Childhood bereavement

Distress and long term sequelae can be lessened by early intervention

When Alison Hargreaves lost her life climbing K2 in the Himalayas, her widower was strongly criticised for acceding to their 6 year old son's request to see "mummy's last mountain" and even more so when he took along on the trek their 4 year old daughter. But the ensuing expedition clearly enabled the children to process the information about their mother's death and to begin the task of mourning. As the general practitioner who accompanied and counselled the children reported,[1] after seeing the mountain, building a memorial cairn at its base, and using a workbook designed to help young children to understand and come to terms with death,[2] Kate was able to say, "Mummy had tried her best to come down and see us, but she just couldn't, the storm was so strong."

Bereaved adults caring for young children often deny them the opportunity to understand what has happened to a parent or sibling who has died, in the mistaken belief that the children are best protected from this knowledge or cannot understand it. Yet studies have shown that even young children have quite well developed concepts relating to death and are able, with help, to understand that death is permanent, universal, irreversible, has a cause, and involves separation, and that dead people are different from live people in a number of respects (for example, they cannot move, feel, or eat).[3] Children also have ideas about heaven and hell which reflect the limitations of their understanding as well as the sometimes confused and contradictory information they receive. Asked how you get to heaven, most children in a survey conducted in three London infant schools thought that you fly or float up.[4] One 5 year old said, "God picks you up, you have to wait 12 days for a flight and then the flight takes eight hours." Others, when asked to describe heaven, were worried about overcrowding or seeing blood, although most saw it as a nice place.

Controlled studies based on population samples have confirmed earlier clinical impressions that bereaved children have a significantly increased risk of developing psychiatric disorders and may suffer considerable psychological and social difficulties throughout childhood and even later in adult life.[5-7] Standardised diagnostic interviews with bereaved children have shown a high incidence of affective symptoms.[7] For example, Weller *et al* found that 37% of their sample of 38 bereaved prepubertal children met the criteria for a major depressive disorder one year after losing a parent.[7]

Unfortunately, there have been no longitudinal studies of bereaved children. Retrospective studies have suggested an increased vulnerability to adult psychiatric disorder, most notably depression.[8] The long term risks of bereavement in childhood are associated with inadequate physical and emotional care, particularly after the loss of a mother.[9] Certainly, the outcome for a child is strongly related to the way that adult carers are able to cope with their own grief and the changes to their lives, especially when bereavement is brought about by disaster or war. Children and adults who are bereaved by catastrophic events are particularly at risk of psychiatric disorders.[10 11]

What help can be offered to prevent some of these reactions? Primary prevention involves preparing the child for bereavement, supporting parents and caretakers after bereavement, explaining and talking openly with children about their experience, encouraging children's involvement in shared mourning practices and resumption of normal activities, and providing early professional help if needed. Counselling after bereavement is one of the few preventive interventions shown to promote mental health in adults,[12 13] and despite the paucity of good controlled trials[14] there is no reason to believe that it is any less effective in children.[15] Understanding about death is the first step on the way to recovering from bereavement and can be helped by being sensitively prepared by trusted adults for seeing and touching the dead body and encouragement to attend the funeral.[16] Bereaved children have fears of abandonment, fear of the death of those they love and themselves, guilt and fear of retribution for imagined or actual transgressions, difficulties in attaching to new caretakers, and difficulties at school. These problems need specific work done by those who can communicate at the child's level, who understand children's thinking and can use play materials appropriate to the child's developmental level.

Counselling for the bereaved adults caring for children is equally important. Helped by recommendations on good practice, services are developing in health, educational, and voluntary settings for individual bereavement from illness or accidents. Services for traumatically bereaved children and adults lag behind. When a community has been traumatically bereaved (as happened this year in Dunblane, Scotland, where 16 children and their teacher were shot, and in Tasmania, where another gunman ran amok) the delivery of adequate counselling services requires prior planning for disaster: there is wide variation in the readiness of communities, leading to a lack of provision or, equally bad, a chaotic overprovision from too many sources. A working party commissioned by the Department of Health produced recommendations on how to plan services,[17] but these have largely not been implemented.

Interventions exist that can alleviate the immediate distress of childhood bereavement and help prevent depression and other mental health problems in the future. We cannot afford to ignore the needs of bereaved children. HIV infection, war, civil conflict, mass transport disasters, and violence are all likely to increase the number of children at risk.

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