

Parental Loss During Childhood and Outcomes on Adolescents' Psychological Profiles: A Longitudinal Study

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Abstract The loss of a parent during childhood is a traumatic experience that can bring about several difficulties in adaptation and psychopathological problems over time during the child's development. The present study assesses the psychological functioning of a sample of non-referred pre-adolescents and adolescents and considers the impact of the loss of a significant caregiver on their current psychological profiles. Three groups of subjects were considered, as follows: Group A experienced loss between birth and 3 years of age; Group B experienced loss between 3 and 10 years of age; and Group C experienced no loss. The results show that there is a significant decrease in psychopathological risk and improvement in subjects' scores in the transition from pre-adolescence to mid-late adolescence. Adolescents who have suffered the loss of a caregiver within the first three years of life, however, continue to report higher scores than the other two groups, denoting no improvement in their psychological welfare.

Keywords Adolescence · Loss · Psychological profiles

Introduction

Many authors have suggest that the death of a parent during childhood is a unique and overwhelming event that may have potentially traumatic consequences over time (Binger et al. 1969; Davies 1998; McCown and Davies 1995; Cerel et al. 2006;

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Melhem et al. 2008). In the theoretical framework of developmental psychopathology, the international scientific literature supports an association between parental bereavement and several difficulties in children's and adolescents' adjustment (Dopp and Cain 2012). Yet, most of these studies have not considered the specific developmental stages in which the loss occurs (Ratnarajah and Schofield 2007). It has been suggested that more severe psychological consequences from the loss of a parent are experienced by individuals who lost their caregiver in the first three years of life (Abdelnoor and Hollins 2004). Over time, subjects are able to adjust to these consequences in different ways, depending on their developmental stage.

In normal circumstances, pre-adolescents (11–13 years of age) can rely on fewer resilience factors compared to adolescents (14–18 years old; Rheingold et al. 2004). In fact, adolescents can count on a larger and more intimate group of peers, with which they usually establish bonds of psychological closeness; further, the tie with the surviving parent can be stronger and sustained by adolescents' capacity to communicate and share affective contents by means of more sophisticated verbal skills and metacognitive processes (Haine et al. 2008). In sum, the loss of a parent during childhood can affect the capacity to form and maintain intimate relationships in later life, cope with stressful life events, and fulfill developmental tasks. There is consensus that the death of a parent in early childhood is a very complex experience for children to face, placing them at risk for future psychopathology (Stroebe et al. 2005).

Some authors have shown that late adolescents who experienced parental death during their childhood exhibit severe eating disorders (Beam et al. 2004). Increased psychopathological risk, dissociative symptoms, and eating disorders all seem to represent maladaptive defensive strategies used by the subject to cope with overwhelming affect caused by the death of a parent. In particular, dissociative functioning seems related to the subject's difficulty when it comes to integrating the experience of being permanently separated from the parent, whereas eating disorders appear to be related to an impaired capacity to regulate intense and negative emotions through metacognitive processes (Schmidt et al. 1997; Cimino et al. 2012b).

A transitional theoretical framework has been proposed to understand the variability in children's adaptation to the death of a parent. This model proposes that children's adjustment after the loss can be influenced by the more proximal negative life events in which a child is involved following the death, his or her protective resources, and the complex interaction between proximal negative life events and protective resources (Felner et al. 1988).

One of the many variables responsible for different outcomes following the death of a parent during childhood is the surviving parent's caregiving quality. Positive parenting has been broadly recognized as central for adaptive child outcomes in development (Wyman et al. 2000; Kwok et al. 2005). However, the surviving parent may find it difficult to fulfill the parental role while coping with his or her own grief for the loss of his or her partner (Saldinger et al. 2004). It has also been suggested that secure attachment to the parent may constitute a resilience factor that can prevent or remedy the onset of maladaptive emotional and behavioral functioning in children who were exposed to traumatic experiences and losses in their first years of life. On the other hand, it has been suggested that poor caregiving quality, maladaptive patterns of interactions, and insecure attachment are promoted by parental psychopathological risk; Out et al. (2009) studied caregivers' psychological profiles as proxies of parents'

attentiveness and their ability to fulfill their parental role in potentially traumatic experiences, such as the loss of an attachment figure.

Some research has underlined that males who have experienced parental losses in infancy show more aggressive behaviors than females (Dowdney et al. 1999; Elizur and Kaffinan 1982), and that boys tend to manifest more internalizing symptoms (Gersten et al. 1991; Cimino et al. 2012a).

Weller et al. (1991) found that children who lost a father reported a greater number of depressive symptoms compared to children who had lost a mother. The scientific literature, however, shows conflicting data in this regard: Two recent studies assessed depressive symptoms in children who had lost a parent and found no significant differences between children who had lost a father and those who had lost a mother (Kalter et al. 2002; Raveis et al. 1999).

It is important to emphasize that the maladaptive outcomes related to the loss of a caregiver are influenced by the developmental stage of the subject, and this is particularly true when considering the passage from childhood to adolescence. In one of the few studies addressing this specific issue, Shultz (1999) pointed out that children express their bereavement in a different manner compared to adults and in a way that is specifically related to their developmental phase. Five-year-old children, for example, start to appreciate that death is a permanent condition. Moreover, when entering early adolescence, children have a better understanding of the universality, irreversibility, causality, and non-functionality of death (Corr 1995). In addition, according to Blos (1989), entering adolescence brings to the fore the re-elaboration of past traumas (such as the loss of a parent) which must be integrated into the Self.

It must also be stressed that grieving has to be defined as a process that can be characterized according to a variety of tasks a child has to work through (Baker et al. 1992; Worden 1996). For this reason, it is particularly useful to consider longitudinal studies, which can appreciate the course of the bereavement from the immediate aftermath of the parental death in childhood to longer term effects that are seen well into adolescence. Yet, there is a dearth of longitudinal studies focusing on children's response to their parents' death in specific developmental states (i.e., infancy, toddlerhood, pre-adolescence, adolescence; Cimino et al. 2012a, b). The Child Bereavement Study (Worden 1996) indicated that 15–20 % of parentally bereaved children could present significant emotional and behavioral difficulties at 2 years post-loss, even after showing an initial resilience in adjusting to loss.

Based on these theoretical premises, we adopt the conceptual model of developmental psychopathology, which assumes that traumatic experiences and losses in the first years of life may have potentially maladaptive consequences on psychological functioning over time. This model also states that earlier losses are likely more predictive of psychopathological risk, and we aim to longitudinally analyze the outcomes of parental loss during childhood on the psychological profiles of parentally bereaved pre-adolescents and adolescents. As seen above, previous international literature in the field has scarcely addressed non-referred samples, concentrating instead on clinical populations and mostly evaluating the psychopathological consequences of parental loss in adolescence and adulthood. The present paper, therefore, intends to consider a community sample focusing on different outcomes of parental bereavement confronting pre-adolescents' and adolescent' psychological response to loss experiences. At time 1 (T1), pre-adolescents (11–13 years of age) were assessed through self-

report questionnaires in terms of possible psychopathological risk, eating-related difficulties, and dissociative symptoms. At time 2 (T2), the same sample of subjects (now adolescents, 14–16 years of age) was evaluated and we assessed the psychological profile of the surviving caregiver. At both T1 and T2, we specifically considered the effect of the developmental phase in which the subject had lost the parent (0–3 years of age or 3–10 years of age).

In particular, this study intends to verify whether adolescents' psychological profiles significantly differ from T1 to T2 considering the following factors: the age and gender of the adolescents; the age at which the loss occurred during childhood; and whether the loss involved a mother or father. As a secondary objective, we aim to verify the possible association between the characteristics of the psychological profiles of adolescents and the possible psychopathological risk of their surviving parent at T2.

Methodology

Participant Recruitment and Characteristics

From a population of pre-adolescents ($N=742$) recruited from schools in Central Italy, subjects were selected through an anamnestic questionnaire. For the purpose of this study, we excluded those subjects from the research who had suffered from traumatic experiences other than parental loss, such as sexual or physical abuse, neglect, or physical injuries ($N=78$); had been diagnosed with for psychiatric disorders ($N=24$); had suffered from serious or chronic illness ($N=96$); had divorced parents ($N=98$); had been adopted by stepparents or were in foster care ($N=6$); had severe economic problems ($N=103$); did not complete all of the questionnaires or missed items ($N=103$); did not receive consent to participate in the study (underage subjects, $N=83$). Using these exclusion criteria, the present longitudinal study included the following three groups at T1 and T2:

- Group A ($N=48$): Subjects who suffered the loss of a parent from birth to 3 years of age;
- Group B ($N=52$): Subjects who suffered the loss of a parent from 3 to 10 years of age; and
- Group C ($N=51$): Subjects who had suffered no parental loss (Table 1).

All subjects were Caucasian and most (87 %) were of middle socioeconomic status (SES; Hollingshead 1975). With regards to subjects' parents, most of the parents lived with a partner (68 %), and 89 % of parents were employed. The subjects' mothers had a mean age of 43.5 years (standard deviation [SD]=3.3), whereas the mean age of the fathers was 49.1 years (SD=2.4).

Measures

The Symptom Check-List (SCL-90-R) is a 90-item self-report symptom inventory aimed to measure psychological symptoms and psychological distress (Derogatis 1994). Its main symptom dimensions are Somatization, Obsessive-Compulsivity,

Table 1 Demographic data

Loss period		T1		T2	
		<i>N</i> (male/female)	Age	<i>N</i> (male/female)	Age
Group A	From 0 to 3 years of age	48 (22/26)	Mean=12.31 SD ^a =1.23	35 (17/18)	Mean=17.01 SD=0.75
Group B	From 3 to 10 years of age	52 (26/26)	Mean=13.01 SD=1.31	33 (16/17)	Mean=16.23 SD=0.65
Group C	No loss	51 (25/26)	Mean=12.45 SD=1.44	35 (18/17)	Mean=16.41 SD=0.73
Total		151 (73/78)		103 (51/52)	

^a Standard deviation

Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. The SCL-90-R has been shown previously to have good internal coherence (α coefficient=0.70–0.96) in adolescents and adults (Italian validated version: Prunas et al. 2012).

The Eating Attitudes Test (EAT-40) is a 40-item self-report symptom inventory that identifies concerns with eating and weight in the adult population. It is scored on the following three subscales: Dieting, Bulimia/Food Preoccupation, and Oral Control. A high total score reflects dissatisfaction with body image and a desire to be thinner, as well as a preoccupation with eating, its effect on body size, and self-control when eating. It has shown a high degree of internal reliability (α coefficient=0.79–0.94), and has been validated for adult patients with anorexia nervosa.

The Adolescent Dissociative Experience Scale (A-DES) is a 30-item, 11-point Likert scale self-report screening measure for dissociation. It has been used with non-clinical and clinical samples (Armstrong et al. 1997). The A-DES has shown good internal reliability with non-clinical subjects (split-half $r=0.91$, $\alpha=0.93$; Armstrong et al. 1997), and adequate 2-week test-retest reliability in a mixed junior high and high school sample ($r=0.77$). The A-DES includes subscales measuring Dissociative Amnesia, Absorption and Imaginative Involvement, Passive Influence, and Depersonalization and Derealization. The clinical cut-off is equal to 4 (Smith and Carlson 1996).

Study Design

A 3-year longitudinal study was conducted with two serial assessments. The initial assessment (T1) was conducted face-to-face on a sample of $N=151$ subjects ($N=100$ with parental loss) over a period of 6 months by a group of trained psychologists who visited the adolescents at school. The second assessment (T2) was administered 3 years after T1 on $N=103$ (dropout rate after T1= $\sim 31\%$; $N=48$). Subjects were lost to follow-up for the following reasons: inability to re-contact subjects ($N=21$); refusal of adolescents to participate further in the study ($N=19$); and refusal of the parent to participate further in the study ($N=8$). Through the Chi-square test, we have verified the homogeneity of the three groups in terms of age and gender (Chi-square=0.063; $df=2$;

$p=0.969$). At the T1 assessment, we administered the SCL-90-R, EAT-40, and A-DES. At T2, the same questionnaires were administered on the adolescents, and SCL-90-R was also administered on the surviving parent for Groups A and B. Although our study design included administering SCL-90-R to parents both at T1 and T2, we could not assess parents at T1 due to the refusal of the schools where the recruitment took place. At T2, some of the subjects ($N=7$) were excluded from the analyses due to missing data in the questionnaires. Therefore, the analyses at T2 were performed on $N=96$ subjects. Before administering any procedure and/or questionnaire, written informed consent was provided by all parents. All analyses were performed using SPSS software (version 15.0).

Results

Adolescents' Psychological Profiles from T1 to T2 Considering Gender and the Age at Which the Loss Occurred

Using repeated measures analysis of variance (ANOVA) on the pre-adolescents' (T1) and adolescents' (T2) scores, the results showed no significant difference in terms of gender for any of the groups (Groups A, B, and C) on the SCL-90-R and A-DES questionnaires. A significant gender difference was found only for the EAT-40 scores in Group A, where females had higher total scores than males ($p<0.01$).

In relation to SCL-90-R, a significant decrease was noted from T1 to T2 for the three Global Indexes (all at $p<0.001$) in Groups B and C. In particular, a decrease in the scores occurred from T1 to T2 for the following specific subscales: Obsessive Compulsivity, Anxiety, Hostility (all at $p<0.05$), Depression, and Phobic Anxiety (both at $p<0.001$). In the above subscales, Group B showed significantly higher scores than Group C ($p<0.01$). In addition, Group A showed an increase from T1 to T2 in the scores for Paranoid Ideation, Psychoticism (both at $p<0.01$), and Interpersonal Sensitivity ($p<0.001$). These scores exceeded the clinical cut-off at T2 (>0.91 , >0.91 , and >0.42 , respectively) for an Italian population of adolescents (Italian validated version: Prunas et al. 2012).

With regards to EAT-40, a significant decrease resulted between T1 and T2 for the total scores in Groups B and C ($p<0.01$). Specifically, the decrease related to the following subscales: Dieting, Bulimia, and Food Preoccupation ($p<0.01$). In contrast, Group A showed a significant increase in the scores for Bulimia and Food Preoccupation from T1 to T2. The increased scores exceeded the clinical cut-off (>30) at T2 for the Italian population of adolescents (Cuzzolaro & Petrilli 1988). Group B showed significantly higher mean scores than Group C ($p<0.01$), while Group A showed the highest scores ($p<0.01$).

In terms of A-DES scores, a significant decrease was shown between T1 and T2 for the total scores in Groups A, B, and C ($p<0.001$). Specifically, Group A, B, and C showed decreased scores over time for the sub-scales, all significant at $p<0.001$. Group A showed the highest mean scores for the above subscales, exceeding the clinical cut-off (>4) at T2 for the Italian population of adolescents (Table 2).

Using a multivariate ANOVA (MANOVA), we checked whether the differences between preadolescents and adolescents could be affected not by only the

Table 2 Adolescents' psychological profiles from T1 to T2

From T1 to T2				
Significant decrease in Groups B and C			Significant increase in Group A	
<i>SCL-90-R</i>	<i>F</i>	<i>p</i>	<i>F</i>	<i>p</i>
Global Severity Index (GSI)	$F=14,040$	$p<0.001$	–	n.s.
Positive Symptom Total	$F=17,502$	$p<0.001$	–	n.s.
Positive Symptom Distress Index	$F=7,39$	$p<0.01$	–	n.s.
Somatization	–	n.s.	–	n.s.
Obsessive Compulsivity	$F=5,697$	$p<0.05$	–	n.s.
Depression	$F=15,14$	$p<0.001$	–	n.s.
Anxiety	$F=5,099$	$p<0.05$	–	n.s.
Hostility	$F=5,885$	$p<0.05$	–	n.s.
Phobic Anxiety	$F=14,943$	$p<0.001$	–	n.s.
Paranoid Ideation	–	n.s.	$F=7,051$	$p<0.01$
Psychoticism	–	n.s.	$F=7,420$	$p<0.01$
Interpersonal Sensitivity	–	n.s.	$F=20,14$	$p<0.001$
<i>EAT-40</i>	<i>F</i>	<i>p</i>	<i>F</i>	<i>p</i>
Total scores	$F=8,957$	$p<0.01$	–	n.s.
Dieting	$F=10,536$	$p<0.01$	–	n.s.
Bulimia and Food Preoccupation	$F=8,034$	$p<0.01$	$F=9,023$	$p<0.01$
Oral Control	–	n.s.	–	n.s.
Significant decrease in Groups A, B, and C				
<i>A-DES</i>	<i>F</i>	<i>p</i>		
Total scores	$F=25,676$		$p<0.001$	
Dissociative Amnesia	$F=24,734$		$p<0.001$	
Imaginative Involvement	$F=30,636$		$p<0.001$	
Passive Influence	$F=24,778$		$p<0.001$	
Depersonalization and Derealization	$F=37,16$		$p<0.001$	

developmental stage at hand, but also the amount of time that had elapsed since the parent's death. The results showed no significant difference in terms of the amount of a time elapsed since the parent's death in the scores of preadolescents (T1) and adolescents (T2) in Groups A and B.

Adolescents' Psychological Profiles at T1 and T2 Considering Whether the Loss Involved a Mother or a Father

We conducted a Student's *t* test to analyze the effect of the loss of a mother or a father during childhood. The results suggest that, independent of the gender of the subject and the age at which the subject lost the parent, adolescents who had lost a mother showed higher total A-DES scores than those who had lost a father ($t=7.2$; $p<0.05$), both at T1 and T2.

Association Between the Characteristics of the Psychological Profiles of Adolescents and the Possible Psychopathological Risk of Their Surviving Parent at T2

We conducted linear regression to verify whether the characteristics of the adolescents' psychological profiles may be predicted by the possible psychopathological risk of their surviving parent at T2. The results showed that the GSI ($\beta=0.966$; $t=29.295$; $p<0.001$), the Positive Symptom Total ($\beta=0.970$; $t=31.686$; $p<0.001$), the Positive Symptom Distress Index ($\beta=0.853$; $t=12.893$; $p<0.001$), and all subscales of the surviving parent's SCL-90-R (all significant at $p<0.01$ or higher) seemed to predict the scores of the adolescents on the same questionnaire.

Finally, it was noted that 31 parents in Group A, five parents in Group B, and no parents in Group C exceeded the clinical cut-off for SCL-90-R with regards to the GSI (>0.57 ; Nifosi et al. 2007).

Discussion and Conclusion

Several international studies have confirmed that the loss of a parent during childhood is a potentially traumatic event bearing possible consequences for the child's psychological functioning over time (Rheingold et al. 2004; Melhem et al. 2008). It has also been suggested that adolescence can be a particularly complex phase in the life of an individual, and that parentally bereaved adolescents can show several severe psychological difficulties (Stroebe et al. 2005). Yet, few studies have analyzed the effect of the parental loss on specific phases of youth in a longitudinal fashion to distinguish between early and late adolescence.

The results of the present paper suggest that parentally bereaved individuals may show more impaired psychological profiles in pre-adolescence (11–13 years of age) than in adolescence (14–16 years of age), presenting more severe psychopathological symptoms, specifically higher scores for eating difficulties and dissociative symptoms. Consistent with the international literature, our results show that the loss of a parent can have a severe impact on the psychological functioning of the bereaved during pre-adolescence (Steel et al. 2008). We suggest that this strong effect may be due to the specific developmental tasks that the pre-adolescent must face, such as significant physical changes with the onset of puberty, as well as interpersonal and psychosocial transitions (Blos 1989).

As mentioned above, the results showed a decrease in psychopathological symptoms from pre-adolescence to adolescence. However, this is not true for those adolescents who lost their parents within their first 3 years of life. It seems that the earlier the loss occurs, the more likely it is that the psychopathological symptoms will persist over time. It has been demonstrated that the persistence of psychological malfunctioning over time in adolescence may bring about a fivefold risk of developing psychiatric disorders in later life (Christ 2001).

Our results also indicate that maternally bereaved adolescents exhibit higher dissociative scores than paternally bereaved ones. Bromberg (1998) states that dissociation symptoms are a frequent and adaptive response to traumatic events. When this response is persistent over time and during particular and complex developmental stages such as pre-adolescence and adolescence, dissociation symptoms can foster psychiatric

disorders such as clinical depression and/or anxiety. Cohen et al. (2004) have proposed that persistent (and not only acute) psychological difficulties may be defined as part of the specific symptomatic frame of complicated grief. Moreover, in the case of a maternal loss during early childhood, the bereavement can interfere with the construction of a personal and coherent identity, which is the major developmental task the individual has to face in his or her adolescence (Balk 1991; Balk and Corr 2001; Erikson 1968; Tyson-Rawson 1996). It has been suggested that the loss of a mother during childhood may impede the process of formation of an adolescent's identity, as this process also takes place through parental relationships. In fact, adolescents also explore identity alternatives and begin to define themselves in contrast and continuity with their parents (Balk and Vesta 1998; Tyson-Rawson 1996).

Our results suggest that the psychological profile of the surviving parent can have an impact on the psychopathological symptoms of the pre-adolescent and adolescent. This result is in line with several studies that have suggested that psychopathological risk in the surviving parent may impair an attentive relationship with sons and daughters, who cannot rely on a sensitive, caring, and supportive social environment. This, in turn, may impede the development of satisfying relationships and inhibit individual maturity and personal growth (Angell et al. 1998; Balk 1999; Davies 1991; Klass et al. 1996).

The present study has some limitations. First, we did not assess the loss of significant figures other than mothers or fathers during childhood. It has been demonstrated, for example, that sibling loss may be considered a potentially traumatic experience, as well as the loss of a grandmother or grandfather. In accordance with this, it would be also useful to consider the attachment models of adolescents and to obtain more information on their life experiences during childhood. In addition, we did not address the possible role of SES or the characteristics of the adolescents' temperament. Moreover, we assume that the group of subjects who did not experience any losses in their childhood showed a decrease in psychopathological risk scores because pre-adolescence is characterized by several physical and psychological reorganizations, and these are frequently connected to an unstable psychological functioning (Weller et al. 1991); however, this hypothesis was not confirmed by direct assessment of resilience factors in the present study. Further, we did not assess surviving parents' psychopathological risk at T1. Evaluating their psychological functioning at both T1 and T2 could have been useful in terms of determining the stability and change of an important protective or risk factor related to pre-adolescents' and adolescent' outcomes. We look forward to broadening the sample and to addressing all the limitations we have mentioned in future studies.

The present paper has several strengths as well. To our knowledge, this is the first research that has assessed specific phases of development, distinguishing between pre-adolescence and adolescence in relation to the consequences of early parental loss. This issue is relevant and adds to the previous literature in the field of prevention and intervention practices, since it can be very important to evaluate and differentiate psychopathological symptoms in pre-adolescence (which might be temporary) and maladaptive functioning in adolescence. This could orientate clinical work and early intervention that can discriminate between different developmental phases in the specific field of parental loss. Second, we chose well-validated and widely used empirical tools and employed a longitudinal design.

Further research should be conducted to confirm these results and remedy their limitations in order to propose more efficient assessment and intervention policies for pre-adolescents and adolescents in the case of early parental loss.

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