Creative Interventions for Bereaved Children

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Introduction

When children enter therapy because they have experienced the death of a family member or close friend, they are at a very vulnerable time in their lives. They are often anxious about the therapeutic process and reluctant to talk directly about the death. Activities that are creative and play-based can engage children and help them to express their thoughts and feelings. The purpose of this book is to provide mental health professionals who work with bereaved children with creative interventions to engage, assess, and treat them. A range of innovative activities are presented, including therapeutic games, art, puppets, role-plays, and stories. Studies have demonstrated the effectiveness of these play-based interventions for children (Utay & Lampe, 1995; Burroughs, Wagner, &Johnson, 1997, McCarthy, 1998, Johnson et. al., 1998). Most of the activities in this book have been developed for children ages 7 through 12, but many can be modified for both younger and older children.

Practitioners using this book should have clinical training and a sound knowledge base in: child development, attachment theory, psychopathology, childhood trauma, childhood bereavement, and child therapy. A list of suggested readings and professional training associations is provided at the end of the book for those who wish to broaden their knowledge. The activities presented here can be integrated into any theoretical orientation that uses a directive child therapy approach. Thus, practitioners from a wide range of theoretical orientations will find many activities to incorporate into their therapy sessions.

The first section of this book, which contains guidelines for practitioners, lays the foundation for effective grief counseling with children. Section Two presents a theoretical overview of childhood bereavement and it incorporates some of the latest literature on children's bereavement. Additional reading on the topic can be found in the *References and Suggested Readings* section. The third section provides material for use with the child's caregivers. It includes a letter to give caregivers in the first session, informing them about the therapeutic process, and a social history questionnaire to be used as part of the clinical assessment. A handout on bereaved children is also included, which will help caregivers better understand and respond to their child. The remaining sections offer assessment and treatment tools and interventions. Special sections have been included to assist children in dealing with specific kinds of loss, namely cancer, suicide, and homicide. In addition to individual therapy activities, there are also sections with interventions for children's bereavement groups and family sessions. An overview for practitioners is presented at the beginning of each section, to provide clinical guidelines for how to use the interventions. The appendix includes: a sample letter for the practitioner to give to the child upon termination from therapy; a treatment plan; a handout on bereaved children to give school personnel; and resources for children, caregivers, and professionals.

The interventions in this book have been specially designed to capture and sustain children's interest and motivation in therapy, and to help bereaved children approach their grief within the context of a safe therapeutic environment. Practitioners can make an enormous difference in the lives of bereaved children by providing them with a positive and engaging therapeutic experience.

Contents

Section 1

GUIDELINES FOR PRACTITIONERS

Have a Strong Theoretical Foundation

Practitioners should be well grounded in their theoretical orientation before using any activities or techniques in therapy sessions with children. Interventions should not be used indiscriminately or in a manner that ignores clinical theory. The activities in this book can be integrated into any theoretical orientation that uses a directive child therapy approach.

Be Well-Informed in Child Language Acquisition

Many of the activities in this book depend on language as the primary means of communication, and require the child to have language mastery. The practitioner therefore must be well-informed in child language acquisition, and only use the activities in this book with children who have the capacity to comprehend the activities and, where needed, verbalize their thoughts and feelings.

Use Activities That Are Appropriate for Each Client

There are a variety of activities to choose from in this book. The child's developmental capacities should be considered to ensure that the selected activity is age-appropriate. (The *Activities at a Glance* has been included to guide the practitioner in this regard.) The child's interests should also be considered so the activity appeals to him or her and sustains his or her motivation. Select activities to fit the child's treatment goals. Pacing is also important. Consider the child's level of engagement in therapy and degree of defensiveness before implementing activities that are more emotionally intense, or that require the child to take greater emotional risk.

Involve Primary Caregivers and the Family in Therapy

Whenever possible, the child's primary caregivers should be involved in the treatment. The caregiver may be a parent, stepparent, foster parent, grandparent, childcare worker, or some other adult responsible for the care of the child. When primary caregivers are included in treatment, their children generally experience greater improvement. By facilitating optimal communication between children and their caregivers about the death, caregivers can continue to help children after therapy has ended. Lack of follow-through with therapy, or premature termination of the child's therapy, is less likely if the caregivers are part of the process.

Bereaved children need physical and emotional comfort, reassurance, and consistent routine. Educating caregivers about how to understand and respond to the needs of bereaved children is also an important treatment goal. Thus, sessions with caregivers to facilitate effective parenting should be a part of the treatment process.

If the deceased person is a family member, then the child's caregivers and siblings will be dealing with their own grief issues. Efforts should be made to involve the whole family in therapy. Although the interventions in this book have been developed for individual sessions with the child, many of the activities can be adapted for family therapy. There is also a special section in this book that presents interventions for use in family sessions.

Be a Support to the Child's Teacher

Bereaved children often struggle at school. For example, they may have difficulty concentrating on schoolwork, or present behavioral difficulties during class. With the client's consent, the practitioner can be a helpful resource to the child's teacher and other school personnel. By providing the child's school with information on bereaved children, teachers can then respond with greater sensitivity to the needs of their students. An information sheet for school personnel is included in the Appendix and can be copied for this purpose.

Develop a Therapeutic Rapport

Regardless of the activity being used, the therapist-client relationship is central to the client's realization of treatment goals. Since rapport that develops between therapist and child forms the foundation for therapeutic success, the practitioner must create an atmosphere of safety in which the child is made to feel accepted, understood, and respected.

Conduct a Thorough Assessment and Develop a Treatment Plan

The clinical assessment is a critical component of the intervention process, as it is the basis for effective treatment planning. A thorough and comprehensive assessment should examine specific bereavement issues, loss history, behavioral and emotional changes and concerns, as well as other presenting problems. An assessment should always be completed prior to beginning treatment. Therefore, the assessment interventions in Section Four should be completed prior to using any of the treatment interventions.

If the child and family are in crisis, the assessment should be completed in a timely fashion, and crisis support should be offered in the interim. Crisis work offered during the assessment phase should focus on strengthening supports and coping skills.

Selected assessment activities from this book can be combined with additional assessment information, family interviews, collateral reports, and diagnostic measures to evaluate the child and his or her family, and to formulate a treatment plan. The treatment plan should set realistic, measurable goals, and be revised as needed with caregivers, the treatment team, and (if appropriate) the child. A Sample *Treatment Plan* is included in the Appendix.

Once the assessment is completed, a meeting with the caregivers should take place to provide feedback on the assessment, consider treatment recommendations and contract for service.

Understand the Difference between Clarification and Correction

During the assessment phase, the goal is to understand and clarify the child's perceptions about self, others, and the world. For example, in an assessment activity, if the child says, "My mom's death was my fault," an appropriate clarification response from the practitioner would be, "Tell me why you think it is your fault." During the treatment phase, the goal shifts to doing corrective work, or challenging the child's cognitive distortions.

Give Each Client a Scrapbook

It is recommended that the child be given a scrapbook in the first session in which to place activities completed during sessions. The scrapbook has several benefits: it allows the child to see the progression of sessions; it provides immediate tangible reinforcement of each therapeutic success; and it gives the child a lasting record to have once therapy is terminated.

All therapeutic activities completed by the child during sessions should be placed in the scrapbook, and it should be kept in a locked place in the practitioner's office. It can be given to the child in his or her last session, with a discussion regarding who, if anyone, should see it, and where in the child's home it should be kept to ensure its privacy. (A complete copy of the scrapbook must be made for the practitioner's file prior to giving it to the child.) For further information about the use of therapeutic scrapbooks, refer to the article, *The Resolution Scrapbook as an Aid in the Treatment of Traumatized Children* published in the Journal of Child Welfare, July 1995 (this article can also be found on the author's web page: www.lianalowenstein.com

Give Each Client a Feel Better Bag

Encouraging self-care and teaching healthy coping strategies is important to do with clients. It is particularly crucial for bereaved children dealing with the death of a family member, since their caregivers may be consumed with their own grief and may not be able to meet the child's emotional needs. It is also important to teach coping skills at the beginning of the intervention process when working with children with traumatic bereavement, so they can master these skills prior to facing anxiety provoking material during treatment. The *Feel Better Bag* is used as a tool to facilitate self-care. This bag is given to the child in the first session to take home, and in each subsequent session the child is provided with a self-care item to add to the bag. Ideas for the *Feel Better Bag* are incorporated throughout this book. In order to encourage the child to use the *Feel Better Bag*, it is recommended that the child's caregiver coach the child on its use at home. In addition, the practitioner should ask the child at the beginning of each session whether s/he used the *Feel Better Bag*, and whether it was helpful.

Maintain a Consistent Structure to Sessions

Each session should adhere to a similar structure, so the child knows what to expect. It can be helpful to begin each session with a check-in ritual to assess current functioning and facilitate self-expression. For example, the client can be asked to rate his or her week on a scale of one to ten (one being terrible and ten being perfect), or draw a feeling face to show how s/he feels. The client can also be asked if s/he used a strategy from his or her *Feel Better Bag* and how it helped him or her to cope better. A quick engagement activity can then be played, such as *Feelings Tic-Tac-Toe* (see Section Four).

Next, the child can complete the activity or activities planned for the session. (The practitioner should be prepared to divert from the planned activity if needed.) The child can then choose an activity to do, such as a board game, craft, or playing with toys in the room. Some children will need a more energetic activity at the end of the session to appropriately channel excess adrenalin caused by anxiety. As mentioned above, all completed activities should be placed in the child's scrapbook, and the child should be provided with something to take home to add to his or her *Feel Better Bag*.

Be Well-Prepared in Advance of Sessions

Before using any assessment or treatment exercise, the practitioner should first review the activity and gather any necessary materials. If the practitioner lacks confidence, then practicing and rehearsing the activity with a colleague before the session may be helpful. However, no matter how well prepared the practitioner is for the session, the unforeseen can happen. Flexibility in meeting children's emotional needs over the sessions is therefore essential.

Introduce, Process, and Bring Closure to Each Activity

When implementing an activity, first consider how it will be introduced to the child. The therapist's enthusiasm, creativity, and overall style will be key factors in determining if the child will become interested and engaged in the activity. All activities should be carefully processed and used as a point of departure for further discussion. The practitioner can encourage the child to elaborate by asking open-ended questions such as, "Tell me more about that," or by inquiring about a particular detail of the child's work. As the child moves to a more engaged and ready state, deeper issues can be skillfully explored and processed. When the activity has been completed and sufficiently processed, the therapist provides positive feedback to the child on his or her completed work and brings closure to the activity.

Set Appropriate Limits

Bereaved children often "act out" as they feel overwhelmed by their grief, and may lack the capacity to handle their strong emotions. It is necessary to provide the child with limits and structure. The nature and intensity of the limits will depend on the child's existing capacity for self-control, as well as his or her responsiveness and ability to handle such limits. Ideas to manage such behaviors can be found in the author's book, *More Creative Interventions for Troubled Children and Youth.*

Recognize the Impact of Grief on Affect and Behavior

Children's emotional presentation in therapy may be related to where they are in their grieving process. For instance, if they are in the initial stages of grief, i.e. shock and disbelief, they may present as emotionally numb or detached. Or if they are in the anger stage, they may be highly susceptible to aggressive outbursts or fits of rage. If they have been traumatized, they may be in a constant state of anxious-arousal (which is often misdiagnosed as ADHD). Recognizing the impact of grief and trauma will help the practitioner better respond to the child's needs.

Be Sensitive to Cultural and Religious Customs and Beliefs

Clients will have specific religious beliefs about death, and will practice certain grieving rituals based on their culture and religion. It is important to honor these beliefs and be accepting of diversity. Practitioners should never impose their beliefs onto clients. Information should be gathered about the client's religious background and grieving rituals during the assessment.

Model Open and Direct Communication about Death

Many people find it difficult to talk openly and directly about death, and so they may use indirect terms, such as "gone" or "passed away." In order for practitioners to model open and honest communication, direct and accurate terms about death should be used when working with bereaved clients.

Provide a Positive Termination Experience

The termination phase of treatment must be handled with sensitivity, particularly with bereaved children who may experience the end of therapy as another loss. During this phase of the intervention process, the child may experience feelings of sadness, anger, rejection, and abandonment. Termination can also be a wonderfully positive experience as the child's therapeutic progress and achievements are highlighted and celebrated.

A graduation ceremony can be planned for the last session with the child, to help create a positive, celebratory atmosphere for this important phase of intervention. If appropriate, caregivers can be invited to the ceremony. The practitioner can write a letter to present to the child at the graduation ceremony. This letter will review goals achieved in therapy, validate the child's efforts and accomplishments, reinforce healthy thoughts, and provide a positive message for the child's future (see Appendix for a sample letter). The practitioner can also ask other people who are significant to the child to write letters for presentation to the child at the ceremony. The letters can be placed at the end of the child's scrapbook.

Obtain Professional and Personal Support

Working with bereaved children can be professionally and emotionally challenging. It is, therefore, important to obtain supervision from a clinician who is knowledgeable in the area of treating bereaved children. It is also important to make use of support from colleagues and friends, and engage in regular self-care rituals.

Section 2

Bereaved Children: A Brief Theoretical Overview

Clinicians using this book should be well-trained in issues specific to bereaved children. Below is a brief summary on various aspects of children and grief. Suggestions for additional reading can be found in the *References and Suggested Readings* section in the Appendix.

Key Definitions

Grief describes the intense emotions one experiences following a loss.

Bereavement refers to the state or fact of having lost a loved one by death.

Mourning refers to the external expression of grief, or the rituals associated with bereavement.

Disenfranchised grief refers to grief that is not socially acknowledged or supported. It is often related to a stigmatized kind of death, such as suicide, drug overdose, or AIDS related death. It can also refer to a relationship loss that is not socially validated, such as grieving the death of a murderer.

Trauma results when an individual is exposed to an overwhelming event leading to helplessness and a diminished capacity to cope and master the feelings aroused by the event.

Traumatic grief refers to when children perceive the death as horrifying or terrifying, and both grief and trauma issues are present. A child can experience traumatic grief even if it was not a violent death. Children who develop traumatic grief get "stuck" on the traumatic aspects of the death and cannot proceed through the normal bereavement process. They may experience symptoms of a traumatic stress reaction: anxiety, nervousness, a heightened startle response, nightmares and sleep disturbances, and intrusive memories of the death. For children with traumatic grief, trauma symptoms must be treated before children can move forward with the grieving process (Cohen et al. 2001).

Children's Bereavement Responses

Regardless of their age, all children grieve. The chart on the next page summarizes children's bereavement responses at different developmental stages. However, as Webb emphasizes, "Development is an individual process that proceeds generally as outlined, but as with all matters human, individual variations occur frequently" (1993, p. 5). Moreover, the chart is a general summary and cannot include all possible reactions.

Risk Factors

According to Worden (1996); there are a number of factors that render a bereaved child vulnerable to increased difficulties:

- Sudden deaths, suicides, homicides
- Death of a mother for girls before, or in, early adolescence
- Death of father for pre-teen and adolescent boys
- Stigma associated with, or media focus on, suicide or homicide
- Conflictual relationship with deceased person prior to death
- Lack of reality, unable to spend time with deceased person after death
- Inadequate preparation for funeral
- Pre-existing psychological difficulties
- Psychologically vulnerable parent, i.e. dependent on child, drugs/alcohol
- Lack of family and community support
- Unstable environment, i.e. disruptions of routine, inappropriate discipline
- Poor family coping, i.e. lack of open communication, poor problem-solving
- Immediate dating by surviving parent
- Remarriage of surviving parent if child's relationship with stepparent is negative

The more risk factors present, the greater difficulty the child will have coping with the death. Knowing what risk factors the child is dealing with will enable the practitioner to intervene more effectively. When there are a number of risk factors, longer term intervention with the child and family by a multidisciplinary team is generally the treatment of choice.

Grief-Focused Treatment Goals

Although an individually tailored treatment plan must be developed for each client, there are a number of grief-focused goals that should be addressed in the treatment of bereaved children (Worden, 1996, Cohen, et al. 2001):

1. Accept the reality and permanence of the death
2. Experience the painful emotions of the death, such as sadness, anger, confusion, guilt
3. Recognize and resolve ambivalent feelings toward the deceased
4. Adjust to changes in everyday life
5. Identify and preserve positive memories of the deceased
6. Redefine the relationship with the deceased as one of memory
7. Develop new relationships and deepen existing relationships
8. Make meaning of the loss
9. Foster enhanced problem-solving and conflict resolution

The activities in this book have been developed with the above goals in mind in order to facilitate the client's grieving process.

The Issue of Closure

A common issue pertaining to the treatment of bereaved clients is closure. Closure is defined as "a conclusion or an end." But closure is an unrealistic goal, as bereaved individuals do not conclude or end their grieving process. A more realistic goal for bereaved children is for the intense pain of the loss to "no longer be psychologically dominant in one's daily life" (Fink, 2002, p. 7). The child is then able to have a healthy capacity for trust, to have a more hopeful outlook of the future, make memories of the deceased, reengage with the community, and function productively. Although no longer dominant, the pain of the loss is not over. One continues to grieve the death, although with lowered levels of intensity. Various events, such as the anniversary of the death date, family celebrations, etc. are likely to intensify painful feelings for a period of time (Fink, 2002, p. 7). For this reason, preparing children for future painful feelings, or "grief attacks," is an important treatment goal.

Section 3

Meeting with Caregivers

It is recommended that the primary caregivers be interviewed prior to meeting the child. The focus of this initial session is on establishing a positive rapport with each caregiver, explaining the therapy process, completing administrative forms, and learning about the child and family. Some caregivers may be reluctant to meet with the child's therapist. This may be due to their fear that they will be negatively judged. The practitioner must make every effort to engage the primary caregivers. One strategy is for the practitioner to communicate to the caregiver (in a caring tone) that the child's therapy will be seriously hindered without their participation.

Letter: The letter (see following sample) can be given to caregivers in the initial session. It covers information about the therapist's role and the therapeutic process.

Questionnaire: Detailed information should be obtained from all primary caregivers as part of the assessment process. The questionnaire collects the following information:

- The child's current living arrangements
- The child's developmental history
- The child's relationship with the deceased prior to the death
- Circumstances surrounding the death
- Feelings and reactions about the loss
- Family information
- Parent history

The information on the questionnaire should be collected via a face-to-face interview with the caregivers. This facilitates rapport-building, and allows the practitioner to elicit more detailed information than would otherwise be obtained if the caregiver were to complete it on his or her own. The practitioner needs to be cognizant of the fact that gathering detailed information regarding the circumstances of the death can be a sensitive issue as it evokes emotionally laden memories for the grieving caregiver. For this reason, the practitioner must be especially careful about establishing rapport with these clients before delving into details related to the death.

Handout: The handout, *How Bereaved Children Think, Feel, and Behave And What Adults Can Do To Help,* provides caregivers with information on children and grief, and with tips on how to help grieving children. The hope is that this information will better equip caregivers to respond to the special needs of their children. It is suggested to review and process the handout with caregivers, rather than simply giving it to them to read on their own.