

CHAPTER 2

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CHAPTER 2

Crux est, si metuas, vincere quod nequeas.

It is torture to fear what you cannot overcome.

Anarcharsis (early sixth century B.C.)

(Othmer and Othmer, 2002:80)

CHILDHOOD TRAUMA: ATTACHMENT, LOSS AND GRIEF

This chapter explores the nature of trauma in children and how this is currently classified according to the DSM-IV-TR (2000). I will then examine the trauma-grief interface through the eyes of current literature. I will make a case for the inclusion of bereavement of a primary caregiver in childhood as a trauma, whether the death is sudden or expected. This will include risk to the child of developing PTSD (Post-traumatic Stress Disorder) symptoms. The purpose of viewing grief for certain children in the context of trauma is important in terms of the therapeutic principles one would work from as a therapist. In creating a case for bereavement to be considered as a trauma, I will examine the literature on childhood trauma, attachment, loss and grief, through past and current literature.

2.1 Trauma in Childhood

2.1.1 Trauma and Post-traumatic Stress Disorder (PTSD)

The event of trauma, per se, encompasses a very broad spectrum of possible events. Traditionally, the term 'trauma' generally refers to overwhelming, uncontrollable experiences that create feelings of helplessness, vulnerability, loss of safety and loss of control in the person. Events which have been

considered traumatic include combat experience, motor accidents, natural disasters, rape and incest, concentration camp experiences, child abuse and woman abuse (Sue, Sue & Sue, 1997:150). These extreme events often lead to PTSD, although many outcomes are possible.

However it is suggested by Greenwald (2000:7), that for children, this category of traumatic events should be spread more widely. Greenwald argues that children who are exposed to upsetting experiences such as hospitalization, divorce, even the expected death of a loved one or any experience which renders the child helpless and overwhelmed, resemble trauma sufficiently for principles of trauma therapy to apply.

In support of this view I will now investigate the DSM-IV-TR (2000:467) criteria for Post-traumatic Stress Disorder, to ascertain the extent to which the criteria fit with children's symptomology, specifically with regard to bereavement or grief.

2.1.2 DSM-IV-TR Criteria for Trauma and PTSD

Prior to the DSM IV-TR, Bereavement met the criteria for an Adjustment disorder. According to the DSM IV-TR (2000:740) Bereavement is "a category that can be used when the focus of clinical attention is on a reaction to the death of a loved one" which may include a Major Depressive Episode. The category offers guidelines in differentiating Bereavement from a Major Depressive Disorder. However, the view I will hold in this research is that grief may be experienced by the child as traumatic and that a child may proceed to experiencing PTSD (Post-Traumatic Stress Disorder) if the symptoms go unrecognized.

Prior to The Diagnostic and Statistical Manual of Mental Disorders, Fourth

Edition, Text Revision (DSM-IV-TR, 2000), bereavement met the criteria for an Adjustment Disorder as death is a normal life event. Greenwald (2000:7) suggests that this is a misnomer in many instances. He continues that the symptoms of bereavement are suggestive of trauma and that many of these symptoms fail to resolve in the specified 6 month period, as would be expected in an adjustment disorder. He suggests further that some children who are bereaved, experience symptoms in keeping with those of PTSD.

According to the DSM IV-TR (2000:740) Bereavement (V62.82) is now a separate category which “can be used when the focus of clinical attention is on a reaction to the death of a loved one”. Reactions may include a Major Depressive Episode. The category offers guidelines in differentiating Bereavement from a Major Depressive Disorder. Greenwald (2000:8) suggests that “for children, at least, there may be very little difference between an unexpected traumatic experience and an unavoidable major loss experience which has been anticipated”.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR, 2000:467) outline diagnostic criteria for PTSD. I will include the comments of Jordan (2001:2) and Figley et al. (1997; xvi, 11, 23, 24, 27, 28) on how symptoms may be expressed in children.

The initial criteria focus on the traumatic event, which indicate that:

A. The person has been exposed to a traumatic event in which both of the following were present:

- (1) “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or

others” (DSM-IV-TR, 2000:467). Figley et al., (1997:xvi) argue that uncomplicated acute grief is a form of PTSD; and

- (2) “the person’s response involved intense fear, helplessness, or horror” (DSM-IV-TR, 2000:467). Jordan (2001:2) notes that, in children, this may be expressed in disorganized or agitated behaviour. Yearning and searching may be additional behaviours.

Further to this, the DSM-IV-TR (2000) outlines the diagnostic criteria for PTSD as follows:

B. The traumatic event is persistently experienced in one (or more) of the following ways:

- (1) Recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions. Jordan (2001:2) and Figley et al (1997:11) comment that young children may engage in repetitive play in which themes of the trauma are expressed.
- (2) Recurrent distressing dreams of the event.
- (3) Acting or feeling as if the traumatic event were recurring (including a sense of reliving the experience), illusions, hallucinations, dissociative flashback episodes, (including those that occur in awakening or when intoxicated. Jordan (2001:2) notes that, in children, re-enactment may occur.
- (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. Figley et al. (1997:23) note that reminders reactivate physiological and somatic distress.
- (5) Psychological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) Efforts to avoid thoughts, feelings, or conversation associated with the trauma.
- (2) Efforts to avoid activities, places, or people that allow recollections of the trauma.
- (3) Inability to recall an important aspect of the trauma.
- (4) Markedly diminished interest or participation in significant activities.
- (5) Feeling of detachment or estrangement from others.
- (6) Restricted range of affect.
- (7) Sense of a foreshortened future.

Figley et al., (1997:24) note that numbing, avoidance, diminished interest and detachment are also common symptoms of bereavement.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) Difficulty in falling or staying asleep.
- (2) Irritability or outbursts of anger.
- (3) Difficulty in concentrating.
- (4) Hypervigilance.
- (5) Exaggerated startle response.

Figley et al., (1997:27) note that apart from an exaggerated startle response, the symptoms of grief overlap with trauma. Hypervigilance may take the form of fear of death or uncertainty of life. These experiences separate bereaved children from non-bereaved children in studies. Figley et al. (1997:28) cite further associated features: guilt or an increased sense of responsibility; suicide ideation and issues of identification with the deceased.

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

- Acute: if duration of symptoms is less than 3 months.
- Chronic: if duration of symptoms is 3 months or more.

Specify if:

- With delayed onset: if onset of symptoms is at least 6 months after the stressor (DSM-IV-TR, 2000:468).

To summarize, Figley et al. (1997:24-27) and Jordan (2001:2) suggest that many of the symptoms of PTSD appear similar enough to acute grief for therapists to consider PTSD as a possible diagnosis when a child is grieving for a parent or primary caregiver. PTSD should especially be considered if the duration of the symptoms continues for 3 months or more or if there is delayed

onset of symptoms. Greenwald (2000:7) suggests that children may experience normal life events such as hospitalization, divorce or death of a loved one, as traumatic. For this reason Greenwald (2000:7) advocates that the DSM-IV-TR PTSD category could be broadened to include some children's experience of normal life events. However, I do not want to suggest that all children's experience of such life events is traumatic. The extent to which a child experiences an event as distressing is dependent on the child's vulnerability to trauma.

2.1.3 Vulnerability to Experience Events as Traumatic

Greenwald (2000:8) looks at certain factors which predispose a child to developing PTSD. They are the severity of exposure, the developmental level of the child, personality style and environmental factors. These factors will now be discussed briefly.

- *The severity of exposure*

Extremely traumatic events, such as those mentioned by Sue, Sue & Sue (1997:150); that is combat experiences, motor accidents, natural disasters, rape and incest, concentration camp experiences or child abuse; may predispose some children more to developing PTSD. However, even in these cases, positive factors of personality, developmental level and social support can mediate in favour of adequate psychological processing of these extreme events.

On the other hand, some children with a sensitive personality style and little social support may experience lesser stressors as traumatic. These children may struggle with lingering thoughts, feelings and visual images, and these memory traces are hard to shake off. It can be very distressing to the

individual when there are intrusive memories set off by a random triggering reminder. There is fear that the trauma may be repeated and there is a feeling of being powerless to control and master their experiences.

- *Developmental level*

Monahan (1993:141-142) notes that “when young children are traumatized, their age often prevents them from complete mastery and understanding” of their emotions. Latency aged children (6-12 years) are thought to be particularly vulnerable emotionally when facing stressors (Rudenburg et al., 1998:107). The effects of trauma in childhood may make an individual develop a sense of the world as a dangerous place. The child may become anxious and worried, holding a “hostile attribution bias”, misinterpreting neutral communication as threatening. This may result in avoidance of or an over-reaction to life-experiences which may prove detrimental to positive personality development in this phase. This is discussed further in the next point on personality style.

- *Personality style*

Greenwald (2000:9) notes that some personality styles, such as those who are sensitive, are predisposed to avoidance, denial, external locus of control. Horowitz, Bonanno and Holen (in Marrone, 1997:21) built a personality-based theory of pathological grief. This theory suggests that a personality which tends towards excessive control to repress unwanted feelings and emotions [together with ambivalence towards the deceased] are more likely to experience complicated grief.

The experience of previous trauma may also increase the likelihood of a vulnerable disposition. For either reason, the individual's sensitivity may lower the threshold at which an upsetting experience constitutes a trauma rather than it being effectively processed as an upsetting experience. For these children, avoiding trauma becomes a "primary organising principle for personality, mood and behaviour" (Dwivedi, 2000:12). This can have devastating results for the child growing into adolescence, where mastery and control over his own life is a cornerstone to healthy identity formation and self-realization.

The power of a trauma to make fundamental changes to the way in which an individual receives and responds to the world is now only fully being recognized. "In recent years, our understanding of trauma has extended into a greater recognition of the profound influence of trauma on relational patterns, including even the most basic capacity for connection" (Saifer, 2003:260). Longitudinal studies indicate that participants who experienced one or more negative life events were likely to change their attachment style. This gives a measure of evidence to the notion that traumatic experience challenges basic assumptions or schemata that an individual has constructed about relationships and the world.

- *Environmental factors*

The literature relates that the single best predictor of a positive psychological outcome for children who are surviving trauma is the support of a significant caregiver (Steele, 2002:518). However, in dealing with the death of a parent, the surviving parent may find it difficult to be of support to the child, as he/she

is dealing with his/her own mourning (Figley et al., 1997:124). This may predispose the child further to developing PTSD.

Steele (2002:518) presents evidence for the hypothesis that secure attachment relationships serve to buffer the impact of trauma and the presentation of trauma-related symptoms and PTSD. Securely attached children are able to draw strength from a secure base and use learned adaptive strategies to contain the experience of danger. Conversely, those experiencing insecure attachment are likely to exercise maladaptive stress-reducing strategies (Steele, 2002:518).

To conclude this section: Research has suggested that the definition of what constitutes trauma, especially for a child, may not be limited to extreme events. In the light of recent literature, the child may experience trauma in the face of normal life events such as hospitalization, divorce or the expected death of a loved one, which the DSM-IV-TR (2000:679) describe as an Adjustment Disorder. However, as has been discussed, the extent to which an event is experienced as traumatic is dependent upon the severity of the trauma, the developmental level of the child, the personality of the individual and the degree of social support experienced.

2.2 Grief as a Trauma

As a continuation of the argument that normal life events can be experienced as traumatic, I will examine the literature with regard to the overlapping of trauma and bereavement.

2.2.1 Trauma-Grief Interface

Recent research investigations into bereavement have looked at the interface between trauma and bereavement.

2.2.1.1 Grief as trauma lobby

The earliest work of bereavement failed to consider trauma. The research fields of trauma and bereavement developed separately for most of the Twentieth Century. Horowitz (1997) was one of the first trauma researchers to recognize an overlap between the fields of trauma and grief in his concept of the “stress response syndrome”. This concept equated bereavement with other traumatic events. Parkes (1976) was one of the first grief researchers to allude to psycho-social stress in his work with grieving adults.

Pynoos and Nader (1988:445) focused on the effects of trauma and death on children. They examined traumatic and grief reactions among children exposed to a sniper attack at school. Their findings suggest that trauma and grief symptoms may be similar and interact to intensify one another. Pynoos and Nader (1988:445) called this “traumatic bereavement”. Marcia Egan (1998:77) bridged the separate theory bases of thanatology (theory of death) and traumatology (theory of trauma). Her work also illustrates the similarities in the experiences of surviving loss and grief over a loved one’s death and other traumatic events. Rubin (1999:681), in an attempt to acknowledge the relationship between the two fields of grief and trauma, suggested that people cope with grief through a Two-Track Model of Bereavement. Rubin’s (1999:681) bifocal approach acknowledged the multidimensional nature of grief and trauma, and that each view is not mutually exclusive.

Jacobs and Prigerson (2000:479) conceptualized the term “traumatic grief” to cover both traumatic and non-traumatic bereavement experiences. Traumatic grief is seen as distinct from normal reactions to bereavement (separation stress) and the researchers describe the relevant criterion as having

“experienced the death of a significant other” where there are additional symptoms such as shock and dissociation.

Thus, the idea of bereavement being a traumatic experience, has achieved scientific support. However, researchers differ in opinion as to whether pathological or extreme grief is an entity distinct from PTSD. Some argue in favour of a new DSM-IV category of pathological grief while others consider bereavement to fit sufficiently into the category of PTSD (Stroebe, 2001:185).

2.2.1.2 Children and Traumatic Grief

What is clear from the differing research findings is that much further investigation is needed in this developing field, specifically in relationship to the developing child and adolescent. According to current research, when a child experiences the loss of a parent or significant attachment figure, the relationship between trauma and bereavement may overlap considerably. Hurd (1999:17-42) found that children and adolescents would always be vulnerable to depression when a parent died because of their dependence on the parent and their incapacity for divesting energy in the deceased. Furman (2003:168) focuses on aspects of children’s intra-psychic and inter-psychic world that make them more vulnerable than adults to traumatic stressors. Furman (2003:170) concludes that a child’s immature ego makes him less able to muster coping resources and that the death of a parent involves the loss of a person who typically plays a pivotal role in helping the child “modulate the intensity of affective experiences”. As mentioned in Chapter 1, page 2, the loss of a parent or primary caregiver may be one of the most stressful and traumatic experiences of childhood (Kranzler, 1990: 513). This view is supported by a study in which children rated potentially stressful experiences. For these 364 children in Grades 4 to 6 losing a parent was rated

by these children as the potentially highest stressor (Yamamoto and Mahlios, 2001:533). What research seems to help us understand is that the death or loss of a parent, whether the death is sudden or expected through a lengthy illness, constitutes trauma in the intra-psychic world of a child.

To conclude, Sagi-Schwartz et al., (2003:1086) summarize the argument well.

“There is a shifting relationship between the bereavement and trauma fields. The earlier tension that characterized the overlap between the fields and a shocking lack of cross-fertilization, has begun to change. In place of over-specialization we have known, where people are specialists in grief but not trauma, or the reverse, there is now an openness where scientists and practitioners from each sub-field are becoming more familiar with the perspective and knowledge base of the other”.

In order to appreciate the meaning of loss as a trauma and of what the death of a loved one means in the world of a child, it is valuable to have an understanding of the concept of attachment.

2.2.2 Attachment and loss

2.2.2.1 Attachment theory

John Bowlby (1969, 1973, 1980), an eminent psychoanalyst, developed the theory of attachment. Attachment theory suggests that far-reaching consequences develop out of “the internal cognitive representations of caregivers laid down in early life” (Steele, 2002:518). Attachment theory describes the universal way in which an infant will ensure close proximity to the caregiver, through its behaviour.

A primary caregiver, who may or may not be the parent, becomes associated with the reduction of discomfort and stress. This process of meeting the needs of the child becomes a pattern where the child feels reliability in the environment, and in which the child feels secure. This pattern forms the basis of making and breaking relationships in the future, like a blueprint for relationships. The focus is on the type of bond made between a caregiver and a child and its effects on the separation from and the loss of attachment figures (Steele, 2002:519).

According to Bowlby (in Steele, 2002:519), an infant may require less or more proximity depending on the temperament of the baby. For example, an infant may become distressed if close bodily contact is not maintained, to which the adequate caregiver responds by drawing near. Another infant may feel satisfied with less physical comfort. This means that "close proximity" is not a predetermined closeness, but one that is comfortable for the infant's individual needs. This is called optimal distance. The need for attachment and optimal distance is not only a phenomenon of infancy, but continues to be of importance throughout childhood, adolescence and into adulthood. For example, as a child matures this optimum distance may stretch to include being within sight of the caregiver and eventually within earshot. During adolescence, optimum distance may be uncertain and changeable, but attachment to caregivers will continue to be of importance. Attachments in friendships and with a special partner will also be influenced by the early internalized 'schema' of the initial attachment. "Bowlby stresses that individual needs for a close attachment with flexible optimum distance vary through life." (Leick and Davidsen-Nielsen, 1991:8).

To conclude, the work of Bowlby aids in the understanding of the nature of attachment and what the loss of a primary attachment figure may mean in the

life of a child. Bowlby's theory was strengthened by the work of Mary Ainsworth (1973) and Mary Main (1979) whose research developed insight into the significance of the type of attachment the child has with a primary caregiver and its effect on separation reaction.

2.2.2.2 Types of attachment style

The nature of primary attachment is significant in itself. In essence, the child's perception of the world is filtered initially through the experience of this primary relationship. Transference from this primary attachment experience affects the nature and quality of attachment in future relationships through childhood into adulthood. The infant develops internal working models (IWMs) of the attachment figures based on shared interaction experiences. "These models provide the infant with an awareness of the caregiver's absence, determine how the child will respond when the attachment figure returns, and ultimately comprise the foundation for anticipating and interpreting interactions with others across the life span" (Archer, 1999:168).

In researching attachment, Mary Ainsworth (1973) identified three types of attachment styles: secure attachment, avoidant attachment and anxious-ambivalent attachment. The latter two attachment styles describe insecure attachment. Mary Main (1979:640-643) added a fourth type of insecure attachment style, disorganized attachment (Kendall, 2003:1).

- a) *Secure attachment* is healthy attachment based on the consistent nurturing behaviour of the parent as described on the previous page. Research suggests that secure attachment results in uncomplicated separation or grief.

- b) *Insecure attachment* - avoidant, anxious-ambivalent or disorganized attachment. Insecure attachment contributes greatly to the development of traumatic grief and requires further investigation.

(i) *Insecure attachment*

Much of the reason for insecure attachment is as a result of dependency and conflict:

- Dependency

When attachment figures are unresponsive to their children's needs, their children are left in an ongoing state of distress. Without the confident expectation of predictable behaviour, these children are inclined to experience a generalized sense of anger and anxiety. Dependency forms the basis of the anxious-ambivalent style of attachment.

Insecure attachment style is usually associated with more intense distress following separation from an attachment figure. Parkes' (1976) studies of grief, showed that atypical patterns of grief with pronounced anxiety and pining, was associated with a dependent relationship. Research results from Hindy and Swartz suggest that there is a link between dependency and prolonged grieving (Archer, 1999:175). Loftland (1999:168) suggests that the link between a dependent relationship and intense grieving is consistent with the view that the more a person's attachments are concentrated in one person, and the more that person fulfils all the functions of human bonds, the greater the grief for them when they die.

- Conflict

Freud's (1957) research suggested that an ambivalent or conflictual relationship would lead to pathological grief in the form of clinical depression. From the view of Freud, the child "undergoes a psychological progression from a relatively undifferentiated sense of self and other to a more differentiated, articulated presentation of both the self and important others" (Marrone, 1997:151).

In Margaret Mahler's (Marrone, 1997:152) theory, the infant is initially self-absorbed. In the process of attachment a merging of caregiver and child arises in which poorly defined boundaries of self and caregiver are present. Over time and with healthy caregiving, the child eventually achieves a sense of psychological individuation and separateness. "Separation consists of the child's emergence from a symbiotic fusion with the mother.....and individuation consists of these achievements marking the child's assumption of his own individual characteristics" (Mahler et al., 1975:4). However, when a child/caregiver relationship is marked by conflict the child may feel conflicted in separating from the caregiver. This conflict may affect the child's ability to meet developmental challenges and tolerate further interpersonal separation. On the death of a caregiver in this type of conflictual relationship with a child, the child may be vulnerable to complicated grief.

Bowlby suggests that an insecure primary attachment relationship, may lead to a later incapacity to manage distress, with the risk for developing psychopathology (Steele, 2002: 519). Even with maturity the insecure attachment relationship can continue to influence psychosocial functioning negatively. Sue Johnson and her colleagues have

developed the concept of “attachment injury” to capture those moments when the experience of abandonment activates attachment patterns that in the effort to maintain survival, may actually jeopardize an already fragile connection” (Safier, 2003: 260).

To conclude, attachment theory focuses on the process of attachment and separation between a primary caregiver and a child.

The style of initial attachment - secure or insecure attachment - is significantly linked to the way in which an individual will form future relationships and will experience loss. It may be of interest to briefly investigate contemporary constructs of attachment theory.

2.2.2.3 Current constructs of attachment theory

Although much condemnation was given to Bowlby’s ideas through the 60s and 70s from psychoanalysts and feminists, attachment theory is now supported by the latest neurobiological research (Kendall, 2003:1). In a series of studies of rat pups and their mothers conducted over the last two decades, the role of brain chemicals called neuropeptides has been found to be significant in pair-bonding. The discovery of these so-called “attachment hormones” has highlighted the physiological basis of various attachment behaviours. According to Schore (2003:1) neurobiological research shows that the child's primary caregiver helps to determine the ultimate architecture of the child's brain.

Current attachment theory also focuses on “mentalized affectivity” (Fonagy et al, 2002:15), and describes the capacity to connect to the meaning of one’s emotions. Mentalization is the ability to reflect upon and understand another's

behaviour and it is a key factor in current attachment theory. Disruptions in attachment are associated with problematic mentalization. The mother's capacity accurately to reflect back and respond to the infant's affective state is associated with secure attachment (Birnbaum, 2003:241).

2.2.2.4 Conclusion

In conclusion, what appears to be well established in the literature is the claim that the nature of the infant-caregiver attachment is an important determinant of how an individual will cope with loss. Attachment theory also provides a fundamental conceptual base for understanding further concepts such as grief, bereavement and trauma.

2.3 *Grief and Bereavement in Childhood*

2.3.1 *A Brief History of Grief Research*

2.3.1.1 The Psychodynamic Model of Grief

According to Stroebe et al., (2001:185) Freud's paper *Mourning and Melancholia* delivered in 1917 was a major landmark in the history of scientific understanding of bereavement. Freud proposed that grief resolution is achieved through withdrawal of bonds with the object of grief, the deceased. This allows for energy or libido to be redirected towards new and healthy attachments. Grief is thus an active process involving the struggle to give up the emotional attachment to a love-object. Freud contended that the pain may be so intense that the bereaved person turns away from reality and clings to the object by refusing to believe that it is no longer there. He also contended that one way of coping with the death of a loved one is to identify with that

person. The pain of separation is diminished by internalizing part of that person.

Psychoanalytic thinking further describes the individual as possibly introjecting or incorporating the love-object into the self, in order to assimilate the “traumatic effects of a loss” (Archer, 1999:16). Klein (1940:311-338) suggested that “when someone dies, the mourner not only regresses and loses the external relationship, but internally may feel as though he has lost his good objects” . Silverman, Nickman and Worden (1992:496) identified five stages in the child’s attempt to maintain “good objects”:

- Locating the deceased parent (for example, in heaven).
- Experiencing the deceased parent (for example, as watching over them).
- Reaching out to the deceased (for example, visiting the grave site).
- Actively waking memories of the deceased parent.
- Cherishing objects shared by the child and the deceased parent.

Winnicott (1971:15) found that mourners create transitional objects to deal with loss and separation. Berzoff (2003:273) found that transitional objects served as representations of soothing and comfort. Volkan (2003:273) also found that transitional objects may help to restore and resolve some of the ambivalence that characterized the relationship with the deceased in life. A positive representation and relationship with the deceased is related to grief resolution (Harvey and Miller, 2000:238). This essentially means that grief resolution is not merely loosening the bonds with a loved one but also about reframing the relationship.

2.3.1.2 The Developmental Model of Grief: Stages of Grief

Much of the grief literature has centred on grieving as explained as a series of stages. The developmental model may be useful, if it is used as a guide, rather than as a blueprint for successful recovery from grief. In the following paragraph I will mention some of the theorists who have observed various stages in the grieving process and make personal conclusions.

Bowlby's (1961:331) four stages of grief are described as numbing, yearning and searching, disorganization and despair and reorganization (Berzoff, 2003:273). Elizabeth Kubler-Ross (1969) developed her stage view through the observation of terminally ill patients. Her five stages of grief are: denial, anger, bargaining, depression and acceptance. Further contributions to grief stage theory are Kavanaugh's (1999:25) stages of: shock, guilt and relief and Parkes' (1999:25) stages of: numbness, pining and despair. Sanders' (1999:25) phases represent a cluster of responses over the grief period. The five phases Sanders suggests are: shock, awareness of the loss, conservation (including withdrawal), healing and renewal. Many researchers have questioned this linear path of grief and the expected norms such an assertion creates (Archer, 1999:25).

On reflection, what is of interest to me is that the stages outlined above do not appear dissimilar to the symptoms after a trauma. There is a struggle to take in reality. There may be denial and emotional numbing which relieves the pressure and allows the individual to cope with daily activities. There may also be intrusive thoughts which allow the individual to slowly accustom himself to reality and work through the surrounding emotions. However failure to habituate to the experience may lead to PTSD (Harvey & Miller, 2000:370).

2.3.1.3 A Post-modern View of Mourning

A post-modern view of bereavement sees grief as neither universal nor essential. Fixed stages are not viewed as the norm. Rather, people are regarded as individuals, active in their own personal grieving process which is unique to themselves. "Grieving offers the mourner an opportunity to create a new narrative about death and its meaning" (Berzoff, 2003:273). Death is an opportunity to make new meaning of relationships, beliefs and assumptions about the deceased and the nature of life itself.

More positively than earlier views, loss is seen to hold the possibility to produce existential and spiritual growth, and contribute to a sense of resilience in the mourner. Death is viewed as an event which begins a process of potential transformation. Klass (1995:244) sees continuing bonds with the dead as healthy and as a strength. Children who have lost a parent maintain an internal bond to the person who has died. Memories of the parent do not stay fixed or static; they are active and ever-evolving representations which change over time. Merwitt and Klass (2003:273) conducted research on adolescents and children who had lost a parent. They found that the deceased continued to act as a role model, a source of guidance, someone to help clarify issues and someone who brings comfort. Ambivalence towards the deceased was not seen to be problematic or indicative of early development failure.

While these post-modern views offer positive and realistic perspectives, they describe the cognitive ability of an individual to understand the concept of death, move through the processes of grief and mourning and gain growth and meaning of this experience. In my view, a child's cognitive ability to do this may be compromised. For this reason the loss of a significant other to a child may be experienced as traumatic.

2.3.1.4 Conclusion

To conclude the brief overview of grief history, psychoanalytic research into grief concentrated on the mourner's psychological structure and past experiences. Berzoff (2003:273) notes that psychodynamic literature has overly emphasized the negative consequences of loss and bereavement. The developmental stage theories have been acknowledged with the conclusion that grief stages appear similar to symptoms of PTSD. A post-modern perspective includes the positives that can be derived from trauma in finding meaning in the experience. However, emphasis needs to be placed on the traumatic experience of grief in the life of a child, resulting in a range of symptoms including undermining psychic functioning.

2.3.2 *Complicated/Pathological Grief or PTSD*

In complicated grief there is cognitive disorganization and emotional turbulence which may threaten to overwhelm the individual. These responses may lead to depression or maladaptive behaviours and away from finding grief resolution (Marrone, 1997:132).

Parkes (in Berzoff, 2003:273) describes the shock response that results in numbness as being protective of the ego. Gradually the numbness blends into pain which may appear to be "restless hyperactivity, difficulty in concentrating, a loss of interest in the outside world and a pining for the deceased". Parkes also suggests that there are three forms of pathological grief. If one compares these symptoms of complicated grief with the criteria for PTSD in DSM-IV-TR (2000:467), it is clear that although the language may differ, the essence of what is being described is the same:

- *Chronic Grief* - prolonged grief with exaggerated symptoms (consistent with intrusive thoughts or increased arousal of PTSD);
- *Inhibited Grief* - where there appears to be absence of emotion (consistent with numbness of PTSD); and
- *Delayed Grief* - where the mourner avoids grief emotions (consistent with avoidance of PTSD).

Other complicated grief reactions include *masked grief* (Deutsch, 1937:12-22) which is the apparent absence of grief with the experience of psychosomatic symptoms. *Exaggerated grief* reactions and clinical depression are also cited by Marrone (1997:134) as complications of grief. Marrone (1997:165) describes the reactions of children to grief which include: regression, hyperactivity, difficulty controlling emotions, difficulty concentrating and fearfulness of the remaining parent's death.

While these behaviours are considered by Marrone to be "normal to the healing process" or "attention-seeking behaviours", I would like to suggest that these reactions are reactions consistent with trauma.

2.3.3 A Holistic Understanding of Death in the World of a Child

Grief and bereavement are experiences that all human beings are destined to face in their lifetime. Holland emphasizes the view that a child's experience of bereavement can be quite different from that of an adult, and that following the death of a parent there may be considerable grief which can remain unrecognized, with effects felt through to adulthood. The meaning attributed to grief in childhood can only be understood in terms of the child's cognitive, emotional and social development of the young child (Corr, 1999:89).

The impact of death on a child should be understood in terms of four factors. These are:

- the child's level of cognitive development;
- the nature of the child's relationship with the person who died;
- the family and community "story" about the death (Webb, 2003:405); and
- the age of the deceased and the type of death (Muller & Thompson, 2003:183).

2.3.3.1 The Child's Level of Cognitive Development

For a child to fully comprehend the reality of death, the child has to have cognitively formed a mature concept of death. The child needs to understand that death is universal, that death is inevitable, that death is irreversible and that, in death the physical self will no longer exist (Marrone, 1997:143). Piaget's general theory of cognitive development has influenced much of the literature around a child's cognitive understanding of death. He explained cognitive development in three phases:

- The Pre-operational Stage (2-7 years).
- The Operational Stage (7-11 years).
- The Formal Operational Stage (11 years+).

- *The Pre-operational Stage (2-7 years)*

Webb (2003:405) describes children in the first stage as often being confused by the terms used to refer to death; especially euphemistic words such as "loss". Literal understanding of such words allows them to think that the lost

object can be found. The very young child does not have a firm sense of object constancy and every separation is experienced as though the person is lost forever. The child then becomes anxious in anticipation of this perceived loss resulting in separation anxiety. Only once cognitive maturation has occurred, can the child realize that the other person does not disappear altogether and the anxiety slowly subsides. For this reason, the child in this stage may not understand fully the permanency of death.

- *The Operational Stage (7-11 years)*

School-age children in the second cognitive stage usually realize that death is irreversible, final and inevitable. They do, however, view death as an event that happens later on in life, in old age. The loss of a parent or a loved one during this phase may produce immense longing and sadness as the child knows he/she will never see the parent again.

Speece and Brent (1992:211) investigated the age at which a mature understanding of death is achieved in children. They concluded that mature understanding does not occur for most children until at least 10 years of age.

- *The Formal Operational Stage (11 years+)*

For a child in the formal operational stage, the death of a significant other produces not only the longing and pain of the previous phase, but the beginning of existential enquiry. The child may ponder the meaning of life and death. This rudimentary ability to explore cognitively the complexities of life, without possibly the emotional or spiritual maturity to contain such thoughts adequately, may bring added difficulty to the middle-school child coping with death.

I will now look at grief theory through the eyes of Parkes and how this perspective resonates with the work of Piaget. Parkes (2001:150) notes that “in all social animals bereavement by death usually gives rise to alarm, separation reaction and changes to the assumptive world”:

- *Alarm*: Where physical and emotional changes occur resulting in the fight or flight reaction to a perceived threat to the ego.
- *Separation reaction*: Where innate repertoires of behaviours, such as crying and searching, occur.
- *Changes to the assumptive world*: Here the individual needs to reorganize the assumptions previously made in his/her life. In the case of a family member's death, the family structure is shaken and the family needs to restructure itself.

The first two reactions appear to resonate with Piaget's initial stages of development. In terms of personal understanding, Piaget's subsequent stages do not replace former stages, but are additions and evolutions. A child in the third phase of cognitive development, when faced with death, would thus experience these evolutionary reactions of earlier stages as well as the understanding and questioning of the later stages.

In terms of the Piaget's formal operational stage, more complex abstract thinking is possible. This is a mixed blessing, with associated advantages and disadvantages. Parkes (2001:150) looks at certain cognitive factors that influence the way in which human beings react to bereavement:

- *The ability to imagine and rehearse complex models of the world.*
Problems with this ability include worry and agonizing over events that are beyond our control and the anticipation of loss that can evoke actual distress.
- *The ability to postpone or avoid disturbing thoughts.*
Problems with this ability can allow individuals to cognitively avoid and deny reality in order to postpone dealing with their emotions. This can have a major impact on a person's emotional world. "Children need to approach experiencing the pain or emotional aspects of the loss, gradually and in ways that do not overwhelm the coping capacity, which is generally less well developed than that of adults" (Worden, 1996:14).
- *The ability to communicate social expectations of behaviour, thoughts and feelings.*
"Social assumptions can conflict with our felt needs" (Parkes, 2001:150). Often there may be a conflict between social expectations to suppress or inhibit the expression of grief and the internal workings of mourning and grief.

In conclusion, the cognitive ability of a child is on a developmental continuum. The effect of a death on a child will depend on where the child is cognitively on this continuum. This significantly contributes to the way in which a child will adjust after the death of a loved one. Latency-aged children who are developing abstract thought, but who may not have the emotional maturity to deal with the feelings evoked by these thoughts, may be particularly vulnerable to trauma (Rudenburg et al., 1998:107). Developmental age therefore significantly contributes to the way in which a child will adjust after the death of a loved one.

2.3.3.2 The Nature of the Child's Relationship with the Deceased

The nature of the child's relationship with the deceased greatly influences an individual's emotional response to the loss. As discussed in the section on attachment, the style of attachment is highly significant in the way in which a child will deal with death. One would expect that the death of a primary family member may be experienced more intensely than in the more extended family. It is, however, the attachment style and the meaning that the child attributes to the relationship with a particular individual that is significant in terms of the intensity of the grief reaction.

In the loss of a parent or significant caregiver, however, there are two aspects to consider. The affective grief associated with the loss of that parent and the secondary consequences of the parent's absence. The latter may include financial loss for the family, lack of protection and/or nurturance. A secondary loss is "a physical or psychosocial loss that coincides with or develops as a consequence of an initial loss" (Rando, 1995:217).

2.3.3.2 The Family and Community Story about Death

It has already been said that the child's adjustment to bereavement is closely related to the coping style of the parents. In fact it is the single most important predictor of a positive outcome in a child dealing with death.

Culture and society also have significant contributions to make in this regard. A community has specific ways of expressing distress and emotions. Grief and bereavement are not universal constructs. Grief and rituals of mourning are culturally constructed. Thus what would be considered as pathological would vary from culture to culture (Min-Tao Hsu et al, 2002:43). The spiritual framing

of death is very important in this context. Jung was a pioneer in asserting that all human problems are spiritual. Furthermore, he suggested that healing is not possible without spiritual awakening or addressing the issues pertaining to spiritual distress. Contemporary literature in counselling and psychotherapy also suggests that successful treatment includes the sensitive addressing of spiritual issues.

A shared spiritual understanding of the existential meaning of death can strengthen the child's connections within his/her community, thus aiding adjustment. Most cultures have different beliefs about the after-life and different rituals that are associated with keeping connection with the deceased after death. Constructive factors in bereavement are "seeing some good resulting from the death, having a chance to say goodbye to the deceased and intrinsic spirituality" (Gamino et al., 2000:633). Mourning practices are also vastly different. In South Africa's multicultural experience, cultural and spiritual beliefs vary significantly. In Hindu culture it is honourable not to talk about the person who has died and keep emotions separate from daily activities. In Jewish culture, rituals encourage the mourner to experience the loss for a prescribed period of time with suffering being a shared value (Berzoff, 2003:273). In many black cultures it is believed that the soul of an individual lives on after death. The good souls of the loved ones who have died, the wise parents' souls, still accompany their living children and grandchildren. These are the ancestors. The ancestors can be communicated with and are consulted when important decisions need to be made (African Mythology, 2004: 1-7). Diverse belief systems need to be understood and taken into account in the therapeutic environment.

2.3.3.4 The Age of the Deceased and the Type of Death

- *The age of the deceased* is relevant according to Muller and Thompson (2003:183). The younger the deceased, the more tragic it is socially considered and the greater the emotional response (Gamino et al, 2000:633).
- *The type of death* and subsequent social response also frames the way an individual may adjust to grief. Terminal cancer may be viewed quite differently from terminal AIDS in a given community. Stigma surrounding certain diseases may prevent families from revealing the actual cause of death and subsequent realities. The type of death is also linked to the amount of suffering which the deceased has experienced and influences the emotional response (Muller and Thompson, 2003:183).
- If a person has been suffering for a long time, people may feel relieved and thankful that the deceased is at peace. Traumatic death as in suicide, violent death, murder or accidents may dictate the degree of support available from a community. Suicide may be socially or religiously unacceptable, or it may be considered an event of pride.

To summarize, it may be said that higher levels of pathological grief or PTSD in children may be dependent on the child's cognitive level, the attachment relationship the child had with the deceased, support from family and community, the age of the deceased and the type of death. Research, as outlined by Alat (2002:3) and Gamino et al. (2000:633), has summarized the risk factors which make children vulnerable to traumatic grief. They include:

- *individual factors* – low IQ, low self-esteem, poor self-control (Alat, 2002:3);

- *age factors* – older children (8-15 years) appear to be at higher risk for developing PTSD/traumatic grief (Alat, 2002:3);
- *the child's perceived absence of social/family support or parental distress*, are further risk factors (Alat, 2002:3; Gamino, 2000:633);
- *the unexpected or traumatic death* (Gamino et al.,2000:633);
- *death associated with an over-lengthy illness* (Gamino et al., 2000:633);
- *death of a younger-aged person* (Gamino et al.,2000:633; Alat, 2002:3);
- *a death that the mourner perceives as preventable* (Gamino et al.,2000:633);
- *a relationship with the deceased marked by conflict, ambivalence or dependency* (Gamino et al.,2000:633);
- *prior losses, especially unresolved losses* (Gamino et al.,2000:633).

Research suggests that these risk factors contribute to the onset of PTSD symptoms or traumatic grief. Conversely research has also identified certain protective factors that result in uncomplicated mourning. Research suggests that the adequate support from the surviving parent and support from the broader cultural community is significant in uncomplicated grieving. Protective factors within the child may lead to uncomplicated grief. Child trauma research (Alat, 2002:2-7) concludes that there are the following protective factors:

- *Individual factors* - cognitive, personality and gender factors are significant in terms of successfully completing the mourning process. Higher IQ is a protective factor. Girls appear to be at higher risk for PTSD/traumatic grief than boys.
- *Age as a factor* – Younger children (2-7 years) appear to be a lesser risk for PTSD than older children. Older children (8-15 years) appear to be at risk for increased distress.

- *Familial/social support* – protective elements include the presence of at least one loving dependable parent/person, socio-economic advantage, extended family network (Worden, 1996:35).
- *The child's positive relationship with the deceased* is a protective factor.
- *The older age of the deceased*.

2.4 Conclusion

This chapter has explored trauma in childhood and the traumatic effects that the death of a significant caregiver has in the life of a child. It has explored PTSD, grief as trauma, attachment and loss and their meaning in the world of a child. The findings of this literature research, has suggested that the definition of what constitutes trauma, especially for a child, may not be limited to extreme events. This suggestion has been supported by recent literature so much so, that therapists should consider PTSD as a possibility when treating a child who is bereaved.

Through this literature research I reached the conclusion that educational psychologists and counsellors may find it valuable to bear such findings in mind when counselling a child who has lost a primary caregiver. These findings may encourage the educational psychologist or counsellor to investigate the possibility of traumatic grief as a diagnosis.

Chapter 2 has researched the literature on traumatic grief in children. The next chapter will open with looking at the types of therapy available for children experiencing traumatic grief. The chapter will focus on art therapy as an appropriate therapy for traumatic grief.

The research then focuses on the type of therapeutic intervention which is most suited to children experiencing traumatic grief. Chapter 3 specifically researched the literature on art therapy as a therapeutic intervention.

This chapter has explored trauma in childhood and the traumatic effects that the death of a significant caregiver has in the life of a child. Research has suggested that the definition of what constitutes trauma, especially for a child, may not be limited to extreme events. This suggestion has been supported by recent literature so much so, that therapists should consider PTSD as a possibility when treating a child who is bereaved. However, while the death of a primary caregiver may be experienced by the child as traumatic, it does not mean that all children respond in this way. The extent to which a child experiences an event as traumatic is dependent on the child's vulnerability to trauma. This vulnerability may be dependent upon the severity of the trauma, the developmental level of the child, the personality of the individual and the degree of social support experienced.

To support the argument in favour of the death of a significant caregiver being viewed as traumatic, attachment in the life of a child has been explored. Four types of attachment style appear out of the literature: secure attachment, avoidant, anxious-ambivalent and disorganized. Insecure attachment appears to be the result of dependency and/or conflict. The child's style of attachment to a caregiver is significantly linked to the way in which the child will cope with the death of this caregiver.

This chapter investigated grief and grief theory. Psychoanalytic research into bereavement concentrated on the mourner's psychological structure and past experiences. The developmental stage theories have been acknowledged with the conclusion that grief stages appear similar to symptoms of PTSD.

A post-modern perspective includes a positive perspective in that, if meaning can be derived from grief, this can allow for emotional growth. However this ability may be compromised for children due to developmental and cognitive limitations.

In holistically understanding death in the world of the child, emphasis was placed on the child's cognitive level, the nature of the child's relationship with the deceased, the family and community story about death, the age of the deceased and the type of death.

The next chapter will open with looking at the types of therapy available for children experiencing traumatic grief. The chapter will focus on art therapy as an appropriate therapy for traumatic grief.

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