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Evidence-Based Practices for Parentally Bereaved Children and Their Families

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Abstract

Parental death is one of the most traumatic events that can occur in childhood, and several reviews of the literature have found that the death of a parent places children at risk for a number of negative outcomes. This article describes the knowledge base regarding both empirically-supported, malleable factors that have been shown to contribute to or protect children from mental health problems following the death of a parent and evidence-based practices to change these factors. In addition, nonmealleable factors clinicians should consider when providing services for children who have experienced the death of a parent are reviewed.

Keywords

parentally bereaved children; risk and protective factors; evidence-based practices

What are the most effective evidence-based practices for working with children who have experienced the death of a parent or primary caregiver? Many providers are faced with this question in their child and family clinical practices. Parental[1] death is one of the most traumatic events that can occur in childhood[2]. An estimated 3.5% of children under age 18 (approximately 2.5 million) in the United States have experienced the death of their parent (Social Security Administration, 2000), and reviews of the literature indicate that parental death places children at risk for many negative outcomes, including mental health problems (e.g., depression, anxiety, somatic complaints, post-traumatic stress symptoms), traumatic grief (e.g., a yearning for the deceased and lack of acceptance of the death), lower academic success and self-esteem, and greater external locus of control (e.g., Cohen, Mannarino, & Deblinger, 2006;Dowdney, 2000;Lutzke, Ayers, Sandler, & Barr, 1997). Although there is an elevation of risk for negative outcomes, many parentally bereaved children adapt well and do not experience serious problems (Worden & Silverman, 1996).

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[1]The terms "child", "children", and "childhood" are used throughout the article to refer to the early childhood through adolescence age range.

[2]The terms "parent" and "parental" are used throughout the article to refer to a parent or other primary caregiver.

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A diversity of theoretical models have been proposed to help understand and guide research concerning an adult's responses to death of a loved one that focus on aspects of adaptation to the loss as well as adaptation to the stressors that follow the death (Archer, 1999; Rubin, 1999; Stroebe & Schut 1999). A conceptual framework that has been useful in studying children's adaptation to other major stressful events (Sandler, Wolchik, MacKinnon, Ayers, & Roosa, 1997) but that has been less often applied in understanding bereavement is the transitional events model (Felner, Terre, & Rowlison, 1988). This model, which is widely used in the study of child risk and resilience, has been a particularly useful framework for developing interventions to improve outcomes for children under stress by targeting potentially malleable risk and protective factors that occur following the marker stress event (e.g., Wolchik, Wilcox, Tein, & Sandler, 2000).[3] The transitional events model suggests that children's adjustment following a major stressful event such as parental death is heavily influenced by the cascade of stressful events that occur following the death. The model proposes a dynamic interplay between the smaller, more proximal stressful events a child experiences following the death (e.g., separation from other family members, parental distress, financial difficulties), the child's protective resources (e.g., self-esteem, coping skills, positive parent-child relationship), and the interaction between the proximal stressful events and protective resources (Felner et al., 1988).

The transitional events model also provides a useful framework for designing interventions for parentally bereaved children. Following this model, the primary goal of interventions would be to decrease children's exposure to stressful changes following the death and to strengthen child and family resources for dealing with those stressors (Sandler et al., 2003; Sandler, West et al., 1992). It is also important to note that in cases where parental death is expected, interventions can potentially provide support and assist the family in strengthening its resources for dealing with the death both before and after the death has occurred.

An emphasis has been placed recently on bridging the gap between research and practice in the treatment of bereaved adults and children (Bridging Work Group, 2005). While the empirical intervention literature for parentally bereaved children is limited, it has yielded some information that can be useful to clinicians (Ayers, Kennedy, Sandler, & Stokes, 2003; Ayers & Sandler, 2003). Thus, this article is designed to contribute to bridging the research-practice gap by providing clinicians with a summary of empirically-supported, malleable risk and protective factors identified for parentally bereaved children that have implications for the design of interventions to promote healthy adaptation. In addition, the extant research will be summarized regarding some important nonmealleable factors clinicians should consider when providing services for parentally bereaved children. The discussion will draw from the empirical literature on the effects of parental death on children, the small number of published descriptions of interventions for children and families following the death of a parent, and the very few published evaluations of interventions for parentally bereaved children and their families. Two evaluations that will be highlighted in this review are the experimental trials of the Family Bereavement Program (FBP) conducted by our research team at Arizona State University (ASU) (Sandler et al., 2003; Sandler, West et al., 1992).[4] The ASU FBP is the only intervention with parentally bereaved children to date that is directed at families where the death has occurred due to a variety of reasons and that has been evaluated using a randomized experimental design, multiple-method and multiple-reporter assessments, short-term and longer-term follow-up, and relatively large sample sizes (Sandler et al., 2003; Sandler, West

[3]Although the transitional events framework shares many features with other bereavement models, an additional advantage of the transitional events framework is that it connects with a broader literature of adaptation to other stressors.

[4]The first experimental trial conducted at ASU was called the Family Advisor Program, which yielded several positive effects (Sandler, West et al., 1992). The Family Advisor Program was redesigned as the FBP, which has been demonstrated to be effective across a wide range of outcomes (Sandler, Ayers et al., 2003). The strategies and techniques presented in this article are drawn from the ASU FBP manuals.

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et al., 1992). It is important to note that the children in the FBP sample should be considered a "clinical" sample in that the families self-selected into the program based on a desire to receive intervention services. The ASU FBP will be used as an example throughout this article to illustrate how an intervention can focus on multiple target areas using a variety of methods to support parentally bereaved families.

Before reviewing the empirically-supported risk and protective factors for parentally bereaved children and the evidence-based practices associated with those factors, it is important to discuss the significance of increasing children's understanding of their grief experiences. One of the primary ways clinicians can facilitate child and parent adaptation following the death is to provide information about the grief process (Corr, 1995). Information about the grief process may decrease thoughts that may lead to serious adjustment problems (e.g., responsibility for the death) and children's feeling that they don't understand what is happening to them and how to deal with it (e.g., unknown control beliefs). Descriptive studies have identified several important areas for such education (e.g., Lohnes & Kalter, 1994; Silverman & Worden, 1993).

Both the ASU FBP (Sandler et al., 2003) and an intervention designed by Tonkins and Lambert (1996) included a focus on education about the grief process. The primary goals for children were to normalize the grief process and to provide information that can reduce anxieties about the future, including (but not limited to): (a) children whose parent has died feel a wide range of emotions, including anger and guilt, (b) the death is never the child's fault, (c) it is acceptable to talk about the parent who has died, (d) it is not unusual for children to think they see their parent who has died or to dream about the deceased parent, and (e) children will never forget their deceased parent. In working with parents, it is important to help them understand that children often communicate their difficulty adjusting to the changes following the death by misbehaving. It is also important as part of accepting the finality of the death to support parents and children in acknowledging that the deceased parent is indeed gone but that the child can maintain a relationship with that parent (Silverman & Worden, 1993). Strategies to maintain a connection with the deceased include discussing positive memories of the deceased, sharing feelings and thoughts about mementos of the deceased, symbolic communication such as attaching a message to a balloon and then releasing the balloon or writing letters to the deceased parent, and memorial activities such as visiting the grave or memorial services or rituals (Lohnes & Kalter, 1994; Sandler, Ayers, Twohey, Lutzke, & Kriege, 1996; Tonkins & Lambert, 1996).

Evidence-Based Practices for Empirically-Supported Malleable Risk and Protective Factors

Increasing child self-esteem

The death of a parent can have a significant negative impact on children's self-esteem (Worden & Silverman, 1996), and lower self-esteem has been associated with greater mental health problems in parentally bereaved children (Haine, Ayers, Sandler, Wolchik, & Weyer, 2003; Wolchik, Tein, Sandler, & Ayers, 2006). Parentally bereaved children often experience negative events following parental death that reduce self-esteem, such as a loss of positive interactions with significant others and/or increases in harsh parenting from a depressed surviving parent (Haine et al., 2003; Wolchik et al., 2006). Several strategies in the ASU FBP focused on increasing the child's self-esteem. One skill set that was taught was to reframe negative self-statements into more positive self talk. As an example, the program helped children to focus on reframing both general and bereavement-specific hurtful thoughts into more positive hopeful thoughts (e.g., "I did something bad to deserve this." compared to "It's not my fault that bad things happen."; "No one wants to be my friend anymore." compared to

"Things may be bad now, but they will get better."). Through exercises and role-plays, group leaders demonstrated how these negative self-statements create additional problems and that more positive reframes help children feel better (Sandler et al., 1996).

Clinicians can also encourage parents to provide increased positive feedback and opportunities for esteem-enhancing activities outside of the therapy context (Ayers et al., 1996). One tool utilized by the ASU FBP is "one-on-one" time, which is described below under *Parental Warmth*. Another tool that both parents and clinicians can use to promote self-esteem is to engage in activities with the child that provide concrete mastery experiences such as art activities where there is little possibility for failure (Zambelli & DeRosa, 1992), as well as other activities that the child may enjoy or are domains of competence for the child.

Increasing child adaptive control beliefs

Parentally bereaved children can feel more helplessness and believe that they have less internal control over events happening to them than their non-bereaved peers (Worden & Silverman, 1996). A more external sense of control has been associated with increased mental health problems following parental death (Silverman & Worden, 1992). Believing that one can control the occurrence of negative events outside of his/her control can lead to negative self-evaluations (e.g., "It's all up to me."; "If I can't solve this problem, terrible things are going to happen.") (Sandler et al., 1996). Thus, healthy control beliefs involve giving up the belief that one can control uncontrollable events (and instead using emotion-focused coping strategies to deal with these events), and identifying events one can control (and using problem-focused coping strategies to deal with these events). The ASU FBP promoted an adaptive sense of control by focusing on distinguishing the problems that are the child's "job to fix" versus the problems that are adults' responsibility (Sandler et al., 1996). For example, parentally bereaved children sometimes feel it is their job to take care of a grieving parent and make them feel less sad (Sandler et al., 1996). Clinicians can work with both children and parents to communicate that although children can give encouragement to their parents and let them know that they hope they feel better, children are not responsible for *making* their parents feel less distressed. Children benefit from hearing that the parent will be able to manage his/or her distress better over time and that their job involves focusing on tasks such as completing homework assignments and spending time with friends. In addition, it is important to work with parents to ensure that they are not relying on their children for too much emotional or practical support and entangling children in the problems of the family. Clinicians in the ASU FBP encouraged parents to find "adult ears" to listen to their own problems.

Improving child coping skills

The use of active coping strategies and coping efficacy have been associated with more positive adaptation following the death of a parent (Wolchik et al., 2006). Specific coping strategies taught in the ASU FBP included positive reframing coping, which includes optimism and a focus on the positive aspects of a situation; problem-solving coping, which includes identifying positive and negative goals and utilizing both cognitive and behavioral efforts directed at solving problems confronted in daily life; and support-seeking coping, which involves seeking out emotional support to help manage stressful situations that cannot be changed (Sandler et al., 1996). Coping efficacy refers to the sense that one has a repertoire of coping tools that can be used effectively to manage stressful events and circumstances (Sandler, Tein, Metha, Wolchik, & Ayers, 2000). To enhance a child's sense of efficacy, clinicians can utilize strategies such as: (a) having children select their own goals and using their coping skills to work on these goals, (b) providing children with specific positive feedback concerning their successful coping efforts, and (c) expressing an ongoing belief in children's efficacy to deal with their problems.

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Supporting adaptive expression of emotion that the child wishes to express

Clinical observations of parentally bereaved children highlight the range of emotions that these children experience, which can include feelings of sadness, guilt, anger, and anxiety (e.g., Silverman & Worden, 1993; Worden, 1996). While highly prevalent soon after the death, over time children's overt affective responses such as crying and sleep disturbances do decrease (Silverman & Worden, 1992; 1993). The existing research suggests that although there is little evidence that cathartic expression of emotion is necessary for all children, that when children feel they must inhibit the expression of negative emotions they would like to express, they are more likely to experience greater mental health problems (Ayers, Sandler, Wolchik, & Haine, 2000). Illustratively, the ASU FBP found that program effects to reduce inhibition of emotional expression partially accounted for (i.e., mediated) program benefits to reduce girls' mental health problems over 11 months following program participation (Tein, Sandler, Ayers, & Wolchik, 2006). Another aspect of emotional expression that may be improved by clinical interventions is to increase the likelihood that significant others show that they understand children's feelings. Illustratively, the child's belief that their surviving parent understands how they feel has been shown to negatively relate to parentally bereaved children's adjustment problems (Ayers et al., 2000). This emotionally supportive aspect of the child's relationship with the surviving parent will be further discussed below under *Parental Warmth*.

One technique that has been employed in several interventions that both parents and clinicians can use to elicit discussion about emotion-laden topics involves sentence stems focused on bereavement issues (e.g., "The times when I feel most sad about my parent's death are…"; Sandler et al., 1996). Topics that can be utilized to help a child talk about the parent who died include discussing a favorite time together, a favorite gift from the deceased parent, or what the child liked most about the deceased parent (Black & Urbanowicz, 1987; Sandler et al., 1996; Zambelli & DeRosa, 1992). Children can also be asked to share personal mementos related to the deceased parent (Huss & Ritchie, 1999; Sandler et al., 1996). While these activities provide the opportunity to discuss feelings and normalize emotional expression when it occurs, this technique must be done sensitively without specifically trying to deepen the level of affective expression or giving the message that children *must* express their negative affect. Another useful tool for providing a safe environment for children to express negative emotions is reading books together. Joint book-reading has been identified as a useful method for promoting discussion and understanding about death (e.g., Moody & Moody, 1991). Further, reading books together provides the surviving parents, who often are emotionally and financially overwhelmed, with an inexpensive and quick way to bond with their children and provide a positive routine in the post-death household.

Facilitating a positive parent-child relationship

Positive parenting by the surviving parent is the single most consistently supported malleable mediator of the adjustment of parentally bereaved children. A positive parent-child relationship reflects the parent's creation of a supportive and structured environment that allows for open communication and includes a balance of warmth and effective discipline. Several studies have demonstrated a strong link between a positive relationship with the surviving parent and children's adaptation following the death (e.g., Kwok et al., 2005; Haine, Wolchik, Sandler, Millsap, & Ayers, 2006; Raveis, Siegel, & Karus, 1999; Saler & Skolnik, 1992; West, Sandler, Pillow, Baca, & Gersten, 1991). Evaluation of an experimental trial of the ASU FBP (Sandler, Ayers et al., 2003) found that the program was effective in promoting positive parenting in bereaved parents, and that increases in positive parenting partially accounted for program-related reductions in child mental health problems for girls (Tein et al., 2006). Studies have also identified the important role surviving parents can play in facilitating an ongoing attachment between terminally ill parents and children (Saldinger, Cain, Porterfield, & Lohnes, 2004).

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Parental warmth

Negative relations between parental warmth and parentally bereaved children's mental health problems have been well-documented (e.g., Saler & Skolnik, 1992; West et al., 1991). Elements of warmth include having general positive regard for the child, conveying acceptance, expressing affection, fostering open communication, and providing emotional support (e.g., Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Maccoby & Martin, 1983). Strategies to improve warmth utilized in the ASU FBP include teaching parents listening skills, such as reflecting content and feelings and summarizing what they hear, as well as methods for reinforcing children's problem-solving efforts (Ayers et al., 1996; Sandler et al., 2003). Parents can also be encouraged to facilitate a warm relationship with their children through "one-on-one" time, which involves setting aside brief (approximately 15 minutes), regular periods of unstructured time with each child in which the child has the parent's undivided attention and all judgment is withheld (e.g., playing a board game together with the child determining the rules). Additional techniques from the ASU FBP to increase parental warmth include encouraging parents to increase their use of regular positive reinforcement by noticing the child behaving appropriately and giving positive physical (hug, smiles) and verbal (compliments) attention for the child's positive behaviors, qualities, and ideas.

Parent-child communication

Communication skills are also important to foster in parentally bereaved families, and open parent-child communication has been associated with reduced problems following the death (Raveis et al., 1999; Saler & Skolnik, 1992). Several strategies to promote open communication among family members were utilized in both the child and parent components of the ASU FBP (Ayers et al., 1996; Sandler et al., 1996). For children, techniques such as "I-messages" that focus the interaction around the child's current experience can be effective. For parents, reflective listening skills can be emphasized (e.g., using appropriate body language and eye contact, identifying underlying feelings). Parents can be asked to "interview" their child as a way to practice listening skills outside of the therapy context (e.g., asking children what they would like to be when they grow up, what foods they like and dislike most, or what their biggest complaint is about the family). Parents can also be encouraged to express their own feelings to their children and to communicate that it is acceptable to feel sad and that the sadness will decrease over time.

Effective discipline

Although less attention has been devoted to examining the relations between effective discipline and parentally bereaved children's mental health problems, the existing research indicates that effective discipline is related to reduced mental health problems in parentally bereaved children (Worden, 1996). Elements of effective discipline include communicating clear expectations and rules, maintaining rules and enforcing rule infractions in a non-punitive manner regardless of mood or context, consistently linking specific consequences to rule infractions, and following through on delivering consequences (e.g., Lamborn et al., 1991; Maccoby & Martin, 1983). Strategies utilized in the ASU FBP (Ayers et al., 1996) to increase effective discipline included teaching parents to: (a) increase their use of regular positive reinforcement for desirable behaviors, (b) be clear, consistent, and calm in communicating expectations for misbehaviors, (c) select the least aversive consequences possible, and (d) be consistent and calm in the implementation of these consequences. The program had the parents practice these skills by developing and implementing a plan to change problem behaviors and by measuring the behavior before and after the change plan to assess change. Also, group leaders normalized the difficulties parents have with discipline and had parents identify and discuss obstacles to providing more consistent and appropriate discipline. Common obstacles included not being familiar with the role of disciplinarian, not wanting to act negatively toward

the child during the grieving period, feeling overly stressed, busy, and tired, and lacking a partner to share the discipline responsibility. One way that clinicians can work with parents to address these obstacles is to identify positive self-statements that help parents use effective discipline (e.g., “I’m not being mean; I’m being a responsible parent.”).

Reducing parental distress

High levels of parental mental health problems and grief have been consistently and positively associated with negative outcomes for parentally bereaved children (e.g., Lutzke et al., 1997). Both experimental trials conducted at ASU (Sandler et al., 2003; Sandler, West et al., 1992) and an intervention designed by Black and Urbanowicz (1987) included a parent support component. Examples of areas to focus on from the ASU program include teaching positive reframing, encouraging support seeking and self-care, acknowledging and reinforcing parents’ efforts to change their parenting practices, and supporting parents in achieving bereavement-related personal goals (e.g., cleaning out the deceased parent’s closet) (Ayers et al., 1996). The ASU FBP also taught parents to protect their children from being overwhelmed by parental distress. Parents were taught that while they did not need to hide their distress from their children, they should try to reassure their child (e.g., by communicating hopeful messages) that although they are sad or upset now, that they or the family is strong and will get through this with time.

Increasing positive family interactions

Studies have found that stable positive events and family cohesion are reduced following the death of a parent and that this reduction is associated with increased child mental health problems (Sandler, West et al., 1992; West et al., 1991; Worden, 1996). In the ASU FBP, family related positive events were increased with an activity called “Family Fun Time” (Ayers et al., 1996; Sandler et al., 1996; Sandler, Ayers et al., 2003). Family Fun Time consists of a weekly scheduled activity in which the entire family participates. Family Fun Time activities are active (e.g., picnic and games, playing on a playground, making a meal together) rather than passive (e.g., watching TV or a movie). Family Fun Time is presented as a “break” from grief and a way for the family to develop a new identity. A regularly scheduled, positive activity can improve both children’s and parents’ mood, increase warmth and open communication among family members, and help develop consistency and structure. Families can brainstorm ideas for activities together with their clinician and then let one of the children select an activity each week. Clinicians can work with parents to identify and address any obstacles to completing Family Fun Time on a weekly basis.

Reducing child exposure to negative life events

Studies have demonstrated significant relations between increases in negative life events following the death of a parent and increased child mental health problems (e.g., Sandler, Reynolds, Kliewer, & Ramirez, 1992), and negative life events have been shown to mediate the relations between parental death and mental health problems (Thompson, Kaslow, Price, Williams, & Kingree, 1998; West et al., 1991). Furthermore, mediational analyses of an experimental trial of the ASU FBP (Sandler et al., 2003) found that program-related reductions in the number of negative life events partially accounted for program-related reductions in mental health problems for girls (Tein et al., 2006).

Clinicians can work with parents to reduce the occurrence of negative life events as well as to shield children as much as possible from events that cannot be prevented. One area that is often of concern to parentally bereaved children is their parent’s beginning to date and develop new long-term love interests. In the ASU FBP, parents were encouraged to introduce a new partner slowly and to talk with their children openly and in an age appropriate manner about the relationship. Another technique from the ASU FBP involved guidelines for dealing with

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holidays and special events. These guidelines include recognizing that holidays can be difficult for bereaved families, encouraged the parents to use good listening skills to provide children with a safe environment to talk about their feelings about the holiday, simplifying life wherever possible during the holidays, and continuing some old traditions while possibly adding new traditions during the holidays.

Nonmalleable Factors To Be Considered When Working With Parentally Bereaved Children

Children's developmental level

It is important to consider developmental differences in children's responses to and experiences following the death of a parent. For example, descriptive studies have found that younger children may be more "harassed" by peers and that in general, younger children are more expressive than older children (Silverman & Worden, 1993; Worden, 1996). Researchers have also noted that older children were significantly more likely to be told they had to act more grown up than younger children (Silverman & Worden, 1993; Worden, 1996). Clinical work with older children may be more likely to include individual sessions that are more focused on cognitive strategies, while involving the surviving parent is appropriate when working with parentally bereaved children of all ages. Christ and colleagues have provided a concise description of children's adaptation to bereavement over different developmental stages during the course of a parents' terminal illness and death that can be useful for clinicians working with this population (e.g., Christ & Christ, 2006).

Child gender

Similar to the general population, evidence suggests that girls on average exhibit greater internalizing problems following the death of a parent while boys exhibit greater externalizing problems (Dowdney, 2000; Saler & Skolnik, 1992). Prospective longitudinal studies have suggested a heightened vulnerability for girls that persists over time (e.g., Schmiege, Khoo, Sandler, Ayers, & Wolchik, 2006). It is interesting to note that the ASU FBP found positive effects on mental health problems for girls but not boys. Sandler et al. (2003) hypothesize that girls take on more parental roles in bereaved families, thereby disrupting normal developmental tasks, and that the intervention effects may be due in part to a restructuring of family roles that allows girls to resume developmentally appropriate tasks.

Cause and type of death

Although studies of the effects of cause and type (sudden vs. expected) of death on parentally bereaved children's adaptation have indicated that cause of death alone is not a major predictor of mental health problems (Brown, Sandler, Tein, Liu, & Haine, in press), addressing concerns and issues that are related to the cause of death is an important focus of treatment. Several interventions for parentally bereaved children and families have been tailored to address specific causes of death. For example, anticipatory interventions have been developed for children and families experiencing the terminal illness of one parent, in particular due to HIV/AIDS and cancer (Christ, Raveis, Siegel, & Karus, 2005; Rotheram-Borus, Lee, Gwadz, & Draimin, 2001). An experimental trial of an intervention for children with a parent in the terminal stages of HIV/AIDS focused on helping parents discuss their disease with their child, preparing the child for the transition to a new caregiver, establishing positive daily routines with the family, and facilitating the child's coping (Rotheram-Borus, Lee et al.; Rotheram-Borus, Stein, & Lin, 2001). The intervention led to improvement in both child and family functioning (Rotheram-Borus, Lee et al., 2001; Rotheram-Borus, Stein & Lin, 2001). More recently, an anticipatory intervention for families with a parental diagnosis of terminal cancer was developed to enhance surviving parents' abilities to provide support for their children,

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provide an environment in which children would feel comfortable expressing their feelings about the loss, and provide consistency and stability in the children's environment before and after the death (Christ et al., 2005; Siegel, Mesagno, & Christ, 1990). Although an experimental evaluation of this program did not yield significant effects on children's mental health problems, there were trends for children who participated in the program to exhibit lower mental health problems and improved self-esteem than those in the control group (Christ et al, 2005). Further, Christ et al. (2005) reported significant improvements in parenting skill and communication (as rated by the children) with the intervention, an advantage that increased over time in comparison with the control group.

Recent attention has also been paid to intervening with children who have experienced the suicide of a parent or other traumatic deaths, such as natural disasters or the World Trade Center and Pentagon attacks of 2001. Traumatic parental death has been associated with the occurrence of child Post-Traumatic Stress Disorder (PTSD) symptoms (Dowdney, 2000). One intervention designed specifically for families where a parent or sibling committed suicide (72% of the intervention condition and 61% of control condition experienced suicide of a parent) focused on many of the malleable factors discussed above, as well as explicit discussions of suicide (e.g., reasons people commit suicide and prevention of children's own suicidal urges) and activities intended to help children manage traumatic thoughts and stigmatizing concerns about suicide (Pfeffer, Jiang, Kakuma, Hwang, & Metsch, 2002). Although the intervention appeared to improve children's symptoms, differential attrition precludes drawing inferences concerning the effects of the program.

Trauma-focused cognitive-behavioral therapy (TF-CBT) has also been proposed as effective treatments for children who experience the traumatic death of a parent (Cohen, Mannarino, & Deblinger, 2006). The basic tenets of TF-CBT include focusing on exposure and direct discussion of the traumatic event, challenging cognitive distortions and correcting dysfunctional automatic thoughts, and stress management and relaxation (Cohen, Mannarino, Berliner, & Deblinger, 2000). Although no randomized trials have been conducted, an open treatment study using TF-CBT found decreased in anxiety and PTSD symptoms by child report and decreases in internalizing problems and PTSD by parent report (Cohen, Mannarino & Knudsen, 2004). Using a repeated measures design without a control group, Pynoos, Layne and colleagues (Layne, Pynoos, Saltzman, et al., 2001; Saltzman, Pynoos, Layne, Steinberg & Aisenberg, 2001) have examined the effects of a trauma- and grief-focused group intervention for traumatized Bosnian adolescents in school settings and have reported reductions in grief symptoms, depression, and PTSD symptoms following completion of the group.

Time since the death

The effects of the amount of time elapsed since the death on child and family functioning are complex. Children's initial responses such as crying, sadness, and dysphoria do decline over time, but mental health and other problem outcomes can persist and may even increase over time (Dowdney, 2000). Studies have shown that time elapsed since the death is not uniquely related to outcomes (e.g., Haine et al., 2006; Raveis et al., 1999); rather as suggested in the transitional events model posited by Felner and colleagues (Felner et al., 1988), the negative events that follow the death and the child's resources for coping with these events determine long-term functioning (e.g., Elizur & Kaffman, 1983). Clinicians can help parents understand that the nature of children's affective reactions change over time.

Cultural background

Very little empirical work has been conducted regarding cultural differences in children's bereavement experiences, and to date no study has examined the role of culture in children's adaptation to the death of a parent. The few cross-cultural comparisons of the development of

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death concepts have found both similarities and differences between cultures. For example, one study compared Israeli and American school-age children and found that Israeli children scored higher on their ability to understand irreversibility and finality, suggesting a more mature understanding of these concepts (Schonfeld & Smilansky, 1989). Discussions of cultural differences in adult conceptualizations of grief have described the culture-bound assumptions of the normal course of bereavement. Illustratively, in the United States, some have argued that there is a focus on individuals rather than relationships, a denial of the notion that important attachments endure following a death, and a pathologizing of atypical grief reactions (Shapiro, 1996). While these assumptions may be prevalent in the dominant U.S. culture, it is important to recognize that minority families may not subscribe to these assumptions. Clinicians should keep in mind that grieving families, including children, will greatly vary in their goodness of fit with the norms of the dominant culture. Clinicians can facilitate families' examination of the match between cultural expectations and their own needs in coping with the death.

Limitations of Existing Studies and Future Directions

Overall, the most remarkable limitation of the existing research is the paucity of well-controlled studies of the effects of programs for parentally-bereaved children. Because of the dearth of well-controlled studies on which to base implications for practice, the current review focused primarily on identifying potentially malleable risk and protective factors for parentally-bereaved children and illustrated approaches that have been successfully used to modify these factors. These illustrations have relied to a large extent on interventions strategies used in the ASU FBP, primarily because this program has been very systematic in articulating the linkage between targeted risk and protective factors and intervention design. Two specific limitations of the extant studies include the lack of assessment of preverbal children, which limits the information available to clinicians who work with very young children, and the variability in intervention modality, which precludes drawing clear conclusions regarding what mode of intervention (individual, family, group) or target (child, parent, family) is most effective.

A recent meta-analysis of intervention programs for parentally-bereaved children found thirteen evaluations that met minimal criteria for acceptable design, only six of which were published (Currier, Holland & Neimeyer, in press). While the conclusions from the meta-analysis were negative concerning the overall evidence for benefits of these programs to improve outcomes for bereaved children, the findings were limited by limitations in the sample of studies, which precluded analysis of critical issues such as the effects of programs over time, effects of programs on important outcomes such as grief, and effects of critical moderator variables such as age and gender of the child.

Because we consider the primary limitation of intervention studies for bereaved children to be the small number of high quality studies, it is useful to articulate characteristics of well-controlled studies that are needed to provide evidence to strengthen future practice, which include adequate sample size, random assignment to the program and a comparison group, a well-described intervention and assessment of implementation, assessment of multiple outcomes using reliable and valid measures, and appropriate data analysis that attends to potential sources of bias due to factors such as non-random attrition. In addition, we have identified six critical issues be addressed in future intervention studies targeting parentally bereaved children: (a) identification of subgroups that experience the greatest or least benefit (e.g., gender, age, exposure to traumatic death, level of problems at program entry), which can guide efforts to identify and reach families in the community who would most benefit from interventions and to assist in resource allocation decisions, (b) examination of whether targeted mediating mechanisms of change are successfully altered as a result of the program and whether change in the mediators account for program effects on child outcomes, (c) measurement of

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child outcomes using measures of a broad range of factors including grief, mental health, substance abuse, and positive functioning (e.g., competence at school and with peers as well as positive feelings about themselves and their ability to deal effectively with life), (d) assessment of program effects across time, including how programs affect long-term development and children's ability to avoid serious problems (e.g., mental health problems, prolonged grief) and to lead healthy and fulfilling lives, (e) building of a knowledge base regarding cultural factors related to children and families' responses to the death of a parent and how culture can influence intervention implementation and effectiveness, and (f) assessment of how well program effects are maintained when the program is delivered in existing community service systems.

Key Treatment Recommendations for Parentally Bereaved Children

Given that the primary goal of this article is to bridge the research-practice gap, two key treatment recommendations are highlighted below.

Providers should be educated regarding the importance of positive parenting

Both mental health specialists (e.g., clinical psychologists, social workers) and other professionals who work closely with children (e.g., teachers, school counselors) need to be educated regarding the importance of promoting specific positive parenting practices (e.g., warmth, open communication, and effective discipline) as well as parents' general role in their child's adaptation (e.g., increasing positive events, reducing negative events, shielding the child from adult emotions). The existing research, although limited, does point clearly to the parent as an important mechanism of intervention for parentally bereaved children, and that positive parenting by bereaved parents can be strengthened by existing programs.

Providers should focus both on the creation of a safe environment for parentally bereaved children to mourn and on cognitive and behavioral skill-building

The extant interventions indicate that effective interventions provide both an open environment for parentally bereaved children to understand and experience their grief and a set of skills that children can utilize to handle challenges related to the death and as well as life challenges more broadly. Although the evidence base is limited, this dual focus appears to be critical to allow children to adapt to the major changes that occur following the death of a parent.

Summary

The death of a parent during childhood is a traumatic event that places children at risk for several negative outcomes. While there is some evidence that clinicians can play an important role in supporting parentally bereaved children and their families, more research is needed to provide a strong evidence-based platform for what kinds of interventions are most helpful for which children. Research has identified several malleable child and family-level factors that can be important foci of clinical work with bereaved families, including providing education about the grief process; teaching parents and children techniques for increasing children's self-esteem, adaptive control beliefs, positive coping, and support for emotional expression; and teaching parents strategies to enhance the quality of the parent-child relationship and to increase positive family interactions as well as to decrease parent psychological distress and negative life events that occur for the children and parent. These potentially malleable mediators of outcomes for parentally bereaved children provide valuable starting points for development of intervention strategies to promote the healthy adaptation of these children and their families.

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