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# The effects of bereavement in childhood

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## Introduction

Bereavement is not an illness in itself, although it may cause illness or predispose to one. The reaction to the loss of a loved one may lead to temporary or long-term psychological distress and/or loss of function, and may occasion consultation with the general practitioner and referral to mental health professionals.

During the first two years of life, through instinctive behaviours which are modified by experience, infants and their main carers develop an attachment.

This bond between a child and his caretaker(s) ensures the child's survival, enables his or her optimum physical, intellectual, and emotional development, and in due course ensures the survival of the species. The nature of the attachment between infant and carer(s) influences the way in which children come to view their social world; the pattern of attachment developed in the first two years of life often remains stable and is associated with the way in which children relate to other people later in their life. Attachment behaviour has been observed across different species and has obvious benefits for survival.

However, part and parcel of attachment for the child is distress at separation.

Infants who develop a secure attachment can gradually tolerate longer periods of separation from their carer and any distress is rapidly assuaged when they are re-united with their carer. When considered within the context of attachment theory, it is inevitable that permanent separation (e.g. through bereavement) will cause distress for the bereaved. Parkes reviews the body of attachment research and offers a comprehensive description of attachment with particular reference to its role in understanding the impact of loss.(1)

The DSM-IV-TR has a classification for 'Bereavement' (V62.82) differentiating it from 'Major depressive disorder' (296.2) which, unless the symptoms are severe, is generally not diagnosed until 2 months after the loss. ICD-10 has no separate classification for bereavement and suggests the use of 'Adjustment disorders'

(F43.2) for temporary reactions to life-events, and 'Death of a family member' (Z63.4) for normal bereavement reactions not exceeding 6 months in duration.

In industrialized countries between 1.5 and 4 per cent of children are orphaned of at least one parent in childhood. Premature deaths in the parenting years may be due to illness, accident,

war, civil conflict, natural and man-made disasters and the incidence of these are all higher in developing countries. It is estimated by UNICEF that, in some developing countries, 21 per cent of children are orphaned of at least one parent; with HIV AIDS responsible for up to three-quarters of the deaths.(2)

## Reactions to the death of a parent

### Research studies

It is generally accepted that loss of a parent in childhood is associated with harmful psychological consequences, however it is difficult to tease out the independent effects of adverse circumstances before the death, the loss itself and the subsequent disruption to the child's life, including the possibility of compromised parenting post-bereavement(3,4). Most published research about bereaved children describes small-scale uncontrolled studies carried out on children and adolescents referred to mental health facilities. Dowdney comprehensively reviews the research examining the psychological impact of being bereaved of a parent in childhood. She concludes that despite methodological weaknesses, certain findings consistently emerge: 'Children do experience grief, sadness, and despair following parental death. Mild depression is frequent, and can persist for at least a year after parental death'. Bereaved children commonly exhibit a range of psychological symptoms that may not constitute a specific disorder, but the severity of which is likely to warrant referral to a specialist service for one in five bereaved children.(5)

### Long-term effects of bereavement

There continues to be debate about a possible link between being bereaved of a parent as a child, and mental health as an adult. The debate is complicated by methodological weaknesses in studies, inconsistent results and difficulty in isolating the impact of experiences which may precede or follow the loss. Any long term consequences of parental bereavement can be mitigated by the subsequent provision of adequate parenting (6, 7). Furthermore, studies in behavioural genetics are increasing the understanding of how genetic endowment interacts with environmental hazards to lead to the presence or absence of mental health problems.(8)

### Cultural and religious issues

Reactions to loss are biologically based and are therefore likely to transcend cultural differences, although culture may modify their expression.(3) Religious beliefs about what happens after death can be confusing to young children at the stage of concrete thinking and

need to be presented taking account of their developmental stage. A helpful text(9) gives guidance on religious and cultural differences in the conceptualization of death.

**Developmental issues**

Young children react to the absence of a parent by developing an anxiety or depressive reaction, often expressed somatically (regression P.1759 in acquired control, anorexia, insomnia), but young children cannot distinguish temporary from permanent loss (3,10). Research consistently demonstrates that children ordinarily do not develop a full understanding of the concepts of death before the age of 7 years, although younger children of 4 years and above can understand it with appropriate help.(11)

Pre-pubertal schoolchildren can be helped more easily to comprehend the reality of death, especially if they are given an opportunity to see for themselves the cessation of function. In cultures where viewing the body is the norm, there may be fewer misconceptions about death among children, but this should not be undertaken where the body is mutilated.(12) Although difficult to substantiate scientifically, clinical literature suggests that attending the funeral helps the grieving process.(5)

For adolescents the death of a parent may come at a time when they are freeing themselves from dependence and may have been in conflict with the parent who subsequently dies, leaving the young person with feelings of guilt and anger.

Suicidal feelings are more likely to be acted upon if part of a depressive reaction. Adolescents are more able to sustain sad affects and express grief directly, but they may also react with behavioural and academic difficulties.

The reader is referred to Dyregrov for a more comprehensive description of common reactions to bereavement in childhood.(13)

Children and adolescents with learning difficulties may be at higher risk for developing psychological problems following bereavement, because of their cognitive difficulty in understanding the components of the concept of death and because of their greater dependency.(14) Everatt and Gale provide a helpful review of the available research and draw implications for bereaved children with learning disabilities.(15)

**Traumatic bereavement**

As with adults, children who witness horrific events involving the death or severe injury of people close to them, or upon whom they are dependent, are at risk of developing post-traumatic stress disorder (see Chapter 9.3.2). Traumatic symptomatology can impede the resolution of grief through mourning as for mourning to proceed, the child has to summon up an image of the dead person.

However, if when she/he tries to imagine the deceased, a frightening picture appears or she/he experiences again the helplessness or terror he felt at the time of the death, she/he will tend to avoid recalling the person and thus will not be able to grieve for her/him. Similarly, children whose parents die through suicide or homicide are more likely to have difficulties. In such cases, not only is the nature of the death traumatic and more difficult to make sense of, but there is often an unhelpful media interest and, social support systems that would ordinarily be available may find the circumstances of the death unbearable.

If there is a body at all it may be disfigured or its release to the relatives may be delayed the investigation or the authorities and mementoes or suicide notes may be retained by the authorities. Children who have been traumatized by experiencing the sudden, violent, or horrific death of someone close to them are unlikely to benefit from bereavement counselling or therapy until the post-traumatic symptoms have been treated(16,17).

**Other losses**

Much of our knowledge of the impact of bereavement on children and young people is drawn from research on children bereaved of a parent. Other losses have been less well studied; however reactions may be similar depending upon the relationship between the child and the deceased. The death of a grandparent, particularly if he or she lived with the child or carried out caretaking functions, can be devastating to child and parents. Sibling death carries a high morbidity for the survivors, but this can be mitigated by preparation for the death when possible and by participation in community rituals.(18) Adolescents losing a sibling often deny the finality and universality of death, even when these concepts are well established prior to the death.(19) The losses of friends, of pets, or of homes, whilst eliciting sadness, are less likely to provoke pathological grief reactions provided that the child is supported by parents and other adults who are not themselves withdrawn in grief. However, adolescents are affected by the suicide of a friend. A controlled study found that there was a higher incidence of depression than in a matched population sample, although the incidence of attempted suicide was no higher.(20)

**Evaluation of treatments**

Many of the adverse squeal of childhood bereavement can be modified or prevented by an intervention before the death or shortly afterwards. In a controlled study, a brief family intervention 2 months after the death of a parent significantly reduced children's morbidity at 1 year post-bereavement.

The differences between the treatment and the control group were no longer significant at 2 year follow up, but some of the more affected children had been lost to follow-up, making comparison difficult. But even if by 2 years the effect of the intervention is no longer significant,

there is an argument for intervening to relieve symptoms and reduce suffering in the short and medium term.(21) Schut & Stroebe's most recent review concludes that, although in the general adult population a bereavement intervention is more effective for those with more complicated grief reactions, 'children are likely to be a special case, perhaps benefiting from primary intervention.' (A primary intervention is one which is open to all bereaved people rather than targeted at those who are at risk of difficulties such as following traumatic death, or those experiencing complicated reactions.).(22)

**Management**

Children whose symptoms reach the threshold for a diagnosable psychiatric disorder require a careful clinical assessment to determine the most appropriate treatment, and other sections detail the appropriate interventions for disorders such as depression (Chapter 9.2.7), anxiety (Chapter 9.2.6) or Post-traumatic Stress Disorder (PTSD: Chapter 9.3.2). Some studies have found that parents report fewer symptoms in their bereaved children than the children do themselves; this means that it is important in research and clinical practice to interview the children individually if possible.(5)

Children bereaved of a carer urgently need to be looked after and will transfer their attachment to a new caretaker who is available for them and responsive to them. Supporting a widowed parent in his or her grief, and enabling the process of mourning to occur by providing practical help (child care, financial advice, etc.), may be as important as counselling in helping the children. It may be also appropriate to offer support, supervision and guidance to other adults involved in the child's life such as teachers and religious leaders.

The therapeutic elements of appropriate interventions include the promotion of communication within the family about the dead P.1760 parent, the promotion of mourning through reminiscing, the appropriate expression of feelings, and making sense of the death. An overview of techniques used directly with children and young people is provided by Stokes.(23) Techniques for use with children, many of which can be done in groups, include:

Using art and story-telling
Writing letters to the deceased
Creating memory boxes to store reminders of the deceased
Rituals (such as lighting candles, releasing balloons)
Making something that represents different aspects of the person (e.g. salt statues of different colours)
Playing games which encourage children to open up
Role playing

As with all direct interventions with children, the choice of which techniques to use depends upon the child factors such as age and intelligence, the therapist's or counsellor's training, skill, and experience, the nature of the therapeutic relationship and the organizational context. These interventions can be provided by carefully selected, well-trained and well-supervized volunteers.

As part of an intervention, young children may require help to understand what has happened to the deceased by offering a careful and sensitive explanation of what death means in straight-forward biological terms ensuring that the child understands what they are being told. They may also need help to recognize, understand and cope with sad affects both in themselves and in the surviving family members.

Given the indications that problems may develop much later, a useful intervention strategy should include follow-up appointments after any time-limited intervention.

Children who have been prepared for the death of a family member have been shown to fare better, in terms of anxiety levels, than those who have not.(24)

**Conclusion**

Bereavement in childhood, particularly the loss of a parent, represents a significant adversity, although the majority of bereaved children do not develop anything other than transient symptoms. Nevertheless, there is evidence that a brief preventive intervention can reduce subsequent morbidity. Children, who lose a parent through suicide, homicide, accident, or disaster, especially if they have witnessed the death, are at high risk of developing post-traumatic stress disorder and other psychiatric disorders and their treatment needs should be assessed by mental health professionals.

Further information

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Cohen JA, Mannarino AP, Deblinger E (2006). Treating Trauma and Traumatic Grief in Children and Adolescents. New York, The Guilford Press.

Various useful resources for professionals, parents, carers and bereaved young people and children are provided by the UK child bereavement charities: The Child Bereavement charity (www.childbereavement.org. uk) and Winston's Wish (www.winstonswish.org.uk).

Help is at Hand: A resource for people bereaved by suicide and other sudden, traumatic death. This booklet is published by the National Health Service in the UK, and provides particularly good advice for parents of suddenly bereaved children. www.dh.gov.uk/ assetroot/04/13/90/07/04139007.pdf

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