

Running head: ANALYSIS ON SEPARATION FROM PARENT AND RESILIENCY
FACTORS

When a Child Loses a Parent; a Review of Differences Associated with Type of Loss and
Resiliency Factors that Help Maintain Positive Health in Adulthood

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Abstract

Losing a parent by either separation (divorce) or death is one of the most distressing events that could occur in a child's life. Studies suggest that when a young child encounters the loss of a loved one, the experience could be detrimental to psychological well-being later in life (Bowlby, 1963). This review unveiled different features that could impact a child's psychological development when going through such separation. Studies found mixed results when looking at the development of emotional tribulations (i.e. depression, feelings of well being, conduct disorder, etc) in children who have suffered such losses. Resiliency factors shown to promote positive mental health include support from family, internal family strengths, religion and positive parenting.

When a Child Loses a Parent; a Review of Differences Associated with Type of Loss and Resiliency Factors that Help Maintain Positive Health in Adulthood

Within a sample of 148 participants living with a serious mental illness, 33 individuals reported losing a loved one and nearly 67% of these deaths involved the loss of one or both parents (Jones, Harvey, Rodican, Barreira, & Macias, 2003). This finding suggests that if a child is separated from a parent at a young age, this could open the door for mental illness later in life. Separation is defined as losing a parent or primary caregiver as a result of a divorce or death. There are different factors that could influence the outcome of the child's mental health. These include the age of the child, the quality or type of parenting the child receives before, during and after separation, and the type of death whether it be sudden (suicide) or unremittingly (terminal illness).

In this review, studies are examined that have identified different variables in how children's mental health is affected when they experience such loss. In addition, results from these studies can assist in keeping children safe from developing psychological disorders by exposing the strongest resiliency factors. Research on this topic is essential as separation from loved ones at some point in all of our lives is unavoidable. It is imperative to understand what the child might be experiencing and how to best handle these delicate emotions.

Literature Review

Conducting research involving recently bereaved children presents many challenges. Included in these challenges is acquiring the consent of not only a mourning child, but also getting approval from a parent who is mourning the loss of a spouse. Nevertheless, there are many published studies on this important topic (Dowdney, 2000).

Maier and Lachman (2000) examined consequences of losing a parent either by death or divorce at an early age and what effects this had when that child reached midlife. The

researchers hypothesized that children who had experienced suffering of either kind would have lower levels of well-being and higher levels of depression in adulthood than other adults who had not experienced such losses. Researchers also predicted that those children who came from divorce would have higher rates of health problems than those children who experienced parental death. Assumed health problems would be influenced by socioeconomic status and behavioral factors such as drug/alcohol abuse, smoking and levels of social support.

In this study, an obtained sample of 4242 adults responded to the survey of Midlife Development in the United States. Participants ranged in age from 24 to 74; however, the study only included those aged from 30 to 60 in order to focus on midlife. 49% of those interviewed were male, and 89% were Caucasian. The questionnaire included several inquiries pertaining to both mental and physical health. Participants were asked about feelings of their general well-being and any apparent signs of depression. Well-being questions were aimed at reaching conclusions on participants' positive relations and independence and included questions such as "maintaining close relationships has been difficult and frustrating to me" and "I have confidence in my own opinions even if they are different from the way most other people think" (p.184). To gain information on chronic physical health problems, questions were asked concerning 28 different health problems in the preceding 12 months. Some questions used a 1-7 point scale taking the mean; others were based on the amount of times the participant answered "yes" to a given question. Other variables such as education level, income, smoking, drug and/or alcohol abuse, and social support were taken into consideration when gathering participant information. Researchers began by asking participants if they lived with both biological parents up until the age of 17. If they did not, they were asked when and why the separation of their parents occurred. There were 173 men and 207 women who stated their parents were divorced before

they turned 17. Eighty-nine men and 93 women reported that one of their parents had died before the participant reached age 17.

Results from this study showed that parental loss either by death or by separation (divorce) negatively affected both psychological and physical health in midlife. Researchers' hypotheses were supported as these effects were more severe in those participants who experienced divorce rather than the death of a parent. The participants whose parents were divorced showed lower education levels, less income, more drug use, and less social support than those who suffered parental death. Parental death also resulted in lower income levels, but no relationship between adult health and the loss of a parent was found in this study. The study showed that men who had experienced the death of a parent before they turned 17 were more autonomous in midlife than those who did not. However, these participants were not necessarily raised in a one parent household after their parent had died. The women in the sample were more likely to report depression than the women who did not experience the death of a parent.

Results showed that men whose parents were divorced had higher levels of depression, whereas within the women in the sample divorce was not significantly related to any of the psychological measures. Neither parental divorce nor parental death were viable predictors for alcohol abuse or marital status. This study failed to show any connections between physical health in later life and parental death in early childhood.

This study suggests that there is a negative impact on adulthood well-being for those who have experienced the death or divorce of parent or parents before age 17. These effects were shown to have more of an impact on children of divorce, possibly because in the event of a divorce, the child's relationship with one or both parents may undergo significant changes. On the other hand, when a parent dies, the child's relationship with the surviving parent is rarely disrupted.

Critique of Research Methodology

This study used a large sample size which would allow the findings to be compared to the general population. There was an almost equal amount of males and females that participated in this study; however, 89% of participants were Caucasian, which is not a representative sample of the general population. The main method of obtaining information in this study was with the use of questionnaires. Because of the information needed in this study, this may have been the only method possible. This study only focused on the medical history of the previous 12 months. Before beginning the study, researchers could have gained information on previous health problems (both physical and mental) the child may have had. This would allow for the separation of developing health problems versus problems that were already existent in each participant. The study may have produced more accurate results if the researchers used a longitudinal design and attempted to keep contact with the participants over a number of years to see how these changes may develop, increase, or decrease.

Although there may be differences between the psychological implications of one losing a parent from separation versus losing a parent to death, potential outcomes are suggested to be similar. Changes are dramatic in both events and neither loss essentially is easier than the other.

Sandler, Reynolds, Kliewer, and Ramirez (1992) examined the correlation between certain life events and psychological symptomatology. Researchers hypothesized that children who had survived separation events would be depressed and children who had survived conduct events would have developed conduct disorder. In this study, a separation event was defined as “any event which involved decreased contact with important people in the child’s family” (p. 243). Conflict events were defined as “any behavior involving the disruption of harmonious family relation” (p.243). These behaviors include arguing, hitting, and any and all expressions of anger, conflict or negative emotion between members of the family. Because these behaviors

can be seen in any family, researchers validated four specified conflict events such as “people in your family physically hit each other hard or hurt each other (parents, brothers or sisters)” and “your relatives (aunts, uncles, grandparents) said bad things about your parents” (p.243).

There were 359 children ranging in age from 8 to 16 with a mean age of 11. 57% of participants were male. The children were divided into four groups; those who had experienced parental divorce (n = 94); those who had experienced parental death (n = 92); those who had experienced high stress events represented by children with asthma (n = 99) and a comparison group in which participants had not experienced any high stress events (n = 74). There were significantly more boys in the childhood asthma group (representing the actual gender segregation of the disease), and those children in this group were significantly younger than the children in the other groups. Those children who had survived parental death or parental divorce had a lower family income than those in the childhood asthma group or those in the comparison group.

Participants for this study were gathered using different methods. Children who had experienced a divorce were contacted by both letter and by telephone. Their parents' names were listed in court records as being divorced within the last two years. Researchers also contacted families listed in the state health department, who had lost a spouse in the preceding two years. Children who had chronic asthma were found by contacting those who were outpatients of pediatric allergists. Comparison group participants were recruited by randomly selecting 20% of children in the divorce and death groups, then contacting families in the child's neighborhood.

Parents of the children in the divorce group had been divorced for less than two years, but had been separated for a period of time ranging from 3 to 84 months with a median separation

time of 24 months. Participants in the parental death group had lost their parent sometime within the preceding 3 to 50 months, with a median time of 16 months.

The Childhood Assessment Schedule was used to measure the levels of depression and conduct disorder symptomatology. The General Life Events Schedule for children was administered to all children participating in the study. This includes 38 items that characterize a range of possible stressful life experiences for children aged 8 to 16.

Results from this study showed a significant relationship between children who had experienced conflict events and conduct disorder. There was not a noteworthy relationship between conflict events and depression. Separation events were significantly related to depression symptoms and not to conduct disorder. The conflict events in the study were more highly correlated to conduct disorder than was separation to depression symptoms. These results suggest that there is a relationship between life events and certain symptomatology. Results from the children in the divorced group had opposite results of what the researchers expected. Conflicts in these children were related to depression symptoms as opposed to separation events which were related to conduct disorder.

Critique of Research Methodology

The groups in this study held approximately the same amount of participants. This would ensure that results from one group would not overshadow the other groups because of the equal amount of participants. These researchers utilized a control or comparison group in order to directly compare results of those affected versus those who have not been affected. In gathering participants for the control group, researchers used random sampling which would allow the results to be more accurate when compared to the general population. This group came from these children's neighborhood, excluding any significant differences in income, schools, etc. The researchers employed experienced professionals to conduct interviews. Before being

allowed to participate, these interviewers had to reach a reliability rate of .80 on two interviews before being asked to collect any data. The CAS (Child Assessment Schedule) was explained as having (Child Assessment Schedule) good inter-rater reliability (.90). The events that were selected in this study did not reflect characteristics of the children (e.g. choosing those with low grades).

Researchers had several limitations in this study. The meanings of events occurring in the child's life needs to be evaluated using the context of the child's life situations. Children may display symptoms of conduct disorder because they blame parents for the divorce and are acting defiantly as a result. All events in this study were weighted equally, and the intensity of the actions was ignored. This study used a correlational design, therefore researchers cannot say if the given life events caused the development of particular symptoms. Future studies should utilize a longitudinal design to better assess development of such indicators.

Not only are there discrepancies in outcomes for children who experience loss of a parent as a result of divorce over death, but variations may also occur based on the type of death. As observed in the subsequent study, a child who lives through a parent dying from a terminal illness, such as cancer, will see death very differently than children who lose a parent to an unexpected death, such as suicide.

In a study examining the effects of parental death in early childhood, Pfeffer, Karus, Siegel, & Jiang, (2000) compared the impact of losing a parent to suicide as opposed to cancer. Researchers noted depressive symptoms, social skills, and behavior problems. It was hypothesized that those children whose parent had committed suicide would develop a greater number of and more severe depressive symptoms than those children who lost their parent to a terminal illness (cancer).

Participants included 11 families with a total of 16 children (mean age of 8.9 years) who had experienced a parental death by suicide. There were a total of 64 children (mean age of 9.5 years) in 57 families who had lost a parent as a result of cancer.

To gather participants for the first portion of the study, researchers identified qualified individuals by obtaining records from the local medical examiner. An initial phone interview was conducted with the surviving parent explaining what the study was about and asking for permission to meet with both the parent and child. Only those children who were aware and fully understood their parent's suicide were able to participate. When the researcher met with the child and parent, the study was explained to the child; the child was told that researchers wanted to find out how they were feeling after losing their parent. In order to continue with the study, written consent from the parent and assent from the child was required.

Children who suffered a loss of a parent from cancer were gathered from two different studies of bereaved families. Researchers used a cross sectional design consisting of a sample of children who had lost a parent within the past 3-14 months. This study examined the nature and extent of apparent psychological problems. Participants for this design were gathered from hospital records of recently deceased patients. Researchers also used a longitudinal design examining the effectiveness of an intervention program with adjustment in children whose parents were terminally ill. Participants from the longitudinal design were randomly assigned to either participate in the intervention program or be a part of the control group. Participants met with the researcher for a pre-death interview during the parent's final months of life, and then interviewed twice more within 14 months of the parent's death. Participants in this design were selected by contacting patients who were determined by the hospital to be in an advanced state of cancer. In order for a participant to be eligible for the study, the child had to come from a two parent household, speak fluent English, and be between the ages of 5 and 12.

The research assessments used in the study were standardized assessments which imply they are both valid and reliable and have normative scale scores for children in the population. To determine depressive symptoms, a 27-item self report questionnaire (the Children's Depression Inventory) was completed by children in both samples. Using the Child Behavior Checklist, surviving parents reported social skills and any known behavior problems.

The results of this study showed that children who had lost a parent to either suicide or cancer reported depressive levels to be equivalent to a normative sample. When researchers asked the surviving parents about the child's social skills and psychological health, results showed that they were also in line or below the normative population. This would suggest a high level of resiliency in these children who had lost their parent to either form of death. When comparing the groups exclusively to each other, those children who survived a suicide reported higher levels of depressive symptoms than those who lived through a parental death due to terminal illness.

Critique of Research Methodology

The sample used in this research study was relatively small. There was not an equal amount of participants in each group (cancer vs. suicide), however, the significant difference between the two suggest a strong division. Random assignment was used to place participants in either the intervention program or no-treatment control group which helps to decrease the influence of confounding variables. Researchers used both a cross sectional design, which would allow researchers to see any noticeable differences in the different ages of children, and a longitudinal design for a portion of the study. Researchers may have shown more significant results if they had used only a longitudinal design for all parts of the study; however, these designs take much longer to complete, are more expensive and have a high rate of participant withdrawal.

Results from this study can possibly be attributed to the fact that suicide is abrupt, and the child has no way to prepare for such an event. Whereas in the case of terminal illness, much of the child's grieving could be seen at an earlier stage. However, this is not to say that a child who is losing a parent to a terminal illness will be prepared or able to accept their parent's subsequent death. This child will be exposed to the explicit physical, mental, and emotional deterioration of their parent. Saldinger, Cain, and Porterfield (2006) suggest that one of the most stressful events a child could undergo would be to watch a parent die from an incurable disease. These researchers examined traumatic stress in children whose parents were fighting a losing battle with a terminal illness.

Data in this study were collected using a longitudinal design in a community based study of different families, all of which had school aged children who were coping with a parental loss. Researchers used semi-structured interviews which lasted 7-9 hours with parents, and 2-4 hours with the children. Only two children per family could participate in the interviews and procedures. The children interviewed were between ages of 6-16. All participating family members were interviewed 8-36 months after the death. Interviews were tape recorded and led by social workers who were all advanced graduate students. The study consisted of 58 families where 95% were Caucasian with a mean income of the post death family of \$40,000 annually. 29% were Protestant, 51% were Catholic, 10% Jewish, 2.5% other, and 7.5% had no religious preference. Of the surviving parents, 24 % were male and ranged in age from 32 to 55 with a mean age of 42 years. Of the children in the sample 56% were female. Of the illnesses involved, 84% were cancer, 2% were alcoholism, 1% was juvenile diabetes, 1% degenerative arthritis, 1% diverticulosis and 11% of illnesses were unspecified. The length of illness ranged from 2 months to 10 years with an average of 2.8 years.

When interviewing the adults, researchers asked about the direct conditions of the death, funeral services, and religious beliefs the family held which could have impacted the child's development. Researchers also asked about mental health services that might have been used to cope with the death, and any signs of continued attachment between the deceased and the child. Parents were asked about how their parenting styles may have changed when going through the illness of their spouse and then asked to ruminate on what they felt were parenting challenges during this period.

When talking to the children, the focus of the interview was on the child's reactions to the funeral and to the viewing of their deceased parent. Additionally, they were questioned about relationships with friends and whether there was any apparent continued attachment to the deceased.

Findings in this study suggested that parents who were dealing with a dying spouse were both mentally and physically drained and did not attend the needs of their children. These children were exposed not only to the physical deterioration of their dying parent, but also watched as their surviving parent went through personality and emotional changes. Based on interviews, researchers noted that many of the children became targets for the dying parent's anger and withdrawn states. A child would be unable to understand that these reactions are symptoms of the disease, and not an attack aimed at the family. Researchers noted that in the case of an anticipated death, loss may begin well before the death itself. Children in this study may have been exposed to secondary traumatic stress depending on available resources and on the challenges the surviving parents faced in dealing with the death. Conclusions of this study did not specify direct results from the children's interviews. It was suggested, however, that the children may be trying to hide depressive symptoms so as not to upset their parent or other family members.

Critique of Research Methodology

This study examined 58 families in which a parent had died from a terminal illness. Researchers used a longitudinal design, which reveals the most accurate data because it is collected using the same participants over an extended period of time. By examining the same participants, the possibility of the outcome of the study being affected by differences in participants is eliminated. Almost all participants in the study were Caucasian, which is not a representative sample of the population. The sex of the children was nearly equally distributed with a little more than half being female. Most participants were Protestant and had a family income over \$40,000 annually, which would not allow these findings to be applicable to a large amount of the general populace.

With the loss of a parent, there comes inherent psychological strain on both the surviving parent and the child, no matter how long the death has been anticipated. Greeff and Human (2004) examined the resiliency factors in families who have suffered the loss of a parent.

Using a cross sectional design and self report questionnaires, researchers attempted to identify which factors would help families to recover after the traumatic loss of a parent/spouse. There were 39 families in the study contacted by phone or visited at home, that met the criterion to participate in the study. In each family, the oldest child had to be an adolescent (aged 12-19) and still living at home. The death must have occurred anywhere within the previous 4 years, the surviving parent had to have remained single, and both the parent and the child had to agree to participate in the study.

Of the families, 41% were English speaking, the other 59% speaking a form of African language. 82% of the surviving parents were female. The mean age of the surviving parent was 46 years of age. 67% of the participating children were girls, and the median age of all children

was 16. The average length of marriage before the death was 17.97 years. The average time that had passed since the death was 3.32 years.

For researchers to collect biographical information, they used a questionnaire on family composition, employment, education level, income, age, and gender. In this questionnaire, there was also an open-ended question which the respondent was asked which factors or strengths were most helpful during the stressful period of the loss.

To gain information needed for the study, researchers used a variety of questionnaires and indexes. The Family Hardiness Index (FHI) was used to measure internal strengths and the resiliency of the family. Hardiness in this context is defined as having a sense of control over outcomes as well as being able to manage stressful situations. The FHI has an internal reliability of .82. The Family Sense of Coherence (FSOC) was used to measure the level of coherence in terms of the domestic and the outside environment. Family coherence is defined as the extent to which the internal and external stimuli surrounding the family are predictable. It also measures the resistance resources that are available. The FSOC has an internal reliability coefficient of .92. The Relative and Friend Support Index (RFS) was used to measure the use of support systems the family has available to them, and has an internal reliability of .82. The Social Support Index (SSI) was used to evaluate how involved the family was within the community, and whether they viewed that community as a foundation of support. This index has an internal reliability of .82. The Family Crisis Oriented Personal Evaluation Scales (F-COPES) was used to measure any problem solving skills and behavioral strategies that these families used in this time of crisis. The F-COPES has internal reliability equal to .77.

Results of this study showed that the most important factors related to the resiliency of families that have lost a parent are extended family support, the immediate family's support for one another and the hardiness (internal strengths and resiliency) of the family. Religion was also

an important factor in resiliency. 77% of the families mentioned the use of religion and spiritual support as important coping strategies. Participants commented on how their beliefs gave purpose and meaning to their experience, which helped them accept their loss. The adolescents in this study were the only ones to report emotional, esteem, and network support from their community as a resiliency factor. These results may suggest that in time of suffering, families prefer going to people and places with which they are familiar.

Critique of Research Methodology

This research study had a reasonably small sample size with only 39 families involved. 89% of the surviving parents were female, which may be relative to the population, as men have a lower life expectancy than women. The average length of time since the death was over 3 years, which may have been too long. Families would have adjusted since the death and may not be able to accurately recall details of how they coped with the loss at that time. Although the use of questionnaires can allow researchers to gather information other research methods cannot provide, participants are able to directly influence the results by giving answers that may or may not be honest. Researchers used several standardized questionnaires which increased the study's validity and reliability. Nowhere in the questionnaires were there queries that pertained to specific cultural or religious beliefs, specific feelings about the death of the parent, the way the parent died, and the death's effect on the family or the family life before the death occurred. When responding to these different issues, a participant may see life and death very differently (optimistically or pessimistically) than another participant who does not share the same views.

In another study examining the resources one can use to help cope with the stresses of losing a parent, Haine, Wolchik, Sandler, Millsap, and Ayers (2006) reviewed the effects of positive parenting as a resource for children who have lost a parent to death. By contacting school counselors, service agencies and police departments in a southwestern metropolitan area,

researchers obtained the information on 432 eligible families to participate in this study. In order for a family to be eligible, the family needed to speak fluent English, not have been receiving any treatment for grief-related issues, have at least one child between the ages of 8 and 16 and the child(ren) must have lost their parent (caregiver) 3 to 30 months prior to the date of the first interview.

There were a total of 207 families with 339 children that participated in this study. The average age of the children was 11.5 years, and ranged anywhere from 8 to 16 years. 46 % of these children were female. 78 % of the caregivers were female, and ranged in age from 19 to 64 with a mean age of 41.2 years. The average time since death was 10.4 months. 87% of the caregivers were the biological parent of the child, 7.4% were the aunt/uncle/sibling of the child, 5.1% were grandparents, and .03% had no relation. The causes of death included illness, (70.9%), accident (17.6%), or death by homicide or suicide (11.5%). Ethnicities of the children included Caucasian (65.8%), Latino (a) (16.6%), African American (8%), Native American (2.9%), Asian/Pacific Islander (1%) and other (5.7%). 22 % of the caregivers had a college degree or graduate school experience, 5.8% had technical school experience, 23.3% had a high school diploma and 8% did not finish high school. The median family income of all participants was between \$30,001 and \$35,000 a year. Hypotheses for this study were not explicitly stated.

Researchers used a pre-test post-test design as well as an 11 month follow-up. All interviews were given by trained professionals. The consent of both the surviving caregiver and child was granted before interviews began. Families were given \$40 for the initial interview and \$30 for each additional interview as incentive to participate. To assess positive parenting, caregivers reported on their own parenting and the children reported on the parenting that was provided to them. The caregiver's affective relationship with the child was measured by answering questions on acceptance such as "Your parent/guardian enjoyed talking things over

with you” (p.7) or “Your parent/guardian acted as if you were in the way” (p.7). Dyadic routines were measured using both the child’s and the adult’s reports on items such as “your parent/guardian had a regular fun time of play time with you.” Other items on questionnaires included “Your family spent enjoyable times together as a group” (p.8) which measured the stability of positive events. Questions were asked that pertained to positive reinforcement such as “how often did your parent/guardian compliment you?” (p.8). To measure the child’s perception of their parent/guardian’s empathy, questions such as “when you tell your parent/guardian about a problem, he/she really tries to understand” (p.8) were asked.

The results from this study showed strong support for positive parenting as a defensive resource for parentally bereaved children. Positive parenting was shown to have a direct positive effect on children’s mental health and it was shown to be independent of the outcome of negative life events. It was suggested that positive parenting creates an atmosphere that supports the fulfillment of the child’s needs and goals (esteem and control) which balances the harmful effects of the negative stressful events that threaten contentment of these needs, goals and accomplishments of important developmental tasks. This study suggested that with positive parenting comes a low occurrence of negative reinforcement and harsh punishment, both of which may lead to mental health problems. Lastly, this study suggested that positive parenting promotes the development of coping and problem solving strategies which can help defend against mental illness. There was no support found that positive parenting could be used as a stress-buffer resource.

Critique of Research Methodology

The sample size used in this study was rather large when comparing it to other studies reviewed on this topic, with nearly 350 participants. The average time since death was less than twelve months prior to the first interview, which would not allow for a lot of recovery time

allowing less chances for the influences of confounding variables. Although it was stated that the researchers utilized a pre-test post-test design, specifics on how they did so were not given. There were an equal amount of boys and girls in the study, and 65 % of these children were Caucasian. Researchers used multiple questionnaires and several reporters. Inquiries in each of the questionnaires were written in such a way that the child could understand precisely what the researcher was asking, while the answers would still provide an in depth analysis of how the child felt.

Current Applied Practices

By reviewing the previous studies, information gathered on the loss of a parent due to death or divorce can only be translated by applying results to current therapy applications. Different forms of separation could result in higher levels of depression and different life events could open the door for conduct disorder in that child's adult life (Sandler et al, 1992). Therefore, contingent upon on which form the severance takes, therapeutic approaches should be specific. Marwit and Carusa (1998) found that when comparing those who had suffered from a divorce to those who had suffered the death of their parent, tangible support was rated rather low. Researchers suggested this was because when dealing with a death, there are tangible tasks that need to be completed such as dealing with the deceased's belongings, setting funeral arrangements and so on. When asked about receiving compliments about the parent the child had been separated from, researches noted that those adolescents who had suffered a death found this more helpful than those who had experienced a divorce. This is explained because with death, a highly positive inner representation of the deceased follows.

Specifically in the cases of death, there is nothing accessible that can make dealing with painful loss easy. As shown in the previous research studies however, there are ways in which

parents, family members, community centers and members, counselors, etc. can make the event more enduring. In the case of anticipated death, something as simple as letting the child know you are there and you are supportive can help tremendously in their battle against mental illness. Therapists and support groups should understand that just being available can help a child move on from this life changing event. The child can feel an excess of feelings including the obvious feeling of loss, but also anger, confusion, they may want a biological explanation for the event, and fear or vulnerability for another death to take place (Kaufman & Kaufman, 2005). Research shows that letting the child express any feelings about the deceased parent and discussing any conflicts the child is having with the surviving parent can be a strong resiliency factor. Support from family members can help children and parents deal with the loss of a loved one. Attending religious services and promoting religious beliefs may also end up benefiting both the child and the parent in the event of a death. In the case of a terminal illness, studies have suggested that the surviving parent can help by explaining to the child exactly what is going on with the dying parent. A parent should help the child understand that it is not anything he or she is doing that is upsetting the parent or making him or her sick; it is instead the illness itself.

Possibly the most effective way of therapy would be to offer support during (if the death involved a long term illness) rather than waiting until the death or separation transpires. To build upon social networks and relationships or strengthening the existing ones in a child's life could be the most effective way to ensure recovery. Jones et al (2003) suggested the grieving to build up friendships, relationships and other social contacts to ensure endurance after such loss. Support for having access to both immediate family members and extended family members was shown to be a strong resiliency factor in a grieving person's life. Community support was specific to adolescents who needed emotional, esteem and network support (Greef & Human, 2004). This is currently being practiced as many web sites and help groups have been organized

for those who have themselves been diagnosed with a terminal illness or those whose family member has. With the use of internet search engines, people can find many ways to connect to others dealing with the same losses as themselves.

Theoretical Foundations

John Bowlby, a developmental psychologist, has done extensive research on the connection between a child and their caregiver (specifically mother) and has developed the Attachment Theory. While completing his first approach to systematic research at the London Child Guidance Clinic, he inspected the lives of 44 juvenile thieves. He matched the participants with a control group and came to a startling conclusion. When the thieves' lives were compared to the lives of the control group, he found that the thieves had suffered from extended experiences of mother-child separation or suffered from lack of maternal care all together. He found that these experiences were especially linked to the juveniles who had been previously diagnosed as affectionless (Ainsworth & Bowlby, 1991). These findings convinced Bowlby of the considerable role that is played by the interaction between a parent's relationship with the child and the child's personality development.

Bowlby's theory proposes that as early as the child's first year of life, an attachment may form between the infant and the caregiver. When the child is first born, behaviors such as crying are used to gain the attention of others. As the infant gets older, these behaviors may change and become specific to gain the attention of a few select caregivers. By the middle of the first year, the infant has developed some sort of understanding that the caregiver continues to exist even when that person is not in the presence of the infant. This is when the baby can develop separation distress, causing him or her to be upset when that caregiver is not around (Ainsworth, 1989).

This theory suggests that if a child, even as young as several months, is separated from their caregiver for extended periods of time, this can affect development and behavior later in life. If this theory, which has the support of the strong evidence, is correct, a child could be emotionally wounded as early as infancy if a parental separation due to divorce or death occurs.

According to Maier and Lachman (2000), women who suffer the loss of a parent as a result of death are shown to have more depression in later life which is consistent with Bowlby's theory. Evidence to support this theory also comes from Sandler, Reynolds, Kliever, and Ramirez (1992). These researchers showed that when a child has undergone separation events this undoubtedly leads to depression.

However, several studies examined in this review conflict Bowlby's theory. Men who suffered the death of parent were shown to be more autonomous later in life. Women who suffered divorce showed no connection to psychological health and divorce. Siegel, & Jiang, (2000) found that when comparing children who lost their parents as a result of suicide or terminal illness, their depression levels were not significantly different than those children in a normative sample.

Resiliency factors have a strong impact on how a child will react to such separation. Although Bowlby found that prolonged periods of separation could be detrimental to a child's mental health and well-being, other factors need to be taken into consideration, such as the relationship between the parent and child, the age of the child, the support system to which the child had access, and internal strengths of the child. These factors need to be considered before assuming such negative outcomes.

Conclusions

There is no question that separation of any kind is difficult for a child. Research indicates that people's responses may be different depending on characteristics they have specific to them

and their situation. Included in these would be the sex of the child who has suffered the loss, the support system the child has, and how the surviving parent deals with the ensuing stress that comes along with the death or the separation.

In the examining separation as a result of divorce versus losing a parent to death, men are shown to have increased levels of depression, while women show no connection to specific life events and psychological symptoms. Results from this review suggested that children who survived divorce rather than death would sustain more severe consequences than those who had lost a parent to death. Such effects included lower increased drug use, less income, less education and less social support. Neither form of separation predicted drug or alcohol abuse later in life.

A change in daily life will indubitably occur as the child will have to adjust their routines once their parent has passed. If the deceased was the main source of income for the family, the child may have to move homes, thereby forcing him/her to make new friends and adjust to a new school environment (Dowdney, 2000).

In examining all of these studies, it is apparent that as a child goes through a separation, honesty, encouragement and attention are needed to help both the child and the parent deal with the resulting trauma. This helps by creating an environment that supports the child's needs and goals. Positive parenting was revealed as a strong resiliency factor as it is shown to involve less negative reinforcement and also have less harsh punishment which may lead to mental health problems. Positive parenting was also shown to expose the child to coping and problem solving strategies which can be helpful well into adulthood.

For future studies researchers should focus on recovery rather than which form of separation leads to more mental, physical, social, or health problems. Because of the nature of the study, researchers should continue to use questionnaires, as that may be the only way to gain

access to the information desired. Longitudinal designs should be implemented more as attitudes and mental health may adjust as participants grow and learn new information. When investigators are gathering information on any form of separation or death, further questions should be posed. Important questions such as if the surviving parent remarried and if so, how long after the divorce or death did it happen were not asked in these studies. Other important questions left out pertain to the relationship between the child and either the surviving parent and/or the new parent if that parent was remarried. Was the child allowed to mourn the death or divorce in the presence of the parent? Was the child given options and opportunities to regularly attend therapy? All of these are essential in determining the ways the mental health of the child could be improved or remain healthy.

References

- Ainsworth, M. (1989). Attachments beyond infancy. *American Psychologist, 44* 709-716.
- Ainsworth, M. & Bowlby, J. (1991) An ethological approach to personality development. *American Psychologist, 46* 333-341.
- Bowlby, J. (1963). Pathological mourning and childhood mourning. *Journal of the American Psychoanalytic Association. 11*, 500-541.
- Dowdney, L. (2000). Annotation: Childhood bereavement following parental death. *Journal of Child Psychology and Psychiatry, 41*, 819-830.
- Greeff, A.P. & Human. B. (2004). Resilience in families in which a parent has died. *The American Journal of Family Therapy, 32*, 27-42.
- Haine, R.A., Wolchik, S.A., Sandler, I.N., Millsap, R.E. & Ayers, T.S. (2006). Positive parenting as a protective resource for parentally bereaved children. *Death Studies, 30*, 1-28.
- Jones, D., Harvey, J., Giza, D., Rodican, C., Barreira, P.J., & Macias, C. (2003). Parental death in the lives of people with serious mental illness. *Journal of Loss and Trauma, 8*, 307-322.
- Kaufman, K.R., & Kaufman N.D. (2005). Childhood mourning: Prospective case analysis of multiple losses. *Death Studies, 29*, 237-249.
- Maier, E.H. & Lachman, M.E. (2000) Consequences of early parental loss and separation for health and well-being in mid-life. *International Journal of Behavioral Development, 24*, 183-189.
- Marwit, S. & Carusa, S.S. (1998). Communicated support following loss: examining the experiences of parental death and parental divorce in adolescence. *Death Studies, 22*, 237-255.

- Pfeffer, C.Y., Karus, D., Siegel, K. & Jiang, H. (2000). Child survivors of parental death from cancer or suicide: Depressive and behavioral outcomes. *Psycho-oncology*, *9*, 1-10.
- Saldinger, A., Cain, A., & Porterfield, K. (2006). Managing traumatic stress in children anticipating parental death. *Psychiatry*, *66*, 168-181.
- Sandler, I.N., Reynolds, K.D., Kliwer, W., & Ramirez, R. (1992). Specificity of the relation between life events and psychological symptomatology. *Journal of Child Psychology*, *21*, 240-248.