Notes on

Helping Children Cope with Separation and Loss,

Claudia Jewett
Harvard Common Press, Boston,

Claudia Jewett, in her book, *Helping Children Cope with Separation and Loss,* groups children's stages of grief in three categories:

1. Early Grief
2. Acute Grief
3. Integration

These stages incorporate the tasks and expand upon the five familiar steps identified in Elisabeth Kubler-Ross's work – Denial, Anger, Bargaining, Depression and Acceptance.

- In working with parents and children who are separated due to substance abuse, it is important to remember that children may have experienced multiple separations, out of home placements, loss of parents, a series of marital partnerships, separation from siblings and loss of homes, possessions, familiar friends and schools.
- They may have also experienced the "daily or periodic loss" of a sane, sober and healthy parent who changes personality depending on whether he/she is sober, actively using or hung over. This change in personality represents a significant loss although parent and child may continue to live in the same household.
- Therefore, children from AOD abusing homes may have experienced repeated episodes of grief and separation, which have never been resolved, and as a result, continually fall back into earlier periods of grief.
- Parent/participants may recognize these patterns in themselves as well as their children.

EARLY GRIEF

The early grieving process includes shock and numbing, alarm and denial.

Shock and numbing may be expressed physically in feeling cold and ill, becoming less resistant to infections, colds, sore throats and other minor illnesses. Children may be withdrawn and frightened. They may go through the motions of everyday life mechanically, like robots. They seem lifeless, with emotional flatness occasionally broken by outbursts of panic. Often children fall asleep in the midst of moving from one place to another or throw up when their body seems to shut down in shock and get rid of the experience they "can't stomach."

Alarm sets in somewhat later. Part of the physical response to danger the "fight, flight or freeze response." Children may experience increased heart rate, muscle tension, sweating, dryness of mouth, or bowel/bladder sphincter relaxation. Shortness of breath is common. Exhaustion and weakness sets in. Children often want to leave coats on for warmth as well as security.

These symptoms may reappear when children are thrown back into early grief by subsequent moves, changes in visiting patterns with parents or other upsets.

Denial and Disbelief. A child may cover his eyes and ears and yell, "no-no-no!" or look out the window expecting to see the parent coming to he him. They may refuse to hear or believe that a separation from their parent is temporarily necessary, even though this has been carefully explained to them. Children may falsely adapt. Some need a time free from pain and achieve this through denial.

Hyperactivity as Denial. Whereas some children tend to withdraw, sleep more and regress with intense early grief, others may become more hyperactive. We are all familiar with some people who withdraw and "cave in" under stress and others who go on cleaning binges, over work or become highly agitated in the face of stress or crisis. In the same way, some children's high level of mental and physical activity has a distracting effect which blocks out the reality of events and feelings. They may might talk a great deal with their mouths but never really complete a thought. Children may rock back and forth, banging their heads on walls, chairs or cribs. They may fidget continually, squirm and giggle with little ability to relax. Adolescents may use headphones, video games or alcohol or drugs to distract or numb the painful feelings.

Clinicians who diagnose children as "hyperactive" or with "attention deficit disorder" could benefit from considering looking into the child's history to determine whether frequent and/or traumatic loss, separation and unresolved grief may be causing these symptoms.

ACUTE GRIEF

Yearning and pining for the lost person are common for all of us: thinking obsessively, hoping, wishing that things could go back to how they used to be. We create an image of the lost person (or object) in our minds and cling to it, many times ignoring outer reality. This image may be idealized, such that negative aspects of the parent like physical or sexual abuse, abandonment or out-of-control substance abuse may be ignored and only the positive elements of the parent-child relationship are remembered. Yearning and pining can be rekindled with every visit with the parent, especially in early stages when the new pattern of contact with the parent has not become established. Yearning is best resolved by a sensitive approach which allows it to be experienced over time rather than hurrying them to "get over it" and accept substitute parents.

Searching. The following behaviors are common in the searching phase:

1. Children may be so preoccupied with intense yearning and pining that they have a compulsion to speak to the lost person, to review a lifetime of memories about him/her and to ignore anything not relevant to his/her hoped for presence memory. They may search through the memories of others for clues, try to call on the phone, try to run away to look for them.

2. Children may experience a sense of waiting for something to happen. It seems as though even commonplace daily events can't proceed until the lost person is found. Thinking of plans for even the near future is difficult if not impossible. Everything is "on hold" until the lost is found.

3. Children are often restless, moving around aimlessly with an inability to sit still – a constant searching for something to do, scanning the environment watching for any clue to the whereabouts of the lost person. This is not unlike the agitated behavior described under *Hyperactivity as Denial* and sometimes has a similar outcome for children who are medicated as ADD when their behavior is, in fact, a normal reaction to loss.

4. Older children may begin actual searches – running away to places they used to live or to where they think parents may actually be found. For some, running away seems to be without destination – an extension of the random agitated movement mentioned earlier. They wander searching for whom?, for who-knows-what? The aimless searching takes on a life of it's own. .

5. When adults adopted in childhood search for long lost birth parents, the search can be extremely healing because the mystery has been solved whether or not a positive reunion can occur.

As long as the child believes that the loss is retrievable he is impelled to action. Slow, painful yearning, pining and searching can help her satisfy the need to try to recover the loss, and when it fails, to move toward acceptance.

Strong feelings: Sadness, Anger, Guilt and Shame. As an awareness of the loss begins to become clear, children begin to respond with feelings of acute grief. Deep sadness is usually easy for caregivers to understand and accept.

Anger can be directed at the lost parent or at others. If anger can be accepted and allowed to be challenged without doing harm, it's positive can move the child toward resolution. Children caught in what Rudolph Dreikurs can be caught in the mistake goals of needing to establish their dominance over others or to act out their revenge. With no parent available, others (schoolmates, teachers, and caregivers) may become the targets of their angry, controlling or rebellious and vengeful feelings and behavior.

Adults often overlook the aspect of guilt and shame in children's grieving processes. It doesn't naturally occur to us that children would feel that they are at fault for their parents' absence, whether due to death, abandonment or Court intervention due to abuse, neglect or parental substance abuse. Children often feel that they are somehow at fault. Perhaps they have been told that the parent wouldn't drink/use if the child would behave. In many instances, the child takes on this guilt without prompting as a lame attempt to gain some control of the situation. "If I get straight A's, help take care of the family, etc., my parent won't drink or use. Then we can live happily together again. For now the separation is my fault."

Shame goes deeper than guilt. Guilt implies that some *behavior* is at fault. Shame implies that the total person is unworthy, tarnished, and hopelessly inadequate due to a situation or separation from parents which is, in fact, not under the control of the child. Helping children understand the disease concept of parental alcohol and drug abuse can be extremely helpful in healing their shame.

Disorganization. While strong feelings can be easily identified and comforted, disorganization can be harder for caregivers to recognize and respond to. As adults, we all know the feeling of being unable to concentrate, forgetfulness, absent-mindedness and random bouts of crying that accompany dealing with a loss. Children experience much the same thing. They can't remember three simple instructions in a row . They loose their school books, forget their chores, blank out when you remind them of something you told them five minutes ago. In the midst of this they may be expected to learn the rules in yet another new household, or worse yet, learn the mysteries of long division or algebra. On top of the losses they experienced, they accumulate new ones as developmental tasks are unmet and schools, parents and other caregivers become frustrated and critical.

Despair. This is the most difficult stage to experience or witness. Sinking into hopelessness where normal interest in eating, sleeping, grooming and socializing diminishes. Speech and movement are often slowed. Children may over-eat or-under eat. Helplessness and dependence, sometimes interspersed with bouts of anger, characterize this stage.

Reorganization. In this stage, the child begins to experience less anger and depression and may be better able to attend to tasks. She may be able to discuss some the facts with acceptance and to relate to the new circumstances. There is less preoccupation with the loss and more readiness for relationships.

INTEGRATION OF LOSS AND GRIEF

The child reorganizes himself to get on with life. The worst possible thing has happened and he's survived and is not ready to get back to living and growing. Physical and psychological well being return. The child's self-esteem is restored. The child may develop some positive growth and learning as a result of successful coping with loss.

This is the best possible outcome for a child from a secure family who has experienced only a few significant losses. I is reasonable to expect a longer and more complicated recovery and need for greater support and guidance for those children who have experienced long histories of parental substance abuse, multiple separations. They will need more time, more patience and more help to work through old grief. They will need more patience and support to "bounce back" from new inevitable losses such as the death of a pet or a friend moving out of town.