens to Bereaved Children?

The grief that does not speak
Whispers the o'er-fraught heart, and bids it break
(Macbeth).

About 200 000 children in England and Wales, one-fifth of all single parent families, have lost a parent (usually father) by death (Finer 1974). We know that bereavement is associated with severe physical and emotional disorders in adults Lindeman 1944, Parkes 1965, 1972, Young *et al.* 1963, Rees & Lutkins 1967, Parkes *et al.* 1969, Ward 1976). There is evidence that bereaved adults who are able to mourn appropriately have a better outcome than where there are delayed, absent or distorted grief reactions (Maddison 1975, unpublished; Parkes 1975, publication pending).

There have been few studies of what happens to bereaved children. Young children are developmentally unable to care for themselves and so the loss of a parent renders them especially vulnerable. Can children mourn? Many psychoanalytic writers believe that children are developmentally unready to do the work of detaching themselves from a loved and needed parent until adolescence, and therefore are more likely to react with symptoms which include denial, fantasies of reunion, persistent feelings of anger and reproach and the absence of overt grief (Bowlby 1960, 1961, 1963, Wolfenstein 1966, Nagera 1970). Others suggest that even a quite young child can complete mourning successfully provided that he has immediate substitute care and that he is given the opportunity to express his grief in ways appropriate to his age and stage of development. If these conditions are not present, then there is the possibility of interference with normal development (Furman 1964, 1973).

Several studies have shown that bereaved children are more often referred to child psychiatrists

than their non-bereaved peers. For example, Rutter (1966) compared 739 children referred to a child psychiatric clinic with neurotic and conduct disorders, with control groups from pædiatric and dental clinics. Of the disturbed children 11% had lost one or both parents by death. The rate was over twice that found in the pædiatric controls and five times that of the dental controls. The most vulnerable children were those bereaved between 3 and 4 years of age although symptoms may have developed some years later. In my child guidance study (Black 1974) 14% of 278 children referred to the clinic had been bereaved and three-quarters of them had depressive symptoms. Of the school children, nearly half presented with school refusal. Other child guidance clinic studies (Arthur & Kemme 1964, Caplan & Douglas 1969, McGlashan 1968) have found a high incidence of depression and phobic disorders. Caplan & Douglas (1969) found an association between depression and post-bereavement placement in a children's home.

What happens when bereaved children grow up?

Brown (1961) was the first in this country to recognize the association between childhood bereavement and adult depression. The early studies (reviewed by Granville-Grossman 1968) were confusing and contradictory mainly because of methodological difficulties. Birtchnell (1972) largely overcame these difficulties and, using a psychiatric case register of over 7000 cases, found a small but significant excess of parental deaths before the age of 10 years in depressed women. Studying psychiatric in-patients, Hill & Price (1967) obtained similar results.

Most of the studies on the effect on children of the death of a parent indicate that affective and phobic disorders are more common than in their non-bereaved peers, although most children do not have more than transitory disturbances. The often considerable delay before onset of symptoms suggests that the subsequent life experiences following bereavement may play a larger part in the genesis of the disorders than any specific effect due to the loss itself. Why do the majority of bereaved children negotiate such a potentially hazardous experience with only transient upset? Caplan (1961) has put forward the hypothesis that at times of crisis people are more open to influence than at other times and that only a little help then may be all that is necessary to ensure healthy modes of adjustment.

If it is true that for children, as for adults, it is necessary to 'give sorrow words' then we need to understand why some children and their parents find it so difficult to express their grief. The answer may lie in the family and in the characteristic ways they communicate with each

other. Bowlby & Parkes (1970) have suggested that in families which view the attachment behaviour of the child unsympathetically, as something to be grown out of as quickly as possible, the child is likely to come to accept these standards for himself. So when he suffers serious loss, instead of expressing feelings he is inclined to suppress them. In this he is encouraged by his relatives who are products of the same family culture. Studies on the outcome of bereavement (Maddison & Walker 1967) and of the functioning of families containing a disturbed member (Paul & Grosser 1965) suggest that a maladaptive response to loss was associated with the lack of a supportive network of people who encouraged the expression of grief.

The concept of death develops slowly in children. At first children cannot distinguish between a temporary and permanent absence. By 3 years, although they know that death exists, they do not know of its irreversibility. It is not until about 10 years that they begin to realize that death is final, that it happens to everyone and that it will eventually happen to those they love (Nagy 1948, Anthony 1971, Kastenbaum 1967).

It seems reasonable then, for therapists to aim to help families to express their grief and share their mourning. The therapist's task is to promote and facilitate shared grief and mourning; to bear anger; and to help the individual or the family to 'remain open to recollection' (Harris 1973). The children will need to know the reality of death, for 'one cannot grieve what one does not know' (Reeves 1973).

Family therapy is based on the theory that symptoms in an individual belonging to a family are often an expression of disturbed interaction within the family system and that the family as a whole should be the patient. As practised in this country it draws on group analytic theory as well as systems theory (Skynner 1969) and seems particularly indicated where the family is reacting to the loss of one of its members (Martin 1976, unpublished). I suggest that intervention at the time of the loss may prevent or modify the pathological sequelæ for both children and parent. Maddison (1975) used various techniques of short-term therapeutic intervention with widows who had been previously identified as likely to have a bad outcome. He was able to reduce the frequency of physical and mental ill-health compared with an untreated control group. Parkes (1976, in preparation), in evaluating the family care service offered by a hospice specializing in the care of the dying patient and his family, has shown that support to the survivors rendered them less liable to autonomic symptoms, depression, or increased consumption of alcohol, tobacco and drugs than an untreated control group.

Conclusion and Summary

We know little of the way in which children of different ages react to the loss of a parent. There appears to be an increase in affective disorders both immediately and more remotely. Clinical studies suggest that the way the family handles the loss affects the outcome for the children. I suggest that brief family therapy may help prevent or mitigate some of the adverse consequences by facilitating the expression of grief and the sharing of mourning.

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Meeting 4 June 1976

Cases**Sclerødema of Buschke with Pericarditis**

S H Roussounis MRCP DCH
(for Mary Smith MB DCH)
(Kingston Hospital,
Wolverton Avenue,
Kingston upon Thames, KT2 QB)

C E, girl aged 11 years

History: Two weeks after an attack of scarlet fever she developed pain, swelling and hardening of the skin of the neck. Over the next two weeks hardening and stiffness of the skin spread to the shoulders and upper arms. Dressing became increasingly difficult. She felt well in herself. Admitted to hospital five weeks after the onset of scarlet fever.

On admission: Apyrexial. Marked hardening and thickening of skin limited to the neck, shoulders and upper arms. Unable to raise arms to 90°. Neck and elbow movements moderately limited. Difficulty in protruding tongue, which felt hard and thickened. CVS: triple rhythm, heart rate 120/min.

Investigations: Hb, WBC, ESR, ASO titre, cardiac enzymes, immunoglobulins, LE cells, antinuclear factor and chest X-ray all normal. Skin biopsy normal. ECG: biphasic T waves in left precordial leads. Echocardiogram: abnormal pattern of right ventricular wall movement typical of pericarditis.

Progress: No further progression of skin changes after admission. Pericarditis diagnosed on the basis of triple rhythm, marked 'Y' descent in the jugular venous pulse, and echocardiogram findings. Over a period of several months skin condition greatly improved and all limitation of movement disappeared. The abnormal cardiac signs became less prominent. No specific treatment given.

Discussion

The diagnosis of sclerødema of Buschke was made because of the characteristic evolution and distribution of the skin changes. Sclerødema was first fully described by Buschke in 1902. Recent reviews show that children constitute a high proportion of the cases and that the old term sclerødema adutorum was a misnomer. By 1963 about 250 cases had been reported (Greenberg *et al.* 1963).