ASSUMPTIONS AND ATTITUDES TOWARDS CHILDHOOD BEREAVEMENT.

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Abstract:
Childhood bereavement has been a matter of intense discussion among the Palliative care providers. Yet, there is little evidence base behind the notions, which are prevalent among the population in general, and Palliative Medicine providers in particular. Among the masses, there is still prevalence of ‘protecting the child’ phenomenon. Beliefs, like this, create confusion among the providers while recommending the strategy while dealing with the bereaved children. There is definite need to develop plans to deal with this difficult problem, while recognizing some other issues like culture and spiritual mechanisms.

Introduction:
Healthcare has multiple roles to offer. Caring for death and dying remains a pivotal role for doctors and other healthcare professionals. Bereavement support or preparation for families is also a role, doctors should have understanding of. Over the last decade, there has been a growing acknowledgement among the healthcare professionals about the needs of bereaved children. Hospices, in particular, and palliative care providers, in general, have developed programmers of skills and resources to meet this demand (1). However, it is also of concern that at times, children are excluded from the grieving process as there is not enough appreciation in the wider community that children of a very young age could go through same emotions. The notion of ‘protection’ can sometimes be overused. At the same time, the published data, agreed standard or guidelines are sparse and although totally sympathetic, even palliative care workers find it confusing to guide families through this difficult time.

Here we will discuss three real life case studies with different scenarios dealing with people’s assumption about Children’s perception of death.

Case Study One ‘Not to tell’:
Eighty years old Ian was a farmer and was suffering from peritoneal secondaries from unknown primary. He had a very hard earned estate where he lived with his wife Nora, sons Graham and Geoff. Whilst Graham had no children of his own, all the family enjoyed Geoff’s young children Josh aged 9 and Amy aged 7. Nora very much enjoyed being the organizer of the family. After successive admissions to the hospice for aspiration of recurrent Ascites, Ian deteriorated and died with his wife and daughter-in-law Jane in attendance. Nora had made the decision for the family that Amy and Josh would not visit Ian during the terminal stages. Following his death, there was a huge argument between Nora and Jane about the children coming to see Ian. Jane stated that children loved their grandfather and had made their wishes known that they wanted to see Ian. While Ian was alive, she respected Ian’s wish, not to bring in the children in to see him, but now, Jane felt that children had a right to see their much loved Grand-dad. Nora argued that the children would never be able to understand what was going on and they were better left alone. She felt if the children are allowed to see Ian after his dying, it will be a horrible experience and will leave them scarred emotionally. She suggested that children are told after the funeral that Ian had died.

Case Study Two ‘How to tell’:
Pauline had colorectal carcinoma and was undergoing palliative treatment only. She had a daughter Lorna who was divorced and had two children Hannah aged 12 and Connor aged 8. As Pauline was in her terminal stage, she wished to see the children. Lorna approached the hospice staff and said that she could not face telling the children and ‘was it appropriate to tell them as they will not understand it anyway?’ Hospice staff supported Lorna and Pauline and called the Child Bereavement Counsellor, who helped Lorna speak to the children. Pauline died after the children had been in to see her and left.

Case Study Three ‘let us tell’:
Seventy-seven years old ex-teacher Maureen was suffering from cancer of the pancreas. When she was diagnosed, she was also told of the poor prognosis. Maureen had four children and nine grand children with age ranging from 15 to 4. Maureen spoke to the grand-children openly and they kept visiting their granny with no hesitation. When Maureen died, her eight years old grand daughter Jade drew a picture of her understanding of Maureen’s death and was happy to share it with hospice staff.

Discussion:
The case histories described reflect different attitudes among the society towards childhood grief. While in the case history one, the elderly lady had a notion of ‘protection’ of the child, lady in case history two, though agreed to tell the children but found it hard. Both of these attitudes come from the background that putting
plexed children where the truth was hidden. Children, if holistic care and honesty. It is not uncommon to find per-
dren of young age’. It also corresponds to the ethos of good grounds to support the theory of ‘being open to chil-
rial on the childhood bereavement, there are still very
Though, there is very little written evidence based mate-
Conclusion:
- There is need to recognise the fact that there still is the notion of ‘protecting the child’ while actually what is happening is the ‘harm to the child’ by being dishonest and making them unable to open up.
- We also need to find more evidence to help us channel the resources in the right way, whether it is to support the parents or to set up support groups. It is without doubt that all of these may have their own role. Given the confusion we have, due to lack of data about the childhood bereavement, it is hard to support one strategy over the other.
- We also need more evidence to know whether there are any long terms psychological influences left with the bereaved children. It will help us plan our pro-
grames as well as provide information to the family, although it needs to be emphasized, in a very sympathetic manner.
- We also need to recognise the fact that bereavement is influenced directly by social, spiritual and cultural issues, while setting up any such programme, we will have to consider the local implications based around the needs of the particular situation.

References:
2. Stokes, Pennington, Monroe et al. Developing services for bereaved children: a discussion of the theo-