Facing the death of a child: effects on the family system

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Abstract
The death of a child could very well be the most difficult crisis a family system can face. The uniqueness and severity of this type of crisis make it quite important for those in the counseling field to be aware of the many different aspects of a child's death which may be very significant to the child's family.

For this reason, the purpose of this paper is to describe a number of variables which affect the healing process. These variables include the cause of death, the age of the child at the time of death, family dynamics, and the relationship between the surviving family members and the deceased child. Interventions which will be helpful in the healing process for all family members, and specific interventions for parents and for siblings are also included.
FACING THE DEATH OF A CHILD: EFFECTS ON THE FAMILY SYSTEM

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Of all developmental issues faced by families, death of a family member may be the most difficult circumstance with which most people eventually cope. While the birth of a child is meticulously planned, talk of death is avoided in our society. This is ironic, because it is the only developmental phase of which anyone can be certain. Even when death is imminent, families seem to discuss only the bare essentials, as if avoiding the issue could somehow make it easier for both the dying individual and for the surviving members of the family.

The death of a child could very well be the most difficult crisis a family system can face. While painful, we expect the death of an elderly family member. The loss of a child seems unnatural and unfair. This is even more true today than it was 100 years ago. In 1900, parents could expect a 50% chance that any child born to them would die before he or she reached his or her fourteenth birthday (Pine, as cited in Dannemiller, 1998/1999). Today, 94% of children can be expected to survive childhood (Uhlenberg, as cited in Dannemiller).

This fact alone implies a number of ways in which this situation is especially difficult for families. For example, families who lose a child will be less likely to know other families who have faced the same or similar situations. Because the situation is unusual, many friends and relatives will have no experience in dealing with such a situation, and may therefore feel awkward or may even avoid the grieving family members.
The uniqueness and severity of this type of crisis make it quite important for those in the counseling field to be aware of the many different aspects of a child's death which may be very significant to the child's family. Each family member is bound to be profoundly affected by the crisis. Counseling families, family subsystems, or individuals who have been affected by a child's death can be very difficult. A clear knowledge of available research in this area is the first step for counselors hoping to effectively guide clients through this difficult adjustment. The ability to understand ways in which the client might be affected by the death, along with a knowledge of interventions which have been shown effective with grieving family members, can help the counselor to be a positive asset to the client in need during what may be the most difficult period of his or her life.

For this reason, the purpose of this paper is to describe a number of variables which affect the healing process. These variables include the cause of death, the age of the child at the time of death, family dynamics, and the relationship between the surviving family members and the deceased child. Interventions which will be helpful in the healing process for all family members, and specific interventions for parents and for siblings are also included.

Variables Affecting the Impact of the Death

The experience of a child's death is an inevitably negative one for families. However, several variables can make important differences in the impact of the
child’s death upon family members. The cause of death, age of the child, and family dynamics can all make significant differences in how surviving family members experience their grief.

How Cause of Death Affects Surviving Family Members

One hundred years ago, the most common cause of death among children was infectious disease (Rosof, 1994). Many parents today still grieve for children lost because of chronic illness, and this cause of death does have a unique impact on the families involved (O'Neil, 1996). For example, O’Neil found that many of these parents felt animosity from health care providers, especially when these families made decisions which did not coincide with the advice provided by these providers. Additionally, Miles and Demi (1992) reported that 71% of parents whose children had died of chronic illness experienced feelings of guilt following their child’s death, although these parents described excessive loneliness as the most distressing aspect of their grief.

Although many children continue to die because of incurable illnesses, this is no longer the most prominent cause of death in children. Violent deaths, including accidents, suicides, and murders, are now the most prevalent types of death in people between the ages of one and 25 (Holinger, as cited in Dannemiller, 1998/1999). In one study which included an analysis of 85 bereaved parents
(Owen, Fulton, & Markusen, 1983), accidents were shown to be the most common cause of death.

Research varies in regard to grief intensity in correlation to cause of death. In a 1980 study, Sanders found no differences in grief intensity between parents whose children had died of chronic illness or of sudden death. However, in a more recent study, Marrone (1997) indicated that parents who lose their child suddenly are more likely to suffer more intense reactions to the death.

These types of death carry their own unique form of grief. For example, parents whose children had died in accidents were found likely to experience feelings of anger and blame (Marmer, 1995). However, Miles and Demi (1992) reported that the most distressing aspect of grief for parents whose children died in an accident was loneliness. One effect which counselors may need to watch for is the possibility of post traumatic stress disorder (PTSD). Applebaum and Burns (1991) indicated that, in families that had lost a child unexpectedly, 35% of parents and 45% of siblings met the diagnostic criteria for PTSD.

Another situation of which counselors need to be cognizant is death by suicide. Among parents whose children commit suicide, 92% report feelings of guilt, and these parents describe guilt as the most distressing aspect of their grief (Miles and Demi, 1992). One possibly unexpected feeling which has been described by parents whose children had committed suicide was that of relief
Parents who described this feeling had generally experienced much difficulty in dealing with their children’s severe depression which manifested in numerous suicide attempts, hospitalizations, and even arrests.

Finally, one other aspect of sudden death which may be difficult for families is the manner in which they learn about the death. Parents usually learn of a child’s death from a coroner or police officer (Owen, Fulton, & Markusen, 1983), rather than from a family member or doctor. This may be disturbing because these individuals generally do not know the family. Police officers and coroners may not be able to help families with immediate coping strategies and are not known to make referrals to community support systems who could be helpful to the family.

Because the differences in cause of death can mean differences in grieving patterns, counselors who work with these family members may want to ask family members about how the child died and explore how the cause of death could be affecting the family. Even though feelings of guilt, animosity, loneliness, and relief may not be immediately reported by family members, these clients may indeed be experiencing them.

**Age of Child at the Time of Death**

One aspect of a child’s death which counselors may want to consider is the age of the child at the time of death. Schatz (as cited in Sanders, 1999) found a tendency for mothers to report that their children died at a special age, regardless
of the age at which the child died. However, families who lose an unborn child live through a very different experience than those who lose an adult child.

Helping professionals who work with families who have lost an unborn child need to be particularly sensitive to this type of loss, because many parents who lose an unborn child feel that their loss is unacknowledged by family and friends (Leon, as cited in Bernstein & Gavin, 1996). Lewis (as cited in Berry, 1999) indicated that two thirds of mothers who had experienced a stillbirth or neonatal death felt that their most desperate need was to have others acknowledge that their baby was a real person who should be mourned.

When counseling individual parents or couples who have lost an unborn child, professionals may want to consider differences in the ways that mothers and fathers mourn these deaths. In a study of 19 couples who had experienced a recent miscarriage, Alderman, Chisholm, Denmark, and Salbod (1998) reported that women and men experienced this type of loss differently. Women, particularly, reported experiencing significantly more anger, despair, rumination, and loss of control than their partners.

This strong difference in bereavement experiences between mothers and fathers may be explained by the actual physical closeness between women and the infants they carry. For mothers, the unborn child is quite literally a part of themselves. Regardless of how close a father may feel toward a pregnancy, they
cannot experience this kind of closeness. This hypothesis is supported by the findings of Theut, Zaslow, Rabinovich, Bartko, and Morihisa (1990), who report that mothers who carry their child longer tend to display more unresolved grief than mothers who lose their babies earlier in the pregnancy.

When considering the loss of a school age child, the very nature of the relationship between children of this age and their parents is one of dependency and involvement. Parents who lose a child in this age group are bound to feel helpless and empty when this relationship is suddenly ended.

The death of an adult child brings an intense grief to the parents. However, Marmer (1995) reported that parents whose adult children had died were likely to blame the deceased child for their own deaths because they often felt their children had not taken care of themselves and that their deaths resulted from this self-neglect. This blame could very likely be accompanied by anger and subsequent guilt as a result of being angry with someone who is missed so dearly.

The Effects of Family Dynamics on Grief

In addition to the effects of the cause of death and the age of a child, other family dynamics can have a serious effect on the family’s ability to overcome the loss. For example, Talbot (1999) found, in a study of 80 bereaved mothers who had lost their only child, that this loss was particularly significant. These mothers not only lost their child, but also felt as though they had lost their role as mothers.
Also, losing more than one child at once is apt to cause more severe grief reactions than losing one child (Marrone, 1997).

The nature of a child-parent relationship is one of dependency. Parkes (as cited in Berry, 1999) indicated that if the relationship was dependent in any way, that the person grieving was likely to be more at risk for problems following the death. One of the reasons why parental grief is so intense is because of the level of investment in the relationship by the parent (Marrone, 1997). As with any other characteristic, this level of investment varies from family to family.

One other important family dynamic involves the role which the deceased child played in the family system. For example, guilt may be more intense in the parents of a child who was scapegoated. The youngest child may be seen as more fragile than other siblings, therefore bringing more feelings of helplessness to the grieving family. In a study of 263 families, Littlefield and Rushton (as cited in Marrone, 1997) found that healthy children were grieved more than unhealthy children and that male children were grieved more than female children.

Although counselors are probably safe in assuming that family members will be devastated by the loss of a child within the system, this may be the only thing that these families have in common. A family that has lost an unborn child to miscarriage is living through a very different experience than a family that has lost a teenage son to suicide. Counselors cannot assume that every family that has lost
a child will react the same way, in part because of differences in cause of death, age of the child, and family dynamics. Even within families, different individuals and subsystems can be experiencing very different kinds of grief.

Effects on Individuals and Family Subsystems

When a child dies, families are faced with an unimaginable loss which has the capacity to decimate the marriage and send family members into incomprehensible states of depression, loss, and despair. Some effects of grief may be experienced by one or all family members. Lindemann (as cited in Sanders, 1999) identified five common characteristics of grief. These are guilt, hostile reactions, loss of usual patterns of conduct, a tendency to be preoccupied with the image of the deceased loved one, and somatic distress.

Although many grief responses are quite general regardless of the relationship to the deceased, other effects of grief are more specific to those that filled particular roles for the child. Mothers and fathers often experience quite unique forms of grief, distinct from its impact on them as a marital dyad. Siblings live through an even different experience, and their experience is often misunderstood or ignored.

Effects on Parents

Research shows that parental grief may be the most intense form of loss (Sanders, as cited in Dannemiller, 1998/1999). Immediate effects are intense and
overwhelming. After some of the shock has subsided, parents find themselves in an entirely new situation, one in which they may feel as though a part of them is lost forever.

Immediately after a parent learns that his or her child has died, he or she is often overcome by somatic symptoms. Physical effects reported by parents following the death of a child include a hollow feeling in the stomach, tightness in the chest and throat, breathlessness, dry mouth, and aching limbs (Berry, 1999). Johnson (1987) also reports migraine headaches, nasal congestion (due to increase in crying), uncontrollable shaking, and over- or under-sensitivity to stimuli.

In addition to physical symptoms, newly bereaved parents usually have several thought processes in common. Normal cognitions reported by parents after their children’s deaths are disbelief, confusion, and an obsessional preoccupation with the deceased child. Some parents also experience hallucinations, both visual and auditory (Berry, 1999). Marmer (1995) reported, in her study of 118 grieving parents, that every parent experienced feelings of despair. These feelings were described as an inability to care about anything, withdrawal, and uncontrolled crying and sobbing.

Often, after parents have survived the initial shock, they find it very hard to continue their day to day lives. Many parents have great difficulty returning to their home for the first time, and many avoid it, sometimes for weeks (Johnson,
Other common long term effects of a parent’s loss of a child are depression and PTSD. Vance, Boyle, Najman, and Thearle (as cited in Berry, 1999) found that mothers were more likely than fathers to suffer from depressive symptoms after a child’s death. However, it is common for either parent to experience depressive symptoms (Johnson, 1987). Applebaum and Burns (1991) indicated that 35% of parents who had lost a child because of homicide or accidental death met the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev. [DSM-III-R]; American Psychiatric Association, 1987) criteria for PTSD.

Some methods of coping used by family members are ineffective and tend to cause compounded problems for the families involved. Some of these behaviors, which Johnson (1987) calls “flight behaviors,” include drug and alcohol abuse, affairs, and literally running away. Other parents may become excessively involved in their work or other activities in an attempt to avoid the intense pain they feel. Vance, Boyle, Najman, and Thearle (as cited in Berry, 1999) found that fathers were more likely to increase alcohol intake after a child’s death.

In her 1996 study, Sheedy reported that escape-avoidant coping, which includes such behaviors as attempting to stay away from reminders of the child and trying to forget the situation, was related to a number of negative effects on parents. These effects included general aches and pains in addition to depression. Videka-Sherman (1982) also found escape to be an ineffective coping method.
Interestingly, preoccupation with the deceased child, an almost direct opposite to escape, was also found to be an ineffective coping strategy.

**Effects on the Marital Dyad**

Because a child’s death has such a significant negative impact on parents, strain on the marital relationship is inevitable (Bernstein & Gavin, 1996). Couples who have lost a child to death are significantly more likely to divorce or separate (Lehman, Lang, Wortman, & Sorenson, 1989; Sheedy, 1996). All couples are not the same, however, and some marriages are able to survive the event much better than others. A number of variables seem to be significant in understanding why some marriages are more resilient than others.

In a study of 109 parents who had experienced a child’s death, Devine (1993) found that the most accurate predictor of marital stability following the death was the state of the marital relationship before the child’s death. However, some predictors of marital breakup are not so obvious. Two demographic characteristics have been shown, in one study (Sheedy, 1996), to be predictive of marital break-up after the death of a child. These are low family income and younger age of the wife.

Some research may give us evidence that spouses’ ability to cope with their children’s deaths may have a strong effect on the marital relationship. Bohannon (1991) reported a significant positive correlation between spouses’ negative
feelings toward their partners and higher levels of grief. Sheedy (1996) indicated
that men reported greater satisfaction in their marital relationships three months
after the death of their children when their coping styles were similar to those of
their spouses.

Even when marriages survive the child’s death, both partners may find it
very difficult to continue their day to day lives with their spouses. Many marriages
suffer from sexual difficulties after their children’s deaths, and communication
difficulties are also common.

Hagemeister and Rosenblatt (1997) found that two thirds of couples who
had experienced a child’s death reported either a break or a decline in sexual
intercourse. Kaplan (as cited in Berry, 1999) indicated that sexual disorders most
often associated with a child’s death were those in areas of desire and frequency.
Johnson (1987) reported that it is not unusual for couples to abstain for a period of
several weeks to even a year or more after a child’s death.

Some marital difficulties may be the result of the different effects on each
parent. In our society, men and women have different roles as parents, and this
may be evident when we look at the different ways in which the loss of a child
affects mothers and fathers.

Fathers may be affected differently than mothers simply because they often
see themselves in the role of the “protector.” Some fathers might see themselves
as having failed in that role when a child dies. While a father sees himself in the role of protector, mothers may see themselves as nurturers, and this role may be threatened when a child dies (Berry, 1999). Carroll and Shaefer (1994) reported gender differences in the frequencies with which spouses expressed their feelings after their children's deaths, particularly finding that women cry more frequently. Irizarry and Willard (1999) found that women score higher than men on both measures of grief reactions and solace seeking after losing a child from Sudden Infant death Syndrome (SIDS).

Although many marriages do not survive a child's death, some marriages seem to strengthen under the pressure. Lehman, et al. (1989) reported a polarization effect on couples' marriages after the death of a child, meaning the marriage is either strengthened or dissolves after the loss.

There is evidence that, if a marriage is able to sustain the first year after a child's death, it may be strengthened. In a study of 48 families who had a child die of cancer seven to nine years before the study, almost half of the partners in the 36 intact marriages reported that their relationships were better than before the child's death. Only three couples in this study stated that their marriages were less satisfying than before the death of the child (Martinson, McClowry, Davies, & Kuhlenkamp, 1994). Although higher levels of grief are positively correlated with
marital dissatisfaction during the first year after the child’s death, this correlation declines significantly after the first twelve months (Bohannon, 1991).

When a child dies, much attention is paid to the grieving parents. This is a reasonable reaction, given the severity of the parents’ loss and their reactions to the loss. However, surviving siblings also face an enormous loss, and this is one area in which professionals may need to pay considerable attention, because parents may not be in a position to consider these children’s needs.

Effects on Siblings

When a child loses a brother or sister to sudden death, the effect is overwhelmingly negative (Lehman, Lang, Wortman, & Sorenson, 1989). Researchers have shown evidence that surviving siblings are greatly affected by a number of situations connected with the loss. Perhaps most important is the fact that many siblings report feeling, not only a loss of their brother or sister, but a loss of their parents during the time when their parents were grieving (Martinson, McClowry, Davies, and Kuhlenkamp, 1994). This is especially disturbing because this is a time when children may need their parents’ support more desperately than ever before in their lives.

Cobb (as cited in Bernstein & Gavin, 1996) found that siblings who have lost a brother or sister suffer symptoms such as loss of appetite, separation anxiety, and extreme reactions to minor illnesses. Other effects include depression, drug
abuse, and suicidal ideation (Lehman, et al. 1989). As previously mentioned, 45% of siblings who lost a brother or sister because of accidental death met the DSM-III-R criteria for PTSD. All siblings in this study (Applebaum & Burns, 1991) had symptoms of this disorder. This problem may be exacerbated by the fact that the parents in this study were not aware of the surviving children’s symptoms.

Rosof (1994) discusses several ways in which children’s grief is different than that of adults. For example, children tend to express their grief more physically. Younger children may want to pound blocks together, while older children may find some relief from participating in sports. They may also show more physical symptoms, seemingly unrelated to the death, such as headaches or stomachaches.

Children’s interpretation of death varies according to the child’s age. For example, children under the age of five usually expect the dead loved one to return at some time, as though they were on a trip. Between the ages of five and nine, children are likely to believe that death can be avoided by good behavior, and only when a child reaches the 9 to 12 age group does the child get an idea of the permanency of death (Sims, as cited in Marrone, 1997).

Birenbaum and Robinson (as cited in Marrone, 1997) indicated that children whose siblings had died within the most recent year were more likely to demonstrate higher levels of behavior problems and lower levels of social
competence. Zisook and Lyons (1988) found that even when siblings were adults, sibling loss was as distressful as was loss of parents or even spouses.

Unfortunately, in some families, surviving siblings may be scapegoated by the parents or other siblings, especially if these siblings were present or somehow connected to the other child's death (Johnson, 1987). This problem may become a significant one for families, because scapegoated children tend to take on the role assigned to them, often displaying disruptive behavior or turning toward self-destructive behavior, such as drug abuse.

Siblings who have lost a brother or sister may face a particularly difficult period of their lives because their parents may be emotionally unavailable to them. Mental health counselors may be able to provide support and guidance to these young people as they face this difficult transition. Professionals who work with grieving families have access to sound research and useful tools for helping these family members.

Interventions and Available Resources

Obviously, a child's death may be one of the most serious crises which can affect families. Each individual may be affected so seriously that family members may be incapable of assisting one another. Because family members tend to turn to one another in times of crisis, this may be one of few instances in which a family must depend to a great extent on resources outside the family.
**Importance of Mourning**

As previously stated, coping styles which attempt to avoid the mourning process are detrimental to the bereaved family members. Family members who attempt to avoid the grieving process are likely to suffer a number of consequences from their unresolved issue, and these may include extreme anger, excessive guilt, and agitated depression (Sanders, 1999). Mental health counselors will inevitably deal with clients who are either actively experiencing grief or suffering from symptoms of unresolved grief. A thorough understanding of useful interventions will help these professionals to guide their clients successfully through this desperate time of their lives.

Mourning after a stillbirth or neonatal death is particularly important because parents are often confused by the differences in their intense feelings and others' indifference toward the situation. Lewis (1979) found that parents often fail to mourn after losing a child to stillbirth or neonatal death. He finds that this tendency is encouraged by hospital staff, who often fail to acknowledge the seriousness of the loss to the family. Lewis insists that a failure to mourn this death so early in life can have serious consequences for the family, and that viewing the body, naming the baby, and keeping physical reminders of the child such as baby clothing or a lock of hair can be important to the process of mourning.
All grieving clients will overcome their loss more successfully if they are able to work through their grief. Worden (as cited in Berry, 1999) cited four tasks that the bereaved must work through in order to recover from the loss. Worden claims that the grieving individual must accept the reality of loss and experience the pain of the loss. The individual must then adjust to the new environment in which the child is missing. Finally, the family member can withdraw emotional energy from the grieving process and reinvest in healthy ways. Worden specifically differentiated these as tasks, as opposed to phases, because he said that one task need not be completed before the family member can begin working on the next task.

Interventions for All Family Members

One of the first and most important roles of the mental health counselor is to assess the family situation in terms of their grief (Rando, 1984). Rando suggests that the counselor begin by determining the family’s current situation. For example, which family members are actively grieving and which ones are not? Are any family members using avoidant coping methods, and if so, how is this affecting the rest of the family? Much assessment can be done by simply listening to the family members talk about their situations, and this in itself can be therapeutic for the client.
Many family members may be confused and upset because of the intensity of their reactions to the loss. One of the most important tasks for the mental health counselor is to normalize the grief process, to let parents know that their extreme reactions are quite normal, given the extreme nature of the crisis (Romanoff, 1993). At this point, the therapist can begin to help the client to assess their own situation and begin to plan for recovery.

Bernstein and Gavin (1996) specifically state that the most important therapeutic tool for grieving families is to focus on the families' strengths. This may include a discussion of the strengths of relationships in the family, abilities of individual family members, and outside resources upon which the family may draw. This may be difficult because families may hope for and expect more support from family and friends than they are actually offered. Brabant, Forsyth, and McFarlain (1995) found that parents perceive support from friends and extended family to be too short-lived. Although families are often overwhelmed by offers of support immediately following a child’s death, this type of support is almost nonexistent months or even weeks after the death.

Mental health counselors may help the family members by suggesting sources of support which the family might not consider. Surprisingly, subjects in the Brabant et al. (1995) study reported employers and coworkers to be even more
supportive than family and friends. Perhaps this strong support is in some way connected by the increased time spent with others in the workplace.

Brabant et al. (1995) found that many of the families in their study reported receiving positive support from members of the clergy. Many parents whose children had died are likely to experience an increased sense of spirituality (Marmer, 1995). For this reason, counselors may encourage families to seek support from their pastors or other religious professionals. However, counselors should be aware of research which give us evidence that, although frequent churchgoers tend to show higher levels of optimism after a child’s death, they also tended to show more repression of bereavement responses (Sanders, 1980).

In some circumstances, school personnel are in a position to help families through the mourning process. Peikes (1993) described several ways in which school personnel were helpful to both parents and siblings of the dead child. For example, one teacher in her study brought the deceased child’s belongings and papers to the parents, staying to talk with the parents about their child in the classroom. One school planted a memorial tree in the schoolyard, thereby offering support to surviving siblings who still attended the school.

A thorough evaluation of available support with which the family feels comfortable may be extremely important for family members. Symptoms of grief such as those of depression, anger and guilt may keep family members from
seeking help when they most need it. Although many family members may tend to isolate themselves after a child’s death, Johnson (1987) warned clinicians to encourage these clients to participate in social interaction which they consider safe.

After an evaluation of a client family’s resources, counselors can begin to suggest behavioral interventions which family members can begin in order to alleviate some of the pain they are experiencing. Several methods of coping have been found helpful to grieving clients. Many of these may be suggested for clients of any age and clients may choose for themselves which they find most helpful.

If the counseling relationship begins very soon after the child’s death, counselors can help by guiding clients through the funeral and burial process. Johnson (1987) has found it extremely helpful for grieving family members to physically see the dead child’s body. This seems to be necessary to grieving families who may otherwise have difficulty letting go of fantasies in which their child is somehow still alive. Johnson has found it helpful, in cases in which the child’s body is deformed or mutilated by the death, to allow family members to view a nonaffected part of the body, such as the child’s arm or leg. Rosof (1994) found it helpful to include the entire family in the process of funeral planning. Although many parents are hesitant about the inclusion of siblings, Rosof has found that children more often feel like outsiders when they are not included.
Johnson (1987) encouraged grieving family members to journal during the grief process. This helps clients to keep track of, and to better understand feelings and ideas between therapy sessions. Videka-Sherman (1982) indicated that the most effective coping methods for bereaved parents were active and externally directive, such as altruistic endeavors or assuming a new active role in life. Talbot (1999) reported that altruistic activities such as volunteering were positively correlated with positive changes for bereaved mothers.

Bibliotherapy can be very helpful to grieving families. When a child dies of SIDS, it is important to educate the parents about SIDS because many parents tend to feel excessive guilt (De'Epiro, as cited in Marrone, 1997). Johnson (1987) often reads poems, short stories, or children’s books to clients during sessions, encouraging them to explore the underlying themes. She also encourages clients to seek out and read poems or stories which relate to their own issues.

The idea of encouraging continuing connection with the child can be a difficult one. As mentioned previously, preoccupation with the dead child can be a severe hindrance for recovering family members. Toder (1986) suggested packing away reminders of the child during the initial mourning period so that parents and siblings are not constantly being taken off guard with overwhelming feelings. Rosof (1994) encouraged grieving family members to set aside a particular time
each day to reminisce about the child, and keeping this time distinct in order to avoid an unhealthy preoccupation.

**Interventions for Parents**

Although many interventions are useful for the entire family, some have been found to be particularly helpful for the parents. Groups for bereaved parents are available throughout the country and are easily accessed through the internet. Because a child’s death is such a rare event today, group therapy is an excellent way to connect parents who are experiencing similar situations. Because the experience is so intense and unfamiliar, parents are bound to benefit from talking with others in the same or similar situation. Soricelli and Utech (1985) found that parents find groups to be most helpful when they are joined between six weeks to eight months after the child’s death. Parents who join before six weeks tend to be experiencing denial, and therefore impede progress for other members. After eight months, parents often feel as though the intervention is coming too late.

Berti and Berti (1994) designed a logotherapy group especially to help bereaved parents. This group is facilitated in three stages. First, new members are encouraged to share their experiences with the group in order to better understand their own situation. The second stage, enlightenment, begins when parents have accepted the reality and are ready to come to terms with the permanence of the loss. During this stage, parents listen to and consider suggestions and perspectives
of other group members. Finally, during the life-planning stage, parents explore ways to move onward. Berti and Berti believe that this group format meets the needs of bereaved parents and helps them to overcome their traumatic situations.

Confrontation of parental guilt is an important component of working through the grief process. Rando (1984) suggested several interventions for dealing with this guilt, including confrontation of irrational beliefs, focus on positives of relationships, encouraging altruistic efforts, and writing a letter of self-forgiveness. Rando also suggests that parents who are unable to work through their guilt be encouraged to learn to live peacefully with it.

Finally, it is important to understand that in the midst of all this upheaval in their lives, parents will eventually need to reestablish some sort of routine. Counselors can help parents by helping them to work through basic issues, such as scheduling their days or adjusting family rituals. Because of the cost involved with medical expenses and funerals, counselors should ask parents whether they need assistance with financial issues. If so, counselors can make referrals to appropriate agencies.

Interventions for Siblings

Researchers have spent a great deal of time looking at ways to effectively assist parents who have lost a child. Because many believe that parental grief is the most intense form of loss, this focus is understandable. However, in
comparison to parents, sibling grief has not been researched to a great extent. For this reason, interventions for this group are not as well represented in the literature.

Cook (as cited in Marrone, 1997) found that siblings were significantly better able to deal with the death of a sibling when they were kept informed of the situation. Rosof (1994) seemed to agree. She assures parents that children can benefit enormously when given accurate, age appropriate information about their sibling’s death. Sanders (1999) insisted that children need to be encouraged to express their feelings and thoughts openly after their siblings’ deaths.

As mentioned previously, parents are often unable to offer emotional support to surviving children, especially immediately after their child’s death. Counselors can be of great help to these families if they are able to identify support systems and community resources that may help the children in these families.

Children should not be isolated from the rituals of grief and mourning, such as attending the funeral or wake. Because parents are often unable to offer all the emotional support needed at this time, inclusion in rituals may help children to understand that they are not being abandoned by the family (Rando, 1984). Rando explained that children are able to deal with these situations quite well if some details about what to expect are explained beforehand.
Conclusion

The death of a child is a serious and overwhelming crisis for the family. Grief is a complicated process, and a child's death brings about a uniquely intense form of grief. Several variables are bound to effect the impact of the death on the family, such as the cause of death, the age of the child, and the dynamics of the involved family.

Parents often suffer from a number of somatic symptoms, and most parents experience despair, depression and anger. Many parents use coping methods which inevitably exacerbate the problem, such as increased alcohol use and denial of the child's death. Marriages generally suffer, and divorce rates among grieving families are higher than those in families who have not experienced this sort of problem. Marriages that manage to stay intact often suffer from sexual difficulties and communication problems, often as a result of differences in mourning styles between the parents. Marriages that do survive are often strengthened as a result of the experience.

Siblings of the deceased child suffer from their own sort of grief, often marked by a loss of their parents who are unable to offer emotional support. Children often suffer additional symptoms, such as loss of appetite and separation anxiety.
Many interventions are available for mental health counselors of grieving families. Counselors may start with an understanding of the importance of grieving. After assessment of the situation and of resources available to the family, counselors can apply a number of educational and behavioral strategies which can help to alleviate immediate symptoms and help the client to avoid long term difficulties.

The death of a child may be one of the most serious and painful issues faced by families. Mental health counselors who work with these families face an enormous challenge. By learning to effectively evaluate each family's unique situation and gaining a knowledge of interventions, mental health counselors can help these clients to overcome and even to find new meaning in lives that may otherwise be marked by hopelessness and despair.
References


