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The Bereaved Child

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Summary: This is a one-year prospective study of one hundred and five 2 to 17 year old children of a consecutive sample of young widows and widowers in the community and of the children of controls. The children's reactions to the parental death were recorded at one month and thirteen months after the event in a structured interview with the surviving parent. The interview included items of general adaption to the death, school performance, behaviour problems, symptoms relevant to psychopathological manifestations (depression, anxiety, etc.) and general health. The results indicate a significant increase of dysphoria which disappears over time ($P < 0.0001$), the persistance of a minor form of depression ($P < 0.03$), an increase in bedwetting ($P < 0.03$), and a significant degree of impairment in school performance ($P < 0.0001$). There were no significant increases in behaviour problems and severe forms of depression. The children's general health was not affected. Those results are compared to currently available data on childhood bereavement and discussed in the light of conflicting reports relating parental loss to adult psychopathology.

The impact of the death of a parent on the child's psychological development has long been emphasized in the psychoanalytic literature. Two studies (Wolfenstein, 1966; Miller, 1971) are clinical descriptions of intensive psychotherapy cases, and although they do not report follow-up results into adulthood, they imply long-term consequences for mental health. In the main, they agree that the process of mourning, as described by Freud (1950) in the adult, does not occur in the child. The child is thought to use mechanisms of denial, identification and idealization to protect itself against the loss (Wolfenstein, 1966). Since most of the studies were of patients referred for emotional problems (some antedating the death of the parent), these analyses may not reflect the population of bereaved children as a whole.

Retrospective studies have also addressed the question of a possible link between early life losses (by death, separation or divorce of the parents) and psychopathology developing in adult life. Lloyd (1980) recently reviewed this and found the results contradictory, probably, as Gregory points out (1958), because of the methodological problems inherent in retrospective studies.

Prospective studies are few in number. Several authors, Gregory (1965), Markusen and Fulton (1971) and Bendiksen and Fulton (1976), followed at three different periods in time a large sample of Minnesota ninth graders gathered in 1954 by Hathaway and Monachesi for their MMPI study of predictors of high school dropout and delinquency. They looked into their home situations at the time of intake and isolated three groups of subjects: those who had lost either parent by death, those whose childhood had been disrupted by parental divorce or separation, and a control group.

Gregory (1965), in the three year follow-up, found in children of both sexes a higher rate of delinquency in the first two groups than in controls if the child had lived with the opposite-sex parent, whether the loss was due to death, divorce or separation. The same was true for non-delinquent high school dropouts.

Markusen and Fulton (1971), studying the same cohort in their mid-twenties, looked at two outcome variables: marital disruptions and rate of offenses against the law (for boys only). The bereaved male and female children were not significantly different from the controls. There was a trend for the bereaved males to have had more offences against the law but fewer than those whose parents were separated or divorced.

Bendiksen and Fulton (1976), following the sample into their early thirties, did not confirm Markusen's previous findings attributing this to an 'age-graded' effect. However, he found the bereaved subjects to be suffering from significantly more serious medical illnesses and more 'emotional' distress than controls.

To our knowledge this is the first prospective, controlled study of bereaved children from the

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general population inquiring systematically about a wide range of psychiatric symptoms, aspects of general health, and sociodemographic data.

Methods

The present study was undertaken while performing one month and thirteen month follow-ups of a consecutive group of recent, young, white widows and widowers and appropriate controls in the St Louis Metropolitan area. Methods concerning the adult part of the study are explained elsewhere (Clayton, 1979).

Bereaved subjects and controls with children were interviewed at the one month and thirteen month follow-up, using a structured interview, about their children's reactions to the death of the other parent. A maximum of three randomly selected children per family, between the ages of 2 and 17, were inquired about. The structured interview included items on general adaptation to the death (role changes, identification, etc.); school performance; behaviour problems at school or at home; symptoms relevant to depression, anxiety, phobias and hysterical manifestations; and general health (number of physician visits, hospitalizations, new health problems or change in previous health problem, etc.). Where appropriate, responses were rated in terms of before the index death, during the index illness, and since the death.

Statistical analysis was performed using a χ^2 test with continuity correction when subjects were compared to controls, and a McNemar χ^2 with continuity correction when compared to themselves at different points in time. A t-test was used for continuous variables. Symptoms for which, because of the age of the child, no relevant information could be obtained were not included in the analysis.

Results

Characteristic of samples of subjects and controls

Information was obtained about 111 children of 50 widows and widowers at one month. At thirteen months, three families refused to be interviewed, leaving 105 children for whom information was obtained twice. Tables I and II give some sociodemographic information on the index children and parents, and their controls. No significant differences were found in sex distribution and age, nor did the parents and their controls differ in socioeconomic status, number of children or psychiatric diagnoses. In addition, prior to the parental deaths, the bereaved children had school performances identical to their controls.

Frequencies for individual symptoms in index children and controls are given in Table III. The period covered was the last thirteen months for the bereaved and the last year for the controls. The symptoms are grouped by categories (depressive, somatic, behaviour disturbance and school performance). Strikingly, all but three items were more frequent in the bereaved children than in controls but only few of them were significantly increased. A significant increase in dysphoric mood, characterized by sadness, crying or

TABLE I

*Sociodemographic data of beareved and control children**

		Bereaved (N = 105)	Controls (N = 80)
Sex:	M	63	36
	F	42	44
Age	mean	11	10
	range	2–17	2–17
Performance of student—	A	21.2%	21.7%
	B	38.8%	38.3%
	C	32.9%	33.3%
	D and under	7.1%	6.7%

* All the results are not significant using a chi-square statistic for the qualitative variables and a t-test for the quantitative variable.

TABLE II

Sociodemographic data and psychiatric diagnosis of interviewed parents†

	Bereaved (N = 47)	Controls (N = 35)
Sex: M	23	16
F	24	19
Age mean	37	37
range	21–45	27–45
Child/parent ratio*	2.2	2.4
Lifetime psychiatric diagnosis:		
Unipolar depression	17% (8F)	9% (2F + 1M)
Alcoholism	13% (6M)	3% (1M)
Bipolar illness	2% (1F)	3% (1F)
Hysteria	2% (1F)	3% (1F)
Undiagnosed	9% (3F + 1M)	12% (2F + 2M)

* Ratio of number of children interviewed by parents interviewed. Not statistically tested.

† All the results are not significant using a chi-square test for the qualitative variables, and a t-test for the quantitative variable.

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TABLE III

Frequency of symptoms in bereaved (at 1 month and/or 13 months) and control sample

	Bereaved N = 105** (%)	Controls N = 80** (%)	Significance† P<
Depressive mood:			
Sadness	52	10	0.0001
Crying	65	15	0.001
Irritability	39	23	0.03
Any of the three	77	34	0.0001
Depressive symptoms			
Withdrawn	31	13	0.005
Sleep troubles	19	6	0.02
Nightmares	11	9	
Decreased appetite	15	5	0.05
Decreased weight	5	0	
Headaches	22	15	
Disinterest in school	25	13	
Loss interest in general	11	3	
'Severe' depressive syndrome (at least 4 symptoms)	6	4	
Depressive syndrome (at least 3 symptoms)	14	4	0.03
Somatic symptoms			
Headaches (see depression check list)			
Bowel troubles	7	5	
Abdominal pain	21	13	
Vomiting	7	1	
Excessive accidents	16	8	
Bedwetting	19	7	0.03
New health problem	10	7	
Visits to physician (actual number)	1.78	2.13	NS‡
Hospitalization(s) (at least one)	7	5	
Behavioral symptoms			
Behavior problem other than school	5	10	
Temper tantrums	35	20	0.04
Fighting sibs	64	65	
Fighting others	11	6	
Increased interest in general	51	37	
School problems			
Disinterest (see depression check list)			
Change school (moving)*	9	6	
Fail grade (this year only)*	1	0	
Change in school performance*			
poorer	18	0	0.0001
better	7	0	
School phobia	6	4	
School dropout	6	1	

† Chi-square test.

* Rated only at second interview.

‡ t-test.

** N varies slightly depending on the relevance of some symptoms for each subject in particular.

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irritability was found in the index children (77 per cent vs. 34 per cent, P <0.0001). Other symptoms showing a significant increase were: sleep difficulties (P <.02); decreased appetite (P <.05); withdrawn behaviour (P <.005); and tempers (P <.04). A severe depressive syndrome, using criteria similar to those used in adults (Kuperman and Stewart, 1979) (i.e. presence of dysphoria and at least four depressive related symptoms), was not significantly more frequent. However, when a depressive syndrome was defined using only three positive symptoms from the depression checklist, in addition to having a dysphoric mood, the group of bereaved children showed a frequency of 14 per cent compared with 4 per cent for the controls (significant at the .03 level).

Among somatic symptoms, bedwetting was significantly increased (P <.04) but no significant differences were found in number of physician visits (including psychiatrist) or hospitalizations.

There was a highly significant drop in school performance which, however, in the interval covered, had not led to school dropout or grade failure (P <0.0001).

Of interest, even though 89 per cent of both groups of children had 'acquired some concept of death', only 34 per cent of the bereaved children and 24 per cent of the controls who had experienced the loss of a close relative or friend during the year covered by the interview (NS) asked questions about the dead parent, relative or friend. If the bereaved children did ask questions, however, they were more likely than their controls to ask *frequent* questions (24 per cent com-

TABLE IV

Frequencies of symptoms in bereaved children at 1 month versus 13 months

	1 month % (N = 105)	13 months % (N = 105)	13 months only* % (N = 105)	Significance† P<
Depressive mood				
Sadness	41	26	12	0.02
Crying	56	26	9	0.000005
Irritability	18	29	21	
Any of the three	70	43	8	0.00005
Depressive symptoms				
Withdrawn	14	22	17	
Sleep trouble	12	11	7	
Nightmares	5	10	7	
Decreased appetite	10	9	6	
Decreased weight	1	3	3	
Headaches	11	16	11	
Disinterest in school	11	26	17	0.006
Disinterest in general	6	6	5	
'Severe' depressive syndrome (4 symptoms)	1	6	5	
Depressive syndrome (3 symptoms)	4	11	11	
Somatic symptoms				
Bowel trouble	4	4	3	
Abdominal pain	8	18	13	0.01
Vomiting	4	5	3	
Excessive accidents	7	11	9	
Bedwetting	13	14	6	
Behavioral symptoms				
Temper tantrums	18	28	18	
Fighting sibs	41	60	25	0.001
Fighting others	8	6	3	
Increased interest in general	15	47	36	0.000005
School phobia	1	4	4	

† McNemar chi-square, between 1 month and 13 months data.

* Symptoms present since the first interview excluding the subjects who had symptoms at 1 month.

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TABLE V

Comparison of severe depressed bereaved children and depressed control children

Depressed bereaved Case No.	Deceased diagnosis	No. Affected/Total No.†	Sex child	Age child at T_2	Diagnosis of surviving parent	Sex of surviving parent
04	No	1/3	F	16	Unipolar D§	F
12	No	1/3	M	6	Unipolar D§	F
25	No	1/2	M	17	Normal§	F
28	No	1/3*	M	17	Unipolar D§	F
46	Alcoholism (also cause of death)	1/3	M	18	Undiagnosed§ (? depression)	F
57	No	1/2	F	13	Hysteria 2°Depr.§	F

Depressed controls Case No.	Diagnosis of other parent	No. Affected/Total No.†	Sex child	Age child	Diagnosis of parent interviewed	Sex of parent interviewed
02	No information	1/3	M	14	Normal	F
40	No information	1/3	M	12	Unipolar D	F
43	No information	1/3	F	17	Normal	M

* Diagnosis of depression at 1 month only.
All other diagnosis were made at 1 year follow-up only.
† Ratio of number of children affected by total number of children interviewed in each family.
§ Psychiatric status of parent present before and after death.

pared with 3 per cent, $P < 0.0005$). Also of interest, parents reported that their bereaved children took more responsibilities and were more helpful (49 per cent) than they had been prior to the parental death. Encouragingly, only rarely did any of the children view the future pessimistically (8 per cent bereaved and 5 per cent controls, NS).

Table IV gives an idea of the evolution of symptoms between the two evaluations. There was a significant decrease in dysphoric mood and a significant increase in abdominal pain and fights with siblings, with lack of interest in school but increased interest in general non-academic activities. The other symptoms in which index and control children had differed significantly remained unchanged. Table IV also shows that the index children who presented symptoms or abnormal behaviour for the first time at the second interview (thirteen months) were not different from their controls (see Table III).

Even though the severe depressive syndrome in bereaved children had not been significantly more frequent than in controls (6 per cent compared with 4 per cent), children with this depressive syndrome were characterized further as shown in Table V. The size of these two groups is too small for statistical analysis. However, one characteric of the depressed bereaved was similar to that described by Rutter (1966), showing a majority of adolescent boys who had lost their fathers. In addition all but one surviving mother received a diagnosis at some time of primary or secondary depression, considered to have been present before and after the death of the spouse.

Discussion

Our results are in agreement with the psychoanalytic literature indicating that the immediate reaction of a child to the death of one of its parents is usually mild and shortlived. Wolfenstein (1966) reviewed 42 children ranging in age from latency period through adolescence. She confirmed that the process of mourning as described by Freud and others does not occur in children; in general there is little weeping and no withdrawing behaviour but, on the contrary, a tendency to get involved in activities. We found a significant increase in dysphoria shortly after death, decreasing significantly over time; it seemed that a mild depressive state was characteristic of the bereaved children. This mild form of depression was present in nine of our 15 depressive children, but none of the control children experienced it. This mild depression could be typical of the bereavement process in the child, whereas the more severe depression would be another clinical entity found equally in the control population, even though the bereavement experience may have acted as a triggering factor in its appearance in the index children. Other symptoms that occured more frequently did not change strikingly through the

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year. The parents in our study also reported an increased interest in their children's activities at thirteen months compared to the first month after the index death; there was no significant difference, however, between the bereaved children and controls though it was reported more frequently in the former (57 per cent compared with 37 per cent).

Rutter (1966) pointed out that the reactions of children in such circumstances are likely to be heterogeneous: conduct disorders, depressive reactions, and psychoneurotic reactions. This is also our impression, since many of the significant symptoms (either when compared to controls, or over time within the group of bereaved) belong to different categories of childhood psychiatric disorders (depression, somatic or anxiety reactions, behaviour problems, school problems). Interestingly, as mentioned first by Wolfenstein (1966) and later confirmed by Rutter (1966), and now by this study of bereaved in the community the severely depressed bereaved children seem to be mostly adolescent boys who have lost their fathers. In addition our results indicate that the great majority (83 per cent) of the surviving mothers of these depressed bereaved children were suffering from a primary or secondary depression that began prior to the death of the spouse. The data may indicate that the older the child the more likely it is to show a grief reaction comparable to an adult reaction and, also, that losing a parent of the same sex (particularly for boys) is a significant risk factor for depression. Our data do not confirm Gregory's (1965) findings of an increase in high school dropouts in non-delinquent children. However, the disinterest in school and the tendency for poor school performance may indicate the possibility of such a development in later years. Rutter (1966) pointed out that attending a psychiatric clinic is most likely to occur five years after the death of the parent, except for bereaved adolescent boys in whom depression is likely to start within six months of the parent's death.

Arthur and Kemme (1964) published an uncontrolled study of 84 bereaved children attending a child guidance clinic; most of the children had been referred for problems antedating the death of the parent. In some, however, the death was clearly the precipitating factor for the referral. They reported feelings of hopelessness in 20 per cent, decrease in appetite in 19 per cent (significant in our study), phobic reaction (mostly separation anxiety) in 45 per cent, and nightmares and terrors in 23 per cent (not significant in our study). In the immediate reactions they reported increased crying in 13 per cent and noticeable sadness in 35 per cent (significant in our study). They also reported symptoms like soiling, and isolated two groups of children with opposite reactions: one with inhibited withdrawal and one with impulsive agressive behaviour. Our study cannot be fully compared to this one since the sample was drawn from a psychiatric population and is thus biased, as the authors note.

Our study can be criticized because the children were not ascertained independently and because the interviews were not carried out with the children in person. Schyving Payne *et al* (1979), studying families who had lost a sick child, noted the lack of awareness of the parents to the emotional problems of their surviving children. The former were so involved in coping with their own grief that little attention was given to the rest of the family. It could be that our bereaved children appear overall well adjusted for a similar reason. However, recently Reich *et al* (in press) have compared psychiatric diagnosis of children obtained through two structured interviews, one with the mother and the other with the child. They have demonstrated acceptable agreement between the two interviews (Kappa of 0.3 or higher) for the diagnosis of 'possible depression' in both sexes and three categories of ages from 6 to 9, 10 to 11, and 12 to 16. In our study some subjectivity on the part of the parents was suggested by the answers to questions as to whether the symptoms had ever been present before the death (with index families) or the last year (in the controls). All symptoms were reported as less frequent among the bereaved compared to the controls, but there were no statistically significant differences. This raises the possibility that the bereavement affected the surviving parent's memory, or that being in the midst of a tragedy caused the parent to minimize past bad experiences, viewing these now as negligible compared to the current symptoms/behaviours since the loss.

To conclude, our results suggest that in children at least during the year following bereavement, there is little psychopathology and even less general impairment of health, aside from an early dysphoria that disappears overtime and a mild depression that appears early or within the year following the death. However the academic difficulties already mildly present at this early stage may lead to further aggravation like early school dropout and its consequence in terms of social maladjustment as adults. Since parental death alone does not seem to trigger important psychiatric problems, at least in the short term, intervening variables must play a role in determining who will develop problems in later years. Further studies are needed on a larger and possibly unrelated group of bereaved children, eventually comparing them to a group of children undergoing other forms of early parental loss (for example, by divorce or separation), to evaluate their long term outcome

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taking into account potential risk factors like: mental illness in the surviving parent, socioeconomical status of the family before and after the death of the index parent, the sex of the child and of the surviving parent, the stability of the home environment prior to or after the death, the quality of the marital relationship before the death, the coping capacity of the surviving parent, the quality of the support system of the family after the death, to cite only a few.

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