Everywhere and Nowhere
Grief in Child and Adolescent Psychiatry and Pediatric Clinical Populations

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In her foreword to the book, On Grief and Grieving, by Elizabeth Kübler-Ross and David Kessler, Maria Shriver wrote, “we are a grief-illiterate nation” and “we live in a culture that doesn’t know how to grieve.”1 Western societies have been criticized for struggling with death and bereavement generally, leading to a “public absence/private presence of death.”2 Discussing the death of her husband, Facebook executive Sheryl Sandberg said that grief taught her, “I got it all wrong before. I used to say, ‘Is there anything I can do?’ I used to say, ‘How are you?’ or not say anything. Every mistake that someone else made with me, I’ve made.”3 Why is the culture illiterate with respect to grief? Why do compassionate, thoughtful adults not know what to say when someone nearby is grieving? If this criticism holds for society at large, with adults often ill-equipped to navigate grief, what does this mean for children and adolescents? The purpose of this article is to

KEYWORDS
- Grief • Child • Adolescent • Psychiatry • Pediatric • Illness

KEY POINTS
- Grief is ubiquitous in the experience of children and adolescents with illness but not always recognized or named, and as a result grief is not always treated effectively by child/adolescent psychiatrists or pediatricians.
- Grief can be misinterpreted or treated as stress, anxiety, depression, adolescent moodiness, or behavioral concerns.
- Pediatricians and child/adolescent psychiatrists are often insufficiently educated on the topic of grief.

In her foreword to the book, On Grief and Grieving, by Elizabeth Kübler-Ross and David Kessler, Maria Shriver wrote, “we are a grief-illiterate nation” and “we live in a culture that doesn’t know how to grieve.”1 Western societies have been criticized for struggling with death and bereavement generally, leading to a “public absence/private presence of death.”2 Discussing the death of her husband, Facebook executive Sheryl Sandberg said that grief taught her, “I got it all wrong before. I used to say, ‘Is there anything I can do?’ I used to say, ‘How are you?’ or not say anything. Every mistake that someone else made with me, I’ve made.”3 Why is the culture illiterate with respect to grief? Why do compassionate, thoughtful adults not know what to say when someone nearby is grieving? If this criticism holds for society at large, with adults often ill-equipped to navigate grief, what does this mean for children and adolescents? The purpose of this article is to

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review basic types of grief and discuss how psychiatrists and other clinicians can support grieving youth.

The death of a loved one engenders perhaps the most recognized form of grief that children and adolescents experience—often seen as devastating, disruptive, and outside the natural order of childhood experience (eg, parental or sibling death). Additional losses leading to grief in children and adolescents with medical and/or psychological illnesses are discussed. Curiously, grief is a topic that does not appear in medical education, or in the child and adolescent psychiatry literature, as often as might be beneficial to our clinical work. If child/adolescent psychiatrists remain mindful of the decentering potential of grief in the lives of young people, they can assist patients more ably through this process, decrease isolation, and reduce the impact of comorbidities associated with grief in childhood.

National statistics and studies regarding the prevalence of childhood and adolescent grief are limited and vary in estimates, and some although oft-quoted sources are now outdated. Yet overall, extant sources reveal that grief often touches the lives of children and adolescents. US Census Bureau data have shown that 1 in 20 children under age 15 years has experienced the death of 1 or both biological parents. As high as 92% of adolescents and young adults in a UK study had experienced grief from the death of a “close” or “significant” relationship. In another, 78% of children aged 11 years to 16 years reported experiencing the death of a close friend or relative. Approximately 70,000 to 75,000 children die each year in the United States, and more than 80% of them have siblings who must live with this primary loss. Additionally, 1 to 2 million American children live in single-parent households as a result of a parent’s death. A recent longitudinal study of 7 million people in Scandinavia revealed that youth suffering parental death prior to age 18 remain at increased risk for suicide “for at least 25 years,” and the risk for men is twice that of women. In addition, adults who experienced parental loss as children have 50% higher all-cause mortality rates and die earlier than same-aged adults with living parents.

In 2012 the American Federation of Teachers and New York Life Foundation undertook a national childhood bereavement survey of schoolteachers; 70% of teachers knew at least 1 student who lost a parent, guardian, sibling, or friend in the past year, whereas only 1% received bereavement training in university or graduate school. The impact of grief noted by teachers included: 87% reported grieving students with impaired classroom concentration, 82% observed withdrawal/disengagement and decreased classroom participation, 79% noticed depression/sadness in students, 72% documented student absenteeism postloss, 68% reported lower quality of schoolwork with 66% noting a decrease in homework submission, and 63% observed anger in grieving students—78% of teachers were unaware of any community bereavement supports.

Given such evidence and the lack of bereavement training among teachers, social workers, and other frontline professionals, child and adolescent psychiatrists have an essential role in grief education and clinical practice, and must remain cognizant that grief has the potential to appear anywhere in the lives of children and adolescents, and grieving youth require unique supports.

Grief is not limited to the experience after another person’s death, and clinicians must consider the range of losses that create grief for a child or adolescent. Grief follows diverse losses, including deaths of pets; loss of intact families through separation or divorce; loss of home, neighborhood, friends, and school through moving; loss through adoption or foster care; and loss of loved ones to homelessness, addiction, or incarceration. For youth with medical illnesses, grief can be ubiquitous, emerging from various deficits and constraints that illness imposes on their bodies and life
trajectories. For youth with combined physical and mental health issues, such losses can disrupt multiple domains of life, including physical, social, psychological, educational, familial, and existential, among others. When clinicians recognize that grief arises from differing losses, grief becomes more visible in the lives of youth with illness. For children with chronic or life-limiting illness (medical or psychiatric), the following losses, among others, may occur:

- Loss of connection with school, peers, family, or pets, due to symptoms, prolonged treatment, and/or hospital admissions
- Loss of participation in cherished activities (sports, music, and art)
- Loss of physical capacity, bodily integrity, or prior appearance
- Disruption to developmental trajectories in social, educational, home, and physical spheres
- Loss of personal identity, self-concept, self-esteem, resilience, hope, even stable mood or behavior

Prevalent themes among grieving youth are that their experiences or emotions are not acknowledged, they feel different from peers, and that they often find there is nowhere to discuss their feelings. Children and adolescents may not know peers with similar experiences. Without spaces in which to process and integrate their losses with informed adults or grieving peers, young people may feel confused, guilty, or alone and may miss opportunities for culturally accepted grief support. Thus, although grief may be nearly everywhere for young people, it may also feel to them that it is nowhere—particularly given limited societal grief literacy.

Despite the prevalence and diversity of grief, it remains the case in North American medical education that little time is dedicated to training physicians in the diagnosis or management of grief in adult patients, let alone pediatric patients. Given grief’s broad reach, increased dialogue among child and adolescent psychiatrists, primary clinicians, and interprofessional colleagues is critical to bring child/adolescent grief more into the collective professional consciousness and daily clinical care.

THEORIES AND MODELS OF GRIEF: STAGES VERSUS TASKS

The psychiatrist Elizabeth Kübler-Ross made famous the concept of traditional, ordered stages of grieving (denial, anger, bargaining, depression, and acceptance). In recent decades, however, the field has evolved from this 5-stage model to a set of theories where those grieving must eventually navigate tasks of grief. Well known examples include Worden’s 4 tasks of mourning or grieving, Wolfelt’s 6 needs of mourning, and Rando’s 6 R processes of mourning. Children move through these tasks at different rates, in different order, and over variable periods of time.14 Worden’s classic tasks of mourning for children and adolescents include the following:

1. “Accepting the reality of the loss (according to the developmental stage/age of the child)
2. Working through the pain and emotional aspects of grief
3. Adjusting to an environment in which the deceased is missing
4. Finding ways to relocate the deceased person within one’s life and to memorialize the person”

Many youth find their way through these tasks without requiring professional support, whereas a subset need guidance from clinicians to navigate grief’s complex landscape. Psychiatrists may encounter either group clinically, thus defining terms and reviewing types of grief is useful.
DEFINITION OF TERMS

**Bereavement**
The state of having experienced a loss through death (not the response to such a loss).15

**Mourning**
“The array of psychological processes set in motion by the loss to facilitate adaptation”16 or, “the outward expression of [one’s] thoughts and feelings.”12

**Grief**
“Intense sorrow, especially caused by someone’s death.” (Oxford English Dictionary)
“The psychobiological response to bereavement.”16

The “psychological, behavioral, social, and physical reactions to the perception of loss.”13

Importantly, grief is unique to individuals and no 2 grieve in a similar fashion; thus, people in 1 family grieving the same loss grieve differently. Because grief experiences are sundry, there is no single way to grieve, and terms such as normal or ordinary, although used in the past, are now often avoided. The term typical grief is used by some contemporary writers to capture this concept.

**Acute Grief**
“The initial response, often intense and disruptive, to a loss.”16

A “definite syndrome with psychological and somatic symptomatology.”17

Acute grief occurs in the immediate aftermath of the loss but is often present for several months.

**Integrated Grief**
“The permanent response after adaptation to the loss, in which satisfaction in ongoing life is renewed.”16 The reality of death has been incorporated into life, and one begins to return to active, meaningful participation in a changed life.18 Research indicates that typically within 6 to 12 months, many people transition through acute grief to more integrated grief, although this can take longer.

**Uncomplicated Grief**
Grief experienced after the death of an important person (called “typical” grief by some investigators),14 which often becomes integrated grief 6 months to 12 months later.

Grief is never a linear experience internally—it is unpredictable, with significant ebbing and flowing for adults, children, and youth. This unpredictability and the attendant jumble of feelings and physical symptoms experienced can be confusing for youth. The following is a list of potential symptoms and signs that children and adolescents may manifest during grief.

<table>
<thead>
<tr>
<th>Emotional signs/symptoms of grief</th>
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</thead>
<tbody>
<tr>
<td>• Sadness, with or without crying</td>
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<tr>
<td>• Anger, with or without aggression</td>
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<tr>
<td>• Guilt, blame</td>
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<tr>
<td>• Fearfulness (of being/sleeping alone, or of other family members dying from accident or illness)</td>
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</tbody>
</table>
### Physical symptoms or behaviors of grief

- Anxiety (eg, for others’ physical health and safety)
- Irritability
- Confusion
- A jumble/mix of emotions, difficult to describe or distinguish one from another
- Loneliness, isolation, feeling different from peers
- Low frustration tolerance
- Feeling overwhelmed
- Feeling of going crazy
- Disbelief, denial
- Amotivation
- Ruminating/preoccupation about the death or deceased person
- Yearning to be with the deceased person (common, different entity from active suicidal ideation, must not be pathologized)
- Silliness
- Oppositionality or defiance
- Believing everything is fine

<table>
<thead>
<tr>
<th>Physical symptoms or behaviors of grief</th>
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<tbody>
<tr>
<td>• Fatigue</td>
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<tr>
<td>• Difficulty with concentration, focus, attention, memory (especially at school)</td>
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<tr>
<td>• Speaking rarely or frequently about deceased</td>
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<tr>
<td>• Insomnia, hypersomnia</td>
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<tr>
<td>• Increased or decreased appetite</td>
</tr>
<tr>
<td>• Nausea, abdominal discomfort, diarrhea, gastrointestinal upset</td>
</tr>
<tr>
<td>• Somatic complaints (headaches, pain, drop attacks, and so forth)</td>
</tr>
<tr>
<td>• Regression</td>
</tr>
<tr>
<td>○ Bladder/bowel incontinence</td>
</tr>
<tr>
<td>○ Sleeping with parents</td>
</tr>
<tr>
<td>○ Thumb-sucking</td>
</tr>
<tr>
<td>○ Speaking in baby voice</td>
</tr>
<tr>
<td>○ Separation anxiety</td>
</tr>
<tr>
<td>• Aggressive outbursts at any age (or angry play in younger children)</td>
</tr>
<tr>
<td>• Nightmares</td>
</tr>
<tr>
<td>• Withdrawal from family/friends</td>
</tr>
<tr>
<td>• Imitation of deceased person</td>
</tr>
<tr>
<td>• Restlessness</td>
</tr>
<tr>
<td>• Behaving as if everything is fine</td>
</tr>
<tr>
<td>• Decline in school performance; school avoidance</td>
</tr>
<tr>
<td>• Substance use (drugs, alcohol, and so forth)</td>
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<tr>
<td>• Self-injurious behavior</td>
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<td>• Other high-risk behaviors</td>
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</tbody>
</table>
GRIEF AND DEVELOPMENTAL STAGES

Young children, school-aged children, preteens, and adolescents grieve differently according to their different cognitive and emotional developmental stages, and this can confuse adults around them. What follows is a brief introduction to grief and developmental stages.

Bowlby,19,20 and others describe infants detecting caregiver absences, so routines should be maintained as much as possible when a parent or caregiver dies. Preschool children do not yet comprehend death as permanent. Believing it is temporary, they often ask if the deceased is still eating, walking, or sleeping or when the deceased will be returning. Again, routines and schedules are to be maintained as much as possible with familiar caregivers. Younger children typically grieve in bursts or doses, for example, embarking on death-related play during the funeral or social gatherings after a death. They may halt play, ask a trusted adult detailed questions about the death, and then swiftly return to other play and laughter. This is normal grief behavior for young children and should be understood in developmental context and not pathologized. Magical thinking characterizes this age—children may believe they caused the death or are somehow to blame for their thoughts, words, or deeds. Younger children do not possess comprehensive language or understanding for the emotions of grief, and this can lead to palpable confusion, loss of control, and acting out. Adults can help by providing age-appropriate details about illness, death, funerals, and so forth, in small doses, with concrete explanations. They can show by example it is okay to cry and talk about and remember the deceased in various ways over time.

Schoolchildren may focus more on their own needs and concerns than on the deceased. They may ask questions about who will put them to bed, take them to school, make lunches, or drive them to lessons or games in lieu of the deceased. School-aged children begin to understand death’s finality and may focus on the surviving parent/caregivers, worrying significantly about their health or potential death. They often ask specific, scientific questions about death, what happens to the body once buried, and so forth. They may still hold magical thoughts, believing they somehow caused the death, which may induce regret, fear, and self-blame. It is essential to reassure children the death is not their fault. Adults can provide consistency, reassurance, and honest, developmentally-appropriate answers to this age group.

For adolescents in Western cultures, it is developmentally appropriate to process feelings, thoughts, and stressors with peers, not parents. It may be unrealistic, therefore, to expect a teenager to discuss grief or death with a parent. Adolescents and children wish to appear normal, and grief marks them as different from peers, thus underscoring their yearning. They may be unwilling or unable to discuss grief with any peer inexperienced with it, which can lead to a double sense of isolation for adolescents. Externalizing and internalizing tendencies may drive risk-taking behaviors, substance use, changes in personality and school performance, and so forth. Piaget’s formal operations stage affords adolescents the capacity for existential and abstract thought, thus increasingly adult approaches to grief.21 Teens may thus eschew familial world views (eg, religious beliefs, rituals, and values). After a death, grieving teens may find previously held religious beliefs challenged; similarly, those without prior faith may explore spirituality. Overall, grieving adolescents are greatly aided by finding other grieving teens, and family bereavement centers can be safe havens for peer support.

An informed child/adolescent psychiatrist or primary physician can normalize aspects of grief; anticipate symptoms of grief for clients/families; provide psychoeducation, support, and risk assessment throughout the tasks of grief across developmental stages; and remind families and clinicians not to over-pathologize grief in youth.
COMPLICATED GRIEF

Because many children and adolescents move toward integrated grief without professional intervention, it can be clinically challenging to know when to intervene or when to let grief travel its natural course. It becomes important, therefore, to resist the temptation to provide unnecessary therapy or medications and to develop skills to discern when grief warrants intervention.

Thoughts, emotions, and behaviors may arise during grief that (1) persist longer than expected by cultural norms and evidence-based expectations, (2) disrupt the natural progression from acute to integrated grief, and (3) become maladaptive. This extended and problematic process is called complicated grief (CG) or prolonged grief and requires intervention by the child/adolescent psychiatrist. CG is a term used by researchers for more than 20 years to describe grief that does not progress to integrated grief but becomes persistent and impairing instead. A similar entity is called prolonged grief disorder (PGD), a phrase that arose more recently in grief literature. In the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (DSM-5), an entity called “Persistent Complex Bereavement Disorder” appeared in an effort to combine criteria and concepts from both CG and PGD. Although lack of consensus remains about precise terminology, there is recognition of an entity characterized by longer duration and severity than that found with acute grief and by impeded/delayed progression to integrated grief. The DSM-5 definition and criteria include a shorter duration for extended grief symptoms in children than adults (6 months vs 12 months). Complicated or prolonged grief is intense, turbulent, intrusive, prolonged, and maladaptive. The term, complicated, is used in the medical sense—to indicate a process that impedes, slows, or complicates healing and integration. CG “is a distinct mental health disorder,” and research indicates it affects 2% to 7% of the population. Symptoms of CG or PGD include “intense yearning, longing, or emotional pain, frequent preoccupying thoughts and memories of the deceased person (or avoidance of such thoughts), a feeling of disbelief or an inability to accept the loss, and difficulty imagining a meaningful future without the deceased.” It also includes deep sorrow, perseveration about details pertaining to the death, self-blame, feeling alone, feeling empty, or feeling that life has little purpose now. Poor health outcomes are associated with CG in adults, including lower quality of life, cardiovascular disease and cancer, disrupted sleep, and suicidal ideation. Research on CG has been conducted primarily with adults, but studies in children/adolescents show that young people also experience CG. Familiarity with this entity is, therefore, paramount for clinicians.

Symptoms of complicated or prolonged grief must be distinguished from other comorbidities that impair functioning. Important distinctions exist among grief, major depressive disorder, and posttraumatic stress disorder (PTSD) (Table 1). If child and adolescent psychiatrists and pediatricians are aware of these differences, they will be better equipped to diagnose, guide, support, and recommend interventions for grieving patients. The adult literature reveals that a significant percentage of patients with bereavement-related depression also have CG. Likewise, among patients with CG, many experience depression. It remains to be seen with further research if similar trends exist in children and adolescents.

ANTICIPATORY GRIEF/MOURNING

Anticipatory grief is a term coined in 1944 by Erich Lindemann, a psychiatrist at Massachusetts General Hospital studying trauma-related grief after a historic fire in Boston, where many survivors with severe burns were treated at his hospital. Lindemann defined anticipatory grief as a response to the threat of death, rather than to death itself.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Complicated Grief</th>
<th>Major Depression</th>
<th>Posttraumatic Stress Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affective symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressed mood (sadness)</td>
<td>Prominent, focused on the loss; core symptom</td>
<td>Prominent; diagnostic criterion</td>
<td>May be present</td>
</tr>
<tr>
<td>Anhedonia (loss of interest or pleasure)</td>
<td>Not usually present (and interest in thoughts of deceased is usually maintained)</td>
<td>Prominent and pervasive; diagnostic criterion</td>
<td>May be present</td>
</tr>
<tr>
<td>Anxiety</td>
<td>May be present, focused on loss and insecurity without the deceased</td>
<td>May be present</td>
<td>Prominent, focused on fear of recurrent danger; diagnostic criterion</td>
</tr>
<tr>
<td>Yearning or longing</td>
<td>Prominent, frequent, and intense; core symptom</td>
<td>Not usually present</td>
<td>Not usually present</td>
</tr>
<tr>
<td>Guilt</td>
<td>Common, focused on regrets related to the deceased</td>
<td>Usually present, related to feeling worthless and undeserving</td>
<td>May be present, focused on the traumatic event or its aftermath</td>
</tr>
<tr>
<td>Cognitive or behavioral symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>May be present; not a core symptom</td>
<td>Common; diagnostic criterion</td>
<td>Common; diagnostic criterion</td>
</tr>
<tr>
<td>Preoccupying thoughts</td>
<td>Common, focused on thoughts and memories of the deceased; core symptom</td>
<td>May be present, focused on negative thoughts about self, others, or the world</td>
<td>Negative, exaggerated, distorted thoughts related to event; diagnostic criterion</td>
</tr>
<tr>
<td>Recurrent preoccupying images or thoughts</td>
<td>Common, focused on thoughts or memories of the deceased</td>
<td>May be present</td>
<td>Common, focused on event, usually associated with fear; diagnostic criterion</td>
</tr>
<tr>
<td>Avoidance of reminders of the loss</td>
<td>Common, focused on reminders of the finality of the loss and associated emotional distress</td>
<td>May be present, related to general social withdrawal</td>
<td>Common, focused on loss of sense of safety or reminders of event; diagnostic criterion</td>
</tr>
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</tr>
<tr>
<td>Seeking proximity to the deceased person</td>
<td>Common, focused on wanting to feel close to the deceased</td>
<td>Not usually present</td>
<td>Not usually present</td>
</tr>
<tr>
<td>Suicidal thinking and behaviors</td>
<td>Suicidal ideation often present; increased risk of suicidal behavior</td>
<td>Suicidal ideation present; diagnostic criterion; increased risk of suicidal behavior</td>
<td>Suicidal ideation present, increased risk of suicidal behavior</td>
</tr>
<tr>
<td>Abnormal eating behaviors</td>
<td>Avoiding certain foods or mealtimes to avoid reminders of the loss or eating favorite foods to feel close to the deceased</td>
<td>Change in eating due to change in appetite; diagnostic criterion</td>
<td>Not usually present</td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disturbed sleep</td>
<td>Sleep disturbance related to avoiding bed or other reminders of the loss or rumination about troubling aspects of the death</td>
<td>Sleep disturbance common; diagnostic criterion</td>
<td>Sleep disturbance related to anxiety; diagnostic criterion</td>
</tr>
<tr>
<td>Nightmares</td>
<td>Not usually present</td>
<td>May be present</td>
<td>Related to the traumatic event; diagnostic criterion</td>
</tr>
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</table>

Anticipatory grief is now understood to occur before an impending death.\textsuperscript{18} It is experienced by loved ones and individuals facing their own impending death. It is distinct from grief that occurs after death, although there are shared features. Anticipatory grief not only focuses on future losses but also on past and present losses too. This combination differentiates it from post-loss grief: there is some rehearsal of death, attempts are made to accept death or adjust to its consequences before death occurs, and time remains to resolve issues and say goodbye. Grief scholar Therese Rando\textsuperscript{25} advocates for the term, \textit{anticipatory mourning}, versus anticipatory grief, arguing the former conveys a more complex experience that better represents the anticipatory process. In this article, the phrase “anticipatory grief” is used for simplicity’s sake.

Relatives of a dying person can experience debilitating anticipatory grief, with resultant emotional confusion, hypervigilance, difficulty concentrating or making decisions, and sleep or appetite disruptions producing exhaustion. Anticipating the death of a child creates an unfathomable state for parents or siblings. During anticipatory grief, a person is in the present moment with an ill loved one, while simultaneously mourning both the person who existed in the past and the future the person will never enjoy. Anticipatory grief can engender similar emotional and physical symptoms as those from grief after death. Anticipatory grief cannot be stopped, fixed, or completely averted. A crucial role of the child/adolescent psychiatrist is to recognize, name, contain, and support the experience of anticipatory grief for those enduring it, which reassures them they are experiencing a known entity that others have endured before.

\textbf{DISENFRANCHISED GRIEF}

Kenneth J. Doka,\textsuperscript{26} a scholar who has written extensively on disenfranchised grief for 30 years, defines this term as grief that “results when a person experiences a significant loss and the resultant grief is not openly acknowledged, socially validated, or publicly mourned. Disenfranchised grief is grief that is not culturally recognized. There is no social recognition that the person has a right to grieve, or “a claim for social sympathy or support.”\textsuperscript{26}

Examples of disenfranchised grief include grief after miscarriage or the death of a lover from an affair, the death of a partner from any culturally unsanctioned/unsupported relationship, or grief after the loss of physical integrity (eg, amputation or mastectomy). It may arise from multiple pregnancy losses or failure to conceive a child or for adolescent girls who have lost a pregnancy undisclosed to family members through miscarriage or elective termination. It may be grief over the death of an unknown biological parent. These and many other losses are sources of disenfranchised grief, and clinicians must consider this entity when younger patients present with emotional distress without verbalizing underlying etiology or appear to struggle with disclosure involving loss.

\textbf{CHILDHOOD TRAUMATIC GRIEF}

Bereaved children can develop a form of maladaptive grief associated with death-related trauma symptoms.\textsuperscript{27} Judith Cohen, Anthony Mannarino, and Esther Deblinger\textsuperscript{14} have researched extensively the treatment of children and trauma, and have written about the concept of childhood traumatic grief (CTG). They describe traumatic grief that develops after certain types of death/loss, including violent, accidental, sudden, and unexpected deaths (eg, from war, terrorism, suicide, homicide, and natural disasters). These can cause maladaptive patterns of grief and related cognitions and behaviors, wherein “both unresolved grief and PTSD symptoms are present, often accompanied by depressive symptoms as well.”\textsuperscript{14} These investigators caution that
children and adolescents can also develop CTG after deaths/losses that may not be violent, sudden, or deemed “traumatic” by adults around them. One study of children and teenagers revealed that those who endured a parent’s death after a lengthy illness “were more likely to develop PTSD and maladaptive grief symptoms than those who experienced the death of a parent due to sudden natural causes (eg, heart attacks).”27 When treating youth with any history of grief or trauma, it is vital to remember these 2 entities may be linked, and trauma and grief may require separate treatment approaches to help the youth with CTG.

Cohen and colleagues14 have developed a validated therapeutic intervention for CTG, called trauma-focused cognitive behavioral therapy (TF-CBT). Their research and that of others have demonstrated that TF-CBT interventions focused on trauma and CTG produce improvement in maladaptive and trauma-related symptoms. They recommend, however, that as a general rule, trauma issues should be addressed before grief issues can be appropriately navigated. They further note that CTG comprises a broader range of experiences and symptoms than the DSM-5 entity Persistent Complex Bereavement Disorder. Children may develop CTG if they see or hear vivid images of a dying loved one’s suffering or death if they also did not comprehend that person would die from his/her illness, or if they blame themselves for the death. Some children also develop somatic symptoms from the inability to process these experiences and negotiate the traditional tasks of mourning or grief.

GRIEF IN SOMATIC SYMPTOM AND CONVERSION DISORDERS

While assessing or treating children or teens with any of the types of grief described previously, psychiatrists may encounter significantly impairing physical symptomatology. Likewise, when observing somatic symptom or conversion disorder symptoms, psychiatrists may be sitting with a grieving youth. Somatic symptom and conversion disorders have been described for centuries, including in ancient Egyptian and Greek writings, and are increasingly common reasons for children and adolescents to see psychiatrists. Research from the 1980s and 1990s supports the concept that unresolved grief can cause conversion disorder in children and adolescents. In 1980, Michael Maloney28 published a study exploring conversion reactions in 105 children and teens in which 54% had “unresolved grief reactions.” Wolfelt29 also noted that converted grief results in somatization and conversion reactions and called this a “grief avoidance response style,” whereby the person unconsciously protects him/herself from the pain of loss and the psychological pain converts into physical symptoms. Lewis and Shonfeld30, wrote that surviving children of deceased parents or siblings may develop conversion symptoms from identification with the dead loved one. Although this topic has not been extensively explored in recent literature and current research is required, it reminds clinicians to consider the possibility that grief may underlie a majority of somatic symptoms and conversion disorder presentations in youth. Addressing the grief may yield swifter resolution of impairing somatic symptoms in these conditions that historically have been difficult to treat.

TREATMENT INTERVENTIONS FOR GRIEF IN CHILDREN AND ADOLESCENTS

Death and its attendant losses are permanent. The death of a loved one cannot be reversed in the life of the child or adolescent who endures it. Because losses last a lifetime, grief can too. Grief does not disappear; rather, it ebbs, flows, lessens, and evolves over time but is not something young people necessarily get over or complete. As previously described, however, many children and adolescents traverse the tasks of mourning and find their way to integrated grief without professional assistance.31
The same is true of adults, and there is a body of literature on resilience that indicates it can be unproductive to introduce what Freud called “grief work” to a person when it is not needed. For the smaller percentage of those who experience grief that significantly disrupts functioning in the months or years after a death, therapeutic interventions can facilitate more constructive coping and the road back toward integrated grief.

Bereavement counselors and family bereavement centers offering peer-support groups are excellent resources for families and youth experiencing the death of loved ones. These centers provide stabilizing support, education, processing space, and healing activities, and they provide a community of youth and families who understand, which mitigates the isolation so common in grieving youth. These centers often hold special events during holidays—Mother’s Day, Father’s Day, and so forth—which can help families navigate such moments in a supportive and safe environment. Agencies dedicated to specific diseases such as cancer and Alzheimer’s disease, often provide support groups for bereaved families or for current caretakers enduring anticipatory grief. Child and adolescent psychiatrists may be called on to assess children/adolescents referred from these centers, from bereavement counselors, or from schools and pediatricians when grief appears complicated/prolonged or when it fails to respond to initial interventions. It is therefore important to maintain a list of local grief counselors, family bereavement centers or agencies, and related resources in one’s region (eg, Compassionate Friends, community support groups, religious organizations, local bereavement counselors, and online resources). Child psychiatrists are further aided by knowing what interventions are empirically validated and what other therapeutic options might be clinically valuable.

Research has demonstrated that different psychotherapeutic interventions can be helpful in supporting a young person’s grief. Among these, CG therapy (CGT) has been rigorously evaluated and found more effective than interpersonal therapy for CG/PG. It is a structured course of weekly therapy focusing on resolving complications related to grief and supporting adaptation to the loss, with 2 main components: (1) restoration of function by finding enthusiasm and future planning and (2) integration of thoughts about the death that evoke less intense emotions, with incorporation of the loss and resumption of a meaningful life without the deceased person. Evidence supports allowing the bereaved person to tell and retell the story of the death, until it has been better incorporated and processed. As previously discussed for CTG, TF-CBT is an evidence-based structured approach offered through training workshops and literature to guide the clinician in therapy, with 10 trauma-focused components and 4 grief-focused components. Family-focused grief therapy (FFGT) is a form of family therapy specific to bereaved families in the palliative care setting and has shown modest positive outcomes in functioning for specific types of families. For psychiatrists unable to obtain training in CGT, TF-CBT, or FFGT, or in whose region family bereavement centers are not available, other more generalized psychotherapeutic strategies will still prove valuable.

First and foremost, it is important for child psychiatrists and other clinicians to use active listening with grieving children and teens, and grant safe space in which they can tell and retell their stories of grief, until they feel the narrative is more integrated. Provide psychoeducation about grief, its symptomatology, and its unpredictability, duration, and uniqueness for each person. An important component of therapeutic interaction is to normalize grief experiences and provide reassurance youth are not going crazy (if they describe preoccupation with the deceased, talking to the deceased, distractibility, and so forth). Other strategies include: reassuring youth that the death was not their fault—this can be stabilizing and anxiety-reducing; encouraging parents to be transparent about the death circumstances and to let children...
attend funerals, with adequate support; helping youth identify their personal supports/circles so they know whom to call, text, and so forth when they need to talk or emote or want reassurance or guidance; reinforcing young patients’ resilience and ability to tolerate their grief. Reinforce young patients’ resilience and ability to tolerate their grief. Finally, helping youth identify which of Worden’s tasks of mourning is most troublesome and providing support through the tasks of mourning can be useful.

Explore defenses mechanisms and positive and negative coping styles. Differentiate depression from grief and provide anticipatory guidance about the potential for CG. Identify avoidance behaviors and teach youth to avoid avoidance (ie, there is no way through it but through it). Cognitive behavioral strategies to help grieving youth reframe negative cognitions (filtering, personalizing, catastrophizing, and so forth) can be extremely helpful, and reality testing or generating evidence for/against can assist with prevalent guilt. Work with children/teens to create coping skills toolboxes, including strategies for use when they feel overwhelmed (coping cards, emotion-regulation strategies or options, and so forth). Help children memorialize and retain connection to their loved ones through memory boxes, artwork, writing letters, keepsakes, or what Volkan and others call “linking objects.” Recognize that death anniversaries, birthdays, holidays, special days such as Mother’s Day, Father’s Day, and graduations, may be triggering events for grief, and encourage youth or families to plan ahead as to whether/how they might observe these events, which will afford control and predictability. Connect youth to local or online family bereavement groups or community grief networks.

Clinicians can further participate in additional grief training online or through workshops/conferences; they can help develop grief curricula for professional students they supervise and can advocate at regional, state, and provincial levels for greater grief awareness for children, youth and families in schools, hospitals, health centers, and so forth.

Psychiatric medications, such as selective serotonin reuptake inhibitors (SSRIs) and mirtazapine, may be beneficial primarily if there is comorbid depression, anxiety, insomnia, or poor appetite, or if a clinician is concerned about suicidal ideation from clinical depression. Research on psychopharmacology in grief is limited, and to date has largely involved adult subjects. Some evidence suggests that SSRIs can be helpful in both symptom relief and treatment adherence. Benzodiazepines have not been found helpful, similar to findings in PTSD, where benzodiazepines are ineffective in improving outcomes. Given a lack of definitive data, the general approach in child and adolescent psychiatry—that of trialing therapy/counseling for a period of months prior to initiating medications—may prove the most prudent course. If evidence of significant suicidality, major depressive disorder, or impairing anxiety or panic symptoms exists, an SSRI trial should be more swiftly considered, based on clinical judgment and in accordance with standard best practices.

SUMMARY

As she was dying, Elizabeth Kübler-Ross reflected on her 5 stages of death and dying and recognized that the particular stages themselves and the order therein were not absolute. She wrote, “I now know that the purpose of my life is more than these stages…I have loved and lost, and I am so much more than five stages. And so are you.”

The work of child and adolescent psychiatrists, among other clinicians, in supporting youth who are grieving, extends beyond an earlier, 5-stage model of grief. Different professionals will have different training or skill levels in supporting grieving children and adolescents, and different community bereavement resources exist depending on practice location. In the context of this variability, child psychiatrists at minimum must seek
education that allows them to differentiate the various forms of grief experienced by young patients and to offer useful interventions. The provision of active listening; psychoeducation about grief—its physical, psychological, and spiritual effects; and the primary tasks of mourning, performance of risk assessment, and teaching of coping strategies are all important components of effective work with grieving children and families.

Because so little about grief is taught in medical school and residency, child and adolescent psychiatrists must attend to this knowledge gap in their own continuing medical education and in their teaching of trainees. Although education on death and dying and end-of-life communication is growing in the profession, it is not the same as education about grief, especially with youth. Advocacy and curricular development can ensure the next generation of medical professionals is adequately equipped to support grieving young patients and families. The Dougy Center (The National Center for Grieving Children & Families) in Oregon suggests to families that if a child needs help with grief due to impaired functioning after a death, the family should feel free to seek the advice of a qualified mental health professional and not be afraid “to ask about their experience and training in grief and loss, and their treatment philosophy and methods.”

Grief may indeed be everywhere for children who have physical and/or psychological illness, yet medical providers do not always recognize or describe it as grief. Clinicians, educators and other providers who focus on whole-person and family-centered care will want to attend to childhood, adolescent and family grief by increasing the space and time within clinics, schools, and communities for children and teens to give voice to grief—both the nonpathologic and complicated/prolonged forms alike. They, and we, can serve as a powerful collective voice to increase grief literacy and resilience in patients, communities, schools, and society at large (Box 1).

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<thead>
<tr>
<th>Box 1</th>
<th>Selected resources for clinicians</th>
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<tr>
<td>Center for Complicated Grief at the Columbia University School of Social Work (<a href="http://www.complicatedgrief.org">www.complicatedgrief.org</a>)</td>
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<tr>
<td>Compassionate Friends network (<a href="http://www.compassionatefriends.org">www.compassionatefriends.org</a>)</td>
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<tr>
<td>The Dougy Center/The National Center for Grieving Children &amp; Families (<a href="http://www.dougy.org">www.dougy.org</a>)</td>
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<td>National Alliance for Grieving Children (<a href="https://childrengrieve.org">https://childrengrieve.org</a>)</td>
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<td>Olivia’s House (<a href="http://www.Oliviahouse.org">www.Oliviahouse.org</a>)</td>
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<td>Winston’s Wish (<a href="http://www.winstonswish.org.uk)%E2%80%94UK">www.winstonswish.org.uk)—UK</a> charity for bereaved children</td>
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<td><a href="http://www.Helpwithgrief.org">www.Helpwithgrief.org</a></td>
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<td><a href="http://www.Centerforloss.com">www.Centerforloss.com</a></td>
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Some clinical instruments used in adult grief assessments

- Brief Grief Questionnaire
- Inventory of Complicated Grief
- Hogan Grief Inventory
- Texas Revised Inventory of Grief
REFERENCES