Effectively addressing the needs of bereaved children

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Abstract
Any professional counselor who works with children will eventually be presented with children who have lost a loved one due to death. It is important, therefore, for counselors to acquire basic knowledge about how children understand death, how children are affected when shielded from the facts about death, what the grieving process looks like for children, and whether a child's reactions to death is typical or whether it is a sign of more serious mental health problems.

A brief overview summarizing these factors is included in the first section of this paper. In the second section, the author will explore how the professional counselor might best address the needs of grieving children, including the utilization of specific interventions and techniques. A brief discussion of the impact of religious and cultural influences on grieving children will also be included.
EFFECTIVELY ADDRESSING THE NEEDS OF BEREAVED CHILDREN

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Death is a naturally occurring aspect of life, yet people in American society deny this fact. It is not socially desirable to discuss death in American culture, and it is often considered a taboo subject by adults. Fulton (1965) discussed the increasing denial of death in our society, saying that “the present generations in America can be said, in a manner of speaking, to be the first in the history of the world never to have experienced death” (p. 79). Americans dislike acknowledging endings. People are taught to pretend that pain does not exist and that all is well (Williams & Sturzl, 1990).

Children in American society today have a different experience with death than children in previous generations. In the past, it was common for people to die at home with family members gathered day and night around their bed. The surviving family members were active in preparing for the death and the rituals following it, often preparing the body for burial and holding a wake in the family parlor or main room of the house (Charkow, 1998; Williams & Sturzl, 1990).

Today, ill and elderly family members are often removed from the home and placed in institutional settings such as hospitals or long term care facilities where they are likely to die alone (Charkow, 1998). Currently in America, after a loved one dies, the body is immediately taken to a funeral home where people outside of the family prepare the body for burial. This, combined with the fact that death is an uncomfortable subject for adults, means that American children rarely experience death as a normal part of life (Charkow, 1998).

Many parents do not tell their children about a loved one’s death. Parents may try to protect their children from experiencing the pain and grief that follows death by not telling them a death has occurred. Many adults think that children
will only be confused by death, so they refrain from telling them when death occurs (Charkow, 1998). Adults might also think that because children may not fully understand death that they will not grieve the loss (Wass, 1991). If adults do discuss a death with their children, they often try to shield their children by using euphemisms about death that are misleading. Thus, the reactions and needs of children who are told about the death of a loved one are often overlooked or misunderstood.

Children will inevitably experience death whether or not adults try to shield them from it. One in twenty children will lose a parent by the age of 18, and many others will experience the death of a pet, sibling, grandparent, friend, or other loved one (McGlaflin, 1998). Even if they are not honestly told about a death or do not witness the death of a loved one at home, any child who can feel emotions will still experience pain and grieve the loss and separation that results from death (Charkow, 1998). Children are unable to cope with feelings of grief on their own because they lack the resources and life experiences to know how.

Children do not normally discuss death with their peers because they fear that they will no longer “fit in.” Having a loved one die sets them apart from others and being “different” from their peers often leads to rejection and further distress (Webb, 1993b). In addition, many adults are uncomfortable discussing death with their children, or may be so overwhelmed with their own grief that they cannot provide what their children need emotionally. It is evident that counselors are extremely important resources for grieving children. A counselor may be the only adult willing to talk with children honestly about death itself and about normal feelings that might be experienced following the death of a loved
one. When children have no one who will discuss death with them, they become confused and even more distraught (Charkow, 1998). They are at risk for more behavioral problems and suicidal ideation than adolescents or adults if their emotional are not addressed (Lenhardt, 1997).

While children encounter and grieve many types of losses, such as moving and divorce, this paper will deal solely with children grieving the death of a loved one. Any professional counselor who works with children will eventually be presented with children who have lost a loved one due to death. It is important, therefore, for counselors to acquire basic knowledge about how children understand death, how children are affected when shielded from the facts about death, what the grieving process looks like for children, and whether a child’s reactions to death is typical or whether it is a sign of more serious mental health problems.

A brief overview summarizing these factors is included in the first section of this paper. In the second section, the author will explore how the professional counselor might best address the needs of grieving children, including the utilization of specific interventions and techniques. A brief discussion of the impact of religious and cultural influences on grieving children will also be included.

Background Information about Children and Death

How Children Comprehend Death

It was once believed by Freudian theorists that children’s egos were not fully developed and, as a result, they were incapable of feeling grief if a loss occurred (Costa & Holliday, 1994). This idea was refuted in the 1960s after a
A ground-breaking study was conducted by John Bowlby (cited in Costa & Holliday, 1994). Bowlby found that children do feel grief, and that like adults, they go through a painful grieving process when separated from loved ones.

Seager and Spencer (1996) reported that even before they are capable of understanding the meaning of death or of remembering the person who has died, children as young as one and two years old can sense a change in the emotional atmosphere after a death occurs and are affected by such changes.

In her studies of Hungarian children in the 1940s, psychologist Maria Nagy found three phases in children's awareness of death (cited in Grollman, 1996). The first phase includes children ages three to five. During this developmental phase, children do not recognize death as a regular and final process. They comprehend it more like a state of sleep and therefore conclude that one who is dead will later awaken and be alive again. They may also perceive death as a journey in which a dead person will not only return after being gone for awhile (Grollman, 1996), but also that it is possible to go visit the deceased (Seager & Spencer, 1996). Children of this age may repeatedly ask when the deceased loved one will stop being dead and come back to play with them (Cassini & Rogers, 1991).

This stage can also be understood using Piaget's conceptualization of child development. Piaget’s Preoperational Stage (ages 2-7) is characterized by egocentricity and magical thinking. Children with egocentric thinking believe everyone else sees the world as they do. Magical thinking refers to having no differentiation between thoughts and deeds. For example, children may experience guilt when a loved one dies because they believe that their anger
toward that person caused the death (Williams & Sturzl, 1990). Children in this stage of development cannot understand death as permanent. They think if they scream loud enough, the deceased, whom they perceive as sleeping, will wake up. The younger children in this stage may go to a funeral but not understand that the person can no longer feel or move, so they express concern about how the deceased will breathe in the coffin or how the deceased will be able to go to the bathroom.

Children under the age of five may generalize about how death takes place or the circumstances surrounding death. They may also associate unrelated events with death. For example, if a child observes a shooting death on television, at a later date, upon hearing of a family member’s death, they may assume that the family member was also shot (Edgar & Howard-Hamilton, 1994).

Very young children are not yet fearful of death because they do not understand it as universal. As children gain insight about what death means, they may begin to fear it. For example, children may hear that a loved one died in the hospital, or they may observe a hospital death on television. If they are old enough to understand some of what death means, they may become fearful of the hospital or even the doctor’s office because they associate such places with death. They may believe that if they avoid the “places where people die” they will avoid dying themselves. In the world of a young child, all things are connected (Brooks, 1996; Cassini & Rogers, 1991).

Five to nine year old children are included in Nagy’s second developmental phase. Children in this category likely see death as final and permanent, but do not understand that all people, including themselves, will
someday die (Grollman, 1996; Seager & Spencer, 1996). Nagy’s second stage overlaps with Piaget’s Concrete Operational stage, which includes children ages 7-11. This stage is characterized by less egocentric thinking and more ability to reason. Children in this stage realize death is irreversible, but may not believe it will happen to them. They will typically believe death happens to all people “sometime,” but perceive the old and weak as the people who die. During the ages of 6-8, children may think that people only die because they cannot escape the pursuing ghost, angel, or alien who causes death. They see themselves as strong, powerful, and able to escape death. By this age, children are also capable of understanding the separation of body and spirit or that the deceased can simultaneously be in a grave and in heaven if this is part of the family belief system (Cassini & Rogers, 1991; Webb, 1993b). A more realistic perception of this abstract concept develops during the next stage.

Nagy’s final phase includes children age nine and ten. Children in this category likely recognize death as both final and inevitable, while also understanding their own mortality (Grollman, 1996; Webb, 1993b). They may also view death as punishment (Seager & Spencer, 1996). By this age, children can understand feelings of loss, not only of themselves, but also of others. Having such understandings means they are now able to empathize with others and may be concerned about how other survivors are coping (Cassini & Rogers, 1991; Furman, 1986).

Piaget’s final stage, the Formal Operational Stage of development, includes children over the age of twelve. Children in this stage are capable of relating death to a complex system of religious and philosophical thought and
have beliefs about whether or not life after death exists (Brooks, 1996).

How Children are Affected when Shielded from the Facts about Death

Developmental stages affect how children comprehend death, but whether or not adults choose to educate children about death also has a great impact on a child’s understanding. Children who are denied the opportunity to grieve the loss of a loved one may have unrealistic views about death even when they are developmentally capable of comprehending it as inevitable and final (Edgar & Howard-Hamilton, 1994); and their sense of support and ability to resolve grief may be negatively impacted (Cook & Dworkin, 1992).

Adults often add to the misunderstandings and anxieties that children have about death by communicating with euphemisms in their efforts to make death less painful for children. For example, telling children that grandpa is sleeping can evoke a fear in children that either someone they love or they, themselves, may die if they fall asleep (Williams & Sturzl, 1990). Telling children that a loved one who has died is on vacation will likely result in children who are confused as to why people are so upset and wonder when grandma will return. It can also lead to feelings of desertion (Cassini & Rogers, 1991). Later, when children learn the truth about the death of their loved one, they may resent parents for being dishonest. Words such as “passed on,” “departed,” “lost,” or “gone away” are confusing, especially to young children (Cassini & Rogers, 1991; Williams & Sturzl, 1990). Such euphemisms can also reinforce the inaccurate concept that death is reversible (Costa & Holliday, 1994).

Talking openly with children about death is important for three reasons. First, children need to learn facts and realities about death, thus dispelling
misperceptions. Adults can help children by using correct terminology and avoiding euphemisms. Second, it is important to address children’s anxieties and misunderstandings. Children often fear what is unknown and unexpected, and some of these fears can be alleviated when a trusted adult helps reassure them. Finally, children need to be able to grieve the deceased loved one, share in the grief with other family members, and cope with their own feelings in addition to eventually developing empathy for others. Learning about and dealing with death is difficult for adults and children both, but it is an inevitable part of life.

In an effort to protect children from pain and sadness, caregivers often do not let them take part in rituals following death, such as a funeral or a visit to the cemetery (Cedar Valley Hospice, 1997; Lenhardt, 1997). This takes away the opportunity for children to share grief or to participate as a member of the family. Allowing children to participate in funerals helps them to understand the finality of death and helps dispel misconceptions they may have. It is important, however, that children are fully prepared as to what they might observe at such a service (i.e., people crying or an open casket with a dead body in it) and where and with whom they will be sitting (Charkow, 1998; Cook & Dworkin, 1992; Daunton, 1974; Grollman, 1996; Webb, 1993b). Children should not be excluded from such rituals, but they should not be pressured or forced into attending them either (Grollman, 1996; Worden, 1996). Including children in memorial rituals gives them the chance to remember the loved one they lost and a way to say good-bye. Just as it is important for adults to have closure, it is also important for children to have this opportunity (Cedar Valley Hospice, 1997).
The Grieving Process for Children

“Grief is the emotional, physical, and spiritual response to the loss or anticipated loss of someone or something in whom or which one has been invested. Grief is part of the human condition, a part of love. The more one loves, the more acute the pain will be at the separation from the beloved” (Williams & Sturzl, 1990, p. 35).

Worden (1996) conducted a child bereavement study to address limitations found in previous research with regard to children and grief. The subjects included 125 children, ages 6-17, from 70 different families who were experiencing bereavement after the death of a parent. The study followed the children for 2 years after the death and compared them to a sample of children who were not experiencing bereavement. In his research, Worden (1996) identified four tasks of the mourning process for children.

The first task was to accept the reality of the loss. Worden (1996) determined that, in order for this to occur, children must be informed of the death in ways that are accurate and in language that considers their level of comprehension. He also concluded that children need to be told repeatedly and over time about the death as they grow and can understand the meaning of death differently. The second task identified by Worden (1996) was experiencing the pain and emotional aspects of the death. Children exhibited feelings similar to what adults exhibit, and their feelings were influenced by what they saw modeled by grieving adults. The third task was adjusting to the environment without the deceased. Worden’s (1996) research indicated that children’s adjustment was determined by the role that the deceased played in their life and in the life of the
family. The fourth and final task indicated by Worden (1996) was for children to relocate the dead person within their life and to find ways to memorialize them. This task is accomplished when children have found ways to go on living effectively, but without giving up the relationship they had to the deceased entirely. The deceased will always remain alive in their hearts and memories.

Normal Grief Reactions of Children

Children go through many of the same reactions to grief that adults encounter. They may deny that the death has occurred, appearing to be unfazed by the death. A lack of response to the death usually signifies that the child has found the death too overwhelming to accept (Grollman, 1996).

Children may bargain with God or with caregivers of their dying loved one by vowing to never misbehave again. They may come to the conclusion that if they do not allow anyone to speak of their loved one as dead, that he or she may come back to life (Williams & Sturzl, 1990).

Children may react with anger and hostility toward the deceased or toward others. They may feel abandoned by the deceased and resentful toward them. Children who do not fully understand what death means may also feel that the deceased did not really love or care about them or they would not have deserted them. Children may feel intense anger about the death and project this toward others such as doctors or caregivers who they perceive to be at fault for the death of their loved one. Children may also react with anger to anyone who mentions the shortcomings of the deceased. They may remember only the positive qualities of the loved one or idealize the deceased in an effort to cope with the death (Grollman, 1996). Children may be angry about being forced into a new role. For
example, they may be the only child at school with a dead father, or they may be the oldest or only child now that their sibling has died. It can be very difficult for children to accept a new identity, and they may feel that they must “fill the shoes” of the dead parent or sibling (Cassini & Rogers 1991). Children may also express anger in other ways. For example, they may exhibit an increase in discipline problems or deviance, temper tantrums, and aggressive behavior (cited in Cook & Dworkin, 1992).

Children may experience feelings of depression or guilt after a loved one has died. Since young children often have egocentric or magic thinking, they may assume that the death is their fault as they remember saying or wishing out of anger that they hoped the loved one died. Even if a significant amount of time has gone by since they expressed such a desire, if they recall having ever felt that way, they may feel as though they are to blame. They may also perceive death as a punishment and think that if they had behaved better and not “acted naughty” that their loved one might still be alive (Charkow, 1998; Grollman, 1996). They may also think that there is something magical they could have done to stop the death. For example, they may think they did not try hard enough with their imaginary power to “beat up” the disease that killed someone they loved (Cedar Valley Hospice, 1997).

Children may also express fear in response to a death. They may panic as they wonder who will provide for their needs now that a significant person in their lives has died. They may feel very insecure about whether their surviving caregivers will also die soon (Grollman, 1996). Children who feel such anxiety may respond with clinging and dependency behaviors (Cook & Dworkin, 1992).
or with possessiveness, excessive caregiving, or newly developed phobias (Cedar Valley Hospice, 1997). They may show extremes in behavior, becoming either hyperactive or passive and withdrawn (Costa & Holliday, 1994). Children may also regress into behaviors associated with earlier stages of development such as thumb-sucking or wetting the bed (Cook & Dworkin, 1992; Costa & Holliday, 1994) and show signs of lowered self-esteem (Cedar Valley Hospice, 1997).

In addition to behavioral and emotional problems, children may also experience physical symptoms as a reaction to death. They may feel that it is difficult to breathe or that they are weak and fatigued. They may also have trouble sleeping or eating (Grollman, 1996). One somatic reaction might include the development of an eating disorder such as anorexia or overeating because food is being used to provide comfort and compensate for the loss (Smith & Pennells, 1995). Children may suffer from physical ailments such as diarrhea, vomiting, constipation, loss of bladder or bowel control, loss of appetite and sleep, tightness in chest or throat (Costa & Holliday, 1994) frequent nightmares, and headaches (Cook & Dworkin, 1992).

Children often cope with overwhelming emotions by taking a break from grieving. They have the unique ability, unlike adults, to grieve in a clumping pattern of sometimes intense periods separated by intervals where they appear to be unaffected by the death. For example, it would be normal to see children crying uncontrollably, and then later the same day running and playing. Such extremes can be confusing to adults. Intermittent grief is a means for children to protect themselves, not a tactic to manipulate adults for attention or evidence that
children are done with their grieving process, as many adults assume (Cedar Valley Hospice, 1997; Seager & Spencer, 1996).

It may take a considerable amount of time for children to work through the tasks associated with grieving the loss of a loved one. They typically grieve just as long, if not longer, than most adults after experiencing the death of someone significant (Cedar Valley Hospice, 1997; Seager & Spencer, 1996). Even with adequate support, it may be several years before they have completed the grief process. This is important to note because delayed or prolonged grief in adults is viewed as pathological. Such a view would not be applicable to children who often re-experience grief throughout different developmental stages growing up or address issues they were unable to address earlier in life due to their developmental capabilities (Webb, 1993c; Seager & Spencer, 1997). Children have less adequate coping skills than adults and must continually reprocess their grief as they encounter various stages in their development (Tonkins & Lambert, 1996). During transition times in their life, children may regrieve the deceased, for example, at the onset of puberty, before their first prom, when they graduate, or as they prepare to get married or become a parent (Cedar Valley Hospice, 1997).

Abnormal Grief Reactions of Children

With such a wide variety of normal and acceptable ways for children to react to grief, it may seem that there is nothing that should be perceived as "abnormal." It is important to note that some reactions are identifiable as "red flags" and may warrant special attention. Children are often referred to counselors for professional help when their grieving is characterized by the following:
hyperactive behavior and lack of focus on school work for a significant amount of time; avoidance of speaking about or expressing feelings about the death; continued physical symptoms with no medical explanation or continued symptoms related to problems that the deceased encountered; a desire to cut-off all former relationships that could provide support and understanding; continuous hostility that is causing significant dysfunction socially or at school; or self-defeating coping mechanisms such as drugs and alcohol, self-mutilation, or hair-pulling (Cassini & Rogers, 1991; Worden, 1996). Other signs of complicated grief in children might include: persistent nightmares or sleep disorders (Webb, 1993a); an extended period of depression with loss of interest in previously pleasurable activities or events; persistent anxiety or panic; persistent self-blame or guilt; regression to previous behaviors for an extended period of time; excessive imitation of the deceased; and suicidal ideation (Cedar Valley Hospice, 1997; Worden, 1996).

Factors Influencing Children’s Reactions to Death

Children’s cognitive abilities and developmental level have an effect on their grief because both influence children’s capacity to understand what the death means and how it will impact their life. Children who have had previous experiences with death that were met with sufficient support will likely grieve in a healthier manner than those children whose previous experiences with death did not include the opportunity to grieve appropriately (Charkow, 1998; Warmbrod, 1986).

Personality is another factor influencing their response to death. Children who are able to express their emotions freely usually have an easier time grieving
than those who normally do not express their feelings well (Charkow, 1998). Other characteristics of children such as their age, gender, and self-perception also have an influence on how children grieve the death of a loved one (Charkow, 1998; Worden, 1996).

Children's relationship to the deceased is another factor influencing their response to death. The loss of a parent can be particularly devastating because the children lose emotional and psychological support on which they could depend previously (Charkow, 1998; Worden, 1996). Unlike adults who often have strong relationships with coworkers and other friends, children often rely solely on receiving support from family members, particularly their parents (Furman, 1984; Tonkins & Lambert, 1996). When a parent dies, not only do children lose the support of the deceased parent, but often the surviving parent is preoccupied with the death and unintentionally neglects providing for the children's emotional needs. The functioning of the surviving parent and his or her ability to parent the children as well as the size, structure, family style of coping, and changes or disruptions that occur in the family's daily life all impact how children will react following the death of a parent (Worden, 1996). The death of a sibling can also be devastating and especially frightening to children because this experience is so personally threatening (Williams & Sturzl, 1990).

The circumstances surrounding the death are another factor influencing children's grieving. Sudden deaths such as accidents, suicides, and violent deaths are commonly the most difficult to handle because they are unexpected and do not allow the survivors any closure to their relationship with the deceased. In addition, deaths that occur as a result of suicide or violence provide little room for
meaning or solace and therefore can be particularly difficult to comprehend (Charkow, 1998; Warmbrod, 1986).

Counseling Bereaved Children

The Need for Mental Health Professionals

Bereaved children may need the assistance of mental health professionals for many reasons. Since many adults need help themselves with issues regarding death, either because they, too, are grieving or because they have difficulty talking about death, counselors become very important to children who look for stability and support from adult figures (Costa & Holliday, 1994; Glass, 1991). Children may also try to protect parents or other family members by not discussing their grief (Munroe, 1995).

Another reason a counselor’s assistance may be necessary is because children rarely discuss death with their peers for fear of being “different.” In addition, children’s peers often feel inadequate and uncomfortable themselves with regard to providing support (Webb, 1993c). Bereaved children often have no one available to console them. If they do have someone available, the person still may not be able to meet their needs because comforting grieving children is not an easy task. (Webb, 1993c). Often it requires nonverbal methods of helping children express their feelings about death (Glass, 1991; Seager & Spencer, 1996)

Counselors can be a positive force for children in many ways. They can help children have realistic expectations of themselves with regard to grief work, and they can encourage children to take breaks from their grieving to have fun without feeling guilty. Counselors can also help children see the importance of continuing to eat properly, exercise, and get adequate sleep (Glass, 1991). They
can help the children learn about the meaning of death in ways that are accurate and developmentally appropriate, help normalize the reactions that children are having with regard to the death, and help encourage children to remember the deceased person realistically as someone who had both strengths and flaws (Costa & Holliday, 1994; Glass, 1991). Counselors can also help monitor a child’s sense of guilt (Costa & Holliday, 1994).

Counselors, because of their special training, can meet the needs of children in ways that other adults cannot. Not only do counselors have the training to provide empathy, genuineness, and unconditional positive regard to grieving children, but many of them are also educated in how to most effectively communicate with children in distress. Counselors often can “talk” to children and encourage them to use their own unique coping style by playing with them and communicating through puppets, metaphors and other methods that do not demand that children verbalize their feelings outwardly or maintain eye contact, which can often be uncomfortable for children. Counselors are trained to look for subtle messages from the children and for red flags in their behavior. In addition, the counselor can model or suggest other effective coping strategies such as going for a walk, drawing, journaling, and managing anger.

Educating Parents

Counselors can begin to address the needs of grieving children by educating caregivers about the importance of open and honest communication with their children. They can reassure parents that it is okay for them to communicate to their children that they do not have all the answers about death (Grollman, 1996). Counselors can encourage caregivers to be understanding of
their children’s unique ways of expressing grief. Children need to know from their parents that they will not be punished for having “bad” or “wrong” feelings about death (Seager & Spencer, 1996).

Mental health professionals can also encourage parents to widen their children’s support network by encouraging relatives, clergy members, youth club leaders, and teachers or counselors at the school to assist them in meeting the needs of their grieving children. Counselors can provide resources such as pamphlets, books, videos, music and scripture that may help caregivers communicate with their children or may assist in the children’s understanding of grief (Munroe, 1995). Mental health professionals can also remind parents or caregivers to share memories of the deceased with their children and to be aware of events that might trigger children’s grief, such as birthdays, holidays, and developmental milestones (Cedar Valley Hospice, 1997; Costa & Holliday, 1994; Williams & Sturzl, 1990).

Educating parents about how to talk to their children and provide a supportive environment is not always enough. Often grieving children need help from someone who is removed from the family and the circumstances of death to meet their emotional needs.

The Therapeutic Process

Counselors first need to assess whether or not the children with whom they are working were provided with truthful answers to their questions about death and whether they were given or denied the opportunity to participate in grief-related rituals. They need to expect that nonverbal means of gathering information about children’s grief is likely to be more effective than “talk
therapy.” They also need to be aware that gestures of suicide among children may take unique forms, and so the traditional approach to assessing lethality may be inappropriate (Cook & Dworkin, 1992).

Worden (1996) found in his bereavement study that grieving children have the following needs which mental health professionals should address. They need to be provided with adequate information, they need reassurance for their fears and anxieties, they need to know that they are not the cause of the death, they need someone to carefully listen to them, they need validation of their feelings, and they need help with the feelings that overwhelm them. In addition, four other needs of children include the need for (a) involvement and inclusion, (b) a continued routine at home, (c) appropriate models of grief, and (d) opportunities to remember the deceased. The last four needs are difficult for the counselor to meet alone, since they usually involve decisions made by caregivers, but they are needs that the counselor can help meet by providing education to the children’s caregivers about their importance (Worden, 1996).

According to Warmbrod (1986), three stages exist in the counseling process when working with grieving children. The first stage involves a focus on the death and the funeral. During the second stage, the counselor helps children consider what the dead person was like and what is missed about that person. In the final stage, the focus is on the present. During this stage, the counselor determines what the sources of comfort are, what is most difficult for the children to cope with, and in what ways he or she could best help children adjust and work through their grief.
Major goals of therapists working with grieving children might include helping them to identify and understand their feelings, helping them to feel safe in expressing such feelings, and helping them to develop insight and feel understood by interpreting their thoughts and feelings and gently confronting discrepancies (Cook & Dworkin, 1992). Counselors have the unique opportunity to be the adults in the lives of grieving children who allow them not only to express negative emotions, but also who meet such emotions with acceptance rather than the rejection or punishment that might be expected from other adults (Cook & Dworkin, 1992).

Counselors can help bereaved children develop alternate coping strategies and effective coping mechanisms. They may help children to look at new ways of viewing a situation that are less self-defeating than the way they looked at things previously (Cook & Dworkin, 1992). Children need to be allowed to deal with grief in their own particular way, and they need to be given adequate time to cope. Mental health professionals need to reassure them that their ways of grieving are appropriate and acceptable (Costa & Holliday, 1994). Counselors can assist children in breaking through the myth that they should be “strong enough” to cope on their own. They can help children to build up a network of support. “By being available, encouraging and strengthening existing relationships, and helping to develop new ones, the counselor will assist the grieving person to reestablish a sense of self” (Lenhardt, 1997, p. 269). Counselors can help children make positive changes so that they emerge more resilient and with more restored self-confidence than they would without help (Cook & Dworkin, 1992; Lenhardt, 1997).
As they near the final tasks of grief, children should be encouraged to think about the struggle as something very difficult that they survived. This will help them in future struggles to take some comfort in the fact that they made it through one of the worst things that could have happened to them (Costa & Holliday, 1994).

Counseling Considerations

There are several tenants that are important for counselors to remember when working with grieving children. First, bereavement is a normal and natural experience. Second, it is necessary to assess the child’s personality, coping style, support system, developmental capabilities, and cultural background when choosing specific counseling techniques. Third, the choice and timing of chosen therapeutic interventions should be geared toward the child’s needs and goals. Finally, the counselor’s role includes being a facilitator, teacher, supporter, and encourager of effective coping strategies and the growing process (Cook & Dworkin, 1992).

It is important for counselors to maintain boundaries in their relationships with grieving children, just as they would with any client. Children who have lost a parent may be looking for an adult to “replace” the deceased. They often look to the warm and empathic counselor to meet the emotional needs that their deceased parent once did. One problem with this is that children may feel they are being disloyal to the deceased if they see the counselor as fulfilling some of their parent’s roles. The counselor should take care to communicate to children that no one will ever replace their lost loved one (Costa & Holliday, 1994).
It is also important for counselors to remember that their own characteristics can either help or hinder the therapeutic process. In this respect, counselors should continually evaluate themselves and be attentive to their own personal issues with regard to death and grief (Cook & Dworkin, 1992; Warmbrod, 1986). In addition to having self-knowledge, counselors who work with grieving children will not be effective unless they have knowledge about the ways that children understand death and express grief (Warmbrod, 1986).

Utilizing Specific Counseling Interventions and Techniques

Interventions with grieving children can be explained using four broad categories which include peer groups, individual counseling, family interventions, and combination models (Webb, 1993c; Worden, 1996). Each approach to treatment, as described by Webb (1993c) and Worden (1996), has both advantages and disadvantages, and some models are more appropriate for specific age groups. Under the broad categories, specific techniques could then be utilized.

Approaches to Counseling Bereaved Children

Peer groups. The purpose of working with bereaved children in a group setting is to help educate them with regard to death and grief, to help them gain support from peers are feeling similar emotions, and to help prevent pathological grief reactions (Cook & Dworkin, 1992). Peer groups can be helpful and effective for bereaved children because they help children feel that they are not alone in their loss as they find others who have common experiences and feelings. Peer groups also provide a place to safely discuss feelings without worrying about how family members might react or be impacted. Group counseling is also beneficial
because it is a cost-effective method of providing treatment. Groups are especially suitable for children dealing with tasks in the middle stages of grief and for adolescents who are capable of providing support and empathy to one another, but who typically try to avoid turning to peers who have not experienced a death because they do not like to stand out or appear different.

This model has limitations. It is not as effective with children who have severe or pathological reactions to the death of a loved one. In addition, this model excludes the other members of the family, who likely will have the most influence on how the child deals with the death.

A study conducted by Tonkins and Lambert (1996) measured the affect group grief counseling (an eight week psychotherapy group) had on bereaved children. The results indicated a decrease in the children’s depression and overall emotions, as well as a decrease in behavioral disturbances. The children who received the group treatment showed significantly reduced grief symptomology when compared to children on a waiting list to receive treatment. Such results indicate the likelihood that the changes occurred due to the treatment rather than because of other factors such as the natural healing process, the passage of time, or social supports.

Individual counseling. This method of treatment is the best method to use when working with children who are having serious emotional or behavioral problems after experiencing the death of a loved one. It is effective because it provides an environment of emotional security and stability as well as a supportive adult relationship for children who might not be receiving such conditions at home. An environment that is safe for children may also help them
through the grieving process. In addition, this model has the advantage of allowing for in-depth exploration of children's thoughts, behaviors, and feelings through one-on-one interaction. This approach to treatment has the disadvantages of being the least cost-effective method and of not focusing on the family system or the interactions between children and their other family members.

**Family interventions.** This type of treatment helps grieving children address and express their feelings about the death, and it includes the other family members in this process. This model is typically used early in the grief process. The counselor can help members to communicate effectively with one another and to bond as they support one another and work together to provide solutions to problems in the family. This method is advantageous in that it allows the therapist to assess the whole family and change negative aspects of the home environment.

Having the whole family come to treatment can be a disadvantage because the attention from the therapist must be spread among all of the family members. This can mean that important information and reactions of children can be missed, and it may take longer for the children to make progress in working through their grief. It is also less cost-effective than the peer group method of treatment (Warmbrod, 1986).

**Combination models.** This method of treatment may combine group, individual, and family treatment in a number of ways. One example might include having the child partake in individual counseling, but then also working separately with the caregivers to give them support in their grief and to teach them ways to help their grieving children and to provide a supportive and safe environment at home. Although this may not be the most cost-effective method
of treatment, it can be one of the most effective at providing support to a children struggling with grief.

**Specific Techniques for Counseling Bereaved Children**

Specific techniques can be used with all of the intervention models presented. Techniques should be chosen that are relevant to the children’s age, circumstances, and culture, and that reflect the beliefs and experience of the therapist. The major goals of specific therapeutic techniques are to provide children with opportunities to express themselves, to work through their grief, to gain knowledge and accurate information about death, and to help make discussions of death comfortable and normal for the children (Worden, 1996).

Cook and Dworkin (1992) organized grief techniques under three major categories according to their primary purpose. These techniques included: promoting understanding and acceptance of grief, exploring and expanding the legacy of the deceased, and externalizing grief through symbolic acts. These techniques appear to be intended for use with a variety of clients and could easily be adapted to use effectively with children of different ages.

Strategies for promoting understanding and acceptance of grief include techniques that help inform and educate clients about the grief process and the normality of emotions they may be experiencing. Bibliotherapy is one technique that falls into this category. The mental health professional can carefully select literature specific to the children’s ages, culture and experience with death. The children can either read the literature on their own, or it can be read to them in sessions. Therapists can use literature to help children gain knowledge and insight about death and grief and to help them feel comfort as they relate to some of the
characters or situations. Stories can provide grieving children with a sense of relief, reassurance, and hope as they discover that others have survived the intense pain of grieving the death of a loved one.

The technique of reframing also falls into this category. Reframing can help children see things in perspective and redefine their perceptions to focus more on ways to positively adjust. Children can be reassured, for example, that the death of a loved one does not mean that their needs will never again be met, nor does it mean that all of the people they love will soon die.

In the category of exploring and expanding the legacy of the deceased, Cook and Dworkin (1992) included shared reminiscence and ethical wills. Shared reminiscence is a technique that encourages recalling memories of the deceased and sharing the story about the death. Often children can be helped with this process by using photographs, videos of their loved one, and other tangible objects to help them remember. Ethical wills are documents or letters that the deceased wrote before they died. Ethical wills can include journal or poetry writings by the deceased. This technique would likely work well with children who are older and have a grasp on the meaning of death and who are in advanced cognitive stages of development.

The third and final category, externalizing grief through symbolic acts, includes expression of grief and unresolved feelings through modes such as art, music, and poetry. Children can be helped to find a symbol to represent their loved one such as planting a tree in his or her memory. They can make something to place at the gravesite that is a meaningful reminder of something they shared with the deceased.
Research indicates that specific techniques such as play therapy, games, storytelling, bibliotherapy, writing, drama, and art have been effective when used with grieving children (Cedar Valley Hospice, 1997; Cook & Dworkin, 1992; Pennells & Smith, 1995; Webb, 1993b; Worden, 1996). A mental health professional should carefully select the techniques he or she will use when working with grieving children. Not all techniques work with all children, and not all techniques are used with equal effectiveness by therapists. “Techniques are tools for facilitating the process of growth, change and healing- nothing more, nothing less. They are only as effective as the therapist who is using them” (Cook & Dworkin, 1992, p. 74).

**Play therapy.** Play is children’s natural way of communicating and escaping from pain that they are feeling. Play therapy is a technique used in counseling where the trained play therapist looks at the symbolic language expressed in children’s play to help them understand the world view and the life experiences of the children with whom they are working (Kottman, 1995; Sweeney & Landreth, 1993; Webb, 1993b). Play therapy can be much more successful than traditional talk therapy when working with children since they tend to be limited in verbal and cognitive abilities (Sweeney & Landreth, 1993). A therapist can use some of the basic concepts of play therapy to work effectively with grieving children and to enter into their world of play (Seager & Spencer, 1996).

Children tend to feel more comfortable expressing feelings and beliefs that they see as taboo by communicating through playing a game. They likely view it as “only a game” and thus open up more. Playing games with children also helps
them to learn new ways to cope and relate to one another, and it provides an opportunity to normalize discussing the topic of death.

Using puppets as a part of play therapy with children can be another safe way for them to express their feelings. If they are having thoughts or feelings that are difficult for them to own, they can project this onto the puppet and communicate in this manner (Worden, 1996).

**Storytelling.** Using the natural power of stories and storytelling is another very effective way to communicate with children (Webb-Mitchell, 1995). Specific forms of storytelling that might be beneficial include biblical storytelling, which uses words that have a healing effect (Stover & Stover, 1994), or using metaphors in stories, which can help children to process feelings, thoughts, attitudes and experiences in an indirect way (Kottman, 1995). Elaine and Mark Stover (1994) recommended that, when using storytelling, the storyteller individualize the story by interjecting the child’s name, gender, and personal circumstances. This helps the child to connect more easily what is being said (both consciously and unconsciously), and it keeps him or her engaged. In addition, they recommended the use of open-ended questions when processing the story and encourage therapists to tape the stories or provide a copy for the children to keep.

**Art therapy.** Art is a beneficial tool to use with grieving children. Like play, it is a safe and more comfortable way for children to express feelings and emotions that can offer an objective distance from feelings to help children gain insight.

Using art in therapy can also give children a sense of control at a time when they may feel very powerless and can be a way for the therapist to offer
experiences for the child that are success-oriented, helping build and repair self-esteem (Cassini & Rogers, 1991). Art activities such as drawing or using clay to sculpt can help children express their feelings without having to find adequate words. Children also can gain a sense of mastery and control as they create their work of art.

Research studies of the art work done by bereaved children commonly find symbols such as monsters, rainbows, dead trees, fire, and human figures that lack body parts (Cassini & Rogers, 1991). When trying to discern what a picture means in terms of the child’s grieving, mental health professionals should proceed with caution and discuss the art with the child first. While some symbols in art appear to have universal meanings, they may have a personal meaning for the child that can be overlooked or misunderstood (Cassini & Rogers, 1991).

Colors that children choose to use may exhibit some of what they are feeling inside. For example, red may reflect feelings of anger, or blue may reflect feelings of sadness. The therapist should remember, however, that interpretation of the children’s work is subjective and that children may choose specific colors for other reasons (Worden, 1996).

Writing techniques. Children can be encouraged to process feelings and work through grief using writing techniques as well. They can journal about questions, thoughts, or feelings they are having or they can be encouraged to write a letter telling their loved one what they would want to say if they were still alive. Writing techniques usually work well with older children who have a sense of what death is and who have developed some basic writing skills (Worden, 1996).
Cultural and Religious Considerations

Children learn what is being said and done in their surroundings. This includes the customs and beliefs about death defined by their family, religion, and culture. They use their imagination to interpret their unanswered questions about the family beliefs (Webb, 1993b). For the counselor, this means two things. First, inaccurate views that the children have about death will need to be addressed because they may have misinterpreted their surroundings. Second, the therapist will need to assess and respect the religious and cultural background of the children’s family.

In addition to children’s age, developmental stage, and the circumstances of death affecting how children grieve, cultural factors also have an affect and need to be considered by the mental health professional. Ideas about health, illness, healing, and death are often determined by cultural values. Individuals who belong to some cultures are reluctant to seek professional help or to let family members do so because they fear it indicates they are weak and cannot care for themselves or because they view it as inappropriate to burden people outside of the family with their problems (Cook & Dworkin, 1992).

It is important to consider cultural factors that might have an influence on the therapeutic relationship such as language barriers and ethnic, gender, or social class differences. Some ethnic minorities may prefer to seek help from folk healers or religious leaders rather than mental health professionals. For example, some Hispanics/Latinos practice curanderismo which is rural folk medicine (Cook & Dworkin, 1992).
With specific regard to how culture might impact the grief process, it is important for therapists to examine what the norm is in their client’s culture for expressing emotions in reaction to a death and what the rituals look like that follow a death in that culture. This will help professionals working with clients who have experienced the death of a loved one to avoid any misdiagnosis of pathology.

There is little research that specifically addresses how different cultures involve or exclude children in discussions and rituals following the death of a loved one. Nevertheless, when defining what is normal when assessing children’s responses to death one must take culture into consideration. Knowing what the practices and norms of various cultures might be can give therapists a clue as to what children might be accustomed to with regard to death. The therapist can question the children or the family for more specific details as to what was specifically experienced.

In American culture, a certain level of depression is expected as a part of the grieving process, but the norm is that such depression should only last a “reasonable” amount of time, typically no longer than a year or two following the death (McGoldrick, Almeida, Hines, Rosen, Garcia-Preto, & Lee, 1991). In Japanese culture, depression is not the norm, but rather it is appropriate for grieving individuals to smile so that they do not burden others with their sadness and they avoid humiliation when in public by keeping emotions in tact or “saving face.” Many Puerto Rican females, by contrast, display intense emotion, even hysteria, when expressing their feelings of grief (Cook & Dworkin, 1992).
The death of a family member might mean very different things depending on cultural factors. For example, in some African societies that are matrilineal, it would be inappropriate for one to grieve the loss of a family member on the father’s side, since one is only considered a relative of the mother’s kin. In the Irish culture, whether the death is viewed as a tragedy or a joyous occasion depends on the age of the deceased (Cook & Dworkin, 1992). In cultures such as Italian, Greek, Puerto Rican, and East Indian, many individuals would consider it a double tragedy if their sick loved one died in a hospital instead of under family care in the home (McGoldrick et al., 1991). Thus, children in these families would be exposed to different views and direct experiences with death than children from other cultural backgrounds.

Rituals and customs after the death vary depending on culture as well. For example, in the Jewish tradition, it is customary after the funeral for friend of the family to prepare a meal that includes boiled eggs to symbolize the pain of grief, since both grow harder with time. People will call to express their regrets to the family for a period of up to seven days. The family members wear torn clothing to mark them as mourning for thirty days, and during this time they do not attend social functions unless they are baby namings, Bar and Bat Mitzvahs, or weddings (Williams & Sturzl, 1990).

In the traditional African American practice, children are included in all of the rituals surrounding death. They participate in the funeral service and in singing spiritual music, unless they prefer not to do so (McGoldrick et al., 1991).

Whatever the rituals and cultural customs are, children need to be prepared for what they are likely to experience. They need to be told if they will see crying
adults and an open casket with the dead body in it, or if it will be a time of
drinking, joking, and storytelling as in the Irish culture when an older individual
dies (McGoldrick et al., 1991).

The role of spirituality and religious beliefs are often ignored or
overlooked by mental health professionals (Cook & Dworkin, 1992; Prest &
Keller, 1993), but such beliefs can often foster healing after the death of a loved
one. In his work with adolescents and young adults who were trying to cope with
issues of separation and loss, LaGrand (1986) found that many discovered having
faith in God, praying, and being religious helped them to find meaning and to deal
more effectively with death or loss of a loved one. Older children may also
benefit from using such religious beliefs and practices as a coping mechanism.

A study conducted by Austin and Jennings (1993) measured whether
religious beliefs had a positive influence in moderating the grief of 57 subjects
experiencing significant bereavement. The study found that a belief of God,
whether or not it was a strong belief, was indeed associated with lower levels of
both depression and hopelessness.

In a study conducted by Galanter, Larson, and Rubenstone (1991), 193
psychiatrists who were members of the Christian Medical and Dental Society
responded to questionnaires that assessed beliefs about using the Bible and prayer,
in addition to other variables, in their treatment of clients. Bible and prayer were
scored as being most effective when used with clients who had a commitment to
Christian beliefs and who were having problems with either suicidal intent,
sociopathy, alcoholism, or grief reactions. Since incorporating the Bible and
prayer was cited in this study as being helpful when treating the issue of grief,
ment health professionals who are working with grieving children who have Christian beliefs would likely benefit their clients if they kept an open mind regarding the utilization of such techniques in their own plan of treatment. It is important to note, however, that using a technique that is not compatible with one’s own beliefs is worthless. The counselor who tries to help grieving children by comforting them with religious explanations when they, themselves, do not believe in such ideas will be of no assistance. Children can sense such a contradiction and will be confused (Furman, 1984).

It is important for mental counselors to consider the impact of religious values and teachings on children, and to educate caregivers that young children cannot think in the abstract ways that it requires to grasp religious or philosophical explanations. A religious explanation often provides much hope to a grieving individual, but to a child who is too young (below age five), such explanations can be scary and should be reserved to use when the child is a bit older (Furman, 1986). Furman (1984) recommended that young children who overhear conversations about heaven and God with regard to death can be told that they will understand more about such beliefs when they are older, but that they first need to learn what death means first. Thus, using religious explanations to help explain death may more often benefit older children.

The research seems to indicate that Christian clients prefer Christian counselors because they perceive them as able to better understand and help them. However, counseling graduate training programs across the nation provide little, if any, opportunity to be trained in such an area. The result of this is that clients often turn to religious leaders who have very little training in counseling and often
cannot provide help as effectively as a mental health professional could (Moon, Bailey, Kwasny, & Willis, 1991).

Mental health professionals need to consider how their own cultural and religious beliefs can bias their work with a client who differs from them in these areas. Being open to learning about various religions and cultures will help professionals be more effective therapeutically with a variety of populations.

Since views of death and bereavement are influenced by culture, it is important for mental health professionals to be sensitive to the culture of their clients and to be aware of how their own cultural and religious beliefs can potentially bias the counseling relationship. A useful tool for counselors to explore their own cultural beliefs and attitudes is described by Don Locke (1992, cited in Wilby, 1995). Locke (1992, cited in Wilby, 1995, p. 233) encouraged counselors to ask themselves a range of questions pertaining to culture such as:

What is my cultural heritage? What was the culture of my parents and grandparents? With what cultural group(s) do I identify? What is the cultural relevance of my name? What values, beliefs, opinions and attitudes do I hold that are consistent with the dominant culture? How did I learn these?

Conclusion

It is likely that all mental health professionals who work with children will eventually encounter some who are grieving the death of a loved one. Children are often given little support by adults after the death of a loved one because they are forgotten. Adults either do not think children understand the situation enough
to be grieving, or they are emotionally drained because of their own grief and cannot provide for the emotional needs of their children. Counselors often become the primary source of support for grieving children.

Children react to death and work through the process of grief in diverse ways depending on their individual circumstances, experiences, and culture. It is important that counselors are aware of the ways in which children of different developmental stages comprehend the meaning of death as well as how other family members can have an impact on their understanding.

Children who are given the opportunity to understand the meaning of death and who are provided with opportunities to grieve the death of a loved one will gain strength from such experiences and will be equipped better to handle future encounters with death.
References


