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ORIGINAL PAPER

# Exploring Characteristics of Children Presenting to Counseling for Grief and Loss

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**Abstract** To date, researchers exploring childhood bereavement have largely relied on unstandardized assessment instruments and/or have independently evaluated specific constructs rather than factoring in the dimensionality of loss. The purpose of this study was to utilize psychometrically established instruments to examine the multivariate shared relationship between characteristics of bereaved children referred for counseling--their ages, genders, ethnicities, types of loss, and life stressors—and their behavioral manifestations as well as the relationship between these characteristics and levels of parent-child relational stress. Utilizing archival clinical files, we examined these characteristics from bereaved children ($N = 98$) whose parents sought counseling services from two university-based counseling clinics. Two canonical correlational analyses (CCA) were conducted to examine the following: (1) relationship between characteristics of bereaved children and their subsequent behavioral manifestations, (2) relationship between characteristics of bereaved children and levels of parent-child relational stress. Correlational findings from this study provided insight into bereaved children's manifestations of loss and levels of parent-child relational stress as contingent upon these specific characteristics. Specifically, results indicated a strong relationship between age and bereaved children's behavioral manifestations. This finding reinforced the importance for clinicians to understand developmental implications when working with bereaved children. Furthermore, caregivers who reported minimal overall external stressors also reported less parent-child relational interference. This finding further emphasizes the importance for caregivers to maintain utmost stability for bereaved children.

**Keywords** Bereaved children · Grief · Loss · Multivariate · Canonical correlation analysis

Approximately 4% of children will experience the death of a primary caregiver before the age of 18, and this statistic does not take into account the losses that fall outside the realm of primary caretaker, such as a sibling, grandparent, or friend (Melhem et al. 2007). Experiencing such a loss impacts many facets in the lives of children including their home and academic functioning, relationships with peers, spiritual beliefs, and self-concept, amongst others (citation). The residual impact of loss often manifests in maladaptive behavioral and emotional struggles that further interfere with children's functioning across home and academic settings. Such struggles often lead caregivers to seek out mental health support for their children; thus, clinicians must be informed about the unique mental health needs of bereaved children.

The universality of death has made the topic historically prevalent across literature; as such, the topic has birthed a number of approaches and theoretical conceptualizations intended to explain and extrapolate meaning from the loss process (Bowlby 1980; Kübler-Ross 1969; Murray-Parkes 2008; Stroebe and Schut; 1999; Wolfelt 1996; Worden 1982). Sigmund Freud (1917/1957) was the first to discuss grief and loss in the context of psychology. Since then, researchers and practitioners in the field of psychology have continued to explore the progression of the grief process on

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individuals and have evolved to specifically study childhood bereavement (Freud 1966/1989; Furman 1974; Lindemann 1944; Peretz 1970). Researchers have found that loosing a direct caregiver can affect even the youngest of children as such a loss is distressing and threatening to their sense of security (Bowlby 1980).

In an attempt to describe, better understand, and make meaning from the grief process, a number of notable theorists crafted grief conceptualization models. Kübler-Ross (1969) is likely the most well known of these theorists with her five-stage paradigm of denial, anger, bargaining, depression, and acceptance, which was based primarily on bereaved adults. Since her work, the mental health field has moved beyond the medical, structured perspective of loss to a model emphasizing the intricacy and uniqueness of each individual's grief process. More recent theorists include the work of Wolfelt (1996), who specifically focused on childhood grief, and Stroebe and Schut (1999, 2010), whose model takes into consideration how individuals adaptively respond to their loss experiences and avoids pathologizing the grief process. Even with the breadth of available theoretical perspectives, many of these conceptualizations lack empirical support and are historically derived from the personal experiences of clinicians working with bereaved individuals.

In considering how children respond to and perceive the death of a significant loved one, children's understanding of the concept of death and their cognitive development at the time of the loss are essential factors to consider (Webb 2011, 2015). These perspectives are primarily based on the works of Piaget and Erikson, known for examining cognitive and social development respectively (Berger 2011; Burris 2008). For instance, children's level of understanding regarding the irreversibility, finality, inevitability, and causality of death impacts their general perceptions and how they take in a loss (Christian 1997; Wolfelt 2013). These more cognitive aspects are directly connected to a child's level of developmental functioning at the time the death occurs, a concept which was explored and found to be relevant by Nagy (1948). Children at any age react to the death of a loved one; however, it is believed children's developmental level affects their understanding regarding death and informs how they experience and make sense of the loss (Bowlby 1980; Krupnick 1984; Webb 2011). This belief, though founded in the direct clinical experiences of many experts in the field of counseling, appears to lack concrete empirical support grounded in standardized measurement.

Because the duration and intensity of grief is unique for each child, caregivers often have trouble determining typical and atypical manifestations of their loss processes (ie., times when they should recognize children's emotional and behavioral demonstrations as expected reactions to loss or times when they should be concerned with the heightened degree at which the loss is impacting children). Researchers and experts in the bereavement field additionally note this struggle as some argue grief is always typical to the individual child responding to such woes, while others denote specific struggles as markers for increased concern and thereby identifying some manifestations of grief as atypical (Webb 2011; Wolfelt 2007). Left unattended, bereaved children enduring intense struggles may experience emotional and/or behavioral interference inhibiting the typical progression of grief (Edgar-Bailey and Kress 2010). Although grief is an expected reaction to loss, children may need assistance beyond what caregivers can provide should the subsequent emotionality and/or behavioral manifestations become pervasively disruptive to children's lives and their overall functioning (Webb 2015).

Bereaved children often experience intense psychological ramifications following the death of a significant loved one (Burris 2008; Edgar-Bailey and Kress 2010; Webb 2011). Children experiencing such emotional stressors manifest their grief in unique ways and may internalize and/or externalize these struggles. That is, some children may struggle internally so that others are not aware of the depth of their struggles, whereas others may express their struggles outwardly in ways that may be disruptive to others. In regards to common grief related internalizing struggles, bereaved children have been found to demonstrate depressive symptomology, feelings of isolation and heightened anxiousness or clinging behaviors, somatic complaints, and increased frequency of crying following the death of significant loved ones (Cain et al. 1964; Dyregrov and Dyregrov 2012; Furman 1974; Raphael 1983; Sanchez et al. 1994; Schreiber et al. 2017; Silverman and Worden 1992; Van Eerdewegh et al. 1982; Webb 2011; Wolfenstein and Kliman 1965). Schreiber et al. (2017) specifically explored parentally bereaved children by suicide and found that children often experience feelings of abandonment and feel responsible for their parent's death. Additionally, bereaved children have also been found to experience adverse shifts in their self-concepts and self-esteem following the death of a significant loved one (Dyregrov and Dyregrov 2012; Webb 2011). In regards to more externalizing emotional struggles, McCown and Davies (1995) examined specific behaviors reported by parents of children who lost a sibling and noted aggression to be the most commonly observed behavior in bereaved children. Moreover, Krupnick (1984) noted children who experience difficulty verbally expressing their emotions tend to externalize their distress in the forms of aggressive behaviors. Because loss can increase fearfulness in children, they often demonstrate this fearfulness through aggressive actions, such as obstinate or rule-breaking behaviors and/or rage (Di Ciacco 2008; Dyregrov and Dyregrov 2012; Bowlby 1980; Krupnick 1984).

Experiencing the loss of a loved one in childhood not only affects emotional and behavioral expression, but may also predispose those affected to long-term consequences and impact the quality and longevity of an individual's life (Dowdney 2000; Freud 1915/1991). Researchers have explored impaired emotional development in adults bereaved as children; however, these retrospective studies have historically received criticism due to the methodological design problems, including the implication of causality when utilizing correlational analyses and threats to internal validity (Cerniglia et al. 2014; Dowdney 2000; Siegel et al. 1996). Nevertheless, many scholars working in the bereavement field continue to stress the longitudinal impact of unprocessed grief from childhood (Webb 2011, 2015; Wolfelt 2007).

Collectively, the complexity of childhood bereavement includes many factors. Researchers have found children experience a number of struggles including depression, anxiety, somatic complaints, and aggression or disruptive behaviors (Van Eerdewegh et al. 1982; Weller et al. 1991; Worden and Silverman 1996). Theorists conjecture that further contributing factors may affect children's manifestations and expressions of grief such as the gender of the grieving child, the nature of the relationship with the deceased, the circumstances and nature surrounding the death, and social, cultural, and familial contexts, such as spirituality (Webb 2011; Wolfelt 1996). Moreover, whether the death was sudden or unexpected and how bereaved children see others responding to the death can also impact their grief (Webb 2011).

Those working with the bereaved population have generally believed these factors influence children's expression of grief; however, early literature exploring such factors are historically anecdotal. A number of quantitative studies have attempted to fill this gap; however, these studies have typically utilized unstandardized measurements and/or relied on analyses that independently evaluated specific constructs rather than factoring in the dimensionality of loss. Thus, research is needed to further examine the intricacies of childhood bereavement utilizing standardized measures and methodological approaches that consider the dimensionality of grief.

Knowledge regarding the typical progression of grief and various conceptualizations of loss is important; however, it can be difficult for clinicians to navigate and put such perspectives into practice. Furthermore, understanding how children grieve is also crucial to gaining perspectives regarding how children typically manifest their grief. Mental health professionals working with bereaved children could benefit from gaining a greater understanding of children's grief manifestations and how these manifestations may affect the parent-child relational system.

Collectively, relevant literature suggests a number of factors contribute to children's manifestations and expressions of grief. These contributing factors include the gender and age of the bereaved child, the nature of the child's relationship with the deceased, the nature of the loss or more specifically the circumstances surrounding the death, as well as social, cultural, and familial contexts (Cerel et al. 2000; Goldman 2004; Hunter and Smith 2008; Silverman 2000; Webb 2011; Wolfelt 1996; Worden 1982/2002). These contributing factors serve as the basis for the present study. The purpose of this study was to explore the relationship between characteristics of bereaved children ages 3 to 11 and their behavioral presentations to counseling as well as consider how their characteristics relate to levels of stress in the parent-child relational system. The current study is based on the following two research questions: (1) To what extent do characteristics of bereaved children, including gender, age, ethnicity, type of loss, and life stress, predict or explain behavioral manifestations of children who are seeking counseling services? (2) To what extent do characteristics of bereaved children, including gender, age, ethnicity, type of loss, and life stress, predict or explain levels of parental stress in the parent-child relationship?

## Method

### Participants

Children were recruited utilizing archival clinical files from two university-based community-counseling clinics. The initial sample consisted of 98 total participants, with 67 boys and 31 girls between the ages 3 and 11 years old ($M = 6.28$, $SD = 2.33$). Gender as well as ethnicity was reported on the intake form. The majority of participants (67%, $n = 66$) identified as Caucasian, 10% ($n = 10$) as African American, 10% ($n = 10$) as Hispanic/Latino, 6% as Biracial ($n = 6$), 4% as Native American ($n = 4$), and 2% as Asian ($n = 2$). Fifty-four percent ($n = 53$) of the participants experienced the death of a grandparent, 30% ($n = 29$) experienced the death of a parent or primary caregivers, 9% ($n = 9$) experienced the death of an aunt, uncle, or cousin, 5% ($n = 5$) experienced the death of a sibling, and 1% ($n = 1$) experienced the death of a friend.

### Procedure

Data from child clients meeting the following criteria were included in this study: (a) Children between the ages of 3 and 11 years at the initiation of counseling services; (b) The parents and/or guardians must have completed the child/adolescent background information form (CABIF), Child

Behavior Checklist (CBCL), and Parenting Stress Index (PSI); (c) Parents or guardians must have indicated on the CABIF their presentation of their child to counseling specifically in response to the death of a loved one or the intake counselor must have specified this presenting concern on the intake summary report (ISR); (d) Parents and/or guardians must have received a copy of the notice of privacy practice and informed consent notifying them of the use of mental health information in research and training as well as signed a confirmation of receipt of privacy notice and informed consent during their initial intake appointment; (e) Parents and/or guardians must have attended this initial intake between years 2007–2015.

Approval was obtained through the institutional review board and data from child client files ages 3 to 11 whose parents pursued counseling services from one of two university based counselor training clinics serving local community clients. Full-time program faculty members direct the university-based counseling clinics. Counseling interns providing services at these clinics include both doctoral and master's level students. Interns completed all clinical preparation courses and are in the clinical phases of their programs. Collectively, these clinics serve over 300 active community clients weekly who are typically low socioeconomic status, with ages ranging from those as young as 3 years old and those in their elderly years. Children make up approximately 60% of current clientele, with adults accounting for the remaining 40%. The clinics offer a sliding scale fee for all clients. Caregivers of child clients, who have historically comprised the majority of clientele within this clinic, most often refer their children for counseling services due to behavioral or emotional struggles demonstrated by their children. To examine client functioning and collect data on client progress, the university clinics utilize a number of assessments. Specific to young children, the clinics utilize two assessments: one for behavior, the CBCL, and one to examine the parent-child relational system, the PSI.

Participants' demographic information, including age, gender, and ethnicity were available from and were collected from the CABIF. Information regarding presenting concerns as they relate to the loss of a loved one was available from the CABIF as well as the intake summary report (ISR). The type of loss child clients experienced was collected from both the CABIF and ISR. Results from the PSI and the CBCL completed by parent and/or guardians at the initial intake appointment were also collected. Scores from the CBCL, including Anxious/Depressed, Withdrawn/Depressed, Somatic Problems, Attention Problems, and Aggressive Behavior scales, as well as scores from the PSI, including the Child Domain, Parent Domain, and Defensive Responding scores, were procured for the purposes of this study. Data from the archival records was then coded to maintain the confidentiality of child clients and transferred to a Statistical Package for Social Sciences (SPSS) database for analysis

## Measures

Two instruments were utilized to assess initial presentations to counseling, the Child Behavior Checklist (CBCL) and the Parenting Stress Index (PSI).

### *CBCL*

The CBCL was used to measure behavioral manifestations of children's grief. The CBCL (Achenbach and Rescorla 2001) was administered to participants' caregivers. The CBCL has two age specific versions, including the CBCL for children ages 1 ½ to 5 (CBCL/1.5–5; Achenbach and Rescorla 2000) and the CBCL for children ages 6 to 18 (CBCL/6–18; Achenbach and Rescorla 2001). With participants ranging in age between 3 to 11 the present study utilizes both versions of the CBCL. Although item content varies to emulate age differences and covariation, Achenbach and Rescorla (2000, 2001) confirmed the comparability between the two age-specific versions of the CBCL for five of the eight syndrome scales, including Anxious/Depressed, Withdrawn/Depressed, Somatic Problems, Attention Problems, and Aggressive Behaviors.

The CBCL/1.5–5 is composed of 99 items and the CBCL/6–18 is composed of 118 items. For each item, the caregiver is asked to rate their child's behaviors based on a three level scale: 0 = not true (as far as you know), 1 = somewhat or sometimes true, and 2 = very true or often true. The items describe various problem behaviors demonstrated by children, including anxious, withdrawn, somatic complaints, attention problems, and aggression. Caregivers are additionally provided four open-ended questions to report additional concerns. The CBCL requires approximately 20 min to complete and was scored with a computer software program designed to score the CBCL.

### *CBCL/1.5–5*

Test-retest Pearson correlations were computed for CBCL/1.5–5 and indicate overall high reliability. The test-retest reliability coefficents for the syndrome scales of the CBCL utilized in the present study are: (a) Anxious/Depressed, $r = .68$, (b) Somatic Complaints, $r = .84$, (c) Withdrawn, $r = .80$, (d) Attention Problems, $r = .78$, and (e) and .87 for Aggressive Behavior, $r = .87$. The content validity was reported to be strong and supported by research. Achenbach and Rescorla (2000) reported both content validity and

criterion-related validity differentiated between referred and non-referred children.

*CBCL/6–18*

To address reliability of the CBCL/6–18, Achenbach and Rescorla (2001) computed the intraclass correlation coefficient (ICC) from one-way analyses of variance. For test-retest reliability the overall ICC was .95 for the 118 problem items ($p < .001$). Achenbach and Rescorla (2001) computed Cronbach's alpha to estimate the internal consistency of scale scores. Findings indicated Cronbach's alpha coefficients ranged from .78–.94 for the syndrome scales, indicating high reliability for the CBCL/6–18. Specific for the syndrome scales utilized in the present study, Cronbach's alpha coefficients were computed as follows: (a) Anxious/Depressed, $\alpha = .82$, (b) Withdrawn/Depressed, $\alpha = .89$, (c) Somatic Complaints, $\alpha = .92$, (d) Attention Problems, $\alpha = .92$, and (e) Aggressive Behavior, $\alpha = .90$. These coefficients collectively indicate high reliability for the CBCL/6–18. The content validity was reported to be strong and supported by research. Achenbach and Rescorla (2001) reported on both content validity and criterion-related validity indicating the items were significantly ($p < .01$) differentiated between referred and non-referred children.

*PSI*

The PSI is a parent report measure utilized to assess characteristics of caregivers and children that may contribute to stress in the parent-child relational system (Abidin 2012). The PSI is for use with parents of children between 1 month and 12 years. It is a self-administered instrument and takes approximately 20 min to complete. The instrument includes 120 Likert scaled items. Due to the archival nature of the present study, both the PSI-3 and the PSI-4 were utilized. Abidin (2012) reported that correlations between the two versions ranged between .85 and .99, suggesting comparability between the two editions.

Abidin (1995, 2012) reported adequate internal consistency for the Child Domain (PSI-3, $\alpha = .90$; PSI-4, $\alpha = .96$) and Parent Domain (PSI-3, $\alpha = .93$; PSI-4, $\alpha = .96$). Abidin (1995, 2012) reported the test-retest reliability were adequate, emphasizing stability of the instrument. The PSI-3 and PSI-4 manuals detailed relevant empirical research supporting the validity and reliability of the PSI.

*CABIF and ISR*

A university-based clinic in the southwest United States designed the CABIF. Parents and/or guardians seeking counseling services for their children at the university-based clinic completed the CABIF during the initial intake appointment. Information gathered from the CABIF included demographic information, such as age and ethnicity, and current psychological stressors, such as the loss of a significant loved one.

The ISR was designed for use at a university-based clinic in the southwestern United States. The intake counselor utilizes the ISR during the course of the initial appointment and finalizes the form to completion immediately following this initial appointment. The counselor gathers information regarding presenting concerns during this appointment and then synthesized this information on the ISR form.

## Data Analyses

Canonical correlational analysis (CCA), which is used to quantifiably examine the relationships between two sets of variables, was the primary analysis for examining characteristics of children who present to counseling following the death of a loved one. CCA is most suitable as it can address the multivariate characteristics and dimensionality between these variables of interest for the present study. The following were factored into the model: (1) age, to explore developmental aspects, (2) ethnicity, to explore social/cultural contexts, (3) type of loss, to explore the nature of the child's relationship with the deceased, (4) life stress, to explore the familial context, and (5) gender to explore its impact on bereavement. Due to the use of archival data for the present study, it was precluded from exploring the nature of the loss as this information was not consistently available within archival records.

To answer the first research question, type of loss, gender, age ($M = 6.28$, $SD = 2.33$), ethnicity, and life stress ($M = 16.98$, $SD = 12.91$) served as the predictor variables and scores on the CBCL on the scales of Anxious/Depressed ($M = 59.78$, $SD = 9.49$), Withdrawn/Depressed ($M = 59.61$, $SD = 9.44$), Somatic Complaints ($M = 55.89$, $SD = 7.73$), Attention Problems ($M = 58.15$, $SD = 8.60$), and Aggressive Behavior ($M = 63.21$, $SD = 11.60$) served as the criterion variables. To answer the second research question a separate CCA was conducted, with type of loss, gender, age ($M = 6.10$, $SD = 2.24$), ethnicity, and life stress ($M = 18.19$, $SD = 13.19$) serving as the predictor variables and scores on the scales of Child Domain ($M = 118.75$, $SD = 25.13$) and Parent Domain ($M = 124.80$, $SD = 22.56$) of the PSI serving as the criterion variables.

Utilizing SPSS, we ran these canonical correlational analyses and interpreted the results by following statistical procedures outlined in Sherry and Henson (2005) and Thomson (2000). These procedures include initially examining the full canonical model to determine if the results are noteworthy to warrant further exploration, and then extending consideration only to those functions which account for a reasonable amount of variance between the

two sets of variables; to do this we examined Wilks' lambda ($\lambda$), $F$ statistic, and $p$-value. Typically, if the full canonical model and the subsequent canonical functions are noteworthy, the researcher can then examine the standardized weights and structure coefficients to identify what variables are contributing to the relationships across the predictor and criterion variable sets.

Practical significance was also explored through the use of effect sizes to ensure the practicality of the results. When considering measure of effect size in CCA, the squared canonical correlation was interpreted in a similar manner to the adjusted $R^2$ in multiple regression (Thomson 2000). In determining the noteworthiness of such results, the interpretation of effect sizes specific to CCA is contingent upon the researcher's subjective judgment and the specific foci of the research (Sherry and Henson 2005; Thompson 1984).

## Results

A CCA was performed in SPSS for each set of criterion variables (CBCL scores and PSI scores) to evaluate the multivariate shared relationship between characteristics of bereaved children and their behavioral manifestations and the relationship between these characteristics and levels of parent-child relational stress. The assumptions of linearity, multivariate normality, homoscedasticity and multicollinearity were all analyzed and reasonably met.

Upon initial data screening, measures were implemented to maintain the integrity of the data and subsequent analysis. These measures included re-coding of data due to the composition of the sample under study, particularly with ethnicity and type of loss. More specifically, with respect to ethnicity, the largest representation were those participants identifying as Caucasian ($n = 66$, 67.35%) and the smallest representation were those identifying as Asian ($n = 2$, 2.04%). Because of the dispersion of data and limited representation in regard to ethnicity specific to certain populations, data grouping measures were revised. This included utilizing two groups for ethnicity, specifically Caucasian and Culturally Varied. Similarly, with respect to the grouping variable for type of loss, the dispersion was also variable with the largest representation being children who experienced the death of a grandparent ($n = 53$) and the smallest representation being those who experienced the death of a friend ($n = 1$). To address this, the type of loss grouping variable was re-coded to form two distinct groups: primary losses ($n = 34$), which encompassed losses in the immediate family (ie., parents, caregivers, and siblings), and secondary losses ($n = 64$), which encompassed losses outside of the immediate family (ie., grandparents, cousins, and friends). Table 1 presents the correlations among all predictor and criterion variables.

The analysis yielded five functions with squared canonical correlations ($R_c^2$) of .239, .128, .052, .027, and .002 for each successive function. Collectively, the full model across all functions was statistically significant using the Wilks's $\lambda = .611$ criterion, $F(25, 328.41) = 1.862$, $p = .008$. Because Wilks's $\lambda$ represents the unexplained, or residual, variance not accounted for by the model, $1-\lambda$ yields the effect size of the full model in an $r^2$ metric unit. Therefore, for the five derived canonical functions, the $r^2$ type effect size was .389. This indicates the full model explains a considerable portion, about 39%, of the variance shared between the two variable sets.

Researchers are able to test the hierarchical arrangement of the functions for statistical significance through dimension reduction analysis. As previously mentioned, the full model (Functions 1 to 5) was statistically significant. Function 2 to 5 did not explain a statistically significant amount of shared variance between the variable sets, $F(16, 272.54) = 1.267$, $p = .218$, but yielded a noteworthy effect size of, $R_c^2 = .128$. Function 3 to 5, 4 to 5, and 5 did not explain a statistically significant amount of shared variance between the variable set and overall yielded small effect sizes, $F(9, 219.19) = .838$, $p = .581$, $R_c^2 = .052$,

**Table 1** Behavior CCA: correlations for predictor and criterion variables

| Variable | AD | WD | SC | AP | AB | Age | Ethnicity | Gender | Type of Loss | Life Stress |
|---|---|---|---|---|---|---|---|---|---|---|
| Anxious/Depressed (AD) | 1.00 | | | | | | | | | |
| Withdrawn/Depressed (WD) | .494 | 1.00 | | | | | | | | |
| Somatic Complaints (SC) | .521 | .248 | 1.00 | | | | | | | |
| Attention Problems (AP) | .416 | .342 | .052 | 1.00 | | | | | | |
| Aggressive Behavior (AB) | .538 | .374 | .307 | .488 | 1.00 | | | | | |
| Age | .152. | .387 | −.084 | .239 | .124 | 1.00 | | | | |
| Ethnicity | .075 | .090 | −.076 | .093 | −.099 | −.035 | 1.00 | | | |
| Gender | −.127 | −.006 | −.054 | −.061 | −.206 | .085 | −.006 | 1.00 | | |
| Type of Loss | .231 | .133 | .210 | .164 | .152 | −.011 | .005 | −.103 | 1.00 | |
| Life Stress | .035 | .012 | .161 | .063 | .195 | −.179 | −.080 | −.093 | .106 | 1.00 |

**Table 2** Behavior CCA: canonical solution for child behaviors and characteristics

| Variable | Function 1 | | | Function 2 | | | |
|---|---|---|---|---|---|---|---|
| | Coef | $r_s$ | $r_s^2$ (%) | Coef | $r_s$ | $r_s^2$ (%) | $h^2$ (%) |
| Anxious/Depressed | −.240 | −.455 | 20.74 | .264 | −.457 | 20.89 | 41.63 |
| Withdrawn/Depressed | −.800 | −.856 | 73.29 | .081 | −.266 | 7.05 | 80.34 |
| Somatic Complaints | .378 | .114 | 1.30 | −.480 | −.606 | 36.74 | 38.04 |
| Attention Problems | −.373 | −.601 | 36.13 | −.043 | −.378 | 14.26 | 50.39 |
| Aggressive Behaviors | .257 | −.238 | 5.66 | −.915 | −.912 | 83.12 | 88.78 |
| $R_c^2$ | | | 23.91 | | | 12.79 | |
| Age | −.913 | −.890 | 79.19 | −.172 | −.034 | <.001 | 79.19 |
| Ethnicity | −.399 | −.365 | 13.35 | .369 | .420 | 17.68 | 31.03 |
| Gender | .019 | −.031 | 0.09 | .433 | .514 | 26.38 | 26.48 |
| Type of Loss | −.217 | −.214 | 4.58 | −.384 | −.490 | 24.04 | 28.62 |
| Life Stress | −.030 | .141 | 1.99 | −.616 | −.695 | 48.35 | 50.34 |

*Coef* standardized canonical function coefficients, $r_s$ structure coefficient, $r_s^2$ squared structure coefficient, $h^2$ *Coef* communality coefficient

$F(4, 182) = .673$, $p = .611$, $R_c^2 = .027$, and $F(1, 92) = .172$, $p = .679$, $R_c^2 = .002$, respectively.

Upon examining the respective functions and their subsequent $R_c^2$ effects, only the first two functions were considered noteworthy to warrant further interpretation in the context of the present study as they accounted for approximately 23.9 and 12.8% of shared variance, respectively. Because the final three functions collectively explain less than 9% of the shared variance, no further interpretation is presented regarding the last three functions. This finding suggests two mathematically viable ways in which the predictor variables relate to the criterion variables.

The standardized canonical function coefficients and structure coefficients for Functions 1 and 2 are provided in Table 2. Both the squared structure coefficients and communalities ($h^2$) across the two functions for each variable are provided. Considering the Function 1 coefficients, the most relevant criterion variables were Withdrawn/Depressed and Attention Problems, with Anxious/Depressed making a secondary contribution to the synthetic criterion variables. This finding was supported by the squared structure coefficients. Withdrawn/Depressed additionally appeared to have a large canonical function coefficient, which further supports its primary contribution to the synthetic criterion variable. Anxious/Depressed appears to receive the least credit among all criterion variables specific to the canonical function coefficient, but as previously mentioned demonstrates moderate contribution to the synthetic criterion variable per structure coefficients; this is likely the result of the multicollinearity that this variable shares with other criterion variables (see Table 1). Furthermore, Somatic Complaints demonstrates a comparable canonical function coefficient to Attention Problems; however, as previously mentioned, Somatic Complaints contributes minimally to the synthetic criterion variable per structure coefficients suggesting it is acting as a suppressor variable. Furthermore, with the exception of Somatic Complaints, the structure coefficients of all criterion variables have the same sign indicating they are positively related. Somatic Complaints was inversely related to the other child behaviors. Regarding the predictor variable set for Function 1, age was the primary contributor to the predictor synthetic variable, with ethnicity making a secondary contribution to the synthetic predictor variables. Because the structure coefficients for age and ethnicity are negative, they are positively related to the more meaningful contributors from the criterion variable set, including Withdrawn/Depressed, Attention Problems, and Anxious/Depressed. Taken together, this suggests younger bereaved children tended to demonstrate lower Withdrawn/Depressed, Anxious/Depressed, and Attention Problems scores, indicating that younger children in the sample had less symptoms of withdrawal, anxiety, and inattention."

Moving on to Function 2, the coefficients suggest Aggressive Problems and Somatic Complaints are among the most relevant criterion variables. The squared structure coefficients supported this conclusion. Furthermore, all of the structure coefficients of the criterion variables for Function 2 had the same sign, indicating that they were all positively related. Coefficients of predictor variables indicate life stress was the primary contributor to the synthetic predictor variable with Gender, Type of Loss, and Ethnicity serving as secondary contributors. This is supported by both structure coefficients and squared structure coefficients. Collectively, this second function suggests another, lesser contributory way in which characteristics of bereaved children and their demonstrated behaviors as perceived by caregivers go together. Specifically, this suggests a combination of bereaved girls, children who experienced a primary loss, and children whose caregivers reported less life

stress are associated with lower Aggressive Behaviors and Somatic Complaints scores. That is, children who are girls and experienced a primary loss and whose parents reported less life stress demonstrated less aggressive behaviors and fewer somatic complaints.

Examining the full model, communality coefficients indicate Withdrawn/Depressed, Aggressive Behaviors, and Attention Problems as the dominant criterion variables across both functions and Age and Life Stress as the dominant predictor variables across both functions. This, along with the entirety of the canonical solution, can be found in Table 2.

The second CCA was conducted using bereaved children's characteristics as predictors of the levels of parental stress to evaluate the multivariate shared relationship between the two variable sets. Initial sampling included 98 participants; however, due to defensive responding ($n = 11$) and incomplete or missing data ($n = 3$), 14 cases were excluded resulting in a final sample of 84 participants. Similar coding procedures were again employed; Table 3 presents correlations amongst all predictor and criterion variables.

The analysis yielded two functions with squared canonical correlations ($R_c^2$) of .160 and .059 for each function. Collectively, the full model across all functions was statistically significant using the Wilks's $\lambda = .790$ criterion, $F(10, 154) = 1.926$, $p = .045$. For the two derived canonical functions, the $R^2$ type effect size was .210. This indicates the full model explains about 21% of the variance shared between the two variable sets. Function 2 did not explain a statistically significant amount of shared variance between the variable sets, $F(4, 78) = 1.223$, $p = .308$, and yielded a small effect size, $R_c^2 = .059$. Upon examining the respective functions and their subsequent $R_c^2$ effects, only the first function was considered noteworthy to warrant further interpretation in the context of the present study. The final function was considerably weak, explaining only 5.9% of the remaining variance in the variable set after the extraction of the first function. Therefore, no further interpretation will be presented regarding this final function.

The standardized canonical function coefficients and structure coefficients for Functions 1 and 2 are provided in Table 4. Because only one function was interpreted, communalities ($h^2$) are not provided. Considering the Function 1 standardized canonical function coefficients, the most relevant criterion variable was the Child Domain; this finding was supported by the structure coefficient and squared structure coefficient. Canonical function coefficients further suggest a moderate contribution by the Parent Domain; however, the structure coefficient indicates negligible correlation. This is likely due to the multicollinearity that this variable shares with the Child Domain (see Table 3).

Regarding the canonical function coefficients for the predictor set for Function 1, age appears to be the most relevant predictor variable, with Ethnicity making a secondary contribution to the synthetic predictor variables. These findings are supported by the structure coefficients and squared structure coefficients. Furthermore, with the exception of ethnicity, all of the variables' structure coefficients had the same sign, indicating that they are all positively related. Ethnicity was inversely related to the other characteristics. Taken together, this suggests that a combination of younger and culturally varied bereaved children are associated with lower Child Domain scores. That is, caregivers of younger culturally varied (i.e.,

**Table 4** Parent child stress CCA: canonical solution for child characteristics and parenting stress

| | Function 1 | | |
|---|---|---|---|
| Variable | Coef | $r_s$ | $r_s^2$ (%) |
| Age | −.855 | −.813 | 66.16 |
| Ethnicity | .497 | .528 | 27.90 |
| Gender | −.019 | −.103 | 1.06 |
| Type of Loss | −.159 | −.077 | 0.59 |
| Life Stress | −.217 | −.129 | 1.66 |
| $R_c^2$ | | | 16.05 |
| Child Domain | −1.103 | −.897 | 80.40 |
| Parent Domain | .488 | .023 | 0.05 |

*Coef* standardized canonical function coefficients, $r_s$ structure coefficient, $r_s^2$ squared structure coefficient

**Table 3** Parent child stress CCA: correlations for predictor and criterion variables

| Variable | CD | PD | Age | Ethnicity | Gender | Type of Loss | Life Stress |
|---|---|---|---|---|---|---|---|
| Child Domain (CD) | 1.00 | | | | | | |
| Parent Domain (PD) | .492 | 1.00 | | | | | |
| Age | .240 | −.063 | 1.00 | | | | |
| Ethnicity | −.144 | .046 | −.072 | 1.00 | | | |
| Gender | −.127 | −.122 | .041 | .008 | 1.00 | | |
| Type of Loss | .113 | .023 | .031 | −.010 | −.116 | 1.00 | |
| Life Stress | .188 | .267 | −.179 | −.080 | −.093 | .106 | 1.00 |

children other than Caucasian) bereaved children are likely to report less overall stress related to child characteristics.

## Discussion

### Behavioral Manifestations of Bereaved Children

Correlational evidence generated from this study suggests a relationship exists between bereaved children's characteristics and their subsequent behavioral manifestations. Specifically, parental report suggests younger bereaved children tended to demonstrate less withdrawn/depressed, anxious/depressed, and attention-related struggles. Relative to typical development, this finding is consistent with prior literature as young children tend to experience and subsequently demonstrate emotionality for shorter periods of time (Berger 2011). The ability to sustain such emotional intensity increases with age (Berger 2011; Greenspan and Greenspan 1989). Parents' perceptions of fewer withdrawn/depressed and anxious/depressed behaviors in younger children may be indicative of younger children traditionally relying on more externalizing behaviors to express their emotional states. Moreover, younger children are far more likely to engage their parental figure in times of stress, which would likely result in similar findings to the present study (Bowlby 1980). Related to the lowered attention-related struggles, parents who reported lower attention-related problems may have been picking up on this developmentally appropriate struggle for young children and hence less sensitive to attentional problem behaviors (Berger 2011).

Bereaved children whose parents report less life stress also reported fewer aggressive behaviors and fewer somatic complaints for their children. Specifically, caregivers who reported few external stressors, such as a lack of family divorce or family moves, experienced their children displaying fewer aggressive behaviors and fewer complaints of somatic symptoms. This is consistent with prior literature that suggests that families who experience fewer external stressors possess a more stable home environment. Ultimately, the more stable a child's world is, the more capable they are of experiencing and recovering from the death of a loved one and thereby may demonstrate positive coping skills (Bowlby 1980; Webb 2011; Wolfelt 1996).

Girls whose parents also reported less life stress appeared to demonstrate less aggressive behaviors and fewer somatic complaints. Prior studies suggest boys demonstrate more externalizing behaviors, such as aggressive and disruptive behaviors, whereas girls tend to demonstrate more internalizing behaviors (Hope and Hodge 2006). However, inconsistent with prior works is the connection with fewer somatic complaints as prior works suggest that girls may be more likely to complain of somatic symptoms than their boy counterparts (Hope and Hodge 2006). This may be specific to the sample of the current study.

Results from the current study indicated that a bereaved child's ethnicity did not appear to be correlated with behavioral characteristics, and therefore implies children in this particular sample tended to grieve similarly across cultures. This initially appears inconsistent with prior literature, which suggests cultural differences appear to influence children's grief experiences. However, the sample under study was not highly diverse and this finding should be interpreted with caution (Hunter and Smith 2008).

### Parent-Child Relationship Stress

Findings indicated parents of younger bereaved children, as compared to older children, reported experiencing less stress in the parent-child relationship specific to aspects of the children. This is consistent with prior studies that found parents of older children report greater parenting stress than those of younger children (Putnick et al. 2010; Williford et al. 2007). Parents of older children may experience increased parental stress due to children's developmentally appropriate tendency towards autonomy. Due to limited autonomy, young children demonstrate an increased need for their caregiver's attention and time comparative to older children. Parent expectations of younger children may contribute to their ability to respond more effectively and relationally to grief expressions in contrast to parental expectations of older children. Specifically, parents may expect younger children to respond to loss with behavioral problems yet older children may be expected to regulate their expressions of grief through appropriate behaviors. Therefore, parents of younger children may have noted lower overall stress stemming from the child due to perceiving their children's behaviors as developmentally appropriate and not contributory to stress in the parent-child relational system.

Parents of culturally diverse children appeared to experience their children's behaviors as minimally stressful to their overall parenting role. This finding appears consistent with those from other studies specifically exploring levels of parenting stress and race; these studies found that parents identifying as White report higher parent-child relational stress than racial and ethnic minority parents (Emick and Hayslip 1996; Williford et al. 2007).

Several predictor variables present in previous literature did not appear to be significantly related to levels of stress in the parent-child relationship (Abidin 2012; Hansen 2004; Webb 2011). Specifically, gender, type of loss, and life stress did not appear to heavily contribute to stress in the parent-child relationship. Life stress did not appear to have a meaningful relationship, whether positive or negative,

with parenting stress either related to characteristics of the child or the caregiver's parenting. For the present sample, this suggests a couple of possibilities regarding parents of bereaved children: (1) parents are not experiencing significant external stressors, or (2) parents are not perceiving external stressors as significantly contributing to stress in the parent-child relationship. Regarding type of loss, whether bereaved children experienced a primary loss, such as the death of a parent or sibling, or a secondary loss, such as the death of a grandparent or friend, caregivers did not appear to report more or less parenting stress. Additionally, the gender of bereaved children did not appear contributory to stress in the parent-child relational system. This suggests that loss in general, including both primary and secondary losses, as well as the bereaved child's gender contribute equally to stress in the parent-child relationship.

### Limitations and Implications for Research

Due to the use of archival data, this study may suffer from several inherent limitations. Data collection for this study was limited to existing data generated through two university based community counseling clinics. Several features of loss that impact children's bereavement processes remain unexplored in the present study due to the use of archival data. Some information was not available for further study, including the specific nature of the loss, the depth of interaction between the deceased loved one and the bereaved child, and whether the loss was sudden vs. anticipated. Due to the confines of archival data, these aspects remained unexplored in the present study.

Because the selected instruments for this study are based on parental perception, the actual emotions and behaviors demonstrated by child clients may be misrepresented. Due to the nature of loss, caregivers were likely experiencing and working to cope with the same loss the child experienced. Therefore, parental perceptions may have been affected by their own grief process. Additionally, children may have experienced behavioral and/or emotional struggles prior to the reported death of a significant loved one and may be related to another factor apart from and unrelated to the death of a significant loved one. Because mediating/moderating effects of other variables were not assessed in the present study, the possibility that correlational findings may be independent outcomes of variations of other variables cannot be discounted.

In regard to external validity with the specific setting and sample, the results may not be reflective or applicable to children across different geographical and demographic backgrounds (Heppner et al. 2008; Rubin and Bellamy 2012). Moreover, because of the limited number of participants, the predictive results derived through the course of this study may need to be interpreted with caution.

Although correlational evidence generated from the present study provided substantial support regarding developmental implications and regarding bereaved children, further research in this area is needed in order to determine fitness and efficacy of results. Much of prior literature is dated, therefore, to better inform clinical practice it is important to conduct further studies exploring bereaved children and their subsequent needs following the experience of loss. Future researchers might consider exploring bereaved children's systems of support following loss as well as the impact of multiple losses and/or the nature of loss experienced. Clinicians interested in more deeply exploring needs of bereaved children might also consider conducting a more thorough intake specifically focused on losses, including such aspects as age of loss(es), nature of loss(es), and depth of relationship(s) with the deceased, amongst others. Moreover, longitudinal research into children's loss is needed to explore long-term needs and well-being of bereaved children. One area remaining largely unexplored is research exploring specific developmental periods, such as young, pre-adolescent, and adolescent bereaved children. This subject of inquiry would provide practitioners with more empirical information regarding the developmental needs and experiences of children specific to their age. Furthermore, in light of the relationship between the number of behavioral problems demonstrated by bereaved children and stressful life events reported by parents, future research could additionally explore the protective factors of bereaved children and their needs from optimal recovery from the loss. Overall additional stringent research into children's loss would further strengthen the field and services available for bereaved children.

Specific to the instruments utilized in the present study, future studies could explore the appropriateness of use of the Child Behavior Checklist specific to bereaved children. Due to moderate correlations identified in the present study between scores on the scale of Anxious/Depressed and the other four CBCL scales, factor analysis may be an appropriate pursuit in this exploration. Furthermore, the PSI includes a specific scale exploring caregivers' relationships with their spouse. For caregivers who experienced the death of their partner, this question may not be applicable and even more so insensitive to the bereaved caregiver. Without scores on the spousal scale, many of the scales cannot be calculated. Therefore, a more sensitive instrument specific to the needs of bereaved caregivers would be useful to work with the present population.

**Author Contributions** LE: designed and executed the study, conducted and interpreted data analysis, and was the primary author for the manuscript. DCR: collaborated with the design of the study and assisted with writing and editing the manuscript.

**Compliance with Ethical Standards**

**Conflict of Interest** The authors declare that they have no competing interests.

**Ethical Approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

**Informed Consent** Informed consent was obtained from all individual participants included in the study.

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