Telling The Truth Or Hiding The Facts:

An Evaluation of Current Strategies for Assisting Children Following Adverse Events

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Children not infrequently observe scenes their parents would prefer they did not observe; they form impressions their parents would prefer they did not form; and they have experiences their parents would like to believe they have not had. (Bowlby, 1979).

Introduction

In 1970 my mother was diagnosed with cancer. I was 19 years old. The doctor did not want her to know what disease she had and neither did my father. She died half a year later. Her illness was never dealt with openly. At this time there was no kind of support for families in dealing with such an adverse event in the family. I gained first hand experience of how certain tumours grow within family communication as well as in the human body. I openly admit in being biased in the direction of communicating openly about disease and trauma in the family.

In 1983 I was asked to assist a family with a 13-year-old son with a brain tumour. The father wanted us to hide the facts of the disease from the boy and explain his radiation treatment by telling him that they were just taking photographs. The mother wanted to tell the truth, but was so afraid of her husband. The son's illness became part of a long-standing conflict in their marriage. During the boy's first days at the hospital the tension was strongly felt whenever we entered the boy's room. We felt we could not tell the truth to the boy without more backing and help from the family. On one of our early visits the boy said: 'I am ill, and they get to know everything'. When the mother decided that the boy needed to learn the truth, not only was the tension broken but so was their marriage. During the years from his first radiation treatment and until he died a couple of years later, the mother was able to support the boy in a very sensitive manner, while the father did his best to sabotage.

Around 1996 I was asked by the intensive care unit to talk to a mother and her 14-year-old son and her 20-year-old daughter following a fatal suicide attempt of their father. His respirator was to be turned off later on the day we spoke. The mother had come down to the basement right after her husband had hung himself from a hook in the ceiling. She managed to lift him up, get the rope off his throat and get him down on the floor. At this moment, her son and his friend came in and started life-saving measures. The mother said there was something wrong with his heart. It was only during the first night at the hospital when the 20-year-old daughter overheard two doctors talk about the suicide attempt that the two children learned what had happened. The older sister immediately informed her younger brother. Suffice to say the climate during our first conversation was not the best. I asked the mother if there were any other secrets she had kept from the children, and she said, 'Yes, there is the suicide letter'. Apparently her husband had written in the letter: 'If you had been more like my mother, this would not have happened'.

These three situations, around 10 years apart, all illustrate different aspects of how difficult it can be to communicate in situations that include dying, death and trauma. The first situation describes how, only 30 years ago, even communicating a life-threatening diagnosis to a young adult was badly handled. How much more difficult was it then to try to be open, honest and direct with children. When Myra Bluebond-Langner in 1978 wrote her book, *The private worlds of dying children*, she described in great detail how children so often were left with their fantasies when facing death, because adults had problems in communicating openly and honestly about the situation. The knowledge

accumulated by Bluebond-Langner and others was of great help when we worked with dying children in the early eighties.

The third situation, which took place in 1996, involved secrecy and misinformation following suicide but probably no longer represents the norm. During the nineties, in many Western countries, facts have been openly shared with children, they have been included in rituals, and many take part in family meetings following adverse events. A pertinent question will be to ask if we have gone too far in this direction? Do we really have good solid knowledge that it benefits children to be so open and direct in our communication, and include them in rituals to the extent that we do today? This question can be answered rather bluntly by saying: no, we do not have extensive empirical data in the form of rigorous studies to support this active inclusion. But rigorous data are not the only form of knowledge available. The following presentation will draw on studies and this author's clinical experience from more than 20 years of working in the area. It is probably biased, and it may be one-sided, but hopefully it will make the reader reflect on these issues.

This paper will have a wider focus than the title implies and will look at how we share difficult facts, information and feelings surrounding illness, death and trauma. A special section is devoted to how we include children in rituals. To prevent having too wide a focus, serious illness in the child him or herself will be excluded, and situations where the child loses somebody close or survives or experiences a traumatic event that happens to their closest family members will be given special attention.

Death and loss

In March 1929 Bertrand Russell discussed children and death and ended up with the following conclusions:

> In regard to the painful hazards of life, knowledge of them, on the part of children, should be neither avoided nor obtruded. Such knowledge should come when circumstances make it unavoidable. Painful things, when they have to be mentioned, should be related truthfully and unemotionally, except when a death occurs in the family, in which event it would be unnatural to conceal sorrow. The adults should display in their own conduct a certain gay courage, which the young will unconsciously acquire from their example. (pp. 177-178)

Koocher (1974), on the basis of a study of 75 children between the ages of 6 and 15, suggested that there should be no 'unspoken barriers' when discussing death with a child who has suffered a loss. He writes that children are capable of talking about death, and seem to want to do this. He states that the best explanations for children, especially those under age 7 or 8, will be those that are simple, direct, and draw as much as possible from the child's own experiences. He writes that adults who undertake explaining death to a young child will be wise to ask the child to explain back again what he or she has been told. This will offer the opportunity to detect and correct any gross distortions or misperceptions on the part of the child.

In another study, Rosenheim and Reicher (1985) divided 44 children (6-16 years) into an informed (18) and uninformed (26) group on the basis of whether or not they had been clearly told that their parent was suffering from cancer. They found that uninformed children were significantly more anxious than informed children. In another study, Rosenheim and Reicher (1986) found that the degree of affective hardship and behavioural disruption suffered by these children tended to be hidden from the eyes of their parents, leading to loneliness, apprehension and helplessness for the children. Not only has restraint in providing information or facts been shown to increase children's anxiety and confusion, the same has been found when parents withhold their feelings and are unable to share with the child expressions of grief and memories of the deceased (Elizur & Kaffman, 1983).

Silverman, Weiner and El Ad (1995), in a study of 43 children aged 6-16, found that there was little communication between parents and their children when there was an impending death of one of the parents. Very few children talked to the dying parent about the death, some more to the healthy parent. Parents rarely were direct in telling their children that the other parent was going to die, even when the death was only days away. It was the fear of 'traumatising' their child that kept them from doing this. However, still more than half of these children

had been aware that their parent might die. For those who did know, this seemed to have a positive effect. Many of the parents, whose spouse died suddenly, simply did not know how to communicate such news to their children. Sometimes it was left to children to figure out what was going on.

Providing updated medical information when a family member has a life threatening or terminal illness is a special problem in relation to children. Although parents may actively exclude a child from such information, lack of updated information may also reflect that the burden on the well parent becomes too high. Christ et al. (1993) found that most latency-age children could not understand the complexities of incomplete and changing medical information. They found that it was not unusual for children to be misinformed or have misconceptions about the parent's illness and this again shaped emotional reactions. These, in turn, further distorted their understanding of the terminal illness.

Throughout the last three decades a number of clinicians have argued that not explaining about illness and death to children can lead to reality confusion, and they recommend clear, comprehensible and open communication (i.e., Adams-Greenly & Moynihan, 1983; Koocher, 1974; Salladay & Royal, 1981; Worden, 1996). There seems to be little reason to change this policy.

In sum, the evidence from both studies and clinical experience in relation to terminal illness and the impending death of a family member seems to be in favour of telling the truth. The more family members are able to communicate with one another, to share information, and to share in decision-making, the greater the likelihood of an effective adjustment during the post death period (Cohen, Dizenhuz, & Winget, 1977).

Traumatic events and deaths

The situation within the trauma field echoes the situation from the illness and expected bereavement area. Clinicians and researchers in the trauma field often find that adults underestimate children's reactions (cf. McFarlane, 1987; Yule 1999), and that children can be poorly informed. Thus it is advocated that a good understanding of how children understand and react to a situation or event is only achieved when information is solicited directly from the child about what they know and how they experienced the situation. Some children find that parents simply do not want to talk about the event. It is therefore no surprise that studies show that children and adolescents often feel that parents do not understand the impact or long lasting nature of an event's effect on them (Dyregrov, Gjestad, & Raundalen, in press; Stallard & Law, 1994). It also causes pressure on children to appear well and keep their distress to themselves.

However, it is not only that facts are kept from children, but also that children and adolescents may have to protect their parents by not discussing a traumatic event, because this may make the parents upset. Stallard and Law (1994) report that this was common in adolescents following a road traffic accident. Dyregrov et al. (in press) found the same in children who witnessed a tragic war event (bombing of a shelter in Baghdad during the Gulf war), and Yule and Williams (1990) report how children who survived the Herald of Free Enterprise ferry disaster were unwilling to describe their innermost thoughts in front of their parents for fear of distressing them further.

Some years ago I became part of such a collusion. A person was held hostage and his life threatened by a man who had murdered several people. I was brought in to assist him and his co-workers. The event received major media coverage including a picture of the murderer. Two years later the family contacted me to help their 13-year-old son, who had developed a fear of being alone in their house, even during daytime. It turned out that he had a fantasy where he believed the murderer was inside the house, or in the process of breaking into the house. We asked him how he learned about the event; he said that he was rushed to his grandfather while his mother drove to the father's place of work. It took 2 hours before she returned and told him what had happened. When asked what he thought had happened when his mother rushed off, he said that he believed his father was dead. He lived with this fear for 2 hours and it had continued in a different form afterwards. I committed the mistake of not involving him in the follow-up, or second best, not using enough time to educate the parents on how an 11-year-old boy could react to such an experience. This event was not talked about in the family, but the boy observed how the father started to lock the door and draw the curtains. Having seen the picture in the paper and read the stories, without his parent's knowledge, his fear increased and gradually made him incapable of spending any time alone in the house. Eye

Movement Desensitisation and Reprocessing (EMDR, see Shapiro 1995) helped to take the charge away from his fantasy picture of the murderer, and gradual exposure combined with relaxation and coping statements increased his ability to be alone in the house. If this event had been discussed in the family context in a thorough way when it happened and the communication lines had been kept open afterwards, the ensuing problems may well have been prevented.

As with adults, the situation for non-severely injured survivors from accidents may be especially difficult. They also may be given little opportunity to discuss feelings, and they early on experience that enforced normality is imposed on them, as found after road traffic accidents (Di Gallo, Barton, & Parry-Jones, 1997). Children are often told that they have been fortunate and that their condition could have been worse.

Almqvist and Broberg (1997) have provided a deeper analysis of some of the denial mechanisms used in families of traumatised pre-school children following organised violence and illustrate the reciprocal aspects of these mechanisms. Parents may continue to remain silent about traumatic events because it would remind both parent and child of what happened, and parents would again be faced with a sense of having failed to fulfil their role. The child has a need to deny his parents' failure, since their inability to protect him represents a threat to his psychological development. Almqvist and Broberg (1997) also describe how the strategy of silence is used to protect the individual and his/her family against shameful traumatic events by not speaking and not recalling. Such mutual protection and desire not to distress each other has also been registered following road traffic injuries (Di Gallo et al., 1997).

Ways of exclusion

Following traumatic situations there are a variety of ways in which adults may non-communicate or exclude children from learning all there is to know about a loss or traumatic event. This can be done by:

- Providing wrong information
- Withholding information about the event
- Not relating new facts as more information become available
- Not explaining certain facts
- Not answering children's questions about an event
- Hiding feelings or not explaining feelings for children
- Not talking about or signalling to the child that they should not bring up the event in conversations
- Pressure to exclude feelings from consciousness
- Preventing children from meeting people who can relate facts
- Excluding children from rituals and (re)visiting the scene of the event

Although the situations mentioned above seem very straightforward, the processes can be subtle and hidden. Years ago John Bowlby (1979) integrated cognitive psychology with his vast knowledge of human nature in a superbly written paper entitled 'On knowing what you are not supposed to know and feeling what you are not supposed to feel'. As Bowlby (1979) points out, there are situations where the child's private world of feeling has to be shut out more than facts, i.e., when the child is explicitly told or let to know that it is not appropriate to cry, feel sad, or angry and where pressure is put on the child to exclude feelings from consciousness. Impressions, scenes and experiences, although apparently forgotten, can continue to influence thought, feeling and action. Children observe and learn from parents' concrete acts, lack of acts, verbal and non-verbal messages, mental or emotional presence, punishment and recognition.

When a traumatic event or facts related to the event are never talked about or treated as if it never happened, the integration of the experience will be hampered. The child will doubt his or her own experience, or that it ever took place. A child who understands that something is not to be talked about will of course refrain from asking questions. Unfortunately, adults may take this as a sign that he or she has forgotten what happened, while the child may continue to think or fantasise about it. In Kranzler, Shaffer, Wasserman and Davies' study (1990) of children facing parental death, they found that the 3- and 4-year-old boys who were least able to discuss sad feelings in connection with losing a parent were the most symptomatic group. How parents model emotional expression and respond to children's distress is a key mediator of children's responses. In my clinical practice I see many young adults who have lost a parent in childhood, and they very often comment on how, in many ways, they

feel they lost both parents. The family atmosphere is predictive of grief and PTSD problems in children, with a depressive or irritable atmosphere predicting more symptoms (Green, Korol, Lindy, Gleser, & Kramer, 1991).

There is increasing evidence that creating a family climate where children can talk about emotion early in life contributes to their later understanding of others' emotions (Dunn, Brown, & Beardsall, 1991). Of course, talking about emotions will probably be related to talking about other aspects of events in children's lives, such as the causal content and meaningful aspects, in sum contributing to a child's understanding of the outer world and the events that happen to him/her.

When facts about traumatic events or an impending death are hidden or kept from children, or discussion avoided, it is often based on the wrongful assumption that children cannot understand, cannot bear to talk about it, or that it in some other way will be harmful to them. There does not seem to be any truth to this fear. The relatively new concept of family resilience (Hawley & DeHaan, 1996; Walsh, 1996) in many ways encompasses the family's capacity to share and acknowledge adverse family events together, with open communication to share the experience. Our clinical challenge is to foster this development in families in the midst of trauma and crisis. Walsh (1996) argues for developing relational resilience, to help families deepen their bonds and confidence when pulling together through a crisis.

Family secrets

Family secrets can create walls of silence within the family, walls that are difficult to tear down when solidified over time. The consequences of family secrets in general are described by Brown-Smith (1998). When facts about a trauma are hidden from children, this can greatly affect their future trust in adults. No more tragic is this than in cases of suicide where children are told that a sibling or a parent died of a heart failure or another less stigmatising cause, and then they learn the truth from their social network or they are finally told the truth later in life. Persons of authority can also create this lack of trust in adults:

> In a family with a 7-year-old boy and a 9-year-old girl, the father committed suicide by shooting himself in the stomach. The mother was away for the weekend and the father had placed the children in his sister's care when he took his life. When I came to visit the mother and children on the second day after this had taken place I was met by the mother downstairs outside their apartment block. She said that the children did not know that it was a suicide but had been told by a priest that the gun accidentally had gone off. She wanted us to tell them the truth, as their nieces already knew what happened. We quickly discussed how to tell them, and when we sat down with them the mother told them in a very sensitive and straightforward way what had happened. 'Then the priest lied', the girl exclaimed. We tried to explain how he had wanted the mother to be present when the children were told, but the girl cut us short by saying: 'I looked him in the eyes and asked him "Are you telling the truth?" and he answered "Yes". He lied'. We had to agree with that. The girl has been very distrusting of adults since this happened.

From my clinical experience I have sensed that communicating the facts following a parent's or sibling's suicide is especially difficult. Bowlby (1979) relates a report by Kane and Fast who studied 45 children aged 4-14 years. They had all lost their parents through suicide and all had become psychiatrically disturbed. The suicide resulted in what the authors called grave distortion of the communications between parent and child. About 25% of the children had personally witnessed some aspect of the parent's death. Following this they had been subjected to pressure from the surviving parent to believe that they were mistaken in what they had seen or heard, and that the death had not been due to suicide but to some illness or accident. When a child described what he/she had seen, this was discredited by the surviving parent either by ridicule or by insisting that the child was confused by what he/she had seen on television or by some bad dream he/she had had. Confusion was added too by the child hearing several different stories about the death from different people or even from the surviving parent. Kane and Fast (reported in Bowlby, 1979) concluded that the children's psychological problems seemed directly traceable to their having been exposed to situations of these kinds. The problems they suffered included chronic distrust of other people, inhibition of their curiosity,

distrust of their own senses and a tendency to find everything unreal.

The tendency to 'protect' by moving around the truth is strong, and many 'family secrets' are formed around such traumatic deaths. Many of the parents who contact our centre want advice on how to tell the truth, as they cannot face founding their future relationship with their children on a lie, a white lie or a half-truth. We do not know, however, whether children who only much later learned the truth about a family member's mode of death have fared worse that those who were given the true facts at an early stage.

The scarcity of information available to children gives free rein to the child's misconceptions and cognitive distortions, and without adequate parental communication and balance, fantasies are harboured. But even more tragic, secrets make children confused and they can begin to mistrust their own perceptions. Secrecy may also lead to the formation of secret alliances within the family, especially when some siblings know while others do not. Difficult cognitive processes develop as the children have to learn who they can talk to. Problem solving is more difficult when information feedback mechanisms are restricted in the family. But secrets can also be of a different nature. In a study we are currently undertaking with bereaved families after the suicide of a young person, we have interviewed several adolescents/young adult siblings who 'know' about aspects surrounding their sibling's death (i.e. previous attempts unknown to parents) that have not been communicated to the parents. Parents cannot understand why their child committed suicide, and siblings cannot share their secrets.

Children who do not want to talk

Although children may be informed about trauma, there may be factors working to exclude this information from consciousness. Children can avoid the pain associated with thinking about a trauma by trying to suppress distressing thoughts. Unfortunately, this strategy can have the paradoxical result that they have more intrusive thoughts and imagery than those who allow themselves to remember and process their experience. These children run the risk of increased symptoms of PTSD (Aaron, Zaglul, & Emery, 1999). Children who have a mother or father who has cancer and avoid thoughts about their parent's disease experience greater symptoms of anxiety and depression (Compas, Worsham, Ey, & Howell, 1996). Compas and co-workers (1996) also found that the more serious the cancer, the more children tried to avoid it. However, these efforts were ineffective and associated with increased distress.

Although the emphasis here has been on adults refraining from including children in conversations, children and adolescents often do not want to talk about a loss or traumatic event. There can be different reasons for this, and as adults we have to respect their reasons while at the same time providing the climate and situations in which they feel freer to talk. I vividly remember a family the police urged me to see. Although there was a 2-hour drive to where they lived, I agreed to see them because there had been a total communication breakdown in this family. I came there one week following the suicide/accidental drowning of a 19-year-old son. This was a family where the mother talked, the father never talked, and the 15 year-old daughter took after the father. 'I am too old to learn to talk about feelings', was how he met me. The daughter refused to be part of family sessions, but eventually sought out a special education teacher that she trusted. To her she could come to talk, but only when she was allowed to bring her best friend. She knew that her mother was seeing me, and the teacher was allowed to pass on questions to me that I could ask her mother. One thing she was very afraid of was that her mother would also commit suicide, because she had seen her mother stare into the water at one point. When there is a communication breakdown like this, it is extremely difficult to handle a traumatic loss within the family. This girl is now around 26 years old. One wonders how she and others who come from families with a similar communication climate will tackle communication when they establish families of their own.

Another factor that complicates the situation for children is the fact that they, as adults, commonly react with dissociative adaptations when feeling immobile, helpless and powerless. It is very easy for adults to misunderstand children's unattached, nonreactive behaviours as 'not being affected' rather as a trauma-adaptive or surrender response (Perry, Pollard, Blakey, Baker, & Vigilante, 1995). Perry and co-workers (1995) called it an ultimate irony 'that at the time when the human mind is most vulnerable to the effects of

trauma - during infancy and childhood - adults generally presume the most resilience' (p.272). If this reaction is taken as a token of lack of interest, children will not receive the information necessary to integrate the traumatic event into their cognitive structures.

The younger the child the more he or she depends on adults for information about an event. Young children have less knowledge and understanding of life to help them integrate what happens to or around them and thus may make wrong inferences and assumptions about traumatic events, leading to confusion and misunderstanding. Our task and challenge in helping children is not only to try to prevent adults from hiding facts, but also to help to sustain open communication about events over time. Younger children cannot control this by themselves as older children can; they have to rely on adults for a facilitative processing environment.

Sometimes children, especially adolescents, do not want to talk about a loss or trauma. I think it is important that we understand that there can be good reasons for this. If the adolescent is functioning well in school, does not isolate him/herself from others, and does not change his/her behaviour in a dramatic way, I think we should respect this. Parents can be informed about this to lessen their anxiety as well as taught how to create a good communication climate or use good opportunities to facilitate conversations about a loss or trauma.

If we consider what children want when it comes to receiving information about traumatic events we lack solid research. From a separate area, however, Dyregrov and Raundalen (1997) gathered some interesting information related to this subject. They conducted a study of Bosnian families regarding their war experiences and the decision to return to Bosnia. Both children and adolescents were very clear that they wanted to be included in discussions and receive information. The researchers found something intriguing, however. Children and adolescents, regardless of age (when over 6 years), wanted those of their own age and older children to be included, while they excluded those who were younger. So, a 6-year-old did not want younger children to be included, and the same was true for a 12-year-old. And more, they wanted to exclude them for the same reasons that adults want to exclude children: they said they would not be able to understand the information, it would make them afraid, and therefore they should be shielded from this information.

Including children in rituals and confronting events

Several authors (Dyregrov, 1996; Eth & Pynoos, 1994; Worden, 1996) have recommended that children should be included in rituals following the death of a family member or friend. The rituals may include viewing the body and participating in the funeral. Currently, it is hard to find anyone who recommends that children should be kept out of these activities; ritualisation is used more and more within the school community, kindergartens and other social gatherings following traumatic losses. Adolescents also use spontaneous rituals in ways that show us that they have an important purpose for them. The reasons for including children usually have been that they help the child comprehend what has happened, that the event becomes more real, and that it facilitates children's processing of the death. When including children in the rituals, several factors are considered important: i.e., the child's age, relationship to the death, the degree of physical injury of the dead person, etc.

Studies from the 1970s about children attending their parent's funerals have not been consistent. Some reports indicated that children who did not participate in funeral activities had a more difficult time accepting the death (Bowlby, 1963; Furman, 1970; Grollman, 1967), while other reports indicated that children developed psychiatric symptoms as a result of attending (Furman, 1974, Schoewalter, 1976). However, the research methodology was inadequate, often lacking control groups, and the reports provided little systematic information.

During the 1980s some studies assessed the impact of children viewing the body and attending the funeral. McCown (1984) studied the funeral attendance of 65 boys and girls aged 4-16 (33 males and 32 females) following the death of a sibling. Mothers of these children were interviewed 2 to 12 months after the death. In addition, the Child Behavior Checklist (CBCL) developed by Aschenbach and Edelbrock was used as a standardised measure. Children themselves were not interviewed. The study found higher behaviour problem scores among those who attended the funerals than those who did not. Females showed significantly more behaviour problems in comparison to norms, while males did not, and in particular younger children (4-7 years old)

evidenced problems. In McCown's study the norm was for children to attend (72%) and parents in the study did not regret the decision to include children. The authors at this time, 1984, state that none of the current literature suggests that parents insist or force a child to attend; rather, the child should share in the decision-making and be allowed to attend. The authors state that the study does not show cause and effect. McCown concludes that supportive measures might include special preparation and help in understanding and interpreting the meaning of the ritual event and experience. She also highlights the need for an adult who is emotionally comfortable with the child to act as a support person during the funeral proceedings. McCown also writes about how parents indicated that the issue of cremation was awkward to explain to children, and painful both for parents and children to share.

Weller, Weller, Fristad, Cain and Bowes (1988) studied the effect of funeral attendance on 38 children from 26 families (46% of the families that met inclusion criteria) who had lost a parent. In this study the child was evaluated independently, as well as by the parents. Almost all (92%) of the children attended their parent's funeral. Most parents and children (76%) described the child's reaction as controlled i.e., little or no crying. Atypical reactions at the funeral included 'withdrawn or passive' or 'extremely upset'. The agreement between children and parents on who evidenced such reactions was low. Four factors were associated with children who had atypical reactions: having helped with funeral arrangements; having gone to funeral arrangements despite not wanting to go; having known someone who died before; and, believing that death meant the parent 'was buried'. When psychiatric status was assessed 2 months post death, the attendees and non-attendees or those with an atypical reaction and those without, did not differ significantly in depressive, anxiety, or other psychiatric symptomatology as rated by the child or parent.

In the 1990s only a few studies have addressed the issue of children and funerals. In a prospective study of acute bereavement responses in pre-school children, Kranzler et al. (1990) found that those who attended their parent's funeral were significantly less anxious than those who did not. However, the authors think this is most likely due to parental disturbance, as parents of children who did not attend the funeral tended to be more symptomatic themselves, rather than a direct effect of not attending the funeral. Saler and Skolnick (1992), who studied adults who experienced a childhood parental death, found that those who reported less opportunity for participation in activities such as funeral-related events had higher rates of overall depression and were more prone to guilty self-reproach.

Silverman and Worden (1992) studied 120 children who had lost a parent. Almost everyone (95%) attended the funeral, although nine children did not see the actual burial as the parents felt it might be too upsetting for them. There had been little discussion about whether or not to include the children. The majority (77.6%) saw the body after the death. When asked about the funeral 4 months after the death, many of the parents had difficulty recalling how they involved the children, and smaller children found it difficult to provide many details about the funeral. Around the first anniversary, when the children were asked about how they felt about attending the funeral, they were all pleased that they had gone but did not elaborate. In conclusion, Silverman and Worden state that they learned that the children had similar needs to those of adults. They mention how inclusion provided an opportunity to show respect and say good-bye and so to acknowledge the death. Inclusion also gave the children a feeling of being consulted and supported by their families. The authors link this to other data in their Child Bereavement Study (Silverman, Nickman, & Worden, 1992) where they found that children do not detach from the deceased but find ways of carrying an inner representation of the deceased with them. Visiting the cemetery is one way of actively seeking a place where they can 'find' the deceased, and thus it is important to allow children inclusion in these ritual visits. However, the notion that children construct an inner representation of the dead person also increases the burden on adults. To help a child in this process, we need to be able to honour, remember, talk about and include children in conversations about the bereaved.

In his book about the Child Bereavement Study, Worden (1996) reports that having no preparation for the funeral was one of the strong predictors that a child would be found at risk 2 years later. The children who were not prepared showed disturbed behaviour, low self-esteem, and low self-efficacy 2 years after the death of the parent, as well as experiencing more difficulty talking about the

dead parent. Those most unlikely to receive preparatory information tended to be younger children who had lost a mother. Lack of preparation is usually related to the dysfunction of the surviving parent, a factor found to be one of the strongest mediators affecting the course and outcome of the child's bereavement. Worden also found that children with a more mature understanding of death in the early months were those who had attended the funeral and had gone to the gravesite at some point during the first year. Based on this study, Worden recommends including children in funeral planning and in the funeral itself. Over the age of 5 children should be given the opportunity to decide whether or not they want to attend, but it should be an informed decision. Preparation is required to make it an optimal experience.

Traumatic events often include what can be called confronting behaviours in addition to seeing dead bodies, i.e., visiting the scene of events. Although sparse, research shows little evidence of any deleterious effects of participating in confronting behaviours (Milgram & Toubiana, 1996). Milgram and Toubiana (1996) studied the reactions of 675 7th graders who were grieving the death of 19 and injury of 14 fellow students. They looked at different confronting behaviours such as talking about the event, watching or listening to TV/radio, attending funerals, visiting bereaved families and participating in memorial services at school, and found that although most children could have engaged in the more intense, direct confronting behaviours (e.g., attending the funerals or visiting families of deceased or injured children), only a minority did so. Those who did participate were those who had suffered the greatest personal loss and consequently were most upset. This means that most children found it difficult to participate in these activities or were less motivated to do so, while commitment to their friends overrode the avoidant tendencies in those who had suffered more personal loss.

Winje and Ulvik (1995) investigated families following a school bus disaster where 12 children and 4 adults died. Family members found that a confronting-crisis intervention service, that included visiting the accident site, viewing the dead body, and meeting the pathologist, had not been too stressful for the relatives and they did not regret their participation. When used early following traumatic events, the confronting approach hopefully may prevent unsuccessful avoidant activity, which often characterises chronic emotional processing (Joseph et al., 1996). Early intervention involving children in confronting activities in many respects uses some of the same principles believed to be at work in Cognitive Behavioural Therapy (CBT) that has proved helpful when children develop posttraumatic stress disorder (March, Amaya-Jackson, Murray, & Schulte, 1998; Saigh, Yule, & Inamdar, 1996). Emphasis here is most often on exposure-based paradigms, providing psychoeducational information and constructing a narrative.

Conclusion regarding children and rituals

There is little to suggest that taking part in the funeral harms children. However, lack of preparation for the funeral is associated with more risk of problems later. In a study of schoolmates following several suicides in Northern Finland, Poijula, Wahlberg, Dyregrov and Jokelainen (2001) found that those who participated in the funeral were at an increased risk of developing PTSD (measured by the IES) and high intensity grief (measured by the Hogan Grief Inventory). Partly, this can be explained by the fact that the students who took part in the funeral felt more close to those who committed suicide, but this does not fully explain the results. Again, it might be the lack of preparation of the students for this emotional event that has the potential to make it harmful.

It seems that when advocating children's right to be included in ritual practises it is of utmost importance that they are well prepared for the different aspects of the ritual, have good adult support throughout the ritual, and are allowed to ask questions and express their thoughts and emotions following their participation. Unfortunately, many health professionals just focus on the recommendation that children should be included, without giving proper attention to the preparation, support and follow-up of ritual participation. Let an example illustrate this:

> A 12-year-old boy lost his brother in a tragic accident. He saw his brother in the coffin but started having intrusive images of this situation during the day and especially while trying to sleep at night. He started having severe sleep problems, and his mother contacted us for help. It turned out that he was not at all prepared for the sight of his brother. He looked very

different from usual, as they had combed his hair backwards, probably to cover extensive head injury, while he always had it to the side. In addition, his mouth was partly open giving him a peculiar look. The problem was quickly solved by Eye Movement Desensitisation and Reprocessing.

This author has treated several similar cases where children developed problems related to viewing a dead family member. The problem usually originates in an aspect of the sensory experience that they were unprepared for, be it that the body was so cold upon touching, there was a certain smell in the room or, most commonly, there was something about the visual experience that burned itself into their memory. Sometimes children have been unprepared for the strong emotions that adults evidence: 'I never thought I would see my parents like that. I have always looked upon them as the strong ones and here I had to support them' (16-year-old daughter). We have to make sure that children are well prepared for the sensory exposure involved in these rituals, and for the emotional reactions that can be expected in others and themselves.

Another consequence is that it may be ill advised in some situations to allow all classmates or distant friends to view the body, when the body, for example, has been disfigured or looks very different. Here a balance must be struck between what is gained in reducing the unreality and the other cognitive or emotional gains that may result from participating in the ritual versus the possibility of traumatisation from the sensory input. There is often a delicate balance between what is therapeutic or helpful and what may be traumatising.

Taking part in confronting behaviours seem to be helpful for children in providing a chance to make losses real or in counteracting avoidant behaviours. Johnson and Foley (1984) have stated that memory is improved when the original physical or cognitive context is reinstated, and returning to the scene of a traumatic event could thus serve as a memory anchor in reconstructing and making an event whole. However, in this area also, one should tread cautiously and await more research.

How can we improve help in this area?

Based on this review the following recommendations are made:

1. There is a need to improve families' awareness about the necessity to communicate openly and directly with children. In particular, we have to educate adults about the long-lasting effect trauma can have on children and adolescents, and thus their potential need to talk about the event or its consequences long after it has happened. It is, however, not enough to point out the need for open and honest communication; families need practical suggestions and role models for how they can communicate about traumatic events, and the family changes that can develop following such events.

   Early intervention in families who experience trauma should include helping them to develop constructive ways of communicating openly and honestly about what happened and its effects on the family. By providing a model for emphatic listening, ways of asking questions, clarifying affects, allowing children to have their say, providing feedback, etc., a caring, supportive climate within the family can be established. By making the discussion of communication, role distribution, emotional gratification, and conflict part of the follow-up sessions, it is possible to work directly to establish a favourable climate for recovery from loss or trauma. By regularly having family meetings, at increasingly spaced intervals over an extended period of time, this supportive communication climate can be sustained.
2. We need to educate adults on children's need to make sense of events, by creating or constructing a narrative or total picture of what happened, even when children are quite small (Osofsky, Cohen, & Drell, 1995). Although the word debriefing has mistakenly been used to describe all assistance in this regard, having a chance to describe what happened, the thoughts related to what happened, understanding what caused an event and what they did to survive it, as well as giving words or another form of expression (i.e., drawing) to the different sensory impressions experienced during the traumatic event, and the reactions that ensued, is needed and recommended to prevent the event from having unnecessary consequences (see Yule & Udwin, 1991; Stallard & Law, 1993). If parents or other children or

adolescents were part of the event, this detailed review should be done with all persons involved in the event present, as this increases the chance of getting a full picture of what happened.

A caution should be raised regarding individuals who are naturally disposed towards emotional dissociation, if the research results for adults is also applicable to children. In a study of bereaved adults, Bonanno, Keltner, Holen and Horowitz (1995) states that these people should be encouraged to describe their thoughts, feelings and memories (of the deceased) at whatever pace they feel comfortable. Such repressors are able to avoid the experience of negative affect, although they experience a larger physical toll over time. However, they do appear to have poorer memory for past negative emotional experiences (Holtgraves & Hall, 1995). The problem will be to discriminate early on as to who belongs to this group, without asking them to fill in questionnaires at a time when it might be ethically questionable. Currently, it seems most viable to continue to provide everyone with a good opportunity to organise the event through formulating a narrative early after a traumatic event or bereavement.

3. We need to talk to children directly about traumatic events. This is the only way to ensure that we understand what children have experienced, how they have understood their experience and the facts they are missing to be able to construct a full narrative of what happened. We also need to make sure that children are asked, or that we listen carefully, about their understanding of 'why' something happened. Cause and meaning are important aspects of the reality construction that takes place following adverse events, and this construction has an important impact on the development of basic assumptions throughout childhood.
4. When telling the truth we do not need to hit the child over the head with facts. While the focus is on open, truthful and direct information, we need not give them all details, i.e., about parental disputes that preceded a suicide, how the brain matter was spread near the head, etc. If children ask about details, however, I suggest we tell the truth without deliberating on the grotesque or scary details. Telling the truth is a good strategy even when it comes to deeper explanations of the background to a tragic event, i.e. why a person committed suicide. The following example illustrates one way of telling children about this:

   > 'Mama was sad from before you were born. She had such difficult and painful thoughts in her head that she eventually did not want to live any longer. She tried as well as she could to live with these painful thoughts, but they became too strong for her, and then she started thinking that to die was the only way she could get rid of these thoughts. It was as if she had a disease in her thoughts and more and more she convinced herself that it would be best for all that she died because she also caused pain in others. This does not mean that you or your dad or others you love will want to die if they have a painful thought. There was something inside your mama's thoughts that was ill and that made her not think clearly and then she killed herself.' (Partly based on Müller, 1997).

5. Trauma will often affect the family system in different ways, and family intervention will need to explain family dynamics to children and adults alike, in addition to providing information on normal trauma reactions. The therapeutic tasks of preparation, explanation, interpretation and teaching are activities that help foster the intra-family environment and can prevent the development of blocks to recovery. For example, the child and the family need to be prepared for the sights, smells, and sounds of the intensive care or trauma unit (Di Gallo et al., 1997; Dyregrov, Raundalen, & Reppesgård Grung, 1996; Cope & Wolfson, 1994), as well as how their injured or ill family member looks.
6. While there is a wealth of studies documenting the importance of preparing children and adults for surgery (cf. Johnston & Vögele, 1993), there is little about the importance of providing children and adolescents with a map of the terrain they are going to walk in following the experience of traumatic events. Stallard and Law (1994) report how adolescents received no information on psychological help available

following a road traffic accident. I foresee that trauma intervention in the future will be much more specific in providing children and adolescents with advice on how to handle the after-effects of traumatic events. This information will have to be provided both verbally and in written form.

7. We need to reconsider how we include children in rituals. Although clinical experience and empirical research support including children in such activities, we do need to put more emphasis on preparing children for and helping them through such activities. In addition, we may have to rethink how wide the circle should be for inclusion, i.e., whether school or more distant friends should also see the body.

Conclusion

All in all, arguments seem to favour including children in conversations and sharing information and facts. But are there situations where shielding may be correct? Adults have, and always will, simplify the world for children. We will go on shielding them from the fears we have as adults. If I work with a child who has lost his or her mother, I will not describe to the child the different risks there are that their father might die in a traffic accident or develop a serious illness. Parents and professionals will continue to keep some aspects of adult reality away from children. We will not overstimulate them with all we know, nor will we tell them about or share all our fears, but we should advise parents to share important facts, communicate important information, and openly talk about the emotions connected with serious illness, death and trauma.

Looking back over the last 20 years I can see how much we have increased our knowledge about trauma and loss in children, yet I am sure that when in 2020 we take another look back we will think, 'How little we knew'. Much of what we believe is good practice today will be revised. Twenty years ago siblings were not allowed into our Neonatal Intensive Care Unit, and they were seldom allowed to see their dead baby sister or brother. This is considered outdated today. What in today's practises will we consider as outdated some years from now? It is very doubtful, however, that we will look back and say that it was wrong to talk directly and openly to children about painful or difficult things.

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