Describe one specialist area of work with young people and evaluate the use of a variety of creative interventions in your working practice

Introduction

The topic of bereavement in children is large, so I will mention the salient points here and then go on to elaborate the most important.

There are a number of factors that contribute to the overall effects that a bereavement will have on a child. Firstly, the mode of death of the so-called Special Person: perhaps murder, death through illness or accident, suicide, natural but sudden death, and death through terrorist attack. Secondly, the relationship of the child to the Special Person: often the main attachment figure such as a parent or carer, perhaps a sibling, wider family member, peer, someone close to the child (or not), someone frequently seen (or not), someone who has been in conflict with the child, or someone they feel ambivalent about. Then there are social variables such as where and how the child lives, the cultural background, level of family income, past exposure to death, security, stability and emotional well-being in the child's environment. And finally, personality factors within the child or young person.

All these variables will intertwine with the age, the cognitive ability, developmental stage and resilience of the child to make it impossible to give a definitive way of working within the area of bereavement. The therapist will have to look on each young person as unique with individual needs, and act accordingly - as is best practice for a client of any age:

'Every person is in different ways like all persons, like some persons and like no persons.' (Wilby, 1995: 239)

Is adult grief relevant?

Various people have observed normal grief reactions and processes in adults (see below). But Holland (2001: 31) argues: *'A potential problem with extending adult models to children is that this assumes that their experiences of bereavement are similar.'* And LeVieux (1999: 381) says: *'Their grief responses are many and varied…Each age group has its own grief responses.'*

So although adult models have some relevance, there are special considerations when working with young people and grief, and the following three considerations are the most important, in my opinion.

Support

Kubler-Ross' (1971) stages, Lindemann's (1980) reactions, and Murray Parkes' (1998) phases, mainly indicate behaviour that would appear to be 'normal for the circumstances' in adults. But children may need support or 'holding' even while their reactions are normal (Harris and Curnick, 1995: 195), because they are still dependent on adults and may lack other support. This will enable possible problems to be caught early.

For instance, if someone attempts to restore normality, a child is often sent straight back to school where he faces not only teachers' reactions but also insensitive remarks or isolation from peers on account of his different experience (Smith, 1999: 21). If his work also appears to suffer from inattention, he will need extra support. A young child who 'bargains' may really believe he can win the dead person back. Depression and numbness may be

misunderstood as acceptance, and acceptance may well be dissociation in a child. Teens will suppress emotions rather than break down. Disorganisation and despair can lead to suicide ideation, perceived guilt may lead to self-harming behaviour, and reorganised behaviour may be over-control not recovery.

A child will find it harder to move on if the family itself is stuck, and a child from an enmeshed family may need extra support (Carroll, 1995: 77). Other children will need additional support in proportion to concurrent life crises. Support in response to immediate colateral losses (Smith, 1999: Chap 3) may be necessary.

Both Baulkwell and Wood (1995: 167-8) in their work with children, and Holland (2001) offer examples of what children say they need or needed in terms of support. But any support must be consistent. And care must be taken with endings because this can replicate the bereavement if insensitively handled.

Age-appropriate communication

Worden's (1991) and Fox's (1991) task lists are an indicator of what needs to be done by bereaved people if they are to take up life again: accepting and understanding, working through and grieving, adjusting (perhaps by the act of commemorating), and finally moving on. To do this, children need to make meaning of what has happened, and their ability to do so is limited by many things such as age, cognitive and developmental stage, and how adults communicate with them.

The therapist will need to be aware of what children understand. Young children do not always understand death. They need bite-sized pieces of information and explanation about what has happened at a level consistent with their developmental age – which is not necessarily their chronological age. The youngest children will only know that an attachment figure has gone missing and will display behaviour in line with that and look for the return of the person or withdraw into themselves (Sharp and Cowie, 1998: 38). Children from two to seven may say that the person has died but simply not understand that death is final. They may feel they caused it and magically think they can undo it.

Children at primary school will gradually master the cognitive aspects of death but need concrete explanations and images about the here and now. Older children who are not learning disabled will think more abstractly and start to make spiritual meaning of life and death, but may also feel suicidal, take an interest in the occult, use drugs and lose a sense of meaning in their lives (Smith, 1999: 22). They may also be concerned with how the bereavement may affect their future (Pennells and Smith, 1995: 146).

Nevertheless, children will have different experiences of loss and death from beforehand, and this, too, will effect their cognitive understanding of the new grief (Dyregrov, 1991: 9-13 and chap 3).

Reconstruing

For this, young people need time set aside in which they are empowered to get in touch with their feelings of fear, insecurity, guilt, anxiety, anger and sadness etc (Dyregrov, 1991: 13-27), and engage constructively with the loss. In so

doing, psychosomatic and behavioural complaints will also be dealt with. They need space to show the pain that they may hide from parents, and to master the event and locate it satisfactorily in the construct system:

> *'Mourning…is not a finite process but a lifelong adjustment to a world without the deceased person…Through mourning, the child experiences the meaning of the loss for* them *and learns to* live *with their bereavement.' (Hemmings. 1995: 9)*
> *'Bereavement may be better understood as a process of narrative reconstruction. The aim is the construction of a new self and a new narrative which encompasses and accomodates the memory of the deceased.' (Diploma course notes, 1999)*

This meaning-making needs to be done within the child's cultural context. As Wilby (1995: 234) says:

> *'Culture…determines our view of mortality and how we are prepared to face bereavement. It determines the rituals surrounding death and provides a structure through the rituals which in turn give some sense of security at a time of great distress and disorientation.'*

For instance, a child of Christian parents may talk of heaven and the therapist will respect this view. A Muslim is always buried. Buddhist children may be involved in yearly ceremonies when 'merit' is passed on to the dead person. Jewish funerals happen as soon as possible after death and the child has less time to assimilate what is happening. Significantly, Sikhs teach that dying is no different from going to sleep (a metaphor therapists would normally be reluctant to use with children on account of its vagueness and seeming denial of the reality of death) and that the soul simply wakes up in another body ready for life again – hence there is no need to be unhappy. Children who have been

taught this may feel guilty at being sad and will need sensitive handling. A Hindu child might tell you that the Special Person's ashes have been sent to India for scattering in the Ganges and ask questions about it. (Penney's (1988) *Discovering Religions* series).

Because children have their whole life before them, they may well find that grief is renewed at subsequent developmental stages such as puberty, teenage years, college graduation and marriage - Holland's C/D losses (2001: 173) - since the Special Person may well have been expected to be there to enjoy or share the experience with them. These later experiences, too, will need to be processed.

Interventions

There is bound to be overlap in my following sections but I have divided them to facilitate explanations.

Talking therapy

Talk is often appropriate. All children may need explanations of what has happened and what it means - perhaps many times and with different detail. A child of any age who thinks he caused the death, will need straight explanations. Straightforward counselling may be very suitable where a teenager wishes to address existential issues or discuss how to solve a particular problem. But a learning-disabled teenager may not be able to use this approach very well. So when using a counselling room that is not specifically laid out as a playroom, most young people's counsellors will want to have at least some appropriate media in the room as a possible way of facilitating the process of talking. Having a choice is empowering at a difficult time.

Play therapy

Play therapy is the main intervention with younger children (Geldard, 1997, West, 1992, Schaefer, 2003 etc) and might include any of the creative interventions mentioned later. It is useful because:

> *'Play grants children the opportunity to solve problems, release tension, discover alternative adaptive behaviours, heal their emotional injuries, and amplify their understanding of the world.'* (Gil, 1994: 40)

In relation to a child's bereavement, and in addition to those mentioned below, important toys are baby-sized dolls, miniature members of an extended family, a dolls house or house corner, doctors and hospital sets and equipment, telephones and emergency vehicles, military figures and guns if the therapist has no objection, and possibly dressing up clothes and items that allow for regression: a blanket or feeding bottle perhaps.

The reason for these is obvious: a child may wish to play out various aspects of the way a person died until they have mastery of it in terms of understanding and acceptance:

> *"The child needs to do one of the following…re-experience past events or traumas by re-enacting them, acting them out or re-explaining them…he may need to engage in an activity which will enable him to experience, in his imagination, the effect of his changed role… a sense of mastery over the event or trauma…simulate an event which will allow him to experience the feelings of power and/or control which he may not have experienced in previous instances."* (Geldard, 1997: 93)

A boy I was seeing made 'grandma' die and come to life alternately. He then made crying and weeping sounds for over a minute when the miniature 'grandma' died of a 'red bug invasion' in one of his dolls house stories. I

occasionally reinforced the idea that it was okay to be sad about such an 'awful event'. The 'real' event was never mentioned and I respected this defence. So play therapy with bereaved children must include all the extras to facilitate this process, as well as the opportunity for other creative work. As Mook says:

> *"Imaginative play is indeed a most suitable way for children not only to discover and express personal meanings, but also create and recreate new meanings and thus shape and reshape their own worlds."* (Quoted in Schaefer. 2003: 265)

I cannot see any particular contra-indications for younger children, but would prefer the child to initiate any re-plays of the event himself, as a safety precaution against pushing him to acknowledge what he may not be ready to attend to.

However, this method of play would be unlikely to *automatically* appeal to anyone over the age of 12 if they think it babyish – and the feelings of older children need to be treated with respect. However, Ryan *et al* (1992: 156-7) give examples of the need to allow young adolescents access to toys in order to facilitate regression and integration of material into their emerging identities. This could be connected to earlier losses, for instance, highlighted by a recent bereavement. The authors outline the need to offer permissiveness and also a respect of their true age, together with an appropriate selection of media, some of which will be items in my sections below. But equally, small animals, cars, people, bricks and other items can be used symbolically and intentionally, on account of teenagers' increased ability to think conceptually. In this way they

can take age-appropriate responsibility for making meaning of their bereavement.

Hickmore (2000: 119) gives the example of a 15-year old boy whose healing came via energetic ball games that allowed him to get rid of the pent-up angry energy from his body. The permission was in the two soft balls already in the room.

Art therapy

The use of art materials is often appropriate to facilitate words about death or to simply replace them, since words are only another form of symbolism. Children will often show in their pictures what happened, or what is not understood, or draw intense feelings via the content, colour or manner of marking the paper. This puts the distress outside the child in a relatively uncensored fashion:

> *"The permanence of the object produced is one of the benefits of art therapy: it is a spontaneous creation and not subject to memory distortion."* (Pennells and Smith, 1995: 145)

The permanence of a drawing is also useful in expressing a remembered good time with the Special Person. A child might draw a memorial for the dead person, incorporating - if he wishes - some words of farewell. Neater materials (felt pens and pencils), messy ones (pastels and finger paints), bold colours and muted ones allow for messed up emotions, heightened/muted/depressed feelings and 'tidying up' of confused events.

Teenagers are also willing to use art materials. I cannot envisage any time when it would be inappropriate, but I can imagine children with whom it would not be appropriate to ask for any meaning to be explained. A child who has

turned her back on the therapist to draw something is unlikely to want to explain the drawing. Whether discussed or not, the therapist can observe the progression of the images over time (West, 1992: 84), which will help in assessment.

One child I saw drew his dead grandfather's garden in Germany. He said he was to receive a certain statue he'd drawn, as a memento. This proved (understandably!) impossible, and he received a photo of it instead. However, next time he drew the garden, there was no statue, so I presumed that he had in fact 'introjected' the gift in some way.

Puppetry

Personal construct theory says that we use the same constructs to construe others as we use for ourselves (Butler and Green, 1998: 43). It is therefore obvious that the words and actions children give to puppets will reflect their own way of seeing things, whilst distancing a painful topic.

For this to be useful in bereavement, puppets must be available that are angry-looking, wild, unfriendly, fierce or dangerous, as well as soft cuddly ones. This encourages the full range of emotions that may be difficult to verbalise. Harris and Curnick (1995) tell how a child used a crocodile to be 'leukaemia' and another puppet to be 'doctor', and acted out how doctors were meant to kill leukaemia but that leukaemia kills – as the crocodile grabbed the doctor and threw him across the room. It would be very difficult for a child to describe this source of anger in words.

These authors answer the charge of allowing displacement (and therefore denial of reality) by asserting that they do not believe they have the right to

challenge a child's defences: *"The merits of offering the child a new channel of expression …outweigh the possible disadvantages."* (p197)

Whether invited to play out a drama or left to choose puppets intuitively, children will project their distress onto the puppets and work out mastery and powerfulness over the traumatic event, problem-solve about how to manage, and gain insight into what it all means for them (Geldard and Geldard, 1997: 141). But whereas Geldard and Geldard do not advocate puppets for teenage work, Wilson et al (1992: 156) find that, with younger adolescents, the writing of scripts for puppets and the staging of a play (with the therapist's participation) is popular and acceptable for the age-group. As usual, therapy must be tailored to the presenting age and personality of the young client but puppetry is a relatively 'safe' intervention to use with them. And older clients are likely to have the insight to discuss what they acted out.

Sand and clay

Both of these are messy and 'earthy'. Clients of any age will engage with clay, perhaps accepting an invitation to make 'visible' a particular feeling, or form an image of the Special Person (Oaklander, in Schaefer, 2003: 154) and speak to it, or even simply pound the clay in anger.

After a bereavement, young children tend to use sand instinctively to be whatever it needs to be – cliffs, volcanoes, sandstorms or sinking sand – to represent their inner world of chaos, trauma and insecurity. Things can be buried in sand or clay. They can be rediscovered alive, or finally left dead. Children may, under direction, make a 'picture' in the sand tray and discuss it.

Most teenagers, too, will accept this task, and show their thoughts about the bereavement. Many of them like working with symbols and abstract shapes, and a sand tray is ideal for this as it can be changed around as the narrative progresses.

Playing indeterminately with sand and clay also offers release from tension and brings a feeling of re-groundedness. This can be therapeutic after a tension-filled session addressing grief. In my opinion, sand and clay are undemanding by nature, yet strangely compulsive.

As with play and art work, the young person can be helped to feel less isolated in their loss and supported in their grief by being invited to work with these materials in a group (Smith, 1999: 92), where they can talk about their creations as they make them or simply witness them. Or the therapist may invite participants to discuss what they have done – which in turn may open up topics that were confusing or distressing others too.

Structured Activity (individual or in groups)

Interventions here would be things like the making of a book or treasure box or other commemorative task. This helps the child remember the person as they were when alive, and produces something to keep – which is useful where the client thinks they will forget the Special Person (Gordon, 1995: 129). Less permanent but equally effective is the selection – from what is on offer or what they bring from home - of certain objects that the child deems to characterise their special relationship with the dead person (Schubach De Domenico, 1999:

224) and the discussion that follows. These activities gather up the person and help to tie up ends.

Alternatively, the young person might make a family tree and talk about the changes in it (Harris and Curnick, 1995: 196). Gordon (1995: 123) uses this technique to advantage with family groups. Other activities suggested by Pennells and Smith (1995) for use in bereavement *groups* include a question box, sculpting, brainstorming of feelings and subsequent use of the answers, and dramatherapy. Stories and books are popular with groups, too. As are music activities, guided journeys and relaxation techniques.

The aim of all such activities is to bring to the fore feelings and thoughts that are painful and easily repressed, which would lead to trouble later in the form of depression, anxiety, acting out or withdrawal. Because of the need to intervene early and prevent later trouble, many therapists work with groups of children where grief is not yet problematical – and the work in the group helps to normalise death as part of life as well as offering support:

> *"Through group activities the child often feels the support, encouragement, and sense of being heard by group members… Knowing that the group will be there to support them offers children the opportunity to be vulnerable and grieve."* (Le Vieux, 1999: 385)

Structured activities are therefore very appropriate for this work, perhaps with some free play for younger children during each session (Le Vieux, 1999: 382). The therapist must choose very carefully which activities she imposes on the group, taking into account what she knows of each child and their

developmental stage and cognitive ability. Otherwise more harm than good may ensue. With these provisos, there are few contraindications per se.

Conclusion

There has been no room to go into details of every possible effect of bereavement on a child or young person, nor describe every possible creative intervention that might help. I have selected a few aspects to demonstrate that there are special considerations when working with children and a need to choose and evaluate an intervention with knowledge of how it might help, and how a particular child might benefit in their specific bereavement situation.

Overall, whether the bereaved person is young or adolescent, there are certain to be factors involved in his or her reaction that are to do with youthfulness. These might include feelings of being uninformed or misinformed, confused, powerless, insecure, angry and isolated. The possible outcomes of these feelings continuing, unaddressed, into adulthood are serious. The young person may become subject to ongoing episodes of depression or suicide ideation because feelings have been turned inwards and hope lost. The person may become delinquent if the anger is not given expression with relation to its cause. There may be an inability to form a satisfactory relationship with another adult if the dependency needs of a very young child were not attended to, and an inability to commit to a relationship if trust in the adult world is not restored or addressed. This might include the belief that adults cannot be trusted to tell the truth. A misunderstanding of how or why a death happened, and a generalised feeling of powerlessness from the bereavement experience, can lead

to adult feelings of not being competent or in control unless explanations are given and understood and mastered. This can lead to enduring victim mentality and a refusal to take control of one's day-by-day life.

From this, it can be seen that not only is the topic of bereavement in childhood a large and serious one. It is also of immense importance in dealing with the whole business of human existence. In this light, interventions to help bereaved children are seen, not as pandering to a society that is no longer able to maintain a stiff upper lip, but as an important way of ensuring that our children have the best start emotionally that they can have, in order to be subsequently strong and robust in dealing with the fact that life is *not* secure, *not* predictable and *not* always pleasant.

Bibliography

Baulkwell J and Wood C. (1995), Sharing Experiences: The Value of Groups for Bereaved Children, in Smith S and Pennells M. (Eds.), Interventions with Bereaved Children, London: Jessica Kingsley

Butler R and Green D. (1998), The Child Within: The Exploration of Personal Construct Theory with Young People, Oxford: Butterworth Heinemann

Carroll J. (1995), Non-Directive Play Therapy with Bereaved Children, in Smith S and Pennells M. (Eds.), Interventions with Bereaved Children, London: Jessica Kingsley

Dyregrov A. (1991), Grief in Children: A Handbook for Adults, London: Jessica Kingsley

Fox (1991) Psychological Tasks of Grief, in Goldman (Ed.), Life and Loss, Indiana: Accelerated Development Incorporate, quoted in Holland J. (2001), Understanding Children's Experiences of Parental Bereavement, London: Jessica Kingsley

Geldard K and Geldard D. (1997), Counselling Children, London: Sage

Gil E. (1994), Play in Family Therapy, New York: The Guilford Press

Harris A and Curnick S. (1995), Group Work with Bereaved Children, in Smith S and Pennells M. (Eds.), Interventions with Bereaved Children, London: Jessica Kingsley

Hemmings P. (1995), Communicating with Children Through Play, in Smith S and Pennells M. (Eds.), Interventions with Bereaved Children, London: Jessica Kingsley

Hickmore H. (2000), Using Art and Play in Assessment and Intervention for Troubled Children, in Barwick N. (Ed.), Clinical Counselling in Schools, London: Routledge

Holland J. (2001), Understanding Children's Experiences of Parental Bereavement, London: Jessica Kingsley.

Kubler-Ross E. (1971), On Death and Dying, London: Macmillan

Le Vieux J. (1999) Group Play Therapy with Grieving Children, in Sweeney D and Homeyer L. (Eds.), The Handbook of Group Play Therapy, San Francisco: Jossey-Bass Publishers

Lindemann, E. (1980), Beyond Grief: Studies in Crisis Intervention, New York: Aronson

Murray Parkes C. (1998), Beareavement: Studies of Grief in Adult Life, London: Penguin Books

Pennells M and Smith S. (1995), Creative Groupwork Methods with Bereaved Children, in Smith S and Pennells M. (Eds.), Interventions with Bereaved Children, London: Jessica Kingsley

Penney S. (1988) Discovering Religions (6 main religions in separate books), Oxford: Heinemann Educational

Schaefer C. (Ed.) (2003), Foundations of Play Therapy, New York: Wiley

Schubach De Domenico G. (1999), Group Sandtray-Worldplay, in Sweeney D and Homeyer L. (Eds.), The Handbook of Group Play Therapy, San Francisco: Jossey-Bass Publishers

Sharp S and Cowie H. (1998), Counselling and Supporting Children in Distress, London: Sage

Smith S. (1999), The Forgotten Mourners, 2nd Ed., London: Jessica Kingsley

West J. (1996), Child Centred Play Therapy, 2nd Ed., London: Arnold

Wilby J. (1995), Transcultural Counselling, in Smith S and Pennells M. (Eds.), Interventions with Bereaved Children, London: Jessica Kingsley

Wilson K, Kendrick P and Ryan V. (1992), Play Therapy: A non-directive approach for children and adolescents, London: Bailliere Tyndall

Worden J. (1991), Grief Counselling and Grief Therapy, London: Routledge

ends