Review Paper

Adjustment to Parental Loss in Childhood and Adolescence

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ABSTRACT

Parental loss is likely to be a stressful life event for bereaved children. Several studies have shown an increased risk of mental ill-health and psychosocial problems among affected children. The aim of this study was to systematically review literature in this area and to identify gaps in the research. Results indicate that research in this area is still in its infancy. While this topic has generated some interest in the West, particularly in the last 2 decades, no published literature in the Indian context was available. The importance of research in the Indian context pertaining to this area is elucidated.

Key words: parental loss, bereaved, childhood, adolescence

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INTRODUCTION

Childhood and adolescence are crucial developmental stages in an individual's life. The process of development encompasses physical, cognitive, social and emotional development. Both maturational and learning processes play a role in development. Parents are a child's first window particularly to emotional and social development. Parental loss in childhood/adolescence is therefore a significant event that a child/adolescent has to adjust to in multiple ways.

EARLY PARENTAL LOSS AND ADULT PSYCHOPATHOLOGY

A significant body of existing work draws associations between early parental loss and adult psychopathology. Schlesinger [1] draws links between early parental loss and difficulties in adult life. These difficulties can present in various forms which include anxiety, depression, anger towards the deceased parent, guilt, feelings of powerlessness or helplessness.

Eminent psychoanalyst, Salman Akhtar [2] talks about the 'myriad manifestations of parental loss' in childhood. These include a continued intrapsychic relationship with the dead parent, mental pain and defences against the loss, narcissistic imbalance, disturbances in the development of aggressive drive, problems in the realm of love and sexuality, disturbances in the subjective experience of time, and attitudes towards one's own mortality.

Studies have been carried out on how parental loss in childhood can contribute to adult psychopathology [3-4]. The studies indicate that early parental loss can contribute to alterations in cortisol levels, and change in the Hypothalmic – Pituitary – Adrenal Axis functioning in adulthood.

THEORIES OF GRIEF

Bowlby [5] propounded one of the first theories of grief. According to this theory, there are 4 stages of grief – numbing, yearning and searching, disorganization, despair and reorganization. Elisabeth Kubler Ross's model of grief is one among the most well known for explaining adult grief reactions [6]. It talks about stages of grief starting with denial, anger, bargaining, depression and finally culminating in acceptance. However, various aspects of the model have been criticised, particularly its failure to expound on its theoretical basis and it's lack of empirical validity [7]. The model has also not been found to be applicable to children and adolescents.

Worden and others [8] proposed a model for grief in children. He distinguished among four tasks of mourning for children who have undergone parental loss: (1) accepting the reality of loss, (2) experiencing the pain or emotional aspects of loss, (3) adjusting to an environment in which the deceased is missing, and (4) relocating the person within one's life and finding ways to memorialize the person.

According to the Transitional Events Model [9] children's adjustment following a major stressful event such as parental death is heavily influenced by the cascade of stressful events that occur following the death. The model proposes a dynamic relationship between the smaller, more proximal stressful events a child experiences following the death (e.g., separation from other family members, parental distress, financial difficulties), the child's protective resources (e.g., self-esteem, coping skills, positive parent-child relationship), and the interaction between the proximal stressful events and protective resources.This model has been more applied in studying children's adaptation to other major stressful events but less often used in understanding bereavement. It seems applicable to bereavement as well.

PSYCHOLOGICAL ADJUSTMENT TO PARENTAL LOSS

Psychological adjustment is defined as normative, age-appropriate behaviour and functioning that follows a course of positive functioning into adulthood. Psychological adjustment includes behavioural functioning, emotional functioning, social functioning, and quality of life [10]. Methods for assessing psychological adjustment in children are diverse and can include checklists, questionnaires, and clinical interviews which may be completed by many informants including the child, parents, teachers, and/or other individuals who interact with child [10]. There are a number of theories that explain psychological adjustment/adaptation to stressful events in adults. However, theories on psychological adjustment in children are few. Considering the developmental differences between children and adults, one may presume that there will be differences in the way children and adults process and adjust to traumatic situations.

Lieberman and others [11] date back literature on parental loss to the writings of Anna Freud [12], Dorothy Burlingham [13], Rene Spitz [14], John Robertson [15] James and Joyce Robertson [16] and John Bowlby [17-18]. These early studies did not focus on the actual physical loss of a parent but on the responses of infants, toddlers and pre-schoolers to protracted separation from their mother or parents due to a variety of reasons such as war, hospitalization, maternal incarceration, or family circumstances. Some of the earliest work in this area was carried out by Anna Freud and Dorothy Burlingham [19]. They opined that infants and toddlers may respond with intense grief to both prolonged separation and loss because in both situations the emotional impact of the parent's absence is immediate and severe. The responses of children to loss observed by Anna Freud included intense anxiety and fear that the loss was a permanent one and regressive behaviour.

Lieberman [11] has extensively studied the impact of parental death in infancy and early childhood and has drawn up guidelines for the treatment of traumatic bereavement in infancy and early childhood. The authors opine that loss of a parent during the first 5 years of life is always traumatic because the child is still in the process of building a separate sense of self that is reasonably autonomous of the parent's

protection. Foster and Sissler [20] concluded that even children as young as 4 years will show expressions of grief, though their reactions to the death may not conform to social conventions or closely mirror those of adults.

Early studies in this area talk about 'pathological mourning' [21], following the death of a parent in terms of depressed mood; phobic disorders; and school refusal [22-23]. However, most often, they are descriptive and based on psychoanalytic case studies [24], or consider children referred for psychiatric difficulties [25].

Studies have examined impact of parental loss on children and adolescents using different methodologies and at varied time points. Some of the significant ones are reviewed below in detail.

The Harvard Child Bereavement Study (HCBS) [26] was one of the pioneering longitudinal studies in this area. The authors interviewed and tested 125 children between the ages of 6 and 17 and their families. Of these children, 74% had lost a father, and 26% had lost a mother. A control group of 70 children were also studied. Standardized instruments, such as the Smilansky Death Questionnaire and the Child Behavior Checklist, the Self Perception Profile, the Locus of Control Scale as well as interviews, were used in this study. Children and their surviving parent were assessed four months, one year, and two years after the death.

Most of the difference between the two groups was not apparent until two years after the death. The bereaved showed higher levels of social withdrawal, anxiety, and social problems as well as lower self-esteem and self-efficacy. Although most bereaved children did not show signs of major emotional / behavioural disturbance, there was a significantly large group of children who showed serious problems at one year (19%) and at two years (21%). Somatization increased during the first year after the death of a loved one in 13% of the children studied [11]. Parents and teachers were seen to observe outbursts of anger and acting-out behaviour among children who have lost a loved one.

The strengths of the above study lie in its longitudinal design and use of both child and parent measures to understand how school age children adjust to parental death. However, there has been no measure of child's behaviour prior to parental loss. Also, details of the content of the semi – structured interviews used in the study have not been provided by the authors and there is no analysis of the information generated from the interviews. Thus, there is no qualitative analysis and the essence of the loss experienced by the child/adolescent is missing in the study.

Researchers studied 16 families with children aged 5 years to 14 years who had experienced the suicidal death of a close relative within the last 1 month to 3 years. The deceased relatives included 8 fathers, 4 mothers, 3 brothers and 1 sister. The sample was recruited from the community and evaluated with standard research instruments for levels of children's psychiatric symptoms and social adjustment. Measures included The Spectrum of Suicidal and Assaultive Behavior Scales, The Social Adjustment Inventory for Children and Adolescents, The Childhood Post-Traumatic Stress Index, The Children's Depression Inventory, The Revised Children's Manifest Anxiety Scale, The Coddington Social Readjustment Rating Questionnaire for Children and Adolescents, The Child Behavior Checklist and The Child Behavior Profile, The Beck Depression Inventory, and The Symptom Checklist 90 Revised. Child survivors of suicide were found to have a higher rate of anxiety, depression symptoms and poorer school adjustment than a standard community sample. 25percent of the families had children who reported clinically significant symptoms of depression. Approximately 40% of the families included children who reported at least moderate symptoms of posttraumatic stress. Approximately 31% of families had at least one child who reported suicidal ideation. The bereaved caretakers were also found to have higher levels of anxiety and depression compared to adults in the community. Psychosocial features of these children were found to be significantly related to parental psychiatric symptoms and stressful life events.

The strengths of this study include its use of standardized tools and assessments of children as well as parents. An important limitation is that some of the families were seen too early after the loss occurred (1 month). Assessment at such an early stage may have inflated the results obtained on the study. Small sample size, lack of homogeneity with respect to the relationship with the relative who died, and a lack of qualitative measures and analysis are some limitations that may have affected the results of the study.

Researchers [28] assessed family histories of psychopathology and family environment before and after the death of a parent. Twenty-six suicide-bereaved children, aged 5 to 17 years, along with their surviving parents, were compared with 332 children and their surviving parents who had experienced a non-suicide

parental death. Comparisons were made through the use of structured and semi-structured interviews conducted at intervals of 1, 6, 13, and 25 months after the death of the parent. Measures included the Grief Interview-Child and Parent forms, The Diagnostic Interview for Children and Adolescents-Revised, The Diagnostic Interview for Depression in Children and Adolescents, The Children's Depression Inventory, The Children's Depression Rating Scale-Revised, The Piers-Harris Self-Concept Scale, the Child Behaviour Checklist-Teacher's Report, the Conners Revised Teacher Rating Scale, The Health/Sickness Questionnaire, School and Physician Rating Forms. Results indicated that suicide-bereaved children exhibited greater evidence of psychopathology than those whose parents died from other causes. These families exhibited less stability, and relationships with the deceased parent prior to the suicide had been less satisfying. However, the surviving parents in the suicide-bereaved group had no more evidence of psychiatric disorders than the non-suicide group, and there were no differences found between the groups related to the children's relationships with the surviving parents.

The strengths of this study include its longitudinal design, a comparison group, comprehensive assessment tools and use of interviews along with standardized questionnaires. The study was limited by a small sample size and the use of only self report measures. Also, these measures may not have been appropriate for younger children whose verbal ability would have been limited by their developmental stage.

Brown, Sandler and Tein [29] analysed data from the FBP (Family Bereavement Program) to understand whether the type of parental death (suicide, homicide, and accidents) may have a role to play in the development of interventions for parentally bereaved children. The functioning of 24 children and adolescents from 15 families who had experienced the suicidal death of a parent was compared to the functioning of 302 children and adolescents from 186 families who had experienced the death of a parent from all causes other than suicide. A variety of variables were assessed. Child mental health problems included internalizing and externalizing problems were assessed from a multi – pronged perspective; child report (Children's Manifest Anxiety Scale—Revised, Children's Depression Inventory and the Youth Self-Report externalizing problems subscale); parents (Child Behaviour Checklist), and teachers (Teacher's Report Form, Achenbach). Grief was assessed using two measures, the Texas Revised Inventory of Grief and the Bereavement Rumination Scale. Children's beliefs about themselves and their world, control beliefs, self-worth, children's appraisal of threat from the most stressful events that occurred to them, children's coping strategies such as active coping, children's coping efficacy and their inhibition of expression of feelings were assessed. Family variables such as positive parenting, caregiver and child reports of warmth and discipline, surviving caregiver mental health problems, parent scores on the Beck Depression Inventory and the PERI demoralization scale and, the broad range of stressful events to which families are exposed following the death were measured. The researchers tested whether the relations between risk and protective factors and problem outcomes differed for the 24 suicidally bereaved and 302 children bereaved from other causes by using hierarchical multiple regression to test the risk/protective factor by cause of death (suicide vs. not suicide) interaction after entering the main effects of cause of death and the risk/protective factor to predict the mental health problem/grief outcome

Analysis of data found minimal differences in these variables based on cause of parental death. In addition, cause of death did not substantially affect the relations between risk and protective factors and bereaved children's outcomes. The authors concluded that the type of death is not a very useful indicator of bereaved children's need for or likelihood of benefiting from an intervention. The strengths of the above study include a multiple informant based assessment and the use of sophisticated statistical analysis. However, as the authors themselves point out, the sample size of suicidally bereaved children is too small. Also, the absence of a measure of the child's behaviour prior to parental death and a lack of qualitative measures and analysis are limitations of this study.

Melhem, Shamsedeen, Payne and Brent [30] conducted a 3 year longitudinal study to understand the course of children's and adolescents' grief reactions after sudden parental death and the effect of those reactions on subsequent psychiatric and functional status. The study sample included a total of 182 parentally bereaved children and adolescents aged 7 through 18 years whose parent died due to suicide, unintentional injury, or sudden natural causes. The modified version of the Adult Inventory of Complicated Grief - the ICG-RC, was used to assess grief phenomenology in children and adolescents younger than 18 years. The Circumstances of Exposure to Death semi-structured interview was used to

assess the children's and adolescents' experience surrounding and after the death of their parent. Past and current psychiatric disorders in children and adolescents younger than 18 years were assessed using the Schedule for Affective Disorders and Schizophrenia for School-Aged Children, Present (K-SADS-PL). For children who turned 18 years old during the study and for surviving parents, the Structured Clinical Interview for DSM-IV Axis I and II Disorders (SCID-I and SCID-II) was administered. At follow-up, the K-SADS-PL, SCID-I, and SCID-II were used along with the Longitudinal Interval Follow-up Evaluation to assess the longitudinal course of psychiatric disorders. Psychiatric assessment of the deceased was conducted using a psychological autopsy procedure. Functional status was determined using the Children's Global Assessment Scale (CGAS) or the Global Assessment Scale (GAS) for adult children and surviving parents. A history of physical or sexual abuse was assessed using screens from the PTSD section of the psychiatric interview and the Abuse Dimensions Inventory. A battery of self-reported instruments also was administered to assess the severity of symptoms in offspring. Self reported symptoms of depression, anxiety, PTSD, and suicidal ideation were assessed using the Mood and Feelings Questionnaire, the Screen for Child Anxiety Related Emotional Disorders, the Child PTSD Symptom Scale–Interview, and the Suicide Ideation Questionnaire–Junior, respectively. Parallel measures in offspring who became adults during the study period were obtained using the Beck Depression Inventory, the Beck Anxiety Inventory, the PTSD Symptom Scale–Interview, and the Adult Suicide Ideation Questionnaire.

Factors that might buffer the effect of bereavement also were assessed in offspring. Socioeconomic status and household income were rated using the Hollingshead scale. Intercurrent life events were assessed using the Life Events Checklist and the shortened Social Readjustment Rating Scale created by Holmes and Rahe for offspring younger than 18 years. Family cohesion was assessed using the Family Adaptability and Cohesion Evaluation Scales. Social support was assessed using the Survey of Children's Social Support and the Multidimensional Scale of Perceived Social Support. Aggression and self-esteem were assessed using the Aggression Questionnaire and the Weinberger Adjustment Inventory self-esteem subscale. Finally, coping style was assessed using the Kid Cope checklist in offspring younger than 18 years and the Ways of Coping Questionnaire in older offspring. When different measures were used for offspring who were 18 years or younger or older, scores from these measures were standardized.

Three discrete pathways of grief reactions were observed in the study participants. More than half of children and adolescents bereaved by sudden parental death experienced relatively rapid resolution of their manifestations of grief within 1 year of the loss of their parent. However, sometimes the course of grief was more problematic, with 30.8% showing a more gradual attenuation in grief symptoms and 10.4% showing high and sustained prolonged grief manifestations nearly 3 years after parental death. The experience of a prolonged grief reaction was predicted by a prior personal history of depression and was associated with greater functional impairment beyond that accounted for by other psychopathologic conditions. Children and adolescents with prolonged grief reactions also show an increased incidence and earlier onset of depression predicted by their grief reactions and those of their surviving parent 9 months after the death, even after controlling for characteristics before and after the death.

The above study's strengths include its large sample size, use of multiple informants, sophisticated statistical analysis and a longitudinal design. The limitations of the study include the possibility of a sampling bias being present, a racially homogenous sample (primarily whites), the psychological autopsy procedure being entirely informant based and lack of qualitative measures and analysis.

One study [31] used longitudinal data collected in Aceh, Indonesia, before and after the Indian Ocean tsunami to identify the impact of parental deaths due to the tsunami. Baseline data were collected on 1,173 children age 9-17 years as part of a population-representative survey conducted ten months prior to the December 2004 tsunami in areas that were subsequently heavily damaged by the tsunami. With data from interviews with the same children after the tsunami, comparisons were drawn between those who lost one parent, both parents and those whose parents survived. Shorter-term impacts on school attendance, aspirations and time allocation a year after the tsunami were examined as well as longer-term impacts on education and marriage five years after the tsunami. They found that the impact of parental death varies with the age and gender of the child and that shorter term impacts were not reliable indicators of the effects that emerge in the longer-term. An older male child who lost his father or lost both his parents in the

tsunami had substantially lower levels of education and was more likely to be working than a son whose parents survived the tsunami. An older female was more likely to be doing housework if her mother, father or both parents died suggesting that she substitutes for the parent who died. Also, in the long term, the rates of marriage for older males who lost parents was lower while the same in the case of older girls was higher as compared to a control group who had not lost parents in the tsunami.

The impact of parental death on younger children was found to be lesser in intensity, probably due to the high levels of assistance that came in after the tsunami. (opening of temporary schools, rebuilding of infrastructure etc.

One of the very few intervention studies in this area study the impact of the Family Bereavement Program. Sandler et al. [32] developed the Family Bereavement Program (FBP) for the general population of parentally bereaved children. The FBP was a 12-session group program consisting of concurrent groups for surviving caregivers, children, and adolescents, plus two individual sessions; groups were designed specifically to change risk and protective factors that had been identified in the literature as being correlated with mental health problems of children and adolescents. These factors included providing education about the grief process; teaching parents and children techniques for enhancing children's self-esteem, adaptive control beliefs, positive coping, and support for emotional expression; and teaching parents strategies to enhance the quality of the parent-child relationship and to increase positive family interactions as well as to decrease parent psychological distress and negative life events that occur for the children and parent. The groups for the surviving caregiver included activities designed to promote positive parenting, reduce children's exposure to stressful events, and reduce caregiver mental health problems. The groups for the children and adolescents were designed to promote positive coping, reduce negative thoughts about stressful events, reduce inhibition of expression of grief-related emotions, provide children with an understanding of why negative events occur (i.e., reduce their feelings that they do not understand the cause of events), and improve self-esteem. The findings at post-test indicated that the FBP was successful in promoting positive parenting and positive coping, reducing children's exposure to stressful events, reducing their inhibition of expression of negative emotions, and reducing caregiver mental health problems. At 11- month follow-up, girls who participated in the FBP showed improved internalizing and externalizing problems as reported by caregivers and children, in comparison to those in the self-study condition. Boys in the two conditions did not show differences in mental health outcomes. Mediational analyses found that the effects of the FBP to improve mental health problems of girls at 11-month follow-up were partially accounted for by the program's effects to improve positive parenting, reduce inhibition of emotional expression, reduce exposure to stressful events, improve positive coping, reduce negative thoughts about stressful events and increase children's healthy control-related beliefs [33].

META ANALYTIC STUDIES/REVIEWS

Dowdney [34] conducted a review of the few methodologically rigorous studies on parentally bereaved children. The author found results varying across studies but concluded that children do experience grief, sadness, and despair following parental death. Apart from clinically referred children, psychiatric disorder characterised only a very small minority of children. Most common manifestations included depression or dysphoria. Symptoms also included anxiety, anger outbursts, and regression in developmental milestones. Parents reported less symptomatology and disorder in their children than do the children themselves.

The author attempted to explain variance in findings between studies. The differential rates of disorder were attributed to methodological variations in sample ascertainment, inclusion criteria, sample size as well as the influence of mediating, moderating variables like varying backgrounds, psychiatric disorder prior to parental death, surviving parents having high levels of previous or subsequent psychological morbidity. Also, boys appeared more vulnerable to high-level general disturbance than girls did and tended to show more externalising difficulties while girls were more likely to evidence internalising symptoms.

Ratnarajah and Schofield [35] conducted a review of quantitative and qualitative studies on parental suicide and its effect on children. On examining the quantitative studies the authors found that children bereaved by parental suicide show a marked increase in psychiatric symptoms and social maladjustment when compared to control groups. However, the authors opine that the quantitative literature in particular,

is scant, with small, discrepant, often unrepresentative samples, under reporting due to the difficulties in gaining consent, and other ethical issues that come to the fore when working with this group of individuals. The lack of longitudinal studies is another major lacuna in the existing body of work in this area. The authors are of the view that the qualitative literature in this area is richer and of more value in developing a deeper understanding of the impact of parental suicide on bereaved children. These include some case studies and autobiographical accounts. On an examination of these, the authors found that younger children were often not told the circumstances of the death. Children often felt excluded and invalidated. They expressed a desire to be included in the bereavement rituals, and sought to be reassured. One of the autobiographical accounts is a retrospective account of an adult who talks about her experiences after her mother's suicide, her father's subsequent distance, and then her long period of recovery and healing during the therapeutic process in adulthood.

Currier, Holland and Neimeyer [36] used meta-analytic techniques to evaluate the general effectiveness of bereavement interventions with children. On the basis of a thorough quantitative review of the existing literature (13 studies) the authors concluded that the child grief interventions do not appear to generate the positive outcomes of other professional psychotherapeutic interventions. However, studies that intervened in a timely manner and those that had specific selection criteria produced better outcomes than studies that did not attend to these factors.

The authors attempt to explain these findings through various hypotheses. For instance, too much time may have passed from the child's loss to the beginning of intervention in many of the studies. Thus, it seemed that children responded more favourably to grief therapy the closer the treatment followed the time of the loss, which indicates that many of the treatments were probably delivered at a point when they were simply too weak to produce measurable effects, perhaps after children and families had already accommodated the loss, either ideally or with significant difficulties. Also, the principal treatment objectives (e.g., psychoeducation about loss, allowing for grief – related ventilation) may not have addressed the needs of the children whose losses had occurred sometime ago, at which time a different form of intervention focusing less on grief and more on other forms of psychological or behavioural problems might have been more appropriate.

Haine and others [37] reviewed literature related to both empirically-supported, pliable factors that have been shown to contribute to or protect children from mental health problems following parental loss and evidence-based practices to change these factors. Also, non malleable factors clinicians to be kept in perspective when providing services for children who have experienced the death of a parent were reviewed. Malleable child and family-level influences that can be critical areas of clinical work with bereaved children, included providing education about the grief process; teaching parents and children techniques for enhancing children's self-esteem, adaptive control beliefs, positive coping, and support for emotional expression; and teaching parents strategies to enhance the quality of the parent-child relationship and to increase positive family interactions as well as to decrease parent psychological distress and negative life events that occur for the children and parent. Non malleable factors included the child's developmental level, the child's gender, the cause and type of death, time elapsed since the death, and cultural factors. The review identifies the glaring limitation in the existing research being the paucity of well-controlled studies of the effects of programs for parentally-bereaved children. Also, the limited assessment of preverbal children, and the variability in intervention modality (individual, family, group) or target (child, parent, family) are large lacunae in the existing body of research, which limits an understanding of inter intervention efficacy and generalizability.

Rosner, Kruse and Hagl [38], carried out a review that aimed at providing a quantitative and methodologically rigorous evaluation of existing treatments for bereavement and grief reactions in children and adolescents. The authors conducted two meta - analyses: 1 on controlled studies and 1 on uncontrolled studies. The 2 meta-analyses were based on a total of 27 treatment studies published prior to 2006. Hedges's g and Cohen's d were used as measures of effect size and a random-effects model was applied. Results yielded small to moderate effect sizes. Interventions for symptomatic or impaired participants tended to show larger effect sizes than interventions for bereaved children and adolescents without symptoms. Promising treatment models were found to be music therapy and trauma/grief-focused school based brief psychotherapy.

INDIAN STUDIES

The researcher did not find any published Indian studies pertaining to this area specifically. Indian studies that are partly relevant are quoted below.

Agrawal [39] conducted a study to examine the concept of death in pre-schoolers. The sample comprised of 25 children. The age range was 3 to 5 years. The children were screened using the Children's Behaviour Questionnaire for any behavioural or emotional problems. Interview with the mothers was held to rule out presence of psychiatric problems or mental retardation. Mothers were interviewed in depth regarding child's exposure to death of an animal or of a known person. The concept of death was elicited from children using a combination of story construction and play method followed by a semi – structured interview asking the relevant questions. The results indicated that a significant proportion of children have had exposure to death of an animal or a known person. It was found that majority of the children understood the concepts of universality and irreversibility related to death. However, only few understood the concept of non – functionality related to death. A major limitation of this study was a small sample which limits its generalizability.

In a controlled comparison study of child and adolescent survivors of a family suicide with an age-matched group of children bereaved by family death due to illness, Sethi and Bhargava [40] assessed both groups for psychiatric symptoms and social adjustment 6 to 24 months following a family member's suicide. The sample comprised of 20 Hindu families in urban India with a total of 26 children, ages 6 to 16 years, who were compared with an age-matched group control group of 26 children with no history of family suicide. Both groups participated in a structured psychiatric interview that screened for the presence of psychiatric disorders. The children were also assessed for social adjustment and symptoms of posttraumatic stress disorder through semi-structured interview tools. Their findings indicated that child and adolescent survivors of suicide were at an increased risk for major depressive, posttraumatic stress, and panic disorders, as well as difficulties with social adjustment. The study concluded that losing a family member to suicide is associated with instant and ongoing consequences, resulting from the emotional and physical absence of deceased and grieving parents, the disruption of the family unit, and factors such as financial instability, social isolation, and stigma. Limitations of this study include a small sample size and a wide age range of subjects, as well as differences in the time period of assessment following the suicide of a family member. However, it is one of the few studies examining the effects of suicide in an immediate family member on children, and in particular psychosocial functioning and psychiatric symptoms.

INTERVENTION RESEARCH

Evidence – based intervention is a fairly new development in this area. Bergan, Axberg and Hanson [41] carried out an exhaustive and methodical review of the effects of support programs for parentally bereaved children and their caregivers. The review examined 17 studies in the area published between the years 1985 and 2015. Interventions were found to be varying in their theoretical orientation, with family interventions forming the bulk. Some of the programs include 'Writing for recovery', 'Camp MAGIC', 'The Parent Guidance Program' and 'The Family Bereavement Program'.

In general, it was seen that the participants benefitted from all the interventions; evidence being stronger for some programs as against others. The authors point out that apart from the Family Bereavement Program [33] all the existing programs have not been evaluated rigorously enough.

SUMMARY OF THE REVIEW OF LITERATURE

A review of the existing literature indicates that while parental loss is a significant event in a child's life, there have been no Indian studies on how children adjust to parental loss. Studies carried out in the West may not reflect the reality in the Indian context because of the large social and cultural differences.

A review of the existing literature points to the fact that psychological adjustment in children and adolescents following parental loss, has been looked at more from the parental perception of the child's

adjustment rather than the child/adolescent's perspective. Also, measures used have often been quantitative rather than qualitative. This has limited the ability of the tools to understand the essence of the grief experience of the child.

Early research in this area was limited by small, homogenous samples and a lack of control over confounding factors. Earlier studies also focused more on parental rather than child/adolescent self - report of emotional and behavioural problems. Also, earlier studies have used primarily questionnaires and this has resulted in a lack of qualitative work in this area. Studies have also not taken into account functioning of children prior to parental loss.

However, particularly in the last decade, there have been some studies with sound methodology that can be used to develop interventions for e.g. the Family Bereavement Program [33] which is strongly grounded in evidence – based research. A lot of the current research in this area is based on the data yielded in the evaluation of the Family Bereavement Program.

Studies aiming to understand psychological adjustment of children and adolescents to parental loss can have a number of implications. They may help to identify children/adolescents at risk for significant difficulties and provide appropriate intervention at the opportune time. [37]. These findings may also be applied in developing a model that may be used to develop an intervention for these children/adolescent.

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