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The Effect of Grief and Loss
On Adolescents and their Development

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By:

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Abstract

The loss of a parent to death is a traumatic experience for children that can impede their normal developmental process as they encounter the tasks of life. Children going through adolescence may have more difficulty with this loss because of the challenges and changes that accompany this stage of development. Contemporary research offers insight into the risk factors and symptoms that differentiate uncomplicated grief from complicated grief. This thesis explores using a combination of individual, family and group therapy as the most effective way to help adolescents through the grieving process.
The Effect of Grief and Loss
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Approximately 2 million children in the United States have lost a parent due to death before the age of 18 according to estimates given on the NYU Child Study Center website (Goodman, 2007). Losing a parent to death is a traumatic event for children of any age, but adolescents may have greater difficulty because of the normal developmental challenges they experience at this stage. This stage of development may be defined by loss, such as the loss of childhood, the loss of innocence, the loss of idealistic thinking. Experiencing this traumatic loss at a time when adolescents are trying to cope with other losses, could affect their social, emotional, and psychological development and may cause pathological problems for some children.

Studies done in 1998 and 1999 found that children who have lost a parent to death have greater levels of emotional and behavioral problems than children who have not experienced this type of loss (Kirwin & Hamrin, 2005). One of these studies reported that “37% of bereaved children had a major depressive disorder 1 year after bereavement” (Kirwin & Hamrin, 2005). Another study found that 21% of bereaved children exhibited behavior problems two years after the death compared to only 3% of the control group (Sandler et al., 2003). However, as reported in the Kirwin & Hamrin article, the study done in 1999 found that bereaved children did not receive mental health services on a regular basis despite the fact that they faced a high risk for developing psychiatric and behavioral problems.

One explanation for the lack of services may be that mental health professionals have disagreed on whether or not adolescents have the capacity to grieve. There has
been insufficient information on how children process grief, but more attention has been
given to this discussion recently since the 9/11 terrorist attacks (Kirwin & Hamrin, 2005).
The research also shows that parental death is a risk factor for the development of
psychiatric and behavioral problems in adults who did not work through the tasks of
grieving when they were children (Kirwin & Hamrin, 2005). More research is being
done to better understand and develop new theories on how the loss of a parent affects
children and their development.

This thesis explores the history of grief theories and current research to see how
parental loss impacts adolescents’ development and their ability to be successful in the
tasks of life. It also reviews the methods and results of using individual, family, and peer
group therapy with bereaved adolescents and proposes that a combination of all three
types of therapy would best address the problems of grief-stricken adolescents.

**Definition of Terms**

_Adolescence_

The developmental stage defined as adolescence was created by G. Stanley Hall
and his associates in the late 1890s (Bembry & Ericson, 1999). Hall described
adolescence as a period of “storm and stress”, comparing it to the evolution of a human
being from a primitive existence to a more civilized lifestyle (as cited in Bembry et al.,
1999). Future research found that most adolescents do not go through a major personality
change, but do exhibit more negative behaviors and may experience some psychological
problems as they distance themselves from their parents (Bembry & Ericson, 1999).
Information sources differ on the age at which adolescence begins. Since adolescence is usually defined as the beginning of puberty, the age of the child will differ. One source defined adolescence in three stages: early adolescence from age 10-14, middle adolescence from age 15-17, and late adolescence from age 18-22 (Balk, 1996). For purposes of this thesis, the term “adolescent” or “child” refers to a child between the ages of 12 and 18.

Bereavement, Grief, and Mourning

The term “bereavement” is most often used when describing the normal grieving process with the expected reactions, stages, and behaviors. In one article, Steen (1998) wrote: “bereavement is the internal process of having lost a significant other; grief is the personal response to the loss; mourning is the external expression or public expression of that loss” (cited in Kirwin, 2005).

However, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), (2000) has the diagnosis of V62.82 for bereavement in the section titled “Additional Conditions That May Be a Focus of Clinical Attention” (p. 740). When the symptoms of grief become prolonged or increase in severity in response to the death of a loved one, an individual may need to seek professional help.

According to the DSM-IV-TR, to differentiate bereavement from other diagnoses, the presence of the following symptoms would need to be identified:

1) guilt about things other than actions taken or not taken by the survivor at the time of the death; 2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person;
3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged and marked functional impairment; and 6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person.

In this thesis, the terms “bereavement, grief, and mourning” are used interchangeably when referring to the experience of loss following the death of a parent.

The Life Tasks

Alfred Adler, a psychiatrist who developed the holistic theory of “Individual Psychology,” identified three main challenges of life that determine an individual’s ability to survive and succeed which he called “the life tasks” (Mosak & Maniacci, 1999). Work, social relations, and love are the three main tasks of life to which everyone must decide how to respond. Two additional tasks of self and spirituality were added later by Adlerian theorists (Mosak & Maniacci, 1999).

The life task of work determines how individuals will spend their time and carry out their obligations and responsibilities. For an adolescent, the work task would involve the commitments of school and other activities. The task of developing social relations determines a person’s sense of belonging. Rudolf Dreikurs, an Adlerian analyst, believed that the fundamental question for humans was “How do we choose to belong?” (Mosak & Maniacci, 1999). Adlerians believe that the family setting is where an individual first learns how to belong. For most adolescents, however, the focus on family becomes less important and being accepted by their peers seems to be their highest priority. According to Mosak and Maniacci, feelings of inferiority are less likely to be reported when a person has a sense of belonging to a group.
The love task is very difficult for adolescents who are experiencing many biological, psychological, and emotional changes. They are beginning to develop an adult body and to have feelings for the opposite sex, yet do not often have the emotional maturity to cope with complex, intimate relationships. The task of self is a process of discovering and creating one’s image. This would involve a person’s forming an opinion of others, the world and self, developing personal likes and dislikes, and cultivating feelings of self-worth. The task of spirituality involves people’s quest for the meaning of life, finding their place in the universe, and defining their concept of “God”. In this thesis, the “life tasks” refers to all of the five tasks.

Adolescent Development

Adolescence is defined as moving from childhood into adulthood; a time when a child experiences a loss of innocence and begins to view the world and others in a more realistic way. This is the time when an individual moves from a child’s body to an adult body, from dependence to independence. At this stage, children begin detaching from their parents and look outside the family for love and support (Polmear, 2004). The self task becomes a high priority for adolescents as they begin to define who they are as independent human beings, separate from their parents.

Alfred Adler did not believe that a child’s character changes during adolescence, but said in one of his writings, “for almost every child, adolescence means one thing above all else; he must prove that he is no longer a child.” (as cited in Manaster & Corsini, 1982). Adolescents are often described as ‘difficult’ as they exhibit normal oppositional behaviors and engage in conflict with their parents. The normal
developmental process for adolescents includes letting go of their dependency on their parents and grieving the loss of childhood. Experiencing a trauma during this stage can create additional stress causing adolescents significant problems that can have long-term effects if they are not given the necessary support.

*Piaget’s Theory of Intellectual Development*

According to Jean Piaget’s theory of intellectual development, adolescents arrive at a stage of “formal operations, a stage in which they are less dependent on concrete objects for solving problems and are increasingly capable of independent and hypothetical thinking” (Hurd, 2004). Unlike a younger child who is mostly concerned about the present, the adolescent has the capability for abstract and hypothetical thinking (Crain, 2000). According to Hurd (2004), the adolescent no longer makes decisions based solely on parental influence, but is able to reason independently based on his or her personal convictions.

As they consider such abstract ideas as freedom and justice, adolescents begin to think about the future, the problems in the world, and their part in creating a better place to live. Children’s view of death changes as they develop cognitively and socially. Adolescents have the cognitive skills to understand the biological, social and psychological aspects of death, but view death as something that happens to others, disregarding their own and their family member’s mortality (Pettle & Britten, 1995)

*Erikson’s Psychoanalytic Theory of Development*

Adolescence is a challenging stage of life marked also by important physiological and psychological changes. Erik H. Erikson defined adolescence as a time of “identity vs. role confusion” when adolescents are engaged in the primary tasks of discovering who
they are and establishing their place in society (Crain, 2000). This is also a time of
tremendous physical growth and developmental changes in the body as they reach
puberty. Adolescents tend to become very concerned about their appearance and how
others view them. As they struggle with finding their identity, they separate from their
parents and look to their peers for acceptance.

As cited in Hurd (2004), J.E. Marcia’s *Handbook of Adolescent Psychology*
(1980) expanded on Erikson’s stage of adolescence to include four possible outcomes in
the search for one’s identity: “identity achievement (some adolescents successfully
establish an adult identity); identity foreclosure (some adolescents reactively adopt the
plan and preferences of authority figures such as their parents); identity moratorium (an
“on hold” time for some adolescents during which they avoid the rigors of self-
examination); and identity diffusion (some adolescents both avoid rigorous self-
examination and adopt the behaviors and values of assertive peers)”. The death of a
parent may push adolescents into one of the lesser desirable outcomes in their search for
identity instead of the preferred outcome of “identity achievement”.

Losing a parent to death may affect adolescents’ development in two major ways.
The loss may cause injury to their sense of self and may also hinder the natural separation
process from their parents (Sussillo, 2005). Regarding their sense of self, some
adolescents report feelings of vulnerability, helplessness, disorientation, rage, and
profound anxiety as reported in the Sussillo study. The person who would normally be
the adolescent’s support in time of crisis is now the one who has, in a sense, caused the
crisis.
The normal separation process that adolescents go through as they try to distance themselves from their parents and reject their values can cause a great deal of conflict. Losing a parent to death during this time of rebellion against parental authority can instill a sense of guilt and remorse in adolescents (Marwit & Carusa, 1998). Confusion can result for adolescents as they struggle with the desire for independence and yet feel the need to identify with their lost parent and receive support and love from the surviving parent. Adolescents may instead retreat from the individuation process of their self task as they work through the grieving process.

**Theories of Grief**

Theorists differ in their views on whether children are able to grieve. In 1960, Anna Freud wrote that children do not have the “ego capacities” to work through the process of grief, which differed from John Bowlby’s (1961) view that even infants are able to experience grief (Charles & Charles, 2006). Research, however, supports the belief that children do grieve and experience the loss of a loved one in much the same way as adults as stated in the article by Hope & Hodge (2006). As one expert in grief work said, “Anyone old enough to love is old enough to grieve” (Hope & Hodge, 2006).

*Freud’s “Mourning and Melancholia”*

Theories of how grief and loss affect children have changed since Sigmund Freud first wrote about the grief process. In “Mourning and Melancholia” (1917), Freud defined mourning as the normal process of letting go of the feelings of attachment to the lost person and developing feelings of attachment to someone new (as cited in Hurd, 1999).
Freud viewed the inability to let go of the attachment feelings to the lost person as pathological and gave the term “melancholia” to this suffering.

Although Freud was referring to adult mourning, future therapists assumed that children who lost a parent were always prone to melancholia because of their inability to detach from feelings of dependency on the parent (Hurd, 1999). This hypothesis became known as “later behavior disorder” and was used by therapists in the diagnosis and treatment of bereaved children from the 1920s through the 1970s (Hurd, 1999).

Wolfenstein, a Freudian analyst, also concluded from his work that children were not capable of mourning until they had separated from their parents during adolescence (as cited in Hurd, 1999). Many analysts of this time believed that healthy mourning involved the letting go of all ties to the deceased loved one.

**John Bowlby’s Attachment Theory**

During these years, John Bowlby, who had done extensive research on attachment and separation, expanded his theory to include permanent loss and bereavement research (Baker, 2001). Although Freud’s theory accurately described the mourning process, John Bowlby’s evidence-based research questioned the validity of focusing on detachment from the deceased parent as the goal, and of labeling the inability to detach as pathological (as cited in Baker, 2001).

Bowlby believed that the “psychological response to the trauma of separation and loss is biologically programmed and the later phase of grief represents the realization that the secure base to which the adult could return for comfort and protection is no longer available” (D'Elia, 2001). He also believed the state of grief was the process of
comprehending that the loss of a primary attachment figure was not a temporary absence, but a permanent one (Archer, 2001).

Bowlby’s research found that many healthy individuals continued to possess feelings of attachment to their loved one as part of the normal process of mourning (Baker, 2001). As stated in Baker’s article, he believed that children, like adults, could mourn the death of a parent in either healthy or unhealthy ways. In his research, Bowlby found that both adults and children continued to think about the person they loved for many years following their death, without pathological symptoms (Baker, 2001). Bowlby stated in his book *Attachment and Loss* (1980, p.100), “Failure to recognize that a continuing sense of the dead person’s presence, either as a constant companion or in some specific and appropriate location, is a common feature of healthy mourning has led to much confused theorizing” (as cited in Baker, 2001).

His attachment theory is the basis for understanding the grief reaction of children to the loss and separation of a parent. In a secure attachment relationship, children learn that their attachment figure will return after a temporary separation. When an attachment figure dies, the normal response is to seek out and recover the loved one. Healthy mourning is the process of accepting that the parent is not returning and finding new ways to integrate their loved one into a world without their physical presence (Field, 2006). Reorganizing one’s life to accept this loss is a very difficult and painful process that could result in the development of psychiatric disorders for some children.

“Continuing Bonds” Theory

The shift from Freud’s focus on detachment to more current views on maintaining some form of attachment to a loved one who has died was influenced greatly by
Bowlby’s research (Stroebe, 2002). Dr. Margaret Stroebe strongly believes that Bowlby “rescued” bereavement research theory from the narrow perspective offered by Freud in her statement: “I would even go so far as to say that attachment theory is the most powerful theoretical force in contemporary bereavement research…” (Stroebe, 2002).

The current theory that “an ongoing attachment to the deceased can be an integral part of successful adaptation to bereavement” is becoming increasingly accepted by theorists and practitioners (Field, 2006). The term “continuing bonds” (CB) was introduced in 1996 by Dennis Klass and his colleagues in their book with the same name. They wrote about the function of maintaining a bond to the deceased loved one in an individual’s journey towards resolution of grief (Klass, 2006).

In 1992, a study was done that interviewed 125 boys and girls, ages 6 to 17, from seventy families of differing incomes and ethnic backgrounds, who had lost one of the parents to death (Silverman, Nickman, & Worden, 1992). The interviews in this study were conducted with the children and their surviving parents four months after the death, again a year later, and at two years to specifically look at how the children stayed connected to the deceased parent. Silverman et al. found that most of the children remained connected through “dreams, waking memories and by keeping personal objects that had belonged to the parent.” This study found that 81% of the children believed that their deceased parent was watching over them and about half of the children reported talking to their parent through their thoughts.

Silverman et al. (1992) found that this internal connection to the deceased parent was more vivid and interactive than previously thought and seemed to help the children adapt more readily to life without their loved one. The love and acceptance children
receive from their parents nurtures the development of their self image as one who is loved and is lovable. Constructing an inner model of their parent with whom they can continue to relate through images and memories can be a healthy part of the bereavement process for children.

This construction of the image of the lost parent is consistent with children’s cognitive development and will change as children grow and mature in their development (Silverman et al., 1992). In this study, Silverman et al. also found that the role and view of other family members can impact the creation of this image. Their study suggests that this is an important way children attempt to make sense of their loss and maintain a connection to their loved one as they adapt to life without them.

Silverman et al. found that these children created a connection to their deceased parent in five ways: “1) making an effort to locate the deceased, 2) actually experiencing the deceased in some way; 3) reaching out to initiate a connection, 4) remembering, and 5) keeping something that belonged to the deceased.” Almost 75% of the children reported that they believed their parent was in “heaven” and yet described them with characteristics of a living person, not a spirit (Silverman et al., 1992). Of the 125 children in this study, 81% experienced their parent by believing he or she was watching over them and about half of this group felt fearful that their deceased parent might disapprove of their actions. Over half of the children reported experiencing their parent through dreams and a few felt their presence in non-living things such as the wind.

This study found that 57% of the children initiated contact with their parents by speaking to them, telling them about their day or “visiting” them at the cemetery, the last place most of them had seen their parent. The most common way the children
remembered their parents was through their thoughts and memories of them. Some of the children found it comforting to keep something personal that belonged to their parent to retain a way of connecting to them. As time progressed, the item became more of a keepsake rather than a powerful presence of their deceased parent (Silverman et al., 1992).

In another study the children reported that wearing an article of clothing that belonged to their deceased parent helped them feel close to them (Lohnes & Kalter, 1994). Some of the children in this study reported that they made gifts for their parents, but did not share this experience with their friends for fear of being labeled “crazy.” Other children in the Lohnes & Kalter study tried to connect with their parent by claiming they had attributes of their deceased parent. Current research supports Bowlby’s view that healthy mourning is not a process of detachment from the loved one but rather a transformation and creation of an internal relationship with the deceased (Baker, 2001).

The Grief Process

Alan Wolfelt, a grief counselor who has written books on the grieving process of children and adults, stresses the importance of seeing grief as a journey and allowing for each person to move in and out of the process at his or her own pace (Kirwin & Hamrin, 2005). According to Wolfelt, factors that influence the grief process of children are the relationship they had to the person who died and the circumstances surrounding the death. Their age, gender, personality, ethnicity, culture and religion can also affect the way they process their grief. The family’s communication style, their financial resources,
and changes in the family’s environment will also influence children’s ability to process their grief in healthy ways (Kirwin & Hamrin, 2005).

*Uncomplicated Grief*

What, then, distinguishes uncomplicated grief from complicated grief if continued attachment behaviors to the deceased are no longer seen as symptoms of pathology? The healthy mourning process involves moving through stages of grief in a timely manner and arriving at an acceptance of the loss and a transformation of feelings of attachment into memories of the deceased. The work of mourning, as reported in current research, includes both identification with and separation from the deceased parent (Sekaer, 1987).

*Stages of grief.*

Bowlby was the first to describe the mourning process in “stages” from his work with institutionalized children who had lost parents in the Second World War (Stroebe, 2002). According to Bowlby, the early phase consisted of “protest and attempts to recover the missing attachment figure” (Stroebe, 2002), followed by the middle phase with feelings of hopelessness and depression and eventually resulting in emotional detachment and reorganization in the late phase. Colin Murray Parkes, who worked with Bowlby for many years, developed the concept of stages in grief further by conducting empirical research with bereaved individuals (as cited in Stroebe, 2002). Later, Bowlby and Parkes added “numbing” as the first phase of grief (Kirwin & Hamrin, 2005).

*Tasks of grief.*

Based on Bowlby’s three phases of grief, Baker, Sedney & Gross expanded the phases to include tasks that better defined each phase (as cited in Kirwin & Hamrin, 2005):
Early phase: 1. Understanding the fact that someone has died and the implications of this fact
2. The children focus on the protection of themselves and their families

Middle phase: 1. Accepting and emotionally acknowledging the reality of the loss
2. Exploring and re-evaluating the relationship to the lost loved one
3. Facing and bearing the psychological pain that accompanies the recognition of the loss

Late phase: 1. The child needs to invest in a new relationship with others
2. The child must be able to internalize the lost relationship with the deceased person that will be there for him/her over time
3. The child will be able to return to their current developmental level and activities
4. The child will be able to cope with the return of painful affect at different times in their developmental transitional periods

Baker’s early phase of grief is the time when children need extra support from their parents. Providing information and education to parents regarding the needs and abilities of their children’s developmental level is critical in the early phase. The middle phase focuses on the emotional pain children feel in losing a parent. Children may have feelings of anger at being abandoned or feelings of guilt thinking that somehow they could have prevented the death, but may not be able to verbalize those feelings (Kirwin & Hamrin, 2005). In the late phase of Baker’s tasks, children adjust to life without their parent and begin to focus on building new relationships (cited in Kirwin et al., 2005).
Another study considered how developmental factors enable or inhibit adolescents as they move through the tasks of grieving (Balk, 1996). These tasks were defined as:

1. to establish the meaning of the event and to comprehend its personal significance
2. to confront reality and respond to the situational requirements of the event
3. to sustain interpersonal relationships
4. to maintain emotional balance; and
5. to preserve a satisfactory self-image and maintain a sense of self-efficacy.

There is no order in which these tasks must take place and adolescents will move in and out of them at their own pace.

The first task is one that will be on-going and change over the course of the grieving process. As reported in this study by Balk, adolescents are able to intellectually understand and accept the finality of death, but must work to integrate this loss into their view of the world and its impact on their life tasks. The second task focuses more on the present and how adolescents navigate through the events connected to the crisis, especially the funeral and burial of their parent. This task will be defined by the cultural and religious norms and expectations of their family (Balk, 1996).

The third task considers the adolescent’s ability to maintain relationships with close friends and family members (Balk, 1996). This task is crucial in the healthy recovery and processing of the death. Other research supports the view that this task is the most critical for preventing future mental health problems for adolescents. Encouraging adolescents to communicate their thoughts and feelings during this time of
crisis gives them the necessary support to deal with the stress and confusion caused by their loss.

The fourth task, as stated in the Balk article, is to encourage adolescents to express their deepest feelings of anger and despair, and to offer professional help if needed. Losing a parent can affect adolescents’ self-image as they struggle with overwhelming feelings of abandonment, guilt, depression, confusion, loneliness, and fearfulness. They often have a sense that life is out of control and succumb to hopelessness. The fifth task of this model involves regaining a sense of personal power that enables adolescents to make plans and set goals for the future. As they work through this task, they gain a sense of competency and control over their lives and are less inclined to be overwhelmed by negative feelings (Balk, 1996).

Worden, another theorist, identified four tasks of mourning which he modified for each developmental level of a child (as cited in Kirwin, 2005). The first task relates to the child’s ability to accept the reality of the death, the second task focuses on the child’s ability to experience emotional pain of loss, the third task looks at the child’s level of adjustment to the new situation without the parent, and the fourth task is discovering ways to keep the deceased part of their life.

**Complicated Grief**

Complicated grief, in contrast to uncomplicated grief, is seen when individuals are in a chronic state of mourning and unable to accept the reality of the loss. They exhibit an intense yearning for the lost loved one and long for the time when they were alive. Preoccupation with the loss inhibits them from living in the present and finding joy in other relationships (Zhang, El-Jawahri, & Prigerson, 2006). Differentiating normal
adolescent reactions from pathological symptoms can be difficult for the surviving parent which may determine whether or not a child receives therapeutic support.

Elisabeth Kubler-Ross, the author of the well-known book *On Death and Dying*, labeled “adolescent griever as the ‘forgotten ones’” (as cited in Lenhardt, 2000) because theorists have assumed that they either process their grief like younger children or in a similar, but less intense, way than adults grieve. “Adolescents are a distinct group with very specific developmental needs that complicate the normal grieving processes” (Lenhardt, 2000). Often an adolescent will deny feelings of sadness or grief in response to the death of a parent. The denial may be their way of protecting themselves from being overwhelmed by their feelings and a desire to conform to the expectations of acceptable behavior by their peers (Lenhardt, 2000).

Since grief and bereavement are viewed as a normal part of life, and the majority of individuals are able to work through the stages of grief without long-lasting difficulties, family members may dismiss the signs of distress in a child and not offer the support and help needed in the early stages of grief. Losing a parent is a traumatic experience for a child that has the potential for developing serious complications or psychological problems. Mental health professionals need to be able to distinguish the differences between complicated and uncomplicated bereavement, to identify risk factors and symptoms of complicated grief, and to understand the importance of early interventions to prevent or treat complicated grief (Zhang et al., 2006).

*Risk factors of complicated grief.*

Research has found that secondary factors have a significant influence on how children work through the process of grieving. Some of the contributing factors that
affect children’s adjustment to the death of their parent are the surviving parent’s well-being, the timing and cause of death, the relationship to the parent prior to death, the family’s financial and socioeconomic status, pre-existing health problems, and the child’s age, sex, and personality characteristics (Goodman, 2007).

Hope & Hodges, (2006) interviewed professional social workers who counseled bereaved children and reviewed current literature to study how the specific factors of age, gender, circumstances of the death, and the adjustment of the other parent affected the grieving process in children and adolescents. Most of the social workers reported that the level of adjustment depends more on a child’s cognitive ability and emotional maturity in understanding death rather than the child’s actual age.

Two studies reported conflicting results regarding the relation of age to the development of psychiatric disorders (Dowdney, 2000). One of the studies found that depression and guilt were seen more often in adolescents than in middle school aged children. In contrast, the other study found that age was not a factor in the reporting of symptoms of depression, withdrawal, anxiety and somatic complaints. One possible explanation may be found in a study which reported that, regardless of age, the emotional and cognitive development of the child played a role in the child’s ability to understand and process the death of a parent (Dowdney, 2000).

A majority of the people interviewed for this study reported that males tended to externalize their grief by exhibiting more behavior problems, whereas females tended to internalize their grief and reported more somatic complaints. The Dowdney study also found that externalizing disorders, such as aggressive and acting-out behaviors, were reported more commonly in boys and internalizing disorders, such as depression, were
reported more often in girls. The researchers also reported that two-thirds of the children in this study, who were diagnosed with severe depression, were girls and that the rates of depression increased with the age of the child (Dowdney, 2000).

Another study reported that adolescent girls are more likely to exhibit unresolved grief in response to the death of a mother than are adolescent sons because of the importance of relationships to a female’s identity (Lenhardt, 2000). As cited in this study, adolescent girls grieved longer and with more intensity than did adolescent boys. In the death of a mother, an adolescent daughter may feel pressure to fulfill a maternal role. Studies cited in Lenhardt et al. found that girls who had to take on caretaking responsibilities exhibited more anger towards their deceased mother. The study found that adolescent sons exhibited more anger towards the deceased mother after a father remarried which may be a result of feeling abandoned first by his mother and now by his father (Lenhardt, 2000).

Many of the social workers who were interviewed for one study, believed that all types of parental death are traumatic for a child and did not report any difference in the levels of adjustment between sudden and anticipated death (Hope & Hodge, 2006). One of the social workers reported that, in her work, losing a parent to suicide is the most difficult death for adults and children and complicates the grieving process. All the participants agreed that the surviving parent’s adjustment to the loss has the greatest influence on the child’s ability to grieve in healthy ways and to adjust to life without the other parent (Hope & Hodge, 2006). The workers stressed the importance of the surviving parent receiving the necessary support for themselves so that they can help their child through the grief process.
The child looks to the parent as a role model on how to grieve. Adolescents are especially vulnerable to denying their grief so that they do not cause more pain for their parent. They need to be given permission to grieve and should not be put in the role of a caretaker to their surviving parent. All who were interviewed agreed with current literature that the remaining parent can best help a son or daughter by being emotionally available, encouraging open communication, and by seeking support for one’s own grief.

How well the surviving parent copes with the death of their partner will greatly impact the child’s ability to grieve and can determine whether or not the grief intensifies and becomes traumatic grief. Interviews conducted by Stoppelbein and Greening in a study done in 2000 with bereaved children has shown that children who live with parents who exhibit symptoms of PTSD, report similar symptomatology (Hope & Hodge, 2006). Another study done in 2002 by Raveis, Siegal, & Karus (1999) found “a higher level of open communication by the surviving parent to be significantly related to lower levels of depression and anxiety in bereaved children” (as cited in Hope & Hodge).

Other research that looked at the effects of grief and loss on children found that the cause and timing of a parent’s death has a deep impact on how the children work through their grief. The type of death, such as death due to suicide or a terrorist attack, can complicate the grieving process for children as they must also process the trauma surrounding the death. One study found that about 50% of bereaved children present with symptoms of depression, anxiety and behavior problems during the first year after the death (as cited in McClatchey, 2005). Other secondary factors that can influence the grieving process is the change in the daily routine, the weakening of financial resources,
moving from one’s house, school or city which can result in loss of friendships and a support network (Dowdney, 2000).

Another important factor studied by Dowdney et al. was the functioning of the family in its organization, cohesion and communication. Those children at the highest level of risk for developing a disorder were those children from families who presented with a history of conflict, poor communication, disorganization, and previous mental health problems (Dowdney, 2000). The risk was also found to be greater with children who lost the parent with whom they had the deepest and most involved relationship.

_Symptoms of complicated grief._

Withdrawing from the tasks of life is an early warning sign for adolescents who are at risk for complicated grief. The symptoms may present in their work task by lowered school performance and in their social task by isolating themselves from others. Depression, anxiety, and symptoms of Post Traumatic Stress Disorder (PTSD) are the most common symptoms of unhealthy mourning. The stages of normal grieving include many of the symptoms of PTSD, but these symptoms should diminish over time and acceptance of the reality that the person has died should increase.

Those bereaved individuals who continue to have adjustment difficulties and present with symptoms of PTSD or Major Depressive Disorder after 6 months are at risk for physical, mental and social dysfunction. (Zhang et al., 2006). Studies have shown that adults, who never resolved the loss of a parent when they were children, are at greater risk of developing depression and anxiety related disorders (Kirwin & Hamrin, 2005).
In a study of 24 school children between the ages of 8 and 16 who experienced the death of a parent, feelings of abandonment and depression were the two major symptoms reported by the children (Freudenberger & Gallagher, 1995). The loss of a parent is a severe hardship that can damage the self-esteem of adolescents. Freudenberger stated that the self-image of these children became distorted in three ways: “1) the denigrated self image, with a lack of sense of self worth; 2) the often fantastically high ego ideal, which carries the seeds of grandiosity as found in manic states, as well as evident suicidal trends developed when failure is present; 3) and last, the deep dependency feelings that lead to fear of school work and work efforts and to such frequent failure in human relations.”

The symptoms of mourning may also include denial and rage. Whether or not adolescents’ grief becomes complicated and results in unresolved mourning can be a result of other determining factors. Adolescents’ maturity level, their degree of attachment to the deceased parent, the presence of pathological symptoms prior to the death, the ability to communicate feelings, and the support given by the surviving parents and extended family will affect their ability to process grief in healthy ways (Haig, 1990). An adolescent who is not given the support necessary in the mourning process may exhibit antisocial or self-destructive behaviors including illegal use of drugs and alcohol, truancy from school, engaging in promiscuous sexual activity or suicide attempts (Haig, 1990).

As reported in another recent study, the loss of a parent affects adolescents in two major ways, causing injury to their sense of self and hindering the natural separation process from their parents (Sussillo, 2005). Regarding their sense of self, some
adolescents report feelings of vulnerability, helplessness, disorientation, rage, and profound anxiety (as cited in Sussillo, 2005). Bereaved adolescents may also experience a sense of guilt for their normal pulling away and gaining independence from the deceased parent, especially if the individuation process involved a great deal of conflict.

The adolescent may also feel compelled to support their grieving parent and may not want to burden them further with their own feelings of loss and grief. All of these factors can contribute to the adolescent’s denial and inhibition of their grief (Lenhardt, 2000). Adults may mistakenly view the absence of symptoms in adolescents as a sign that they are not distressed. However, the lack of symptoms should alert caretakers that the adolescent is at a greater risk of developing a form of complicated grief or unresolved grief (Lenhardt, 2000).

Most of the studies previously done were with adults who had lost a parent when they were children and were currently receiving psychiatric treatment for unresolved grief. A more recent study was conducted over a two year period with children and their surviving parent (Cerel, Fristad, Verducci, Weller, & Weller, 2006). The purpose of this study was to better understand the symptomatology of bereaved children compared to non-bereaved children and to clinically depressed children. The study found that bereaved children and adolescents showed more signs of impairment than non-bereaved children but less than clinically depressed children. A significant risk factor for a child needing mental health services that emerged from this study was having a parent with depressive symptoms (Cerel et al., 2006).

Some researchers have proposed that a diagnosis of “traumatic complicated grief” should be added to the new Diagnostic Statistical Manual (McClatchey & Vonk, 2005).
Death due to a trauma can prolong or postpone the grieving process and create serious long-term consequences well into adulthood if not resolved. The study done by McClatchey & Vonk found that the PTSD symptoms continued in children who experienced a traumatic death if no treatment was received.

In another study, Zhang et al. distinguishes “Complicated Grief Disorder” (CGD) from PTSD and other psychiatric disorders and lists the diagnosis description as proposed for the DSM-V. They state in their study that other psychiatric disorders may also present in someone who is bereaved, but CGD has a distinct set of symptoms that differs from depression and anxiety symptoms. The specific symptoms that define CGD are a longing for the person who died, an inability to move beyond the loss, and feelings of detachment, bitterness and anger that may impede the person from maintaining their personal relationships and developing new ones.

As a result of their research, Zhang et al. have proposed the following criteria for the diagnosis of Complicated Grief Disorder to be included in the DSM-V:

**Criterion A** Yearning, pining, longing for the deceased.

Yearning must be experienced at least daily over the past month or to a distressing or disruptive degree.

**Criteria B** In the past month, the person must experience four of the following eight symptoms as marked, overwhelming, or extreme.

1. Trouble accepting the death.
2. Inability trusting others since the death.
3. Excessive bitterness or anger about the death.
4. Feeling uneasy about moving on with one’s life (e.g., difficulty forming new relationships)

5. Feeling emotionally numb or detached from others since the death

6. Feeling life is empty or meaningless without the deceased.

7. Feeling the future holds no meaning or prospect for fulfillment without the deceased

8. Feeling agitated, jumpy or on edge since the death

**Criterion C** The above symptom disturbance causes marked dysfunction in social, occupation, or other important domains.

**Criterion D** The above symptom disturbance must last at least 6 months.

This study reported that since CGD results from an insecure attachment, children who experience the death of a parent are vulnerable to presenting with CGD later in life (as cited in Zhang et al.).

One study considered the tasks and conflicts of adolescents and how bereavement affects their ability to cope at each stage of their development (Balk, 1996). While a sense of belonging is of utmost importance to younger adolescents, the Balk study found that the most common belief reported by this age group is a feeling of not belonging. The article reported that this age group is less inclined to talk about their grief and the death of their parent with their peers and exhibits more signs of physiological pain such as headaches and stomachaches.

The Balk article also reported that older adolescents have a better sense of identity which enables them to talk about their grief with friends, but they report more symptoms
of psychological pain such as depression. At this stage, death is no longer seen as reversible and denial is not used as a coping response. Depression is a result of the perception and acceptance of the reality of the death and its effect on the adolescent’s well-being (Krueger, 1983).

*Childhood traumatic grief.*

Since the attacks on 9-11, a new term of “Childhood Traumatic Grief” (CTG) has been used to describe the condition of bereaved children who have experienced the death of a parent due to a traumatic event (Brown, Pearlman, & Goodman, 2004). As stated in this study, the symptoms for CTG are similar to PTSD but also include a yearning for the lost loved one and an inability to accept the death. In addition to these symptoms, severe depression and anxiety are commonly found which together impede or prevent the child from working through the normal stages of uncomplicated grief (Goodman, Morgan, Juriga, & Brown, 2004).

*Resiliency*

One study examined the factors that differentiate resilient children and adolescents from those that present with psychological problems (Lin, Sandler, Ayers, Wolchik, & Luecken, 2004). The researchers in this study viewed bereavement as a process rather than an event. From this point of view, the study reviewed all the changes children go through over time as a result of their parent’s death and the resources used for adapting to those changes. This study used a “person-centered approach” to determine whether or not a child experienced mental health problems by interviewing more than one person significantly involved in the child’s life.
As reported in the study, children may be doing well in one domain of their life and not in another. Also, children may not show significant behavior problems, but self report feelings of depression (Lin et al., 2004). Other variables such as environment, family functioning and the personal characteristics of each child were considered when looking for what factors influence a child’s resiliency. Findings in this study were consistent with other studies in noting that the surviving parent’s mental health has a direct correlation to the child’s mental health.

One study, reported in the article by Lin et al., found that bereaved girls who do not receive emotional support from their surviving parent are at a greater risk to suffer from depression than girls who do receive support. The results of this study indicated that the children who were most resilient had a close parent-child bond and maintained family routines and structure after the death of their parent. They also reported in this study that the drop in financial income rather than the level of income was one family variable that contributed to the possibility of bereaved children needing mental health services.

Another study attempted to answer the following three questions in their research of adolescents who had coped well with adversity: “Why are some children resilient and others not? What are the sources of resilience? How is resiliency nurtured in children and youth?” (Hurd, 2004). This change in focus from an illness model to a strength-based model looked at factors that enhanced children’s ability to cope with stressful events and their capacity to adjust and grow in spite of hardship (Hurd, 2004). This study looked at both internal and external factors that contributed to resiliency.

Their intellectual development, sense of humor, ability to problem solve, sense of purpose in life, social framework, and talents and abilities were all important internal
factors in resilient children (Hurd, 2004). Those children who rate high in the life task of self and have a positive self-image as one who helps others, one who is capable of making friends, and one who is hopeful of the future are predictably more resilient. The external factors included a nurturing family, supportive relatives, household structure and rules, high parental expectations for behaviors, and a supportive network of friends and other important adults (Hurd, 2004).

The research done by David Balk (2001) found that bereavement was a maturing process for resilient adolescents as they developed the strength to persevere through hardship. The adolescents in his study were found to be more caring of others who had experienced similar pain or sorrow than peers who had not lived through a traumatic event. Baker explained their maturity by saying, “they do not literally or figuratively flee when someone else is in emotional distress” (Baker, 2001). For these adolescents, bereavement becomes a catalyst for growth in the tasks of life.

Religious Beliefs and Spirituality

One area of research that assesses the presence of hope is examining the effect of religious beliefs on the coping ability of adolescents. Adolescents are confronted with the life task of spirituality as they ponder questions about the finality of death, the meaning of death, and life after death. Studies have shown that bereaved adolescents who reported having religious beliefs had lower mean scores on the Beck Depression Inventory than those without religious beliefs (Balk, 1996). These adolescents reported feeling more confused, but less depressed and fearful than other bereaved adolescents.

A more recent study completed in 1999, examined the “spiritual and religious transformation of women who were parentally bereaved as adolescents” (Cait, 2004).
This study found that bereaved adolescents often reorganize their world view and sense of self after the loss of a parent to death. Many of them turn to religious beliefs for support as a way of finding purpose and making sense out of the death.

This study defined religion as “an external set of guidelines that help us characterize and structure our faith and belief systems” and defined spirituality as “a more abstract subjective set of practices that governs our faith … something that can be innately ‘felt’ without having to be articulated” (Cait, 2004). The Cait study found that religion and spirituality can have a significant impact on the identity development of adolescents as they attempt to give order and make sense of the world.

The development of one’s identity is a life-long process that affects how an individual views life experiences, relationships, and the world in relation to oneself. For adolescents, in particular, identifying their own beliefs about God in their spiritual life task may be part of their separation process from their parents. With the death of their parent, adolescents may find comfort in the faith of their parents or feel anger towards a God who would allow this to happen to them.

In the research conducted by Cait, the women reported that their faith helped them continue a bond to their deceased parent and gave meaning and comfort to them in understanding and accepting the death. Some of these women identified with organized religions and others said they developed their own spiritual beliefs that served as a means of comfort to them. The women in this study reported that their religion and spirituality had a positive influence on how they viewed the world, their relationships with others and their view of themselves.
Treatment and Interventions

Many of the articles showed the benefits of specific types of treatment for bereaved adolescents. In reviewing the treatment methods presented, a three way approach seems to be the most beneficial. Including individual, family and peer group therapy in a child’s therapeutic plan for recovery would be the most comprehensive method to address all the issues facing a bereaved adolescent.

Individual therapy offers adolescents a safe place to explore and express their feelings, ask difficult questions, and process their grief in a therapeutic setting. Family therapy provides a time for parents and their children to learn about the grief process together and to help parents provide the on-going necessary support for their children. Group therapy is recommended to help adolescents regain a sense of belonging to their peer group and offers a setting that encourages the development of new friendships with children who understand the process and pain of grief.

One empirical study used a treatment model of 12-16 therapy sessions that significantly reduced pathological symptoms in bereaved children and adolescents (Cohen & Mannarino, 2004). This study suggested using individual therapy for 8-12 of the sessions and using the last four sessions for family therapy. Including one session of family therapy every other week during the individual sessions may be an even better model for integrating the family members early on into the therapeutic process. Adding 4-6 additional peer group sessions would address the social task for adolescents and offer a more complete therapeutic plan.
Individual therapy

Alfred Adler believed emotional problems resulted from the failure to gain a sense of competence, to increase self-esteem, and to achieve success in the tasks of life (Oberst & Stewart, 2003). The death of a parent can increase the possibility of failure in these three main areas for adolescents. Individual therapy has three main objectives for an Adlerian counselor: to help clients successfully meet the tasks of life, to instill a sense of courage in overcoming their problems, and to reduce their pathological symptoms (Oberst & Stewart, 2003). Using a self-rating scale to identify how adolescents view themselves in each of the five tasks of life can be a helpful tool for a therapist in developing a treatment plan (Dinkmeyer & Sperry, 2000). Seeing improvement in one’s ability to meet the five tasks of life is one method in charting a client’s progress.

Current research has shown the importance of maintaining a connection to the deceased parent. The counselor can keep this as a focus by encouraging adolescents to write about their memories or to create a book of photos and memorabilia of the deceased parent (Goldman, 2004). Creating a narrative with a child about the deceased parent and the death can help the child accept the reality of the loss and begin to replace the physical relationship with an inner relationship with the parent.

This exercise helps the adolescent become more comfortable talking about the death experience and the parent they lost. The narrative also allows the therapist to deal with any distortions that the client may have about the death. The therapist serves as a safe person to whom the adolescent can share any worries, concerns, distorted thoughts and feelings.
A study done with children who were diagnosed with Childhood Traumatic Grief used two intervention methods to treat both the trauma and the grief (Cohen & Mannarino, 2004). The grief-focused interventions included talking about the death, grieving the loss, identifying ambivalent feelings, remembering the loved one through memories, finding meaning in the loss, redefining the relationship to the deceased, and committing to new relationships (Cohen & Mannarino, 2004). The trauma-focused interventions in this study included the use of affective expression and stress management skills, understanding the “cognitive triangle”, and creation of the adolescent’s trauma narrative (Cohen & Mannarino, 2004).

The “cognitive triangle,” as defined by Cohen & Mannarino (2004), is the relationship of thoughts, feelings, and actions. The therapist works with adolescents to help them understand how their inaccurate and self-defeating thoughts can create negative feelings which can cause behavioral problems and difficulties with relationships. Helping clients replace negative thoughts with positive affirmations will help them deal more effectively with difficult situations and build their self-esteem. Adlerians also hold the view that emotions are a product of one’s thoughts (Manaster & Corsini, 1982). As clients begin to understand the effect their thoughts have on their emotions, they realize the power they have to control their negative feelings. At a time when an adolescent’s life seems out of control, gaining a sense of empowerment can be a step towards one’s healing.

The grief-focused interventions are helpful for all adolescents who experience a loss, but the addition of the trauma-focused interventions in individual therapy showed significant reduction in PTSD and depressive symptoms in the adolescents in this study.
In individual therapy, adolescents are encouraged to identify a wide range of feelings, including feelings of anger or fear that they may view as unacceptable, and to express them in appropriate ways.

The trauma-focused therapy includes learning stress management skills to help adolescents gain a sense of competence and control over their response to stressful triggers and situations (Cohen & Mannarino, 2004). These techniques may include deep breathing, guided imagery, muscle relaxation and positive self-affirmations. Asking clients for their input on what they enjoy doing for relaxation helps engage them in this process. The therapist encourages clients to practice these techniques when under stress to discover the ones that work best.

One of the most powerful tools Adlerian therapists use is “encouragement” (Watts & Carlson, 1999). In communicating the belief that their clients have the ability to work through their problems, therapists nurture that spirit of encouragement as clients begin to believe in themselves and take steps towards healing and recovery. Encouragement cultivates hope and optimism that gives clients the strength to persevere as they move through the stages of the grief process.

Family Therapy

Losing a spouse to death forces the parent to make many difficult decisions and transitions that may affect the family financially, socially and logistically (Saldinger, Porterfield, & Cain, 2004). The physical exhaustion parents may experience leaves them with little strength to be a good parent. Bereaved parents may be overwhelmed with feelings of anger, sadness, anxiousness or helplessness and may withdraw from their
children. At a time when children are most in need of their parents’ support, they may find that their parent is unavailable.

As the research has shown, the most important variable in adolescents’ recovery is their parent’s ability to process their own grief in healthy ways and to show support and concern for their child during this difficult time. Including the surviving parent in some of the therapy sessions is an important part of recovery in the social life task. The purpose of these sessions is to educate parents on the grief process and to facilitate communication with their child. Family therapy is also a time to introduce Adlerian concepts that help parents see their children’s behaviors not as “good or bad”, but as an expression of their desire and need to belong (Manaster & Corsini, 1982). During these sessions both children and parents are encouraged to ask questions of each other to give permission to share concerns in a safe setting (Cohen & Mannarino, 2004). These family sessions provide time to express their feelings of sadness and loss and join together in supporting one another.

Since traditions and rituals are an integral part of bereavement, the therapist should become knowledgeable regarding the family’s culture and religion as it relates to death (Cohen & Mannarino, 2004). The therapist should not make assumptions, but ask the family directly what practices and traditions are important to them and what beliefs they hold regarding death. Upon receiving this information, a “culturally competent” therapist will validate and encourage the family’s ethnic identity and help them identify appropriate support systems and resources (Gil & Drewes, 2005).

If the therapist is involved from the beginning, it is suggested that children be included in some of the planning and executing of the funeral arrangements (Combrinck-
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Graham, 2006). This is a critical time for a child to feel a part of the family and to participate in the rites, rituals and ceremonies that offer an opportunity to communicate and work through feelings of grief (Combrinck-Graham, 2006). Some families even create special rituals to “send the parent off”, such as going to a special lake and placing a photograph of the parent on the water or burning a photograph to send the ashes into the air (Combrinck-Graham, 2006).

After the funeral, a therapist can encourage a family to take time to look through family photographs and reminisce of times spent with the deceased parent. This also provides an opportunity for the therapist to address and normalize ambivalent feelings family members may have regarding the deceased (Cohen & Mannarino, 2004). Family members should be encouraged to talk about how they may experience their loss in the future during holidays and special family events (Cohen & Mannarino, 2004). They may want to discuss ways to remember their loved one during these times.

One study investigated the capacity of bereaved parents to perform specific tasks to create a supportive environment for their children (Saldinger et al., 2004). The study looked at the parents’ ability to encourage a continued attachment to the deceased parent, to communicate accurate and appropriate information regarding the death, to express their feelings openly and honestly, to maintain a stable home environment, and to obtain the necessary support for their child.

The quality of the parenting was measured by interviews and a variety of tests given to surviving spouses and their children (Saldinger et al., 2004). This study found, as predicted, that the adults who exhibited the highest degree of child-centered parenting in these tasks had less symptomatic children. The results of this study provide a better
understanding of the challenges facing bereaved parents and effective ways for mental health professionals to address those challenges in family therapy.

**Group Therapy**

The feeling of not belonging or feeling isolated is a commonly expressed feeling of bereaved adolescents. Research has shown that one of the most beneficial types of therapy for adolescents is group therapy where adolescents can give and receive support from each other (Ward, 1993). The group format offers a safe place for the children to express their thoughts and feelings with each other, helping them to realize that they are not alone in their grief. The goal of group counseling is to normalize the feelings of loss that adolescents experience and reduce feelings of social isolation that are often reported by bereaved children (Finn, 2003).

Group therapy provides a setting in which the therapist can observe adolescents’ interactions with others and also creates an opportunity for group members to learn better ways to approach their tasks of life. Adler believed that individuals can only gain a sense of their own self-worth as they grow in their relationships with others (Manaster & Corsini, 1982). The therapist creates a climate where everyone is accepted and valued as a unique individual to encourage open and honest communication of thoughts and feelings (Dinkmeyer & Sperry, 2000). The therapist also models the social skills of showing care and concern by listening attentively and confronting compassionately.

One article reported that a study done in Canada found only 8% of adolescents interviewed said they felt their peers understood them after their loss (Quarmby, 1993). The percentage jumped to 76% after the bereaved adolescents participated in peer group
counseling (as cited in Quarmby, 2003). Research has validated the claim that peer
support groups are beneficial in the mourning process of adolescents.

One article reported on the research of early adolescent bereaved children who
attended a grief group (Tonkins & Lambert, 1996). The symptoms assessed were feelings
of “sadness, anger, withdrawal, guilt, anxiety, loneliness and helplessness” as reported by
the children, their parent or guardian, and their teacher (Tonkins & Lambert, 1996). This
realization of “sameness” or “universality” with other bereaved adolescents was shown to
be therapeutic in this study.

This study found that the children’s symptoms significantly decreased over the
eight week period in comparison to those children who were on a waiting list and did not
participate in the group process. The results from this study are consistent with previous
studies that found “the outcome of grief therapy results in ‘improved family and peer
relationships, improved school performance, dissipation or disappearance of
somaticization and withdrawal’” as stated in Tonkins & Lambert.

One article describes the benefits of using art as a therapeutic tool for bereaved
children in group counseling. In this study, art projects and games were used in grief
groups to facilitate the expression of thoughts and feelings. The goal of artistic expression
is to help children “find their voice” to express their grief (Crenshaw, 2005). Even though
adolescents have more language and cognitive abilities, they, too, find it difficult to talk
about their personal grief. Encouraging adolescents to keep a journal, write a letter, and
create poetry or a song can be therapeutic tools to help them express their thoughts and
feelings of grief (Crenshaw, 2005).
The facilitators also spent time educating the children on the grief process and its impact on them now and in the future to diminish the myths and misconceptions regarding grief (Tonkins & Lambert, 1996). Another author suggested the following guidelines when talking to children about death: 1) answer children’s questions as honestly as possible and tell them if you don’t know the answer; 2) allow children time to process and respond; 3) avoid euphemisms; 4) honor children’s responses, even if they are not what you expected; 5) do not put words in their mouth or force a reaction; and, 6) assure children that this was not their fault (Willis, 2002).

According to Finn (2003), the four main objectives for using art in group therapy are: awareness, expression of energy and emotion, working through a problem, and creativity and joy. This author notes that these objectives are similar to the tasks of grief that are based on helping a client develop an “awareness of loss, express feelings of grief, and learn new ways of coping” (Finn, 2003). Finn states that art therapy can help children express thoughts and feelings that they have been unable to articulate during this difficult time. As these thoughts and feelings surface, children may unleash the negative feelings that they have tried to bury. The therapist is then able to help adolescents process these feelings in appropriate ways. Art therapy can be a catalyst for communication with the therapist and between the members of the group. As stated in the article by Finn, many case studies have documented the positive impact of art therapy on decreasing behavior problems in children who have experienced other types of trauma.

Art can be successfully incorporated into traditional counseling programs. As stated by Finn (2003), “specific training in the use of art is unnecessary.” A therapist can experiment with different mediums to become comfortable using a variety of tools. The
goal of art therapy is not the creation of quality artwork, but rather to facilitate the process of mourning and encourage communication (Finn, 2003). Art is also an expression of a person’s creativity which gives children the chance to be in control of the process, develop problem solving skills, and increase their self-esteem. The therapist can help the child transfer these skills to cope with the challenges they face every day.

**Conclusion and Recommendations**

Current research has determined that children who have lost a parent to death may be at risk for developing certain pathological symptoms such as PTSD, depression, and behavioral problems (Goldman, 2004). The research has shown that adolescents, in particular, are at risk for developing mental health problems if no support or therapeutic interventions are provided. Adolescence is a challenging stage of life defined by many physiological and psychological changes. Parental loss during this time may weaken adolescents’ self-esteem and deter their striving for autonomy as they suppress their natural inclination to pull away from parental authority.

John Bowlby’s attachment theory is credited with changing the goal of bereavement therapy from detachment to transformation of the relationship with the deceased love one (Stroebe, 2002). Current research supports the theory that the healthy grieving process involves maintaining an on-going, internal connection to the deceased after the external relationship is no longer possible. This internal connection with their lost parents can help adolescents maintain their “continuity of self” in this stage of personality development (Lohnes & Kalter, 1994). This theory, labeled “Continuing
Bonds” by Dennis Klass, has changed the interventions used by present-day therapists in treating clients who exhibit symptoms of complicated grief.

As suggested by the research, many bereaved adolescents do not experience complicated grief and are able to process their grief in a timely manner. These adolescents typically have favorable environmental factors, such as positive relationships with their parents, good communication with family members, and a sense of belonging in a supportive community. Therapists and family members need to be aware of the risk factors and the symptoms of complicated grief in order to provide early therapeutic interventions that may prevent pathological problems later in life. Adolescents who are unable to move forward in the tasks of life after a reasonable amount of time following a parent’s death may be in need of mental health services.

The research suggests that secondary factors have a significant influence on whether or not adolescents are able to move through the stages of grief successfully. The most important factor that affects children’s ability to process their grief in healthy ways, as reported in these articles, is the parents’ emotional well-being and their capacity to support their children through the grief process. The research has shown that grief therapy can improve family and peer relationships and can contribute to the disappearance of grief related symptoms (Tonkins & Lambert, 1996).

Intervention methods used in the past offered only individual counseling for parentally bereaved children (Lohnes & Kalter, 1994). More recent research has shown the benefits of adding family and group counseling to address the particular needs of these children. Individual therapy is the first step in helping adolescents begin processing their own personal grief. These sessions allow individuals to tell their story one-on-one
and not be overwhelmed by the traumatic stories of other children. Including parents in some of these sessions provides a setting to move forward in their social task by encouraging and supporting healthy communication of feelings. Family therapy also provides important information and education on the grieving process for parents and their children.

Peer group counseling is a more recent intervention for bereaved children that addresses not only the social task, but also the self-task. Group counseling would be most beneficial after adolescents complete individual and family counseling. This is a time for them to gain a sense of belonging to their peers as they realize that other children have experienced similar feelings in their grief process. This setting also offers adolescents a chance to reach out to their peers to support them in their pain. As individuals begin to look beyond their own pain and reach out to help others, the true healing process will begin.

This thesis has reported on the research done that supports the conclusion that adolescents who have lost a parent to death and who exhibit pathological symptoms for complicated grief can benefit from a treatment plan that includes individual, family and peer group therapy. Using these three methods of therapy together will best help clients move through the stages of grieving to successfully meet the tasks of life and instill a sense of courage to meet the challenges and hardships that life can bring.
References


