

Commissioned Review

Childhood Bereavement: Consequences and Therapeutic Approaches

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Introduction

Many professionals are unaware that there has been an enormous expansion in our understanding of bereavement during the last decade. Researchers have questioned many of the old beliefs held by clinicians and researchers alike about different aspects of grief, i.e. that grief follows certain stages, that everybody will react with intense distress, and that grief is time limited, etc. Many of these beliefs lack empirical support (see Stroebe, Stroebe & Hansson, 1993). In the area of childhood bereavement many old beliefs prevail.

It is widely believed that children must mourn, that they must go through deep pain, they must detach their feelings from the dead person and the concept of phases prevail in the thinking about children's reactions (e.g. see Costa & Holiday, 1992). Silverman, Nickman & Worden (1992), pointed out how such conceptualizations that prescribe detachment from the dead person were drawn primarily from clinical interactions with troubled people seeking help for their problems. They state that bereavement should not be viewed as a state which ends or from which the child should recover, and argue for a process view where the loss is negotiated or renegotiated over time as the child develops and can view themselves and others differently at different developmental levels. They describe how children develop an inner construction or representation of a dead parent, and how this facilitates their coping with the loss as they continue to keep the loved one present in their inner life in various ways.

Another widely held belief is that bereaved children will lose self-esteem (Costa & Holiday, 1992), but several studies have failed to support such a notion (Balk, 1983; 1990), and some have even showed that self-esteem can improve (Balk, 1983; Martinson, Davies & McClowry, 1987). As conceptions or misconceptions about grief guide our thinking about how children react and what we can do to help them, it is important that we continue to critically review what is a fact and what is a myth.

Reactions to bereavement

Immediate bereavement reactions

Without trying to give an extensive description of children's reactions following the death of a parent, sibling or friend, some important findings over the last decades will be reviewed. Conclusions are mostly based on data from children and adolescents who experienced their loss at a time when much less attention was given to children's grief by the adult community. Research conducted in recent years finds less psychopathology in children following a loss than even a decade ago.

Following the death of a parent, immediate reactions often include feelings of daze or shock, together with disbelief and a sense of unreality. Dysphoria, social withdrawal, changes in appetite and sleep and school difficulties are among the common reactions in the period following the loss. Minor illnesses are also quite common, and grief sometimes becomes somatic, especially in preadolescent children.

Immediate reactions following sibling loss and the loss of a close friend involve shock

and numbness, confusion, depression, fear, guilt, sleep difficulties, worsened study habits, loneliness and anger, feelings of powerlessness and helplessness, and concentration difficulties. After a child's death increased parental anxiety for surviving children, often with resulting overprotection is very common.

Long-term reactions

Features described during the first year of bereavement encompass a wide variety of cognitive, affective and behavioural manifestations. These include sadness, crying and mild depression, yearning and longing for the lost person, irritability, anxiety, anger and aggressive behaviour, withdrawal, sleep disturbances, and different somatic or psychosomatic complaints, as well as academic problems. However, the diversity of reported reactions does not indicate any specific constellation of symptoms that can be considered typical.

Although normal, transient reactions are to be expected following the loss of a parent, sibling or close friend, there are conflicting conclusions regarding the development of long-lasting problems. Much of the conflict and confusion can be explained by methodological differences, limitations and restrictions. While considerable clinical and research literature from the 1970s and 1980s documented that the death of a parent placed a child at risk for psychopathology both concurrently and in adulthood, more recent research fails to replicate this finding (Sood et al., 1992, Fristed et al., 1993). Most children do not go on to develop psychopathology. Many studies, however, find thoughts about the deceased to linger on, with recurrent periods of distress, especially around holidays and anniversary dates.

Studies have also shown how the death of someone close can lead to 'positive' changes in children and adolescents. They can experience feelings of increased maturity, learn that there are ways to cope with adversity, and develop a greater appreciation of people (Balk, 1983, 1990; Martinson, Davies & McClowry, 1987). Parents report that their children are more compassionate

and understanding of others following the death of a sibling, and after parental death bereaved children take on more responsibility and become more helpful. Unfortunately children can also 'grow up too fast', taking on too much responsibility and we need to be sensitive to how roles are reallocated in a bereaved family.

Important issues in childhood bereavement

The nature of the pre-existing relationship

When a child loses a parent (or sibling) it is important to ask what kind of relationship existed prior to death, and what is the child's relationship to the surviving parent. If a child's relationship to a dying or dead parent has been close, but is more distant or problematic with the remaining parent, the child often feels particularly abandoned and vulnerable. Many adolescents report that they struggle with the relationship with their surviving parent, and indicate that their best help often comes from friends or peers.

Studies on sibling grief have seldom reported on the kind of relationship that existed between the siblings before death. As sibling conflict tops the list of family problems that parents bring to professionals (Dunn, 1993), the preloss relationship will be important to examine in future studies.

Siblings and friends can develop their own world of humour, play and shared fantasy, but there are large differences in such relationships. In some sibling or friendship relationships there is a lot of self-disclosure and discussion of feelings, while in other relationships this is rare. Imagine the difference when a sibling or friend dies where there was an intense and close relationship, compared to a less involved relationship. Such dimensions need more attention in future studies.

Unfortunately, few studies have looked at grief among friends, in spite of the intense relationships with peers, such as best friends, boyfriends and girlfriends, particularly in adolescence. Friends are not recognized as bereaved. There is no social status given to them during the arrangements surrounding death, and they have no natural role to play

in the rituals that support their emotional and cognitive adaption to the loss. Friends also lack a grieving family at home.

Maintaining the relationship

Following the death of a loved person a child maintains the relationship in various ways.

Table 1

Children maintain the relationship by:

- * Seeking out places of special significance.
- * By the use of linking objects, i.e. objects of concrete or symbolic significance.
- * Seeking out clothes, perfumes etc, to feel close to the deceased.
- * Talking to or having an inner dialogue with the deceased.
- * Feeling the presence of the deceased:
 - seeing the person in front of him/her
 - hearing the person's voice
 - feeling the presence without seeing him/her
 - imagining the dead person in heaven watching him/her
 - having 'visits' during dreams
- * Looking at albums, viewing videos, etc.

Silverman, Nickman & Worden (1992) found that 95 out of 125 children (77%) had kept something personal that belonged to their dead parents, things that had been given to them by the parent or that belonged to the deceased.

Through these experiences and also inner representations of the dead, the children can remain in a relationship with the loved person, and ease pain:

Liss (10 years old) regularly sprays her father's deodorant spray in the air, as this makes her feel particularly close to her father who committed suicide two years ago. Her mother comments: 'I feel the same way. We feel so close to him through the smell'.

Sometimes these experiences takes on a more hallucinatory nature, being mixed up

with fear of revenge from a dead person with whom an ambivalent relationship existed before the death. This can be interpreted as ghost phenomena, i.e. that the dead person is returning to haunt them.

Reunion fantasies are fairly common as representative of the children's wish to restore the relationship:

Cecilie (12 years old) found her father dead and came for help because of intrusive images of seeing him dead on the floor. She wished to be reunited with him in heaven, but made a comment reflecting a wish to retain the old relationship: 'What if I live to be eighty and come up to heaven? Then I will be much older than him. I would not like that. Then I would like to be twelve years old again'.

Temperament and personality

From a clinical viewpoint, parents often report vast differences in how children within the same family cope with their loss.

Research on resiliency in children has identified characteristics of children who despite environmental stressors and deprivations can function well (Milgram & Palti, 1993). Some children possess what Milgram & Palti (1993) have termed support-seeking and support-attracting characteristics that in various ways secure social support. They make friends easily with peers and adults, help others, enjoy positive relationships with others, and usually have received attention and care in their homes. In addition, the authors postulate that some children possess cognitive ability-enhancing characteristics that also can buffer the effects of environmental stress (i.e. can take the initiative, function autonomously, are reflective, alert, attentive to stimuli, self-confident, and relaxed). Christ et al. (1991) have expanded the concept of resiliency to encompass resilient families. Interestingly, they state that such families often seek out professional intervention and cooperate with offers of assistance. These families in many ways show the same support-attracting characteristics that Milgram

and Palti (1993) postulated for resilient children.

Several of the resilient characteristics just noted are the same as those found to be associated with low negative health risk among bereaved children. How temperament and buffering personality characteristics (resilient mechanisms) can help bereaved children are some of the complex tasks we need to study more thoroughly.

Developmental considerations

Children's understanding of death develops from a belief in the reversibility of death in the preschool years to a gradual understanding at age 6 or 7 of death's finality, irreversibility, and knowledge that all life functions have ceased. However, while this previously was tied to maturational stages in children's development, more emphasis is now placed on children's concrete experience with illness and death. Consider the following example:

Kyrre, my 4-year old son lost his best friend (same age) and this boy's sister (3 years old) who also was a good friend, in a traffic accident that killed their mother as well. He could not grasp what had happened and several times said: 'After the summer holiday they will come back'; 'In 14 days they will come'; 'When they come we will go bathing'. However, on the way back home after viewing them in their coffins, having stroked Tord (his best friend) on his cheek, his statements reflected a more elaborated understanding of death's finality: 'I can never go bathing with him anymore'; 'I can never play in the sandbox with him again; 'We will never go to fetch berries anymore'.

Although research has tried to find stages or ages where children are more at risk, no clear pattern has been established. From a theoretical viewpoint, it can be predicted that losing someone close to the time when a child is entering school or entering secondary school or high-school may interfere with

learning. There are several ways that school work can be affected by a loss: a) children may lose the motivation for schoolwork; b) a depressive reaction may slow cognitive functions; c) intrusive images and thoughts (especially following traumatic deaths) may interfere with concentration and memory functions; d) a child may try to suppress intrusive images or thoughts - but achieve this at the loss of creativity, spontaneity and other higher cognitive functions important for schoolwork; and e) the child may have to take on new functions in the family/household that takes time and energy away from school tasks. Given the degree of documented school problems that can follow childhood bereavement, preventive programs should include an educational focus that helps children keep up with their peers, and that sensitizes parents and teachers to both the immediate and long-term problems of concentration and motivation.

Interaction with parents, other adults and friends

A home climate of consistent care and support seems to be a protective factor attenuating the impact of the loss. However, at a time when the demand for attention and care is high from the child's side, the parents may function below their ordinary capacity as parents, due to the effects of the loss and/or trauma.

A common finding in bereavement studies is that many parents and other adults are unaware of children's feelings and thoughts, and the questions children are left with. Not only do parents and other adults underestimate children's need for information, but they underestimate the intensity, longevity and depth of children's reactions. Many children spend much time figuring out what is happening on the adult level, what they can do to help, and whether things will get better. Various clinical reports have illustrated how children get enmeshed in the family dynamics, taking active roles in 'saving' the family, caring for younger siblings, or pulling their parent(s) out of the grip of death. Clinically we find that children actively try to find ways to support, help or

cheer up their parents. They try to limit parents' grief in different ways:

Susan (12 years old) lost her father in an accident. Her mother, although able to continue her work, was exhausted when returning home. Susan took over the cooking and tried to cheer up her mother as best as she could. She tried to be exceptionally good to her mother - taking on a comforting, reassuring role. However, the mother cried a lot, something that angered Susan. She said to her mother: 'Don't you care about me? Why don't you stop crying and spend more time with me? You never say nice things to me anymore'. The mother had problems telling Susan how she felt as Susan did not want to talk about her father at all. Often the mother tried to keep a happy face at home, something that resulted in more tension building up, with occasional breakdowns. Joint sessions with mother and child improved communication between them.

Children have problems with getting precise, adequate and updated information about the illness and death of a close person. Parents generally underestimate the need to inform children, or they refrain from providing the child with information, often to protect, defend or otherwise keep the child from being hurt. Even adolescents report that the cause of parental death remains unclear either because they are not informed or because information was distorted or insufficient. Several studies have shown how children in families that provide open communication fare better than where communication is inadequate or insufficient.

Siegel et al. (1990) have shown that healthy parents perceived their competence to meet children's needs during the terminal illness of their spouse as significantly lowered, especially in the area of emotional sensitivity to their children's needs and in establishing and maintaining rules and discipline. Parents

raise the same concerns following sudden death. They often feel unable to meet their children's demands, and experience a decline in confidence in their own parenting. The change in family functioning and roles will be very different following the death of a parent or a child in a family. In the first case, there may be reduced financial resources, changes in leisure and social activities, and the parent may try to fulfil two roles at once. In addition, there may be a redistribution and change in the demands upon the child as well as the parent. Following the death of a child, both parents are still able to fulfil their roles, at least in theory. After a parent dies, an older child may take over parental functions, even a surrogate parental role, while following a sibling death the child sometimes tries to fulfil the role or identity of the dead child.

When both parents are grieving, as after a child's death, studies indicate that there is more loneliness in bereaved children - and they have to seek out others (friends, other adults) to get support. Following the loss of a parent, adolescents have identified peers as those who were most helpful, although help from this group varied greatly. Gray (1989) found that adolescents were particularly helped by talking about the loss. However, many adolescents refrain from talking with friends, as they believe it will be too overwhelming for their friends, or perhaps because they are afraid of how their responses will be perceived by others. Balk (1990) found that more adolescents reported that their relationships with peers worsened rather than improved after a sibling's death. The presence of a best friend can offer comfort and support, but vulnerability is high if that relationship is disrupted.

The adolescent may also be especially afraid of losing emotional control, and unsure how emotional responses will be perceived by friends and their social network. Clinically, adolescents frequently suppress or repress their emotional responses, and may easily feel that their responses are unacceptable to their friends and peers.

When children and adolescents refrain from talking to parents, this often leads to

extreme worry in parents, and they think that their child or adolescent needs professional help. From clinical experience it seems that if the child functions well socially (does not isolate him/herself) and keeps up with his/her schoolwork, it should be regarded as a normal reaction that permits a gradual exposure to emotional pain.

Boys generally have more difficulties discussing feelings than girls (Dyregrov, 1988; Silverman & Worden, 1992). This is especially so for older boys, where the support network reinforces the containment of feelings. Males seem to be more controlling of their feelings than females following a loss, and it has been found that even 3- and 4-year-old boys were less able to discuss sad feelings than girls.

Trauma and grief

Regardless of type of loss, a sudden loss seems to shatter many children's sense of a secure and safe world. Sudden, traumatic loss makes them more prone to think that 'anything can happen', and even that 'something will soon happen'.

Although there is some research suggesting that sudden death can be more difficult to recover from for children and adolescents, more research is needed to understand the relative importance of being a witness or surviving the death of someone close. Previously, this author has described the interrelationship between trauma and grief in more detail (Dyregrov, 1993). The dramatic circumstances of a death may create strong intrusive recollections involving all sensory systems or recurring fantasies about what happened. Children may struggle with post-traumatic stress reactions and grief concurrently, but often the child has difficulties with reminiscing about the lost person because of intrusive recollections, or traumatic anxiety. Emotional constriction and avoidance of the painful memories may preclude normal grief. While memories and reminders that follow an anticipated death are often welcomed by the child and can help the child process the loss, most reminders that follow a traumatic death will trigger the memories of the horror of the death.

Working through the trauma takes priority over mourning.

Intervention

Important guidelines or aims in helping children in grief are:

- Ensure that the child gets information and facts about illness and death that are necessary to promote a concrete understanding and grip' on the situation.
- Increase parental understanding of the nature and range of children's bereavement reactions at different developmental stages - and their support needs at these stages.
- Identify misconceptions, misunderstandings, misperceptions, and magical thinking that create difficulties for the child.
- Support and help the child's caregivers to promote their capacity to provide a positive recovery environment for the child.
- Give the child permission to grieve and stimulate ventilation of feelings.
- Provide the child with anticipatory information regarding usual grief reactions that allows the child a proper interpretation of his or her own thoughts and reactions.
- Reestablish routines concerning kindergarten, school and home to help the child regain security and order in their world.
- Stimulate reintegration in kindergarten and school by providing staff with information that facilitates the staff's understanding of the child, and enlist the personnel's help in promoting peer interactions and peer support.
- Stimulate the child's inherent resources to handle the situation and secure social support, including how to respond to parental reactions.
- Help the child in forming new attachments, including the sometimes difficult acceptance of a new partner for his or her surviving parent following a parental loss.

Although a variety of clinical programs to help and support bereaved children have been described in the clinical literature, few programs have been evaluated. Children with fatally ill parents have been helped by intervention programs instigated before death and providing follow-up after death. Brief psychological intervention based on parent guidance has been used to enhance children's

relationship to their surviving parent. Parents have been provided with support, knowledge and insight to help them understand and meet their children's heightened needs for emotional support and physical care. Programs have provided opportunities for catharsis, realistic perspectives on the outcome of the disease, affective clarifications, support and occasional environmental manipulations. Reinforcing parental competence, stimulating open family communication about the illness, advice on maintaining rules and discipline, and securing stability in the child's environment has usually been part of the intervention, as have preparation for the death and assisting the well parent and children in facing the grief process.

Counselling can reduce emotional distance within the family and keep the family unit functional. It can help family members reallocate their roles, and provide a normative perspective on the feelings that are experienced, as well as provide helpful coping advice based on accumulated experience from other families.

Following the death of a family member, programs have been specifically aimed at preventing parental demoralization through teaching them relationship skills, increasing positive exchanges between family members, increasing quality time between the parent and child, planning stable positive events (such as a regular bedtime talk or a regular family meal), and improving coping with stressful family events. The aims of other programs have been to promote mourning in both the children and the surviving parent, and to improve communication between them. A review of the events leading up to the death are often conducted, and play material appropriate to children's age and developmental stage have been used to help them talk about the loss and associated feelings.

Special programs have been outlined in the event of a parent being murdered, especially when father kills mother, including procedures in relation to placement, emotional first aid, therapy, court procedures

and reconciliation (Hendriks, Black & Kaplan, 1993).

Early interventions aimed at supporting parents often follow an outreach model where the professional actively clarifies issues, sets goals, gives concrete advice, helps parents' anticipate problems, and plans responses, while all the time fostering a collaborative effort aimed at stimulating parental competence and resources. This indirect targeting of children in the early intervention following the loss, can be changed to a more direct child intervention when the child shows very pronounced behavioral changes, school problems or isolation from his or her social environment. When professionals target the children too early, parents may be rendered more helpless and out of control. However, professional intervention may be warranted when the child has witnessed or experienced the death of a loved one in a particularly grotesque or traumatic death.

Primary crisis intervention for families with bereaved children should help them develop an open, honest and direct way of communicating about different aspects of the loss. Parents or surviving parents need to be made aware of children's cognitive understanding and emotional reactions to a loss, and that the child's experience of the loss often differs from that of the parent(s). Written and verbal information provided to the family can heighten parents' awareness of the child's needs.

As intra-familial problems increase over time, follow-up should continue to ensure that intra-familial communication is facilitated. Children sometimes get confused when they observe that parents return to normal work and normal life, and take this as an indication that they are 'over the death', while the children still harbour sad feelings and longings inside. Some children think adults have a special way of overcoming the loss. To prevent fantasies, misperceptions and wrong interpretations adults must be willing to share their thoughts and feelings by giving children a report 'from the inside'. In this way longing and yearning can be shared, and differences between adults' and children's reactions understood and accepted.

For intervention purposes we do well to remember that children and adolescents usually benefit from explicit and concrete information about all aspects of a disease or a death. As adults it is not enough to know we have informed children, but we need to know how our information was interpreted and understood. Children easily pick up or understand that parents or other adults prefer them not to know, talk or react to the event, and they easily conform to adult wishes. Parents benefit from being told that painful feelings are normal and expected and that the best support they can give their children is to share and help them bear facts and feelings, not shield and protect them.

The opportunity to say goodbye is important, whether following anticipated or sudden death. The use of rituals is especially important in this regard, as they give children a possibility to express their grief in a direct nonverbal manner. Unfortunately many children and adolescents are not offered this opportunity, and report anger, guilt, frustration and disappointment at this. Guidance on how to prepare for and support a child through the viewing of a dead person is found in Dyregrov (1991). The child must be thoroughly informed about the sensory impressions they will experience (how the room is decorated, how the dead person looks, the coolness of the body, etc.) and they need the support of a person they trust through the experience. The child must be allowed to concretize their goodbye (placing a letter, drawing, toy or other symbolic object in the coffin), and have the opportunity to talk about the situation afterwards.

Parents must be able to stay with the children when they struggle with the difficult questions of why it happened and where the dead person is now, etc. Adults often fail to listen for the hidden meaning behind children's questions, being too eager to reassure them and give firm answers to questions that concern the uncertain existential areas of life. We underestimate children's need for making sense of what has happened. This existential dimension where children dwell on issues concerning perspectives on life, other relationships, the

future and themselves, easily goes unrecognized. If we do not recognize and communicate with children about these issues, they may feel alone or isolated.

When the child has survived an event where a loved one was killed, or he or she found the dead person or witnessed the death, a direct approach that helps the child process in detail the traumatic circumstances should be taken. Depending on the age, the child can go through the event in play or in conversation. Preschool children may enact the traumatic event many times in the weeks following the event, and adequate play material should be present to facilitate their processing. Interventions for preschool children must include explanations and reassurances that can prevent unnecessary guilt as their cognitive immaturity and magical or egocentric thinking can lead them to think that the event was caused by their own thoughts or actions.

Hilde experienced that her mother threw herself off a high bridge when Hilde was 7 years old. Three and a half years later she said that at first she thought that her mother did this because Hilde had not made up her room.

Music, art and bibliotherapy can help children in grief in most age groups. By choosing expressive means geared towards evoking targeted emotions, the child's similar feelings can emerge and be expressed. Art activities can help children symbolically express different feelings, difficult to express through words.

The kindergarden and school system are key resources for helping children. Children spend much time in these institutions, they are staffed with personnel attentive to children's needs, who know the children well and that the children trust.

Early intervention in the kindergarden in preparation for and/or after the loss of a peer may help prevent unnecessary anxiety and confusion. Provision of adequate disease or death-related play-material, proper preparation of the peers for what is going to

happen, and appropriate books to read for children are helpful in this regard. Children are often concerned about: 'Why were the doctors not able to help the child?'; 'Where is he/she now?'; 'Can this happen to me?' (e.g. hair falling off, becoming very ill or die).

Meeting(s) and written information for concerned parents informing them about the illness and/or death, and the steps planned or taken to help peers integrate the event, as well as advice on how they can assist their children should be an integral part of the kindergarten intervention.

In some areas kindergartens and schools have developed good crisis contingency plans, in others children get little attention following losses. Practical guidelines on how to help children in crisis within the school-system have recently become available (e.g. Yule & Gold, 1993).

Clinical intervention should help mobilize supportive social relationships. The child can be stimulated to make use of prior relationships, or new relationships can be stimulated through grief group membership. Although group interventions are widely used, little empirical work exists that document their effect. However, the fact that children who participate in such groups report that they are important and helpful makes them important in themselves. Research on grief groups in general do indicate that they should be structured, time limited and have a clear focus for each session. Clinically there is some consensus that the best group size is about six to eight members, that similarity in age and maturity is desirable, that groups can be held parallel to groups for parents, and that there should be professional but not too directive leadership. The groups can combine verbal and nonverbal methods of communication and expression, provide opportunities for sharing experiences, information and facts, stimulate helpful methods of coping, and reactions can be normalized. In addition, groups reach many children, and provide a possibility for screening those in need of further help.

Conclusion

From a period that focussed on symptomatology and psychopathology, the area of childhood bereavement is coming of age. A more differentiated and fuller understanding of the complex interactions between the child and the dead person, the child's personality and experience, and the recovery environment of the child, is developing. Most children grieve and continue to grieve, but do so in their own way and at their own pace. Their responses vary greatly, and although they continue to experience periods of distress, many become more mature and perceptive as a consequence of the loss. As adults, our challenge is to find ways to help the child confronting the loss in a way that allows him or her to gradually master it and continue his or her development.

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