Children bereaved by parent or sibling death

Linda Dowdney

Children grieve following the death of a parent or sibling. Their reports of grief-related feelings and behaviour are similar in many respects to those expressed by grieving adults. Children report shock, confusion and disbelief at learning of the death. Subsequently they experience sadness, a longing for the dead person to return, concentration difficulties, sleeping and eating difficulties, and anger.[1] Children express grief differently according to their understanding of death and their developmental level – which can confuse those caring for them.

Concepts of death

Prior to the age of 7 years, children are unlikely to understand the irreversibility of death leading to repeated questions about their parent or sibling's return. They believe that their own thoughts or behaviour can cause or reverse death. Concepts such as 'heaven' and 'spirit' will be difficult to grasp. By 9 years of age, children understand the universality and permanence of death, but continue to wish for the return of their sibling or parent. They believe they could have influenced events leading up to their death. Until children fully grasp, around the age of 11 years, that death equates to a full cessation of bodily function, they will have anxieties about the loneliness, hunger and cold of the dead person. Even at this stage, they actively imagine an afterlife in which their family member behaves in much the same way as when alive: eating, drinking and enjoying their favourite pastimes. Adolescents pose questions about the unfairness of death and the meaning of life.[2] Children who are particularly able in their cognitive and verbal abilities will grasp the concept of death more quickly. Even children as young as 8 years old will understand the permanence of death if they have known a person who has died.

Developmental trends in children's expressions of grief

Bereaved children and adolescents have a capacity for distracting themselves through activities such as play or social activities, which causes some adults to question whether they are truly grieving. This uncertainty is compounded by children's difficulties in verbalizing feelings. Children's intellectual curiosity which can lead to persistent questioning about death unaccompanied by expressions of loss may distress grieving adults.

Preschool children do have a sense of loss when a parent or sibling dies, and may actively search for them. Their sense of loss will be compounded by major changes to their routine and the grief of those around them. They can show regression in developmental milestones, increased dependency, crying and distress can be evoked by minor upsets, and relationships with other children can be disrupted by unexpected expressions of anger or aggression.

Middle childhood: with an improvement in verbal abilities, bereaved children can begin to express their fears – for example, about going to sleep. There may be difficulties going off to sleep in 5- to 7-year-olds, while older children report sleep disturbed by nightmares. Parents report their bereaved children up to the age of 12 years have difficulty sleeping, unless near an attachment figure. Dreams are not always negative, however, and many children say that dreaming about their parent is comforting.[1] From about 8 years of age, children report an increase in headaches and other physical manifestations of distress. They may find it hard to concentrate at school. Children's questions about death can reflect curiosity or underlying anxieties about their 'responsibility' for the death. Once children realize that their questions distress grieving adults, they attempt to protect them by not asking questions. This carries the risk that children's misconceptions will continue unchallenged. The death of a parent or sibling challenges children's beliefs that death is a manifestation of old age, and the separation anxiety that young children can evince, causes worries in middle childhood about the vulnerability of other family members.

Adolescents report a similar range of feelings to younger children, and they express them in a variety of ways. They may withdraw from family activities, and/or seek support from peers. Death leads bereaved adolescents to question the meaning of life. Some challenge their own mortality with risk-taking behaviours such as drinking or taking drugs.[3] Adolescents have the cognitive capacity to review the past and contemplate the longer-term consequences of death. Their ability to recall and review the relationship with the deceased, can be a source of comfort. Alternatively, where there is guilt or regret for past behaviour towards the parent or sibling, they can become more distressed. At a time of approaching individuation, parental or sibling death can charge the adolescent with new family roles and responsibilities, and expectations of adult-like behaviour. Their sense of responsibility and desire to protect grieving adults can lead to a disguised grief which results in mixed messages to those around them.

Grief symptoms in bereaved children start attenuating within 4 months post death. Generally, these symptoms do not interfere with children's overall functioning, although emotional and behavioural disturbance in bereaved children can persist for up to 12 months.[4] While the death of a parent changes a child's life path irrevocably, grieving children can also respond in positive ways to bereavement, with an increase in independence, a determination to do better at school, and a heightened capacity to understand the distress of others.[4] Some adolescents report an increased appreciation of family relationships and also a growth in spirituality.

***Linda Dowdney** is a Consultant Clinical Psychologist who has worked clinically, and also undertaken research, with bereaved children. Until recently, she was course director of the PsychD Clinical Psychology training programme at the University of Surrey, UK.*

 © 2005 The Medicine Publishing Company Ltd

Morbidity in bereaved children

Distress does not equal pathology.[5,6] The proportion of bereaved children showing disorders of clinical significance varies from study to study depending on inclusion/exclusion criteria, recruitment practices and measures used. In general, children report more symptoms than their parents do of them. Inevitably, studies including referred children show the highest rates of disorder with as many as two-thirds showing clinical dysthymia (persistent mild depression). However, data from the best controlled studies of bereaved children, indicate that only one in five bereaved children will show disturbance at a level warranting clinical referral.[4]

Studies generally agree on the symptoms shown by bereaved children, with dysphoria (a state of unease) being frequently found. Clinicians and researchers find that many children report a wish to be dead. While this needs careful exploration, for many bereaved children this reflects a desire to be with the deceased rather than a wish to end their own life. Children infrequently develop anxiety or somatizing disorders, although headaches and stomach aches increase and anxieties about separation are common. In general, disturbance is nonspecific, taking the form of a marked heightening in the frequency and persistence of grief symptoms – crying, sadness, guilt, anger, behavioural acting out, and despair.[4,7]

Children bereaved by familial murder or suicide form a high-risk group, with as many as 63% reporting internalizing symptoms of probable clinical severity.[8] Post-traumatic stress symptoms are commonly reported and make bereavement more problematic as protectiveness towards other traumatized family members can inhibit support seeking and family communication.[9] While traumatic symptoms usually attenuate within the first few weeks or months, guilt, stigma or shame, and anger are more persistent in children bereaved by murder or suicide.[3]

Traumatic bereavement: most recently, 'traumatic bereavement' has emerged as a putative clinical disorder in a sub-group of children.[3] This differs from grief accompanied by post-traumatic stress disorder, because trauma symptoms persist for lengthy periods and are not merely aroused by reminders of traumatic events. Extreme symptoms of heightened arousal and distress are evoked by even positive reminders of the dead person, or by referral to life changes that have followed the death. The result is an emotional numbing and avoidance of any reminders of the dead person or the death. It is their refusal to participate in mourning rituals, such as memorial services at school, their continued refusal to talk of the deceased even when the family is remembering happy times, or their withdrawal from family life or peer relationships, which leads parents to seek help. It is unclear why some children respond in this way, as present understanding does not suggest a prior vulnerability or attachment difficulties.[3]

What influences child morbidity?

Studying bereaved children is difficult as they are hard to find and access. Consequently, there is little systematic exploration of variables that might influence child morbidity. Research evidence suggests children's involvement in mourning rites, whether the death was expected or unexpected, and whether it was the mother or father who died, does not influence child pathology, even though these matters can affect the distress children express. By contrast, the age and sex of the child do influence clinical outcomes. Younger children more often show behavioural or anxiety problems, while dysphoria or depression are more common in adolescents who can show the profound sadness, appetite and sleep difficulties found in adult bereavement. Generally, boys exhibit higher rates of overall difficulties and acting out/aggressive behaviours than girls who are more likely to show sleep disturbance, bedwetting and depressive symptoms.

Research evidence suggests that mental health difficulties in either parents or children prior to bereavement may increase vulnerability to disturbance post bereavement. Parental mental health difficulties after the death are more clearly seen to influence child outcome. Parents, teachers and children concur in reporting higher rates of child depression, conduct disorder, anxiety and somatic symptoms, when parents report they are experiencing mental health difficulties. This suggests an enhanced risk for children when parental difficulties limit the support they can give.[4]

Families vary in the ways in which they organize themselves, how they talk together and share family tasks. These patterns influence how grief is expressed and the type of role changes necessary following a parental or sibling death.[10] However, there is no strong evidence that normal variations in family life influence the development of child pathology. There are some indications that prior marital conflict, separations and divorce can increase the risk of child disturbance. There is difficulty assessing the importance of these factors because information on them is provided retrospectively by bereaved parents whose memories may be affected by their grief and distress. Also, there may be genetic influences upon child outcome when pre-existing psychiatric morbidity is found in family members.[11] Childhood resilience remains largely unexplored in bereavement studies, in spite of its potential importance for prevention and intervention.

Interventions with bereaved children

Theory, culture and intervention

Two theoretical models have particularly influenced interventions with bereaved children: those of Bowlby and Worden.[12,13] Bowlby describes child grief as a process spanning an initial disbelief in the parent's death, a yearning for them accompanied by a sense of their presence, and distress as the permanence of the loss is realized. Grief is appropriately resolved when the child accepts the death, emotionally separates from the deceased, resumes their developmental trajectory and forms satisfactory new relationships. Whether children negotiate this process satisfactorily will be influenced by the quality of their prior and current attachment relationships. Worden, in his description of adult bereavement portrayed the grief process as a series of tasks that the mourner needs to accomplish in order for grief to be resolved. Worden's model has been adapted and applied to bereaved children.[14] The tasks that bereaved children have to complete include: gaining an understanding of how the death occurred; accepting the pain and permanence of loss, tolerating mixed feelings such as sadness and anger; renegotiating the relationship with the deceased so that a positive internal image and psychological connection is maintained; forming a new identity that reflects role changes, and finding new and supportive relationships. Both theorists recognize the importance of family relationships, share an emphasis

© 2005 The Medicine Publishing Company Ltd

Download English Version:

https://daneshyari.com/en/article/9381776

Download Persian Version:

https://daneshyari.com/article/9381776

Daneshyari.com