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Childhood Depression Resulting from Parental Loss: Subsequent Obstacles to Maturation and Developmental Treatment Implications

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CHILDHOOD DEPRESSION RESULTING FROM
PARENTAL LOSS: SUBSEQUENT OBSTACLES
TO MATURATION AND DEVELOPMENTAL
TREATMENT IMPLICATIONS

by

Elizabeth M. Prokof

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
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VITA

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INTRODUCTION

Statement of the Problem

Major Depression in childhood is defined as one or more major depressive episodes in which depressed mood and loss of interest in activities occurs for at least a two-week period (American Psychiatric Association, 1987). Associated symptoms are lowered self-esteem, social withdrawal, suicidal ideation and suicide. The problem arising is: what may cause this disorder? Many writers support the notion that parental loss (i.e., parental death or parental divorce/separation) may lead to subsequent depression in childhood (Beck & Rosenberg, 1986; Bloom-Feshbach & Bloom-Feshbach, 1987; Kalter, 1987; Krakowski, 1970; McConville, Boag & Purohit, 1972; Petti, 1983; Roseby & Deutsch, 1985; Rutter, Izard & Read, 1986; Spitz & Wolf, 1946; Thiers, 1987; Wallerstein & Kelly, 1980). There may also be sequelae of childhood depression in adolescence and adulthood. The form which the disorder can take in adolescence may be depression and suicide. In adulthood, individuals who have experienced parental loss may undergo depression and difficulties in intimate relationships.

However, one child may develop normally and one child may develop a psychiatric disorder after experiencing the death or divorce/separation of a parent. These factors which are significant in accounting for individual differences in severity of subsequent dysfunction are age, developmental capacity for grief, sex of the child

and child's parent, quality of the parent-child relationship, circumstances surrounding death, and social environment following loss. Depending upon the effect which parental loss may have upon a child in his/her early and later years, treatment implications will vary. However, there are professionals who agree that mourning the loss is critical in order for negative psychological consequences not to appear in childhood, adolescence or adulthood (Bloom-Feshbach & Bloom-Feshbach, 1987; Bowlby, 1980; Gelcer, 1983; Hochman, 1987).

Purpose of the Study

The purpose of this thesis is to explore several significant questions regarding childhood depression: What are the behavioral manifestations of childhood depression in children aged 0-12? Given an awareness of the disorder, can parental loss be a correlatable factor of childhood depression? If so, what are the maturational obstacles an individual encounters in childhood, adolescence and adulthood given a parental death or divorce/separation? Can these obstacles be mediated by factors which will decrease the likelihood of subsequent pathology? Given that depressive states result, what are the treatment implications which arise for helping children, adolescents and adults? These questions will be addressed via a thorough exploration of the literature.

CHAPTER I

CHILDHOOD DEPRESSION (0-12 YEARS OF AGE)

Behavioral Manifestations

Poznanski (1982) cites nine cardinal symptoms of childhood depression and believes five symptoms must exist in order to make a diagnosis of a depressive syndrome. These symptoms are as follows:

1. Depressed Affect. Poznanski (1982) regards this symptom to be the sine qua non of childhood depression, and this emotional state must exist for one month prior to a diagnosis. In contrast, the American Psychiatric Association (1987) contends that depressed or irritable mood and loss of interest in activities need only occur for two weeks prior to a diagnosis of major depression.

Further definition of depressed affect is discussed by several authors (Petti, 1983; Schaefer, Millman, Sichel & Zwilling, 1987; Spitz & Wolf, 1946; Thiers, 1987; Wallerstein & Kelly, 1976). This emotion may be expressed by crying, pessimism and despairing mood, pervasive sadness or sad expression and brooding. Depressed mood may occur for the majority of each day and may be recounted by the child or observation by others (American Psychiatric Association, 1987).

2. Anhedonia: inability for a child to have fun, boredom existing 50-90% of the day (Poznanski, 1982). Petti (1983), Schaefer et al. (1987) and Thiers (1987) also maintain that these children lose

interest in or experience nonenjoyment of previously pleasurable activities. Diminished interest or pleasure may occur almost every day, as reported by the child or significant others (American Psychiatric Association, 1987).

3. Lowered Self-Esteem. Depressed children may experience a low opinion of themselves, feelings of worthlessness, inadequacy and self-depreciative statements on a daily basis (American Psychiatric Association, 1987; O'Connor, 1986; Petti, 1983; Rutter et al., 1986; Schaefer et al., 1987; Thiers, 1987). Poznanski (1982) contends this concept is difficult to measure because the self-concept does not develop until 6-9 years of age and because of a child's sensitivity and subsequent need to hide his/her true emotions.

4. Social Withdrawal. Depressed children can be socially isolative (O'Connor, 1986; Poznanski, 1982; Schaefer et al., 1987; Spitz & Wolf, 1946) and lack interest in any relational life with peers. Poznanski contends that prior to depression, children are capable of establishing interpersonal relationships with peers. For example, "one boy commented that the teacher last year said he was one of the most popular kids in the classroom, but he currently showed little interest in interacting with his peers" (p. 310). Children may also withdraw from others by setting themselves up to be rejected. This may be in the form of controlling all rules in a game so they lose friends. In addition, a child may withdraw from others yet express his/her need for a relationship by becoming close to a family pet.

5. Impairment of Schoolwork. Similar to social withdrawal, prior to the depressive state the child was able to perform in school.

His/her behavior may be characterized by a diminished capacity to think, concentrate and to be productive at school on a daily basis (American Psychiatric Association, 1987; Poznanski, 1982; Schaefer et al., 1987; Thiers, 1987). This change in behavior may be due to an internal preoccupation with thoughts/worries and variability in school performance can be exhibited depending upon his/her mood (Poznanski, 1982).

6. Complaints of Fatigue. A depressed child may be characterized by low energy and chronic tiredness nearly every day (American Psychiatric Association, 1987; Petti, 1983; Schaefer et al., 1987; Thiers, 1987). Poznanski (1982) finds this to be a common characteristic of depressed children. For example, a child may take voluntary naps or be too tired to play with friends.

7. Psychomotor Retardation. A moderately or severely depressed child is often hypoactive. The child may stare at the floor, sit in a slumped position, speak and move in a slowed, listless manner (O'Connor, 1986; Poznanski, 1982; Thiers, 1987).

8. Difficulty with Vegetative Functions. A depressed child may have difficulty sleeping (Petti, 1983; Spitz & Wolf, 1946) and can usually explain this symptom clearly to practitioners (Poznanski, 1982). Schaefer et al. (1987) and Thiers (1987) assert that sleeping difficulties can take the form of either insomnia or hypersomnia, and may occur almost every day (American Psychiatric Association, 1987). A depressed child may also have a poor appetite (Petti, 1983; Poznanski, 1982) or an increase in appetite (American Psychiatric Association, 1987). Significant weight loss or weight gain may result (i.e., more

than 5% of body weight) in one month (American Psychiatric Association, 1987).

9. Morbid Ideation or Suicide Attempts. A depressed child may have thoughts of death or attempt suicide (American Psychiatric Association, 1987; O'Connor, 1986; Poznanski, 1982; Schaefer et al., 1987; Thiers, 1987). Poznanski says these thoughts may involve a precipitating event, such as the death of a close relative (i.e., grandparent) or a pet. The theme of death recurs repeatedly in a depressed child. Thus, a (grand)parental death may lead to depression, being presented symptomatically as morbid ideation or suicide attempts.

In addition to Poznanski's (1982) above-noted behavioral manifestations of depression, O'Connor (1986), Schaefer et al. (1987) and Wallerstein and Kelly (1976) mention anger as a primary characteristic of depressed children 10-12 years of age. This anger is usually focused on a particular object (i.e., parent) and may be expressed via tantrums and demandingness. Finally, Hughes (1984) adds somatic complaints, especially abdominal pain, as a symptom of depression in children.

In conclusion, childhood depression does exist and is defined by behavioral manifestations in the professional literature. These symptoms may be present in children who experienced parental loss prior to the age of 12 years.

CHAPTER II

CHILDHOOD DEPRESSION RESULTING FROM PARENTAL LOSS

Purpose

The types of parental loss which a child could sustain: loss by death and loss by divorce/separation will be explored. In addition, the effect parental loss has upon an individual in childhood, adolescence and adulthood and individual differences regarding susceptibility to childhood depression will be addressed.

Description of Parental Loss

Bloom-Feshbach and Bloom-Feshbach (1987) point out the differences and similarities between parental death and parental divorce/separation. They define parental death as a sudden and permanent separation, whereas divorce is a drawn-out separation process. Secondly, parental death is an event occurring at a precise moment in time, while divorce is a process not an event. Third, death involves the absence of a parent and the beginning of a grieving process. However, with divorce, there is still the presence of a living parent. Thus, the needed mourning of the parental loss may not occur due to continued parental contact and a child's wish that the parental separation was merely temporary. Another distinction between parental death and divorce is given by Garbarino (1988) who cites psychological maltreatment that appears to fall within the realm of

divorce. A child may view a parent's divorce as a rejection and as a message that he/she is no good and that his/her parent does not want him/her. The second category of psychological maltreatment is ignoring, and this may occur when a divorced parent is emotionally unavailable for the child. In contrast, Bloom-Feshbach and Bloom-Feshbach believe a similarity exists between parental death and divorce/separation: both involve a mourning of a loss. The loss entails the death of an individual, a marriage, or the "belief that a parent is a reliable part of one's life" (p. 319).

Many writers argue that not only can mourning take place with the death of a parent but with the death of a grandparent (Cohen-Sandler, Berman & King, 1982; Matter & Matter, 1984; O'Connor, 1986; Poznanski, 1982). Cohen-Sandler et al. and Matter and Matter assert that early parental loss (i.e., loss of a parent or grandparent through divorce or death) is a stressful event in the lives of elementary school children. O'Connor refers to the case of David who experienced the affective pain of the death of his maternal grandmother. He was seen for psychotherapy between the ages of 5.7 to 8.1 years to treat his depression. Morbid ideation (thoughts about death) or a suicidal attempt may also follow the demise of a close relative, such as a grandparent (Poznanski, 1982). Moreover, there appear to be differences and similarities between parental death and divorce/separation. The critical similarity is that parental or grandparental death and parental divorce/separation are difficult losses for children to endure.

Parental divorce/separation needs to be further defined.

Several authors do not distinguish between divorce and separation as events which differentially affect children psychologically (Adam, 1973; Bloom-Feshbach & Bloom-Feshbach, 1987; Bowlby, 1973; Pfeffer, Plutchik, Mizruchi & Lipkins, 1986; Roseby & Deutsch, 1985; Thiers, 1987). Hence, divorce and separation will be used synonymously in this thesis.

Maturational Obstacles

Given that these losses may have an effect upon children, there are specific sequelae in childhood, adolescence and adulthood.

Effect of Parental Death in Childhood

Various authors support the hypothesis that if parental death occurs, then a child may experience (a) depression, (b) depression and suicide, and/or (c) suicide (Adam, 1973; Bowlby, 1980; Bowlby & Parkes, 1973; Cohen-Sandler et al., 1982; Krakowski, 1970; Matter & Matter, 1984; McConville et al., 1972; Petti, 1983; Poznanski, 1982; Spitz & Wolf, 1946; Thiers, 1987; Toolan, 1981). Krakowski, McConville et al., Petti, Spitz and Wolf, and Thiers contend that depression in childhood results from parental loss. Spitz and Wolf believe that anaclitic depression (depression caused by loss of a person upon whom the child is dependent, such as a mother) can occur in children as early as 6-12 months. These children are characterized as experiencing weight loss, sleep disturbances, crying and withdrawal. In addition, Bloom-Feshbach and Bloom-Feshbach (1987) hold that children experience immediate and intermediate psychological reactions to parental death. The immediate reactions are disturbances in eating and sleeping, withdrawal and regression. All these reactions are

symptoms of depression, according to Poznanski (1982). The intermediate reactions to the death of a parent are symptoms of depression (i.e., sadness and crying), social isolation (i.e., withdrawal from interaction with peers and family members) and learning problems (i.e., difficulties in concentration and retention).

O'Connor (1986) proposes the following model for children who experience parental loss. A child experiences (a) affective pain (which may be parental death), (b) anger directed towards the object, and (c) depressive symptoms. A child may defend against anger by becoming depressed. Since a child is totally dependent upon parents, he/she may be fearful of alienating himself/herself via expressions of anger. The anger is thus channeled into depression and serves to protect the child from future loss and pain. The internalization of anger in the form of depression serves a dual purpose. One intention is to defend against anxiety engendered by displays of anger. The second aim is to defend against the pain of parental loss. In this way, a child does not have to cope directly with the stressful situation (i.e., parental loss). Petti (1983) appears to agree with O'Connor in his belief that a child's aggressive instinct may be turned inward because of the loss of an ambivalently loved object (i.e., parent). This aggressive instinct is then changed into depressive affect in order to reduce the anxiety a child may experience when displaying anger.

However, Wolff (1971) and Kaplan (1978) disagree. Wolff argues that depressive illness does not result from parental death. The problems that may result are due to changes after the death, not

the death itself. However, Wolff does not specify the types of changes subsequent to death which may lead to future emotional difficulties. Kaplan also disputes the idea that depression results from parental death. After a parent dies, a child develops a fragile constancy (emotional acceptance of good [love] and bad [hatred] aspects of the self) and experiences guilt, anger and sadness. Kaplan believes children handle anger and sadness by either idealizing the dead parent or by projecting their anger on someone or something else other than the deceased parent, thereby preventing mourning from occurring. The dead parent may be perceived by the child as the good parent while anger may be projected onto the surviving bad parent (Bloom-Feshbach & Bloom-Feshbach, 1987). This idealization and devaluation may serve to make amends for earlier feelings of anger toward the deceased parent.

There is also the possibility that depressive illness may not result because of the influence of cultural factors (i.e., religion, socioeconomic status and ethnic background). Bloom-Feshbach and Bloom-Feshbach (1987) state that socioeconomic status may influence an individual's perception of and reaction to loss. For example, children from lower-class families are more familiar with the idea of death because of the increased frequency of death and violence in their environment. Thus, these children may be conditioned to cope with death because of their social setting. However, there is little empirical evidence to support this claim (Bloom-Feshbach & Bloom-Feshbach).

The second result of parental death is depression and suicide (Bowlby, 1980; Matter & Matter, 1984; Poznanski, 1982; Toolan, 1981).

Bowlby and Toolan hold that loss from a central figure, such as a mother, can result in a depressive disorder. Loss of grandparents can also result in depression (Matter & Matter, 1984). These losses may thus precede suicidal ideation or a suicide attempt. Matter and Matter maintain that elementary school children plan, attempt and successfully complete suicides. These children's actions may prove to be an attempt to communicate a need for control over a familial situation or be a symptom of depression. However, Matter and Matter's argument does not appear strong because it does not propose a substantial link between parental death and suicide attempts. Given that depressed children are at risk for suicide, Toolan warns against parents merely perceiving their child's problems as a phase or growing pains and encourages them to admit that situational depression may exist.

The third effect of parental death is suicide. Adam (1973) contends that children who experienced the death of a parent before the age of 16 showed serious suicidal ideation. Cohen-Sandler et al. (1982) and Bowlby and Parkes (1973) agree that a child may attempt suicide subsequent to parental death. Bowlby and Parkes regard the psychological reaction to loss as an "urge to recover the lost object" (p. 54). In order to recover the lost object (i.e., mother), children may think about killing themselves in an attempt to join the dead parent. For example, one 12 year old girl was hospitalized because of extreme weight loss after the death of her mother. She stated, "I want to die and be with Mummy" (pp. 62-63).

Effect of Parental Divorce/Separation in Childhood

Similar to parental death, children whose parents have divorced

or separated also experience depression and/or suicide. Beck and Rosenberg (1986), Bloom-Feshbach and Bloom-Feshbach (1987), Kalter (1987), Roseby and Deutsch (1985), Rutter et al. (1986), Thiers (1987) and Wallerstein and Kelly (1980) state that divorce can have a psychologically negative impact upon children (i.e., depression). Beck and Rosenberg's findings suggest that depressed children (i.e., children whose Childhood Depression Inventory [CDI] scores were two standard deviations above the total group mean and whose Hyperactivity Index [HI] scores on the Conner Teacher Rating Scale were in the normal range compared to the total sample scores) experience more recent familial life stressors than children with behavioral problems (i.e., children with HI scores two standard deviations above the entire sample mean and with average scores on the CDI) and normal children (i.e., children with average scores on the CDI and HI). For example, four depressed children experienced parental divorce within the past one year compared with one behavioral problem child experiencing parental divorce.

Kalter (1987) proposes the idea that depressed children may experience underlying aggression and anger due to parental divorce. Kalter maintains that feelings of parental abandonment and rejection can induce an injury to a child's self-esteem and result in anger. In addition, interparental hostility may exist and the child is put in a situation in which he/she must protect the parent being attacked and anger results towards the attacker. Anger may also be stimulated because it is shown and learned as a model for resolving conflicts with individuals. Given that children from divorced families experience

increased amounts of anger, a problem may arise in their inability to manage aggression. This may be due to inconsistent limits being set after the divorce. Thus, the child may be unable to control his/her own anger independently. The result may be that a child externalizes his/her anger via aggressive behavior. Or, a child may also feel guilty or anxious about angry feelings towards parents and defend against the pain by becoming depressed and internalizing the anger.

A developmental approach can also be taken in understanding children's reactions to parental divorce (Kalter, 1987; Wallerstein & Kelly, 1975, 1976). Wallerstein and Kelly (1975) believe that pre-school children react to divorce by becoming depressed and anxious regarding separation and fears of abandonment. Since these children only have limited cognitive abilities, they usually perceive their environment egocentrically and blame themselves for the divorce. For example one girl said about her five year old brother, "He did it. If he had not bugged Daddy when he talked on the phone, he would not have left. He will not do it again" (Bloom-Feshbach & Bloom-Feshbach, 1987, p. 322). In addition, children at this age are unable to actively seek needed support from parents or friends.

Kalter (1987) also points out the difficulty of children 3-5 years of age whose parents are divorced to accomplish the developmental task of achieving emotional separation. The separation occurs from the primary caregiver, usually the mother, with the aid of a father who helps the child to relinquish his/her relationship with mother and to find more gratifying relationships. The problem of accomplishing this task arises in children whose parents are divorced because the father

is not there to aid in the process. In addition, the psychic pain felt by the mother leaves her emotionally unavailable and with decreased time for her children. Hence, the relationship is affected and a crucial developmental task is left incomplete.

Wallerstein and Kelly (1976) state that the developmental tasks for children 6-12 are academic achievement and relationships with same sex peers. Wallerstein and Kelly found that children's responses varied after the divorce of parents. Some children were able to achieve in school work and rely on peers for support. However, other children experienced problems in relating to peers, behavioral problems and were unable to achieve scholastically. Kalter (1987) goes on to state the reason for impeded development of peer relationships. Kalter states that the following dynamics exist in divorced families which tie the child to his/her family and do not allow the child to develop and attend to peer relationships. First, since the father has departed a young boy may have to be the "man of the house." Second, boys and girls may have to play the role of caretaker and confidante to the parent with whom he/she lives. Third, the children may be expected to be a surrogate parent to the younger children. Hence, these roles leave limited time for the developmental tasks at hand.

Children may also be suicidal as a result of parental divorce/separation (Adam, 1973; Cohen-Sandler et al., 1982; Matter & Matter, 1984). Adam claims that parental divorce or separation must occur before the age of 16 in order for subsequent suicidal ideation to occur. However, Adam does not explain his reasoning for choosing this specific age. Garfinkel, Froese and Hood (1982) studied suicide

attempts in children and found that a child's family plays an important role in influencing the child to attempt suicide. Garfinkel et al. concluded that family disintegration occurred. Both parents were present in fewer than half of the homes (209/442) in which the children attempted suicide. This was accounted for by paternal absence (24.8%) and absence of both biological parents (25.4%) and less often by maternal absence alone (2.4%). In addition to parental absence, the families were also undergoing financial problems. In contrast to the control group, paternal unemployment was 50% greater (14.1% compared to 6.7% in the control group). In addition, 14% more mothers were working full-time (49.6% compared to 35.6% in the control group). Garfinkel et al. believe that the economic problems in divorced/separated families result in decreased time and emotional unavailability for children who need support and guidance during this potentially suicidal period.

In addition, depression, suicidal ideation and suicide may result for some children who have experienced parental divorce/separation (Bowlby, 1980; Matter & Matter, 1984; Pfeffer et al., 1986; Toolan, 1981). Matter and Matter determined that depression may result from a "chaotic and unpredictable family life from an early age" (p. 263). This chaos may include parental divorce, and this loss may precede a suicide. Pfeffer et al. concluded that parental separation in children 6-12 years of age occurred in 60% of the inpatients, almost three times greater than the amount for nonpatients (22%). In addition, a major depressive disorder was found in 21.5% of the inpatients and 0% of the nonpatients ($p < .00001$) and suicidal

ideation or attempt in 54% of the inpatients, 9% of the outpatients and 3% of the nonpatients ($p < .01$). Moreover, increased stress related to interactions with parents may lead to depression and subsequent suicide in inpatients.

Given that depression and suicide may occur, Toolan (1981) declares that depression and subsequent suicidal gestures should not be ignored but instead taken very seriously by parents. In addition, Schaefer et al. (1987) hold that parents can help their children by encouraging them to express their feelings (i.e., sadness and thoughts of self-injurious behavior).

Effect of Childhood Parental Death in Adolescence

The sequelae of childhood parental death in adolescence appears to be depression and/or suicide (Bowlby, 1980; Coleman, 1980; Gelcer, 1983; Hochman, 1987; Lee & Park, 1978). Several case studies have been reported. Lee and Park studied 15 1/2 - 18 year old adolescent females in foster care and found that these depressed girls experienced severe losses in childhood (i.e., parental death) which subsequently resulted in depression in adolescence. Gelcer presents a case study of Melissa who was 13 years old and suffered the mysterious death of her mother at age 6. Melissa was taken in for professional help because of her defiance, laziness and inability to function at school (i.e., skipping classes, failing grades). Melissa was diagnosed as severely depressed. Gelcer states that the problem in this family was the inability to mourn the mother's death and Melissa's subsequent development being arrested. Henri Parens, director of the Infant Psychiatry Section at the Medical College of Pennsylvania states that "the best insurance

against long-lasting depression as a reaction to death is to allow the child to mourn" (Hochman, 1987, p. 6). If a depressed child is not treated, he or she might become a suicidal adolescent. Dr. O. Spurgeon English, Professor of Psychiatry at Temple University Health Sciences Center goes on to state, "I cannot conceive of a teenage suicide that does not have its roots in childhood depression" (Hochman, 1987, p. 1).

Stone (1981) cites cases of adolescents diagnosed as borderline who are not only depressed but suicidal as well. One 12 year old female experienced the death of her father. Between the ages of 13-17, she exhibited the following symptoms of depression: social isolation, despondency, insomnia, eating disturbances and six suicide attempts. In therapy sessions, the theme of loss and death and her inability to replace her father were mentioned repeatedly. One confounding factor appears to exist in Stone's study. The adolescent female's mother and uncle were depressed. This information does not clearly indicate whether familial psychiatric illness and/or paternal death triggered the adolescent's depression and suicide attempts.

Effect of Childhood Parental Divorce/Separation in Adolescence

Similar to parental death, childhood parental divorce/separation may result in depression and/or suicide in adolescence (Bowlby, 1980). Lee and Park (1978) studied the reactions of depressed adolescent girls to the loss of a parent via desertion. These girls experienced lowered self-esteem, hopelessness, sadness, self-hate, rage and a search for identity. One example of rage was exhibited by Leticia when she said, "I hate my natural mother sometimes, that damn whore!" (p. 522).

These manifestations of adolescent depression suggest important

developmental tasks in adolescence that have not been accomplished (Knittle & Tuana, 1980). First, one developmental task for adolescents is to love and appreciate the worth of themselves. In the above example, Leticia experienced self-hatred and low self-esteem and was thus unable to master this task. A second developmental task is to develop a sense of sexual identity. Leticia was still searching for an identity. Kalter (1987) maintains that adolescent males without a close stable relationship with a father will have problems developing an "internal sense of masculinity" (i.e., not assertive, low impulse control, low academic achievement) (p. 595). In addition, sexual experimentation may create feelings of guilt and deepen depression (Mintz, 1971). However, Mintz fails to explain why this would occur. Separation and individuation from parents is the third developmental task. This task involves de-idealization of parents and a perception of oneself as separate from one's parents (Kalter, 1987). However, when adolescents cut parental ties, which are the source of security and approval, they may experience a period of mourning. The subconscious responds to this break as to a loss through death. "Adolescents feel so intensely that they can't imagine everyone doesn't know how miserable they are" (Mintz, 1971, pp. 145-146).

Adolescent depression may turn into self-inflicted death. The depressive state of adolescents who attempt suicide may stem from a series of negative life experiences. For example, a high percentage of young suicide attempters come from disturbed homes - homes in which families quarreled, where one parent was absent or where conflicts arose with a step-parent (Papalia & Olds, 1981). These situations

create anger, resentment and depressed feelings of being rejected and abandoned in young people (Allen, 1976). Some react by withdrawing or running away, but others may be unable to handle their feelings so they turn it against themselves by committing suicide. Paradoxically, many of these adolescents whose attempts end in death do not want to die and only want to change their lives. A suicide attempt is a way of communicating and may be the last effort in a long series of cries for help (Glaser, 1981). Dr. E. S. Schneidman of the University of California states: "Until the very moment that the bullet or barbiturate finally snuffs out life's last breath, the suicidal person wants desperately to live. He is begging to be saved" (Farberow & Schneidman, 1986, p. 102). An awareness of an adolescent's need for help appears critical in order for drastic consequences not to occur.

In conclusion, adolescence is a period of time in which monumental developmental tasks must be mastered. These tasks include appreciating the worth of oneself, developing a sense of sexual identity, and separating and individuating from one's parents. However, adolescents may deviate from normal development due to parental divorce/separation and become depressed and potentially suicidal. It is significant that families and friends be aware of behavioral changes (i.e., depressive symptomatology) and provide social support in order to protect adolescents in crises from depression and suicide.

Effect of Childhood Parental Death in Adulthood

In addition to childhood and adolescence adults may face maturational obstacles given the occurrence of childhood parental

loss. Depression and difficulties in social and sexual relationships are two primary sequelae of parental death in childhood. Ragan and McGlashan (1986) cite Freud and Abraham as believing that the traumatic death of a parent during childhood would predispose a child to later psychopathology, possibly adult depression. Bloom-Feshbach and Bloom-Feshbach (1987) agree that parental death can result in long-term reactions like depressive disorders. Toolan (1981) holds that depressed children may remain depressed as adults.

More specifically, Brown, Harris and Copeland (1977) maintain that the maternal death in childhood can result in depressive disorders in women. These women are at three times higher risk for depression than women whose mothers are still alive. Erikson (1963) referring to the criticality of a mother's role, states,

Basic trust versus basic mistrust in mere existence is the first task of the ego, and thus first of all a task for maternal care. Weakness of such trust is apparent in adult personalities in whom withdrawal into depressive states is habitual (pp. 248-249).

Bowlby (1980) and Gelcer (1983) state that depression may result in adults who have not successfully mourned the death of a parent. A current loss may be the precipitant to grieving for an earlier parental loss. Bowlby says the current stressor could be the anniversary of the death of a parent or reaching the same age as the deceased parent. Thus, a belated loss reaction in adulthood may occur to the loss of a parent during childhood.

In contrast, Ragan and McGlashan (1986) refute the above stances and contend that parental death does not cause adult psychopathology (i.e., bipolar affective disorder, unipolar affective disorder). Ragan

and McGlashan studied severely ill psychiatric inpatients and found that the frequency of childhood parental death was no greater for inpatients than the population in general. However, one possible limitation of this study is that it is narrow in scope because Ragan and McGlashan analyzed only a narrow population of severely disturbed individuals and do not address the effects of childhood parental death on less disturbed individuals.

Rutter et al. (1986) also dispute the possibility that childhood parental death results in clinical depression in adulthood and state shortcomings of previous research. First, previous research does not include the necessity of provoking agents (current adversity) and current vulnerability factors (factors which increase risk of depression given existence of provoking agents) as determinants of onset of depression. However, Rutter et al. failed to take into account Bowlby's (1980) consideration of current loss as a provoking agent. A second problem Rutter et al. found with previous research is that the results are based on psychiatric populations, as noted in Ragan and McGlashan's (1986) study. In order to compensate for the shortcomings in past research, Rutter et al. (1986) studied a normal population of 3,000 women in London who had experienced parental death prior to the age of 17. In this study, they concluded that there is a relationship between early loss of a mother (before age 11) and later depression. Given their analysis, Rutter et al. no longer appear to question the depressive sequelae of childhood parental death.

Despite Ragan and McGlashan's (1986) previously noted contention that adulthood depression does not result from childhood parental loss,

they do believe that social and sexual relationships in adulthood may be negatively affected. Bloom-Feshbach and Bloom-Feshbach (1987) maintain that children who have experienced the death of a parent may, as adults, exhibit an impairment in sexual identity and intimate relationships and become mistrustful and alienate friends and lovers.

In addition, Borins and Forsythe (1985) attempted to determine the relationship between past histories and current health problems. Borins and Forsythe studied 100 women in the Women's Psychiatric Clinic, a division of Toronto Western Hospital. These women were relatively well functioning, nonpsychotic and under a great deal of stress. One relationship Borins and Forsythe looked at was early death experience of family members and present functioning. A significant death experience was defined by the authors as an occurrence in which an individual experiences "one or more deaths of a mother, of a father, or of a sibling before the age of 18" (p. 461). Using intake forms, (demographic information, family history, personal health history) and clinical interviews (medical, surgical and psychiatric diagnoses), they attempted to ascertain past and present functioning. Twenty-five percent of the women had experienced at least one death prior to 18 years of age. Forty-nine percent of the sample had lost a family member by death. Nine percent of the women studied lost a mother, 12% lost a father and 6% experienced the death of a sibling. Borins and Forsythe found a small but significant correlation between death in the family and a personal history of chronic illness ($\chi^2=10.39$, $df=4$, $p<.05$). However, the type of chronic illness was not specified. In addition, Borins and Forsythe concluded that there was a highly

significant correlation between death in the family and request for completion of sterilization ($p < .001$).

Bowlby and Parkes (1973) explore the reason for impairment in these social and sexual relationships. They state that the relationships in a child's family, especially the relationship of a child to his/her mother, determines future emotional bonds in adulthood. Given emotional isolation (loss or lack of intimate tie with a parent) due to death, an adult might be unable subsequently to form close relationships with others and a psychiatric disorder could result. Bowlby (1980) asserts that if an adult has not mourned the death of a parent completely, he/she may be unable to form and maintain an intimate relationship. For example,

In the end, the world has been emptied of every shred of goodness and virtue. At last he is alone, with the devils of his childhood locked inside him - which is the way self-hatred gets expressed when splitting takes over the job of mourning the dead. When the glitter of his partner fades to reveal an in-the-flesh actual person, he will devalue her and cast her away. Sooner or later the world will turn its back on him for his . . . ruthless manipulations, his desperate adorations. He will have been so successful in hiding his helplessness and vulnerability that no one will realize he should be pitied and cared for. Ultimately fortune will deal him the very hand his quivering apprehensions have presaged. He is never filled up or held. He is unloved and unlovable . . . He is not omnipotent; he cannot magically will the comings and goings of those to whom he clings with such desperate neediness (Kaplan, 1978, pp. 47-48).

In addition to depression and relational problems, Gelcer (1983) maintains that unsuccessful mourning in childhood may lead to the following adulthood problems: gender identity, psychosis and somatic complaints.

Effect of Childhood Parental Divorce/Separation in Adulthood

Adulthood depression can also be a consequence of childhood parental divorce/separation (Bowlby, 1973; Brown et al., 1977; Toolan, 1981). Bowlby claims that anxiety and depression can occur in adulthood because of a childhood experience of being separated for a lengthy time from mother. Brown et al. and Toolan also studied the separation from a mother. Brown et al. found an association between maternal separation before 11 years of age and depressive disorder in adult females. The occurrence of depressive disorders was three times more likely to occur in women who experienced maternal loss than in those women whose mothers were still living. Toolan concurs that separation from a central figure, such as a mother, may result in depression in childhood. These children may remain depressed as adults.

Similar to the result of parental death in childhood, adults who have experienced parental divorce/separation also encounter difficulties in choosing and maintaining intimate relationships. Kalter (1987) states that girls in preadolescence are less affected by divorce. However, in adulthood, these females tend to have difficulty forming stable heterosexual relationships.

Bloom-Feshbach and Bloom-Feshbach (1987) hold that children traumatized by divorce may in adulthood choose marriages destined to fail. Why does this occur? Bloom-Feshbach and Bloom-Feshbach believe this process may start in childhood. Children may initially perceive parental divorce as abandonment, and feel they are responsible for its occurrence. This self-blame in children and in adults may be a defense

against the emotional pain of feeling helpless and lacking control over life events. In order to guard against being a victim of abandonment, a person will attempt to regain self-control and mastery. However, these efforts may become self-destructive. Individuals will attempt to repeat circumstances and relationships that recapitulate the traumatic loss. Thus, these efforts to control do not appear to defend successfully against the emotional pain of helplessness and isolation associated with the loss. Undefensive grieving of a parental loss seems critical in order for the earlier pain to be worked through and not merely repeated.

In addition, Garbarino (1988) claims that adults may become "emotional cripples" and be unable to maintain intimate relationships because they are full of rage. The rage towards parents who were rejecting and ignoring the child, now an adult, was never expressed and thus appears to have blocked future psychological growth needed to succeed in intimate, adult relationships. Bowlby (1973) also cites Freud as believing that quarrels between parents and unhappy marriages can prepare the ground for children to have a future disturbance in sexual development.

In conclusion, adults who have experienced childhood parental death or parental divorce/separation may become depressed. More specifically, women who have endured the death of or separation from a mother may be more susceptible to depressive disorders. The mother's role appears critical because of the trust which is formed between mother and child; this formation of trust is critical to the development of the self, as weakness of such trust may lead to

depressive disorders. Other factors which may trigger depression are a current loss or reaching the same age as the deceased parent.

Underlying this issue, however, is the lack of initial mourning of the parent. These studies, however, may be limited because of their sole focus upon the loss of a mother and failure to consider the impact paternal loss may have upon a child (Brown et al., 1977; Erikson, 1963).

In contrast, some authors contend that parental death does not necessarily result in depression (Ragan & McGlashan, 1986). However, Ragan and McGlashan do claim that difficulties in choosing and maintaining social and sexual relationships may result from parental loss. The problem may take the form of mistrust or alienation of friends and lovers. Relationships may be destroyed because an adult may be full of rage and may have never expressed this rage to his/her parents or because an adult may repeat the traumatic parental loss by choosing a marriage destined to fail. Moreover, when grieving a parental loss does not take place, adults may be unable to maintain their intimate relationships.

Exploration of Individual Differences in Susceptibility to Childhood Depression as a Result of Parental Loss

The severity of depression in childhood and sequelae in adolescence and adulthood may differ. The authors note several mediating factors which serve to vary the amount of risk for developing depression due to parental loss (Beck & Rosenberg, 1986; Bloom-Feshbach & Bloom-Feshbach, 1987; Bowlby, 1980; Brenner, 1984; Gelcer, 1983; Hochman, 1987; Krakowski, 1970; Rutter et al., 1986; Sahler, 1978;

Thiers, 1987; Toolan, 1981; Wolff, 1971). These factors are as follows: age, developmental capacity for grief, sex, quality of the parent-child relationship, circumstances surrounding death and social environment subsequent to loss.

Age

The age at which a child experienced parental loss is one factor which may cause children to react differently (Beck & Rosenberg, 1986; Bloom-Feshbach & Bloom-Feshbach, 1987; Toolan, 1981). In general, the younger the child at the time of the parental loss, the greater they are affected (Bloom-Feshbach & Bloom-Feshbach; Thiers, 1987).

Children 0-12 years of age may be affected psychologically in several ways. After six months, a child can be seen to be outwardly distressed when he/she separates from his/her mother (Bowlby, 1980). Children 6-12 months of age may incur anaclitic depression due to parental loss (Spitz & Wolf, 1946). Grief may also be expressed in children 1-3 years of age. Bowlby (1961, 1980) states that a child may exhibit the following behavior when he/she is separated from a mother figure:

1. Protest. Child expresses grief and anger via crying and demanding for mother to return. The duration of this stage may be one week.
2. Despair. Child stops crying and displays inward grief by becoming apathetic, withdrawn, and engaging in self-stimulating behavior, such as rocking and sucking his/her thumb. At this point, the hope the child has for his/her mother's return fades.
3. Detachment. Child loses interest in mother and

becomes emotionally distant. This may serve a defensive function. The child attempts to guard against his/her intense negative emotions previously experienced during separation and against the anxiety triggered by the expectation of losing his/her mother again (Bloom-Feshbach & Bloom-Feshbach, 1987). Toolan (1981) contends that Bowlby's above-noted picture of institutionalized children is one of depression.

In contrast, Rutter et al. (1986) argue that depression is rare in children 2-5 years of age. These differential findings may be accounted for by the study of two distinct populations: psychiatric and normal children. Despite the rich clinical literature, observations of disturbed children may yield narrow responses and these children may not be representative of bereaved children in general.

Sahler (1978) goes on to state that children 4 years old and under are in the most vulnerable age group because they are so dependent on parents, easily overwhelmed and because it is difficult for them to identify feelings. However, Sahler does maintain that children's adaptations to parental death can be aided if they have previously experienced the death of a pet, thus having a concrete experience with death.

Rutter et al. (1986) claim that children are most vulnerable to parental loss between 5-10 years. At this stage, there is an increase for depressive disorders which are characterized by negative self-esteem and self-statements and by self-deprecatory thoughts. In addition, Rutter et al. state that children between the ages of 10-14 who have experienced loss of a parent may be vulnerable to guilt type depression (i.e., depressive disorder that involves an awareness of

one's failure to keep the good opinion of a significant other and the perception that this failure is the basis for parental rejection) and subsequent depression. Bowlby (1980) also asserts that loss of a mother before age 10-11 years will result in a depressive disorder. Finally, Adam (1973) holds that children who have experienced the loss of a parent due to death, divorce or separation before the age of 16 show serious suicidal ideation. However, Adam did not specify the age prior to 16 years which is most critical or his reasoning for specifying the age of 16.

Hence, given the literature presented, it appears that children aged 0-12 years are extremely vulnerable to the loss of a parent and may develop depression. However, there does not appear to be a consensus as to which specific age under 12 years a child is most vulnerable.

Developmental Capacity for Grief in Childhood

Professionals point out the importance of understanding a child's level of conceptualization as a means to comprehend and/or anticipate certain behaviors (Bloom-Feshbach & Bloom-Feshbach, 1987; Brenner, 1984). Bloom-Feshbach and Bloom-Feshbach believe that children grieve differently than adults, and children should not be expected to grieve in an adultlike manner. Children express their unique intellectual and emotional capacity to grieve via their responses. For example, after a death of a parent, a child may play games in which the death or funeral is recreated or he/she may tell strangers that "My daddy died." These behaviors do not reflect lack of caring (as an adult might perceive it), but instead may be the child's

attempt to cope with the loss.

Brenner (1984) goes on to delineate stages of conceptualizing death. Between the ages of 3-5, a child may believe that dead people may continue to live. The child may then act as if the parent is only missing and expect him/her to return. A child aged 6-8 years may perceive that death is a person. Ghosts and monsters may reinforce this belief. A child may also believe that if his/her magic is strong enough, he/she could conquer death. It is not until the child is about 9 years old that he/she will begin to understand the abstract idea that death is final and not reversible. Thus, Brenner emphasizes the significance of helpers taking notice of a child's limited ability to conceptualize death and verbalize grief. A child's ability to grieve can be helped if a caring adult allows the child to express painful feelings (Bloom-Feshbach & Bloom-Feshbach, 1987).

If a child's developmental capacity for grief is not attended to, a child may not feel understood and not mourn the parental death or separation. Hence, a child may react to a parental loss by experiencing "psychosocial acceleration" in which the loss provides an impetus to advance prematurely to another developmental stage or by "retrogression" whereby the child becomes emotionally arrested at a certain stage of development (i.e., Erikson's developmental stage of basic trust v. basic mistrust) (DeAngelis, 1988, p. 22). For example, Gelcer (1983) cites the case of 13 year old Melissa who suffered the death of her mother at age 6 and was taken in for professional help for her severe depression. Gelcer concludes that the problem in the family was the lack of mourning over the dead mother at age 6, and thus

Melissa's development became arrested at the time of her mother's death. Without mourning, the accomplishment of separation and individuation may not occur (Bloom-Feshbach & Bloom-Feshbach, 1987). Moreover, for those children who could potentially develop emotional problems, it appears significant that a child's developmental capacity for grief be addressed. In this way, children may feel understood, be able to mourn parental losses and work more effectively through developmental stages.

In contrast, Bowlby (1980) does not claim that emotional problems due to parental loss take the form of arrested development. If that was true, then all children should have impaired development and this does not appear to be the case. Bowlby's perspective adds a new dimension. It appears that some children, not all children, are developmentally arrested. Bowlby cites that emotional factors may account for the differences between children. Bereavement may serve to aggravate existing psychological disturbances. Bloom-Feshbach and Bloom-Feshbach (1987) agree that a child's prior emotional instability may intensify negative reactions in the months following a parental loss. However, if a child is emotionally healthy prior to the parental loss, impaired development need not occur.

Sex

Sex of the child and sex of the parent are also mediating factors which affect the emotional well-being of a child who has experienced parental loss. Sahler (1978) regards the sex of the child and sex of parent as important. If the same sex parent dies, it may be more difficult for the child to differentiate himself/herself from the

parent. Whereas, if the opposite sex parent dies, it may be easier for the child to differentiate himself/herself. However, Sahler does not elaborate further on this point. Wolff (1971) agrees and states that the sex of the child and sex of parent who dies are important for predicting future disturbance. Wolff concluded that the relationship was apparent in girls: maternal death and psychiatric disturbance were related. However, the same relationship did not hold for boys. In contrast, Pfeffer et al. (1986) found no distinction in severity of suicidal behavior between boys and girls who had experienced parental separation/divorce.

Regarding the sex of the parent alone, many authors claim that loss of a mother results in greater disruption than loss of the father (Hochman, 1987; Wolff, 1971) and may put children at a higher risk for psychiatric disturbances. Psychiatric disorders can result from an individual's inability to maintain emotional bonds with others. The types of bonds that occur during adulthood are determined by relations in one's family of origin during childhood, especially the relationship of a child to his mother (Bowlby & Parkes, 1973). Spitz and Wolf (1946) believe anaclitic depression can result from loss of a mother figure.

Depressive disorders may also continue in adulthood for women who had experienced maternal loss (Brown et al., 1977; Rutter et al., 1986). Brown et al. concluded that depressive disorders are three times higher in women who experienced parental death, desertion or separation in childhood. Rutter et al. studied 3,000 women in London who had experienced parental death or separation before the age of 17.

In this study, they concluded that there is a relationship between early loss of a mother (before age 11) and later depression. What factors could account for this finding? Rutter et al. point out that a vulnerability factor, lack of care (i.e., maternal indifference and lack of concern for discipline) after the initial loss (death or separation) was highly related to subsequent depression. In addition, current provoking agents related to depression are lower socioeconomic class, premarital pregnancy, lack of intimacy with partner and helplessness. Thus, current life stressors may precipitate depression that might have been latent due to a previous maternal loss. It is significant to note that the above clinical studies (Bowlby & Parkes, 1973; Hochman, 1987; Spitz & Wolf, 1946; Wolff, 1971) are in agreement with the empirical studies (Brown et al.; Rutter et al.) regarding the impact of maternal loss.

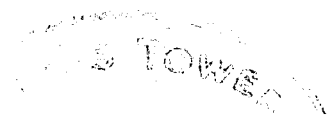
In addition to maternal loss, the effect of paternal loss must also be addressed. These researchers argue that loss of a father does not increase risk of depression (Rutter et al., 1986). In contrast, Stone (1981) refers to the case of a 12 year old female who experienced the death of her father. Between the ages of 13-17, she exhibited the following characteristics of depression: social isolation, despondency, suicidal ideation and attempts, insomnia and eating disturbances. She also thought often about her inability to replace her father. In addition, Bowlby's (1973) definition of a mother refers to a person who mothers a child and to whom he/she becomes attached. This definition does not appear to distinguish between males and females but focuses on the issue of attachment figures.

In conclusion, the majority of studies have focused on the loss of mother and the impact upon children, as mothers have been the primary caretakers. However, this does not necessarily mean that children are not affected by the loss of a father, as seen in Stone's (1981) study. Rather, it appears that children become more closely attached to their primary caretaker, usually the mother, and may suffer subsequent psychiatric disturbances given a maternal loss. Greater attention and care should be given to these children in an attempt to prevent future emotional disturbances.

Quality of the Parent-Child Relationship

In addition to the sex of a parent, it is also important to consider the quality of the parent-child relationship prior to death or divorce/separation (Beck & Rosenberg, 1986; Bloom-Feshbach & Bloom-Feshbach, 1987; Gelcer, 1983; Rutter et al., 1986; Sahler, 1978; Yalom, 1980). Children tend to mourn healthily the death of a parent (considerable expression of feelings about the loss) if the relationship with the parent prior to the loss was warm and secure. If a child is able to share his/her loving feelings towards his/her parents and discuss thoughts about separation prior to death, the result can be comforting memories and an ability to mourn efficaciously (Bowlby, 1980). On the other hand, if a child has a hostile and distant relationship preceding a parental death, this may result in distressing memories and guilt (feelings of responsibility for parental death). However, Bowlby does not specify the types of distressing memories that could result.

The extent of parental hostility prior to divorce is also



significant in terms of a child's potential development of psychological problems (Kalter, 1987). If children are accustomed to parental fighting, the divorce may not be a surprise, but instead a relief. However, children who do not expect the divorce and have been protected from parental conflict may be surprised and shocked (Bloom-Feshbach & Bloom-Feshbach, 1987).

A child's relationship to his parents may also be affected not only by a loss but by the fear of parental loss. This may be due to a relationship characterized by threats of abandonment or death. Bowlby (1973) believes these threats may have a frightening impact upon a child and play a part in the development of separation anxiety and anxious attachments (apprehension that attachment figures, parents, will be unresponsive or unavailable). The child's reaction may be to remain close to the parent in order to ensure parental availability. Bowlby also maintains that a child may develop dysfunctional anger (when a child or adult becomes so angry that the bond between them is weakened); the most violently angry children are those exposed to repeated threats of abandonment.

The fear of parental loss may also be due to a parent-child relationship characterized by excessive ruminations of death. For example, Hughes (1984) quotes the following case of a child who was overly concerned with illness and death. "Tommy worried that his mother might die of her frequent colds" (p. 152). In further discussion with his mother, the psychiatrist found out that Tommy's grandfather died when he was eight and that Tommy and his mother "regularly discussed memories and images of the dead grandfather" (p.

152). Tommy's response to this funeral atmosphere was to become depressed and to manifest his depression in abdominal pain.

In conclusion, the quality of a parent-child relationship preceding death or divorce/separation may affect a child's subsequent mental health. If measures are taken to acknowledge the importance of the relationship and to ensure parental support the sequelae of parental loss need not be harmful.

Circumstances Surrounding Death

The circumstances surrounding parental death may affect a child's course of mourning and long-term functioning (Gelcer, 1983). The first circumstance is type of death. Several authors emphasize the significance of a loss being either sudden or predicted (Bloom-Feshbach & Bloom-Feshbach, 1987; Bowlby, 1980; Brenner, 1984; Rutter et al., 1986). Bowlby asserts that a sudden loss has a greater initial shock than a predicted loss. In addition, Brenner holds that the loss can be more traumatic if a child witnesses a parental death. The experience is traumatic because the child cannot deny or forget what he/she has seen. Jaffe, Wolfe, Wilson and Zak (1986) report that children aged 6-11 years may become severely anxious and helpless subsequent to witnessing a parent's murder. In contrast, siblings who are not present may be shielded from some of the anguish because they are able to deny the reality of the parent's death.

A loss can also be traumatic if a parent's death is a result of a homicide or suicide (Bloom-Feshbach & Bloom-Feshbach, 1987). Bowlby (1980) discusses the sequelae for a child whose parent commits suicide. At the age of 11 years, a boy's father committed suicide by driving his

car over a cliff. At the age of 32, this boy, now a man, believed that he would die of suicide. Consequently, he drove his car over the same cliff. Bowlby declares that some people identify so strongly with a parent that they experience an urge to follow the dead parent and find him or her. In addition, given that his father committed suicide previously, the young man may have been less fearful of suicide as a solution to problems (Lum, 1974).

This identification can also be found in the subgroups of suicidal adolescents. Werry (1986) concluded that friends and neighbors of suicide victims are at a much higher risk (181 times higher) for committing suicide than that of the normal population. However, this finding does not take into account the occurrence of the "copycat syndrome"/"contagion suicides" in unrelated adolescents (Daley, 1987; Karwath & Davidson, 1987). In these instances, adolescents may perceive suicide as an option to problems, as it worked for other adolescents. This perception might also be reinforced by the media who romanticizes suicides (Sudak, Ford & Rushforth, 1984). David Clark, Ph.D. at the Center for Suicide Prevention & Research at Rush Presbyterian-St. Lukes' Medical Center, goes on to discredit the media by stating that "the measure of responsibility must be borne by anyone giving publicity to teenage suicide" (Daley, p. 1).

The second circumstance surrounding parental death is the immediate handling of parental death. Brenner (1984) contends that a child should not be given misleading messages about his/her parent's death (i.e., Your Mommy has gone to sleep). Instead, Bowlby (1980) points out two critical pieces of information which a child must know

about the death of a parent (a) the dead parent will not return, and (b) the body is buried in the ground or burned to ashes. Bowlby asserts that prompt, accurate and direct information regarding parental death will lead to an acceptance of the death and facilitation of mourning. However, if news of a death is kept from children, they may tend to believe the dead parent is still living and will return. This concealment of information will lead to an absence of mourning.

In addition to information given, Brenner (1984) states a child should be allowed to attend and participate in the funeral. This involvement will enable a child to come to a better understanding of the loss by seeing the coffin and gravesite. The child's coping abilities must also be taken into account prior to such involvement in the funeral rites, despite Brenner's lack of attention to this point. Yalom (1980) agrees that a consideration of a child's inner resources is critical in order to prevent severe stress associated with his/her confrontation with death. Parents should express their sadness and provide support to children. If parents refuse to grieve openly, children may have difficulty expressing their sadness. As one boy so aptly said, "How can I cry when I have never seen your tears?" (Bowlby, 1980, p. 272).

Furman (1974) goes a step further by proposing that children can be prepared for the death of a parent if they have had prior experiences with death. Furman claims that even a young child has no more difficulty than adults understanding that death is irreversible. For example, if a child no older than two years is told that a dead bird will not return to life, the child may at first be amazed and then

accept this perception of death. Furman concludes that this approach provides the basis upon which future acceptance of death as permanent will occur and will enable a child to be somewhat prepared for the death of a parent.

In summary, no one can control the type of parental death. However, a child's acceptance of parental death and subsequent mourning can be facilitated by prompt, honest information about the death and prior experience with death. The literature appears to provide insufficient information about the circumstances of divorce and its effect upon children. There is reason to believe, however, that children of divorce can also be helped to grieve their losses more effectively if information surrounding the divorce is presented honestly and clearly and the child is provided with support.

Social Environment Subsequent to Loss

The type of support a child receives from his/her social environment subsequent to parental loss is critical for determining differential reactions (Beck & Rosenberg, 1986; Gelcer, 1983; Sahler, 1978; Yalom, 1980). Two questions become apparent. First, what happens to children who are confronted with unsupportive, hostile or chaotic environments following parental loss? Second, what impact does a supportive and protective environment have upon children following parental death or divorce/separation?

Regarding the first question, Rutter et al.'s (1986) study of 3,000 women points out that lack of care after the initial parental loss (death or separation) was highly related to subsequent depression. In addition, Stone (1981) provides a case history in which the negative

influence of a chaotic familial environment appears subsequent to divorce. As an infant, the patient's mother divorced her father and she never saw her father again. At the age of 20, this woman sought psychological help for depression. The divorce alone did not result in subsequent depression. The patient's mother abused alcohol and heroin. The patient's alcoholic uncle exposed himself to her yet also warned her about the sinfulness of her sexual feelings. At the age of 14, the uncle struck her in the face with a piece of furniture which required facial surgery. Subsequently, she ran away from home and became sexually involved with several men and stole for them. Between the ages of 16-17 years, she was married and divorced. She then was involved in brief relationships which were extremely violent and physically abusive. Stone points out that the later chaotic familial environment in and of itself sufficiently accounted for the patient's depression and inability to form satisfactory relationships with men.

Bowlby (1980) also emphasizes the criticality of stability from a caretaker subsequent to loss. If a child does not have one stable mother figure and instead has several individuals to whom he/she makes brief attachments, the outcome may be problematic. The child may become self-centered and prone to shallow, short relationships. In addition, discontinuities in care (moving from one home to another) may lead to psychiatric disorders. Given an acknowledgment of potentially devastating results, Bowlby contends that good foster care is critical in order to prevent disastrous consequences from occurring.

Regarding the second question, there are factors which can intervene to prevent emotional pain subsequent to parental loss.

Garbarino (1988) maintains that the amount of future emotional damage depends upon the compensation the child receives from other relationships. For example, if a child loses a great amount of time with a custodial parent, it may result in a decreased adjustment to divorce (Bloom-Feshbach & Bloom-Feshbach, 1987). However, if a child does not lose a close emotional relationship to a parent to a great extent, depression will not necessarily follow. Krakowski (1970) asserts that depression can be thwarted given a supportive protective environment being provided for a child who has undergone a parental loss. Additionally, Antonovosky (1980) proposes that generalized resistance resources (i.e., social support and profound ties to others) can facilitate effective tension management, thus enabling the child to cope better with parental death. Adam (1973) states that social support from a stable, nurturing individual can protect a child from suicidal ideation. Bowlby (1980) agrees with Adam regarding the importance of a child having a stable mother figure who will love and take care of him/her. A continuous, stable relationship with a parent after loss will lead to well developed children. Moreover, it appears that the type of support a child receives subsequent to loss is critical to their future emotional well-being.

In conclusion, the mediating factors proposed above do make a significant difference in the type of reaction and future psychological stability of individuals experiencing childhood parental loss. It is essential that these factors be considered and implemented in such a way so as to prevent future emotional damage to children.

CHAPTER III

TREATMENT IMPLICATIONS FOR DEPRESSIVE STATES

There are several considerations in the treatment of depressive states subsequent to parental loss. The first element, which crosses over the lifespan, is mourning. It appears critical that a parental death or divorce/separation be grieved so that a developmental arrest is prevented. In addition, an awareness of depressive symptomatology and a consideration of the previously noted mitigating factors are also important for the prevention of future emotional problems (i.e., depression, suicide, difficulties in relationships). However, given that depressive states in childhood, adolescence and adulthood may arise from parental loss, various therapeutic modalities are recommended: individual, group and family therapy (Bloom-Feshbach & Bloom-Feshbach, 1987; Clarkin, 1985; Coates & Winston, 1983; Gelcer, 1983; Gispert, Wheeler, Marsh & Davis, 1985; Lee & Park, 1978; Levy & Farber, 1986; Matter & Matter, 1984; Roth & Covi, 1984; Stone, 1981; Sudak et al., 1984; Toolan, 1981; Yalom, 1985).

Children Who Experience Parental Loss

There are several different ways to approach treatment of a depressed child. First, a therapist may help a child to mourn his/her loss. Second, clinicians may take a preventive stance in which they consider mitigating factors (Adam, 1973; Bowlby, 1980; Furman, 1974;

Garbarino, 1988; Krakowski, 1970) and become aware of a child's potential for suicide. Third, specific types of therapy may be implemented in order to combat depression.

Mourning the Loss

The criticality of mourning a loss is noted by professionals (Kaplan, 1978; Bowlby, 1980). "The best insurance against long-lasting depression as a reaction to death is to allow the child to mourn" (Hochman, 1987, p. 6). The stages of mourning may be protest and grief (Brenner, 1984) or protest, despair and detachment (Bowlby, 1973). Brenner believes these stages can be worked through more easily if facilitated by adults who respond by being attentive to the child's behavior, allowing the child to work through behavior and by providing the needed emotional support. In addition, Gelcer (1983) maintains that a therapist may facilitate mourning if he/she understands a child's cognitive and emotional capacity to understand death and is able to "unravel a traumatic past that left some lacunae in their life experience" (p. 513). Given that grief resulting from a loss is worked through, a child need not remain developmentally stagnated (Bloom-Feshbach & Bloom-Feshbach, 1987).

Preventive Measures

In addition to mourning, professionals may take a preventive stance. This treatment approach would include an awareness of mitigating factors and a child's potential for suicide. Circumstances surrounding death and environment following loss are factors in which professionals can become involved. They could educate families to the most helpful way of handling a parental death. Information conveyed

should not be misleading but instead be accurate, direct and prompt. If delivered in this manner, a child will begin to accept his/her parent's death and mourning can be facilitated. In addition, professionals can convey to schools and to families the importance of social support for a child subsequent to parental loss. For example, Bowlby (1980) contends that in order for a child to develop in a psychologically healthy manner, he/she needs one stable mother figure who will love and take care of him/her. It is imperative that families become aware of and proceed to convey the needed emotional support.

In addition to mitigating factors, preventive measures for suicide can also be implemented. Given that depressed children may experience suicidal ideation and suicide attempts, professionals can take measures to guard against suicidal behavior. First, it is important that therapists inquire about suicidal thoughts with depressed children (Poznanski, 1982). Parents can also help to prevent depression in their children by encouraging them to express sadness and thoughts of self-injurious behavior (Schaefer et al., 1987).

Second, the American Association of Suicidology (1977) presents five clues of suicidal intent of which counselors, parents and teachers should be aware:

1. Suicidal Threats: cry for help or attempt to control a stressful situation. For example, a child may threaten to harm himself/herself or friends during play. Therapists should take this seriously and alert parents.

2. Attempted Suicide. A therapist should note a child's history in order to assess the seriousness of a threat. This attempt

may be a strategy for the child to deal with stress.

3. Prolonged Depression. Children have the capacity to be depressed given a life situation and may respond by not living.

4. Dramatic Changes in Behavior. Child may become increasingly aggressive, hostile or desperate.

5. Making Final Arrangements. Child may begin to plan own death, knowing he/she will not be alive in the future.

In concert with 3. above, Garfinkel et al. (1982) agree that parents must be aware of signs of depression. In addition, they point out other clues to suicidal attempts. Suicidal attempts occur more in (a) the late winter (January to March - 33%), (b) in the afternoon (26.8%) or evening (49.5%), (c) at their parents' home (73.4%), and (d) with a household pain reliever (87.9%). Garfinkel et al. contend that direct intervention and education regarding the above are needed for families. In addition, it is imperative that parents are knowledgeable about the amount and use of all medications in order to guard against suicide.

In addition to awareness, Matter and Matter (1984) and Pfeffer et al. (1986) propose techniques (i.e., identification of suicidal behavior, demonstration of problem-solving techniques) which must be implemented in order to prevent suicide. In Matter and Matter's study of elementary school children, they found that it was significant for counselors to teach suicidal children better coping and problem-solving skills. For example, counselors explored alternatives to suicidal behavior, such as talking about familial problems. Given these skills, it is hoped that suicide will not be perceived as an option to deal

with life's problems. In Pfeffer et al.'s study of child psychiatric patients, they propose that children who are evaluated psychiatrically should also be evaluated for their suicidal potential. In this manner, factors contributing to the risk of suicide will be considered regarding employment of differential treatment.

Types of Therapeutic Intervention

In addition to mourning and prevention, specific types of therapeutic interventions may be implemented in order to combat childhood depression resulting from parental loss. Individual, family and group therapy are proposed as well as specific therapy for children of divorced families. Individual therapy is suggested by Bloom-Feshbach and Bloom-Feshbach (1987). They emphasize the importance of considering the age of a child in treatment, his/her cognitive capacity, and ability to express feelings.

Schaefer et al. (1987) and Toolan (1981) state that issues of termination are also a central feature in working with children who have experienced a parental loss. Schaefer et al. propose brief psychotherapy (10-12 sessions) following a loss which focuses on termination (i.e., concluding stage of the therapeutic relationship in which the therapist prepares his/her client to leave counseling). The therapist will explore termination in an in-depth manner and attempt to discern how the child will feel about saying good-bye to his/her therapist. However, Schaefer et al. point out that previous to the exploration and the making of interpretations, the establishment of a warm, trusting client-therapist relationship must exist. Given this emphasis, it is hoped that the child will be affected positively.

In contrast, Gelcer (1983) argues that it is important to view the child's problems within a familial context and not see the identified patient alone. Matter and Matter (1984) also cite the importance of psychotherapy for families who have suicidal elementary school children. Finally, Toolan (1981) maintains that a therapist should work with a parent so that therapeutic strides are not countered by parental denial of an existing problem (depression and/or suicide) in his/her child.

In addition to individual therapy, Bloom-Feshbach and Bloom-Feshbach (1987) also propose group sessions in order for children to share problems and focus on separation issues. More specifically, Roseby and Deutsch (1985) studied 57 9-11 year olds who had undergone parental divorce or separation in the past 18 months to 10 years and had subsequently developed depression. Roseby and Deutsch then implemented a 10 week group intervention which focused upon social role-taking and assertive communication skills. Roseby and Deutsch employed the Childhood Depression Scale (CDS) pre- and post-intervention. The test measures symptoms of depression in children 8-13 years of age. After the group intervention, they found no significant change in depression. Roseby and Deutsch propose that the reason for this finding is that a longer treatment time may have been necessary to effect change in depressive symptomatology. In addition, they found no change in deteriorating school performance (depressive symptom noted by Poznanski, 1982) following intervention. They used the Devereux Elementary School Behavior Rating Scale to assess the differences before and after group intervention.

However, Roseby and Deutsch (1985) did find a difference in the children's attitude towards their parents, as measured by the Children's Attitude Toward Parental Separation Inventory (CAPSI). Children no longer blamed themselves or parents for the divorce and no longer feared abandonment or hoped for a reconciliation. They argue that "a period of consolidation" may be necessary in order for cognitive change to result in emotional and behavior changes (p. 55).

In addition to individual, family and group therapy, Bloom-Feshbach and Bloom-Feshbach (1987) and Kalter (1987) point out specific treatment implications for children whose parents divorced/separated. Bloom-Feshbach and Bloom-Feshbach assert that a child be seen with one parent, not both. If a therapist sees the family together, it might only reinforce or aggravate the child's fantasies of a parental reunion. In addition, a therapist should address a child's conflicts of loyalties and guilt feelings. On a long-term basis, a therapist can focus on helping the child to accept the familial situation so that he/she can interact with each parent realistically. Kalter states that brief, one-shot interventions at the time of parental separation are inadequate. Instead, Kalter proposes education to parents about the significance of creating a positive, post-divorce relationship with one's spouse and intermittent, brief interventions with children and families across time.

In conclusion, children who experience depression resulting from parental loss can be helped by individual, group and family therapy. Treatment can be tailored to meet the needs of children whose parents divorced or separated. However, an assessment of the efficacy of these

therapeutic modalities is difficult. It is unclear which kind of treatment, duration or frequency is most effective. In addition, "adherents of each discipline claim superiority for their own method" (Sudak et al., 1984, p. 359). Nonetheless, these differences may be less important than the factors which are common to the above therapeutic interventions. Specifically, the establishment of a therapeutic relationship in which the client is able to divulge painful experiences to a nonjudgmental, empathic therapist who provides emotional support and increases self-esteem. The various therapies are also similar in their emphasis upon the importance of mourning parental losses. This emphasis will not arrest but further the psychological growth of children. In addition, therapists' consideration of mitigating factors and understanding potential suicidal behavior are key to a preventive approach.

Adolescents Who Experienced Parental Loss As Children

Given this depressed/suicidal adolescent population, a therapist's tasks include evaluation of the patient and his/her family (Berkovitz, 1972; Glaser, 1981; Levy & Farber, 1986; Shapiro, 1985; Stone, 1981). In terms of adolescent patients, a therapist must be aware of the impulsive nature of this age group; adolescents often act out in a fit of frustration and anger. Given the cries for help that are apparent, it is also significant that therapists help their adolescent patients recognize their basic desire to live. Other crucial factors for a therapist to consider are the lethality of the means used for self-destruction and the intent of self-destruction (Glaser). Firearms and jumping from high places are highly lethal

whereas wrist cutting and ingestion of substances may be of low lethality (Glaser). In general, the more the rescue process and survival of the adolescent depends on others, the higher the lethality. The timing, location and proximity to others can guide a therapist in assessing the seriousness of intent.

With regard to therapeutic intervention, a therapist may engage adolescents in introspection, "the means by which patients explore, experience, and communicate with their inner worlds. . . experiencing and reflecting on their private thoughts, feelings and fantasies" (Levy & Farber, 1986, pp. 570, 575). A therapist must also recognize that these inner feelings may be frightening and painful. However, Levy and Farber perceive introspection to be an essential component of the analytic process because it allows adolescents to gain insight into their thoughts, feelings and behaviors. In addition, if an adolescent understands and deals with pain internally, "a self is created by dealing with this pain . . . and one gains great strength in bearing the agonies and crises that may occur" in adolescence (Shapiro, 1985, p. 127). Stone (1981) concludes that intensive analytic psychotherapy is beneficial for adolescents who have good motivation, an ability to be psychologically minded and who are not antisocial or paranoid.

In addition to the patient, a therapist must also consider the family situation. Berkovitz (1972) found that suicidal attempts by adolescents are often a response to overt or subtle familial disruptions. Overt disruptions may include fighting, parental loss, parental institutionalization and severe financial problems. When familial trouble arises, some adolescents may not be prepared to handle

dilemmas. Frequently suicide is turned to as a possible answer. Hence, it is significant that families and therapists provide social support (i.e., information leading an individual to believe he/she is cared for, loved, esteemed, and committed to others in an atmosphere of mutual concern and responsibility) because it protects adolescents in crises from depression and suicide (Shapiro, 1985). Social support also provides for the consistency, stability, lowered stress level and mutual concern needed in the overtly troubled family. Boggs (1986) supports this finding and goes on to state that "higher levels of supportseeking would be related to lower levels of subsequent depression" (p. 3236-B).

Group Psychotherapy

Given consideration of depressed/suicidal adolescents and the impact of their families, various forms of group psychotherapy have been cited as effective (Coates & Winston, 1983; Lee & Park, 1978; Roth & Covi, 1984; Sudak et al., 1984). With regard to the benefits of group psychotherapy with adolescents, Roth and Covi found that the curative factors (i.e., hope, altruism) found in Yalom's (1970) group therapy helped depressed patients alleviate depressive symptoms (i.e., social withdrawal, loss of interest in activities). Given the intermember interactions, hope can be instilled by having veteran group members describe their improvement and its relationship to therapy. Altruism can occur when group members help one another, and the depressed individual's belief that "I have nothing to offer anyone" is challenged.

Lee and Park (1978) also concluded that group psychotherapy was

beneficial given their work with depressed adolescent girls. Their group approach emphasized working through depression and its painful origins, not simply avoiding the task. "As depression is dealt with, coping abilities are freed. As coping is more effective, depression is further dispelled. They are in a circular relationship" (p. 525). As the adolescent girls experienced less depression, rage and self-hatred, their strengths (i.e., intelligence, motivation) were revealed. When these strengths were pooled, positive group values began to emerge (i.e., emphasis on higher education, career plans). Thus, an ability to cope with tasks of living were made easier through the emotional support of group members. In addition, the "family-like quality of the group" helped the adolescents to feel they were loved, valued and belonged just for being themselves (p. 525).

Another effective approach to group psychotherapy with depressed adolescents involves the use of peers. Sudak et al. (1984) believe that peer counseling may help the problem of suicide in the schools. Since close friends are likely to know of an imminent suicide, they are in a good position to insure their suicidal friends receive help. Given this approach, students are educated to detect signs and symptoms of depression and suicidal behavior. In addition, the self-selected peer group has been found to be a useful adjunct to identify critical situations and obtain the needed help so that adolescents avoid a suicide attempt or hospitalization. The meaning of deliberately inviting peers to group therapy may be related to increased self-esteem and is significant in connection with the need for adolescents to separate and individuate from parents. The positive functions of peer

support groups found by Coates and Winston (1983) are that support groups provide a forum in which an individual can seek the needed comfort from mutually afflicted others and sense that feelings are shared. In addition, group members realize their suffering is meaningful because they can share with and help others with similar painful experiences.

Family Therapy

In consideration of the impact of families upon depressed/suicidal adolescents, family therapy has also been found to be an effective mode of treatment (Gispert et al., 1985). Clarkin (1985) suggests that family therapy is beneficial given the following conditions. First, the family must be capable of and motivated for meeting within a family context. Second, it is necessary that the adolescent's problem is intimately related to the family interaction pattern. Third, the suicidal behavior stabilizes the current family homeostasis. Clarkin cited the case of a 17 year old female, Sue, who had attempted suicide with an overdose of pills. A clinical analysis of Sue's suicidal behavior served to draw attention to a familial problem. Sue and her mother were depressed because of the father's absence and emotional unavailability. At this time, Sue was preparing to attend college. A dilemma arose because Sue was the last child to leave home, and she would be leaving her parents alone for the first time in many years. If Sue remained sick, however, she would be able to continue being the buffer between her parents who did not get along. Hence, family therapy appears appropriate as Sue's behavior serves to be both intimately related to the familial

interaction patterns and to maintain the homeostatic balance. Yalom (1985) also supports the use of family therapy with patients who are in the midst of an acute situational crisis, such as suicide.

Hospitalization

In addition to group and family therapy, Gispert et al. (1985) and Stone (1981) propose hospitalization as a means of treatment. Gispert et al. recommend short-term hospitalization in order to examine the contributing factors to a suicidal attempt and intervene with the patient and his/her family. Long-term hospitalization is recommended for adolescents diagnosed as borderline with suicidal tendencies. Stone maintains that long-term inpatient therapy will provide strengthening of the ego and increased maturity in relatedness to others. However, Stone does not recommend psychoactive medication for depressed adolescents during hospitalization.

In conclusion, depression and suicide in adolescence may result from parental loss. Psychotherapists must be aware of critical symptomatology and evaluate comprehensively their adolescent clients and their familial environments. Group psychotherapy, family therapy and hospitalization were cited as effective means in which to aid this troubled adolescent population.

Adults Who Experienced Parental Loss As Children

There is not a great amount written regarding the treatment of adults who have undergone childhood parental loss. Perhaps this limited information is due to the length of time which transpires from the childhood loss. Time brings additional losses and there remains the difficulty of distinguishing between the effect of early and later

losses.

However, it should not be forgotten that the present may be closely linked to the past. Thus, present behavior can be seen in light of earlier loss. Bowlby (1973) states,

Since models of attachment figures and expectations about their behavior are built up during the years of childhood and tend thenceforward to remain unchanged, the behaviour of a person today may be explicable in terms, not of his present situation, but of his experiences many years ago (p. 256).

Bloom-Feshbach and Bloom-Feshbach (1987) concur with this conclusion and cite the case of a 36 year old female patient who is excessively self-sufficient. She appears to need no one. What lies beyond this guise? Bloom-Feshbach and Bloom-Feshbach contend that severe loss in the past may result in a fear of needing someone or of being close to another person. Thus, this woman guarded against her fear by becoming wholly self-reliant. Moreover, the present state is influenced by the past.

The woman experienced several losses in her past. At the age of six, her father died of a brain tumor. When she was nine years old, her mother had a severe stroke and died seven years later. This client then sought psychological treatment at the age of 36. After one year of treatment, the client for the first time began to grieve the death of her father, a loss which had occurred more than 30 years before. Bloom-Feshbach and Bloom-Feshbach (1987) believe that the "retrieval and working through of unresolved grief from early childhood can instigate a progressive developmental unfolding within the therapeutic relationship" (p. 376).

The therapist's role in treatment is that of the lost parent and

in that role he/she enables the child (now an adult) to complete the mourning process. The patient is allowed a "second chance" for development (Bloom-Feshbach & Bloom-Feshbach, 1987, p. 393). Bloom-Feshbach and Bloom-Feshbach cite the case of a 27 year old female who suffered from depressive feelings associated with the death of her father. During her individual therapy, this woman complained to her male therapist about his delicate handling of her. She wondered why he did not force her to confess intimate feelings and why he did not push her to be productive. As these reactions were explored, what emerged were her intense feelings of rage toward her father, now transferred to the therapist, for being nonresponsive, passive, nondemonstrative and unsupportive. With the emergence of her rage and disappointment toward her unavailable father, the patient began to mourn her paternal loss.

Bowlby (1980) also points to the importance of efficaciously mourning an earlier parental loss in order to prevent later development of depression. In contrast, Stone (1981) recommends psychoactive medication for combatting depression in adults.

In conclusion, treatment approaches were recommended for clinicians who work with depressed children, adolescents and adults who have experienced childhood parental death or divorce/separation. The treatment modalities included individual, family and group psychotherapy. It is significant that therapists explore and understand their clients' past losses. Through this exploration, clinicians can provide their clients with a needed parental role and aid in the mourning process. In this manner, clients will be able to work through unresolved grief and foster their emotional growth.

CHAPTER IV

SUMMARY

At the outset of this literature review, several questions were posed regarding childhood depression resulting from parental loss. At this point it is necessary to summarize the answers to those questions which have been posed.

QUESTION #1:

WHAT ARE THE BEHAVIORAL MANIFESTATIONS OF DEPRESSION IN CHILDREN AGED 0-12?

Poznanski (1982) cited nine cardinal symptoms of childhood depression. It is critical that attention be paid to depressive symptomatology as suicide attempts may result. In addition, attention should be focused on underlying factors of childhood depression.

QUESTION #2:

IS PARENTAL LOSS A CORRELATABLE FACTOR OF CHILDHOOD DEPRESSION? IF SO, WHAT ARE THE MATURATIONAL OBSTACLES AN INDIVIDUAL ENCOUNTERS IN CHILDHOOD, ADOLESCENCE AND ADULTHOOD?

Parental loss, either in the form of death or divorce/separation was cited in the literature as occurring prior to the development of childhood depression. Parental loss also appears to have an affect in adolescence in the form of depression and suicide. In adulthood, individuals may develop depression and experience difficulties in forming and maintaining intimate relationships.

QUESTION #3:CAN THESE OBSTACLES BE MEDIATED BY FACTORS WHICH AFFECT INDIVIDUAL DIFFERENCES IN SUSCEPTIBILITY TO DEPRESSION AND POSSIBLY DECREASE THE LIKELIHOOD OF SUBSEQUENT PATHOLOGY?

Yes, several mitigating factors may be involved. First the age of a child. Over the age of 12, there is the possibility that greater resilience has developed and that children have been able to work successfully through crucial tasks, such as separation and individuation.

Developmental capacity for grief is a second mediating factor. It appears that parents and therapists should understand the child's level of conceptualization and the stages at which a child is at in the grieving process in order to comprehend and anticipate certain behaviors. Given that a child is well understood and is able to work through painful feelings, the risk for developing psychological disturbances lessens.

The third factor is sex. Children who experience the loss of a primary caretaker usually undergo emotional difficulties. Some studies (Bowlby & Parkes, 1973; Brown et al., 1977; Hochman, 1987; Rutter et al. 1986; Spitz and Wolf, 1946; Wolff, 1971) have reported a higher instance of psychiatric disturbances due to maternal loss while other studies have focused on the impact of paternal loss (Bowlby, 1973; Stone, 1981). Given an understanding of the risk for development of subsequent difficulties resulting from the loss of a primary caretaker, greater attention should be paid to these children and greater effort should be made to prevent future problems via the provision of stable, consistent, loving parental substitutes.

The quality of the parent-child relationship prior to loss is also significant. If parents make an effort to assure children that they are not to blame for divorce and prevent themselves from threatening children with abandonment, guilt, anger and anxious attachments may be prevented. Regarding parental death, if parents discuss openly with children impending death, children will be at a lower risk for difficulties because they will be able to begin the mourning process.

Circumstances surrounding death is the fifth significant factor. There is no way to control the type of loss which a child must endure (i.e., sudden or predicted, suicide or death due to natural causes). However, the manner in which information surrounding parental loss is conveyed is important. Information should be presented to children in an honest, prompt and clear manner. In addition, it is helpful for the surviving parent to express grief in order for children to begin mourning the death. Children may also be facilitated in their grieving if they have an earlier concrete death experience.

Social environment subsequent to loss is the final mediating factor. If support is provided to a child subsequent to loss, the risk for susceptibility to psychological disorders decreases. A beneficial environment is characterized by support, protection, stability and nurturance. Hence, if this support is provided, depression, suicide and difficulties in intimate relationships may be prevented.

QUESTION #4:

GIVEN THAT DEPRESSIVE STATES RESULT, WHAT ARE THE TREATMENT IMPLICATIONS WHICH ARISE FOR HELPING CHILDREN, ADOLESCENTS AND ADULTS?

Clinicians may take a preventive therapeutic stance by

considering the impact of mitigating factors upon the future susceptibility to depression and by serious consideration of potential for suicide. Treatment implications vary in terms of the exact type of treatment modality recommended: individual therapy, group therapy, family therapy or hospitalization. However, one implication which exists for all individuals (whether child, adolescent or adult) is the necessity to mourn a loss. Without mourning, psychological difficulties will occur, possibly in the form of a developmental arrest. However, a therapeutic relationship will provide an environment where mourning and the freedom to grow emotionally will occur.

Future Research Recommendations

The clinical literature presented is rich and provides clinicians with an avenue to explore the human psyche and obtain greater understanding of children, adolescents and adults confronted with parental loss. However, empirical gaps exist in the literature.

The first area that must be addressed is the sample studied. Longitudinal studies of adults who experienced childhood parental losses are needed in order to follow the development of the child into adulthood, not merely retrospectively perceive the affect of loss. This type of research could generate reliable data and increase systematic attention to treatment modalities for adults. In addition, the sample often studied is disturbed children and adolescents whose responses to loss may not be representative of all individuals experiencing parental loss. If normal individuals (i.e., nonpsychiatrically disturbed) who lost a parent in childhood were

studied, the depressive forecast regarding the development of emotional disorders may not appear so ominous.

In addition to the sample studied, treatment is another arena for future research. Greater specificity is needed in treatment recommendations. For example, a clinician should clearly define what he/she means by the importance of increasing "problem-solving skills" or "coping skills." A focus on operational definitions is needed. It is also significant for important terms, such as parental loss and mourning, to be clearly defined. This definitional focus will permit researchers from different disciplines (i.e., psychology, social work, psychiatry) to uniformly define behavioral manifestations to emotional disorders. Finally, efficacy studies need to be conducted in the areas of treatment modalities for depressive states arising from parental loss. In this way, uniform guidelines could be proposed for the treatment of depressive disorders.

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

12/1/58
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