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The Prevalence of Complicated Grief Among Children Who Have Lost Loved Ones in Selected Public Primary Schools in Nairobi County, Kenya

[1]Priscillah Ndunge Omucheni, [2]Margaret Mwenje, [3]Ruth Kamunyu
[1,2,3]Pan Africa Christian University
Corresponding Email: pomush@gmail.com

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Abstract

The inability of children to comprehend and process death due to factors like chronological age, attachment of the child to the deceased, nature of death, and family support, might lead to delayed or prolonged grief and consequently complicated grief (CG). Complicated grief in a child's life can affect his/her social and cognitive functioning manifesting in antisocial behaviours. This study aimed to determine the prevalence of complicated grief among children who had lost loved ones in selected public primary schools in Nairobi County. This study was guided by Piaget's Cognitive Development Theory. Multistage sampling, purposive sampling, inclusion, and exclusion criteria were used to select 259 pupils aged 10-13 years who had lost a loved one in the last year. Purposive sampling was also used to select 22 class teachers of the bereaved pupils who participated in the study. The study employed a convergent mixed-method design. Data was collected through self-administered questionnaires (SDQ, ICG, and STAB) and interviews. Quantitative data was analyzed through descriptive and inferential statistics using SPSS Version 25.0. The findings indicated that the prevalence of complicated grief was 26.1%. The study concluded that complicated grief was prevalent among children who had lost a loved one. Therefore, the study recommends that the Ministry of Education introduce a school-based counseling program incorporating grief intervention techniques in public primary schools. During grief, a child's world changes unexpectedly from conversant, predictable, and safe, to chaotic and dreadful. Parents and caregivers are also implored to brace up and talk about death to children, and involve them during funeral preparations.

Keywords: *Complicated grief, Prevalence, Children, loved one*

1.0 Introduction

In life, numerous losses produce grief reactions. Loss according to Harris and Winokuer (2016) is the real or perceived deprivation of something that is deemed meaningful. Grief on the other hand is a normal reaction to loss (Worden, 2018). Grief is a multidimensional and universal experience ensuing from the loss of a person, or an object, moving away from family, or significant life events, such as divorce, job loss, illness, or physical disability. When experiencing grief, a person's emotional, cognitive, physical, social, behavioural, and spiritual components are often negatively impacted (Brook & Miraglia, 2015). Brook and Miraglia

further noted that grieving is a personal experience with no schedule to recover since the process takes a different amount of time for each person. In addition, Worden (2018) stated that grief is unavoidable and essential. It helps grieving individuals deal with emotional and behavioural pain as well as adapt to the loss of a loved one. It is therefore important for a grieving individual to be patient and allow the grieving process to happen naturally.

As stated by Doka (2016), grief is experienced and expressed through thoughts, feelings, and emotions. Grieving individuals will exhibit feelings of sadness, anger, anxiety, loneliness, fatigue, helplessness, shock, numbness, and yearning. Additionally, Worden (2018) claims that physically, grieving individuals will feel weak, and tired, have breathing difficulties, tightness in the chest or stomach, and dry mouth. Also, Pop-Jordanova (2021) noted that in their cognitions, grieving individuals would experience disbelief, confusion, preoccupation, hallucinations, dreams, and magical thinking. Their behaviours will also change and they will have sleep and eating disturbances, social withdrawal, inattention, agitation, crying, avoiding reminders of the deceased, and having dreams of the deceased. Doka (2016) concedes that spiritually, grieving individuals will challenge their faith, some change their belief in God and start searching for meaning while others' faith may be renewed and strengthened. On the other hand, Harris and Winokuer (2016) noted that socially, grief is expressed through changes in interpersonal dynamics and expectations for the bereaved individual. Such individuals isolate themselves because they have difficulty handling social situations that may trigger their grief.

On the other hand, children experience and express grief in different ways, some of which are distinctive of their developmental milestones (Carter, 2016). Consistent with Jackson (2015), children's grief might take a dual process where they cry one moment and play happily the next. This makes it appear like children are not grieving or are grieving in the wrong way. Nevertheless, children's grief has cognitive, emotional, physical, behavioural, and social aspects. According to Corr and Balk (2010), grieving children experience waves of emotions such as feelings of sadness, anger, fear, confusion, regrets, worry, loneliness, self-blame, and guilt. Occasionally, McCoyd and Walter (2016), stated that children's grief involves fatigue and withdrawal although at times it can lead to agitation, irritability, getting into trouble, or lashing out. They may as well have difficulties with sleeping and have a decline in school performance while others try to be the perfect child by suppressing their grief.

Though children at any age react to the death of a loved one, the developmental stages of children influence their understanding of death and inform how they experience and express grief (Ener & Ray, 2018). For instance, infants and toddlers (children below three years old) experiences are difficult to know but the death of a loved one especially the caregiver has a noticeable impact (Rachamim, 2017). They may be quiet, impassive to smiles, less active, and sleep less. They may also cry and look as if they are devastated (Walsh, 2011). Toddlers (two to three years old) express distress or sadness through withdrawal, loss of interest in normal activities, and being quiet or irritable. They might also have sleep and eating problems where they refuse sleep despite being sleepy, refuse to feed themselves, and in extreme cases refuse to eat. They also regress to earlier states of functioning like bed wetting and thumb sucking, increased tantrums, and separation anxiety (Therivel & McLuckey, 2018).

Children aged four to six years old have a modest understanding of death but confuse fantasy and reality, hence lacking the understanding that the loss is permanent. At this age, they often see death as avoidable and reversible and may even blame themselves for the death (Martell et al., 2013). At the age of six to nine years old, children begin to understand that death is irreversible and universal. They might experience anger, isolation, fear that something may

happen to their loved ones, and feelings of loss of control (Bui, 2018). They also express phobias about school, bodily somatic complaints like headaches, stomachaches and chest pain (Doka, 2016). Children aged nine years and older have concrete mental processes and therefore understand and process death. Their expression of grief is based on what they have learned from their caregivers or parent(s) and other adults around them (Rachamim, 2017).

1.1 Problem statement

McCoyd and Walter (2016) referred to children as the forgotten mourners. Family members tend to think that children are not aware of the loss in their lives unless others draw their attention to them. As a result, children are left out during the grieving process by being excluded from death-related events (Akerman & Statham, 2014). They are not given room or space to share their feelings, thoughts, and questions they have. In the words of Huynh et al. (2019), this hinders children from processing grief which may lead to complicated grief. Complicated grief can manifest in antisocial behaviours like physical and social aggression, and rule-breaking which might affect the child's social, cognitive, academic, and relational functioning. Additionally, Burns et al. (2020) noted that regardless of grief's consequences on well-being and lifetime health, the prevalence of childhood grief is not well understood. Furthermore, there is a gap in the area of CG among children as it has not been researched especially in Africa (Ngesa et al., 2020a). This study therefore sought to address this knowledge gap by finding out the prevalence of complicated grief among children who have lost loved ones in selected public primary schools in Nairobi County.

1.2 Research Objective

To determine the prevalence of complicated grief among children who have lost loved ones in selected public primary schools in Nairobi County.

2.0 Literature Review

2.1 Theoretical Review

Piaget's cognitive development theory was developed by Jean Piaget in the 1920s. Jean Piaget was born on August 9, 1896, in Neuchatel, Switzerland, and died on September 17, 1980 (Miller, 2016). Piaget observed and described children of different ages. His theory includes concepts of schema or schemes, adaptation, assimilation, and accommodation, and four stages of development (Sanghvi, 2020).

Cognition develops through the refinement and transformation of mental structures, or schemes (Flavell, 2011). Children know their world through their schemes. Schemes are how children interpret and organize experiences. Piaget believed that all schemes, all forms of understanding, are created through the workings of two innate intellectual processes: organization and adaptation. Through the organization, children combine existing schemes into new and more complex intellectual schemes. Piaget supposed that children are constantly organizing whatever schemes they have into more complex and adaptive structures (Miller, 2016).

Adaptation occurs through two complementary activities: assimilation and accommodation. Assimilation is the process by which children try to interpret new experiences in terms of their existing models of the world while accommodation is the process of modifying existing structures to account for new experiences. Piaget believed that assimilation and accommodation work together to promote cognitive growth (Gillibrand & O'Donnell, 2016). Rabindran and Madanagopal (2020) highlighted four major stages of cognitive development

identified by Piaget: Sensorimotor stage (birth to 2 years), Preoperational stage (2 to 7 years), Concrete operational stage (7 to 11 years) and Formal operational stage (11 years and beyond).

In the sensorimotor stage (birth to age 2), infants understand the world by coordinating sensory experiences with motor actions. They also develop object permanence. The second stage is the preoperational stage (ages 2 to 7) where children begin to use symbols and language and their thoughts are egocentric. Children become imaginative in their play activities. The concrete-operational stage (ages 7 to 11) is characterized by the appropriate use of language. Children acquire and use cognitive operations. By banking on cognitive operations, they understand the basic properties of and relations among objects and events in the everyday world. They can conclude motives by observing others' behaviour and the circumstances in which they occur. The last one is the formal-operational stage (ages 11–12 and beyond). Adolescents' cognitive operations are reorganized in a way that permits them to function on operations. Their thought is systematic and abstract and logical thinking is no longer limited to the concrete or the observable (Slater & Bremner, 2017). In this study, the cognitive developmental stages were considered in determining if the respondents comprehend death and how well they are able or not able to process grief. Of interest in this theory is stage three which is a concrete-operational stage (ages 7 to 11) and four, the formal-operational stage (ages 12 and above) of cognitive development. Both categories can appropriately use language as well as cognitive operations.

Other scholars like Rachamim (2017), stated that children aged 6–9 years are very curious about death and may ask questions about life after death. They begin to understand the finality of death, and believe it is real but only happens to others, not them. They also have strong feelings of loss but it is difficult to show them hence need permission to grieve. Shaffer and Kipp (2014) referred to this stage as the concrete operational stage where children have appropriate use of language and can use cognitive operations. They can understand everyday events and make conclusions by observing others' behaviours and the circumstances in which they occur. Therefore, as they experience death, they try to make sense of the event and might blame themselves or others for the death. As they strive to master the event, they would want to be part of the mourning process since at this stage they want to be involved in decision-making. This is an indication that children at this age understand death and can experience grief. At age 9 and above, a child can view death as final and that it happens to everyone. They have a clear understanding that death is unavoidable and not a punishment. They have a curiosity about the physical aspects of death. They have the vocabulary to express feelings but will often not express them verbally but in behaviour (Shaffer & Kipp, 2014).

Respondents in this study aged between 10-13 years are categorized under the last two cognitive development stages which indicated that children aged 10 years and above can comprehend and process death due to their cognitive abilities as well as the appropriate use of language. Therefore, if children are not helped to understand the event (death) and to be part of the grieving process, they might not grieve their loved ones. This can cause CG which in turn can lead to maladaptive behaviour like antisocial behaviours. This study applied Piaget's principles of cognitive development to identify children with the ability to comprehend and process death and grief. The theory was also used to identify children who could express their thoughts and feelings in writing.

2.2 Empirical Review

2.2.1 Prevalence of Complicated Grief among Children

Bereavement is a day-to-day human experience and grief characterizes the normal reaction to the death of a loved one (Gesi et al., 2020). Sigmund Freud was the first to describe grief as an occurrence separate from depression (Freud, 1924). Freud considered grief (mourning) to be a common and worldwide response to the death of a loved one, categorized by symptoms of withdrawal, sadness, reduced activity, and loss of the capacity for love. The goal of grieving, according to Freud, was basically to mourn the loss and move on (Falk, 2020). In children, expression of grief can include symptoms like anger, crying, sadness, irritability, temper tantrums, somatic reactions (like stomach aches, headaches, nightmares, insomnia), guilt, confusion, difficulty concentrating, regressive behaviour, disbelief, withdrawal, questions about death, and fearfulness being alone, dying or losing other loved ones (Therivel, 2018). All these symptoms are characteristic of grief and are considered normal responses to the death of a loved one. Nevertheless, if the intensity and period of the grief go beyond the expected duration, clinical intervention might be inevitable (APA, 2013). It is therefore to state that grief in general is a normal reaction to a loss and the bereaved individual might not need any form of intervention. Most individuals who lose someone as stated by Shear (2012), will generally adjust throughout six to 12 months and finally develop a new sense of normalcy in their life. But then for others, this process becomes worrying and elongated. Shear further alluded that when people get trapped for an indefinite period in grieving, this might prevent them from processing the death and moving on with life, leading to a condition known as complicated grief.

Prigerson et al. (1996) categorized grief as normal grief, having the symptoms of complicated grief and definite complicated grief. Normal grief involves a broad range of feelings, cognitions, physical sensations, and behavioural changes that are common after a loss (Worden, 2018). Worden listed the characteristics of normal grief as feelings of sadness, anger, guilt, self-blame, anxiety, loneliness, fatigue, helplessness, shock, yearning for the deceased, numbness, confusion, social withdrawal, sleep disturbance, eating disorders, avoiding reminders of the deceased, and disbelief. However, Nakajima (2018) noted that in normal grief, the transition, however painful, is neither overwhelming, endless, nor prematurely interrupted. Additionally, Duffy and Wild (2023) stated that feelings of grief decrease over time and the bereaved person experiences positive emotions alongside episodes of sadness and loss. There is also a reduced longing for the deceased and gradual acceptance of the death. Smith et al. (2020) added that memories of the deceased are intermingled with other memories and life still holds meaning and purpose, therefore, despite feeling sad and missing the deceased, the bereaved can resume activities and develop relationships. Therefore, in normal grief, individuals overcome the painful emotions and thoughts caused by bereavement and reconstruct their lives to adapt to the world without the deceased. However, if an individual is not able to overcome the normal symptoms of grief, it persists longer impairing his or her daily functioning, and might turn into complicated grief (Nakajima, 2018).

The aspect of CG was first examined and differentiated from depression by Prigerson et al. (1996). By 1999, the language had shifted from complicated grief to traumatic grief, and the first set of diagnostic criteria was proposed (Prigerson et al., 1999). To this day, various names for CG are used, including prolonged grief, complex grief, and pathologic grief, and the term currently recommended in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5; American Psychiatric Association, 2013) is Persistent Complex Bereavement

Disorder (Maciejewski et al.,2016). However, despite decades of research, reflection, and debate, the misperceptions and uncertainty about CG still remain. People suffering from CG may experience disturbing thoughts, intense emotions, distressing longing and searching for the deceased, excessive avoidance of reminders of the deceased or the death, and loss of interest in personal activities (Horowitz et al., 2003 as cited in Thompson et al., 2017). The intensity of the grief prohibits individuals from regaining the pre-loss state of social functioning.

People suffering from CG may be at increased risk for suicide, depression, anxiety, physical illness, and disease (Thompson et al., 2017). Opperman (2004 as cited in Dreth et al., 2012) postulates that the risk of grief becoming complicated increases when the bereaved person's sense of material well-being, emotional security, and self-identity are threatened by the death of a loved one. It is estimated that 10% of grieving persons experience maladaptive grief such as childhood traumatic grief, and prolonged grief disorder (Griese et al., 2017). Additionally, between 3% and 10% of bereaved people will experience CG (Shear et al., 2011). Prigerson et al. (2008 as cited in Drenth et al. 2012) points out that at least 10%-20% of the bereaved population in South Africa will experience complicated grief. On the other hand, some people might have what Prigerson et al. (1996) called symptoms of complicated grief. Such people will have some of the symptoms of CG but do not meet the criteria of CG on the Inventory of Complicated Grief scale. Their grief symptoms are between normal and CG.

In the United States, the Social Security Administration (SSA) and Old Age Survivors and Disability Insurance (OASDI) are frequently cited sources of approximations for childhood parental bereavement prevalence. These estimates normally range from 2% to 4% but account for only those who were eligible for and sought SSA benefits (Burns et al., 2020). Those who never sought SSA benefits are not part of this data. In England, 78% of 11-16-year-olds have experienced the death of a family member or a close friend. In Great Britain, 4-7% of children will experience the death of a parent by the age of 16 (Revet et al., 2018). In Sub-Saharan Africa, UNICEF (2017) recorded that, over 52 million children have been orphaned (Huynh et al., 2019). In Kenya, Making Well-Informed Efforts to Nurture Disadvantaged Orphans and Vulnerable Children (MWENDO) a USAID-funded program projected that there are around 2.6 million children aged below 18 years who have been orphaned (MWENDO, 2021).

Considering that the above data represent a portion of children experiencing grief, it is evident that children are at a higher risk of developing complicated grief if not given a safe space to process grief. As noted earlier in this literature review, guardians or adults living with grieving children lack knowledge on how to help children process grief. They are unable to identify children's symptoms of grief or they disregard them completely. When grief is prolonged, inhibited, or exaggerated, it will end up being complicated which might lead to antisocial behaviours. The state of CG affects about 7% of bereaved people and up to 3.7% of the general population (Shear, 2015; Brandoff, 2018). It has also been estimated that about 10%-20% of the bereaved population will experience CG (Enez, 2018; Kersting et al., 2011). Equally, children with unprocessed grief are at an increased risk of developing CG. Researchers in Sweden found that children who lose a close family member before age 13 are at increased risk of psychosis (Abel et al., 2014) which can lead to antisocial behaviours.

A report by the National Alliance for Grieving Children in the USA (2013) noted that children do present symptoms of complicated grief due to unprocessed grief. The report indicated that 39 % of grieving children and adolescents experience sleep problems, 75% feel angry, and 45 % have trouble concentrating on school work. Additionally, 41% of these bereaved children and adolescents act in ways they know might not be good for them be it physically, emotionally,

or mentally and 34% will say hurtful things to others after the death (National Alliance for Grieving Children, 2013). All these listed symptoms are pointers to antisocial behaviours if not addressed. According to Melhem et al., (2013), 10% of children bereaved by sudden parental death have high and sustained CG reactions approximately 3 years after the death which makes them vulnerable to antisocial behaviours.

In Kenya, a study by Ngesa et al., (2020b) on the Prevalence and Correlates of Complicated Grief among Parentally Bereaved Children in Siaya County, indicated that 66% of orphaned children experience CG. However, Ngesa et al.'s research was conducted among children aged 10-15 who had lost a parent or both parents only and not any significant other like a grandparent, aunt, uncle, or sibling. Ngesa et al.'s study indicated that children aged 10-15 years can experience CG after losing a parent. This study however focused on children aged between 10-13 years who had lost a loved one and were not limited to a parent(s) only.

Most studies globally and locally have focused on death and mourning among children and the few that have focused on grief among children have highlighted the grief reactions of parentally bereaved children. The prevalence of complicated grief among children who have lost a loved one has received little attention. To bridge this gap, this research aimed at attending to this absence of baseline data on complicated grief by exploring the prevalence of complicated grief among children aged 10-13 years who had lost a loved one in selected public primary schools in Nairobi County. Understanding the prevalence of complicated grief among children is important for evaluating the challenges and social significance of CG and to aid in the development of prevention and treatment interventions.

3.0 Methodology

The study adopted a mixed methods approach. Multistage sampling, purposive sampling, inclusion, and exclusion criteria were used to select 259 pupils aged 10-13 years who had lost a loved one in the last year. Purposive sampling was also used to select 22 class teachers of the bereaved pupils who participated in the study. The study employed a convergent mixed-method design. Data was collected through self-administered questionnaires (SDQ, ICG, and STAB) and interviews. Quantitative data was analyzed through descriptive and inferential statistics using SPSS Version 25.0. The findings were presented as tables, pie charts, and graphs.

4.0 Results and Discussion

4.1 Prevalence of Complicated Grief Among Children Who Had Lost a Loved One

The research objective sought to determine the prevalence of complicated grief among children who had lost loved ones in selected Public Primary schools in Nairobi County. If disregarded, factors like the chronological age, attachment of the child to the deceased, and the developmental level of a child (age) can make grieving children experience emotional and behavioural interference impeding the typical processing of grief (Ener & Ray, 2018) which might lead to CG. A report by the National Alliance for Grieving Children in the USA (2013) noted that children do present symptoms of complicated grief due to unprocessed grief. The report indicated that 39 % of grieving children and adolescents experience sleep problems, 75% feel angry, and 45 % have trouble concentrating on school work. Additionally, 41% of these bereaved children and adolescents act in ways they know might not be good for them be it physically, emotionally, or mentally and 34% will say hurtful things to others after the death (National Alliance for Children's Grief, as cited in Shear, 2015).

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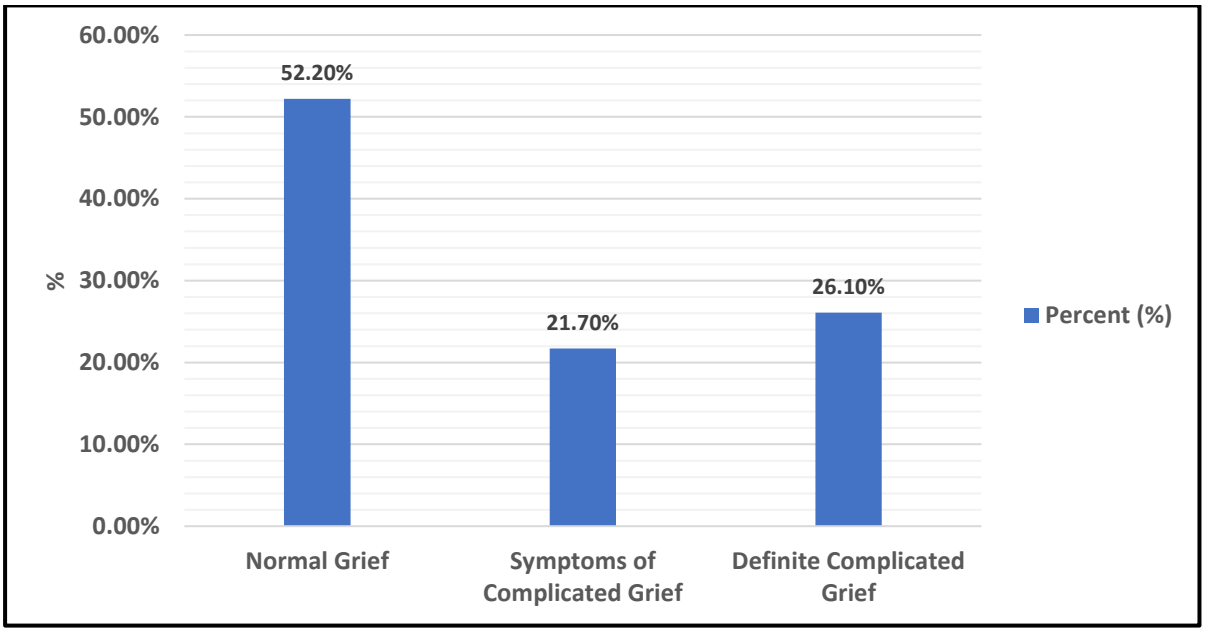
According to Melhem et al., (2013),10% of children bereaved by sudden parental death have high and sustained CG reactions approximately 3 years after the death. In Kenya, a study by Ngesa et al. (2020b) on Prevalence and Correlates of Complicated Grief among Parentally Bereaved Children in Siaya County, indicated that 66% of orphaned children aged 10-15 years old experience CG. When grief is prolonged, inhibited, or exaggerated, it will end up being complicated which might lead to antisocial behaviours. To find out the prevalence of complicated grief among children who had lost a loved one in Public Primary schools in Nairobi County, complicated grieve was rated using 15 items on a Likert scale ranging from Never (0), Rarely (1), Sometimes (2), Often (3) and Always (4) that were presented to the bereaved child respondents. The responses obtained were added up to generate a new variable on a ratio score that ranged from 0 to 60. The scale was then collapsed into three categories that were interpreted as follows: <25 = Normal Grief, 26-30 = Symptoms of Complicated Grief, and ≥31 = Definite Complicated Grief (Prigerson et al., 1996). The findings are presented in Figure 1.

Figure 1: Prevalence of Complicated Grief Among Children Who Had Lost a Loved One



The findings indicated that the majority 52.2% (n=135) of the respondents had normal grief. Majority of the respondents 84% (Figure 7) were allowed to attend the funeral of their loved one while 86% (Figure 9) were supported/comforted during grief and 62% (Figure 11) were allowed to ask questions about the deceased person. This could have helped the respondent's process of grief hence the lower levels of CG.

Respondents who had symptoms of complicated grief were 21.7% (n=56), while those who had complicated grief were 26.1% (n=68). However, children who had symptoms of CG (hence vulnerable to CG) and those with CG combined give a total of 124 (47.8%) from a sample size of 259 children. Despite a majority of the respondents having normal grief, the symptoms of CG and definite CG raised a concern about the number of children at risk of developing CG and those with CG. It shows that a great number of bereaved children are at a higher risk of developing CG. These findings could be associated with studies that have shown the prevalence of CG to be between 2 to3 % and 10-20% of the general population (Shear, 2015; Gesi et al.,

2020). The findings similarly correspond with Melhem et al. (2013) who noted that 10% of children bereaved by sudden parental death have high and sustained CG reactions.

On the other hand, this study differed slightly from other studies that showed higher figures of children with CG. For example, a researcher in the Netherlands found that in a group of bereaved children aged 8–18 years old, 35.2% had symptoms of prolonged grief disorder (PGD) (Boelen et al., 2017) while this study found 21.7% to have symptoms of CG. Also, Ngesa et al. (2020b) found that 39.9% of children aged 10-11 and 34.6% of children aged 12-13 had elevated grief scores. Additionally, a study in Siaya County, Kenya indicated that 66% of orphaned children experience CG (Ngesa et al., 2020b). The high score on CG in Siaya County could be explained by the fact that these were children who had lost primary caregivers (parents) with whom they had a close attachment. Studies that have explored the correlation between closeness to the deceased and level of grief, indicated that the level of closeness was associated with higher or prolonged grieving (Stroebe et al., 2010).

5.0 Conclusion

The study sought to determine the prevalence of complicated grief among children who have lost loved ones in selected public primary schools in Nairobi County. The findings indicated that complicated grief was prevalent among children who had lost a loved one. Additionally, a significant number of children who had lost a loved one had definite complicated grief and symptoms of complicated grief. This is an indicator that grieving children are not helped to process grief after a loss.

6.0 Recommendations

The Ministry of Education needs to introduce a school-based counseling program incorporating grief intervention techniques and recommend trained counselors who do not double up as teachers to be school counselors to negate dual relationships. During grief, a child's world changes unexpectedly from conversant, predictable, and safe, to chaotic and dreadful. As a result, they need to be loved, understood, and involved in all aspects of family grief. With rudimentary age-appropriate resources and guidance, teachers and caregivers should be prepared to address grieving children's emotional needs in addition to guiding them through the challenging feelings related to grief. Parents and caregivers are encouraged to seek professional counseling for their grieving child/children if the symptoms of grief persist.

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