Adolescents experiencing the death of a parent

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Dealing with the death of a parent can be exceedingly difficult at any age, but for adolescents this can pose special problems. Although there has been little research on adolescent bereavement, a number of recent studies suggest a higher incidence of short- and long-term psychological problems for individuals losing a parent during adolescence [1-3]. A relevant finding from my own research[4] is that parentally bereaved adolescents were significantly more depressed than has been reported elsewhere for a normative sample of adolescents.

It should not surprise clinicians that bereaved adolescents are at greater risk than other adolescents for psychological difficulties. The inherently difficult aspects of mourning, when combined with the developmental tasks of normal adolescence, are sufficient to create concerns regarding the individual engaged simultaneously in both[5, 6]. The adolescent, in the natural way of adolescents, is engaged in a letting go of the parent as authority and thus has to work through loss of childhood status and of the protection of the parents. When a parent dies this compounds the experience of loss, including the various emotions associated with loss.

Given that adolescent loss of a parent is difficult for all and a major problem for some, an important issue to be addressed is whether adolescents at high risk for major problems over time can be identified through risk factors. Results of my own research indicate that this is at least partially possible. Before proceeding with a description of risk factors identified through the research, it will be useful to give a brief description of the research.

Description of Research

Fifty persons were interviewed, all of whom had lost a parent through death between the ages of 12 and 19. The death had occurred not more than five years and not less than six months ago. The mean age of participants at the time of the parent's death was 14.9 years, and the mean time elapsed since the death was 28 6 months. All but a few of the participants were students at a secondary school in Peel County, Ontario at the time of interview. Half of the participants had been involved in a peer support group for bereaved adolescents at their local secondary school. It was rare for bereaved adolescents attending one of the several schools offering bereavement support groups to decline being involved in the group. The remaining participants had attended schools where support groups were not offered.

All participants were given several standardised psychological tests. Additionally, a semi-structured interview was conducted by me. Factors considered in relation to bereavement outcome included the following: informal social support; participation in a peer support group; nature of the relationship to the deceased and surviving parent prior to death; personality style; suddenness of death; religious beliefs; age of participant at time of death; time elapsed since death; sex of bereaved adolescent and deceased parent; and social class.

Results

Overall dysfunction

Twenty per cent of bereaved adolescents scored within the major depression category of the Beck Depression Inventory. This compares with 8.6 per cent as reported in a normative sample of American secondary school students[7].

Factors influencing adaptation

1. The nature of the prior relationship with the surviving parent

Adolescents who reported having a poor relationship with the parent who survived prior to loss were found to be significantly more likely to be depressed at the time of interview than those with good relationships. This may suggest that the support of a parent who survives provides a stable environment in which the work of mourning becomes possible. There was an interesting interaction effect, revealing that when the death of a parent was sudden, the importance of the prior relationship with the surviving parent was much more important than when the death was gradual. Perhaps if there is time to prepare for a death, alternative sources for support may be sought out by the adolescent if the relationship with the surviving parent is not good. When the death is sudden, however, this option is removed and the adolescent has to confront loss from a position of isolated vulnerability.

Due to limitations in the design of the research, the findings reported above, as well as those reported below, are open to alternative interpretations than those offered. For example, it must be recognised that the relationship of social support to depression is bi-directional. Nevertheless, the position taken here is that the major path of influence is that of social support of levels of depression. This interpretation has been buttressed by longitudinal studies of social support[8].

2. Informal Social Support Following Loss

A second finding closely related to the above was that adolescents who rated the support of others following loss as poor were more likely to be depressed than were those who rated support more favourably. This finding provides additional backing for the widely discussed idea that social support often provides a buffering effect in situations of stress[9]. The benefits of support extend in the case of adolescent bereavement beyond the environmental response after the crisis, and include the context of support in which the crisis occurs. Thus, with regard to risk factors worth identifying, a clinician would be advised to assess the current support of the bereaved adolescent, as well as the longstanding quality of the relationship with the surviving parent.

EDITORIAL

Children and adolescents coping with death is the theme of articles by Weitz (p.19) and Gray (p.17) in this issue of 'Bereavement Care'. We are pleased to publish original, high quality research which aids our understanding of the processes of grief in children and adolescents and how we might help them.

A great and good children's doctor has died and we mourn his going. David Morris pioneered a bereavement clinic for parents whose children had died in his care at the Brook Hospital, London. His holidays for cerebral palsied children with the Uphill Skiing Club he founded gave immobile children the exhilarating experience of free movement. His pleasure in their achievements was an inspiration.

Barnes, a general practitioner, poignantly describes the effect of the loss of his child from leukaemia. His article is valuable to those who offer counsel to bereaved parents as well.

Editor

One comment is relevant in relation to the above. Many of the adolescents interviewed had some difficulties in the relationship with their surviving parent—both before and after the loss—and yet still rated the relationship as good overall. This is particularly important in terms of parental perceptions. During telephone conversations related to obtaining parental consent for the study, several parents spontaneously mentioned that they felt alienated from their child and unable to be of assistance—and yet in these cases the adolescents later rated their relationships with the surviving parent positively. Perhaps these differing perceptions of the adolescent-parent relationship were due to differing expectations regarding shared experience following loss. Some adolescents found it too difficult to share intense feelings with their surviving parent and had to draw limits on the relationship—thereby giving the appearance of being alienated from that parent. The point to be made, then, is that clinicians must be sure to clarify the adolescent's perception of the surviving parent's helpfulness, rather than relying merely on parental report or observation of behaviour.

The factors most likely to identify a bereaved adolescent at high risk for bereavement complications are: a poor relationship with the surviving parent prior to loss combined with a sudden death; little support available following loss; and a personality which is characterised either by extreme passivity and dependency or by extreme aggressiveness and independence.

3. Personality

Another major finding from this research was that personality influenced the response to loss over time. Using Weininger's personality typology based on theoretical and assessment rationales[10], adolescents were divided into three categories: (1) characterised by a predominantly dependent, or passive manner of expression; (2) characterised by a predominantly aggressive, independent manner of expression; (3) characterised by a balance between independent and dependent, or aggressive and passive modes of expression. Those individuals characterised by the balanced style were significantly less likely than the others to be depressed.

The above finding is an interesting one. We can argue from these results that adolescents with a wider range of behavioural and emotional expression are in a better situation for facing the difficult task of mourning. Theoretically, this makes sense. Having a balanced personality style suggests that one can accept and use the support of others in an appropriately dependent way—unlike the aggressive/independent person who is too threatened to allow such intimacy. The balanced personality also allows for expression of hostile feelings, and thus there may be less guilt and lowering of self-esteem following loss than could be expected from the typically passive and dependent person. As is well known, anger is a normal expression associated with loss[11], and individuals who have difficulty with anger are likely to show a complicated course of mourning.

It is also interesting to consider the different personality styles and the corresponding ways of dealing with loss in the light of theories of personality development. In particular, the work of object relations theorists such as Klein and Winnicott[12, 13], is relevant to personality differences associated with mourning. These writers developed the concept of a 'depressive position' in childhood that was considered central to personality development. The primary aspect of this depressive position is an experience of loss vis-à-vis the parent. Working through this loss—including the toleration of sadness and aggression, and the eventual ascendency of love over hostility—is considered necessary to personality development and future mental health. Thus it could be argued for the present study that adolescents who had successfully negotiated the depressive position at an earlier time were now more able to negotiate the same 'territory' of mourning under different circumstances.

4. Religious beliefs

Another finding worthy of mention is that adolescents who reported having religious or spiritual beliefs were less likely to be depressed than those reporting no such beliefs. It cannot be ascertained whether these beliefs were antecedent to loss or developed as a result of the experience of mourning the lost parent. Therefore, we cannot be sure that an adolescent with religious beliefs at the time of loss is at a lower risk for later difficulties. Further research is necessary to clarify this matter. It is, however, apparent from this and other research[13, 14] that the dimension of meaning is an important one for understanding the psychopathology of bereavement. Resolution of loss is associated with finding some sense of meaning in the loss, and the search for meaning is therefore of great importance to bereaved people. On a practical level, clinicians working with bereaved adolescents may be helpful by acknowledging the legitimacy of existential and religious questioning. Although the process of questioning the meaning of an individual loss (and more broadly the role of suffering and death in life) may be painful to observe, it would seem an important component of dealing with loss.

To summarise, the factors shown in this research as most likely to identify a bereaved adolescent at high risk for bereavement complications are: a poor relationship with the surviving parent prior to loss combined with a sudden death; little support available following loss; and a personality which is characterised either by extreme passivity and dependency or by extreme aggressiveness and independence. When, over time, some positive meaning is given to the loss, or the loss is perceived within a meaningful context, this would seem most often to be a healthy sign of adaptation. Other factors considered in this study were not shown to be relevant to outcome.

It should be noted that the risk factors for poor adaptation identified above are relevant to several theoretical perspectives. What this suggests is that the psychopathology of bereavement can only be adequately understood from a multi-theoretical perspective that includes an analysis of social structures, internal dynamics, effects of early experience, cognitive functioning, and existential and religious aspects. One-dimensional approaches, whether on a theoretical or clinical basis, are likely to oversimplify and do an injustice to the experience of the bereaved person.

Issues of Intervention

Finally, it may be useful to comment on the issue of intervention with bereaved adolescents. Although subjective reports of adolescents participating in a bereavement support group showed that most felt helped by this experience, objective findings showed no measurable benefit. This finding of no clear benefit is in keeping with current literature on bereavement support group interventions[16]. However, the finding of no objective benefit cannot be used to say that groups cannot be helpful. They were, after all, experienced as helpful. Additionally, it may be that changes to the organisation and functioning of groups could make

them more beneficial[17]. It may also be that benefit does not show until a much later time. Despite these qualifications, one must wonder if there are alternative strategies to groups that would be more successful in assisting adolescents to deal with the death of a parent.

The finding that the relationship between adolescent and surviving parent is critical to adaptation suggests that a family-based, or combined adolescent-parent intervention may be of potential benefit for many. In a post-loss environment this may not, however, always be possible or advisable. Individual counselling is likely be of benefit if stigmatisation of the bereaved adolescent is carefully avoided. It is likely that there is no ultimate resolution to the question of the 'best' intervention for high risk adolescents.

In conclusion, there is evidence to suggest that adolescents who have a parent die are at risk for adjustment difficulties and that some adolescents can be identified as being more at risk than others. Several aspects of risk must always be considered, and these necessitate including a number of theoretical approaches in any model of the psychopathology of bereavement. The use of peer support groups in intervening with bereaved adolescents were not shown to have objectively verifiable benefits, but there has as yet been no research to indicate that there is a preferable approach to intervening with high risk adolescents.

References

1. Balk D. Effects of sibling death on teenagers. *Journal of School Health* 1983; **53:** 14-18.
2. Van Eerdewegh MV, Biere MD, Parilla PH, Clayton PJ. The bereaved child. *British Journal of Psychiatry* 1982; **140:** 23-29.
3. Saucier JB, Ambert AM. Parental marital status and adolescents' health-behavior. *Adolescence* 1983; **13:** 403-411.
4. Gray RE. Adolescent response to death of a parent. *Journal of Youth and Adolescence* 1987; **16:** 511-525.
5. Gray RE. Adolescents faced with the death of a parent: The role of social support and other factors. Unpublished doctoral dissertation, University of Toronto, 1987.
6. Sugar M. Normal adolescent mourning. *American Journal of Psychotherapy* 1968; **22:** 258-269.
7. Kaplan SL, Hong GK, Weinhold C. Epidemology of depressive symptomatology in adolescents. *Journal of the American Academy of Child Psychiatry* 1984; **23:** 91-98.
8. Barrera MJ. Distinctions between social support concepts, measures and models. *American Journal of Community Psychology* 1886; **14:** 413-445.
9. Gottlieb BH. Social Support Strategies: Guidelines for Mental Health Practice. London: Sage, 1983.
10. Weininger O. The Differential Diagnostic Technique, a visual-motor projectve test: Research and clinical work. Springfield Illinois: Charles C Thomas, 1986.
11. Bowlby J. Attachment and Loss, Vol. 3: Sadness and Depression. London: Hogarth Press, 1980.
12. Klein M. Mourning and its relation to manic depressive states. *International Journal of Psychoanalysis* 1940; **21:** 123-153.
13. Winnicott DW. A personal view of the Kleinian contribution. In: The Maturational Processes and the Facilitating Environment. London: Hogarth Press, 1962.
14. Parkes CM, Weiss RS. Recovery from Bereavement. New York: Basic Books, 1983.
15. Balk D. Reactions of sibling death during adolescence: Interactions with religion. Paper presented at the Annual Convention of American Psychological Association, Atlanta: August, 1988.
16. Parkes CM. Bereavement counselling: Does it work? *British Medical Journal* 1980; **5:** 3-6.
17. Gray RE. The role of school counsellors with bereaved teenagers: With and without peer support groups. *The School Counsellor* 1988; **35:** 185-193.

Adolescents and Bereavement

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As a teacher, I used to wonder why children and adolescents suffering the consequences of parental divorce or a death in the family would rarely want to talk about the problem.

Two years ago a girl died of leukaemia in the school where I was working. Her death deeply affected us all, staff and students alike, but in very different ways. After a few weeks I realised that one of the girls in my charge had become very depressed. What emerged later was that the student's death had triggered off her own mourning process for her father who had died two or so years previously. She had not wanted to talk about her problems with me or any other authority figure, but she was able to talk to some staff who were not responsible for her. Similarly, I have found that students whom I was not responsible for would come to talk with me.

This particular experience led me to think about how adolescents deal with their difficulties; and, specifically about how adolescents view death, loss and bereavement, and how they might react under those circumstances.

Literature searches world-wide reveal an astonishing fact: there is a wealth of literature on both bereavement processes and adolescence, but almost nothing correlating the two. What little literature exists is largely drawn from clinical experience, and while it is, of course, of paramount importance to those working in psychiatric settings, is of limited use to all those teachers, youth workers, school counsellors and other carers working with young people in their usual settings.

The research that I carried out focused on all adolescents rather than those we know to be deeply grieving. It seemed to me that we, as teachers and other carers of young people, know little about how the average adolescent copes with death and loss. The study did not include separation.

The study must be only considered a preliminary investigation as the sample was small, 49 students aged 16 to 18. The questionnaire was based on one devised by Anita Hufton for a similar study[1], and it was encouraging that many of the results concurred with Hufton's, giving both pieces of research more validity. Descriptive statistics and chi-square tests were used to provide quantitative data; this was backed up with recorded discussions among a group who had experienced a major loss. The data was obtained in five schools, within the context of tutor groups and Religious Education or Health Education classes where the topic was not out of place and where follow-up could be made if necessary. The class's usual teacher carried out a discussion to help pupils become aware of the specific vocabulary associated with death and loss, and to help them to enter into the subject. The questionnaire was administered after the discussion.

The results revealed a number of findings:

1. Grief is the usual reaction of an adolescent, aged 16-18, to loss, and the greater the loss, the greater the grief is likely to be. Despite theoretical differences about the nature of adolescence (e.g. Coleman[2]), there is a consensus that at the very least adolescence is not an easy time, and at the worst it can be tumultuous. Therefore if faced with a bereavement the adolescent may be very vulnerable[3].

2. A majority had experienced a major loss by death, though the term 'major' had been defined differently in different studies. Usually it was the clinician who decided what 'major' means, but here it was the adolescents themselves who decided after discussing it. The questionnaires revealed that although a clinician may not have seen the experience as major, for the student, 'major' signified a traumatic event in their life and within the framework of their experience. Of the sample, 81.6 per cent reported having experienced a loss, of whom 62.5 per cent reported the loss as 'major'.

3. Adolescents were likely to have experienced the loss of a grandparent. This could result in significant distress and grief for some, for example those who have been