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Childhood bereavement: Somatic and behavioural symptoms of psychogenic origin

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In the background of the symptoms of childhood bereavement manifesting themselves in somatic complaints and behaviour disorders, mechanisms analogous to the psychodynamics of adult mourning are functioning which differ only in certain traits. The most specific difference is the belief of children in the reversibility of death. Depression, imaginary reunion and identification with the dead parent are features of mourning observed and reported by several authors. Of the results of the psychological investigation of the present material comprising 22 children, identification through disease and obesity can be emphasized as phenomena not described so far in relevant literature. Naturally, the choice of symptoms is multicausal depending on age, degree of personality development and on the family conditions before and after bereavement as well as on all possible influences upon the child. Actually, the multitude of environmental factors renders impossible their full consideration for drawing general conclusions. In order to study the general validity of the discussed phenomena, further observations, narrowed down to age groups and symptoms, are required.

It is a frequent observation that following bereavement children produce somatic symptoms without an organic basis. The well-known effect of emotions exerted upon the vegetative nervous system makes the psychogenic origin of the complaints evident for the experienced physician. The concept "psychogenic" being too generalized, it seemed interesting to study the psychogenic mechanisms particularly characteristic of mourning and to clarify the psychodynamic factors playing a role in their development.

Material and Methods

In 22 children between 4 and 14 years of age admitted to our department or treated at its outpatient clinic psychological tests were performed within a 1-year period following the death of one parent. Of the 8 girls and 14 boys 5 had lost the mother and 17 the father. Eighteen children were referred to the clinic on account of various somatic complaints and 4 because of manifesting behaviour disorders.

In the older children the examination comprised history, exploration, drawing and dream analysis as well as projective tests (Rorschach, Szondi), while in the younger age group mainly play techniques were applied.

Results

Investigation of this rather heterogeneous group of children revealed the following, particularly characteristic psychogenic phenomena.

Depression, being the most general symptom, could be observed in all the 22 cases. Childhood depression is a rare condition; some authors believe to have traced only a predisposition to future depression in children.

Abraham [1] describes on the basis of psychoanalysis of adults a "primary parathymia" occurring in childhood which he believed to be the prototype of psychotic depressive episodes in adulthood. Klein [6] presumed that all infants between 6 and 12 months of age undergo a "depressive position" which may form the basis of future depression. Spitz and Wolf [9] reported on symptoms termed by them anaclytic depression in such infants who had suffered mother deprivation for a prolonged period before the age of 1 year.

Examination of the younger children did not always show the characteristic symptoms of adult depression such as loss of appetite, sleep disturbances, psychomotor retardation. Some of the children faced and accepted death with seeming indifference. Grown-ups often complain about the heartless attitude of children, that they run about, play as if nothing had happened. At the same time analysis of dream and play content as well as projective tests frequently indicate a deep depression in the background. In the drawings and dreams, loneliness, anxiety, longing for death are reflected and in the projective tests typical depressive symptoms are recognizable. In older children, sleep disturbance and dysthymia become more frequent.

The psychodynamic features of this depression correspond to adult depressive mechanisms differing only in certain manifestations, e.g. children believe, as already stated by Schilder and Wechsler [8] in the reversibility of death. In the eyes of the child the dead parent has only gone away and can return any time.

The conversation of two siblings, a 5-year-old boy and a 4-year-old girl, overheard 8 weeks after the death of their father, illustrates well this attitude.

The little girl was telephoning to her father at his office, as she had done before, asking him to come home, when the little boy reminded her "you must telephone to the cemetery".

This belief in the reversibility of death in younger age is the typical childhood conception of the universe, in older children it means a defence against depression; escape from an unbearable fact. The same holds true for cases where the child states definitely that his parent did not die or if he has died he will come to life.

Anna Freud and Burlingham [3] observed in children who had lost their father during the war that they denied death and believed in resurrection.

As a result of the magic world concept, children attribute a magic power

also to their own thoughts. Thus, as also stated by MAHLER [7], in the experience of a child, the parent died because of the ragefits and death wish the child had felt toward him. These the child lives through as a proof of his omnipotent power. As the opposite of the same magic power, the child believes himself to be capable of achieving resurrection of the dead.

In the background of both processes there is a desire for an imaginary reunion with the lost parent which, besides depression, is the other characteristic feature of childhood mourning.

The reaction of the children was motivated by the identification of the lost parent in 16 cases. This identification had 3 modes of manifestation:

1) identification with death itself;
2) identification with the disease causing death;
3) identification with the personality traits of the deceased parent.

The form of appearance in the examined cases was hysterical (assumption of symptoms) or acting out (suicide, obesity, manifest aggression). Most frequently, however, it remained at the level of wish fantasies about reunion. (The concept of acting out is used in the sense as described by BELLAK [1a], insofar the behaviour of the child expresses simple unconscious contents giving vent to frustration in action.)

A relevant example for the two types of imaginary suicide (death by accident and by starvation) and for the denial of death was offered by a 7-year-old boy:

His father fell victim to car accident. The child, though he saw his dead father, claimed his father was alive staying at a hospital. At the same time he started telling about his own imaginary accident with a motorcycle in which he crashed into a tree and died. The same child, while playing, pointed to his little finger saying "if one does not eat, one will be so small, then always smaller and finally waste away".

A 4-year-old boy produced the symptoms of the disease of the dead parent.

His father had suffered from ulcers and death occurred as a result of gastric haemorrhage. The child was referred to us with abdominal complaints. His stomach ache started one week after his father's death. Clinical investigations yielded negative results. Beside other clinical evidence a sentence said by the boy with an indifferent face was extremely informative of the nature of the symptoms. While he was playing he was asked whether he would like to have a particular toy (a doll), when we received the unexpected reply "I want to live".

The boy was convinced since he also had stomach ache (for him abdomen and stomach meant naturally the same thing), he was also bound to die just like his father. The ambivalent emotions of longing for his father, identification with his death and the fear of death are well reflected in his answer.

Identification with the personality traits of the deceased parent had 3

forms of appearance in the present material.

The strong feeling of guilt aroused by the bad relationship and death wish towards the aggressive, domineering parent resulted in the *identification with the aggressor* in all 4 boys referred to us on account of behavioural disorders. The wish to assume the role of the father also contributed to this defence mechanism. These boys took over following bereavement the domineering role of the father in every respect tyrannizing the mother and siblings. The other form of identification was the *overidealization* of the dead parent. These children cannot bear the experience of identification with a bad parent for then they would have to consider bad also themselves. For that reason they changed the personality traits of the parent to the opposite.

The mother of a 7-year-old girl had expected to improve her unhappy marriage by the birth of the child. Since she was disappointed in her expectations she turned away from her daughter. The sole emotional support of the child was the drunkard and often brutal father, who was kind only to her in the family. While her father was alive, the mother did not dare to hit her, but constantly declared that she was similar to her father in every respect. Thus, the girl had developed ambivalent feelings already in the father's lifetime. She identified herself with an actually drunken and brutal, and subjectively kind and gentle father. After his death she continued to talk about him as if he were still alive and had dreams about her father jumping out of the grave to come home, at the same time she frequently expressed her desire to die to follow her father. As a further defensive mechanism an overidealization of the father's personality trait could be noted: he was kind and good, he was a good husband, rightful, etc., so that the introjected image of the father should not undermine her self-esteem.

Of the forms of identification with the personality traits of parents, a surprisingly frequent incidence of obesity was found in the present material. Six boys began to gain weight rapidly soon following bereavement, while another boy, fat until then, lost weight suddenly. Polyphagia in the period following death played most probably a substituting role as a consequence to love deprivation, but the nature of identification was obvious in every instance.

The example of a 13-year-old boy is illuminating. His father was an alcoholic, vagabond and unreliable in financial matters. The father's obesity could be attributed, according to the son, to excessive eating and drinking habits. When the father died, identification become apparent in various ways. The boy started to loaf about, steal money from his mother's purse, and to eat and mainly drink excessively, for the time being only tea and milk. He gained 3 kg within 3 months following the death of his father.

The other 12-year-old boy lost his mother to whom he was too closely attached. Identification with the fat

mother manifested itself about 6 months after her death in taking up feminine hobbies and tasks within the family and in a weight gain of 7.5 kg. Here identification was extended to the entire female sex, the boy assumed the mother's role in the family.

The case of a 14-year-old boy deserves a more detailed discussion, emphasizing the role of emotional relationships and identifications within the family *before* the occurrence of the mother's death and the changes taking place *afterwards*.

The boy was strongly attached to his mother, being his mother's favourite. According to the father, after the boy was born he had suffered a great deal from the fact that his wife turned with all her tenderness towards this son. For all emotional frustration he blamed his son with whom in the course of rivalry he developed very bad terms. With the younger, 12-year-old son the father was not forced into rivalry but was seeking an emotional alliance against the mother and the elder son and built up thus a very positive emotional relationship with him. The elder son was fat like his mother, while the younger son was thin as his father.

The death of the mother caused a severe depression in the elder son but his good appetite persisted and he lost no weight. He was hospitalized on account of previous cardiac complaints. Since the clinical investigations yielded negative results the boy was discharged to report for control examination two months later by which time we had become aware of the changed family circumstances. Between the elder son and the father, obviously as a consequence of the ceased rivalry after the mother's death, a too close attachment, also of physical nature such as sleeping in the same bed, developed in the course of which mother identification turned into father identification. The boy lost 4 kg of weight in 4 weeks and had a normal appetite. At the same time the younger boy started to loaf about and produced symptoms of anxiety. These symptoms were motivated by the loss of his privileged role in the father's heart and by the fear of a possible return of the deceased mother. The negativistic emotions towards the mother, induced by the jealousy of the elder brother, aroused after the mother's death a guilty conscience and a fear of punishment. This was further augmented by the diminished protection received from the father to a feeling of defenselessness. The wandering expressed the wish to escape.

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