British Journal of Psychiatry (1985), **147**, 188–194

The Bereaved Child:
Variables Influencing Early Psychopathology

MICHELE M. VAN EERDEWEGH, PAULA J. CLAYTON and PAUL VAN EERDEWEGH

Summary: This is a 13-month follow-up study of 105 two to 17 year-old children bereaved of one parent, with 85 controls. Data were gathered on physical and mental health in the children and surviving parents, the child's sex and age and the bereaved parent's sex and psychopathology being included as risk factors. Dysphoria, falling school performance and withdrawn behaviour were significantly increased in bereaved children of both sexes at all ages, while temper tantrums, bedwetting and the depressive syndrome only increased in the age and sex categories normally associated with these conditions. A global index of psychopathology was increased compared with controls on most subgroups of bereaved children ($P<0.0001$), the highest scores for both sexes being associated with having a mentally ill (usually depressed) widowed mother. The results are discussed and suggestions made for future research.

Since Rutter published his monograph on *Children of Sick Parents* (1966), which includes controlled data on childhood bereavement, more statistical associations have emerged which do indicate a link between parental death and increased psychopathology in the child (Bendiksen & Fulton, 1976; Markusen & Fulton, 1971). However, the magnitude and type of difficulties presented are still a matter of speculation. These studies and others (Gregory, 1965; Arthur & Kemme, 1964) are either based on children referred to a psychiatric clinic or are interested in a specific behavioural problem (like antisocial/criminal behaviour or truancy). Moreover, the delay between the time of death and the onset of psychiatric difficulties in the child (Rutter, 1966 p. 72) or in the grown-up child (Brown & Harris, 1978; Birtchnell, 1980; Tennant *et al*, 1980) makes it less likely that the death itself is the sole factor leading to psychiatric difficulties and/or referral.

In a previous paper (Van Eerdewegh *et al*, 1982) we reported short-term symptoms associated with bereavement in children from the community during the year following the death of a parent. The analysis performed on the pooled data 13 months after the event showed a significant increase in dysphoria, a minor form of a depressive syndrome, an increase in bedwetting and a significant degree of impairment in school performance. There was no increase in behaviour problems or severe depression.

Because children have age and sex specific vulnerabilities and because they often present clinically with symptoms linked to environmental stress such as parental distress, an attempt was made to tease out potential risk factors which could affect the distribution of the observed psychopathology among our bereaved children. In this report, we consider the age and sex of the child as well as the sex and psychopathology of the surviving parent.

Method

The study was undertaken while performing one-month and 13-months follow-ups on a consecutive group of recently bereaved, young, white widows and widowers and appropriate controls in the St. Louis metropolitan area (Clayton & Darvish, 1979). Bereaved subjects with children and controls were interviewed, using a structured format, about their children's symptoms, behaviour, school performance and general health.

In addition, the widowed parent was interviewed extensively on his/her own reaction to the death and screened with the early version of the Renard Research Diagnostic Interview (1972) for major psychiatric disorders and undiagnosed conditions.

A more detailed description of the methodology can be found elsewhere (Van Eerdewegh *et al*, 1982; Clayton & Darvish, 1979).

In the present analysis, we looked at the occurrence of symptoms in the children at any time between the death and the 13 month follow-up. In addition, a global *index of psychopathology* (IP) was constructed by summing all the following positive qualitative variables considered in the analysis:

(a) Related to depressive mood: sadness, crying, irritability or a combination (*dysphoria*) of any of the three.

(b) Related to depressive symptoms: withdrawal, sleep disturbance, nightmares, decreased appetite, decreased weight, headaches, loss of interest at school, loss of interest in other activities. A combination of three of these features along with dysphoria was defined as *depressive syndrome*, a combination of four as *severe depressive syndrome*.

https://doi.org/10.1192/bjp.147.2.188 Published online by Cambridge University Press

TABLE I

Frequency of symptoms/syndromes in bereaved and controls, controlling for age or sex of the child.°

	Age ⩽ 12		*Age ⩾ 13*		*Males*		*Females*	
	Bereaved n = 52 (%)	*Controls n = 49 (%)*	*Bereaved n = 53 (%)*	*Controls n = 31 (%)*	*Bereaved n = 63 (%)*	*Controls n = 36 (%)*	*Bereaved n = 42 (%)*	*Controls n = 44 (%)*
Dysphoria§	71.2	32.7	83.0	35.5	76.2	33.3	78.6	34.1
Withdrawal§	28.8	8.2	34.0	19.4	28.6	11.1	35.7	13.6
Temper tantrums§	48.1	18.4	22.6	22.6	39.7	25.0	28.6	15.9
Sleep trouble	17.3	8.2	20.8	3.2*	15.9	8.3	23.8	4.5**
Decreased appetite	15.4	8.2	15.0	0*	17.5	5.6	11.9	4.5
Loss of interest in activities	11.5	0*	9.4	6.5	6.3	0	16.7	4.5
Bedwetting	32.7	8.7**	5.7	3.2	20.6	14.3	16.7	0**
(*n*)	(52)	(46)	(53)	(31)	(63)	(35)	(42)	(42)
Poorer school performance	18.0	0**	17.8	0*	19.6	0*	15.2	0*
(*n*)	(39)	(33)	(45)	(23)	(51)	(23)	(33)	(33)
Depressive syndrome (at least 3 symptoms)	9.6	2.0	18.9	6.5	11.1	5.6	19.0	2.3**
Severe depressive syndrome (at least 4 symptoms)	1.9	2.0	9.4	6.5	6.3	5.6	4.8	2.3

° Only the statistically significant results are listed, except for "severe depressive syndrome".
§ See results of logistic regression in Table II
* $P < 0.05$ [exact level of significance of G^2 statistic = Σ 2 OBS ln(OBS/EXP)]
** $P < 0.01$ (exact level of significance G^2 statistic)

(c) Somatic symptoms: headaches (see depression check list), bowel troubles, abdominal pain, vomiting, accident proneness or bedwetting.
(d) Behavioural symptoms: behavioural problems (major or minor delinquencies), temper tantrums, fights with siblings, fights with others, or increased interest in general.
(e) School problems: loss of interest at school (see depression check list), deteriorating school performance, school phobia.

The analysis of symptoms frequency was performed using log-linear models and logistic regression (Fienberg, 1977). For several symptoms, the frequencies among the probands as well as among the controls were large enough to allow a simultaneous crossclassification according to the age, sex and bereavement status of the child. In these instances a logistic regression (University of California BMDP, 1982) was used to analyse the effect of age, sex and bereavement status three explanatory (independent) variables, on each symptom (dependent variable).

For symptoms with low frequencies the data were crossclassified separately, either by age category or by sex of the child. Tests of independence in a 2×2 contingency table as well as tests of equality of odd-ratios in different layers of a 2×2×2 contingency table were performed. This latter hypothesis is equivalent to the hypothesis of no three-factor interaction in a log-linear model.

We used an analysis of variance for unbalanced designs, the GLM procedure of the Statistical Analysis System (SAS, 1982) program, to study the effects of four factors and their interactions on the global index of psychopathology (IP). Those four factors are: the sex of the child, the age of the child, the sex of the interviewed bereaved or control parent and the psychopathology in the bereaved or control parent.

Results

Sociodemographic data on the pooled bereaved children and their parents, as well as lifetime psychiatric diagnoses of the widowed parents and controls, are reported in our previous article (Van Eerdewegh *et al*, 1982). There were no statistically significant differences in age, sex, socio-economic status and psychiatric diagnoses between the adult subjects and their controls.

There were 49 female and 63 male bereaved children and 44 female and 36 male control children with an age range of 2 to 17.

Tables I and II list the symptoms/syndromes affected by the bereavement status of the child. These variables, except for loss of interest in activities, are the same as those found to be significant in the previous analysis where we did not consider age and sex differences (Van Eerdewegh *et al*, 1982).

Table I gives the results of testing for independence in each 2×2 contingency table (symptom/syndrome by status) given the age category or given the sex of the child for the symptoms/syndrome with small frequencies among the controls and/or bereaved. Poor school performance is significantly increased across age and sex categories ($P < 0.05$ and $P < 0.01$). The bereaved girls show an increase in bedwetting ($P < 0.01$), sleep disturbances ($P < 0.01$) and the syndrome of depression (defined by at least three symptoms), ($P < 0.01$). The younger bereaved display an increase in bedwetting ($P < 0.006$) and loss of interest in activities ($P < 0.03$). In the older bereaved, we find an increase in sleep disturbances ($P < 0.03$) and decreased appetite ($P < 0.02$). However, for each symptom/syndrome mentioned above, there are no significant differences between odd-ratios across age or sex strata in 2×2×2 contingency tables. This is not surprising, in view of the relatively small number of controls with symptoms,

https://doi.org/10.1192/bjp.147.2.188 Published online by Cambridge University Press

TABLE II

Logistic regression of some symptoms/syndromes on Age (A), Sex (S), and Bereavement Status (B) of the child

Symptom/Syndrome	*Model*	G^2	*df*	*P*†	*Coefficients**	*Description*
Dysphoria	[B]	5.96	6	0.43	B = 0.945 C' = −0.271	Bereavement increases frequency. No age or sex effect
Withdrawal	[B]	4.92	6	0.55	B = 0.58 C' = 1.36	Bereavement increases frequency. No age or sex effect
Temper tantrums	[A],[B],[AB]	3.28	4	0.51	A = 0.223 B = 0.355 AB = −0.353 C' = 1.007	Increased frequency with young age and bereavement. Interaction between age and status

† *P* – Significance level of G^2.
* Coefficient in the logistic regression.

and stresses the need for a larger control sample to increase the power of those tests.

Table II displays the results of the logistic regression of the symptoms/syndromes (dependent variable) on the sex (S), age (A) and status of the child (B) (independent variables) when the observed frequencies are large enough to use this type of analysis. Dysphoria and withdrawn behaviour are affected solely by the bereavement status, which increases their respective frequencies, age and sex having no significant influence. Temper tantrums are explained by a more complicated model where, in addition to the two main effects of the age and bereavement status of the child, we also observe an interaction term between those two factors. This can be interpreted to mean that both young age and bereavement will increase the frequency of temper tantrums and that, because of the interaction, the simultaneous presence of young age and bereavement will reinforce the increase. If either young age and bereavement is present, but not both, the interaction term AB will reduce the increase in symptom frequency.

Global indexes of psychopathology

Separate analyses of variance are performed on the

TABLE III

Mean index of psychopathology scores (IP) in bereaved children

		Parent interviewed			
		Father		*Mother*	
		Sick	*Well*	*Sick*	*Well*
Bereaved Children	*(Age)*				
Males	2-12 (*n*)	4.14 (7)	3.70 (10)	6.13 (8)	5.00 (7)
	⩾ 13 (*n*)	3.00 (1)	4.53 (15)	7.63 (8)	6.00 (7)
Females	2-12 (*n*)	5.80 (5)	1.00 (1)	7.88 (8)	6.50 (6)
	⩾ 13 (*n*)	11.00 (1)	4.14 (7)	6.00 (3)	6.00 (11)
Control: Children					
Males	2-12 (*n*)	2.20 (5)	3.20 (5)	5.00 (4)	2.88 (8)
	⩾ 13 (*n*)	— (0)	2.43 (7)	3.00 (3)	4.25 (4)
Females	2-12 (*n*)	1.67 (3)	2.25 (8)	4.00 (7)	1.56 (9)
	⩾ 13 (*n*)	1.00 (2)	3.43 (7)	3.50 (4)	2.25 (4)

ANOVA – 4 factors analysis – Age of child – 2 categories (A), Sex of child (Sc), Sex of parent (Sp), Psychopathology of parent (P).
Best fit model is:

Bereaved				*Controls*			
	Sum of Square III	*F*	*P > F*		*Sum of Square III*	*F*	*P > F*
[Sp]	38.87	3.78	0.06	[Sp]	24.31	4.29	0.04
[P]	44.01	4.28	0.04	[SpP]	33.01	5.82	0.02
[ScSpP]	40.67	3.95	0.05				

https://doi.org/10.1192/bjp.147.2.188 Published online by Cambridge University Press

bereaved children and the control children, as well as on the combined samples.

Table III gives the four-way cross-classification of the global index of psychopathology taking four factors into consideration, the age (two categories) and sex of the child and the sex and psychopathology of the parent, for bereaved and control children.

Bereaved children

The best fit model shows that the source of variation is an effect mostly of the parents's psychopathology ($P = 0.4$) and, to a lesser extent, of the sex of the parent ($P = 0.055$). In addition, there is one significant three-way interaction, between the sex of the child and the sex and psychopathology of the bereaved parent ($P = 0.05$). The age of the child does not significantly affect the results. When the dysphoric symptoms are removed from the symptom count, the main effect comes from the sex of the parent whereas the parent's psychopathology has only a borderline influence.

Control children

Most IP scores are lower for the controls than for the subjects when comparing the scores of matching cells. The statistical analysis performed on the combined control and bereaved samples confirms this observation at $P < 0.0001$. Analysing the effects on the control scores of the four factors as we did for the bereaved children, we find that the sex of the parent (Sp) is a source of variation by itself and in interaction with the psychopathology of the parent ($P < 0.04$ and 0.02 respectively for the main effect of Sp – sex of parent – and for the interaction term SpP – sex of parent and psychopathology of parent). However, if we remove the dysphoric symptoms from the scores those significant sources of variation disappear.

Discussion

The symptoms/syndromes whose frequencies are increased by the bereavement process fall into two broad categories: those for which we do, and those for which we do not, observe vulnerability in a specific age and/or sex category.

The latter are dysphoria, withdrawn behaviour and deterioration in school performance. The former are depressive syndrome (three symptoms at least), trouble with sleeping, decreased appetite, loss of interest in activities, bedwetting and temper tantrums. For some of these, the vulnerable age and/or sex is compatible with what is already known of the age and sex preponderance of these symptoms/syndromes. Depressive syndrome (three symptoms at least) and two of the defining depressive vegetative symptoms (trouble with sleeping and decreased appetite) are seen preponderantly among the bereaved children who are female and or/older. Young bereaved children are mostly affected with temper tantrums, bedwetting and loss of interest in activities (for which the younger children might depend more on the parent). Noticeably, male bereaved did not show significant specific vulnerability to any of the symptoms/syndromes, not even to bedwetting.

Because of the known excess of male bedwetters in the general population (confirmed by our controls) the higher rate of bedwetting among female bereaved only, when compared to female controls, was unexpected (16.7% female bereaved *vs* 0% female controls). We did observe some increase among bereaved boys, but it was masked by an already rather high rate among the male controls (20.6% *vs* 14.3%).

Depending on how the depressive syndrome is defined, the effects on it of sex ratios, age distribution and influence of bereavement status vary. When only three symptoms (in addition to dysphoria) are used to confirm a diagnosis of what might be called "minor" depression, the syndrome is seen only among the bereaved children (8.5% bereaved *vs* 0% controls) and mostly among bereaved girls across age categories. However when four symptoms are required, to define a more severe form of depression, rates in bereaved and control children are similar, with the sex ratio close to unity and the syndrome occurring predominantly among post-pubertal children. It seems as though the milder syndrome is a specific reactive form to the stress of bereavement, particularly (but not exclusively) among girls, whereas the severe syndrome is another entity whose relationship to the loss of a parent is not established, even though the stress may have acted as a triggering factor. This certainly indicates that depression in children has the same heterogeneous quality as in adults, and that "cut off" points in number and severity of symptoms might be a way to identify different subclasses.

One particular symptom drew our specific attention: the widespread drop in school performance in all categories of bereaved children. This is probably a good barometer of inner turmoil within the child and the family unit. Potentially it may lead to rejection of school, underachievement and school dropout, though long term data have also shown the presence of an inverse reaction of overachievement (Gregory, 1965).

It is worth emphasising, also, that behaviour problems (i.e., major or minor delinquencies), major depression and school phobia are not manifestations of the bereavement process, not in the short term at least, but are a function of age only, older children being more often affected by the first two conditions and younger ones by the

https://doi.org/10.1192/bjp.147.2.188 Published online by Cambridge University Press

third. The conspicuous absence of behaviour difficulties of any kind is puzzling in face of some previously published data (Rutter, 1966; Gregory, 1965; Bendiksen & Fulton, 1976; Markusen & Fulton, 1971). Several reasons, perhaps complementary, come to mind as possible explanations for this negative finding. It is possible that: (1) in the short term, behaviour difficulties are masked by a phase of inhibition and depression, or (2) antisocial behaviour takes several years to develop, indicating the influence of factors other than the loss itself upon its appearance, or (3) our white community sample has a lower rate of behaviour problems than a clinic population, and is less likely to manifest behavioural difficulty in response to bereavement.

Our rationale for the creation of a global index of psychopathology lay in the lack of specificity (apart from widespread dysphoria) in the children's reactions to the deaths. On the contrary, there seemed to be an increase in the frequency of all the heterogeneous symptoms. Therefore, it seemed appropriate to sum the positive symptoms, to get a quantitative variable which would serve as a crude index of the degree of reactivity of bereaved children. This enabled us to examine simultaneously the influence of some parental as well as child characteristics on the children's reactions.

Contrary to previous reports, reviewed by Rutter (1966, p. 45), which emphasise significance of the loss (or mental illness) of the same sex parent in the development of psychopathology in the child (or the adult), we find at short-term, that for boys *and* girls the disappearance of the fathers (or the experience of being reared by a single mother) leads to higher average psychopathology scores. The loss of the breadwinner (usually the father) may have more immediate deleterious effect upon the entire family. The widows may react more severely to the loss of the emotional and economic support. This is in keeping with Marris' observations (1958) describing the indifference of some widows to their children's needs as after bereavement they struggle against poverty and loneliness. It is an untimely event to lose a spouse at a relatively young age, and we would argue that young women of childbearing age are less prepared for and more vulnerable to such a loss than young men: they are likely to be unemployed, with little past employment experience, and are not ready to tackle the dual responsibilities of caring alone for their school-age children and finding a job to supplement loss of income if necessary.

Our population of young adult bereaved had a rather high rate of life-time psychiatric disorders (defined as other than a simple grief reaction) and in the subsample with children presently being considered this rate is even higher (42%, *vs* 29% of controls), though not significantly so. Our analysis led us to conclude that the mental health of the surviving parent was a contributing factor to the mental state of the child. Children of psychiatrically ill parents may be more vulnerable to stress than those of normal parents.

Reporting bias, due to the sex of the parent interviewed, cannot be excluded: in both bereaved and control children, we found evidence for increased symtomatology when mothers, as opposed to fathers, were interviewed. Whether mothers are over-reporting or fathers under-reporting we do not know. Earls (1980) for instance observes that fathers, when compared to mothers, have a tendency to under-report behaviour problems in their three-year-old children. On the other hand, Rutter (1966, p. 79), who excludes the possibility of referral biases, mentions that psychiatric illness in the mother is more often associated with disorder in the child than is illness in the father. Our controls confirm this finding, since among them psychopathology in the parent alone does not lead to a higher score in the child *unless* this parent is a mother. Consequently in the controls there seems to be increased pathogenicity when mothers, as opposed to fathers, have a mental problem in the family. One explanation may be that since mothers have more daily contact with their children than fathers they are potentially more harmful if they are disturbed (by mental problems and/or by the stress of bereavement), and that it is not so much the sex of the sick parent as the amount of exposure that matters.

Boys are usually over-represented in a child psychiatric population. In the present community sample, however, the sex of the child by itself was not a factor related to differential psychopathology rates—even though we observed slightly higher scores in bereaved females than in males, and a reverse trend in our controls (NS), which was probably a reflection of the fact that we were counting primarily symptoms of the depression and anxiety spectrum, where the preponderance of boys is not seen (Rutter & Hersov, 1977). The one instance, however, in which the sex of the child was implicated in the results was in interaction with the sex of the parent and the psychopathology of the parent in the bereaved sample. In this case, bereaved daughters of mentally ill mothers had the highest scores.

The age of the child at the time of bereavement has been reported to be of importance in distinguishing the child who will present for psychiatric

https://doi.org/10.1192/bjp.147.2.188 Published online by Cambridge University Press

care in later years (Rutter, 1966, p. 72). Rutter observed that, in a significant proportion of cases, a child who had sustained a loss before the age of four years three months was more likely than others to be referred for psychiatric care five or more years later. Our data deal only with the immediate reaction pattern, and no age effect was found in the global psychopathology scores.

It needs to be emphasised that the above results hold true when the dysphoric symptoms are removed from the index of psychopathology scores. In other words, our conclusions are not based on the presence or absence of mood disturbance alone.

As is suggested by our present results, when planning for future research in childhood bereavement we would emphasise the importance of following the children during a longer period. It is clear from reviewing the literature that problems may develop in later years as indirect consequences of the loss. The child needs to be studied in the context of the family unit, where psychopathology in the survivor (as well as the deceased) should be considered. Other factors of potential importance include the availability of a support system, any change in economic status and the quality of the relationships between the members of the family before and after the death.

The child's reactions should also be examined with reference to its age and sex. Even though there is a heterogeneous overall reaction across age and sex categories, our results indicate that some symptoms/syndromes are specific of a particular class of children. The child is likely to react in accordance with the maturity of its psychophysiological apparatus.

We would also emphasise the fact that, in general, the short term psychopathology presented in our sample was not severe. In particular, it did not lead to an increase in psychiatric or general medical consultations, hospital admissions or new health problems (Van Eerdewegh *et al*, 1982). The observation made by Rutter (1966, p. 46) that "although bereavement may necessitate major readjustment most children develop normally . . . " is supported by our data.

We are still debating the significance of the apparently excessively deleterious influence of the loss of the father (or of being raised by a widowed mother). Our first question is about the validity of such a finding, whether it be a true deleterious factor, a reporting bias or both. More research is needed in this area.

Finally, to address some purely methodological issues, in the light of recent results on child interviewing techniques (Herjanic, 1984) it is mandatory to include in any research project an interview with the child itself. Many of the elicited symptoms are in the subjective area of the depressive spectrum, in which the child has been shown to give more accurate information than the parent. From this one might infer that our present results, if anything, underestimate the children's psychopathology. Moreover, the intricacies of the interactions between child, parent and environmental variables warn researchers to gather a sample large enough to give power to future results.

Acknowledgements

We wish to thank Drs F. Earls, B. Herjanic, and Z. Welner for their encouragements in the preparation of the manuscript as well as Dr R. Cloninger for his constructive comments. N. Rochberg made very helpful editorial comments. We also thank D. Phillips for her skilled typing assistance. This work was supported by USPHS grants MH25430 and MH21027.

References

ARTHUR, B. & KEMME, M. (1964) Bereavement in childhood. *Journal of Child Psychology and Psychiatry*, **5**, 37–49.

BENDIKSEN, R. & FULTON, R. (1976) Death and the child: An anterospective test of the childhood bereavement and later behavior disorder hypothesis. In *Death and Identity* (ed. R. Fulton). Bowie, Maryland: Charles Press.

BIRTCHNELL, J. (1980) Women whose mothers died in childhood: an outcome study. *Psychological Medicine*, **10**, 699–713.

BMDP BIOMEDICAL COMPUTER PROGRAMS (1982) PLR p. 330. Berkeley, California: University of California Press.

BROWN, G. & HARRIS, T. (1978) *Social origins of Depression. A Study of Psychiatric Disorder in Women*. Tavistock: London.

CLAYTON, P. & DARVISH, H. (1979) Course of depressive symptoms following the stress of bereavement. In *Stress and Mental Disorder* (ed. J. E. Barrett *et al*). New York: Raven Press.

EARLS, F. (1980) The prevalence of behavior problems in 3 year old children: comparison of the reports of fathers and mothers. *Journal of American Academy of Child Psychiatry*, **19**, 439–452.

FIENBERG, S. E. (1977) *The Analysis of Cross-Classified Categorical Data*. Cambridge, Massachussets: M.I.T. Press.

GREGORY, I. (1965) Anterospective data following childhood loss of a parent. a. Delinquency and high school dropout; b. Pathology, performance, and potential among college students. *Archives of General Psychiatry*, **13**, 99–109, 110–120.

HERJANIC, B. (1984). Systematic diagnostic interviewing of children: present state and future possibilities. *Psychiatric Developments*, **2**, 115–130.

MARKUSEN, E. & FULTON, R. (1971) Childhood bereavement and behavior disorders: A critical review. *Omega*, **2**, 107–117.

MARRIS, P. (1958) *Widows and Their Families*. London: Routledge.

RENARD RESEARCH DIAGNOSTIC INTERVIEW. (1972) Washington University Medical School: Psychiatry Department.

https://doi.org/10.1192/bjp.147.2.188 Published online by Cambridge University Press

RUTTER, M. (1966) Bereaved children. In *Children of Sick Parents*, Maudsley Monograph XVI, London: Oxford University Press.
—— & HERSOV, L. (1977) *Child Psychiatry: Modern Approaches*. Oxford: Blackwell Scientific Publications.
SAS INSTITUTE (1982) *Statistical Analysis System, User's Guide: Basics and Statistics*. Cary, North Carolina: SAS Institute.
TENNANT, C., BEBBINGTON, P. & HURRY, J. (1980) Parental death in childhood and risk for adult depressive disorders: a review. *Psychological Medicine*, **10**, 289–299.
VAN EERDEWEGH, M. M., BIERI, M., PARRILLA, R. H. & CLAYTON, P. J. (1982) The bereaved child. *British Journal of Psychiatry*, **140**, 23–29.

*Michele M. Van Eerdewegh MD. *Assistant Professor in Psychiatry, Washington University School of Medicine and The Jewish Hospital of St. Louis, 216 South Kingshighway, P.O. Box 14109, St. Louis, Missouri 63178*

Paula J. Clayton, MD. *Chairperson, Department of Psychiatry, University of Minnesota Medical School, Minneapolis, Minnesota 55455*

Paul Van Eerdewegh PhD. *Research Instructor, Department of Psychiatry, Washington University School of Medicine and The Jewish Hospital of St. Louis*

(Accepted 7 January 1985)

*reprint requests

https://doi.org/10.1192/bjp.147.2.188 Published online by Cambridge University Press