4-20-2007

Childhood Bereavement: A Qualitative Study

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Recommended Citation
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Abstract
The purpose of this dissertation is to examine the long-term effects of bereavement on adults who experienced the death of a parent during childhood. By using a qualitative approach, this study is designed to gather information on each participant's unique understanding of how bereavement has impacted his or her life. This information is then used to identify general themes in childhood grief, focusing on long-term individual processes and comparing findings to current grief theories for children. Finally, implications for the conceptualization of children's bereavement process, for current child grief theories, for a new overarching child grief theory, and for future research in childhood bereavement are explored.

Degree Type
Dissertation

Degree Name
Doctor of Psychology (PsyD)

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Subject Categories
Psychiatry and Psychology

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CHILDHOOD Bereavement: A Qualitative Study

A Dissertation
Submitted to the Faculty
Of
School of Professional Psychology
Pacific University
Forest Grove, Oregon

By
Colleen M. Scott

In Partial Fulfillment of the
Requirements for the Degree
Of
Doctor of Psychology

April 20, 2007

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ABSTRACT

The purpose of this dissertation is to examine the long-term effects of bereavement on adults who experienced the death of a parent during childhood. By using a qualitative approach, this study is designed to gather information on each participant’s unique understanding of how bereavement has impacted his or her life. This information is then used to identify general themes in childhood grief, focusing on long-term individual processes and comparing findings to current grief theories for children. Finally, implications for the conceptualization of children’s bereavement process, for current child grief theories, for a new overarching child grief theory, and for future research in childhood bereavement are explored.
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INTRODUCTION

Experiencing the death of a parent is not an unusual occurrence for children; approximately 1 in 20 children will have a parent die before they reach the age of 18 in the United States (U.S. Bureau of the Census, 1990). The death of a family member, especially a parent, is a major disruption in a child’s development, attachment, world orientation, and general wellbeing (Kirwin & Hamrin, 2005). While grief and loss are considered universal human experiences (Allumbaugh & Hoyt, 1999), reactions to death vary considerably, especially in children (Scott, 2004).

Prior to 1960, grieving children were mostly overlooked in the United States. It was thought that children should be protected from the pain of the death and “sheltered both from full knowledge about the death and others’ reactions to the loss” (Oltjenbruns, 2001, p. 176). Psychological literature has shown that this oversight has been detrimental to children. In fact, recent studies have shown that “children who lose a parent have a significantly increased risk of developing psychiatric disorders and may suffer considerable psychological and social difficulties throughout childhood and later in life” (Young & Papadatou, 1997, p. 197).

Despite the statistics and risk factors, there continues to be much debate about the grief processes for children. More specifically, recent studies have been attempting to describe normative grief processes verses pathological grief. This research is crucial, given the high prevalence rate of children who experience the death of a parent. While many psychologists have conceptualized grief as a natural reaction in children, there is currently no standardized criteria or theory in psychology to explain the “normal” processes of grieving children. Since the 1960’s, many theorists and researchers have focused on explaining the
normative grief processes of children through grief stage theories. However, researchers have been unable to agree upon theories, resulting in multiple, contradictory conceptualizations (Scott, 2004).

Currently there is not a grief theory for children that is agreed upon by professionals or supported by research. The lack of a bereavement theory for children is a gap in the research literature on grief and the psychology of children. Theories are used to guide research, assessment, and treatment. A standardized grief theory for children would advance the knowledge about childhood bereavement and inform the development of treatment interventions that are the most effective (Scott, 2004).

Past studies on childhood bereavement have failed at developing a standardized theory for multiple reasons. Initially, theories were extrapolated from adult models (e.g. Lindemann, 1944), hypothesized from attachment research (e.g. Bowlby, 1960), and taken out of context (e.g. Kubler-Ross, 1969) (Scott, 2004). Also, past studies have looked at the immediate effects and impact of the death on the child, rather than observation and follow-up over time.

In order to develop a grief theory for children, it is necessary for research to look at the processes of children in their environments throughout time. More specifically, the development of a functional grief theory for children would need to address "such basic issues as why people grieve, the nature of their reactions, and how individual and social factors interact during the process of adaptation" (Stroebe, Hansson, Stroebe, & Schut, 2001a, p. 745). To date, longitudinal research that observes grieving children over a period of many years has not been done.
STATEMENT OF THE PROBLEM AND PURPOSE OF THE STUDY

Statement of the Problem

Grief theories for children have evolved from adult research and attachment research, where bereaved children were not studied. A grief theory for children is essential for understanding the sequel of childhood bereavement and differentiating between normative and pathological processes. In order to develop such a theory, research that examines the long-term processes of bereaved children is essential.

Childhood bereavement is a common experience, however the impact on a child’s mental health can be substantial. Studies on the short-term impact of bereavement on children have shown an increased risk for these children to develop major psychiatric disorders with long-term suffering. Despite the risk factors that have been identified in recent studies, mental health services are routinely not offered to bereaved children (Dowdney et al., 1999). It is hypothesized by current researchers that mental health professionals disagree about whether bereaved children need services because of the lack of information, and lack of agreement, about the grieving processes of children (Kirwin & Hamrin, 2005).

The Purpose of the Study

The purpose of this dissertation is to conduct a qualitative study that critically examines the long-term impact of parental bereavement during childhood. Given that there is not currently a grief theory for children that is agreed upon by professionals, I designed this study to elicit information about the grief process over time to begin to identify common themes and experiences of bereaved children. The current literature will be augmented by this study, as I will examine childhood bereavement from a retrospective point of view through focusing on long-term individual processes. Unlike other research on childhood
bereavement, I intend to challenge the current grief theories for children. I also intend to advocate for new research that prioritizes longitudinal study, naturalistic observation, and an accurate description of childhood bereavement processes.

I hypothesize that findings from this study will demonstrate how varied the bereavement process is for children. Further, I hypothesize that the subjective experiences reported by the participants will illustrate how current grief theories fail to accurately depict all the aspects of childhood bereavement. While general grief themes from the results of this study may match current theories, I hypothesize that many of the findings will vary from current literature. I anticipate this variation because this study has been designed to elicit information about bereavement that looks beyond psychological symptomology and short-term experiences.

In the following pages, findings from this study will be presented. First, a critical review of the current literature on children’s grief theory and research will be presented. Second, the research design, including how analysis was conducted, will be described. The results of the study will then be explained. Lastly, the implications from the study, including limitations and conclusions, will be explored.
CRITICAL LITERATURE REVIEW

The following section includes a critical review of the literature on childhood bereavement. First, what literature was selected for review and the criteria used will be described. A review of childhood grief theories will then be presented, focusing on the origins of grief theories, the inclusion of children in grief theories, and the limitations of grief theories for children. Next, a review of current perspectives on childhood bereavement will be explored, looking specifically at how attachment, developmental, and trauma theories are influencing grief conceptualization. Lastly, issues related to developing a grief theory for children will be examined and discussed.

Selection of Literature for Review

For this review, the PsychInfo database was used to search for publications under multiple combinations of keywords. These words included, 'children, child, parent, parental, death, bereavement, grief, loss, theory, theories, and mental health'. More specifically, these words were combined and/or entered alone, under 'keyword search' and 'title search' to attempt to locate as many articles as possible on this topic.

Multiple parameters and restrictions were placed on the searches. The searches were restricted to articles published in English. Only journal articles or book chapters were chosen, with preference for being published in the United States. This parameter was used in order to accurately represent what information is currently available to professionals and the public on childhood bereavement within the United States. Publication date restrictions were applied when searching for current research in childhood bereavement. Articles were considered for review if they were published after 1990. However, date restrictions were not applied when searching for articles on grief theory, as a historical look at what has been
published was desired. The publications chosen for analysis were selected based on their inclusion of information on children’s grief theory and/or children’s grief processes, research pertaining to childhood grief, and specific studies examining parental bereavement.

Childhood Grief Theories

In this portion of review, the history of grief theories will be presented to show how perspectives on bereavement have evolved over time. The development of classic theories about grief will be identified, with emphasis on how initial theories have influenced current beliefs about childhood bereavement. A discourse on the limitations of childhood grief theories will then be presented, showing how current assumptions are based on classic research that was not developed by studying bereaved children.

Origins of Grief Theories

Childhood grief theories can be traced back to the psychoanalytic perspectives of Sigmund Freud. In his publication *Mourning and Melancholia* (1917), Freud attempted to explain the processes of mourning in relation to his theories about ego development (Scott, 2004). He stated that the process of mourning ended once a person’s ego had let go of its investment in the “lost object” or deceased. He further hypothesized that pathological mourning would occur if a person were unable to detach from the deceased (Freud, 1917).

Freud’s influence on bereavement literature can be seen in a variety of ways. According to Stroebe, Hansson, Stroebe, and Schut (2001b), he was the first person to use the term ‘grief work’ and the first to suggest that not working through grief can cause depression and other psychological maladies. Subsequent research on bereavement has been influenced by Freud’s concepts, as many theorists and psychologists continue to describe grief as a process that must be worked through (Bonnano & Kaltman, 1999).
In 1944, Erich Lindemann was the first researcher to name grief stages. His stage theory was strongly influenced by Freud’s concept of grief as a process. In fact, his research was conducted by using Freud’s psychoanalytic theory (Scott, 2004). Lindemann studied bereaved adults and used this data to describe a three-stage theory for how adults grieve. He also used his data to begin describing normative grief reactions versus deviations for normative processes (Stroebe, et al., 2001b).

Lindemann’s three grief states for adults included: shock and disbelief; acute mourning; and resolution (Lindemann, 1944). His research not only named these three stages, but he provided detailed descriptions of acute grief reactions. Lindemann’s work was highly influential. Following his publication, researchers studying grief became predominantly focused on defining and redefining grief stages in an attempt to understand normal grief reactions (Scott, 2004).

The next major publication on grief stages occurred in 1969 with Elizabeth Kübler-Ross’s book, On Death and Dying. Kübler-Ross’s model for grief has five stages of grieving including numbness, denial, anger, blame, and acceptance (Kübler-Ross, 1969). Her grief stages were derived from research and observations she made from studying people in the active phases of dying, not by studying people who were grieving a death.

Even though Kübler-Ross’s model was intended to describe stages that dying people experience, it is commonly misapplied to grieving individuals. In fact, her model has been described as “the best known, least understood, and most misused theory about grieving” (Schuurman, 2003, p. 3). She never intended for the grief stages she defined to be “sequential, orderly, or mandatory” (Schuurman, p. 4). However, her model is often
presented as a sequential process through all five stages that all people who are grieving experience.

Inclusion of Children in Grief Theories

In 1960, John Bowlby was the first to conduct research on childhood bereavement (Costa & Holliday, 1994). Bowlby (1960) studied young children, between the ages of one and three, as they were separated from their mothers for a prolonged period of time. During his study he observed that the child’s reactions and responses to separation strongly resembled those of bereaved adults (Christ, 2000).

From his observations during his study, Bowlby began making hypotheses about a child’s bereavement process. He defined three phases of mourning for children: yearning and searching; disorganization and despair; and reorganization (Attig, 1996). In 1971, Colin Murray Parkes conducted research based on Bowlby’s mourning phases. His research was used to verify Bowlby’s ideas about children’s grief phases. Parkes also amended Bowlby’s original three-phase model by adding another initial phase: numbness (Attig).

Bowlby and Parkes’s research and four-stage model for children refuted the earlier held beliefs of Freud and Lindemann that children were unable to comprehend loss or grieve (Costa & Holliday, 1994). Their influence on childhood bereavement is seen in subsequent theories on children’s grief stages (Scott, 2004). For example, in 1974 Erna Furman identified three tasks of children’s grief, which included: understanding and coming to terms with the death; mourning; and resuming and continuing living. Multiple similarities to Bowlby’s initial three phases of children’s grief can be seen by examining Furman’s three tasks of grieving.
Bowlby's first phase, yearning and searching, is almost identical to Furman's task, understanding and coming to terms with the death. Both involve the child seeking and wanting the person who has died, and realizing that the deceased person is permanently gone. The second task of Furman's, mourning, is very vague, but stems from Bowlby's phase of disorganization and despair. Furman hypothesized that children who experienced the death of a parent would experience problems later in their lives if prevented from mourning (Furman, 1974). Similarly, Bowlby observed disorganization and despair in children separated from their mothers. He noted that children who did not experience this phase were less attached to their mothers and hypothesized that these children would experience attachment related problems later in life (Bowlby, 1980). Furman's last task, that the child must resume and continue living, can be seen as a parallel to Bowlby's phase of reorganization. Both assume that the child will "move on" and that movement into this final task, or phase, indicates a completion of the grieving process for the child (Scott, 2004).

In 1988, Edna LeShan used Bowlby and Furman's ideas and conducted research with children following the death of a parent. LeShan described three stages of grief for children based on her findings: denial, disorganization, and integration of loss and grief. Although strongly influenced by earlier stage theories, LeShan added an important idea to children's grief theory. LeShan noticed that "mourning never ends" for the child (Costa & Holliday, 1994) and stated that there is a "resurgence" of mourning that can occur throughout a child's life (LeShan). She stated that as the child develops, he or she experiences events (such as birthdays, graduations, weddings) that can remind the child that his or her parent is deceased. This observation by LeShan was an important divergence from the previous theories on children's grief that assumed that a child would "get over" his or her grief. In fact, the current
heded beliefs by grief theorists are that children and adults often experience grief throughout the lifespan (Davis, 2002) (Scott, 2004).

Following LeShan's work, J. William Worden (1991) developed a four-task model of grieving which aimed to conceptualize grief as an active process. His research was focused on rejecting previous stage and phase theories, which he claimed were lacking because they did not emphasize the need for grieving individuals to actively address their grief (Worden, 1996). However, his four-task model has more similarities than differences to previous models.

Worden's four-task model includes: accept the reality of the loss; experience the pain of grief; adjust to an environment in which the deceased individual is missing; and withdraw emotional energy and reinvest in other activities. His model is practically identical to Furman's (1974) three-task model, except that Worden uses slightly different wording for his tasks. In addition, Worden added a fourth task, which essentially reflects Freud's (1917) idea that detachment from the deceased is an essential part of the grieving process.

Assumptions of Grief Theories

Grief stage theories, from Freud to Furman, and even Worden, had three basic assumptions about the grief process. These assumptions were that the grieving process is time limited, that all bereaved people go through predictable stages of grief, and that working through the loss is essential to recovery (Becuar, 2001). Grief stage theories continue to have a strong impact on how grief is conceptualized, although some of the assumptions of the models have changed with current research.

Beginning with LeShan (1988), contemporary grief stage theorists have tended to conceptualize bereavement as a process influenced by individual beliefs and coping skills.
With this shift of perspective, three new assumptions have emerged in the literature. These assumptions are that the grieving process may last a lifetime, complete detachment from the deceased is impossible, and that grief may take many forms (Becuar, 2001). Current literature tends to identify theories on grief, however, emphasis is starting to be placed on individual differences that may or may not fall into a particular stage theory.

Overall, shifts in perspectives on childhood bereavement have been dramatic. The history of grief stages and children show an adherence to the classic beliefs and assumptions about the grief process. It has only been over the past two decades that these assumptions have been challenged and altered in the conceptualization of how children grieve (Scott, 2004).

Limitations of Grief Theories for Children

Prior to mid-1980, how children were impacted by death was not seriously talked about among experts in the field of death and dying (Schuurman, 2003). As illustrated in the timeline above, children were initially excluded in grief theory due to Freud’s conceptualization of mourning. Freud’s grief theory was based on ego functioning, a component of his psychoanalytic theory, and he believed that children had an undeveloped ego (Freud, 1917). Therefore, Freud concluded that children were unable to comprehend a loss and as a result experienced little or no grief (Costa & Holliday, 1994). Freud’s psychoanalytic theory was a major influence in the research and practice of psychology for the majority of the twentieth century. His beliefs about children resulted in children’s grief not being mentioned or researched by many of his successors.

Lindemann’s (1944) research was done with adult participants, and his stages were defined for adult mourners. Multiple criticisms have been made about Lindemann’s research
over the years. More specifically, critics oppose his attempt to define ‘normal’ grief without examining “samples of unselected bereaved people as opposed to people seeking psychiatric help” (Parkes, 2001, p. 29). Additionally, Lindemann did not study adult mourning over time. He based his stages on psychiatric interviews with adults, not with longitudinal research to examine the sequence of events that occur in the months and years following the death. These two flaws in Lindemann’s research are important to identify due to the lasting effects his grief stages have had on the literature (Scott, 2004). Not only did Lindemann’s research affect how adult grief is conceptualized, but most current grief stages for children are also greatly influenced by his work (Parkes).

As noted earlier, Kübler-Ross (1969) also based her grief stages on observations of adults, not children. She did not initially research or observe grieving adults or children. Despite this, her grief stages are often misapplied to children, which is misinformed and potentially detrimental to children. Even though her theory was intended for dying adults, many professionals and adults working with bereaved children continue to focus on identifying Kübler-Ross’s stages in a child’s grief process (Schuurman, 2003).

Bowlby’s (1960) three phases of children’s grief were theoretically flawed as well. Bowlby based his phases on childhood grief on the attachment research he was conducting at the time. His research consisted on observing children between the ages of one and three who were separated from their mothers (Bowlby). From his observations, Bowlby noticed that children’s reactions to being separated from their mothers strongly resembled those of bereaved adults (Christ, 2000). His grief phases for children were then based on these observations.
Even after Bowlby conducted multiple studies with bereaved children (Bowlby, 1980), he never changed his initial grief theory based on attachment relationships (Bowlby, 1960). Subsequent theories on children's grief stages (e.g. Furman, 1974 & LeShan, 1988) reflect an adherence to the phases that Bowlby proposed. As a result, theories developed after Bowlby are similarly flawed.

Current Perspectives on Childhood Bereavement

Contemporary grief stage theories for children are significantly different from earlier theories. New focus has been placed on the individual processes of children, as well as the incorporation of other childhood theories into bereavement research. While there are benefits to the new perspectives and research, limitations continue to exist and prevent researchers from agreeing upon a standardized way to conceptualize grieving children.

Individual Perspectives

The emotional aspects of children's grief have been the focus of many publications in the 1990's. The departure from previous theories has brought childhood grief new focus and attention in the mental health literature. However, with the new focus on individual processes and experiences, the question about what are normal and/or abnormal grief responses for children has become increasingly complex.

For example, Grollman (1991) published a grief theory in which he emphasized that children go through their own individual stages of grief, but with similar emotional themes such as: shock and denial; physical symptoms; anger; guilt; jealousy; anxiety and fear; and sadness and loneliness. The most important aspect of Grollman's theory was the attempt to normalize children's emotional responses to grief. However, the emotional themes that Grollman described can be seen in many children, not just a grieving child. For example,
Grollman’s research failed to explain how to differentiate the ‘normal’ emotional grief response of sadness and loneliness from depression, a serious childhood mental health disorder. Without clear distinctions about duration, frequency, and intensity of normative emotional responses in grieving children, it is impossible to distinguish between what is expected verses what may warrant psychological intervention (Scott, 2004).

Goldman (2001) also specified four grief stages for children emphasizing normative processes. Her grief stages include: understanding, grieving, commemoration, and going on. Similar to Grollman (1991), Goldman specified normal grief symptoms in an attempt to clarify common reactions that bereaved children experience. A few of these normal grief symptoms are: nightmares, excessive worry, fears, frequent crying, and somatic complaints (Goldman). Again, Goldman, like Grollman, failed to specify when normative symptoms would be considered problematic or psychologically maladaptive. As a result, her theory fails to provide insight into the normal processes of grieving children.

Lack of specific information is not an unusual occurrence in explaining grieving children. Even though hundreds of studies have been published on childhood bereavement, “there is no clear understanding of how a child grieves” (Oltjenbruns, 2001, p. 181). Theories related to childhood grief have tended to be inconclusive and contradictory. Additionally, theorists who have recently attempted to define normative signs of grieving in children have failed to distinguish how symptoms differ from childhood psychiatric disorders. As a result, another trend in the grief literature has emerged. Instead of focusing solely on grief theory, multiple researchers have started using alternative perspectives to conceptualize grieving children (Scott, 2004).
Alternative Perspectives

A major criticism of grief stages for children is that they lack specification (Stroebe & Schut, 1999) and do not account for all the emotional, behavioral, physical, social, and intellectual consequences children endure (Attig, 1996). As mentioned previously, there is no standardized grief theory that can be applied to children because of the lack of specification and theoretical flaws in the research. In an attempt to clarify a child’s experiences, define normative processes, and identify when psychiatric intervention is needed, researchers have started to incorporate other childhood theories into the conceptualization of bereavement.

The three major theories that have emerged as approaches to understanding children’s grief are attachment theory, developmental theory, and trauma theory. While each perspective is being utilized to offer insight into how a child may experience grief, there are similar limitations to their use. Attachment, developmental, and trauma theories were “originally developed to explain specific behavioral phenomena across a range of situational contexts” (Bonnano, 1999, p. 766). None of these theories were designed to explain a child’s grieving process or account for the amount of variance that may be observed in grieving children (Scott, 2004). Despite the limitations, basic knowledge of these perspectives is essential in understanding the influence on children’s grief research.

Attachment Theories. Grief is seen as normal from an attachment perspective. Theorists who study attachment conceptualize grief reactions, such as longing and distress, as responses that children have in an attempt to be reunited with the deceased (Shaver & Tancredy, 2001). Therefore, grieving children are experiencing the permanent loss of an attachment figure and their subsequent reactions are expected.
Attachment is thought to occur in all humans. It has been defined as “an inborn system in the brain that evolves in ways that influence and organize motivational, emotional, and memory processes with respect to significant care-giving figures” (Siegel, 1999, p. 67). The process of attachment is conceptualized as an attribute in a person’s physiology, and the motivation that causes infants and children to seek proximity to their caregivers as a means of survival (Meyer & Pilkonis, 2002).

Bowlby (1960) was one of the pioneering researchers on attachment. From his research, he described three attachment functions: 1) proximity to the attachment figure provided the child with a safe haven from threat; 2) accessibility of the attachment figure provides a secure base from which the child might more confidently confront challenge; and 3) separation from the attachment figure triggers separation anxiety, a state of distress where the child’s energy is directed at regaining proximity to the attachment figure (Bowlby). Based on these three functions of attachment, Bowlby described how loss during childhood causes predictable reactions in children.

For example, Bowlby (1960) conceptualized a loss reaction in a child that involves withdrawal, and lack of interest in activities, as a reflection of a child’s permanent loss of a secure base. Without the secure base, the child is unable to confidently confront challenges and tends to isolate from the world (Bowlby). Bowlby believed that such a reaction was normal for a child experiencing loss. He stated that loss reactions could be seen as a reflection of a child’s attachment relationship with the deceased (Scott, 2004).

Ainsworth, Blehar, Waters, and Wall (1978) furthered the work of Bowlby (1960) and identified three patterns of attachment that distinguished between secure and insecure attachments in children (Parkes, 2001). Essential to the conceptualization of each attachment
style is the initiating behaviors of the parents (Siegel, 1999). More specifically, secure attachment is characterized by sensitivity and responsiveness on the part of a child's parental figures (Ainsworth et al.). Children who are securely attached are able to “tolerate brief separations without great distress, and respond rapidly and warmly to comforting behavior” (Parkes, p. 38).

On the other hand, children who are insecurely attached exhibit varied responses to separation. Ainsworth et al. (1978) named three categories for the varied responses of insecurely attached children. These categories include: 1) Anxious Ambivalent; 2) Avoidant; and 3) Disorganized/Disoriented. The common response to separation by a child with Anxious Ambivalent attachment is great distress, while children with Avoidant attachment respond to separation with behavior that is seemingly detached and uncaring. Children with Disorganized/Disoriented attachment tend to exhibit a combination of both of these responses with behaviors that fluctuate between extreme distress and complete detachment (Parkes, 2001).

From an attachment perspective, the distinction between secure and insecure attachment is a key aspect in understanding normative grief reactions in children. Grief theorists who use attachment theory differentiate normal from problematic bereavement through the concept of ambivalence (Bonanno, 1999). Ambivalence is defined as simultaneous, conflicting feelings that are characteristic of insecure attachments (i.e. avoidant, anxious/ambivalent, and disorganized/disoriented) in children (Parkes, 2001).

In insecure attachment patterns, ambivalence arises as children both desire and reject their attachment figure. Then, when the death of an attachment figure occurs, ambivalent children are thought to encounter more problematic grief reactions due to conflicting feelings
towards the deceased (Scott, 2004). In contrast, securely attached children experience little ambivalence toward their attachment figures, which is believed to result in more normative grief reactions (Shaver & Tancredy, 2001).

While attachment perspectives provide a relational context in which to understand children's grief, attachment theory was not developed to explain the death of a caregiver or children's grief reactions. The theory is useful for assessing the relationship between the child and his or her caretaker prior to the death. However, there is no research to prove that a child's attachment style reliably predicts his or her reactions to the death of a caregiver (Scott, 2004). As a result, attachment perspectives fail to adequately conceptualize or explain children's grief.

**Developmental Theories.** Developmental theories have also been used in an attempt to understand the normative processes of grieving children. Multiple aspects of cognitive, emotional, and social abilities are the main focuses of developmental theorists. From these perspectives, responses and behaviors of grieving children are often compared to their developmental stages (Webb, 2002). There are three main developmental stages for children, which include: early (ages 2-4), middle (ages 4-7), and late childhood (ages 7-11) (Oltjenbruns, 2001). Developmental capacities are conceptualized differently for each stage of childhood with emphasis on the fact “that a young child is significantly different than one in middle or late childhood” (Oltjenbruns, p. 170).

Jean Piaget's (1963) stages of cognitive development are often used to explain children's ideas about death. Piaget (1963) proposed four stages of development for children including: sensory-motor (birth to 2 years), pre-operational (2 to 7 years), concrete operational (7 to 11 years), and formal operational (11 and older). In the bereavement
literature for children, the pre-operational and concrete operational stages receive the most focus (Costa & Holliday, 1994).

For example, research has shown that pre-operational children tend to have less understanding of death than concrete operational children. Children in the pre-operational stage do not have the cognitive capacity to understand that death is “irreversible, inevitable, and universal” (Webb, 2002, p. 4). This finding has multiple implications for how children will react to experiencing a death. Which a concrete operational child may experience anxiety and fear about death, pre-operational children may experience different emotions (e.g. guilt) due to their inability to comprehend the finality of death (Scott, 2004).

Piaget’s stages in children’s bereavement research are used to show how developmental processes impact a child’s responses to death. However, Piaget’s theory never specifically addressed children’s understanding of death, and his stages were not designed to explain environmental stressors (e.g. death) experienced by children (Webb, 2002). Misconceptions about grief are inevitable when using developmental theories to understand children’s grief reactions. Childhood grief is a “multidimensional response to loss” (Oltjenbruns, 2001, p. 176) and development is only one dimension of the grief experience (Scott, 2004).

Experiencing a death interrupts a child’s normative developmental processes and places children at risk for emotional, social, and physical problems (Davies, 1999). A child’s developmental age at the time of the death further influences the amount of risk a child faces (Siegel, 1999). However, developmental theories only allow for the comparison of grieving children with the normative processes of childhood development. Unfortunately, developmental perspectives do not provide information about the variability of the
developmental processes for grieving children. They also do not specify what, if any, impact grief will have on a child’s development over time.

Trauma Theory. Starting in the 1980’s, the increase of focus on childhood trauma in the psychological literature brought attention to the grieving processes of children. Since that time, trauma theorists have attempted to define grief by developing criteria for abnormal processes. Most recently, the concepts of grief and trauma have overlapped in the research, resulting in the terms traumatic grief or complicated grief (Davis, 2002).

Complicated grief is the term most commonly used, although differing definitions exist in the literature. Horowitz, Siegel, Holen, and Bonanno (1997) were the first to define and propose diagnostic criteria for complicated grief disorder. To meet criteria for complicated grief disorder, Horowitz et al. stated that a person must have experienced the death of a spouse, relative, or intimate partner at least 14 months ago. In addition, three of seven symptoms must be experienced. These symptoms include both intrusive (i.e., memories) and avoidance (i.e., loss of interest) components. Horowitz et al. stated that complicated grief symptoms could pertain to children, depending on their age and developmental processes. However, specific criteria for children were not specified.

The Behavioral Training Institute (2003) proposed differing criteria for complicated grief disorder. As opposed to Horowitz et al. (1997), The Behavioral Training Institute defined complicated grief as a bereavement process lasting longer than six months that includes psychological distress and/or the inability to function. The criteria also included a bereaved individual experiencing psychosomatic complaints, anger, depression, fears, sleep disturbances, regression, confusion, and the sense of abandonment. The Behavioral Training Institute also did not provide separate definitions or criteria for children, although separation
anxiety and themes of loss in repetitive play are symptoms that address childhood experiences (Scott, 2004).

Horowitz et al. (1997) and the Behavioral Training Institute (2003) both proposed criteria for complicated grief disorder with different definitions and symptoms. This has led some researchers to object to the term complicated grief. For example, Jacobs (1999) stated that "traumatic grief is preferable to the terms complicated or unresolved grief, which are vague or narrow in meaning" (p. 17). Jacobs, Mazure, and Prigerson (2000) then proposed diagnostic criteria for traumatic grief disorder and stressed the need for traumatic grief to be considered a psychiatric disorder. However, the term traumatic grief is often misinterpreted as meaning that the death was traumatic in nature. Since this is not necessarily true, complicated grief is reappearing in the literature as the preferred term (Davis, 2002).

As mentioned earlier, the specific criteria for complicated grief disorder is not currently agreed upon for adults or children. One major complication in the development of criteria for complicated grief disorder is distinguishing grief symptoms from other psychiatric disorders. For example, loss themes in repetitive play are considered symptoms for both childhood Posttraumatic Stress Disorder (PTSD) and complicated grief disorder (The Behavioral Training Institute, 2003) (American Psychiatric Association, 2000).

An additional complication is distinguishing between whether or not complicated grief is the comorbid diagnosis of bereavement and PTSD, or a separate diagnosis that incorporates PTSD symptomology. With complicated grief, the original ‘trauma’ is always a death, while with PTSD the traumatic event is widely varied. Beyond this distinction, it is very difficult to separate complicated grief and PTSD as independent constructs for children (Scott, 2004).
As a result, some researchers have started to study the traumatic responses of children who have experienced the death of a family member in an attempt to distinguish PTSD from complicated grief. In 1991, Applebaum and Burns conducted research with siblings who experienced the death of a brother or sister without witnessing the death. They found that siblings were at risk for PTSD even though they had only heard about the death. Applebaum and Burns also found that siblings who had lost a brother or sister to different types of death (e.g. homicide or accidental death) were equally at risk for PTSD. They concluded that in order to distinguish between complicated grief and PTSD, future researchers needed to consider the type of death that occurred, how the child found out, and whether or not the death was sudden or expected (Applebaum & Burns).

In another study, Freeman, Fisher, and Abramovitz (1997), looked at the grief processes and recovery of inner city children. They found that children displayed both internal (i.e., avoidance and depression) and external (i.e., aggression and hyperactivity) symptoms after the death of a family member (Scott, 2004). These internal and external symptoms mirror definitions of childhood PTSD defined by the American Psychiatric Association (2000).

However, Freeman et al. (1997) also identified the difficulty in distinguishing between PTSD and complicated grief in their findings. They describe complicated grief as occurring in children “when the grief becomes so intense that the child is overwhelmed, resorts to maladaptive behavior, and does not complete the mourning process” (Freeman et al., http://www.columbia.edu/cu/csswp/research/current/grief.htm). Nonetheless, this definition is vague, encompassing multiple childhood symptoms and psychological disturbances, and does not distinguish complicated grief from PTSD.
Trauma researchers have shown that until there are clear and operational definitions for childhood complicated grief and childhood PTSD, the distinction between the two is impossible. Similar to grief theories, trauma theories for children stem from adult research and there is not a standardized theory for childhood trauma that is used in research (Davis, 2002). As a result, trauma perspectives are limited, as they fail to provide divisions between normal and abnormal responses, and PTSD verses complicated grief symptoms.

In sum, there are limitations in the use of alternative perspectives to understand childhood bereavement. Attachment, developmental, and trauma theories were not originally developed to explain grief reactions. Additionally, in order to develop a grief theory for children, longitudinal research that observes childhood grief reactions over a period of years is essential. The studies described above did not study the same children over time, and did not consider the multiple factors that influence the bereavement process for children.

Developing a Grief Theory for Children

As I summarized in the last section, currently there is no grief theory for a child that explains why grief occurs, what types of losses cause grief reactions, and what symptoms or experiences are considered normal. The history of children's grief stages shows the extrapolation of adult models and theories based on research originally designed to explain other phenomena, such as attachment (Scott, 2004). As a result, subsequent researchers studying childhood bereavement have struggled to conceptualize the grieving child and explain his or her reactions from a cohesive theory. The development of a grief theory for children is essential for many reasons and will require specific research methodology.
Reasons for the Development of a Grief Theory

Psychologists, and other mental health workers who work with children, are likely to encounter a grieving child. While there is a substantial amount of literature on childhood bereavement, there is no over-arching theory to explain the processes of grief apart from other psychiatric disorders. Rather than accessing a theoretical model, clinician’s must try to differentiate what symptoms and disturbances are related to grief verses those that are related to separate childhood disorders (Stroebe et al., 2001b).

The history of grief research illustrates that “researchers’ descriptions of grief have outstripped psychologists’ abilities to explain and understand it” (Stroebe et al., 2001b, p. 11). Therefore, without a general theory, the descriptions of grief responses provide information to mental health workers that cannot be effectively organized. For example, Applebaum and Burns (1991) concluded that children who experienced the death of a sibling were at risk for PTSD. However, without a clear description of childhood PTSD symptoms verses childhood complicated grief symptoms, it is difficult to use this research to assist in the diagnosis of children. Consequently, clinicians are unable to assimilate the information that research continues to generate due to not having a framework in which to conceptualize grieving children (Scott, 2004).

The difference in grief responses further complicates psychologists’ integration of research and clinical practice. Currently, researchers have yet to provide conclusive and consistent outcomes regarding children’s grief processes (Oltjenbruns, 2002). Because varying factors influence these processes, researchers are unable to make predictions about recovery.
Furthermore, there are no empirically supported interventions for grieving children. While theoretical foundations are essential, treatment for children suffering from loss is of equal importance. Well-researched theory must be used to inform well-researched treatment processes. A grief theory for children is needed to provide a coherent and effective understanding of the grief process, as well as guide efficacious interventions for grieving children (Scott, 2004).

**Research Methodology**

Research with grieving children continues to be done using past theories that were either never intended for children, or were theoretically flawed. No longitudinal research has ever been done with grieving children over a period of many years (Oltjenbruns, 2002). Silverman and Wordon (1993) identified four deficits in studies on childhood bereavement. These include: use of clinical populations; outcomes measured too soon after the death; excessive focus on pathology; and lack of controls. In order to establish a grief theory for children, research that observes the long-term processes of bereaved children in their environments is necessary.

Archer (2001) proposed three aspects to consider in future research on childhood grief theory. These aspects included: 1) consideration of the origins of grief and its evolutionary function; 2) the mechanisms that set off the grief process and generate its emotional, behavioral, and cognitive components; and 3) the mechanisms that lead to the changing of these components over time so as to produce the state referred to as resolution (p. 554). More specifically, Archer identified the need for research to define normative grief processes, clarify psychological symptoms, and distinguish between successful adaptation versus maladaptive functioning.
In addition to Archer’s (2001) proposed aspects for research, Oltjenbruns (2001) emphasized the need for researchers to consider the wide range of experiences that lead to a child experiencing grief. For example, variations in who died, the type of death, family structure, and multiple changes following the death must all be considered in developing a functional grief theory for children (Oltjenbruns). Without attending to the multiple mediating factors, it is likely that researchers will continue to identify pieces of the grief process, without agreeing upon an overarching theory.

In sum, almost all research to date on grieving children has failed to study children’s grief reactions for longer than two years after the death (Davis, 2002). Current researchers have also emphasized comparing grief reactions to psychiatric disorders, rather than attempting to define children’s grief. In order to develop a grief theory for children, researchers must deviate from previous theories and research methodologies. Longitudinal research, which prioritizes naturalistic observation and qualitative inquiry, is essential. Additionally, research with large sample sizes of children, from a variety of backgrounds and experiences, will be crucial. In order to create a comprehensive grief theory for children, aspects of emotional and behavioral responses, in addition to multiple environmental factors, must be considered.

In the following section, I will describe my research design. I will specifically address how I developed my study to avoid similar limitations of previous research. Also, I will discuss how I used my review of the literature to guide the structure of my design and address aspects of childhood bereavement that have been previously overlooked.
RESEARCH DESIGN

The following section includes information about the research design. First, a description of the study will be provided, followed by information about the development of the study. Next, selection of the sample and sampling criteria will be described. The selection of the research design and data collection procedures will then be explained. Last, a description of data analysis will be presented, followed by risk factors related to participation in the study.

Description of the Study

In the last section, a critical review of the literature on childhood grief theory, current perspectives in childhood bereavement, and challenges in developing a comprehensive theory for children was presented. Based on my review of the literature, I developed this study to examine childhood bereavement. I specifically designed this study to avoid the limitations of other research on childhood grief theory. I did this by incorporating some of the research ideas reviewed in the last section by Silverman and Wordon (1993), Archer (2001), and Oltjenbruns (2001).

More specifically, unlike previous research, which has focused on the short-term reactions, my study is designed to examine the longitudinal effects of childhood bereavement. Archer (2001) emphasized the need for longitudinal research to distinguish between long term adaptation verses maladaptive functioning. I choose to study a non-clinical sample rather than a clinical population to begin to look at the distinction Archer proposed.

While it would have been ideal to study both a clinical and non-clinical sample, I selected a non-clinical sample in order to examine the variations in functioning and
adaptation among people not receiving psychological services. I additionally chose to use a non-clinical sample to minimize the focus on psychiatric symptoms, which Silverman and Wordon (1993) identified as a limitation to most current research on childhood bereavement. Another aspect of the design of this study is my decision to not use current grief theories to guide my data collection or analysis. Instead, I developed this study to challenge current grief theories for children by using different research methodology and emphasizing qualitative inquiry.

Development of the Study

After critically reviewing the literature, and determining the focus and research methodology of the study, I developed a research proposal and approached The Dougy Center, The National Center for Grieving Children and Families. The Dougy Center is located in Portland, Oregon and was founded in 1982. It was the first center in the United States that offered a “peer-support program for children, teens, and their parent or adult caregivers who’ve experienced the death of a family member” (Schuurman, 2003. p. xiii). There are currently Dougy Centers throughout the United States and abroad, all that were developed based on the center in Portland, Oregon (The Dougy Center, 2007).

I chose to partner with The Dougy Center for multiple reasons. First, employees and staff offer unique knowledge and first-hand experience with grieving children and their families. They work with grieving children on a daily basis, facilitating bereavement groups and observing and listening to children’s grief experiences. I wanted to consult about what I found in my critical literature review, and what additional aspects to consider in my research design.
Another reason I partnered with The Dougy Center was for the information and knowledge of their national director, Donna Schuurman, Ed.D. Schuurman (2003) wrote the book, *Never the Same: Coming to Terms with the Death of a Parent*, which identifies misconceptions about childhood grief, and consolidates research on adults who experienced the death of a parent during childhood. I wanted to consult with an expert in the field of childhood bereavement to review my research and identify any potential errors in my conceptualization or design of the study.

The research questions were the main aspect of my research design and I based them on Oltjenbruns's (2001) research. Oltjenbruns emphasized the need for a grief theory to consider multiple aspects of a child’s experience. These aspects included factors such as: who died, type of death, children’s individual processes, family functioning, and community response (Oltjenbruns).

It was impossible to include questions about all of the potential factors of childhood bereavement in this study due to time restrictions and scope of this dissertation. Therefore, I used consultations with the Director of Children’s Grief Services at The Dougy Center to determine what questions to include. We listed all aspects of children’s grief proposed by Oltjenbruns (2001), as well topics proposed by other researchers, such as childhood attachment (e.g. Bowlby, 1980), developmental processes (e.g. Webb, 2002), and trauma responses (e.g. Freeman et al., 1997).

Questions were selected based on two components: identifying information and general inquiry. Identifying questions were designed to obtain specific data about the death. Questions such as the age of the participant, who died, type of death, age of the participant at the time of the death, and how the participant found out about the death were included in the
identifying questions. On the other hand, general inquiry questions were designed to be open-ended and elicit information about immediate experiences after the death, as well as experiences over time. Topics chosen included: personal reactions; family functioning; peer relationships; school experiences; community response; and personal experiences and understanding of the death over time.

Topics excluded from inquiry were specific questions about current family and employment, current and past psychiatric symptoms, and religious orientation / beliefs. While these topics are important, they were eliminated because the questions about them were too leading. More specifically, the Director of Children's Grief Services and I believed that, if relevant, these topics would surface in the general inquiry questions about personal experiences and family functioning.

Once developed, the questions were taken to staff at The Dougy Center and revised by two separate readers. For example, wording was changed to make the questions more open-ended and general. This was done so that participants would respond based on their own ideas and thoughts about the questions, rather than be led too much in one direction. Additionally, some questions were omitted, as they were determined to be too specific. Specific questions were not desired, as they also tend to lead participants toward a specific response.

After the questions were finalized, the sample criteria and sampling procedures for the study were determined. Again, these aspects were derived from the current literature and designed so that results could be compared to other research on childhood bereavement. In the following section, I detail aspects of these research components.
Sample Criteria and Selection

Given the focus of my study on the long-term effects of childhood bereavement, my target population was participants who experienced the death of a family member during childhood. To narrow the scope of my study, I chose to focus on only participants who had experienced the death of a biological parent. I then identified participants who not only met the criteria, but also had a safeguard in place in case participation in my study caused undue distress.

All participants were recruited and selected from The Dougy Center. Random sampling was not used and every participant was involved with The Dougy Center as a current volunteer facilitator. Volunteer facilitators are extensively trained to work with bereaved children in a group setting, and participate as a facilitator at least two times per month in two hours of supervision and one and a half hours of group with children. By requiring that each participant was a current volunteer, a safeguard was in place given that each participant had access to services and resources through The Dougy Center.

The final sample criteria for each participant included three aspects. These were: 1) aged 18 and older; 2) experienced the death of a biological parent prior to age 18; and 3) current volunteer facilitator at The Dougy Center. There were no restrictions placed on the age of the participant at the time of participation in the study.

Design and Data Collection

A qualitative research design was used for this study following the guidelines described by Lewis (2003). Qualitative research is a “naturalistic, interpretive approach concerned with understanding the meanings which people attach to phenomena (actions, decisions, beliefs, values, etc.) within their social worlds” (Snape & Spencer, 2003, p. 3).
This research approach was selected so that multiple aspects of bereavement could be explored through each of the participant’s experiences.

The study consisted of a semi-structured interview (see Appendix A) with each participant lasting an average of 45 minutes. As mentioned in the description of the study section above, the questions included in the interview were composed of two components: identifying information and general inquiry. Additionally, questions were reviewed and revised by multiple staff at The Dougy Center to ensure that they were open-ended, not too specific, and covered relevant topics identified in the critical literature review.

Prior to data collection, Institutional Review Board (IRB) approval was obtained. Volunteer participants from The Dougy Center were contacted and interviews were scheduled. All participants were interviewed individually in a confidential and quiet setting. Additionally, informed consent was discussed and informed consent forms (see Appendix B) were signed prior to beginning all interviews.

Interviews were conducted by addressing all questions on the semi-structured interview. In order to maintain an empathically neutral role, I sat across from a table with each participant, had the tape recorder visible at all times, and attempted to focus only on pre-determined questions. Questions that did deviate from the semi-structured interview were minimal and for the purpose of clarifying information. I recorded all of the interviews on audiocassette tapes and transcribed the tapes following the interview. Upon completion of this dissertation, I will destroy all of the audiocassette tapes used for the interviews.

The total number of participants was also determined by the qualitative research criteria described by Lewis (2003). Lewis specified that data collection ceases when information obtained from the participants in the study becomes redundant. I interviewed
participants until I began encountering similarities, and data collection ended once I had redundant information. This resulted in a total of nine participants.

Data Analysis

Data analysis consisted of critically examining the content of the transcribed interviews. Ritchie, Spencer, and Connor's (2003) model for carrying out qualitative analysis was used for this process. Overall, the main technique used was data management.

Data management is a process which involves: “identification of initial themes within a data set; labeling and tagging the data; sorting the data by theme or concept; and summarizing or synthesizing the material” (Ritchie et al., 2003, p. 261). I analyzed each transcribed interview by using this process. First, I identified general topics, or meaning units, by comparing the interviews with one another. I looked for common concepts and used a color-coding system to label these concepts. For example, experiences related to overachievement at school were identified and underlined in pink, while experiences related to underachievement in school were identified and underlined in red.

After all meaning units were identified (see Appendix C), I then went back through all the interviews to begin identifying themes and sub-themes. To achieve this task, I examined the content of the meaning units and determined ways in which these units could be summarized and synthesized. The themes I identified were chosen based on the following criteria: 1) the theme was found in every interview transcript; and 2) the theme was related to childhood bereavement. Sub-themes, however, were chosen with slightly different criteria, including: 1) the sub-theme was found in at least five interview transcripts; and 2) the sub-theme enhanced the description of the over-arching theme.
Once I identified all themes and sub-themes, I had a research assistant replicate the data analysis process. Having a research assistant replicate the process was done to verify that themes and sub-themes were consistent between raters. After the research assistant had completed his data analysis, I compared both sets of themes and sub-themes to determine the reliability of the coding. Reliability was determined by examining both sets of coding and listing all of the themes and sub-themes from each rater. Then, all identical themes were accepted. Next, themes and sub-themes that were similar in context, but named differently, were closely examined to determine if they were referring to the same meaning unit. Then, discrepancies in the coding systems were noted and re-analyzed. Coding data was rejected if the criteria for themes and sub-themes described above were not met. Last, I used the comparison and analysis of the two coding systems to develop the final themes and sub-themes for the data (see Appendix C).

Risk Factors

The main risk factor associated with participating in this study was the potential for interviews to cause emotional reactions for the participants. This risk was addressed in the informed consent form. Prior to the interviews, I discussed this potential risk with all participants and told them that they could end the interview at any time and withdraw from the study.

Further safeguarding against risk included all participants being involved with The Dougy Center as facilitators. As facilitators, all participants had access to support services and resources through The Dougy Center. Additionally, I provided all participants with a list of community resources (related to bereavement and therapy) that they could use if in need of further support following participation in the study.
RESULTS

In the following section, I present the results of the research. First, I will provide an overall view of how the data collected was organized into initial and main analyses. I will then present the initial analysis, which consists of descriptive statistics. Last, in the main analysis, I will present the themes and sub-themes derived from the data collected.

Overview

The interview questions were divided into two sections—orienting questions and main interview questions. The orienting questions were developed to obtain descriptive information about the participants. These questions were close-ended and focused on aspects surrounding the details of the death. For example, questions about who died, how old the participant was at the time of the death, and how the person died were included in these orienting questions. The initial analysis found in this section provides information and statistics about these questions as a way to understand the demographics of the participants.

Initial Analysis

Nine people participated in this study ranging in age from 29 to 68. The mean age of the participants was 40, with the median and mode being 38-years-old. In total, there were six women and three men. The mean age of the women was 35, while the mean age of the men was 50.

All of the participants experienced the death of one of their parents prior to age 18. There was significant variability in which parent died, age of the parent who died, type of death, age of the participant at the time of death, and whether or not the death was sudden. For the purpose of this study, the death of the parent was considered sudden if the death occurred within six months from the time of diagnosis or injury (see Tables 1 and 2).
### Table 1

**Identifying Information for Participants**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Parent Who Died</th>
<th>Age of Parent</th>
<th>Type of Death</th>
<th>Age of Participant</th>
<th>Sudden Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female 1</td>
<td>Mother</td>
<td>36</td>
<td>Breast Cancer</td>
<td>12</td>
<td>No</td>
</tr>
<tr>
<td>Female 2</td>
<td>Mother</td>
<td>44</td>
<td>Pancreatic Cancer</td>
<td>10</td>
<td>Yes</td>
</tr>
<tr>
<td>Female 3</td>
<td>Mother</td>
<td>23</td>
<td>Unknown</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Female 4</td>
<td>Father</td>
<td>34</td>
<td>Heart Cancer</td>
<td>11</td>
<td>Yes</td>
</tr>
<tr>
<td>Female 5</td>
<td>Mother</td>
<td>38</td>
<td>Diabetes</td>
<td>12</td>
<td>No</td>
</tr>
<tr>
<td>Female 6</td>
<td>Mother</td>
<td>44</td>
<td>Cancer</td>
<td>7</td>
<td>No</td>
</tr>
<tr>
<td>Male 7</td>
<td>Father</td>
<td>38</td>
<td>Electrocution</td>
<td>8</td>
<td>Yes</td>
</tr>
<tr>
<td>Male 8</td>
<td>Father</td>
<td>32</td>
<td>Brain Aneurism</td>
<td>9</td>
<td>Yes</td>
</tr>
<tr>
<td>Male 9</td>
<td>Mother</td>
<td>27</td>
<td>Accident</td>
<td>5</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Table 2

**Statistical Findings for Identifying Information**

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Mean Age at Time of Death</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother Deaths</td>
<td>35</td>
<td>67%</td>
</tr>
<tr>
<td>Father Deaths</td>
<td>35</td>
<td>33%</td>
</tr>
<tr>
<td>All Deaths</td>
<td>35</td>
<td>100%</td>
</tr>
<tr>
<td>Female Participants</td>
<td>9</td>
<td>67%</td>
</tr>
<tr>
<td>Male Participants</td>
<td>7</td>
<td>33%</td>
</tr>
<tr>
<td>All Participants</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Deaths that Were Sudden</td>
<td>n/a</td>
<td>67%</td>
</tr>
<tr>
<td>Deaths that Were Not Sudden</td>
<td>n/a</td>
<td>33%</td>
</tr>
</tbody>
</table>
There were additional key differences in the experiences of each participant directly following the death of his or her parent. Of the nine participants, none were present at the time of the death. Participants were told about the death by their surviving parent (N = 4), siblings (N = 2), or relatives / family friends (N = 3). The majority of the participants who recalled where they were, were at school when the death occurred (N = 3), while others reported being at home (N = 1), outside (N = 1), or at the hospital (N = 2). Two of the participants were unable to recall where they were when the death occurred.

Many of the participants did not view the body of their deceased parent (N = 6). The three participants who did view the body reported that this occurred either at the funeral home (N = 2), or during the funeral service (N = 1). Only two participants reported that there was no memorial or funeral service for their parent. The participants who did report that there was a memorial or funeral service stated that this occurred in a religious institution (N = 6). The majority of the participants’ deceased parents were cremated (N = 5) and buried (N = 7). One participant stated that she did not know what happened to her mother’s remains, while another stated that her family scattered her father’s remains years after the actual death. Seven of the participants reported that there is a gravestone or memorial for their parent, however, none of the seven participants reported frequent visitation to the location.

Main Analysis

The main interview questions were analyzed based on the procedure described in the Data Analysis section. There were nine main interview questions that covered specific aspects of the bereavement experience. These aspects included personal experiences, family functioning, interpersonal relationships, school experiences, community relations, and aspects of personal thought processes over time. Responses to questions had specific themes
and sub-themes, which are presented in the following analysis. Quotes from the interviews are used to help highlight the content themes that are identified and discussed (see Finalized Themes and Sub-themes in Appendix D).

Immediate Personal Changes

The first major theme that emerged was Immediate Personal Changes. As one female participant put it, “everything changed... I mean, everything about my life completely did a 180 when my mom died”. All participants echoed this sentiment, stating that their lives were not the same right after the death occurred. To clarify these changes, this theme was divided into two sub-themes, Internal Changes and Behavioral Changes. While responses focus on changes that occurred within the first few months after the death, delayed changes, and changes that evolved over time, are also quantified.

Internal Changes. Aspects of personality, emotionality, and overall sense of wellbeing characterized the sub-theme Internal Changes. The majority of the participants (N = 6) reported that immediately following the death these changes took place, and continued to evolve over the weeks and months after the death. For example, one female participant stated, “I feel like everything changed for me when my mom died – I mean, the person that I was five minutes before she died and five minutes after she died are almost two separate people.”

All participants overwhelmingly reported feeling different fundamentally. Where some were previously outgoing and sociable, they were suddenly withdrawn and anxious. There was seemingly little variation based on the age of the participant at the time of the death, almost all (N = 7) reported that their internal changes were immediate and profound.

For example, one participant who was seven at the time of the death stated:
As a 7-year-old...well, I was more carefree beforehand, and then, looking back now, I can say that I was shaken and had an overall feeling of being insecure and scared after the death...I think back then I didn’t even know or was aware of what was happening...this shift occurred in me and I didn’t even know at the time how changed I was.

Another participant, who was 12 at the time of the death, stated that she no longer felt safe and that her life no longer felt sheltered or predictable. Despite their ages at the time of the death, the impact of the death seemingly changed both of these participants’ personality structure, emotions, and sense of well being in the world. The extent of this change was profound; both participants reported that they did not feel like the same person after the death.

Many participants (N = 8) also reported experiencing emotional upheaval immediately after the death. Emotions reported included anxiety, generalized fears, guilt about the death, shame, depression, sadness, profound grief, lowered self-esteem, fears of abandonment, fears of dying, vulnerability, fears of going crazy, and anger. The last emotion, anger, took on multiple forms. Participants reported being angry at their parent for dying (N = 4), anger at their family for not telling them that their parent would die (N = 5), anger at not being present when their parent died (N = 4), anger at their parent for being sick (N = 2), and anger at not getting help to cope with the death (N = 7):

I felt so angry at my father and so betrayed...I remember just thinking, ‘Why did this happen? How could this have happened to me?’ and knowing that there was no reason. There was no reason for me. Life just didn’t make sense and I was so alone and so angry.
Overwhelmingly (N = 6), anger was the emotion that participants reported has persisted over time, with lasting anger about aspects of how the parent died (N = 3), how they were told (N = 2), and how the family responded to the death (N = 5).

*Behavioral Changes.* The second sub-theme, Behavioral Changes, incorporated aspects of Immediate Personal Changes that have to do with daily living and self-care. Many participants (N = 6) commented on Behavioral Changes in relation to Internal Changes, demonstrating the interplay between feelings and behaviors. More specifically, participants (N = 6) reported that their feelings affected how they behaved:

I felt like I became a split personality, which I’ve only begun to understand now...I felt personally very old very fast because I was doing very adult things to take care of myself and at the same time I became very anxious and sick...I became very withdrawn and I didn’t feel safe anymore.

This participant illustrated how both her feelings and her behaviors changed, and how these changes affected how she felt about herself and her environment.

Participants (N = 8) additionally reported a variety of experiences related to behavior at the extreme ends of functioning. For example, some participants (N = 3) reported over-achieving in every aspect of their lives, while others (N = 2) reported extreme under-achievement. Some (N = 5) reported growing up too fast and becoming very independent, while others (N = 3) reported regressing to earlier stages of development and becoming more dependent. Additionally, some participants (N = 5) relayed stories of extreme rebellion and risky behaviors, while others (N = 4) denied ever acting out or causing problems.

Some of the risky behaviors described by participants included suicidal thoughts and/or attempts (N = 2), drug and alcohol abuse (N = 3), and criminal behavior (N = 1). One
participant, whose mother died when she was 12, described the combination of both suicidal behavior and alcohol abuse:

From ages 19 to 22, I was suicidal and was drinking a lot and I remember walking on the top of a hotel building really drunk and wanting to jump off... and there were like these fantasies during that period of wanting to kill myself... and yeah, it was really bad... that was the worst time.

Another participant, whose mother also died when she was 12, had a more immediate shift in behavior. She described engaging in drug and alcohol use right away:

I lost it, you know, I just couldn't handle what was happening... I started drinking and smoking pot and all of those things at 12 years old... and my dad was never home, so everything had changed and no one even noticed what I was doing.

Differences in when behavioral changes took place were common, with some participants reporting changes within one year (N = 4), while others (N = 3) reported that changes didn't occur until years after the death. There were some participants (N = 3) who described fluctuation in behavior over time. For example, one participant reported that initially she became an over-achiever and increasingly independent. However, this same participant reported that years later she became unable to function and started failing out of school, losing jobs, and becoming increasingly dependent on her family.

Complicating Factors

The next major theme that emerged was Complicating Factors. Complicating Factors were classified as events that: 1) occurred after the death; 2) were identified by the participants as negatively impacting their experience of grief; and 3) were identified as
significant by at least four participants. There were four sub-themes for this theme, including Compound Losses, Caretaking Roles, Family Dynamics, and Personal Relationships.

*Compound Losses.* Compound Losses were the most common of the Complicating Factors, as all participants identified two or more ways in which the death of their parent led to subsequent losses in their lives. These losses were related to changes within the family and/or relationships with significant others.

The most common Compound Loss related to the surviving parent. Participants reported that their surviving parent demonstrated mental illness (N = 4), emotional distance (N = 3), and physical absence from the home (N = 3). None of the participants reported that their surviving parent was unchanged by the death. In fact, most participants (N = 8) described their surviving parent as struggling to cope with the loss, resulting in detachment from the children and unavailability to meet emotional and physical needs. One participant described this when talking about her mother’s response to her father’s death:

“Right after the death she just kind of disengaged from us. She couldn’t be home, and when she could be home she was crying all the time. And then she started dating again and trying to escape everything...basically she was in escape mode and all that was so hard on me to not have her be there.”

Other participants reported that immediately following the death their surviving parent would refuse to talk about the death (N = 3), actively avoided negative emotionality (N = 3), and/or would not acknowledge the deceased parent at times when it would be natural to do so (e.g. father’s and mother’s day, the birthday of the deceased) (N = 5).

An additional Compound Loss related to experiencing deaths of other family members or friends. Multiple participants (N = 5) talked about how the death of another
person in their lives heightened their feelings of grief and brought back memories of their deceased parents. As one participant stated:

It was like everyone was dying and no one was safe...I didn’t know how to even begin to understand the death of another person. For me, all I could think about was my mom...it was like she had died all over again.

Overall, two participants reported experiencing the death of a sibling in early adulthood, two reported the death of a stepparent, and two reported the death of a surviving parent.

Experiencing a sibling suddenly leave the home was another occurrence identified as a Compound Loss. Participants (N = 5) described this experience as losing connection with a family member who was previously an integral part of the family system:

My brother essentially left the house...he just couldn’t take it...and my brother and I were always very close growing up and suddenly he was gone...I didn’t blame him because I knew that it was self preservation, but he just left me there (the home)...and I had no one.

Even if the older siblings did not physically leave, some participants (N = 3) described older siblings suddenly spending more time outside of the home.

For example, one participant reported that her sibling “practically moved in” with a friend and never spent time with the family. Another participant reported that her older brother began working after-school and on weekends, resulting in her “very rarely” seeing him or spending time with him. Additionally, one participant stated that her sister “ran away” and was not seen by the family for over a year after the death.

Caretaking Roles. Shifts in caretaking roles within the family were identified as another Complicating Factor. Participants (N = 7) reported that they suddenly had
responsibilities within the family that were not present prior to the death. These responsibilities involved: caretaking for their siblings and/or their surviving parent to meet the needs of the family \( (N = 5) \); taking care of themselves \( (N = 4) \); and accepting being taken care of by siblings or other adults \( (N = 3) \). Participants commented on how shifts in caretaking were another loss due to being forced to 'grow up' too quickly \( (N = 5) \) and not getting their needs met \( (N = 8) \).

Participants who had siblings \( (N = 7) \) reported that their roles within the family shifted, driving relationships with their siblings into dynamics that were not previously present. Common themes that emerged were participants being cared for by older siblings \( (N = 3) \) and participants suddenly being in charge of the care of younger siblings \( (N = 4) \).

Participants who were younger at the time of the death described older siblings stepping in to fulfill the role that was suddenly not being filled by the deceased parent:

I have a sister who is a year and a half older and then two sisters who are much older...and they (the older sisters) started to take care of me and my sister. They just started taking us on little trips and taking us out of the house.

Older participants described the opposite phenomena, reporting that they were the ones who took on the caretaking role with younger siblings. For example, one participant stated, “I took on the role of the guardian, and the bossy big sister.” She went on to describe feeling responsible for her younger brother’s feelings, behaviors, and general wellbeing.

Participants \( (N = 5) \) also reported caretaking roles shifting with their surviving parents, with the child taking care of the parent. As one participant stated, “I just got into a caretaking role with my dad, trying to keep him okay and not sad.”
surviving parent was most common among participants (N = 3) who reported that their surviving parent experienced mental illness following the death.

*Family Dynamics.* The participants described multiple changes within the family following the death that caused Complicating Factors. The Family Dynamics sub-theme includes experiences within the family that made it especially difficult to cope with the death. The two most common experiences reported included the addition of a stepparent into the family, and the loss of extended family.

The introduction of a stepparent into the family was an experience described by most participants (N = 6). Three participants reported that their surviving parent remarried within one year after the death. How each individual participant coped with having a stepparent replace the role of the deceased parent varied. However, all six participants who had a stepparent enter their family reported that it complicated their ability to cope with the death of their parent.

For example, one participant described the difficulty and confusion she experienced with the introduction of her stepfather into her family:

*My mother remarried soon after his death...and I really desperately wanted a father figure, so I put everything into this man, my stepfather, who ended up being really abusive...and so that was the first time that I really felt angry at my father for dying and felt betrayed – like how could my father die and allow this really awful person to come into our lives to hurt us.*

This participant was not the only one who reported experiencing abuse by a stepparent. In fact, three other participants reported being verbally abused and/or emotionally neglected by
their stepparents. Of the four participants who reported this abuse, three stated that their surviving parent did not intervene on their behalf or protect them from such abuse.

Other participants (N = 5) described how the introduction of a stepparent in their family led to the family never talking about the deceased parent. One participant stated, “My father never mentioned my mother because it upset my stepmother. So in turn, we never talked about my mother either.” Not talking about the deceased was identified by another participant as “the worst thing about the death”, which she attributed to her father remarrying and trying to “forget” her mother.

Another Complicating Factor within the Family Dynamics sub-theme was the loss of extended family. Participants (N = 5) reported that following the death of their parent, previous family connections and relationships ended too. It was most common for the deceased parent’s extended family to disengage (N = 3). However, participants (N = 3) also reported losing connection with their surviving parent’s family as well.

Of the lost connections reported, participants identified multiple factors leading to the loss of family. Some (N = 3) identified that it was too difficult for the deceased parent’s family to remain in contact with their family because of the death. Reasons given were: the deceased parent’s family being angry at the surviving parent for the death (N = 1); and the deceased parent’s family being unable to engage with the family without being reminded of the death. Other participants (N = 2) reported that their family had to move after the death. They attributed moving as the reason their family lost connection with the deceased parent’s family.

All participants who identified losing connection with extended family (N = 5) reported that this was an additional loss due to not having a living connection to their
deceased parent. For example, one participant stated, “I lost my mom, and then I lost contact with her family as well. So I never really got to figure out who she was by the people who knew her best.” Additionally, participants (N = 4) stated that they believed that their deceased parent’s family could have helped them cope with the death, and identified the loss of connection as a loss of support.

Personal Relationships. Changes in peer relationships and community relationships were another Complicating Factor for many participants (N = 6). Personal Relationships were identified as relationships that were established prior to the death that were identified by the participants as a significant part of their lives. The participants identified the loss of such relationships as a Complicating Factor due to no longer having support (N = 4), no longer having a friend outside of the family (N = 3), and feeling abandoned because of the death (N = 4).

Multiple factors led to Personal Relationships changing after the death. Participants reported that they lost friends due to changing schools (N = 2), changing communities (N = 4), and changed attitudes (N = 4). Changed attitudes were identified as their friends no longer wanting to friends due to the death (N = 2), the community withdrawing and ignoring the family after the death (N = 2), and friends being scared of them because of the death (N = 2).

One participant described her closest friend being “weird” around her after the death, which ended their friendship. Another participant described her peers making fun of her for not having a mother. She stated that this resulted in her feeling “alienated” and “different” from the peers she was close with before the death. Overall, participants (N = 5) reported that the loss of Personal Relationships was incredibly painful and confusing. They stated feeling
more alone (N = 3), abandoned (N = 2), and different (N = 4) due to losing friends and community support after the death.

*Positive Factors / Resiliency*

In addition to the challenging and negative experiences reported by the participants, all were able to identify ways that they coped well with the death. The third major theme, Positive Factors / Resiliency, includes aspects which contributed to the participants’ ability to manage their grief and continue to function in their lives. Three sub-themes for Positive Factors / Resiliency emerged which included: 1) Connection to the Deceased; 2) Coping Skills; and 3) Getting Needs Met.

*Connection to the Deceased.* Participants (N = 7) identified that a sense of Connection to the Deceased was a significant help in coping with the death. How the participants felt connected to the deceased varied, and often changed throughout the years. While some participants (N = 3) reported experiencing feeling connected to the deceased from the moment of the death, others (N = 4) described a delayed process of feeling connected.

The sense of connection was defined using three criteria. These criteria included: 1) positive identification with the deceased (e.g. liking physical and personality aspects in yourself that are similar or the same as the deceased); 2) imagining the deceased as part of your life (e.g. watching over you or witnessing your life); and 3) lasting affection (e.g. believing that the deceased still loves you and continuing to love the deceased). Of these three criteria, three participants reported positive identification with the deceased, four reported imagining the deceased as part of their lives, and four reported lasting affection for the deceased.
For example, one participant described experiencing a strong sense of connection to her deceased mother when she had her own daughter:

What I discovered having my own daughter was just this constant reminder that, ‘oh my god, I had this with this woman that I don’t remember...but it had to mean something because this means so much to me’...it’s still pretty powerful to remember those times with my daughter and then knowing that I had that time with my mother before she died...I feel very connected and grateful to my mother.

Other participants (N = 4) reported feeling most connected to the deceased during major life events (e.g., graduations and weddings) and during holidays or celebrations (N = 4). Five participants reported feeling comforted by their connection to the deceased parent and four reported feeling motivated to live a life that they believe their deceased parent would be proud of.

*Coping Skills.* There were a variety of activities reported by the participants that assisted in their ability to manage their feelings and cope with the death of their parent. For this sub-theme, Coping Skills were defined as: 1) talents or skills developed by the participants after the death for the purpose of helping them cope with their grief; and 2) activities that the participant engaged in after the death that were identified as positive experiences. All participants reported at least one talent, skill, or activity they used to help them cope with the death.

The most common coping skill identified was writing (N = 7). Participants described writing as a way to express feelings (N = 4), record memories (N = 3), and write what they were unable to speak (N = 3). Talking about the death was another activity identified by
participants (N = 6) as beneficial. Unfortunately, many participants (N = 7) reported that there were few people in their lives with whom they could talk about the death. Two participants reported that their families sought out therapy, which allowed them an outlet to talk about their experiences.

Other Coping Skills identified included physical activity (e.g. exercise and sports) (N = 3), a sense of humor (N = 3), and helping others (e.g. volunteering) (N = 5). Participants who reported engaging in physical activity described this as positive due to being able to exert energy / negative emotions (N = 2) and being able to focus on something other than the death (N = 2). Another participant, who identified a sense of humor as a coping skill, reported that “being able to laugh and not take things so seriously” helped her feel less “depressed” and “enjoy” activities.

Seven of the participants specifically identified volunteering at The Dougy Center as helping them cope with their own grief through helping other grieving children and families. As one participant stated:

Being at The Dougy Center and being able to explore the different facets of the experience of my mother’s death and the other deaths in my life was so powerful for me...and then, being in the groups with the kids...for the first time I felt needed around something that I had always considered so shameful and here was this new way of looking at it and helping kids look at it and that was so powerful and huge for me.

All seven of the participants who talked about their experiences volunteering at The Dougy Center described this combination of helping themselves in addition to helping others.
Getting Needs Met. After the death, participants (N = 8) reported changes in how they had to get their needs met. Needs were defined as emotional (e.g. affection, attachment, love, empathy, etc.) and physical (e.g. food, clothing, shelter, safety, etc.). For this sub-theme, ways in which participants successfully got their needs met after the death are identified and described.

Participants (N = 8) who were able to get their needs met after the death identified multiple people in their lives who filled the gaps left by the deceased or their family. The most common way participants got their needs met was through friends (N = 4) and surrogate parents (e.g. teachers, counselors, neighbors, and friends’ parents) (N = 4). Participants reported that when they felt they were getting their needs met they had a stronger sense of wellbeing (N = 6), increased self-esteem (N = 4), decreased depressive symptoms (N = 5), and less anxiety (N = 5).

For example, one participant reported that she received praise and positive attention from a teacher. She went on to describe how this “affection” from her teacher led her to feel “connected” to an adult, have “positive sense of self” at school, and feel “able to be okay” despite the fact that her father had died. Another participant reported that her best friend’s mother became “a second mom” to her. She described how her friend’s mother would “attend mother-daughter events” with her, talk with her about her deceased mother, and encouraged her to be “kind and gentle” to herself. This participant stated that this relationship with her friend’s mother “saved” her and helped her to “get what I needed so badly from my mom, who was dead”.

Personal Changes Over Time

The next major theme, Personal Changes Over Time, includes ways in which the participants integrated, rejected, and/or ignored the death of their parent over time. All participants described periods of time in their lives in which they vacillated among all of these stances (e.g. integration, rejection, and denial). Personal Changes Over Time were identified using the following criteria: 1) changes which involved personal feelings, beliefs, and/or behaviors; 2) changes which occurred at least one year after the death; and 3) changes which were directly related to the death of the parent. The three sub-themes that were identified were Delayed Grief, Increased Capacity to Cope, and Choices Impacted by the Death.

Delayed Grief. Participants (N = 5) reported delayed grief reactions to the death of their parent. Delayed grief reactions were defined as intense symptoms directly related to the death of the parent that were not experienced until at least one year after the death. For further clarification, Delayed Grief was identified if the symptoms reported by the participant (at least one year after the death) were more severe than the symptoms experienced at the time of the death.

Some of the participants (N = 2) reported not experiencing grief until they left home in their late teens, while others (N = 2) reported not experiencing grief until later in adulthood. Additionally, two participants described how the death of an additional family member caused them to experience intense grief reactions for their deceased parent:

I had a really delayed grief process of about 30 years, until I fully experienced it. And when I fully experienced it, everything about it changed. Up until that point I thought of my mother as someone that I didn’t remember and didn’t know, and
then, when I finally started grieving, I began to know who she was.

Participants identified having delayed grief reactions due to not feeling safe \( (N = 2) \), not being able to talk about the death in their family \( (N = 4) \), and not understanding the impact of the death until later in life \( (N = 5) \).

**Increased Capacity to Cope.** Another aspect of Personal Changes Over Time identified by participants \( (N = 8) \) was the Increased Capacity to Cope with the death. Increased Capacity to Cope was defined by experiencing less debilitating emotional symptoms and less impairment in daily functioning. Participants reported that age \( (N = 6) \), maturity \( (N = 5) \), and increased ability to reflect on the details of the death \( (N = 4) \) led to changes in their abilities to understand and cope with the death.

For example, some participants \( (N = 3) \) reported believing when their parent died that the death was their fault. This led to immediate feelings of guilt, responsibility, and extreme fear:

I felt so guilty because right before she died she had bought this ring that I think she had made for her. And it was gold with a huge diamond in it and I said something like, `oh, I want that, it’s so pretty!’ and my mom said, `you can have it when I die’, and I said, ‘well I hope you die then’ and then it seemed like she died the next week. Like I know it wasn’t the next week now and that it wasn’t because of what I said…but at the time, it was close enough to seem in my head that I had caused her death.

This participant illustrated how when she was ten years old she believed that her wish may have caused her mother to die, a thought which tormented her and made her feel guilty and terrified. This same participant described how over time, through maturing thought processes
and reassurance from others, she learned that it wasn’t possible for her to have caused her mom to die.

Increased Capacity to Cope was also identified in participants (N = 4) due to having more control over their lives. For example, one participant described how she felt “so powerless and at the mercy” of her family as a child following the death of her father. She reported that “feeling stuck and having no control” caused her to feel “hopeless” and “afraid”. However, transitioning into adulthood, where she felt she had more control of herself, led to this participant feeling “more empowered and less victimized” by her father’s death.

**Choices Impacted by Death.** Following the death, participants (N = 8) reported that their choices were impacted by the absence of their deceased parents. The most impacted events identified were graduations (N = 3), marriages (N = 4), and having children (N = 2). These events were described in the context of having to face such tasks without the deceased parent, and the acute awareness of his or her absence.

As one participant stated, “any sort of transition was either lonely or scary”. Changes and events suddenly became more difficult, and at times focused entirely on the loss, rather than the event at hand:

When I got married I chose to elope...for many reasons, but one of the main reasons was that I didn’t want my wedding to be about the fact that my mom wasn’t there...and you know, if I had had a traditional wedding, everything about that day would have been about my mom not being there.

Events that were once a time of celebration and joy became times where feelings of loss and reminders of the deceased parent were unavoidable.
Participants (N = 7) noted that these events have become more manageable over the years, seemingly in relation to being adults (N = 5) and having more control and choice over how events are celebrated (N = 4). Participants (N = 4) described significant life events as still "sad, but not as anxiety provoking" as they were when they were children. However, all participants reported feeling a resurgence of grief at one or more significant events in their lives due to not being able to share the moment with their deceased parent.

Retrospective Reflections

The last theme that emerged was Retrospective Reflections. Retrospective Reflections were identified as experiences the participants reported to be essential to their ability to manage the death of their parent over time. More specifically, this theme involves ways in which the participants, over time, have made meaning out of the death, and how the participants understand how they managed to survive the experience of losing a parent. Two sub-themes were identified for Retrospective Reflections. These sub-themes are Increased Understanding and Valuing Personal Experiences.

Increased Understanding. All of the participants described how their understanding of the death has changed over the years. The sub-theme, Increased Understanding, includes ways in which the participants have gained knowledge about their deceased parent over time. Additionally, ways in which increased understanding of the death has impacted the participants' thoughts and/or feelings about the deceased parent over time are identified.

All participants reported multiple ways they have obtained information about their deceased parent over the years. Some (N = 4) reported asking relatives and other family members for stories or information. Other participants (N = 2) reported obtaining their deceased parents' belongings (such as diaries and/or medical records). Additionally, one
participant described finding her mother’s friends and talking to them about who her mother was, while another participant reported finding her father’s first wife and her family to learn about her father’s role in their lives.

Participants reported that increasing their knowledge about their deceased parent’s life helped them to feel more connected to the deceased (N = 5), put the death in perspective (N = 6), and learn the facts about the death in a way they were never told as children (N = 6). Increased understanding was also identified by the participants as helping to create a cohesive story about the death (N = 5), decrease personal feelings of guilt (N = 4), decrease feelings of anger towards the deceased (N = 5), and appreciate the time the time had with the deceased (N = 4).

Overall, participants (N = 7) reported that obtaining knowledge about the deceased was beneficial in their ability to accept and understand the death of their parent. Participants also reported that a benefit of information about the deceased was less confusion about the death (N = 4). Additionally, participants (N = 6) who were able to obtain information about their deceased parent reported more empathy for how the death impacted everyone involved.

**Valuing Personal Experiences.** The last sub-theme, Valuing Personal Experiences, includes Retrospective Reflections made by the participants about how the death of their parent has influenced their lives. All participants stated that at one point or another they have valued aspects of their experiences related to death of their parent. As one participant stated:

> Having my mom die and going through all the grief...well, it has certainly made me a much more accepting person and even a more optimistic person...I mean, I miss her like anything...but it's okay now. I am okay now and I like the person I have become.
Another participant described how she valued the person she has become today because she is “stronger” and “more aware of how precious life is”. Other participants (N = 3) reported that their experiences showed them that they could “survive anything”, meaning that having their parent die made them realize they had “great abilities for coping”.

Additionally, participants (N = 5) who stated that they currently value the experiences they had reported less fears about death (N = 2). They also reported less worries about reaching the same age of their deceased parent (N = 4), and less concerns about experiencing similar conditions that led to the death of their parent (N = 3). Overall, participants (N = 6) reported that valuing their experiences has led them to have greater compassion for themselves (N = 3), greater belief in their abilities (N = 2), and greater sense of wellbeing (N = 3).
DISCUSSION

In the previous section, I presented the results of this study that included both initial and main analyses of the data collected. In this final section, I will address how the findings from this study relate to my initial hypotheses and problem statement. First, I will present the limitations of the study, followed by the implications of the findings. More specifically, I will compare findings to current grief theories to demonstrate similarities and differences, variations in the grief process, and ideas for a new overarching child grief theory. I will conclude this section with a summary of this study and suggestions for future research on childhood bereavement.

Limitations of the Study

There were multiple limitations to this study that can be divided into two categories: 1) limitations related to the research sample and 2) limitations related to the research design. Limitations related to the sample included aspects of sample size, demographic of the participants, and information about the participants that was not obtained. On the other hand, limitations related to the research design included aspects of the method used to obtain data and how data was analyzed. In the following paragraphs I will identify both sets of limitations, as well as recommendations for how these limitations can be avoided in future research.

Limitations Related to the Research Sample

There were many limitations related to the research sample. First, this study was only one sample of participants who were all selected from The Dougy Center in Portland, Oregon. There was no random sampling and participants were selected based on being over age 18, their experience of having a parent die prior to age 18, and being a current volunteer
at The Dougy Center. Subsequently, randomness in gender, current age, which parent died, type of death, and age at the time of the death was coincidental.

In addition, multiple aspects of the participants' backgrounds were not obtained. For example, I did not ask about current marital status, ethnicity, social economic status (SES), or religious orientation. I also did not ask the participants about their educational background, current vocation, or family structure at the time of the death (e.g. if their parents were married, etc.).

By omitting some basic demographic and background information questions, I was unable to identify multiple aspects about the participants that may have been useful in understanding their experiences. For example, I was unable to draw conclusions about how grief experiences varied based on demographic and/or identifying information. Another limitation of not obtaining some demographic and background information is that it makes this study difficult to replicate by other researchers. Also, without information about the participants' cultures and life styles, comparison with other studies is also limited.

The first change I would make to this study would be to have used multiple groups of participants. Ideally, this study would have incorporated multiple samples of participants from a variety of locations. While the scope of this study was small due to time restrictions and practicality, in the future I would like to repeat this study multiple times with multiple groups so that comparisons could be made within and between groups.

If I were to repeat this study, I would identify all of the participants' demographic and background information commonly found in other research studies. I would use this information to compare and contrast the findings and make hypotheses about possible correlations. Additionally, I would attempt to recruit a sample of participants with a variety
of diverse backgrounds so that all populations and demographics were represented in the study.

Limitations Related to the Research Design

There were additional limitations related to the research design. First, no quantitative data was collected. Results were purely based on qualitative data collected through an interview process with the participants. By using only qualitative methods, the study was limited because there were no standardized samples to which to compare the data.

This study was additionally limited by the variation of experiences that were presented by the participants. While this study focused on adults who experienced the death of a parent prior to age 18, all of the other factors about the participants' lives were varied. As a result, comparison of the findings to other research was limited.

More specifically, research on childhood bereavement has tended to focus on specific demographic or psychiatric factors, type of death, and/or the person who died. Further, published qualitative research on childhood bereavement has tended to be single subject case studies. Given that I designed this study to examine childhood bereavement without focusing on specific factors, there was inadequate ability to relate the results to the current literature.

To avoid these limitations in future research, I would incorporate a quantitative measure into my research design. By having both quantitative and qualitative measures, I would be able to compare my participants to a standardized sample (from the quantitative measure) in addition to obtaining non-standardized data (from the qualitative measure). I would then be able to use my quantitative measures to compare and contrast how my participants ranked among clinical and normative populations, and what influences these attributes may have on their experiences.
In future research, I would also want to attempt to gather information that would help make my data and results comparable to other published research. For example, in addition to general questions, I would incorporate more specific questions into my qualitative interview. These specific questions would be aimed to evaluate whether or not the participants experienced certain psychological symptoms and/or family events that have been identified as significant in the current literature. By making my research design more comparable, I would be able to look at how experiences are both similar and different from other research and more accurately critique my findings.

Implications of the Findings

As described above, there were multiple limitations to this study that make it difficult to compare the findings to other research or make generalizations about the grief process for children. However, despite the limitations, there are many implications of the findings that are worth discussion. First, I will compare the findings to current grief theories. I will highlight the similarities and differences between the results of this study and current grief theories, focusing on variations in the grief processes of children. Last, the implications of the findings will be used to identify criteria for a new overarching childhood grief theory.

Comparison to Current Grief Theories

Current grief theories for children focus on three aspects, including: 1) descriptions of stages or phases; 2) emphasis on individual experiences and processes rather than a general overview; and 3) the use of other perspectives - such as attachment, development, and trauma theories - to describe grief processes. In developing this study, I departed from these three aspects, focusing instead on a general overview of childhood bereavement that encompassed a wide variety of grief experiences. I hypothesized that the findings from this
study would vary from the current literature because this study was designed to elicit information about long-term experiences and did not focus on psychological symptomology. However, when comparing the findings of this study to the literature, I found that there were both similarities and differences to current grief theories.

**Similarities.** There were multiple similarities between the findings and the current literature on childhood grief theory related to the emotional experiences reported by the participants. First, similar to Grollman (1991) and Goldman (2001), I found that the participants experienced a wide variety of emotional responses and reactions. Both Grollman and Goldman attempted to identify normal grief symptoms in children and clarify common reactions that bereaved children experience. A main criticism of their research is that they failed to clearly define normative versus abnormal symptoms and reactions. Although I was not attempting to differentiate between normal and abnormal experiences in this study, similar to Grollman and Goldman, I found myself trying to understand the difference between various responses.

In my findings, a majority of the participants (N = 8) reported emotional upheaval following the death, and all of the participants described various emotional responses over time. When looking at the emotions reported - such as anger, depression, guilt, anxiety, hopelessness, and fears – it was difficult to determine what would be a normal or abnormal response. Without quantifying data about a symptom – such as duration, frequency, and impact on functioning – I found that there was no way to determine normalcy.

For example, depression may be a normal response to grief, given that over 80% of the participants in the study reported this emotional experience. However, the findings illustrated that experiences of depression varied widely with some participants reporting
becoming acutely suicidal (severe depression) to others reporting being sad at times (mild depression). There are many implications for this finding for the future study of childhood grief responses.

First, it is essential that future research focus on the development of criteria to classify normal versus abnormal symptoms and grief reactions for children. It is not sufficient for symptoms to be labeled as “normal” simply because the majority of the population, or participants in a study, experiences them. Specification about frequency, duration, impact on functioning, and variation in presentation of the symptoms are essential for a comprehensive criteria. Additionally, differentiation between childhood grief symptoms and symptoms characteristic of other childhood psychiatric disorders, such as depression and posttraumatic stress disorder, will need to be established.

Further, emotional reactions and responses for children need to be classified so that their mental health needs can be identified and treated. As shown in the findings from this study, I did not attempt to label emotional reactions as either normal or abnormal. However, by looking at the long-term impact of childhood bereavement, my findings suggested that many of the participants experienced psychological distress and impairment in functioning over a period of years following the death of their parent. Dismissing the emotional grief symptoms of children as “normal” can potentially lead to long-term psychological disturbance and suffering.

Differences. The differences between the findings and current grief theories for children were derived through the research design and analysis of the data. First, unlike other current research, I did not attempt to identify grief stages, match my findings to other theories (e.g. attachment, development, trauma), or focus on one aspect of the grief process. I
also used a qualitative method that gathered data from a retrospective narrative and focused on obtaining information about a wide variety of experiences related to the death.

Unlike current grief theories for children, I demonstrated through my findings that there are multiple aspects of the grief process for children that are significant and important. Current grief theories tend to be vague and focused solely on the direct experience of the loss. For example, Worden’s (1991) four-task model of childhood grief, which is commonly used among professionals (Schuurman, 2003), emphasizes acceptance of the loss, experiencing emotional pain, adjustment, and moving on with life. However, Worden does not discuss how environmental factors - such as family, friends, school, and community - impact this process. He also does not clarify how cognitive abilities, emotional functioning, and behavior influence a child’s ability to move through these tasks.

From the findings of this study, I found that children are impacted by a variety of environmental and personal experiences. By comparing my findings to the current literature, I found that other research has yet to incorporate these aspects into current grief theories. For example, a major finding from this study was how compound losses impact a grieving child. These compound losses included experiences such as the surviving parent no longer being able to care for the child, deaths of other family members, and having a sibling leave the home.

Current grief theories for children do not include information or descriptions of environmental changes or experiences that grieving children may endure. By omitting this information, there is no way to identify possible risk factors that could complicate a child's grieving process. The findings from my study indicated that environmental factors greatly
influenced the grief processes of the participants, and suggested that future research focused on identifying complicating factors would be very beneficial.

For example, studying how environmental factors influence a child’s emotional and behavioral reactions to grief could lead to the development of a screening instrument for mental health professionals to use with grieving children. Such an instrument could have questions that addressed environmental risk factors that would complicate grief – such as moving to a new city, changes in family structure, loss of connection to extended family, and loss of friends. By identifying such risk factors, mental health professionals would have a clearer sense of the grieving child in the context of his or her environment.

Criteria for an Overarching Grief Theory

There are multiple criteria that are needed for an overarching grief theory for children. Based on the findings of this study, I propose that a comprehensive theory must include aspects of individual processes and experiences. This would involve focus on identifying information, such as who died and type of death, as well as aspects related to personal thoughts, feelings, and behaviors immediately following the death and over time.

For example, I would propose that an overarching theory for bereaved children would include similarities and differences of grief reactions based on the demographics of the child (e.g. age, ethnicity). The theory would also include criteria for quantifying normative versus abnormal childhood grief responses. Ideally, an overarching theory would contain data about groups of children based on their age, gender, ethnicity, who died, etc. Inner-group and inter-group similarities and differences would be specified, and reactions and symptoms would be quantified based on the normative criteria.
In addition to similarities, differences, and normative data, I propose that an overarching theory would also include multiple environmental influences that impact a child’s grief process. For example, in this study I found that multiple factors related to family functioning influenced how the participants reacted emotionally and behaviorally to the death of their parent. It is essential that an overarching grief theory for children identify environmental risk factors that may complicate bereavement, such as poverty, a surviving parent’s mental illness, and additional losses the child has endured. Ideally, there would be criteria for environmental risk factors, calculating risk from low to high. Then, based on the level of risk calculated for a bereaved child and his or her family, specific recommendations and interventions could be suggested (e.g. counseling services, community activities, school-based services, or support groups).

In sum, the main feature of an overarching grief theory for children would be functionality. Ideally, an overarching theory would provide clear criteria for identifying and classifying childhood grief reactions, as well as criteria to use to assess a child’s functioning and level of environmental risk. Additionally, an overarching theory would include ways to distinguish the similarities and differences between grief symptoms and childhood psychiatric disorders.

Conclusions

In conclusion, currently there is no grief theory for children that is supported by research or agreed upon by professionals. The lack of a bereavement theory for children is a gap in the research literature on grief, as well as the psychology of children. Mental health professionals use theories to guide research, assessment, and treatment. Without an overarching theory for childhood bereavement, the research has shown that professionals
disagree about the conceptualization and treatment needs of grieving children and their families.

In this dissertation, I designed a study to challenge and surpass current grief theories, and used the findings to advocate for a new overarching theory for children’s grief. Based on the findings from my study, I suggested that a comprehensive grief theory for children would include: 1) criteria to differentiate normative and abnormal grief responses; 2) similarities and differences of grief responses based on identifying data (e.g. age, gender, person who died); 3) criteria to differentiate grief responses from childhood psychiatric disorders; 4) identification of environmental risk factors; and 5) criteria to rate overall risk and corresponding suggestions for treatment and/or intervention. Additionally, based on the multiple limitations of my findings, I provided multiple suggestions for future research.

Future research is vital in the area of childhood bereavement due to the frequency of occurrence and the long-term consequences of grief of children. Based on the results and limitations of this study, I recommend that researchers strive to use longitudinal research that follows bereaved children over a period of many years. I also suggest the use of both quantitative and qualitative measures, so that comparison to current research can be done and similarities and differences can be more readily identified.

Additionally, since many current theories were based on research that was never intended to describe the grief processes of children, I recommend that researchers do not attempt to further clarify stages or tasks of current childhood grief theories. Instead, I suggest that focus be placed on observations of grieving children in their environments, and development of criteria for defining grief reactions.
References


Appendix A

INTERVIEW QUESTIONS

Orienting Questions:

a. Name.
b. Age.
c. Who is the person who died?
d. How did that person die?
e. How old were you when this started (if not a sudden death)?
f. How old was the person when he/she died?
g. How old were you at the time of the death?
h. Were you there when the person died?
i. Who told you about the death (if not present at the death)?
j. Did you go to the funeral home / view the body after the death?
k. Was there a funeral or ceremony? Did you attend (if applicable)?
l. What happened to the body after the death (e.g. buried, cremated, etc.)?
m. Is there a memorial / place where you visit to remember the deceased?
n. Do you visit this memorial (if applicable)?

Main Interview Questions:

1. Tell me about personal changes that you have experienced since the death.
   a. What has felt different, what has felt the same?
   b. Tell me about times in your life since the death that have been particularly
effected by the death (e.g. leaving home; celebrations; graduations; dating;
membership; having children; etc.)

2. Tell me about your family after the death?
   a. Relationships with your surviving parent? Siblings? How have these changed?
   b. How did your family cope with the death and how has this evolved over time?

3. Were there changes in your friends, after the death?
   a. How have your relationships over the years been influenced by the death?
4. Tell me about school following the death?
   a. Did school change for you, such as your ability to perform or grades?
   b. Did your teachers know about the death? What about your peers? How did this affect you?
   c. How has your education over time been affected by the death?
   d. Do you feel that your occupations or hobbies have been, or are, influenced or affected by the death?

5. Do you feel there was any community support after the death?
   a. Did your community connections change (e.g. did you have to move; no longer engage in activities that were previously enjoyed by the family)
   b. Did your family seek counseling services (individual, family, group)?
   c. Have you sought counseling services or engaged in other healing activities since the death?

6. How do you make sense of the death when it occurred? How much was this influenced by what you were told?
   a. How has your understanding changed over time?
   b. What meaning, if any, do you make of the death now?

7. Do you have any thoughts about reaching the age in which the person died, or experiencing similar conditions that caused the death?
   a. What was it like to reach the age (if applicable) OR what do you imagine?
   b. How do you cope with reminders of the death?

8. Looking back, if you had one wish that would allow you to change something that occurred after the death, what would that be?

9. Is there anything else you would like to add, or that you would like to tell me?
Appendix B

INFORMED CONSENT FORM

Pacific University
Informed Consent to Act as a research subject

Childhood Bereavement: A Qualitative Study

Investigator Contact Information

Principal Investigator:
Colleen M. Scott, M.S.
Pacific University, School of Professional Psychology
503-473-1540
cscott@pacificu.edu

1. Introduction and Background Information

You are invited to be in a research study of people who experienced the death of a parent during childhood. You were invited to participate because you are a current volunteer at The Dougy Center. Please read this form carefully and ask any questions you may have before agreeing to be in this study.

This study is being conducted by Colleen Scott, M.S. and is being supervised by Daniel McKitrick, Ph.D. The purpose of this study is to examine how the death of a parent affects a person's life in multiple ways.

2. Study Location and Dates

The study is anticipated to begin January 2006 and to be completed by June 2006. The location of the study will be at The Dougy Center in Portland, OR.

3. Procedures

If you agree to be in this study, you will take part in one 30 to 45 minute individual interview with the experimenter that focuses on your experiences of bereavement. The interview will be recorded on an audiocassette tape.

4. Participants and Exclusion

Only participants who meet the following conditions will be included in the study: 1) aged 18 or older; 2) experienced the death of a biological parent prior to age 18; 3) at least two years have passed since the death of the biological parent; 4) current volunteer at The Dougy Center. Participants who do not meet the above criteria will be excluded from the study.
5. **Risks and Benefits**

There are risks and benefits to participating in this research. Possible risks include feeling uncomfortable and having negative feelings about the subject material. To minimize this risk, all participants have the right to decline to answer any questions, end the interview, and/or withdraw from the study at any time. The experimenter may additionally decide to end the interview process, at her discretion, in order to minimize risk to participants.

Possible benefits include experiencing positive feelings and contributing to the research literature about childhood bereavement.

6. **Alternatives Advantageous to Participants**

Not applicable.

7. **Subject Payment**

You will not receive payment or compensation for your participation.

8. **Promise of Privacy**

The records of this study will be kept private. To protect your identity, your name will only appear on this consent form. The experimenter will be the only person with access to the consent forms and the list of subject’s names.

Subject interviews will be recorded on an audiocassette tape. Audiocassettes from the interviews will be transcribed by the experimenter and then erased. All transcriptions will be numbered and will not include information that could identify participants.

All data will be kept in a locked file cabinet in the experimenter’s home. This informed consent form will be kept separately from any data collected. If the results of this study are to be presented or published, the experimenter will not include any information that will make it possible to identify you as an individual. Audiocassette recordings and transcripts from participants will be destroyed upon the completion of this project.

9. **Voluntary Nature of the Study**

Your decision whether or not to participate will not affect your current or future relations with Pacific University. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences.

10. **Compensation and Medical Care**

Not applicable.

11. **Contacts and Questions**

The experimenter will be happy to answer any questions you may have at any time
during the course of the study. The experimenter can be reached by phone at 503-473-1540 or by email at cscott@pacificu.edu. If you are not satisfied with the answers you receive, please call the interim Institutional Review Board Chair, Dr. Erica Kleinknecht, at (503) 352-2037 to discuss your questions or concerns further. Although Dr. Kleinknecht will ask your name, all concerns will be kept in confidence.

12. Statement of Consent

I have read and understand the above. All my questions have been answered. I am either 18 years of age or over, or my parent/guardian has given consent for my participation. I have been given a copy of this form to keep for my records.

Subject’s Signature

Date
Appendix C

MEANING UNITS

- Immediate change – different person / shift in identity and wellbeing
- Compound loss – surviving parent mental illness
- Introduction of stepparent (negative experiences)
- Compound loss – sibling left home
- Life Choices influenced by loss
- Taking on role of caretaker for younger siblings
- Extended family disappeared (-) / Extended family connection remained (+)
- Postponing grief until later in life
- Grew-up quickly
- Overachievement at school (immediate)
- Underachievement at school (later)
- Helpful activities
- Unable to make meaning out of the death
- Coping with bad memories by thinking of good memories
- Coping by engaging in activities outside of the home
- Wishes (other family members)
- Compound loss – surviving parent unavailable emotionally / physically
- Taking on parental role because surviving parent couldn’t
- Emotional functioning
- Dependence on family
- Friends withdrawing and/or losing friends (-) / friends remained the same (+)
- Relationship difficulties
- School response – teachers
- Rebellious / falling apart in early adulthood (after age 18)
- Changing community (-) / staying in community (+)
- Family didn’t talk about it
- Valuing the person he/she has become since the death
- Independence / separation from family
- Being taken care of by older siblings
- Getting needs met outside of the family
- Coping by trying to learn information about the deceased / make sense of the death
- Caretaking for surviving parent
- Religion (-)
- Compound loss – sibling death
- Compound loss – subsequent deaths of significant family members / friends
Appendix D

THEMES AND SUB-THEMES

*Researcher's Initial Themes and Sub-themes*

1. Immediate Personal Changes
   a. Internal Changes
   b. Behavioral Changes
2. Complicating Factors
   a. Compound Losses
   b. Caretaking Roles
   c. Family Dynamics
   d. Relationships
   e. Community Involvement
   f. School
   g. Religion
3. Positive Factors / Resiliency
   a. Connection to the Deceased
   b. Developed Coping Skills
   c. Getting Needs Met
4. Personal Changes Overtime
   a. Delayed Grief
   b. Valuing Adult Self
   c. Increased Capacity to Cope with the Death
   d. Choices Related to Major Life Events
5. Retrospective Reflections
   a. Wishes
   b. Increased Understanding
   c. Gaining Knowledge / Information about the Deceased
Research Assistant's Initial Themes and Sub-themes

1. Personal Changes
   a. Reaction to the Death
   b. Changing Interests
   c. Relationships
   d. School Functioning
   e. Risky Behaviors / Acting Out
   f. Emotional Upheaval

2. Family Experiences
   a. Relationships with family members
   b. Shifting Roles
   c. Coping Ability of Family
   d. Extended Family Involvement

3. Personal Coping Over Time
   a. Reminders of the Death
   b. Reaching the Age of the Deceased
   c. Wishes About Experience
   d. Additional Losses
   e. Counseling Services
   f. Meaning of the Death

Finalized Themes and Sub-themes

1. Immediate Personal Changes
   a. Internal Changes
   b. Behavioral Changes

2. Complicating Factors
   a. Compound Losses
   b. Caretaking Roles
   c. Personal Relationships

3. Positive Factors / Resiliency
   a. Connection to the Deceased
b. Coping Skills
c. Getting Needs Met

4. Personal Changes Over Time
   a. Delayed Grief
   b. Increased Capacity to Cope
   c. Choices Impacted by Death

5. Retrospective Reflections
   a. Increased Understanding
   b. Valuing Personal Experiences