These items are to be used only if facilities exist for intubation and assisted ventilation (e.g. on a high-dependency or intensive-care unit).

**Trauma**
- Hard cervical collars (adult short and regular, paediatric) and sandbags/foam blocks.
- Peripheral vascular cannulae, (18–25G) three-way taps and syringes.
- Scalpels, sutures, needle holders and scissors.
- Splints.
- Chest drains in a range of sizes (12, 18, 20, 22, 28, 32 Ch).
- Dissecting forceps.
- Underwater drainage system, or flap valves.
- Nasogastric tubes in a range of sizes (4, 5, 6.5, 8, 10 Fr).

**Drugs, fluids, etc.**
- Oxygen supply.
- Ringer-lactate or Hartmann’s solution or 0.9% saline, vials and bags or bottles.
- Colloid (e.g. 4.5% albumin, gelatine, hetastarch).
- Adrenaline, 0.1% and 1 mg/mL (1 in 1000).
- Amiodarone, 30 mg/mL.
- Glucose, 10%, 25% and 50%.
- Water for injection.
- Normal saline for injection.
- Mannitol, 20% and/or saline, 2.7% (or 3%).
- Diazepam, rectal solution.
- Lorazepam, diazepam or midazolam (can be used as buccal or IV treatment).
- Phenytoin.
- Phenobarbitone.
- Atropine.
- Sodium bicarbonate.
- Calcium chloride.
- Magnesium sulphate.
- Broad-spectrum antibiotic (e.g. cefotaxime, ceftriaxone, gentamicin).
- Penicillins: penicillin G, amoxicillin, flucloxacillin.
- Metronidazole.
- Hydralazine.
- Misoprostol.
- Quinine.
- Morphine/diamorphine.
- Naloxone.
- Insulin.
- Local anaesthetic (e.g. lignocaine) and general (e.g. ketamine) anaesthetic agents.*
- Paralysing agents.*
- Skin cleansers solution (e.g. chlorhexidine, alcohol, iodine).
- Vaginal antiseptic lotion (Hibitane).
- Steroids (prednisolone, hydrocortisone).
- Salbutamol nebules, inhaler and IV solution.
- Aminophylline.
- Furosemide.

**Monitoring and other equipment**
- Pulse oximeters.
- ECG monitors including one with defibrillator with paediatric pads or an automatic external defibrillator (AED).
- Sphygmomanometer or blood pressure oscillometer.
- Thermometers (including low-reading thermometer).
- Nebuliser.
- Large-volume spacers.
- Blood/urine glucose testing kits.
- Urine protein testing sticks.
- Urinary catheters (silicon, rubber or soft feeding tubes) of various sizes (12–30 Fr).

These items are to be used only if facilities and skills exist for intubation and assisted ventilation.

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1.23 Grief and loss in societies affected by conflict and disaster

**Introduction**

Why do we grieve? Wouldn’t life be much simpler if we did not experience all those painful emotions that occur when someone we love dies? Perhaps so – no weeping and wailing, no stoical silence, no anger and irritation, no smiling and carrying on as usual, no sudden flood of pain and memories to overwhelm and paralyse us, no rush of tears when we hear a familiar tune. That sounds much easier. The trouble is that grief is actually the price tag on another emotional experience, without which human life would be quite unbearable. We grieve because we love. Love is the essential emotion that keeps us connected and attached to family and friends and allows us to survive as rather puny animals in a hostile world. If we did not love we could not suffer loss, but neither could we survive in selfish isolation.

This section provides a brief introduction to understanding grief and loss in families living in societies affected by disaster and conflict, and offers some guidance on how to support these families. It will address the following questions:

- What is the impact of loss on individuals and groups in conflict and disaster settings?
- What is grief and how is it related to attachment?
- Is grief an illness?
- How does grief affect our health?
- When is grief abnormal?
- What is mourning and why does it matter?
What is the impact of loss on individuals and groups in conflict and disaster settings?

The central experience for almost all of those living in communities affected by conflict or disaster is loss. Even if no one in your family dies, something will be lost. You may be injured or lose your health. Your home or your school may be destroyed, or the neighbourhood may be swept away. Your friends or work colleagues may be killed or flee. If you flee yourself you will lose everything that made up your world and kept you rooted and connected. As well as these external losses, you may lose aspects of yourself, such as feelings of being safe and in control, and your sense of identity as, for example, a mother, father, schoolchild, farmer or shopkeeper. Some of the possible losses that can be experienced are listed in Table 1.23.1. Their effect can be overwhelming. Understanding how people react to such losses, how to distinguish between normal and abnormal grief, and how to assist in appropriate mourning will be some of the key tasks for healthcare workers in these contexts. It is also essential to understand other psychological reactions, such as post-traumatic stress disorder (PTSD), and set them in context.¹

What is grief and how is it related to attachment?

The ability to form strong relationships with others is necessary for our survival as human beings. We call this ability attachment. The sense of loss that we feel when a loved one is absent leads us to search them out. Attachment is the glue that keeps families and groups connected together. Human beings could not have survived in previous eras if they had not lived in groups that enabled them to feed and shelter themselves. Loss is the sense of sadness, fear and insecurity that we feel when a loved person is absent. It can also be felt in relation to objects and places.

In the 1950s, the World Health Organization (WHO) commissioned John Bowlby to observe what happened to small children when they were separated from their mothers. In Britain in those days, if a child went to hospital for an operation, the parent was not allowed to remain with them. John Bowlby sat watching the infant to see how they reacted, how they adapted to the separation, and how they behaved when the parent returned. He defined a cycle of behaviours that can be observed in any infant who is separated from their mother and then reunited with her.

First there would be a period of loud and angry protest. The child would hope that their cries would bring their mother running back. When this did not happen, a period of despair and withdrawal followed in which the child would cry, not wish to engage with others, and refuse to eat or play. Later the child might appear to ‘adapt’. They would start to eat again, play with other children, make friends with the nurses and appear detached and indifferent to the loss of their mother. Indeed if the parent reappeared at this stage, the child’s first response might be to ignore her, and then if they did engage with her, to be naughty and angry. Only after some time would the original relationship reform and re-engagement occur. Bowlby noted that this attachment/separation behaviour is most visible in children between 6 months and 3 years of age. However, these behaviours can reappear in any individual throughout the life cycle when they are faced with separation from someone they love.

<table>
<thead>
<tr>
<th>Internal losses</th>
<th>External losses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>Family members</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Friends</td>
</tr>
<tr>
<td>Security</td>
<td>Home</td>
</tr>
<tr>
<td>Identity</td>
<td>Community/country</td>
</tr>
<tr>
<td>Self-respect</td>
<td>Work/school</td>
</tr>
<tr>
<td>Belief in the future</td>
<td>Money and other material possessions</td>
</tr>
<tr>
<td>Sense of belonging</td>
<td>Physical health</td>
</tr>
<tr>
<td>Trust</td>
<td>Religion</td>
</tr>
<tr>
<td>The past</td>
<td>Language</td>
</tr>
<tr>
<td>Meaning of life</td>
<td>Familiar life</td>
</tr>
</tbody>
</table>

Attachment behaviour is any form of behaviour that results in a person attaining or maintaining proximity to some clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever a person is frightened, fatigued or sick, and is assuaged by comforting and caregiving. At other times, the behaviour is less in evidence. Nevertheless, for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security and so encourages him to value and continue the relationship. Whilst attachment behaviour is at its most obvious early in childhood, it can be observed throughout the life cycle, especially in emergencies. Since it is seen in virtually all human beings (though in varying patterns), it is regarded as an integral part of human nature and one we share (to a varying extent) with members of other species. The biological function attributed to it is protection. To remain within easy access of a familiar individual known to be ready and willing to come to our aid in an emergency is clearly a good insurance policy—whatever our age.

Bowlby, 1988¹
Many writers have noted the similarity between a child's behaviour after separation from a parent and our reactions to the loss of a loved person who has died. Death reactivates attachment behaviour. Faced with the permanent loss that death represents, we may find ourselves angrily protesting, searching and yearning, trying our best to maintain and hang on to the connection. Or we may experience periods of indifference and denial as a way of avoiding the pain. Many people alternate between periods of acute grieving and yearning and periods of avoidance or detachment. In the past, some authors have argued that these feelings occur in stages. Elisabeth Kubler-Ross constructed a model of bereavement in which the individual was said to progress through the following periods, often cyclically:  
1. Denial  
2. Anger  
3. Bargaining  
4. Depression  
5. Acceptance  

It was suggested that people could become stuck at different stages, and that 'grief work' was necessary to progress through all the stages to recovery. There is now a growing understanding of the enormous variability in our responses to bereavement. How people grieve and how they cope will depend on individual factors such as their temperaments and personality. What were their experiences as a child? Were they loved and securely attached to those who cared for them or were they abused or insecure? This will affect the way that they form relationships with other people, and the way that they experience loss, as will their age, gender, and experience of previous losses. The way that people grieve will also depend on the nature of the loss and how it occurred. Was it sudden or expected? Was it violent, unjust, or part of a massive loss, or did it occur after a prolonged illness? What did the loss mean to the person? Were they thrust into isolation and poverty, or were they possibly liberated from an abusive relationship?  

In all cases, social factors such as cultural and religious beliefs and community and family dynamics will play a role in determining how grief is experienced and expressed. The current social situation will also influence this. Is the family in danger or in flight? What material resources do they have? Do they face legal difficulties because of the loss? Is social support available or are they isolated? The case examples below and the vignettes in the Appendix all illustrate these variations.  

Table 1.23.2 lists the wide variety of emotional, cognitive, behavioural and physiological changes that can occur in response to bereavement. An individual may experience some, all or none of these. The reactions may occur in many different patterns and combinations depending on the factors described above. Some individuals experience few reactions, others more. Some people find that their reactions change over time or occur in varying combinations.  

People may feel anger and sadness at the same time. An anniversary or a particular place may trigger a memory, which reactivates the feelings of grief again, perhaps years after the event, possibly interrupting a long period of acceptance. Some have described grief as a 'relapsing illness'. Stroebe and her colleagues have created a model to show how many people may fluctuate between a 'loss orientation' of yearning and sadness and a 'restoration orientation' of more avoidant states of denial and getting on with things (see Figure 1.23.1).  

Which feelings and behaviours occur, which state dominates and what is regarded as normal for both children and adults will depend very much on how grief is expressed in that culture, by that family and in that individual, as well as on the religious values, temperament and personality of the individual. For example, in Bosnia it is regarded as appropriate for Serbian women to attend the funeral and to display their emotions visibly, keening and weeping. In Bosnia, Muslim culture values a more stoical approach and sees the open display of emotions as inappropriate. In some cultures, for example in parts of South-East Asia, vivid dreams may be regarded as appropriate messages from the dead. In western culture, dreams may be seen as an upsetting form of sleep disturbance. In Kosovar families with whom I have worked, there was often one individual (usually an older adolescent girl), who might cry a great deal, hyperventilate and faint, while the rest of the family remained stoical. The fainting girl might cause concern, but also seemed to play a role in vividly expressing grief for the rest of the family, whose concern for her also acted as a form of distraction from the loss (see Appendix, Vignette 2).  

Is grief an illness?  

Acute grief may be painful and feel like an illness, but it should be understood, in all its variety, as a normal reaction to loss. Some combinations of reactions do appear to mimic certain acute mental illnesses. For example, loss of appetite combined with sleep disturbance, sadness, ruminations and various somatic complaints appears similar to clinical depression. However, that diagnosis should not be made if someone has suffered an acute loss. Some individuals may adopt the behaviours of the deceased, dress in their clothes, act strangely or hear their voice, see them and talk to them. Again this should not be regarded as psychotic behaviour, but rather as a possible manifestation of acute grief. Or there may be flashbacks, vivid intrusive thoughts and dreams of the deceased, and the individual may be anxious and aroused, similar to those with PTSD. None of these reactions are necessarily pathological.
and widowers. Therefore there is some basis for the saying in specific groups, particularly mothers who have lost a child.

The mortality risk is higher in the earliest months and circumstances, a reduction in material resources, and lack of factors, including loneliness, changes in social circumstances, a reduction in material resources, and lack of care. The mortality risk is higher in the earliest months and in specific groups, namely mothers who have lost a child and widowers. Therefore there is some basis for the saying that you can die of a "broken heart".

When is grief abnormal?
The decision as to what is abnormal and inappropriate grief will depend on an understanding of the individual, the family, the culture and the wider context. You cannot decide what is abnormal without this cultural and personal knowledge. The community and family may be able to tell when they feel that the grief is too intense, too long or unusual in its manifestations. The new diagnostic formulations, DSM-V and ICD-11, that psychiatrists are using to categorise mental disorders are considering formulations for prolonged or complicated grief. For example, the suggested definition of prolonged grief disorder in ICD-11 is as follows:

"Prolonged grief disorder is a disturbance in which, following the death of a person close to the bereaved, there is persistent and pervasive yearning or longing for the deceased, or a persistent preoccupation with the deceased that extends beyond 6 months after the loss and that is sufficiently severe to cause significant impairment in the person's functioning. The response can also be characterised by difficulty accepting the death, feeling one has lost a part of one's self, anger about the loss, guilt, or difficulty in engaging with social or other activities. The persistent grief response goes far beyond expected social or cultural norms, and depends on cultural and contextual factors.'

What is mourning and why does it matter?
Mourning refers to the culturally appropriate processes that help people to pass through grief. All societies and cultures mourn, but they do so in different ways. Mourning processes usually include acknowledgement and acceptance of the death, saying farewell, time periods for grieving, processes for continuing to focus attention on the dead, and processes for moving beyond the loss and forming new attachments. It might be helpful to take a moment to jot down on a sheet of paper the ways in which you mourn the dead in your own culture. Try to answer the following questions:

- How do other people know that someone has died or that you are bereaved?
- What happens at a funeral?
- What are the burial customs?
- What happens to the body?
- Who visits the bereaved?
- What are the different roles, if any, for men and women?
- What do younger and older children do?
- Are there different ceremonies at different time periods after the death to mark different stages of mourning?
- What ways do you use to remember the dead?
- What is the role of the dead person in continuing family life?

Different societies have different time periods set aside for mourning, and different ideas about what is appropriate
behaviour for different family members. They may also have different views on the appropriate role of children in these rituals. Sometimes families may be in conflict over what is appropriate to communicate to children and what is the appropriate way to mourn. This is particularly the case in societies that are in a state of upheaval (see Appendix, Vignette 1).

What happens in situations of massive loss?
Conflict, disaster and displacement disrupt the possibility of appropriate mourning. There may be uncertainty about missing relatives. The body may have been lost, abandoned, treated inappropriately, or buried in a mass grave. During flight it is impossible to carry out the normal mourning rituals. Other processes also occur in large-scale upheavals. For example, in Aceh, Indonesia, after the 2004 Tsunami, people found themselves living in a landscape that had been swept completely clean by the Wave, where every familiar marker had disappeared along with their communities, families and livelihoods. There were no bodies and no places to go to remember the dead. In Haiti, after the earthquake, people camped out among crushed houses that entombed their families. Massive losses that affect whole communities may remove entire social networks of support. Moreover, even in functioning communities, they have the effect of depriv ing each individual of the normal support that they would have received if their loss had been a singular occurrence. Because everyone is affected, few are in the position to play the role of visitor and comforter. There is no one to come round, help the bereaved widow with the childcare and household tasks, arrange the funeral and cook a meal, because everyone who survived is in the same situation. Everyone struggles alone. And the bereaved may become more reticent than usual about their own feelings, not wishing to burden similarly affected neighbours. At the same time, the pain of the loss is amplified by the knowledge that the bereaved person’s loss is one of many in a community. The outside world is focused on the scale of the event: ‘300,000 dead, half a million killed’. Lost within these figures, the individual bereavement becomes insignificant, just one of many thousands, adding to the pain of the survivor.

CASE EXAMPLE: Giving significance to loss
In early 2005 I was working on the East Coast of Sri Lanka after the tsunami. On one occasion, when I was walking along a completely deserted, devastated street, a man came running up to me. I was holding my camera and assumed I might have offended him by taking pictures. ‘No, no,’ he said, ‘please take a picture of this house.’ I looked at the gutted empty building and did as he requested, then turned back. He was near to tears. ‘My mother died here,’ he said. So we sat on the ground and he talked for some time about his mother. I suddenly realised that for this man I was more than just a sympathetic ear, I was the outside world witnessing and memorialising his individual loss. Not just 10,000 dead, but his mother. I was making her significant.

Traumatic experiences, grief and mourning
Traumatic experiences can interfere with mourning. Avoidance that may be protective in helping the bereaved to cope with the memories of a traumatic event may make it difficult for them to mourn their loss because the memories of the lost person are always accompanied by painful memories of the circumstances of the loss, so ‘remembering’ is too painful. In such circumstances, the traumatic symptoms may need treatment before the bereaved person is able to mourn. Table 1.23.3 lists the differences in emotional, cognitive and behavioural reactions that may occur.

Cultural bereavement
The Australian anthropologist and child psychiatrist Maurice Eisenbruch has pulled some of these experiences together in the term ‘cultural bereavement’ to describe the massive losses experienced by refugees and all those displaced by war:

‘Cultural bereavement is the experience of the uprooted person – or group – resulting from loss of social structures, cultural values and self-identity: the person – or group – continues to live in the past, is visited by supernatural forces from the past while asleep or awake, suffers feelings of guilt over abandoning culture or homeland, feels pain if memories of the past begin to fade, but finds constant images of the past (including traumatic images) intruding into daily life, yearns to complete obligations to the dead and feels stricken by anxieties, morbid thoughts and anger that mar the ability to get on with daily life. It is not in itself a disease but an understandable response to catastrophic loss of social structure and culture.’

In his work with Cambodian adolescents, Eisenbruch found that those refugee children who had been encouraged to assimilate rapidly into a new culture suffered more cultural bereavement than those who were encouraged to participate in traditional ceremonies and cultural practices. He believes that the concept allows for a more integrated and culturally sensitive approach to the experience of loss than attempting to classify any disabling symptoms only in terms of pathological categories according to western diagnostic criteria such as PTSD or traumatic bereavement. Disabling symptoms may be best addressed by a combination of restoring appropriate cultural practices and, if necessary, symptomatic relief.

Grief in childhood
The following are some frequently asked questions about children who have suffered a bereavement:

- Do children grieve?
- Are they too young to understand?
- Should we protect them from unpleasantness and distress?
- Will loss in childhood cause later mental illness?

Children’s understanding of and reactions to death
Children’s reactions to death are as variable as those of adults, and any or all of the reactions listed in Table 1.23.2 may occur. The most important point to note is that their understanding of death changes according to their development and life experiences. The following notes are based on western experience, and should be taken as a guide only. Working with victims of conflict and disaster in many low-resource settings has taught me that in many societies, particularly rural ones, children understand death at
Children under 5 years

There is little understanding that death is final. For example, a 4-year-old child in England, having helped to formally bury his dead pet rabbit in the garden, asked if he could now dig it up so that he could have the rabbit back again. Magical thinking results in misconceptions about cause and effect. An egocentric view of the world can lead to feelings of responsibility (e.g. "Mummy won’t come back because I was naughty"). Reactions are similar to those following any separation – the longer the absence, the greater the distress. The death may be followed by detachment, so that the surviving family may think the child does not care about the loss. Regressive behaviour, soiling, bed wetting, clingy behaviour, sleeplessness and minor illnesses can all occur.

Children over 5 years

Children begin to understand that death is irreversible, that certain physical changes occur, and that there is permanent separation. They may still not regard it as something that can affect them. They may continue to have some magical, concrete and egocentric thinking. At this age, children more commonly use concepts of good and bad, they are curious about cause and effect, and are able to articulate concern for others.

There is a desire to stay connected to the dead parent. Many children dream about and talk with the dead parent frequently, feel that the dead parent is watching them, and keep physical objects associated with them. One study found that 43% of children in a large community sample thought about their dead parent on a daily basis 1 year after the death. The reactions were variable. Boys were already learning to suppress their feelings, 91% of the children in the same study cried on the first day, and 50% had transient emotional and behavioural problems. Concentration and school work are also affected, and repetitive play is very common.

### TABLE 1.23.3  Distinguishing between the effects of traumatic events and loss

<table>
<thead>
<tr>
<th>Reactions to loss</th>
<th>Reactions to traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation anxiety</td>
<td>Anxiety about threat presented by traumatic event</td>
</tr>
<tr>
<td>Sadness more than anxiety</td>
<td>Anxiety more than sadness</td>
</tr>
<tr>
<td>Yearning and preoccupation with loss</td>
<td>Fearful, anxiety and preoccupied with traumatic event</td>
</tr>
<tr>
<td>Sense of security intact</td>
<td>Personal sense of safety challenged</td>
</tr>
<tr>
<td>Primary relationships disrupted</td>
<td>Primary relationships intact</td>
</tr>
<tr>
<td>Intrusive memories are images and thoughts of the deceased</td>
<td>Intrusive memories of traumatic event plus re-experiencing accompanying emotions</td>
</tr>
<tr>
<td>Memories are positive and comforting</td>
<td>Uncontrollable intrusions are negative and distressing</td>
</tr>
<tr>
<td>Dream of the dead person is comforting</td>
<td>Nightmares of event are terrifying</td>
</tr>
<tr>
<td>Seeking out reminders of the loved one</td>
<td>Hypervigilant, scanning environment for threat</td>
</tr>
<tr>
<td>Avoidance of reminders of the absence of the loved one (denial)</td>
<td>Avoidance of reminders of threat</td>
</tr>
<tr>
<td>Anger at loss</td>
<td>Irritable, diffuse, unfocused anger and rage</td>
</tr>
<tr>
<td>Guilt about not doing enough</td>
<td>Guilt about surviving</td>
</tr>
<tr>
<td>Mourning as a tribute to the dead person</td>
<td></td>
</tr>
<tr>
<td>Sleep EEG is normal</td>
<td>Increased REM sleep intensity</td>
</tr>
<tr>
<td>Coping involves reconstructing life without the loved one</td>
<td>Coping involves re-establishing a sense of safety</td>
</tr>
<tr>
<td>Recovery: Resolves attachment issues</td>
<td>Recovery: Habituates to fearful responses</td>
</tr>
</tbody>
</table>

Children from 10 years to adolescence

There is a growing understanding of abstract concepts – for example, that death is universal and inevitable and can affect the child or adolescent personally. There is a growing concern with justice and injustice, and an awareness of inconsistencies. The conflict between the desire for autonomy and the need for closeness can be resolved by ‘indifference and detachment’, or by identification and nostalgia. In a group for adolescent refugee boys who had been ‘ethnically cleansed’ from Northern Bosnia (all of them had lost their homes, and some had also lost their family), all of the boys spoke passionately and with great longing about their home towns, describing them as the ‘most beautiful place to live’. Revenge fantasies are not unusual. There are fewer somatic and behavioural problems, and a depressed mood is common. Poor concentration and lack of interest occur at school. The oldest child in the family who has lost a same-sex parent is at greatest risk.

CASE EXAMPLE: The surviving brother

6 is a 13-year-old boy. During a long and brutal war his older brother was killed on the front line. 6 had always been very close to his brother. Three years later he continued to think about him on a daily basis. He visited the grave frequently and watched the video of the funeral once a week. He did not like to sleep alone, and he felt sad much of the time, although he was doing well at school. He talked about his brother a great deal. He wanted to be as much like his brother as possible, whom he believed was one of the bravest and most incorruptible people. He was angry about the peace agreement. He felt that it was unjust and made a mockery of the aims for which his brother fought.

As in adults, the reactions of children to bereavement are enormously variable. Age, personality, culture and family values, and especially the way the parents or surviving caregivers react, will all affect the expression of grief.
Children within one family exposed to the same losses may all handle grief in different ways (see ‘Case example: When to tell the story’, p. 118). And the experience of grief may wax and wane. When discussing grief feelings with children, I sometimes use the image of a wave. (This is obviously inappropriate with children who have either never seen the sea or who have experienced the Tsunami.) I ask them to imagine that they are standing at the edge of the sea and that a big wave comes along and knocks them over. They feel terrible, but manage to struggle to their feet. Then there is a period of calm water before the next wave. This time they are more prepared, so that when the next wave comes it does not knock them over. What will happen over time is that, although the waves never go away completely, the periods of calm sea will grow longer, the waves will get smaller and the child will grow stronger (see Figure 1.23.2).

**Waves of grief. The time intervals between waves get longer, and the waves get smaller.**

### Long-term effects

Many people worry that if children experience the loss of someone significant early in life this will have long-term effects on their mental health. Research evidence suggests that children who suffer an early bereavement do have a higher incidence of psychiatric disorder in later childhood, and that adults who lost a parent in childhood are more vulnerable to psychiatric disorder than the general population, and that adults who lost a parent in childhood are more vulnerable to psychiatric disorder than the general population, and that adults who lost a parent in childhood are more vulnerable to psychiatric disorder than the general population, and that adults who lost a parent in childhood are more vulnerable to psychiatric disorder than the general population, and that adults who lost a parent in childhood are more vulnerable to psychiatric disorder than the general population, and that adults who lost a parent in childhood are more vulnerable to psychiatric disorder than the general population, and that adults who lost a parent in childhood are more vulnerable to psychiatric disorder than the general population, and that adults who lost a parent in childhood are more vulnerable to psychiatric disorder than the general population.

Research has shown that the following life events are most likely to be associated with later mental illness:

- those that require people to undertake a major revision of assumptions about the world
- those that are lasting in their implications
- those that take place over a short period of time without preparation.

A traumatic death can have all of these features. However, there are significant factors that can modify the impact of a bereavement. The child’s long-term mental health also depends on the following:

- the response of the surviving parent or relatives
- the availability of other support
- subsequent life circumstances
- the degree of continuity in the child’s life
- how the loss is viewed by others
- what resources are available.

This list provides an immediate guide to what needs to be done to enhance a child’s resilience and coping in the face of loss. The ‘Case example: Different girls’ from Pakistan illustrates how important these aspects are and what a great difference the behaviour of the surviving relatives can make.

### CASE EXAMPLE: Different girls

After the Pakistan Earthquake in December 2005, I worked with children who had lost their parents. Contrast the experiences of two young teenage girls from the same rural Islamic society, affected by the same terrible event, but living in somewhat different settings with quite different responses from those caring for them. Shamsa was 14 and living with her aunt and uncle and her six younger brothers and sisters in one tent in a displaced persons camp near the town of Balakot. Her village had been completely destroyed and her mother and father had been killed. Shamsa acted as mother to her siblings and helped her aunt to care for her cousins. The aunt and uncle had told the children ‘Your mother is in the village and will come soon.’ Shamsa and her smaller sisters looked ill-kempt and neglected. They cried constantly, which suggested that the comforting lie was not working. They knew that their house had been turned to rubble, so where was their mother now? When I asked Shamsa what she thought, she told me in a whisper that her mother was dead. The aunt and uncle gave me permission to explain to all the children what had actually happened. Their calm reaction suggested that I was confirming something they already knew. Shamsa also told me she would like to get out of the tent. As she was the oldest girl, she carried the burden of household tasks and childcare, and her aunt was very reluctant to let her go to the camp school or any of the other activities arranged for children. However, she let the younger ones go and the improvement in their mood was very apparent. Shamsa continued to weep and grieve. Finally, when the aunt herself became involved in a livelihood programme with other camp women, she gave Shamsa permission to go to school. This had the immediate effect of alleviating some of Shamsa’s sadness. In contrast, 12-year-old Sadia still lived in her village higher up in the mountains above the town. She too had lost her mother when their house was destroyed. She moved in with her grandmother but stayed in her village. When I met her she was laughing and playing with the other village children. She had just had her hands hennaed in beautiful flower patterns. She had been told that her mother was dead and said she still felt very sad. But she liked living with her grandmother and she did not cry all the time. When playing with the other village children she was able to be happy, and she had many relatives and friends who cared about her.

**NOTE:** names changed for reasons of confidentiality

### How do we assist grieving families?

**TABLE 1.23.4 Key actions to support grieving families**

<table>
<thead>
<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Attend to their basic needs</td>
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<tr>
<td>Access resources</td>
</tr>
<tr>
<td>Assist mourning in a culturally appropriate manner</td>
</tr>
<tr>
<td>Answer questions and provide information</td>
</tr>
<tr>
<td>Accompany them</td>
</tr>
<tr>
<td>Be available</td>
</tr>
<tr>
<td>Focus attention on their individual loss; give it significance</td>
</tr>
<tr>
<td>Altruism opportunities</td>
</tr>
<tr>
<td>Avoidance as required</td>
</tr>
<tr>
<td>Advice as needed</td>
</tr>
</tbody>
</table>
Not all grieving families require a health worker’s intervention. But in situations of conflict, disaster and displacement the natural sources of social support are absent for the reasons listed above. In this case, the healthcare worker is the supportive community if unaffected him- or herself. Some key activities are listed in Table 1.23.4. Your role may be to accompany and support the bereaved as any neighbour might do in normal times. Obviously if a family lacks basic resources or is not safe, helping to address these basic needs is a priority. Help may be needed to trace missing bodies or identify them. Outsiders may have a significant role to play simply by encouraging and taking part in the normal processes of mourning. This may involve assisting an individual to organise a funeral, or it may involve helping a community. Vignette 3 provides an illustration of how one non-governmental organisation (NGO) assisted mourning in a disaster-affected community. If any individual has such severe symptoms of distress that they cannot function or carry out necessary tasks, providing symptomatic relief will help.

Regarding discussion of the loss, you should follow the lead of the bereaved. This usually means being available and able to listen without forcing them to talk. There is no evidence that ‘grief work’ (i.e. the experiencing, confronting and working through of negative emotions) is helpful, and there is some evidence that it may have long-term negative consequences. Contrary to some popular western stereotypes, positive emotions in the early period after loss are indicative of good outcomes, not pathology. Individuals who choose the more avoidant orientation (see Figure 1.23.1) are not in harmful denial, and this does not have to be challenged.10

On the other hand, it is not necessary to ‘break down’ continuing attachment to the deceased. Good memories assist mourning and give pleasure and comfort. This connection may be maintained throughout a bereaved person’s life without pathological effect. Depending on the culture, it may involve regular visits to the grave, talking actively or praying to the dead, frequent dreams or visions. Indeed, ritualised celebrations of connection with the dead in some societies actually strengthen living family bonds as they bring families together.11,12 A continuing connection should only cause concern if continuing yearning, searching and longing cause misery and dysfunction, dominate life in the long term and prevent the bereaved from forming any new attachments.

If the loss has occurred as a result of some form of political injustice or abuse, unresolved issues of reparation and justice may prolong grief and make mourning difficult. Helping the victims to access justice may be another part of your role (see ‘Case example: When to tell the story’ on p. 118).

How do we help grieving children?
Many families present to healthcare workers because they have concerns about the long-term impact of events on the child, and want advice on how to talk about such abnormal events with their children. The healthcare worker’s role should be to facilitate the process of normal grieving, and to help to sustain and support the protective aspects mentioned in this section. While treating pathology where it is evident, you should take care to avoid pathologising where it is not.

A particularly important role may be to facilitate clear communication between family members. As some of the case studies and vignettes in this section illustrate, many families are concerned that telling the child what happened will cause unnecessary distress, and that as the child is ‘too young to understand’, it is better to lie or avoid the subject when it comes up. Children are very protective of surviving parents, and are quick to sense when a question is causing distress. They may avoid asking for information because the questions make their parent cry. False information leads to confusion and a lack of trust. The following case example illustrates this.

**CASE EXAMPLE: Telling the truth**
The father of this family was a member of a ‘Liberation Army’, and was killed in the fighting. His 32-year-old wife had two surviving children aged 8 and 9 years, and continued to live with her husband’s relatives. She told the children that their father was working in another country. The children would frequently ask her why he did not phone and if he would bring them presents. They were confused because other children in the village told them their father was dead. When they questioned their mother she would start to cry, so they became nervous about asking her. The mother and her brother-in-law asked for advice about what to do, and accepted my suggestion that they should sit with the children and explain in simple terms what had happened, answering all the children’s questions as they came up, and sharing the experience of grief. The mother told me that the relief of not having to lie to the children had slightly eased her own distress and made it easier to respond to them. Moreover, rather than being bewildered by their father’s silent absence, the children now talked about him in the village with pride.

The following is a list of pointers specifically for supporting grieving children:

1. Provide consistent, enduring, appropriate care.
   - Reunite children with their families or extended families as soon as possible.
   - In the absence of family, create enduring family-type networks with a low ratio of caretaker to children.
   - Consistent caregiving by one or two caregivers, not a number of different volunteers (however well-intentioned), is essential to prevent attachment problems, particularly in younger children.

2. The more continuity that there is with the child’s previous life the better. Children may wish to avoid traumatic reminders, especially at the outset, but removing them completely from a familiar environment will cause more pain and problems in the long term.

3. Support the carers by attending to their basic needs and their own mental states. Help them to access the appropriate agencies to solve the practical problems that they will encounter. Attention to basic needs is essential. Engaging in the process of rebuilding their lives helps families to come to terms with their losses (see Appendix, Vignette 1).

4. Facilitate normal grieving and mourning with memorials for absent bodies, and appropriate religious ceremonies.
5 Don’t hide the truth.
- Children need clear, honest, consistent explanations appropriate to their level of development.
- They need to accept the reality of the loss, not be protected from it.
- Magical thinking should be explored and corrected. If their parents have not mentioned the death, it may be necessary to talk about it. They may ask questions and find ways of coping with the reality of the loss. It is important that they are not left with the feeling that the loss is a secret or something to be hidden.

6 Grief work and debriefing may not be therapeutic or appropriate. The insistence on getting a child to “debrief” or tell the story of their loss may not be therapeutic or appropriate. Not all cultures put as high a value on the ventilation of individual feelings as western culture does. The therapist’s goal should be to encourage a supportive atmosphere for the children, where open communication is possible, difficult questions are answered, and distressing feelings are tolerated. This means that the child will be free to express their grief in the manner that they find appropriate to the person they most trust, and at a time of their own choosing.

7 Provide symptomatic relief. Help the family to cope with traumatic symptoms such as bedwetting, nightmares and regressive behaviour, if they occur. Give the parents information about what to expect and straightforward management advice.

8 Restart normal educational and play activities as soon as possible.

9 Help the child to maintain connection with the lost parent. Encourage the surviving parent to allow the child to choose a memento to keep, to give them access to photographs, or to let the child draw a picture, make objects, or create a memory box. Answer the child’s questions about the dead parent.

10 The question of justice will be important for families in situations of political violence. Many will state that they cannot come to terms with their losses while the fate of loved ones is unknown, bodies remain unidentified, or perpetrators are still at large. These issues will affect the children, and older children may bring them up in the manner that they find appropriate to the person they most trust, and at a time of their own choosing.

Appendix

The following three examples are drawn from fieldwork in various conflict and disaster situations. They illustrate the variability of responses and provide examples of practical ways to support grieving families and communities.

Vignette 1: Complex needs and conflict in a grieving family
A is an 18-year-old high-school student, living in a rural area in the heart of a conflict region, the second oldest of seven children (four girls and three boys). She wanted to study medicine. Her life and health were normal until the shelling began and her family fled to the forest, where they spent 3 months. The local police, who were of a different ethnic origin, found them and separated the men from the women and elderly men and sent the latter home. They got home to find their village full of soldiers and police and themselves under siege at their home, where they were harassed and sometimes beaten. Meanwhile their invalid
pensioner father was shot in a massacre of 10 men from the village. He was buried while they were under siege. A was referred to me 1 month after this by a local doctor who was concerned about her mental state. When I first saw her she was extremely sad and frightened. She was crying all the time, and ruminating about her father being captured. She found everywhere frightening, and was too afraid to go to sleep. When she did fall asleep, she woke early. She had no appetite, and a diurnal mood swing.

I first assessed her at the doctor’s home, where we had a long talk, at her instigation, about everything that had happened to her. I felt that the severity of her depressive symptoms might necessitate use of an antidepressant, but delayed making a decision until I was able to assess her at home with her family. I visited them a week later and found all seven members of the family living in one restored room of their fire-damaged home. To my surprise, A was a great deal better, her sleep and appetite having returned to normal over the course of the week. She informed me that she felt this was because she felt she had someone to talk to, and who ‘wanted to come and visit’. However, all the female members of the family were preoccupied with the father’s death, tearful when discussing it, and had conflicting views about how to manage the grief. The mother and one sister no longer wanted to wear the symbolic mourning clothes, but to move on. The other three sisters were wearing black mourning bands in their hair and wanted to do so for the appropriate period of 1 year. One of these sisters complained of having some panic attacks. They also all felt angry and concerned about their material circumstances. They had no access to their father’s pension, as this would have meant going to a police station run by the ethnic group in power to get new identity papers (all of theirs had been burnt), and identifying themselves as from a conflict area and as being members of a family with a massacre victim. Anxiety made sleep difficult.

Interestingly, the boys in the family (aged 7, 8 and 14 years) appeared cheerful, busy and well, insisting that they were symptom free, although they missed their father. All the boys attended school regularly. The girls did not go, as there was no money for books. They therefore sat around at home with little to do.

We agreed to have family meetings to help them to resolve their conflicting views about how to grieve, and relaxation therapy to provide some symptomatic relief. We did this as a group and they practised themselves on a daily basis, with the mother running the group. Over the next weeks there was a marked improvement in the whole family. The three girls continued to wear their mourning bands, and the mother was more tolerant of this. A began to press me to help her to get an ID card so that she could go to a nearby town, get a job and earn some money. However, the security situation deteriorated too much for this to be possible. My last visit before evacuation was distressing, as there was fighting on the nearest main road and the sound of shelling of nearby villages. We all knew that they might have to flee again in the near future.

I returned to see the family 3 months later. They had spent these months internally displaced, being pushed from one village to another, and with very little to eat. During this time, the 14-year-old son, who had separated himself from the family because he believed that he endangered them, had been killed along with another male relative. The family had returned to their home to find it completely burnt to the ground except for an outhouse. They had nothing left and were using an ammunition box as a table, and sleeping under a small piece of plastic in the garden, because the outhouse attracted snakes. As before, the healthiest members of the family appeared to be the smallest boys, who denied any symptoms except some tearfulness now and then. They appeared active and cheerful except when witnessing their mother’s distress. The mother was devastated, and could not stop crying. She could not sleep, eat or function, and expressed suicidal ideas. A had moved away to live with an aunt in a nearby town, and had a number of somatic symptoms. We provided clothes for the family and basic material equipment for the house. The mother was started on antidepressant therapy.

The family then lost contact with our service for 6 months. They had been provided with materials to build a warm room, but the aid agency had failed to realise that with no adult males left in the family there was no one to build it. The family therefore moved into a grim damp refugee flat in town. The mother had found the antidepressants helpful but had run out of medication. Two daughters had escaped the situation by marriage. The boys were well and attending school. The other daughters remained trapped within the prison of their mother’s unrelenting grief. They spent all day in the flat with their mother talking and crying. She did not wish to be left alone. They wanted to show her how much they cared for her and insisted on doing every household task, which added to her feeling of being a use- less burden. We began ‘family work’ again, encouraging the girls to join the free local youth club and to allow the mother to re-establish her maternal role in the family, supporting her by restarting the antidepressant medication at her request, and getting in touch with the aid agency about the family’s house.

Some reflections on this case: For most families of this particular ethnic group, the immediate and respectful burial of the dead is crucial. This is followed by 7 days of visiting by friends and family, who sit all day with the bereaved and discuss the dead. These normal mourning processes had not been possible either for the father or for the son. It seems likely that the surprisingly sudden symptomatic relief that A gained from my initial intervention was a result of my contributing to some of this normal mourning by being an outsider who visited and listened. A family approach meant that differences could be brought out in the open in a respectful way. The family also formed a natural group so could encourage and support each other in doing relaxation work. Attending to human rights concerns such as identity papers and security was also important. However, all this was undone by the second round of conflict and loss. There is something particularly devastating about loss coming again immediately a family has begun to work its way towards recovery. Being made homeless and not being given support to rebuild their house have contributed to their sense of bereavement and powerlessness, and prolonged the period of grief. The mother told me repeatedly that if she could start rebuilding her house she would feel better.

Some families are strongly patriarchal. There are different coping strategies available to boys and girls. All the women in this family came across as strong and capable, but all of them felt that the loss, first of an invalid father and then of the oldest son, had completely destroyed the family’s capacity to function. Much of the work with grieving female survivors has to address their insecurity and lack
of confidence in their own self-worth. This family required a complex approach, including participation in normal mourning, attention to basic needs, help with family communication, symptomatic relief, help with re-establishing normal family roles, and adapting to new roles in the absence of male support.

Vignette 2: Supporting the whole family
Family B had lost more than 20 members, mostly female and children, in a massacre. I was asked to visit because of concerns about the mental health of the surviving children who had witnessed the attack and were all under 6 years of age. At the first session, most of the remaining extended family, including the children, had gathered to meet me in the only intact room in the house. I already knew the outline of what had happened, and used this first meeting to draw a genogram. I have found that in situations of mass violence, in a culture where the extended family is of central importance, this simple technique has a number of useful functions.

- It is a collective act, with everyone joining in, introducing themselves and explaining their connection to others.
- It is interesting for the children, who join in the actual drawing on a large sheet of paper in the centre of the room.
- By asking the family to include those who have died, it allows for a collective naming of the dead. In this family my symbolically putting a simple black line through these names took on a ritual significance, and the children were quick to point out when I missed someone out.
- The naming allows the person who has died to be identified, but how much is said about that person or what happened is up to the family. Thus it provides the opportunity for storytelling without forcing the issue.
- What is said about the dead is said in front of the whole family, so there is a collective narrative from which the children are not excluded.

Once the genogram had been drawn, the family told me their concerns about the children and their own fears about letting the children talk, as it seemed to upset them. At this meeting, I gave the simple advice about communication outlined above, and arranged to meet the family regularly and to have play therapy with the children. At the next meeting, the family informed me that they were concerned about the oldest teenage girl, who fainted regularly at the same time every afternoon, and was the most nervous and sensitive member of the family. Her sister was one of the dead, and her mother was particularly concerned about her health, but never cried herself. They wanted reassurance that the girl was not seriously ill. Having provided this, I wondered aloud if the teenage daughter was in some way grieving for the whole family and that this exhausting work might be causing her to faint. It also meant that the mother did not have time to think about her own sadness. The daughter said that she wished her mother would cry a bit more, and to have play therapy with the children. At the next meeting, I gave the simple advice about communication letting the children talk, as it seemed to upset them. At this meeting, I gave the simple advice about communication letting the children talk, as it seemed to upset them.

Vignette 3: Assisting communal mourning
The South-East Asian tsunami that occurred on 26 December 2004 destroyed an area along the coast of Northern Sumatra 300 miles long and 6 miles wide. At least 130 000 people were killed in that country alone, and 400 000 were left homeless. In some villages more than 70% of the community were killed. One issue was the problem created by large mass graves. For example, outside the provincial capital Banda Aceh, approximately 20 000 people were buried in a small piece of land next to the main road, with no identification and no acknowledgement of their lives. Nothing grew there. Driving from the airport, one might witness a lone figure standing or sitting on the ground in quiet meditation or prayer. Our non-governmental organisation (NGO) psychosocial team talked with local community leaders in an effort to understand how to assist the Acehnese people in their mourning at this site, and took up their suggestion to collaborate in building a Quiet House. The house was built by local people in less than 10 days with NGO supervision. It overlooked the grave site and provided shelter, privacy and beauty for the relatives of the dead, without the traffic of the main road intruding. The house was designed to emphasise traditional culture, and was landscaped with flowering plants and trees. To provide comfort for the bereaved, the Imam wrote a well-known Muslim prayer: ‘From him (Allah) we come and to him (Allah) we return.’

One of the local workers became tearful, explaining ‘I think my family are buried here but I don’t know. This is why I don’t come here … but now I can come and talk to them. It is very important for the people of Aceh to have a place where they can come and feel a sense of loss and family again.’ The project led to requests for further Quiet Houses at other sites.

Note: Dr Jones is a member of the WHO ICD-11 Working Group on the Classification of Disorders Specifically Associated with Stress, reporting to the WHO International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders. The views expressed in this article are those of the author and, except as specifically noted, do not represent the official policies or positions of the International Advisory Group or the World Health Organization.

References
Obstetric and paediatric anaesthesia in low resource settings

The Safe Anaesthesia Working Group of the World Health Organisation’s ‘Safe Surgery Saves Lives’ global initiative updated the 1992 International Standards for the Safe Practice of Anaesthesia in 2010. The aim of these Standards is to contribute to decreased patient morbidity and mortality worldwide, particularly in lesser resourced countries where regions have not adopted their own standards.

The fundamental principle of these Standards is the continuous presence of an appropriately trained, vigilant anaesthesia professional. The Standards also highly recommend pulse oximetry during anaesthesia, which means it is mandatory, although compromise may be unavoidable in emergencies.

Compliance with these International Standards should be advocated by health care workers in all facilities where anaesthetics are given.

Obstetric anaesthesia

The limiting factor is often the availability of doctors and nurses trained in anaesthesia; women, babies and children die because of the lack of trained staff.

Remember that there are two patients – the mother and the baby. The condition of the mother affects the condition of the baby. Therefore maintaining adequate oxygenation and reususcitation of the mother is the best initial way of treating and preventing fetal distress.

All pregnant mothers after 20 weeks’ gestation who are lying down must be put in the left lateral tilt position to avoid aorto-caval compression and supine hypotension.

Conduct of anaesthesia

Considerations in the obstetric patient in addition to routine anaesthesia include those listed below.