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Bereavement and reactions of grief among children and adolescents: present data and perspectives

Le deuil chez l'enfant et l'adolescent : données actuelles et perspectives

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Abstract

Losing a loved one is among the most common and stressful traumatic events that a child or adolescent can experience and can be associated with mental health and somatic disorders, as well as a range of life issues and potentially negative outcomes that may impact longitudinal development. Complicated grief, a disorder that has been studied primarily among adults, has received increasing recognition among children and adolescents in recent years. The demonstration of the distinctive character of grief reactions in relation to major depressive disorder and posttraumatic stress disorder has resulted in the inclusion of "persistent complex bereavement disorder" in an annex section of DSM-5 and of "prolonged grief disorder" in ICD-11. The grieving process in children and adolescents is not linear and is often characterised by periods of regression. Developmental phases should be taken into account to understand and clinically describe grief reactions occurring during childhood and adolescence. There are currently numerous interventions for bereaved children and adolescents, but little evidence to support them. More research focusing on the understanding of the underlying mechanisms and the risk factors for complicated grief among children and adolescents, as well as the implementation of evidence-based interventions, is definitely warranted.

Keywords: bereavement; grief reactions; complicated grief; children and adolescents; risk factors

Résumé

Perdre un être cher fait partie des expériences traumatiques les plus communes et les plus stressantes qu'un enfant ou un adolescent puisse vivre. Le deuil peut être associé à des troubles psychiques et somatiques ainsi qu'à de nombreux problèmes et événements de vie négatifs ayant un potentiel impact développemental. Le deuil compliqué, un trouble initialement décrit chez l'adulte, a suscité un intérêt croissant chez l'enfant et l'adolescent ces dernières années. Il a été démontré que les réactions de deuil compliqué différaient de l'épisode dépressif caractérisé et du trouble de stress post-traumatique, ce qui a conduit à l'inclusion du trouble de deuil complexe persistant au sein d'une section annexe du DSM-5 et du trouble de deuil prolongé dans la CIM-11. Le processus de deuil chez l'enfant et l'adolescent n'est pas linéaire et est souvent marqué par des périodes de régression. Les phases développementales doivent être prises en compte pour comprendre et décrire cliniquement les réactions de deuil qui surviennent durant l'enfance et l'adolescence. Il existe actuellement de nombreuses interventions destinées aux enfants et aux adolescents endeuillés mais peu d'études validées pour les étayer. De futures recherches centrées sur la compréhension des mécanismes et des facteurs de risque de deuil compliqué chez l'enfant et l'adolescent ainsi que sur l'implémentation d'interventions validées sont nécessaires.

Mots clés : deuil ; réactions de deuil ; deuil compliqué ; enfants et adolescents ; facteurs de risque

Introduction

[The issue of what is normal and what is pathological](#)

The question of bereavement challenges psychiatrists because of its nosographic status, and also with respect to the role of the psychiatrist in this setting. Indeed, it raises reflection, always central in medicine but particularly cogent here, as to the distinction between what is normal and what is pathological. Since the loss of a loved one is a fundamental, universal, existential experience, grieving is first of all an inner process that the survivors must experience and get through, both as an intimate and private experience, and also in its social dimensions. It is the prototype of moral pain, and thus it seems a delicate matter, or even misplaced, for the practitioners to encroach on the experience, which will often also affect them. Melanie Klein very aptly summed up this dual status of grieving in 1940: "*Grief is a normal illness*" [1].

Yet certain experiences of bereavement prove to be more complex, by way of their intensity, their duration, or the inability of the subject to reinvest satisfactorily in social and affective life. These experiences can warrant medical accompaniment.

[A complex nosographic entity that is not well defined](#)

This difficulty in delineating a clear boundary between the normal process of grieving and a complicated or even pathological grieving that is found in the ill-defined nosographic category of complicated grief. There are in English a number of phrases: *complicated grief*, *prolonged grief disorder*, *traumatic grief*, or again *persistent complex bereavement disorder* in the DSM-5. This profusion of terms reflects the difficulty in categorizing and clearly defining this entity. Hereafter, we will use the phrase "complicated grief" to facilitate readability.

In addition, there have been numerous discussions on the complex relations between complicated grief and major depressive disorder (MDD) on the one hand and post-traumatic stress disorder (PTSD) on the other, since both can occur following a bereavement [[2]. Thus the exclusion criterion of a recent bereavement for a diagnosis of MDD, which was present

from DSM-III to DSM-IV-TR, was removed from the DSM-5, since recent studies have shown an absence of differences in terms of clinical characteristics and response to treatment between depressive syndromes occurring in the setting of bereavement and those occurring in a different context [3]. Several studies among adults have provided strong arguments in favor of the distinct nature of complicated grief, MDD and PTSD [4,5], confirmed by a recent study on a large sample of children and adolescents exposed to a single trauma (the September 11th attacks in 2001) [6].

These difficulties indeed appear clearly in the elaboration of the latest version of the DSM-5. Indeed, the task-force that examined this question specifically did not decide on the inclusion of a specific entity of complicated grief in the main section of the DSM, and they merely described an entity entitled "persistent complex bereavement disorder" (PCBD) in a DSM annex corresponding to lines of reflection for future studies. However, a nosographic entity entitled "prolonged grief disorder" (PGD) was included in the main section of the recent 11th edition of the International Classification of Diseases (ICD-11) (WHO).

Definitions

While in French there is only one word, *deuil*, to refer to the loss of a loved one and the grief it generates, in English there is the distinction among three aspects: *bereavement*, which refers to a major life event in the form of the loss of a loved one, *grief*, which corresponds to the cognitive, affective and behavioral response to that loss, and *mourning*, which refers to the process of adaptation to the loss, a dynamic process that is strongly influenced by socio-cultural norms. These distinctions have implications in the clinical setting and for research, and the French language tends to confuse, or at least does not enable the distinction between, exposure to an event, the cognitive, affective and behavioral response to that exposure, and the process of adapting to that exposure.

In the present article we will use the phrase *complicated grief* to refer to a process of grieving which by way of its intensity, its duration and the inability of the subject to satisfactorily

reinvest in affective and social life, leads to a state of distress that can require accompaniment by professionals. Complicated grief can also lead to de-compensation, or the onset of a psychiatric disorder, whatever its nature (MDD, addictions, delusional states etc.).

[Grief among children and adolescents](#)

Recognition of childhood grief, which can concern both children and babies, is only recent. It was long thought that children were preserved from this suffering because of the immaturity of their cognitive and psychic development, so that they were seen as being insensitive to loss. As recalled by H  l  ne Romano, the reality of the suffering generated by bereavement is even more difficult to envisage when it concerns a child [7], probably because of its violence and the vulnerability of children, who are all the more affected when those in charge of their care are themselves devastated and unable to provide that care as well as usual. Indeed, recent studies have clearly established that the loss of a loved one is one of the most stressful life events that a child can have to cope with [8] and that it is a risk factor for numerous disorders [9]. The clinical patterns of grief in children are in fact relatively little known, which can lead to grieving processes that are stopped short because of denial on the part of adults in the child's close environment, themselves stricken by grief.

The aim of this article is thus to present the most recent data on normal and pathological reactions of grief among children and adolescents, and to set out the main lines of research on this issue in the coming years.

[The main aetio-pathological models](#)

In his well-known text, *Mourning and Melancholia*, published in 1917, Freud establishes a parallel between normal, non-pathological mourning and melancholia, which is pathological. He sets out the similarities between mourning and melancholia, showing that melancholia differs from mourning by the presence of morbid self-depreciation. He defines mourning as “*the reaction to the loss of a loved one or of an abstraction replacing that person, such as the fatherland, freedom, an ideal, etc.*”. He takes a particular interest in the process of mourning which, according to him, corresponds to a progressive intra-psychic process of libidinal de-

investment from the object, following on from the ordeal of truth (the fact that the object of love no longer exists) which the subject naturally resists. At the end of this adaptation process, new libidinal investments are then possible. Despite the central nature of the work by Freud in the theoretical elaborations thereafter on grief and mourning, Freud in a sense excluded children from this field of research, assuming that children were not sufficiently mature in terms of psychic development to be able to suffer from the loss of their attachment figures. The specific study of the affective, cognitive and behavioural reactions of grief among children and adolescents is recent. Following on from the work by Spitz on hospitalism and anaclitic depression, which are reactions of distress occurring in infants separated prematurely from their parents, Bowlby stressed the fact that young children also enter a period of grief and mourning when separated from their attachment figures [10]. The central challenge of adapting theoretical models elaborated among adults was the need to find a dynamic development perspective.

The first models for the theoretical conceptualisation of grieving were articulated around a description of the process as limited in time and as comprising a certain number of essential stages, which varied from one model to another. Then, following on from Lindemann [11] and Kübler-Ross [12], Bowlby [10] was the first to adapt these models to children and to develop a model in three phases: a phase of seeking the deceased person, a phase of disorganisation and distress, and a phase of reorganisation. After Bowlby, numerous authors developed their own models, from Parkes [13] to Worden [14] and Furman [15]. The main criticism of these approaches was that they envisaged grieving as a process limited in time, irrespective of duration, while certain authors considered that it was a process that could be reactivated throughout an individual's life. In addition, the rigidity of the models did not allow for individual variability or for the fact that each grieving trajectory is by definition specific to the individual.

Other approaches have explored grieving among children in a developmental perspective, referring in particular to the work by Piaget on the stages of psychological development in

children [16]. Here again, these approaches were criticised for being too rigid, and for failing to take account of the individual variability of grieving trajectories.

Boelen et al. [17] developed a cognitive-behavioural conceptualisation of complicated grief in adults, articulated around three themes: poor integration of the separation, globally negative beliefs and misinterpretations of reactions to grief and bereavement, and anxious and depressive avoidance strategies leading to a maintenance of the symptoms.

Other authors have sought to apprehend the grieving process in an evolutionist perspective making grief the counterpart and the "price to pay" for the ability of humans to create extremely strong attachments [18].

Finally, a recent model developed by Neimeyer et al. suggests using the meaning that grieving individuals give to the loss of a loved one in order to form the central articulation of the grieving process, stressing the link between the inability to find a meaning for the loss and the intensity of symptoms in complicated grief [19,20].

Epidemiology

[Prevalence](#)

Epidemiological studies centered on this issue are sparse. A study conducted in the UK in 2001 on 1746 adolescents aged 11 to 16 [21] showed that 77.6% of the children and adolescents questioned had already experienced the death of at least one person close to them (first or second degree relative or member of the close circle). In the USA, around 4% of children and adolescents (up to age 18) experience the loss of one of their parents [22]. A recent study on a sample of Dutch school children (n=1770, mean age 10.24) noted for 14% exposure to a traumatic event such as a natural disaster, an accident, or domestic violence; it is interesting to note that the sudden death or serious injury of a person close was reported as being the most traumatic experience [23].

[Risk factors for complicated grief](#)

There are few studies exploring risk factors for complicated grief among children and adolescents. A study in 2004 on 146 adolescents exposed to the suicide of one of their peers, with assessments at 12, 18 and 36 months, showed a higher incidence of complicated grief among girls, among those feeling they could have done something to prevent the death of their peer, those exposed to interpersonal conflicts, those with a personal history of depression and those with a family history of anxious disorders [24]. A recent study [25] followed 63 children who had lost parents and found a higher incidence of symptoms of complicated grief and PTSD among children who had lost the parent in a setting of chronic illness evolving over a long duration than among children who had lost their parent from rapidly-occurring death from natural causes, suggesting a specific risk linked to anticipation of death.

Clinical approaches to grief among children and adolescents

[Grief according to age: developmental phases in the understanding of death and evolution in reactions of grief](#)

The clinical approach to grief among children is a developmental approach. It requires the psychic and cognitive developmental phases of the child to be taken into account in order to understand and precisely describe the child's reactions to grief (Table 1). Thus the inability to clearly perceive and apprehend death can lead to reactions of grief where general distress, regression, separation anxiety, somatizations and sleep disorders are predominant. On the other hand, adolescents, who have a clear perception of the concept of death and who are implicated in a process of subjectification and individuation in relationship with their attachment figures, will often express their distress in the form of existential questioning, considerable anxiety, difficulties at school, feelings of isolation from their peers, or risky behaviors.

Another central clinical characteristic of grieving, which is important among adults but even more marked among children and adolescents, is that grieving is not a linear process, and that it is characterized by periods of regression and interruption of the grieving process, which can be re-activated in different manners at other stages in child and adolescent development, or

again in periods of psychic vulnerability in adulthood (pregnancy, birth of a child etc.). Thus the grieving process is not a stable entity, and in a sense it is never completely resolved.

It should finally be recalled that although death is a universal experience, the responses provided by different human groups to give it meaning, in particular by way of funeral and mourning rites, are extremely diverse [26]. Certain studies have underlined the importance of religious and spiritual beliefs in the ability of individuals to navigate the grieving process [27]. There are however no studies specifically addressing this question among children and adolescents, and the modes of accompaniment taking account of this cultural dimension are merely extrapolated from results among adults. Certain authors have attempted to provide a picture of the diversity of individual reactions to loss using the concepts of *grieving styles* and the *mourning journey* [28]. Grieving styles correspond to profiles of individual cognitive, behavioral and affective strategies deployed in order to adapt to loss, strongly influenced by personal and cultural factors. Thus Doughty has described two grieving styles: *intuitive* grievers who do not express their suffering and keep it secret, and *instrumental* grievers who freely share their feelings and emotions linked to their experience of bereavement [29].

[DSM-5 and ICD-11 criteria](#)

Persistent Complex Bereavement Disorder (PCBD) in the DSM-5 and Prolonged Grief Disorder (PGD) in the ICD-11 have points in common. Both consider the feelings of distress linked to separation to be pivotal in the disorder, both use the criterion of 6 months' duration, and conceptualize complicated grief as the persistence of the symptoms of normal grieving. A recent study compared the criteria for PCBD and PGD among children having sustained a loss in terms of prevalence rates and psychometric properties [30]. It concluded to satisfactory validity of the diagnostic criteria, and a good performance in distinguishing this entity from MDD and PTSD, but the prevalence rates found for complicated grief were significantly lower for PCBD (3.4%) than for PGD (12.4%). The authors attribute this difference in prevalence to the fact that the ICD-11 seeks to provide relatively simple descriptions of disorders and diagnostic algorithms that favor sensitivity and specificity [31].

An overview of the diagnostic criteria that are common to PCBD and PGD is provided in Table 2.

Diagnostic tools

The clinical approaches to complicate grief among children and adolescents is often more varied and heterogeneous than among adults, tending to be linked to developmental phases, which often makes diagnosis more difficult. The main differential diagnoses for complicated grief are "normal" grieving, depressive disorders, PTSD and separation anxiety. After lengthy discussion [32], adaptation disorder was not included in the list of the main differential diagnoses for persistent complicated bereavement disorder in the DSM-5, which clearly distinguishes the two entities, in particular on temporal criteria (symptoms in the diagnosis of adaptation disorder are to appear in the three months following the start of exposure to the stressful event, and are not to persist more than 6 months once the event and its consequences are over, which is not compatible with the complicated grieving process as defined here). The diagnostic criteria for PCBD in the DSM-5 and for PGD in the ICD-11 can be used, keeping in mind that the criterion of duration among children is 6 months not 12.

There are numerous screening and diagnostic tools for complicated grief, some of which have been adapted or specifically developed for children and adolescents. Among the most interesting we can cite the *Inventory of Prolonged Grief for Children* (8-12 years) and the *Inventory of Prolonged Grief for Adolescents* (13-18 years) developed recently, which have shown good psychometric properties and good specificity in discriminating between complicated grief, MDD and PTSD [33]. However, these two tools have not been translated into French. It can be noted that there is no diagnostic tool for children under 7, certainly at least in part on account of the heterogeneity of symptoms among children in that age group.

Webb [34] proposes an approach that is easy to transpose in daily clinical practice to the systematic assessment of risk factors and protective factors for complicated grief among children and adolescents, based on the analysis of three areas: individual factors (age, gender, developmental history, medical and psychiatric history, previous level of functioning, ability

to establish strong attachment ties); factors linked to the death itself (type of death, cause of death, relations with the deceased person, presence of the child at the funeral); and family and socio-cultural factors (mental state of the child's attachment figures, the role of the community, religious beliefs etc.).

Comorbidities, evolution and complications

[Frequent comorbidities](#)

The main comorbidities of complicated grief are MDD and addictions among adolescents, and PTSD, in particular when the death of a loved one is the result of a traumatic event, or occurred in violent circumstances.

It can also be noted that a bereavement, in the setting of pathological grief, can lead to de-compensation or to the onset of numerous psychiatric disorders.

[Evolution and complications](#)

Grieving among children and adolescents is a risk factor for the development of numerous psychiatric and somatic disturbances [9]. In addition, the potentially negative impact of this type of traumatic event does not concern solely the pathological dimension, it also concerns the socio-economic situation of the adults in the family (possibly resulting in disruption of schooling or lower income, for instance). Thus a study in the UK showed that the loss of a parent at the age of 16 was associated with a greater risk of being unemployed at the age of 30 [35].

Other studies, however, have also shown that following these early traumatic experiences some young people can also develop coping abilities that are particularly useful in their future lives, for instance resilience, empathy and open-mindedness [36].

Prevention and accompaniment

[Preventing complicated grief: educating on the subject of death and collectively giving it meaning](#)

The social and technical evolutions that have been occurring over recent decades have completely overturned our relationship with death, which has become shameful and banned, and also medicalized, since it frequently occurs in hospital, with the disappearance of the rituals and social manifestations of bereavement and mourning. Certain recent trans-humanist ideologies even envisage the postponement or even the abolition of death [37]. These trends have made it difficult for many parents to talk about death to their children. Yet the prevention of complicated grief in children and adolescents to a large extent depends on the subject of death having been broached before the bereavement occurs, for instance at the time of losses that may seem commonplace (such as the death of a family pet). But preventing complicated grief also means enabling the child, according to modes that will depend on the particular circumstances of each bereavement, to attend and take part in funeral rituals, the purpose of which is to collectively give meaning to the life and death of an individual, and to the ties that the survivors entertain with that individual.

[Avoiding over-emphasis on the psychiatric domain, but remaining able to detect subjects at risk](#)

We need to remember that most bereavements among children and adolescents will not lead to complications, which of course does not mean that they will not be periods of extreme distress. In the case of "normal" grieving, the general practitioner, the pediatrician or the psychiatrist most of the time will merely need to accompany the child. What is important is vigilance towards risk factors and protective factors in situations of grieving that are potentially complicated or pathological. These factors can be classified into factors that *pre-exist the bereavement*, factors *linked to the death*, and factors *linked to the aftermath of the death* [7,34].

The risk factors that pre-exist the event of death concern both the type of ties with the deceased person (conflict, dependence etc.), the developmental history and the life itinerary of the bereaved individual (previous developmental or mental disorders, previous traumatic events, early separation etc.), the nature of the attachment ties (ambivalent or insecure

attachment) or the family history and dynamic (earlier deaths, instability of the family structure, etc.).

The risk factors linked to the death itself are mainly the circumstances in which the death occurred (violent, unexpected death, or death occurring in a traumatic context in which the child was involved, confrontation with a mutilated body, impossibility of seeing the body of the deceased, successions of bereavements, etc.) and the funeral rites deployed (whether the child is able or is allowed to attend, or on the other hand forced and violent participation without psychological accompaniment and adequate scope for the child to find meaning).

The risk factors linked to the aftermath of the death relate to the reactions in the close circle (denial, incomprehension, non-availability for the child's reactions, rejection, aggressiveness, bans on talking about the deceased person or about the related mental distress, failure to accompany the child in the process of giving meaning to the event, etc.), as well as among those in the wider daily circle (stigmatization by peers, cyber-harassment etc.) and also to changes in daily life patterns (moving house, changing schools, placements etc.), which are all further losses for the child.

There is a need to offer accompaniment to children and adolescents who are considered to be at risk, whatever the type of accompaniment required (ranging from simple distance follow-up to talking groups for bereaved children, and full-blown psychotherapy).

[The accompaniment of complicated grief](#)

In a recent editorial, Melhem and Brent, two international specialists of the question, recall that beyond the nosographic and aetio-pathogenic quarrels, a bereaved child whose life will be affected by the distress generated and whose general functioning is altered over several years requires accompaniment [38]. The paradox of accompanying complicated grief among children and adolescents is that because of the considerable prevalence of situations of bereavement that are potentially complicated, there are numerous formalized modes of accompaniment, which are highly varied, involve a range of different professionals as well as volunteer personnel and associations, while there are today few validated practices [39]. Two

meta-analyses that sought to assess the efficacy of therapies centered on bereavement among children and adolescents evidenced overall a lesser effect of these therapies in comparison to therapies used among children with other psychiatric disorders [40,41]. There are many reasons: on the one hand the "natural" tendency towards an attenuation of the symptoms of complicated grief, which as part of the grieving process, makes it more difficult to demonstrate a positive effect of these therapies; on the other, the data relating to parental response to these therapies are not included in the studies analyzed, while the role of parents is a key factor for children and adolescents to adjust to loss; finally, there are few controlled studies of satisfactory methodological quality on grieving among children, which could explain why the few meta-analyses that have studied this issue were restricted in their conclusions.

Existing interventions can be classified into *universal interventions*, which can be offered for any bereaved child whatever their level of psychological distress or social functioning, and *targeted interventions*, which are on offer either for children at risk, or for children presenting symptoms of complicated grief. Further to this, certain interventions target children, adolescents and also their entourage, in particular the *Family Bereavement Programme* (FBP) and the *Trauma-Focused Cognitive Behaviour Therapy* (TF-CBT), while others target adolescents alone, such as the *Trauma and Grief Component Therapy for Adolescents* (TGCT-A).

Among the "universal" interventions that have been validated, we can cite the example of the FBP, which aims to reduce the exposure of children to the series of stressful events following on from the death of a parent, and to strengthen the abilities and resources of the child and his or her environment in order to cope [42]. This program includes psycho-education on bereavement alongside group work for children and adolescents and their close circle. The efficacy of the FBP has been assessed longitudinally over a period of 15 years among bereaved children aged from 8 to 16, showing a benefit at 11 months in terms of the reduction of internalized symptoms (depression, anxiety, somatization) and in externalized symptoms

(hyperactivity, aggressiveness) [42], a more rapid improvement of the symptoms of complicated grief [43], and a reduction in suicidal ideations and suicide attempts at 15 years follow-up [44].

Among the "targeted" interventions we can cite the TF-CBT, the efficacy of which has been satisfactorily validated in childhood PTSD [45,46], but where certain modules were developed specifically for traumatic bereavement. Studies using the complete protocol of 16 sessions [47] or a shorter protocol of 12 sessions [48] have shown an improvement in the symptoms of complicated grief, PTSD, depression, anxiety, and a reduction in behavioral manifestations. The TGCT-A [49], a psychotherapy program administered in school environments, has been evaluated in non-controlled trials conducted in varied settings, from students exposed to community violence [50] to adolescents confronted with bereavement after the September 11th attacks [51], each time showing improvements in the symptoms of PTSD and complicated grief. These results were confirmed in a randomized controlled trial [49]. After a screening phase to identify complicated grief in school environment, the TGCT-A comprises 20 sessions and four modules. The first module is centered on the establishment of group cohesion, psycho-education on PTSD and complicated grief, and the acquisition of coping skills for distress resulting from trauma. The second module is centered on the emotional and cognitive processing of traumatic experiences. The third module explores the relationships between trauma, loss and grieving, working in particular on the "reconstruction" of a non-traumatic memory of the deceased person. The last module is centered on the different stages enabling the adolescent to re-invest in social and developmental activities.

Group accompaniment can present an interest. Among the numerous existing offers we can cite the *Histoire d'en parler* groups ("just talking"), set up by our team ten years ago in the French region previously known as *Midi-Pyrénées*, which also offer a space for contact and exchange for the child's family led by volunteers [52].

Associations also have an important role: we can cite in particular the associations *Vivre son Deuil* ("facing bereavement"), coordinated by the European association of the same name

(<http://vivresondeuil.asso.fr/>) or the association *Empreinte* (<https://empreintes-asso.com>). Finally it can be useful to refer to books suited to the age of the child in order to talk about death; for adolescents, it is possible to suggest certain forums for exchanges on experience among peers [53]. The section *Childhood traumatic grief* which is part of the *National Child Traumatic Stress Network* (<https://www.nctsn.org/resources/childhood-traumatic-grief>) is a source of information and tools in English that is very useful for professionals and non-professionals who find themselves accompanying bereaved children and adolescents.

Because of the wide range of existing interventions and the shortage of studies enabling recommendation of one type of intervention rather than another, we propose a simple algorithm making it possible to guide the accompaniment of bereavement among children and adolescents (Figure 1). It is nevertheless important to always explore and integrate the expectations of children and adolescents and their close circle with respect to this accompaniment, and not to hinder the process of grieving for the child or the family, a process that is singular and subjective, by an excessively medicalized approach.

[Suicide](#)

The question of bereavement following suicide by a person close is delicate, in particular for children and adolescents having lost one of their parents by suicide. There is an increased risk of suicide among young people who have been exposed to suicide of a person close, and particularly when it concerns a parent [54]. In the accompaniment of these young people, there will be a need to find the right balance between on the one hand respect for the deceased person (without condoning the act, accepting the idea that a person can suffer to such an extent that the solution of suicide takes precedence and accompanying the child or the adolescent in an attempt to give meaning to the act) and on the other exclusion of suicide as a solution to put a stop to suffering.

Perspectives and conclusion

Future research on reactions of grief among children and adolescents need to center on the understanding of their aetio-pathogenic mechanisms, and in particular the neurobiology of bereavement and grieving. The longitudinal follow-up of large cohorts of children and adolescents, in different circumstances of death and different relationships between the child and the deceased person, should make it possible to gain a better understanding of bereavement trajectories and their definition, and also of the risk factors and protective factors for complicated grieving [55]. The development of specific psychometric instruments is also an important challenge, as is their validation in French. Finally, the development of validated therapies centered on the family, easy to implement and access, is a priority.

To sum up, the question of grieving among children and adolescents, which was long neglected, is at present expanding fast, with the objective of identifying the specific features of normal and complicated grief in this population as compared to adults. More broadly, we need to be attentive to the potentially negative consequences of grieving among children and adolescents, and not to deny the existence of complicated grief in this population, at the same time avoiding dramatizing or excessively medicalizing extreme grief among children. A child, when given adequate social and affective support, will in most cases overcome this life ordeal by giving it meaning.

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Figures Legend

Figure 1. Proposed algorithm for follow-up and accompaniment of grieving among children and adolescents

Situation of bereavement for a child or adolescent

General principles for accompaniment

- Suggesting active participation by the child in the funeral
- As far as possible avoid upsetting the child's daily life
- Detecting and addressing feelings of guilt
- Favoring exchanges with other bereaved children
- Suggesting books on the question of death and grieving
- Paying attention to secondary losses
- Maintaining the memories of the deceased person without hindering the progressive return to a life dynamic

"Normal" grief

A process of progressive adaptation to the loss, enabling social and affective re-investment while at the same time preserving an inner link with the deceased person

No particular follow-up

- General information on bereavement and support facilities
- No specific accompaniment
- Offer a distance assessment consultation

Risk-prone grief

Risk factors

- Pre-existing the death
- Linked to the death
- Linked to the aftermath of the death

Preventive follow-up

- General information on bereavement and support facilities
- Close monitoring
- Offer a preventive intervention (groups of bereaved children, specialized consultation, etc.)

Complicated grief

A grieving process that differs from the norm by way of the intensity of symptoms, the duration, or the inability of the subject to reinvest socially and affectively

Care centered on grieving

- Offer a therapeutic intervention (psychotherapy, group of bereaved children, etc.)
- Support for the close circle
- Close monitoring of the child and the close circle

Grief as a factor triggering a psychiatric disorder

Grief accompanied by de-compensation or the onset of a psychiatric disorder whatever is nature

Specific care for a psychiatric disorder

- Care appropriate to the psychiatric disorder, combining psychotherapy and psychotropic medication if needed
- Close monitoring of the child and the close circle

Table 1. Development stages for the comprehension of death and reactions to grief according to age.

Developmental stages	Ability to comprehend death	Possible manifestations of grief
Infants (0-2 yrs)	No comprehension of death	General distress, irritability Regression and changes in routine (crying, feeding, sleep) Somatisation Infant withdrawal and depression Abandonment anxiety
Toddlers (2-4 yrs)	Death is seen as reversible, as prolonged physical absence No difference between death and sleep Magical thoughts on the subject of death	Death is seen as reversible, as prolonged physical absence No difference between death and sleep Magical thoughts on the subject of death
Children in kindergarten (4-6 yrs)	Great variability in the perception and comprehension of death and its irreversibility Persistence of magical thoughts on the subject of death	Considerable guilt Incessant questioning about death Anger, hyperactivity, irritability Sadness and great sensitivity towards manifestations of sadness among persons close Regression Insomnia and nightmares Possible protective denial that can perplex adults Taking everything literally (caution with the imagery used to talk about the deceased person) Preoccupied by the changes upsetting daily routine (losses and gains)
Children in lower primary school (6-8 yrs)	Comprehension of the irreversibility of death Inability to generalise the experience of death to self or others	Denial of the fact he/she too could die Fear that something might happen to people close Feeling abnormal compared to peers Repeated questioning about death Anxiety and depression Somatisation Anger Withdrawal and isolation Feelings of loss of control

Child in the period of latency (8-12 yrs)	Death seen as a natural, universal phenomenon Progressive acquisition of the ability to understand the cause of death	Coexistence of considerable curiosity and considerable anxiety towards death Philosophical or religious questionings about death Feelings of guilt Concentration problems Feeling different from other children
Adolescents (12-18 yrs)	Clear perceptions of death and its implications both personal and general Existential questioning about death Abstract reasoning about death	Antagonism between adolescent processes and grieving processes Possible denial of the grief, with deferred grief to preserve adolescent processes Sadness, depression, anxiety Anger Withdrawal and loneliness Importance of identification (groups of bereaved adolescents) Concentration problems, difficulties at school Risk-prone behaviours (addictions, risk-taking, etc.) Protective attitudes towards the family (parenting attitudes)

Table 2. Simplified presentation of the diagnostic criteria for the DSM-5 persistent complex bereavement disorder and IDC-11 prolonged grief disorder

Criterion	Synthetic description
A	Loss of a loved one
B	Desire to see the deceased person again or persistent preoccupation with the person or with the circumstances of death, alongside intense emotional suffering and sadness
C	Cognitive, emotional and behavioural symptoms: <ul style="list-style-type: none">• Confusion as to his/her role in life or altered perception of self• Difficulty accepting the loss• Avoidance of any reminder of the reality of the loss• Bitterness or anger towards the deceased person• Difficulty getting on with life and in making plans for the future• Difficulty trusting others since the death• Emotional numbing since the death• Feeling that life is unsatisfactory, empty or meaningless since the death• Feeling of shock or bewilderment since the death
D	Temporal criterion: the diagnosis cannot be made until six months after the death
E	The symptoms have considerable repercussions on the subject's level of functioning and his/her ability to take part in activities
F	The symptoms of grieving are abnormal in relation to cultural or religious norms or in relation to the subject's age