Grief in Children

Description/Etiology

Grief is a normal, multifaceted response to the loss of someone or something to which an attachment was formed and usually fades as the bereaved person integrates the loss. The term grief refers to a process that has physical, emotional, cognitive, behavioral, philosophical, and social dimensions, whereas bereavement is considered to be the period of mourning after a loss. Typical expressions of grief in children can include sadness, crying, anger, irritability, temper tantrums, somatic reactions (e.g., stomach aches, headaches, insomnia, nightmares), difficulty concentrating, regressive behavior, guilt, confusion, disbelief, withdrawal, questions about death, and fearfulness (e.g., of being alone, of dying or of losing other loved ones).

Current models of grief commonly propose that bereaved individuals have to navigate certain tasks, such as accepting the loss, processing emotions, adjusting to their new reality, and finding ways to memorialize the deceased person. The ability of children to understand and process a death is different from that of adults. In children, outward behavioral expressions of grief may not be continuous: children tend to move in and out of intense feelings, rather than sustaining high levels of an emotion for long periods (Jackson, 2015). Children who experience the death of a loved one are likely to experience a high number of secondary losses in addition to the primary loss, which is the tangible physical loss of the person who dies. Secondary losses may include loss of one’s sense of self, loss of a sense of security and safety, and a loss or change in one’s sense that life has meaning. Children who have experienced the death of a loved one are likely to experience a high number of secondary losses in addition to the primary loss, which is the tangible physical loss of the person who dies. Secondary losses may include loss of one’s sense of self, loss of a sense of security and safety, and a loss or change in one’s sense that life has meaning. Children who have experienced the death of a loved one typically reexamine their loss as they age, especially during major life events (e.g., special birthdays, graduations).

Clinicians working with children experiencing grief should be able to recognize the expressions of grief that are typical for each developmental stage and address the child’s corresponding needs (Jackson, 2015). Most theories related to grief in childhood utilize the framework of Jean Piaget’s cognitive development theory to understand how children conceptualize death at different stages of development. Infants are not able to intellectually understand what death is but nonetheless experience loss and separation when a primary caregiver dies. Infants may indicate grief by being quiet or irritable, experiencing sleep and eating issues, and having a decreased level of activity. Toddlers also lack the ability to conceptualize death. Toddlers may show less of an emotional response, especially if the toddler is experiencing what is referred to as “magical thinking” (e.g., believing that if he or she wishes the person back to life, he or she will come back; or the toddler feeling as if he or she somehow caused the death). The toddler may have issues related to appetite, sleep, and elimination. There may also be an increase in tantrums and separation anxiety. Three- to six-year-olds have a rudimentary understanding of death, although they often confuse fantasy and reality and generally do not understand that the loss is permanent. They may instead view death as a type of sleep in which the person who died is in some way still alive. As a result, during what Piaget referred to as the preoperational period, children may ask if the person who died eats, sleeps, goes to the bathroom, plays, or can come back to visit. Death is considered temporary or reversible. Magical thinking can still take place at this age. Children between ages 7 and 11 are considered concrete in their mental processing of death; their focus and questions tend to concern details of the death and what happens to the body. Grief often is expressed through play and reenactment. Often at this age children understand death as final, although they may think that death is something that happens
only to older persons or is not universal. In school-age children, phobias about school, high levels of anxiety, somatic complaints, and temper tantrums may emerge after a loss. They may also display aggression, antisocial behaviors, mood swings, anger, and irritability. After age 11, abstract reasoning begins to emerge and the child’s understanding of death changes. Children in this age group (i.e., age 12 through adulthood) who have experienced a loss may have anxiety and depressive symptoms, problems with eating and sleeping, impulsivity, and guilt over being the one still alive, especially if the death was that of a peer or sibling. Because normalcy and fitting in with peers are important to adolescents, they may not share their grief process with friends who do not share their experience and as a result they often feel isolated. Opportunities to connect with peers who have experienced a similar loss can be particularly helpful for adolescents. Older adolescents may begin to engage in risk-taking behaviors.

Children who experience the death of a parent or sibling are at increased risk of short-term and long-term impacts, including anxiety, depression, post-traumatic stress disorder (PTSD), and substance use disorders. Childhood traumatic grief, characterized by maladaptive grief as well as post-traumatic stress disorder (PTSD) and/or depressive symptoms, can occur in children who experience trauma as part of a loss. Traumatic aspects of loss can include sudden and/or violent death, exposure to a parent’s suffering during a prolonged illness or witnessing the parent’s death. Trauma-related symptoms including hyperarousal (e.g., being easily startled, difficulty falling asleep or staying asleep, irritability), re-experiencing the trauma (e.g., upsetting thoughts, recurrent nightmares), and avoidance or numbing behaviors (e.g., detachment, difficulty focusing or concentrating) can interfere with the child’s ability to proceed through a more typical bereavement process.

When children are unable to process and integrate the loss, they can experience persistent distress and impairment. Researchers have referred to this as complicated grief or prolonged grief disorder. In the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), persistent complex bereavement disorder was included as a condition for further study. The proposed criteria apply to individuals aged 1 year and over and include persistent yearning for the deceased, intense sadness, and preoccupation with the deceased and/or circumstances of his or her death, distress and social/identity disruption (American Psychiatric Association, 2013).

**Facts and Figures**

Data from the 2016 National Survey of Children’s Health (NSCH) indicate that approximately 3.3% of children in the United States have experienced the death of a parent or caregiver with whom they lived (Child and Adolescent Health Measurement Initiative, 2016). Although there are little data regarding the number of children worldwide who experience the loss of a sibling, scholars have estimated that in the United States 5–7% of children experience sibling death (Fletcher et al., 2013).

In a 2013 U.S. poll of bereaved children and adolescents, 33% reported that their current guardian or caregiver was having difficulty communicating with them regarding personal matters (National Alliance for Grieving Children, n.d.). In the same poll, 75% reported that the most pervasive emotion present during their grieving was sadness, followed by anger, being overwhelmed, and loneliness (National Alliance for Grieving Children, n.d.). Of the children and adolescents surveyed, 39% reported trouble sleeping and 45% reported having trouble concentrating at school.

An estimated 10% of bereaved persons experience maladaptive grief (e.g., childhood traumatic grief, prolonged grief disorder) (Griese et al., 2017). Researchers in Sweden found that children who lose a close family member prior to age 13 are at increased risk of psychosis (Abel et al., 2014). In a large Canadian study, researchers found that bereaved siblings were at significantly higher risk of mental disorders than matched controls in the 2 years following sibling death (Bolton et al., 2016). Investigators in a Dutch study found that adolescents who experienced the death of a parent or sibling had higher rates of internalizing symptoms than non-bereaved peers; low family socioeconomic status and a history of internalizing problems were linked with increased risk of mental health problems in bereaved adolescents (Stikkelbroek et al., 2016). Researchers in the Netherlands found that in a group of bereaved children aged 8–18 years old, 38.6% were resilient, 35.2% had symptoms of prolonged grief disorder (PGD), and 26.2% had symptoms of both PGD and PTSD (Boelen et al., 2017).

**Risk Factors**

Risk factors relating to the child and/or the circumstances of the loss will influence children’s adjustment. Children who experience the sudden death of a loved one, a death involving violence (e.g., terrorist attack), or who witness the death are at higher risk of traumatic or persistent grief. Deaths involving stigma (e.g., those resulting from suicide, homicide, or AIDS) also can exacerbate grief in children. Children who lack a supportive parent or caregiver who is physically and emotionally available to support their grief process are at higher risk of complicated grief. If the parent/adult is in denial or ignores the loss, the child may feel that he or she is unable to openly grieve. The child’s personality will also affect his or her adjustment to loss. A child who is anxious will likely have an increased risk for complicated grief compared with a child who is more pragmatic. Pre-existing conditions (e.g., learning problems, social problems, or mental health conditions) also influence children’s ability...
to cope with loss. Children’s adjustment may also be affected by family structure and functioning. Children in families in which communication is poor and conflict exists may have difficulty adjusting; they may feel guilty if their relationship with the deceased was characterized by turmoil. When families are coping with simultaneous stressors (e.g., divorce, financial problems, unstable living situations) there is a risk to the adjustment of the grieving child. Finally, the support systems that are available before, during, and after the loss can serve as protective factors for the grieving child or as risk factors if they are insufficient.

**Signs and Symptoms/Clinical Presentation**

› Psychological: feelings of depression (episodic or pervasive); hopelessness; isolation; denial; anger directed toward self, the deceased, or remaining caregivers; shame; guilt; fear; worthlessness; nervousness; irritability; loss of pleasure in activities; stress; feelings of stigma; reliving of traumatic events; hyperarousal; yearning to be with the deceased; numbness; curiosity concerning circumstances of death; anxious attachment to surviving caregiver; separation distress; inability to focus; frustration; belief that one caused the death; preoccupation with the life of the person who died

› Behavioral: increase or decrease in sleep, increase or decrease in appetite, inappropriate euphoria, aggression, agitation, loss of interest in activities, risk-taking behaviors, isolation, developmental delays or regression, nightmares, conduct disorder (e.g., breaking rules, lying, truancy)

› Physical: somatic complaints (e.g., chronic muscle and back pain, headaches, fatigue, gastrointestinal problems), changes in weight, neglect of hygiene, psychosomatic mirroring of health problems of the deceased

**Social Work Assessment**

› Client History
  • Biopsychosocial/spiritual assessment of the child and his or her family is essential to evaluate the functioning and resources of the child and family. It is crucial for the clinician to assess and understand the child’s age, developmental abilities, general personality, culture, religion, and support system. This will enable the provider to best evaluate the child’s needs and assist family in providing for those needs

› Relevant Diagnostic Assessments and Screening Tools
  • Post-traumatic stress disorder, childhood traumatic grief, depression, and complicated grief can be measured utilizing the following tools: Clinician Administered PTSD Scale (CAPS), Beck Depression Inventory (BDI), Complicated Bereavement Risk Assessment (CBRA), Beck Anxiety Inventory (BAI), University of California–Los Angeles Post-Traumatic Stress Disorder Reaction Index, and Extended Grief Inventory (EGI)

› Laboratory and Diagnostic Tests of Interest to the Social Worker
  • For adolescent clients, clinicians may want to consider if drug or alcohol testing is warranted

**Social Work Treatment Summary**

› Many children will navigate bereavement without professional intervention. Parents and others in the child’s environment can help in ensuring successful integration of loss by understanding factors that help or hinder this process. When intervention is warranted, services for children should be tailored to their individual needs. In some cases, ensuring that children have a safe place to express and process their feelings with a supportive listener is what is most needed, whereas other children may have complications of grief and/or coexisting mental health problems and will benefit from therapeutic intervention

› Grief counseling with children may involve traditional therapy but also incorporate music, art, or play therapy to facilitate the grief process and allow the child to express his or her emotions (Stutey et al., 2015). Grief support groups and bereavement camps combine psychoeducation and support. Grief counseling with children focuses on specific coping tasks. The child needs to understand that the person has died. This understanding includes believing the death has occurred, understanding his or her own feelings, and coming to a place of acceptance regarding the changes that result from the loss. The child has to cope with the emotions that come with the loss, which includes future re-experiencing of the loss. Evidence-based practice should focus on increasing the child’s self-esteem, increasing the child’s sense of control, improving the child’s coping skills, enabling a positive parent-child relationship (e.g., increasing parental warmth, improving communication, working on effective and appropriate discipline, encouraging truth-telling, helping the parent model appropriate responses to grief), reducing parental distress, and increasing positive family connections

› Trauma-focused cognitive behavioral therapy (TF-CBT), the most widely recognized treatment for child trauma, can be utilized with children ages 3–18 who are experiencing traumatic grief, PTSD, and/or other emotional problems related to trauma. TF-CBT integrates cognitive and behavioral interventions with trauma-specific interventions such as psychoeducation about trauma and common reactions, parenting skills to manage emotional and behavioral reactions, and
individualized stress-management techniques for the child and parent. A key component is the trauma narrative, in which the child describes in detail the most important parts of the trauma(s). It is generally recommended that trauma involved in the death should be addressed before moving into the grief process. Although less rigorously studied, child-centered play therapy is recognized as an alternative approach to treating childhood traumatic grief. Complicated grief treatment, which focuses on restoring functioning, developing a positive sense of the future, and incorporating the loss, has demonstrated efficacy in treating complicated or prolonged grief. Family-focused grief therapy, which focuses on restoring functioning, developing a positive sense of the future, and incorporating the loss, has demonstrated efficacy in treating complicated or prolonged grief. Family-focused grief therapy is associated with positive outcomes with bereaved families. Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

Social workers should practice with awareness of and adherence to the social work principles of respect for human rights and human dignity, social justice, and professional conduct as described in the International Federation of Social Workers (IFSW) Statement of Ethical Principles, as well as the national code of ethics that applies in the country in which they practice. For example, in the United States, social workers should adhere to the NASW Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to grief in children and practice accordingly.

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<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
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<tr>
<td>Child has experienced a loss and is angry, irritable, and/or aggressive</td>
<td>Client will have decreased aggressive behaviors and demonstrate decrease in negative emotions</td>
<td>Developmentally appropriate individual therapy to help client explore emotions, reduce anger, and develop coping strategies. Counsel child on alternatives to aggressive behaviors. Refer for group grief therapy or grief camp</td>
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<td>Child under age 12 is showing signs of developmental regression such as bedwetting, thumbsucking, or “baby talk”</td>
<td>Child will be able to express feelings and behave at a developmentally appropriate level</td>
<td>Individual counseling with play, art, or music therapy elements if appropriate to help client in exploring emotions related to his or her loss. Behavior modification if indicated to reduce the developmental regression and assist client in returning to appropriate level of functioning. Work with family caregivers on establishing routines and ways to help client feel more secure</td>
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<td>Child under age 18 has experienced the death of a parent and is experiencing anxiety when separated from surviving caregiver</td>
<td>Child’s stress and anxiety over being away from caregiver will resolve. Child will develop improved coping mechanisms</td>
<td>Family counseling and play therapy to help child understand and process the changes around him or her and the death. Talk to child about the death to prevent misinformation (e.g., the deceased is sleeping). Use books and other materials about the life cycle and death. Reassure child regarding caregiver arrangements should something happen to the surviving parent/caregiver</td>
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<td>Child is feeling guilt over the death of his or her loved one</td>
<td>Child will develop understanding that he or she is not responsible for the death</td>
<td>Education and information about how the loved one died can counter the child’s belief that he or she caused the death. For older children, psychotherapy that helps them talk through their feelings that their actions or lack of actions caused the death may be utilized</td>
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<td>Child ages 12–18 is engaging in risk-taking behaviors</td>
<td>Prevention and suspension of harmful behaviors such as cutting, substance/alcohol abuse, and promiscuity. Demonstration of improved coping skills</td>
<td>Educate child on feelings associated with grief to help to normalize feelings. Utilize techniques such as psychotherapy, journaling, memorializing the deceased, peer support, relaxation, meditation, exercise, and other stress-reducing activities</td>
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<td>Child is exhibiting signs of persistent depression</td>
<td>Develop new coping skills, alleviate depression, encourage better communication techniques. Child will have reduced negative symptoms of depression and improved functioning</td>
<td>Individual or family psychotherapy to talk through feelings about the death. Engagement with other children who have experienced loss. Referral for medication if indicated</td>
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Child ages 7–18 is expressing a desire to hurt and/or kill him- or herself

Child will not engage in self-harm and will be able to reinvest in enjoyable activities and have improved sense of self

Psychotherapy to discuss stressors leading to feelings of hopelessness. Collaborate with client to develop a safety plan, including a list of specific behaviors to help the client become calm, socialize, and reduce isolation. Inpatient evaluation if indicated

Applicable Laws and Regulations

› In the United States, all social workers, mental health clinicians, and healthcare professionals are bound by the “duty to warn,” which requires them to inform the proper authorities if a person is found to be a danger to him- or herself or others. Clinicians should be aware of the regulations and procedures in their state’s duty to warn law. In the United Kingdom, social services workers are not mandated by law to warn but are expected to act in the best interest of the child.

› Each country has its own standards for cultural competence and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (National Association of Social Workers, British Association of Social Workers, etc.) and practice accordingly.

Available Services and Resources

› Books
  • *After a Suicide Death* by the Dougy Center, Portland, OR, 2001. All ages

› Hospitals, hospice agencies, and mental health agencies can often provide local resources for bereavement programs for children and families.

› Websites
  • Hello Grief, bereavement support: [http://www.hellogrief.org/](http://www.hellogrief.org/)
  • GriefShare, grief recovery support groups: [http://www.griefshare.org/](http://www.griefshare.org/)
  • The Dougy Center, grief resources and support: [http://www.dougy.org/](http://www.dougy.org/)
  • GriefNet, online group support: www.griefnet.org
  • National Alliance for Grieving Children, grief resources and support: [https://childrengrieve.org/](https://childrengrieve.org/)
  • Kids Aid, an online support group for children: [http://kidsaid.com/](http://kidsaid.com/)
  • Child Bereavement UK, bereavement support and information: [http://www.childbereavementuk.org/support/](http://www.childbereavementuk.org/support/)
  • Winston’s Wish (UK), [https://www.winstonswish.org/](https://www.winstonswish.org/)

Food for Thought

› Expressing a wish to be with the person who died is not necessarily indicative of suicidal ideation in a child, but should be investigated.

› In a study investigators found that a significant portion of the children who had experienced the death of a parent were experiencing PTSD and symptoms of traumatic grief, regardless of whether the loss of the parent was expected as a result of illness or was sudden and/or violent (McClatchy et al., 2009).

› Open dialogue and age-appropriate details regarding the death should be encouraged to prevent mistrust and confusion for the child (Jackson, 2015).

› Helping children and adolescents find meaning in life, as well as meaning in the lives of the deceased, can help them transition from traumatic grief to more normal grief (Dickens, 2014).
Red Flags

› When children are not given age-appropriate information about the death of a loved one, they may make incorrect assumptions about the death, which increases their risk of experiencing complicated grief
› When the child is involved in the traumatic death of a parent or other loved one (e.g., child and parent are in a car accident in which the parent dies, a shooting in the child’s home in which a loved one is killed), the trauma needs to be addressed along with the loss in order to reduce risk for PTSD
› The family environment, particularly surviving parents’ functioning following the death of a sibling or parent, is an important factor in children’s ability to successfully navigate the grief process. Parental distress and coping should be assessed and parents referred for services as needed
› Certain losses are considered disenfranchised or ambiguous in that they are not socially recognized or validated. For instance, children’s grief concerning the loss of a stillborn or infant sibling may be minimized because they did not have contact or a significant relationship with the sibling (Jonas-Simpson et al., 2015). Deaths that involve stigma, such as suicide, may involve secrecy and isolation, which in turn contribute to disenfranchised grief (Schreiber et al., 2017)
› Although further research is needed, grief in children has been linked with somatic symptoms and conversion disorder (Mosher, 2018)

Discharge Planning

› Refer child and family for group counseling, bereavement camps, or specialized bereavement services as needed
› Educate family on developmental considerations in children’s understanding of death, the range of normal grief responses they might exhibit, and their need to revisit events as their ability to conceptualize death increases
› Educate family on the importance of providing children with developmentally appropriate, factual information regarding the loss
› Encourage participation by the child in memorial services, if age appropriate, or provide the family with information on how the child can privately recognize and memorialize the loved one (e.g., releasing balloons, sending a letter, planting a tree)
› Recommend books to adults and children that can help explain death and suggest ways of remembering loved ones

DSM 5 Codes

› [N/A]

References


