DEATH—ITS PSYCHOLOGICAL SIGNIFICANCE IN THE LIVES OF CHILDREN*

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The undiscovered country from whose bourn
No traveller returns.

Shakespeare: Hamlet, Act III, Sc. 1

Death, with its disruptive effects, is inevitable and frequent, but research workers have paid little attention to dealing with it in the lives of children, while medical training completely ignores this subject. There are probably many reasons for this, one which is self-evident being our own feelings about death and our hesitation to subject the bereaved, especially children, to probing and research. Some research is obstructed by professional co-workers and by bereaved persons.

My concern with the topic has arisen from experience in working with children in hospital wards and in private practice. I gradually became aware that I had to improve my technique of dealing with bereaved children and children facing serious illness or death.

That the importance of death has been well recognized is evident from Egyptian history and culture and the elaborate rituals of many cultural groups to aid and induce proper mourning. Freud recognized the psychological and psychiatric significance of loss and mourning. But I do not think that the psychiatric effects of death had been studied systematically until three decades ago when Lindemann started his research into the reactions to catastrophic events and bereavement. Retrospective studies of the histories of adult neurotics and psychotics showed an incidence of parental loss during early childhood that was higher than normal. The effects on adults of the loss of a significant person such as a spouse is fairly well documented.

Where children are concerned, most textbooks on psychiatry refer to the effects of maternal loss during the early years on ego development and object relationships. There is very little, however, on the immediate effects of maternal loss and how young children, in particular, deal with it. There is little or no guidance available for relatives and doctors in the management of such a crisis. Only very recently has the profession recognized that children with terminal illnesses or facing serious operations are preoccupied with the possibilities of their own deaths and desperately in need of support and understanding.

DEATH IN THE FAMILY

The loss of a parent is distressingly common; in the USA one child in twenty below the age of 5 years has lost one or both parents through death, and there is no reason why our figures should be significantly different.

It is becoming vital for us as doctors to realize that the death of a loved person is a shocking and painful experience for the survivors, is a hazard to mental health, and may contribute towards psychiatric illness. Beck1 showed a high correlation between childhood bereavement and adult depression. Greer2 found that there was a strong correlation between sociopathy and parental absence or loss in childhood. Gregory3 found that the higher delinquency rate was among children who suffered same-sex bereavement.

SUMMARY

Results of 13 cadaver renal allografts in 11 patients are described. One patient died at 73 months from sepsicaemia. Ten patients with functioning grafts are alive 1 month to 23 months after transplantation.

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ADDENDUM

Since preparing this article a further two patients have died (D.W. and C.V.D.). In both instances the cause of death was pneumonia.

REFERENCES


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Clinical Manifestations
Clinical observations in the period immediately after bereavement may vary considerably. They depend to some extent on the age of the child, the circumstances of the death, the atmosphere created by the adults in the environment, and the relationships among the child, the deceased and the surviving members of the family. On the whole one may say that the younger the child, the less likely is he to weep. Verbal expressions of longing without weeping are more common and may be prolonged, but weeping is often inhibited by the attitude of the surviving parent or adult. Irrespective of the child's age, increased clinging to the surviving parent occurs, even to the extent of wanting to share the parent's bed. In the older age-group the desire for information is common but often unexpressed through a wish to avoid giving pain to others or because it is subtly discouraged.

Kliman and Kliman demonstrated a very marked increase of neurotic symptoms in 18 bereaved children whom they studied intensively. They gave the increase as 350% within one month of bereavement.

Anna Freud classifies the immediate pathological effects under four headings:

(a) Psychosomatic problems such as sleeping, feeding and digestive problems, and increased susceptibility to upper respiratory infections.

(b) Instinctual regression in both libidinal and aggressive areas, with the child experiencing much anger towards the deceased parent.

(c) Regression of ego functions, especially the most recently acquired, e.g. loss of speech, loss of bladder and bowel control. Regression in social functioning may be expressed as school phobias, less confidence with strangers, and an increased reluctance to try anything new.

(d) Disturbance of libido distribution. Libido is withdrawn from the mental image of the deceased and may be invested in either the child's body with a resultant hypochondriasis or into the fantasy world, which may then become pathologically dominant. In the latter case it may then occur that the child identifies with the deceased, assumes some of his mannerisms and attitudes, develops the physical symptoms from which the person suffered, and may even have hallucinations of seeing and hearing him. Other workers have found that learning ability may be impaired, briefly or more or less permanently.

The death of a sibling may have far-reaching effects upon the remaining children. They may, often in an irrational way, feel responsible and therefore excessively guilt-laden, especially if events are shrouded in silence or secrecy. In such cases the parents always go through a process of mourning and if this is pathological they become depressed, often so severely depressed that they are not available to the remaining children, who then suffer from temporary or permanent deprivation.

Because the parents have a sense of guilt and fear repeated loss, they often become excessively protective towards the surviving children. This leads to unhealthy family relationships and may cause rebellious or maladjusted children, with generalized depression in the family as a whole.

Management
Death in a family is a crisis event calling for crisis intervention. The psychiatrist should not be the one to deal with the situation in the first place but it is he who should be the best informed about the psychological reactions, their interpretations, and the manner of dealing with the situation.

Frank and sympathetic verbal communication should be the major aim. Whether one likes it or not, communication occurs and is picked up by even the youngest child. Children are quick to notice anxiety, distress, changed attitudes and unaccustomed activity, and to overhear bits of conversation. If such occurrences are not explained to them, the children have to find their own solutions, and these may lead to isolation, often to intense loneliness, much fantasy and speculation, some of which may be horrifying. Children have been known to suspect the parent of having given a sibling away for adoption and of having committed murder, and they have accordingly developed fears for their own safety. To avoid harmful misconceptions and the undermining of trust, children should be permitted to participate in mourning rituals as fully as possible and in proportion to their maturity. Children of 8 years and over should be permitted to attend the funeral if they so wish, because seeing is more real than being told, and they need to be helped with reality. This also facilitates discussion, with the opportunity for the adult to correct misconceptions.

The tendency to 'protect' the child from the full impact of bereavement may be meant kindly but it is not conducive to mental health. Deutsch believes that it is essential for later mental health that every real loss of a loved person should be reacted to fully; any remaining libidinal or aggressive attachment stores up trouble for the future, and so the child must be helped to mourn properly, with the full understanding that this is a healing and not a harmful process. Anger, guilt, anxiety, grief and protest are all aspects of mourning which may be experienced and must be expressed with the support and the presence of a trusted and sympathetic adult. Childhood mourning may be facilitated by creating an atmosphere in which questions can be asked. Recalling details and having fantasies about the deceased should be encouraged and made easy and natural but should not be dwelt on morbidly. Children's apparent lack of feeling or the brevity of their overt mourning should not be misconstrued, for their pattern of mourning is different from that of adults but no less real or profound. The attitude of the adult should be that death is natural, inevitable, and very distressing, but that the pain can be borne without the sufferer going to pieces. Sharing painful experience gives much mutual support and comfort to all concerned, aiding maturation and promoting development of the ego.

What are the indications that the mourning work is inadequate and therefore pathological and that psychiatric intervention is necessary? There are roughly three aspects of mourning:
(a) Testing and accepting the reality of the loss.
(b) Remembering and thus withdrawing libido from the lost object.
(c) Seeking and finding satisfactory substitutes and interests.

Assessing the adequacy of the process may be very difficult because what may seem strong and adequate in a child may break down under the stresses of adult life or later intrapsychic conflicts. Because of this difficulty Kliman' drew up a list based on statistical, clinical, theoretical and common-sense considerations. He is of the opinion that even in the absence of signs and symptoms of childhood psychiatric illness any one of the following makes preventive intervention desirable, whether or not there is any other factor present: Suicide as a cause of a parent's death; very poor relationship between child and dead parent or between child and surviving parent; where the parent was mentally ill and living with the family during the year preceding death, or the remaining parent is mentally ill; or maternal bereavement of a girl less than 8 years old.

Kliman' continues his list and considers that any two of the following factors make preventive intervention desirable:

1. Age less than 4 years at bereavement.
2. Child at one time having had a neurotic or psychotic illness.
3. Paternal death during a boy's adolescence.
4. Death forces a geographic move or causes serious economic hardship.
5. No readily available substitute object of same sex and appropriate age.
6. Remaining parent has pathological mourning.
7. Remaining parent has increasing physical intimacy with child.
8. Child over 8 years old sheds no tears in first weeks after death.
9. Child over 4 years does not discuss dead parent or fact of death.
10. Child over 5 years refuses to participate in family funeral or religious observances.
11. Child has unusually cheerful mood beginning first week after parent's death.
12. Death was abrupt and unexpected.
13. Terminal illness was more than 6 months.
14. The terminal illness was unusually disfiguring or involved mental or physical mutilation.
15. Death from childbirth or uterine, ovarian or breast carcinoma if child is girl.
16. Family did not explain illness to child or deliberately concealed illness.
17. Family delayed informing child of death when others knew for more than one day.

To this list I would add violence of any description associated with the death.

Suicide of a parent is particularly important; it destroys the basic truth which is one of the cornerstones of mental health. The children often live in fear that the surviving parent may also be driven to suicide by unhappiness, problems or despair. They sometimes feel responsible for causing parental unhappiness or for not having been present and thus preventing the act. I may add that attempted suicide seems to me to be equally serious. In her bitterness, pain and anxiety a child recently said to me: 'It would have been better if she was really dead; that would have been the end. Now I shall never stop worrying. I can't concentrate when I'm not with her for fear of what she may do again. I feel someone must be with her all the time.'

CHILDREN SUFFERING FROM TERMINAL ILLNESS

One of the questions which will always be raised when a serious condition is diagnosed or a child is facing a big operation is whether he should be told. The question is really how and when he should be told. Information on any topic given to a child should be in keeping with his maturity to comprehend the facts. Work by Gartley and Bernasconi on healthy children's understanding of death has shown that the preschool child cannot conceive of its finality. From 6 to 9 years Death is personified and thought of as a malevolent person pursuing the living.

Very little work has been done on children actually facing death: it is too painful, and adults tend to avoid seeing and understanding the children's behaviour and non-verbal communications. Children, too, are bound to have great expressive difficulties in the face of their own impending death. Even the very young are able to experience the fear of death. Solnit and Provence described a 4-year-old boy who was aware of his impending death and asked his favourite doctor to hold him because he was afraid to die.

Kliman' reports on the analysis of a 4-year-old boy who was fatally ill. The case history gives some insight into the child's way of dealing with a painful hospital experience. At first by denial and then, when denial failed, by other defence mechanisms, he attempted to cope with his fears about his symptoms. The death of a pet dog enabled him to say to his analyst: 'You know Spot was sick and died, I'm sick and I'm going to die.' He continued to be preoccupied with the bodily changes and behaviour brought about by death. These changes seem to me to be a matter of concern to many children who have early in life become acquainted with death.

Vermeers and Karon, working in a leukaemia ward, are of the opinion 'that every child lying in bed gravely ill is wondering about dying and is eager to have someone help him talk about it. If he is passive it may only be an indication of how little the environment helps him to express his concern.'

I think this concern is also present in general wards. A 9-year-old boy said to me: 'That girl over there nearly died last night. I know because I saw all the nurses; they didn't want us near and they called the doctors.' He then confessed to his fear about his own impending operation.

Richmond and Waisman found children suffering from leukaemia more passive than others, with diminution of emotional and physical response and acceptance of the discomforts of treatment. They conclude that there was no overt concern about death. This is disputed by other workers, who claim that such a clinical picture is one of melancholia and deep depression.

Management

There is considerable evidence that even very young children 'know' when a serious diagnosis is made; their
parents and the rest of their environment change; people become anxious, secretive and over-protective, and ward off questions. Failure to permit discussion, to give information and to explain medical procedures often leads to disturbances of behaviour, such as extreme negativism and resistance or depression and apathy. Because the child is not armed with real facts he cannot defend himself against questions and sly remarks from outsiders, with the result that he is more vulnerable, is embarrassed, and feels betrayed.

A systematic approach to this problem was made by Vernick and Karon, and though they worked in rather special circumstances much of their approach is applicable generally. Any child seriously ill should be given the opportunity of knowing something about his condition and the medical procedures. It is much kinder to share his anxieties with him than to abandon him to a lonely struggle. It is wrong to think that the facts will frighten him more than his fantasies will. Little in real life can compare with the tortures of the world of fancy. I have frequently been impressed and moved by the courage of children in the face of reality. A close relative of a nine-year-old boy had committed suicide; discussing his younger siblings with me the boy said: 'I think they must also be told about it; I feel much better now that I know the truth; besides one day they will find out the truth, and how will they feel then?'

If such children are informed about illness they must also be assured that everything will be done to help them improve and to minimize their suffering. They must know that helpful and supporting adults will always be available and will respond promptly to calls for help. They gather much strength from the calm and frank attitude of the medical and nursing personnel. Their confidence is greatly increased because they do not feel pushed around and treated like mere objects.

**DISCUSSION**

The need to 'protect' children is natural and universal, but we must ask ourselves whether some of our measures are meant to protect them or to protect us, and whether some protective measures are not eventually harmful to the child. Some of our need to protect children is due to our own inability to face death. In working with such children the adult must be clear about his own feelings. Fears, doubts and anxieties can rarely be hidden from children.

The management of children seriously ill in a hospital ward presents great problems because close teamwork is essential. I am of the opinion that thinking should be in terms of a therapeutic community. The parents must cooperate and they must be given every support; their anxieties must be constantly dealt with. They must be helped to live lives as nearly normal as the circumstances permit. The children's relatives, friends and visitors also become the responsibility of the therapeutic community because they are part of it and therefore of the child's environment.

If a patient's condition deteriorates, doctors and nurses often feel irrationally guilty, feeling that they could and should have done more. They are thus sometimes put on the defensive and may then have difficulty dealing with relatives who are irrationally hostile. In the past the predicament of doctors and nurses has been overlooked or ignored. I think doctors need to know much more about death and the dying patient. It has been said that the denial of death might be a reason for choosing medicine as a profession. I do know that most doctors feel that they have failed or lost when a patient dies: death is seen as an antagonist whose power is to be feared. This is vividly described by Chris Barnard in some passages of his book *One Life*.

The dying patient is often avoided, and on the ward rounds his bed is circumvented if that is possible. The busy routine of the hospital makes rationalization easy. Wanting to avoid embarrassing questions and wanting to avoid coming face to face with the patient's dilemma and our own pain are very understandable. If we are sympathetic and helpful to patients in physical pain, why do we deny our time and support to the patient in mental anguish? I think part of the answer is to be found in the research findings that physicians are afraid of death in greater proportion than control groups of patients; we also see the preservation of life as our responsibility, and so our natural sadness and sympathy are tinged with feelings of inadequacy and failure; our ever-present guilt feelings are triggered off.

I think medical students should receive training in the management of death and be helped to understand and integrate their own feelings about death; it is only to the extent of their ability to cope with what is within themselves that they will be able to help their patients and their patients' relatives. The first essential is to minimize our denial mechanisms and increase our ability to accept suffering.

If it is said that children do not understand death, I agree; if it is said they do not fear it, I disagree. What is dear of death but fear of the unknown, of being alone, of being abandoned, and of being hurt? Are these fears not the constant companions of childhood?

**SUMMARY**

The significance of the death of relatives and its psychological effects on the lives of children are discussed. It is regarded as a mental health hazard.

It is pointed out that parents, doctors and other adults have had no training in understanding of or of methods dealing with this emergency. The same applies to children facing serious operations and terminal illnesses.

Tentative suggestions are made about the management of such a crisis and a plea is made for the training of medical students and others in this aspect of their work.

**REFERENCES**