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Death of a Loved One During Childhood: A Review of Ramifications and Interventions

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Abstract

The death or loss of a loved one and the subsequent accompanying grief is a thoroughly-researched topic. More specifically, the focus on the effects of a loss during childhood is also of great interest and importance. How do these effects manifest, both immediately and later in life? Do the losses of different archetypes in a child's life bring about different reactions? What are the most common and most effective support and/or treatment options? This dissertation will review the existing literature surrounding these topics, and will attempt to make connections in subject areas such as diversity, inclusion, and assessment techniques. Lastly, it will discuss treatment options under a critical lens and offer further inquisitions.

Introduction

Bereavement, confronting the deprivation of a close relation through their death, is arguably a universally-feared experience. It is difficult for any individual to come to terms with such a thing, but it is especially complex and life-changing for a child to lose a loved one. A person who has not yet learned the ways of the world - who is already experiencing new and confusing things everyday - is particularly at risk to the adverse effects of bereavement. Frederick Douglass once said, “It is easier to build strong children than to repair broken men.” This is precisely why I believe it is important to draw attention to the significance of treating children who have lost a loved one, and treating them well. In addition, considering all possible additional factors or stressors (i.e. cause of death, socioeconomic status of family, individual differences, etc.) is of great importance. In this review, I will examine the existing literature and treatment methods under a critical lens. Moreover, this dissertation will incorporate analytical as well as anecdotal viewpoints. As part of my psychology student internship at UngLiv.dk, a private psychology firm in Aarhus, Denmark expert in therapy for children and young adults, I was able to observe the practices and participate in the direction of two grief counseling groups. These groups were for children who had experienced the loss of a loved one and needed guidance. In my nearly 12 sessions with the groups over the course of 3 months, I gained particularly important and useful experience working with children who were experiencing the effects of bereavement. As part of my analysis, I intend to include my experiences working with the groups to help emphasize and highlight particular points. However, I will include these experiences in footnotes as supplemental material to the main topics I will discuss.

Chapter 1

1.1 Groundwork

Intuitively, children - that is those under 18 years of age - are one of the most heavily impacted groups when it comes to traumatic experiences. In a cohesive literature review done by Dowdney in 2000, it was found that approximately 20% of children across studies who were experiencing the effects of bereavement expressed symptoms of emotional and behavioral distress, some examples being bouts of depression, anger problems, or regressions (Dowdney, 2000). And these are just the visible manifestations. Many children may express very few observable reactions, if any. Or they may display “nonspecific reactions” that may seem like they are completely unrelated to the event itself, making them difficult to label as a reaction to the death at all. An example of this may be demanding more attention (Schonfeld et. al., 2020). Children are much less likely to be able to express themselves and do not always have an understanding of their situation or a way to communicate what they are feeling. And this is due to the fact that, for most children, these will be events that they have never experienced before (Schonfeld et. al., 2020). An event such as the loss of a loved one can also be exacerbated further if the child is what is known as “complex bereaved”, defined as having “at least one substantial stressor in addition to (the) death” (Cerel et. al., 2006). Examples of additional substantial stressors in a child’s life might include low socioeconomic status of family or preexisting mental illnesses. For instance, children who grow up in more violent communities may experience multiple other stressors, or even multiple traumatic losses (Bordere, 2009). The way in which grief is experienced by a child will also depend on their relationship to the deceased (Bugge et. al., 2014). For example, the death of a child’s father will be experienced differently from the death of a child’s sister.

1.2 Attachment Theory and Separation Anxiety

One of the most influential thinkers in the field of child psychology and attachment theory was John Bowlby. Bowlby was a child psychologist and psychiatrist, with most of his groundbreaking works being from the 1970s and 1980s[1]. Around the time Bowlby was first conducting his research, the Bureau of the Census reported that 4% of children in the United States experience the death of a parent before the age of 15 (Bureau of the Census, 1985). This is not an insignificant number, so it is unsurprising that Bowlby was so adamant in his research. According to Bowlby, attachment is innate - it is experienced by every child in the early stages of their development. Bowlby identified 5 characteristics of attachment: the first characteristic is that attachment is specific, that is, linked to one person. The second characteristic is that the attachment involves the search for physical proximity - this is the behavior the child will exhibit (for example, clinginess). The third characteristic says that the attachment provides well-being and security through closeness. The fourth characteristic says that the attachment provides a secure base from which the child can move away to explore the world and return to. And the fifth characteristic - the most relevant when discussing bereavement - is that when the attachment is interrupted (by death, for example), the child experiences separation anxiety (Rigo, personal communication). In volume II of his "Attachment and Loss Trilogy" entitled *Separation: Anxiety and Anger*, Bowlby explains how separation can be distressing at any age. Even adults will become anxious in a prolonged period of separation from a loved one. But the younger the age that is being considered, the period of time it takes for a separation to become distressing for the individual becomes shorter and shorter. Thus, to an infant or toddler for example, the separation may take less than an hour to become distressing (p. 30). And, intuitively, the younger the individual, the

[1] I believe something that is worth mentioning is how new the field of child psychology is in the grand scheme of research in psychology. Bowlby's works are often cited as being foundational in the field - especially in attachment theory. He is taught in developmental psychology courses at universities around the world. And yet, all of this theory did not come to fruition (some may say it is still developing) until less than half a century ago.

more traumatic the separation (by death) of an attachment figure will be. A child separated from a parent through death may experience problems explained by separation anxiety such as feelings of abandonment or frightening fantasies about what may have happened to the parent that are out of touch with reality (Saldinger et. al., 2003). Children who have experienced the loss of a parent specifically may also display increased separation anxiety to the remaining parent. In interviews with parentally bereaved children, the subjects will report an increase in anxious feelings which oftentimes have to do with fears about losing the remaining parent, or separation from them in some way (Dowdney, 2000). This is a direct reaction to the trauma of the separation (death) that has already occurred, and the resulting fear that it will happen again.

1.3 Reactions to the Death of a Loved One

As one would expect, no two children are the same, and no two children experiencing bereavement will react in the exact same way. That being said, there are some symptoms and manifestations that tend to crop up again and again when observing grieving children. These may include, but are not limited to: problems with appetite (too much or too little), depressive symptoms, anxious symptoms (may include, for example, increased suspicion, or even unrelated fears), separation anxiety towards caregivers, problems concentrating, somatization (physical symptoms like pains or discomfort), regression (i.e. bed wetting), or sleep problems[2] (Schonfeld et. al., 2020). The risk for developing these symptoms has been shown to be heightened in children who have preexisting mental disorders, whose (surviving) parents show high levels of psychopathy, who are male, or whose loved one died

[2] One of the participants in the grief group I helped to lead during my internship was a 9 year old girl who had lost her sister to illness. I had been told by the director of the group that, after her sister's death, the surviving child had begun sleepwalking when she had never done so before. I even experienced this first hand. We took a weekend trip as a group and stayed in a cabin. I shared a room with the 9 year old girl, as she was the youngest in our group and I acted as her "buddy" for the weekend. In the middle of one of the nights, she sat up in bed and began frantically calling for her mother and attempting to get out of bed. I tried to calm her down, but at first it was as if she did not know I was there. Eventually, she came around and was able to go back to sleep.

in a traumatic way (Cerel et. al., 2006). For example, a child whose parent died in a traumatic car accident will be more likely to display maladaptive symptoms than a child whose parent died in their sleep. In interviews with bereaved children, the most common reactions seen when discussing the death of the loved one include crying, anger, guilt, and despair (Kranzler et. al., 1990; Silverman et. al., 1992; Silverman & Worden, 1992 a; Fristad et. al., 1991). In an article from 2000, Rando (though discussing mainly anticipated deaths and the illness phase) noted some of the traumatic anxious symptoms that may be seen in grieving children. Some of these include the loss of the sense that the world is stable or predictable, intense emotions, death anxiety, or intrusive thoughts about the death (Rando, 2000). Feeling guilty is another common emotion amongst bereaved children, i.e. the guilt that may accompany the feeling of not being able to cope with or handle the emotions that come with the death (Saldinger et. al., 2003). Another common behavior displayed by bereaved children is the wish to die themselves, often confused with suicidal thoughts. It is thought that this wish for death in bereaved children has less to do with the actual desire to die, but more to do with the desire to join their deceased loved one, and to be with them again[3] (Dowdney, 2000).

1.3.1 Comparison with Other Psychiatric Disorders

It can also be interesting to note how the effects of loss and bereavement compare with the effects of other psychiatric disorders. For example, one study on bereaved children 2 years postparental death found that subjects were more impaired in their day-to-day lives than the control sample from the community. However, the bereaved children were less impaired than the sample of children with depression. From this it can be seen that, as per the hypothesis, bereavement negatively impacts children, but not quite as much as clinical depression does (Cerel et. al., 2006). On the other hand, as one might suspect, bereavement *causes* some

[3] Several participants I met in the grief counseling groups had histories of these suicidal ideations - the desire to join their deceased loved one and to see them again. They seemed unaware of what death really was, the permanence of it, and seemed only to wish to be reunited with their loved one.

depressive symptoms as well. For instance, in another study it was found that the sample of bereaved children were classified as mildly depressed at a significantly higher rate (14%) than the control group was (4%) (Dowdney, 2000). The definition of mildly depressed that was used in this study being “displays dysphoria plus three other symptoms” such as appetite loss or trouble sleeping. It is interesting to note that, even though suicidal ideation is often displayed in bereaved children, they are much less likely to actually attempt suicide than children who are diagnosed with clinical depression (Dowdney, 2000), suggesting that the feeling of wanting to die has more to do with the death of the loved one rather than the result of an underlying cognitive problem.

With regards to PTSD, one study found that children who had experienced the loss of a loved one had similar symptoms as well as cortisol levels as children who had experienced other traumas such as experiencing violence (Taylor et. al., 2009). From this it can be seen how traumatic the death of a loved one can be for children.

1.3.2 Death of a Parent

The parent-child relationship is (typically) the longest relationship in the life of every individual. Our parents shape us, our identities, and the people we end up becoming. This is why, when a parent passes away during childhood, it can sometimes feel as if the child is losing a part of themselves (Benson et. al., 2022). Another way of saying this is that when a child loses a caregiver for a reason that is completely out of their control (like death), the child’s appraisal of the situation may be that of a threat to their physical integrity (Taylor et. al., 2009). This can also explain why parentally bereaved children may exhibit reactions that do not always make sense, like strong anger or resentment toward the deceased, for example. A common occurrence in a parentally bereaved family is that the surviving parent will exhibit a high level of psychopathy (Dowdney et. al., 1999), thus it is not uncommon for their children to exhibit depressive or dysphoric symptoms. This is due to the way children model their grieving process based on the grieving processes of their caregivers. Also of interest to note is that, when a parent dies in a family that is experiencing financial hardship,

this will typically lead to the loss of a salary. This is yet another huge stressor for these types of families and may lead to more struggles and traumas with regards to finances because money can be of huge use in finding ways to cope (Cerel et. al., 2006).

1.3.3 Death of a Sibling

The death of a sibling will be experienced differently as compared with the loss of a parent during childhood - even though they are both traumatic experiences. As with any death, the loss of a sibling is associated with reactions like depression, anxiety, and health problems. But more specifically to the situation, sibling death can result in academic or relational problems, and risk of early mortality (Rostila et. al., 2017). It is a common experience amongst bereaved siblings to feel as though they must suppress their own grief in order not to further upset their parents (Horsley & Patterson, 2006). Another common occurrence in the case of sibling loss is the parents redirecting their grief and their anxieties onto their surviving child(ren) (Benson et. al., 2022), which will likely only delay the healing process further.

1.3.4 Familial Reactions

An experience that may not be so intuitive when discussing bereavement in children is the secondary trauma of witnessing surviving family members grieving as well. As a family typically functions as one big unit, each family member will have reactions to the others - they will reverberate off one another (Saldinger et. al., 2003). The way parents model grieving behavior is directly linked to how the child will display their subsequent grieving behavior (Morris et. al., 2016). In this way it can also be seen how the “out of sight out of mind” style of parenting is damaging in loss situations. If a parent chooses to ignore that anything is happening at all, this will only confuse the child and possibly delay the healing process - it will affect their ability to “make sense of” their loss (Steffen & Coyle, 2017). Additionally, children may react negatively to the feeling that, after losing a parent, the

remaining parent is “moving on” (Benson et. al., 2022). This can feel very confusing and unfair for a child with an underdeveloped sense of the world.

1.3.5 Consequences Later in Life

The death of a loved one during childhood is the type of traumatic experience that can lead to negative consequences later in adult life. It has been put forth by Brown et. al., however, that it is not likely to be the experience of bereavement in childhood itself that can lead to depression (as an example) in adulthood. Rather, it is more plausible that it is other factors, such as the reactions of the parent(s) or financial struggles that lead to adult psychopathy (Brown et. al., 1986). In fact, several studies have found that the relationship quality with the parents during childhood is more related to subsequent adult depression than the actual loss is.

Chapter 2

2.1 Common Misconceptions About Treatment

The first topic that should be delved into when discussing the treatment of bereaved children is what not to do. It is common for the significant adults or caregivers in the lives of bereaved children to feel reluctant or uneasy when broaching the topic with them. These adults may feel as though talking about the death will only make things worse (Schonfeld et. al., 2020). This is simply not true. Other myths that tend to surround the topic of grieving in children include “time heals all wounds” or that children do not mourn because they are too young (Benson et. al., 2022). Making the decision not to discuss feelings of grief and mourning with a bereaved child will likely only isolate them further and exacerbate possible negative outcomes. Because there is evidence that suggests the negative effects of bereavement in children are often delayed by up to five years (Rutter, 1966), and because it is common for children not to show outward signs of distress after a significant death, present adults and caretakers of these children tend to overestimate their resilience, not allowing for proper healing (Schonfeld et. al., 2020). It may seem counterintuitive, but parents can even be significant stressors to their child(ren) experiencing bereavement. To quote a paper done by Saldinger and colleagues in 2003, “when a parent insists that children exhibit a level of self-sacrifice that exceeds their level of maturity, the anticipatory experience can become a painful, if not toxic, one for them.”[4] Sometimes, parents may be unable to gauge how their child may be reacting to the death of their loved one, especially if the child is not exhibiting any outward reactions. It is easier to dismiss the trauma of children who internalize their emotions and reactions (Saldinger et. al. 2003). Of course, a parent who may be unknowingly creating an uncomfortable environment for their grieving child should not be

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[4] Again, this anecdote focuses on the 9 year old girl who lost her sister. Understandably, it seemed her parents were not sure how best to talk with her about the death, and her mother would often say things to her such as “you look so much like your sister.” My mentor, the director of the group, had a talk with the mother to remind her that saying such things would do more harm than good, as the child would likely have adverse reactions to sentiments like that.

chastised. Rather, they should be reminded of the humanity of their child. It is of great importance for caretakers of bereaved children to remember that children still have human emotions and that engaging in normal conversation with them is still possible.[5] Children have a better understanding of themselves than we may assume they do. In several studies in which bereaved children are interviewed, they will report more experienced psychiatric symptoms than their parents will report about them in separate interviews (Gersten et. al., 1991; Fristad et. al., 1991). Additionally, the simple acts of showing a child that you want to interact and converse with them, and that you are interested in what they have to say - not apprehensive - can be of huge significance to a child experiencing bereavement.[6] Another damaging assumption that is sometimes made is of the existence of “good deaths” (Saldinger et. al., 2003). For example, if the death was anticipated, that is, the family was

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[5] This paper will not go in depth on the best/most effective specific therapeutic techniques for psychologists. However, one of the most salient pieces of advice I received from my mentor at UngLiv.dk was about asking questions of bereaved children - and that is, to leave space (silence) between them. There are 2 main reasons for doing this: the first being the importance of giving time for the question being asked to “sink in” and to be felt by the child. Most of the time, the questions being asked of bereaved children are very heavy, so it is important to allow the time and space for them to be absorbed and comprehended. And the second reason being that it is crucial to make the child feel like they are competent enough to answer the question and that their answer is something you want to hear and that is worth listening to. Too often, psychologists will show in some way (this can be in a multitude of ways) that the answer they heard was not the one they were expecting or that they wanted to hear. And the most common of these ways is moving on to the next question too quickly.

[6] Another important piece of advice I learned from my mentor at UngLiv.dk was about making eye contact when speaking with bereaved children. It was something I noticed her and her co director doing before she even mentioned it to me as a learning moment. Making direct eye contact - and not breaking it as the child is speaking - can be incredibly helpful in conversation. The main reason why this is done is to make sure the child feels heard and listened to. Secondly, a common phenomenon amongst children in therapeutic settings is answering questions with “I don’t know.” When this happens, oftentimes psychologists will break eye contact because they feel as though the interaction is over. But the advice I was given is to instead maintain that eye contact, and to not move on too quickly to the next question. This is because, if you give them enough time, children will commonly circle back to the unanswered question if they feel that you are still interested in what they have to say. And this is why eye contact is important in these situations.

aware of the fact that the death was inevitable (i.e. an expected death from a long battle with cancer), it may be assumed that the accompanying grief will not be as significant since the loved ones were given more time to prepare. This is, of course, untrue. And, after first considering individual differences and the fact that no two people will grieve in the same way, the sooner assumptions like these are put to rest by psychologists, the sooner treatment for bereavement can be expanded upon in a more fruitful way.

2.2 PTSD/Trauma in Children

Living through the death of a loved one and experiencing the subsequent effects is a textbook example of trauma. Some researchers such as Rando (1997) have even gone so far as to say that all acute grief is traumatic. And the evidence he cites is the fact that grief is anxiety-inducing, victimizing, and exposes the individual to distressing material as well as the feeling of loss of control (Rando, 1997). Whether or not all grief is traumatic or not, Furman (1986) helps to explain why children are especially at risk for the adverse effects of trauma. He posits that it is the immature ego of the child that makes them particularly unable to cope with trauma as well as an adult. And especially with the loss of a parent comes the loss of the precise person who should be there to help the child to develop their own coping mechanisms (Furman, 1986).

The symptoms of PTSD (Post Traumatic Stress Disorder) in children are important to review in this section. They are slightly different from the symptoms that will manifest in adults with PTSD. These will include manifestations such as intrusive, unwanted thoughts, memories, or even dreams. This can also lead to feelings that the trauma is happening again or could lead the child to a dissociative state. When children are engaging in play, they may act out the events of the trauma (this could include, for example, drawing pictures that relate to the event). Children may also actively avoid anything that reminds them of the trauma (for example, certain people or places). They may experience negative thoughts or feelings like guilt or anger, or they may lose interest in activities they once were very excited about.

Lastly, children with PTSD may experience increased arousal, such as feeling jumpy, cranky, or hypervigilant (Schonfeld, 2020).

The best and most common way of assessing PTSD in children is with the CAPS-CA (Clinician-Administered PTSD Scale, Children and Adolescent version). The CAPS-CA is a structured clinical interview based on DSM 5 criteria of PTSD. It asks prompt questions, supplementary follow-up questions, and has a 5-point rating scale that individually assesses the intensity of each symptom (Taylor et. al., 2009). The CAPS-CA is internally consistent (Nader et. al., 1996).

2.3 Assessment

One of the most useful tools that exists for assessing behavioral and emotional problems in children is the Child Behavior Checklist (CBCL). The CBCL is used in interviews with the parent(s) of the child(ren) being assessed. It consists of two scales: internalizing and externalizing. These two scales are assessed and the result is given as a Total Problems score. The internalizing scale evaluates subscales of withdrawn, somatic, anxious, or depressed behaviors displayed by the child. And the externalizing scale evaluates subscales of delinquent or aggressive behaviors displayed by the child. It has been found that children who have experienced bereavement consistently score significantly higher on the Total Problems score, as well as higher on the somatic, thought problems, delinquent, and aggressive behaviors subscales (Taylor et. al., 2009).

2.4 The Treatment Process[7]

Most studies on the treatment of bereaved individuals tend to focus on the meaning-making aspects of the healing process (i.e. Lichtenthal & Breitbart, 2015), that is, when someone

[7] My mentor during my internship taught me that it is important to remember that, as psychologists and the leaders of these grief groups, it is not our job to “cure” any of the participants of whatever it is they may be experiencing. It is our job to simply offer a safe space to work through their emotions and to offer various bits of advice and coping mechanisms.

experiencing loss is able to make meaning of the situation, they are more able to find their purpose and way of life again (they are better able to cope). When parents, for example, are open with their emotions surrounding a loss, and encourage their child(ren) to work through their feelings openly, it reinforces healthy communication techniques and helps the child(ren) immensely in their meaning-making process with regards to the bereavement experience (Davies & Limbo, 2010). Young children must understand four concepts about death before they can really begin to work through their grief: they must grasp the conceptualizations of death's irreversibility, its finality, its causality, and its universality. If any of these four concepts are misunderstood it may interfere with their meaning-making processes and their adjustment (Schonfeld et. al., 2020). When treating bereaved children - or their parents for that matter - a technique that seems to crop up repeatedly in the literature is starting responses with "I wonder" or "might so-and-so work". It is better to phrase advice as a question sometimes, rather than saying "this will work for you". This gives the patient more freedom and authority in the situation. Schonfeld (2020) also outlines 10 steps for caregivers of bereaved children to follow when attempting to provide counseling. The first step is to ask the child what they know about the loss. Second, to be empathetic, concerned, and to offer support. Third, to give some baseline information about the death that the child may or may not already be aware of. Fourth, to allow themselves to feel and show genuine emotional reactions when discussing the topic - this gives the child free reign to react how they need to as well, and to feel that you are being authentic. Fifth, to use direct and broad questioning[8]. Sixth, to listen more than talk, and to discuss in a nonthreatening, non judgemental way. Seventh, to try not to share personal anecdotes - to keep the focus on the child. Eighth, to give practical advice, but only in direct response to something the child has mentioned.

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[8] This directly relates to a technique used in the grief counseling groups I observed and led. The technique is to use "H" questions when discussing the death ("H" refers to the Danish question words, but the English equivalent would be "W" words, such as "who", "when", "where", or "what"). This is used because we do not want to make any assumptions or interpretations of what the child might be saying. These questions are about getting to know them and learning about them and their situation.

Ninth, to be reassuring and committed. And tenth, to stay in contact. Sometimes, consistency alone can be the biggest help in the life of a bereaved child.

Chapter 3

3.1 Limitations

The current literature on bereavement in children is extensive, but not necessarily diverse. Many studies center around white populations, with very few centered around populations of color (Benson et. al., 2022). Whether this is a deliberate choice or something that happens out of necessity is not always clear. Another issue that seems to crop up in bereavement literature is that most samples of bereaved children tend to come from psychiatric clinic attenders. This makes sense as these are the most likely of places to find a big enough sample for research. But it is not nearly representative enough, as children who attend psychiatric clinics are the most likely to be experiencing severe and outward symptoms - symptoms that were the reason they were referred or admitted in the first place. This does not allow for representative sampling of the whole population of bereaved children.

3.2 Discussion

Caring for bereaved children is incredibly important, but it is no easy feat. The most intuitive notion is that the care of the child should come first. But something that maybe is not discussed enough is the care for the carer, so to speak. The health and mental clarity of the psychologist is of extreme importance in instances such as these loss events[9]. Supporting bereaved children in particular can be exhausting. The stories of patients can be difficult to hear. And most children do not yet know how to consider the feelings of others and may not filter the way they speak about what has happened to them - this can even lead to vicarious traumatization in the psychologist (Schonfeld et. al., 2020). Some advice given by Schonfeld et. al. in their 2020 paper is to include activities in one's day-to-day that satisfy the three Rs: relaxation, rejuvenation, and revitalization. Lastly, I believe that the absolute most important

[9] My mentor during my internship taught me that, in order to be a good psychologist, it is incredibly important to be in touch with yourself. To be able to know how you will react to something, and *why.* To be able to anticipate situations, and to *practice* to get into that flow.

practice psychologists can implement in their work is to recognize their own biases and the assumptions they may be making. Of course, it is impossible to approach any situation without bias - it is a completely unconscious and human phenomenon. What we can do, however, is attempt to bring these assumptions to our consciousness. I believe that too often, in the treatment of any psychopathy, psychologists will go in already assuming they have the answers. Again, as mentioned previously, the goal in therapy and treatment should not be to cure anything. It should simply be a conversation about lived experience. I believe that this will make the treatment of bereaved children a much more human experience. It is true that some experiences and manifestations will be predictable, but we must remember that some will not be. And that when something unpredictable happens, there is no need for panic or confusion. It should be treated as a learning moment and an opportunity for growth. This is the only way the field of child psychology can continue to grow and be expanded upon.

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