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Bereavement in childhood: the impact on psychological and educational outcomes and the effectiveness of support services

Rodie Akerman and

June Statham

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Summary

This paper provides a brief overview of educational and psychological outcomes for children and young people bereaved of a parent or sibling, and the effectiveness of services provided for this group. It finds that most children do experience some negative impact on their psychological well-being, which may continue to emerge – and in some cases intensify - for at least two years following the death. Grief is a normal response to death, and many children's reactions are below the level that would indicate disorder. However, a substantial minority will experience clinical levels of difficulty. There is little specific evidence on the impact of childhood bereavement on educational attainment. That which exists suggests that for some children there may be effects on concentration, attendance and attainment, and that these effects are not always short term. The quantitative data on long-term outcomes from parental bereavement in childhood present a complex and contradictory picture, and it is likely that polarised responses from different individuals contribute to the complexity of the longitudinal findings. A new analysis of the 1970 birth cohort study suggests that – after taking account of potentially confounding factors - there may be some longer-term impact associated with childhood bereavement but this was limited when family background was taken into account. For women, this includes outcomes at age 30 such as having any qualification, being unemployed, having symptoms of depression or being a smoker; for men the main long-term impact was found to be raised unemployment.

When children do show a significant negative impact from their experience of bereavement, there is some evidence that specialist interventions and programmes can be helpful, especially those which also strengthen the protective factors within a child's life for example by providing support to parents as well. Even children who do not exhibit clinical levels of distress may benefit in the longer term from programmes which normalize their grief and strengthen their coping strategies. The key conclusion from the evidence reviewed is the importance of a differentiated response to childhood bereavement, taking account of each child's needs and circumstances. This could include both proactive elements applied to whole schools, as well as provision for individual children who have experienced bereavement. Examples of the former might include programmes to strengthen all children's resilience, including elements relating to their capacity to respond to their own or their peers' experiences of death, or to educate teachers in the ways that children grieve. For individual bereaved children, schools might provide differential levels and forms of support and interventions according to the child's needs and preferences.

1. Introduction

1.1 Background and prevalence

Bereavement is one of a range of difficult life events that children and young people may face. Among a nationally representative sample of children aged 5 to 16, 3.5% had experienced the death of a parent or sibling (Fauth et al., 2009). Since many of these children were still young, the likelihood of losing a parent or sibling over the whole of childhood is bound to be higher. A new analysis of data from the British Cohort Study 1970, a longitudinal study of over 11,000 children born in 1970, reported that 5% of these children when interviewed at age 30 had experienced the death of a parent or sibling by the time they were 16 (Parsons, 2011). Children may also experience the death of a friend and/or of other close relatives apart from their immediate family. One in sixteen 5- to 16-year-olds had experienced the death of a friend, according to the Office for National Statistics survey data analysed by Fauth et al.,2009 (as described above, this will be an underestimate of the proportion who will experience bereavement of a friend by the time they reach 16). In another study of 11- to 16-year-olds, over three quarters (78%) reported that at least one of their close relatives or friends had died (Harrison and Harrington, 2001).

Childhood bereavement may have both a short-term and longer-term impact on children's wellbeing, including their psychological health and educational achievement, yet there is little clarity about the kind of support that such children might need, nor the extent to which it is provided. The Childhood Bereavement Network undertook a survey of all local authorities and Primary Care Trusts in England at the end of 2009, but was unable to obtain a clear picture of the support on offer (Penny, 2010). It is suggested that the relatively low response rate to this survey (35% of local authorities) despite reminders, and discrepancies in survey responses, indicates that bereaved children's needs are not recognised as the particular responsibility of any department or aspect of children's services. Few local areas included the specific needs of bereaved children in the Children and Young People's Plan which they were required at the time to produce, or reported having a specialist childhood bereavement service. However, respondents sometimes noted that bereaved children's needs were addressed through more general plans and strategies, such as the Targeted Mental Health in Schools programme (2008-11) (TaMHS) and Child and Adolescent Mental Health Services (CAMHS).

This literature review was commissioned by the Department for Education and undertaken by the Childhood Wellbeing Research Centre as part of the 'fast response' programme of work to inform policy development. It builds on an internal review undertaken by research analysts within the Department, and also incorporates headline findings from a preliminary analysis of British Cohort Study

data, commissioned alongside this review. It was not feasible within the timescale to undertake a fully comprehensive review of the literature, but the aim has been to provide an overview of the main findings from key research studies and relevant reviews published since 2000, identified through systematic searching of journal articles, and supplemented by additional key resources (as explained below).

1.2 Scope of the review

The review focuses on literature relating to two main questions:

a) What is the impact of childhood bereavement on children's psychological and educational outcomes?

b) How effective are services or interventions intended to address childhood bereavement?

The following inclusion criteria were applied:

- Bereavement of children and young people (up to age 16)
- Children who lose a parent or sibling, rather than a less immediate relative (such as a grandparent) or a friend
- Impact in the areas of educational achievement (school attainment) and psychological/emotional wellbeing, including in later life
- Evidence of differential impact (for example according to the child's gender, age or the nature of the death)
- Protective and resilience factors that might influence outcomes
- Evidence on the effectiveness of services to support bereaved children

Broader issues such as the impact of childhood bereavement on offending behaviours, early sexual behaviour and partnering were outside the scope of this review but have been considered elsewhere, for example in Jane Ribbens McCarthy's reviews (2005, 2006).

1.3 Review methods

A search was carried out in the British Education Index, Australian Education Index, ERIC and PsychInfo databases, and Google Scholar. Search terms included children, young people, bereavement, death, grief, education, achievement, emotional wellbeing, mental health, impact and outcomes – and combinations of these and similar terms. Key websites such as the Childhood Bereavement Network were also searched. The search was restricted to material published since 2000, although a small number of earlier key studies that underpin some of the more recent

research was also included. Reports identified in the initial review by the Department for Education were additionally assessed for relevance.

Articles were then excluded if they:

- consisted of a case study of a single child (usually investigating the effects of psychotherapeutic counselling)
- focused on bereavement in war situations or in very different country contexts from the UK (such as children bereaved by AIDS in Africa)
- dealt with adolescent suicide or suicide prevention
- consisted of commentary rather than evidence.

This resulted in a total of 88 articles, books and reports on which this review is based.

1.4 The nature of the evidence

The studies identified were split evenly between those that covered outcomes for bereaved children and young people, and those concerning services or interventions. A few studies covered both outcomes and services. The studies were also split evenly between those that considered bereaved children and young people in general, not differentiating by relationship with the person who died, and those focusing on children and young people bereaved of a parent. Few studies were found which focused specifically on sibling bereavement.

In terms of the type of death, the studies covered children bereaved by suicide, illness (such as cancer or HIV/AIDS) and homicide or other violent or sudden death, although many did not specify the circumstances of the bereavement. Most of the literature referred to a wide age range of children or did not identify children's ages: where findings referred to a specific age group this was more commonly 'young people', 'adolescents' or 'teenagers' rather than children under the age of twelve.

There appears to be far less literature on the impact of childhood bereavement on children's educational outcomes compared to their emotional and psychological wellbeing, and in particular a lack of longitudinal research considering whether there is a long-term impact on educational qualifications and other outcomes when children reach adulthood (the results of an analysis of the British Cohort Study 1970 undertaken alongside this review begin to address this gap). Initial searches identified a large number of studies that report on the potential effects of bereavement on children and suggest how schools may help them to cope, but there were fewer studies reporting empirical evidence of outcomes, especially outcomes in the longer term or outcomes for bereaved children compared with those for non-bereaved children from similar backgrounds and circumstances.

With important exceptions (such as the Harvard Child Bereavement Study, a key study from the 1990s and the most robust study to date which continues to be widely drawn on for later studies), research on the impact of childhood bereavement or the effectiveness of interventions to support bereaved children tends to involve small sample sizes, lacks comparison groups and rarely considers how effects change or develop over time. These methodological weaknesses account in part for the complex and contradictory nature of the evidence. In addition, the 'opposite effects' which bereavement may have in the lives of different children (discussed below in relation to responses in school) may cancel each other out when aggregated for statistical analysis. Such statistical analyses may thus hide some of the complexities in the data and obscure the extent to which individual children's responses to death may be quite polarised (Ribbens McCarthy, 2006).

1.5 Structure of the report

The rest of this review is divided into two parts. The first provides an overview of the impact of childhood bereavement on psychological wellbeing and educational outcomes, summarises findings from a new analysis of British Cohort Study data, and discusses factors which the literature suggests either place children at greater risk of negative outcomes from childhood bereavement or help to protect them from this. The second section describes services to support bereaved children and their families and considers evidence for their effectiveness.

2. The impact of childhood bereavement

2.1 Psychological wellbeing

Reviews of studies from various countries on childhood bereavement following parental death (Dowdney, 2000; Haine et al., 2008) report that children in this situation do experience a wide range of emotional and behavioural responses to grief which could be classified as 'nonspecific disturbance'. Responses may include anxiety, depressive symptoms, fears, angry outbursts, and regression regarding developmental milestones (Dowdney, 2000); lower self-esteem and greater external locus of control (Haine et al., 2008) and somatisation (Servaty and Hayslip, 2001). These reviews suggest that parents tend to report fewer symptoms and disorder in their children than children do themselves. The child often experiences an increase in anxiety with a focus on concerns about further loss, the safety of other family members, and fears around separation. Mild depressive symptoms appear to be frequent, and can persist for at least a year.

Christ and Christ (2006) report that in stable, adequately resourced family situations, around 20% of children will have clinical level symptoms extending beyond a year after a parent's death (see also Dowdney, 2000). Higher rates of clinical levels of symptoms are found in samples of children in families seeking help from bereavement services: for example Lin et al reported levels of 40%. Stokes (2009) reports on the observed resilience of children referred for direct services from a community based child bereavement service (approximately 400 children a year for 15 years). An estimated 10% were highly resilient (easy to engage, likely to have a supportive parent and needing only the core aspects of the service). The majority (75%) were seen as moderately resilient (probably prompted to access the service by a professional, in some cases needing 1:1 sessions before participating in a group programme, needing to re-engage with the service at times of future transition). The remaining 15% were generally highly vulnerable (affected by a range of social and psychological factors, lacking adequate parental support or in public care). Relationships with key workers and frontline agencies was key to successful service delivery.

Haine et al (2008) report that many parentally bereaved children adapt well and do not experience serious problems. However, they report an elevation of risk for negative outcomes. A survey by the Office for National Statistics of the mental health of 5-15 year olds in Great Britain in 1999 found significant associations between mental disorder and the death of a parent, sibling or close friend (Meltzer et al 2000). Secondary analysis of data from a subsequent ONS survey of mental health among 5 -16 year-olds in 2005 suggested that bereaved children are approximately one-and-a-half times more likely than other children to be diagnosed with 'any' mental disorder (Fauth et al., 2009). The analysis did not indicate whether these conditions were present before bereavement and so was not able to comment on whether the

bereavement caused the mental ill health. The study found that children whose parent or sibling had died were more likely than other children to have problems with anxiety and drinking, whereas children who had experienced the death of a friend were more likely to display conduct problems, use substances and engage in troublesome acts such as staying out late or truanting from school. This study did not find higher rates of 'clinical levels' of depression among bereaved children, although this is a high threshold and so milder forms are likely to have remained hidden.

In a survey of 1746 11-16 year olds, Harrison and Harrington found that the death of a first- or second-degree relative or friend was associated with depressive symptoms, while no such association was found with the death of other relatives or pets. Young people who had been bereaved of a parent had a mean self-report of depressive symptoms of 19.7 compared to 14.9 among those not bereaved of a parent; those bereaved of a sibling had a mean self report of 21.9 compared to 14.8 among those not bereaved of a sibling (Harrington and Harrington, 2001). The degree to which young people felt their life had changed since the death mediated the association between depressive symptoms and death of an adult relative, but not between depression and the death of a sibling or friend.

A study of all young people born in Denmark between 1983 and 1989 found that those young people who had been bereaved of a parent were 1.71 times as likely to have attempted suicide as their non-bereaved peers, although the increased risk associated with the mother's death disappeared when fathers had a medium or high income. Losing both parents increased the relative risk to 2.7 (Jakobsen and Christiansen, 2011). The young people in this Danish study were aged between 10 and 22.

Implications over time

While the initial grief responses tend to decline over time, mental health and other problems can persist or even increase. There can be fluctuations over time, and delayed grief reactions may be triggered when subsequent life changes occur (Christ, 2000), such as the remaining parent re-marrying or the bereaved person having their own child. Any negative events that follow the death, and the child's resources for coping with these, seem to be significant for the long term (Haine et al. 2008). However, the difficulty of disentangling the impact of bereavement from other factors increases with the passage of time since the death, so drawing conclusions about long-term impact is fraught with problems.

Dowdney (2000) reports that suitable longitudinal studies do not exist to indicate whether children's emotional or behavioural disturbance following bereavement will persist. However, Christ and Christ (2006) cite Worden's (1996) findings from the Harvard Bereavement Study of 'late effects' of child bereavement – with differences in the levels of clinical difficulty between parentally bereaved school-aged children and their non-bereaved controls becoming significant two years after the death. At

this point, bereaved children's self-esteem and beliefs about their control over life were significantly lower than those of their peers.

Harrington and Harrison (2001) found that deaths that had occurred more than five years previously were just as likely to be associated with depressive symptoms among 11-16 year olds as those that had occurred more recently.

In relation to the implications of bereavement in childhood for adult mental health, longitudinal studies have found raised levels of depression among US adults who were bereaved as children (Mack, 2001) and of depressive symptoms at the age of 36 among women in the UK who were bereaved of a parent by age 16 (Parsons, 2011, see 2.3 below).

A retrospective cohort study explored outcomes for the offspring of all parents who died from suicide, accident or other causes in Sweden between 1969 and 2004 (Wilcox et al., 2010). The participants were all bereaved during their childhood or adolescence, but some had reached late adulthood by the time of the study. Those who experienced the suicide of a parent during their childhood or adolescence were three times more likely than their non-bereaved peers to themselves die by suicide, whilst those who experienced the accidental death of a parent while they were aged between 0 and 12 were twice as likely.

Those who experienced the death of a parent had a greater risk of hospitalization for all types of psychiatric disorder and suicide attempts, as well as violent criminal convictions: generally the risk was greater for those whose parent died by suicide. Among survivors of suicide, those aged between 0 and 12 when their parent died were at particularly high risk for hospitalization for drug use disorders and psychosis than were older age groups. Across mode of death, those whose parent died before they were 12 were at greater risk than older age groups for a variety of psychiatric difficulties. Offspring who had an inpatient psychiatric admission before their parent's death or who were bereaved of both parents were excluded from the study, meaning the estimates of risk are likely to be conservative (Wilcox et al., 2010).

More positive outcomes

Not all outcomes of parental bereavement are negative. Thirteen young people who had attended a child bereavement service in Brewer and Sparkes' ethnographic study (2011a) reported a range of ways in which they had derived some positive psychological changes or post-traumatic growth through their experiences of parental bereavement and participation in the service. These include a positive outlook, gratitude, appreciation of life, desire to live life to the full, and altruism. Wolchik et al (2008) found that over six years after the death of a parent, intra- and interpersonal coping processes explained improvements in several areas of growth including developing new areas of interest, accepting help from others, and coming to a realisation of personal strengths. Such studies point to the great range of responses

that young people may develop to the experience of the death of a parent or sibling, with some finding ways to turn their experience towards positive outcomes, while others may struggle in ways that persist across their life course.

2.2 Educational outcomes

There is relatively little evidence concerning the relationship between child bereavement and educational outcomes, and what there is tends to suffer from the limitation of retrospective parental recall of child functioning prior to the death, and a reliance on indirect measures of educational attainment. Dowdney (2000) notes that this limitation, combined with child differences in academic skills, competence, and response to parental death, means that it is difficult to conclude more than that outcomes will vary between children. A more recent review (Haine et al., 2008) concludes that the balance of evidence does suggest that parentally bereaved children are at risk of lower academic success. For example, a UK study which reported on the GCSE results of 73 pupils who had lost a parent and 24 who had lost a sibling (Abdelnoor and Hollins, 2004b) found that bereaved participants underachieved significantly depending upon age, gender and parents' employment history. The exam scores of children bereaved before the age of five or at 12 years old were significantly more affected than those bereaved at other ages. The researchers suggested that the effect of bereavement may be prolonged, and that intermittent support could be needed throughout secondary and perhaps tertiary education. School attendance seemed to be unaffected, however.

Dyregov (2004), on the other hand, found that bereaved children and those exposed to trauma *were* more absent from school than others, on average. This review also found that school performance could deteriorate following the event, especially in school subjects demanding a high level of attention. While the reasons for this deterioration are not fully known, likely factors are a loss of motivation, a diversion of attention to intrusive material and cognitive processing, and a lowering of cognitive pace due to depression. Lack of perceived support from parents, classmates and teachers has also been associated with more post-traumatic stress and lower attainment in school.

There is some suggestion from clinical experience and research interviews that some bereaved children try harder and do better at school as a form of tribute to their dead parent (Dowdney, 2000). Others report more difficulty in concentration, and distress, particularly when memories of their dead parent are evoked in school. In addition teachers of bereaved children rate them as being significantly less attentive than matched classroom controls, although it is not clear whether this impacts in any systematic way on attainment or school relationships.

2.3 Long term impact – BCS70 analysis

Preliminary analysis of data from the 1970 British Cohort Study (BCS70), carried out especially for this review (Parsons, 2011), provides new information on the impact of childhood bereavement for a normative sample of children, born in 1970. The analysis considered a range of outcomes at age 30 for over 500 participants who had experienced the death of their mother or father by the time they were 16 (this had occurred for 5% of the whole sample). In order to control for confounding factors, outcomes for children in bereaved families were compared with outcomes for those in 'disrupted' families, where the child's mother or father had separated or divorced, or a situation had occurred that resulted in a change to a parental figure (such as a grandmother, step-parent or sibling taking on a parenting role). Family background characteristics were also taken into account.

This BCS70 analysis showed that childhood bereavement does have some long-term impact, but that the effect is limited after family background is taken into account. Other forms of family disruption have a different and more lasting influence on a child's ability to negotiate a successful transition to adult life than does childhood bereavement. Childhood bereavement was found to impact negatively on only one measure for men at age 30, employment rates. It impacted to some extent on a wider range of measures for women at age 30, including gaining any sort of qualification, being unemployed, having symptoms associated with depression and being a smoker.

2.4 Risk and protective factors

There is some evidence in the literature about factors which might increase children's likelihood of experiencing bereavement, and factors which might make some groups more vulnerable than others following bereavement.

Risk of bereavement

Adult and child mortality patterns vary significantly by social class, geography and locality, and young people living in deprived areas are more likely to experience the death of a parent or sibling (Ribbens McCarthy, 2006). Among the 1970 cohort, at birth, children who went on to be bereaved of a parent were less likely than their peers to have parents with some experience of extended education or a father in a professional or managerial occupation, and more likely to have a father not in work (Parsons, 2011). Variations in mortality according to ethnic group are not so well established but may also influence children's likelihood of being bereaved (Ribbens McCarthy, 2006).

Moderating factors influencing responses to bereavement

In her review of the literature, Ribbens McCarthy (2006) summarises evidence on a range of moderating and mediating factors which may account for differences in the risk that bereavement poses in the lives of different children and young people, highlighting the complexities and contradictions in the evidence. Cerel et al. (2006) reported that higher family socio-economic status and lower surviving parents' level of depressive symptoms were associated with better outcomes. In the case of the particular group of children bereaved by parental suicide, Ratnarajah and Schofield's (2007) review found that children's adjustment was influenced by several mediating factors: the child's age, personal attributes, level of family support, social environment, and economic and environmental factors, as well as how the child understood and made sense of the death.

However among bereaved children and young people in general, Mack (2001) found no association between a child's age (or stage of cognitive or emotional development) and response to bereavement, so the evidence on age as a moderating factor is inconclusive. In relation to stressful events in general, not just bereavement, Gerhard and Buehler (2004) found that school achievement and self-esteem compensated for risk, although these offered only limited protection when risk factors operate across more than one domain of children's lives. A recent ethnographic study found that having an area of competence (eg sport, music or academic achievement) was one of the factors that young people identified as helping them to live with their grief at the death of a parent (Brewer and Sparkes, 2011b). The independent review of child and adolescent mental health services in England (Department of Health, 2008) identified a range of risk and protective factors for emotional wellbeing which operate at the child, family and community/ environmental level.

In terms of **family relationships,** Ribbens McCarthy (2006) discusses the significance of relationships before the death, such as level of ambivalence which the young person had towards the person who had died. She also explores literature on the importance of relationships after the death, particularly that with a surviving parent following one parent's death. Broader research on childhood trauma suggests that the quality of relationships within the family are an important influence. An important factor is whether the child feels safe and secure within a loving supportive family with a surviving parent who is able to parent effectively. Studies consistently point to the importance of higher levels of caregiver warmth and lower levels of caregiver mental health problems in protecting against negative outcomes from the death of a primary caregiver (e.g. Christ, 2000; Lin et al., 2004; Luecken et al., 2009; Haine et al., 2006). This has implications for the kind of support and services needed (see section 3.2).

Young people in Brewer and Sparkes' study (2011b) identified the support they gained from positive relationships with their surviving parent, but also described the importance of an ongoing relationship with the person who had died, through visual

or auditory cues, doing things to continue the relationship, or having a ‘secret sense’ that the dead parent was still ‘around’ and supporting them.

Other forms of **social support** including friendships have been highlighted as important (Holland, 2001; Rask et al., 2002; Brewer and Sparkes, 2011b) but bereavement can itself impact on these relationships, making young people feel different from their peers and worried about relationships (Servaty and Hayslip, 2001). Bereavement may also provide a trigger for bullying (Cross, 2002). Those children who are more distressed are more likely to experience unsatisfactory peer relationships (Dowdney, 2000).

Gender, class and race are other factors explored in the literature (Ribbens McCarthy, 2006). Abdelnoor and Hollins (2004a) found that boys bereaved of fathers and girls bereaved of mothers were at increased risk. Boys in general were found in Dowdney’s (2000) review to exhibit higher levels of emotional and behavioural difficulties following bereavement, and Haine et al.’s (2008) review characterises boys as typically displaying higher levels of externalising behaviour problems, while girls display more internalising problems. Parsons (2011) found bereavement by the age of 16 to have more damaging implications in the lives of children and young people from more disadvantaged backgrounds.

The **nature of the death** may also be influential, including factors such as whether the young person expected it. The meanings that children and young people attach to the experience of bereavement seem to affect its impact, for example the extent to which they feel responsible or are able to understand the finality of death (Ratnarajah and Schofield, 2007), and the extent to which it leaves them feeling powerless (Ribbens McCarthy, 2007). Harrison and Harrington (2001) found that the impact of loss depended to an important extent on young people’s perception of how the loss had changed their lives.

Cultural factors are also relevant and should be taken into account. For example in some cultures, extended family members play a very significant role in a child’s life, and the death of someone who is not a first-degree relative can still have a profound effect (Salloum, 2007).

An accumulation of **multiple losses or other stressful events** seems to place bereaved children and young people at increased risk (e.g. Gerard and Buehler, 2004). Christ (2000) describes how ‘blunt trauma’ models which looked at the significance of a death for children’s subsequent psychopathology have given way to more sophisticated models of a ‘cascade of events’ set off by the death, alongside other stressors and mediating and moderating factors. Longitudinal studies have found that children and young people who have experienced three or more stressful events (e.g. family bereavement, divorce, serious illness or the death of a close friend) are significantly more likely to develop mental health difficulties (Meltzer et al., 2003; Parry-Langdon, 2008). The national CAMHS review also highlights the

significance of multiple stressors on children and young people's emotional wellbeing (Department of Health, 2008).

Analysis of a nationally representative sample of 5-16 year olds living in Great Britain (Fauth et al., 2009) showed that children and young people who have experienced the death of a parent or sibling are more likely than their non-bereaved peers to have experienced a range of other stressful events including a parent having a physical illness, serious mental illness or financial crisis. These children were six times more likely than their peers to have been looked after by the local authority at some point. They were living in the most disadvantaged backgrounds relative to other groups, in terms of living in lone parent households, economically inactive households, low earning households and households where educational attainment was low. However, such analyses are unable to demonstrate whether there is a causal link, or the direction of causality.

A common theme in the literature is that there is a wide range of outcomes for children who have experienced a close bereavement. All children and families are unique and have different experiences of bereavement and grief, and responses to them. For example, a qualitative study (Abdelnoor and Hollins, 2004a) found that while some children in their study took a "restorative approach" to school life, preferring to deal with loss-related issues elsewhere, others described chaos and distress in school following the bereavement and were generally more negative.

2.5 Models of impact

Various studies have attempted to provide a model to account for the impact of bereavement on children and young people. Rolls (2010) describes the contribution of psychological theories of cognitive development and resilience, psychoanalytic theories including attachment theory, and sociological approaches including the notion of the sequestration of death (hiding it from everyday life).

Psychological accounts of children's bereavement take account of the complex interacting factors influencing adaptation, such as the positive influence of factors like having a caring, supportive parent. Christ's **bereavement outcome model** (2000) accounts for the differences (and similarities) she observed in the grief of children in 184 families during the terminal illness and death of a parent to cancer. Luecken (2009) proposes a model of stress inoculation and stress sensitisation to account for children's differential responses following parental bereavement. Sandler and colleagues developed a **contextual resilience model** (2008b). The intention was to identify potentially malleable risk and protective factors at the level of the child or the family that were hypothesised to prevent problematic outcomes, and that could be targeted in interventions. These include increasing children's self-esteem and adaptive control beliefs; improving children's coping skills; supporting children to express the emotion they wish in adaptive ways; facilitating positive parent-child

relationships; parental warmth; parent-child communication; effective discipline; reducing parental distress; increasing positive family interactions; and reducing children's exposure to negative life events (Haine et al., 2008).

3. Effectiveness of services and interventions to support bereaved children

In order to assess effectiveness, it is first important to describe the services and interventions that are available. A survey in 2010 of support for bereaved children and young people in England revealed a variety of provision in local authority areas (Penny, 2010). Responses were received from just over a third of local authorities and just under a third of Primary Care Trusts, with a response from either the LA or PCT or both in 85 different areas (representing 56% of all LA areas). Providers of support included community-based child bereavement services, child and adolescent mental health services, young people and school counselling services, hospices, hospitals, education welfare and critical incident teams. Bereaved children's needs were also addressed through targeted mental health in schools programmes, healthy schools initiatives and curriculum development. However, the survey found little evidence of coordination of services, and low levels of planning to meet bereaved children's needs. There was little consistency as to whether a particular child, experiencing a particular type of bereavement, in a particular locality, would be offered supportive services, including basic information (Penny, 2010).

3.1 School based intervention programmes

The ways in which schools can support children going through a significant loss can be categorised as 'reactive', such as providing pastoral support in response to an event which has already happened; or 'proactive', for example providing training in loss awareness to staff, an example being the *Lost for Words* project developed in the Humberside area (Holland, 2008). Other proactive programmes aim to equip children and young people with the skills and knowledge to cope with bereavement and support their peers better. The UK resilience programme (Challen et al., 2011) would be an example of a proactive response to childhood bereavement, since it aimed to make all children better able to deal with difficult and stressful situations; while the Targeted Mental Health in Schools (TaMHS) programme (Wolpert et al., 2010) would be an example of a more reactive response since it focused on pupils identified as needing additional support (although often building on a broader whole-school approach).

Evaluation of the UK Resilience Programme found a significant short-run improvement in pupils' depression symptom scores and school attendance rates, but effects had largely disappeared a year later. There was also an impact on anxiety, but this was smaller, and concentrated in a few groups of pupils: boys, particularly boys with special educational needs or free school meal entitlement, and lower-attaining girls (Challen et al., 2011). In relation to the TAMHS programme, the

schools involved were reported to be developing a wide range of activities to address mental health difficulties which went beyond traditional psychological interventions, and the programme was well received by all those involved (workers, teachers, parents and pupils). However, the evaluation could find no statistically significant effect on primary or secondary school pupils who had emotional difficulties at outset compared to children in schools in local authorities that did not implement TaMHS (CAMHS EBPU et al., 2011). Neither the TaMHS nor UK Resilience Programme evaluation makes specific mention of children who have experienced parental bereavement.

Curriculum approaches

Some commentators have argued for the inclusion of topics of death and bereavement in the curriculum, given that bereavement is a common experience for young people and that they spend a significant proportion of their time in schools (Reid, 2002; Rowling, 2003; Wass, 2004). Children are also more aware of bereavement than adults tend to think (Bowie, 2000). PSHE has been suggested as a suitable area for exploring these topics, but they can also be covered in other subjects such as Religious Education, English and Biology (Job and Frances, 2004). It is suggested that this integration into the general curriculum could help to dispel myths and taboos, normalizing grief and making young people more aware of the support available, meaning they should be better able to deal with it themselves or support bereaved peers sensitively (Ribbens McCarthy, 2006).

While these topics have been included in non-statutory programmes of study in England, the degree to which these topics are actually included in the curriculum is not clear and surveys of teaching staff in the UK, Australia and Greece have shown a reluctance to explore these issues (Katz, 2001; Rowling, 2003; Papadatou et al., 2002). Holland (2001) and others argue that teachers could be helped through training and support, including a knowledge of the wider support available to bereaved pupils, and reassurance that they will not be expected to ‘counsel’ pupils themselves.

An integrated approach is suggested by Rowling (2003), where curriculum development is supported by the school’s organisation and ethos, including a flexible and responsive pastoral system that validates individuals’ grief and supports staff, and by partnerships with families, communities and services.

Pastoral support for bereaved children and young people

Most schools will have at least one recently bereaved pupil in their care at any point, yet surveys suggest that responses are generally uncoordinated. While local authorities will have a critical incident policy to guide staff in dealing with major incidents, many schools have been reported to lack policies in dealing with individual bereaved children in their community (Lowton and Higginson, 2002). The situation

may have improved since 2002 with the introduction of programmes to support pupils' mental health such as Social and Emotional Aspects of Learning (SEAL) and Targeted Mental Health in Schools (TaMHS). Suggestions for a more coordinated response to bereaved pupils include the inclusion of bereavement in relevant policies (Job and Frances, 2003); training, support and designation of particular staff (Holland, 2001; Reid, 2002); the provision of school counselling services and peer support groups and good links with local communities and specialist services (Rowling, 2003). Communication with families is key so that, where possible, children and young people's wishes about how their bereavement is dealt with in school are respected.

Various authors outline strategies that schools can use to assist students experiencing grief and loss, although these are not necessarily underpinned by research evidence (e.g. Ayyash-Abda, 2001). O'Connor and Templeton (2002) recommend group interventions such as SHIFT (Safe, Hopeful, Inclusive environment for Feelings and Thoughts), play therapy, family intervention and various ways of making memorials that a school can undertake. Holland (2004) describes 'good practice' for school practitioners in the immediate aftermath of the death (such as preparing classmates for the child's return to school) as well as subsequent forms of support for those who need it, such as access to a 'quiet room' or allocating a 'special person' if they need to talk.

The literature contains few examples of empirically evaluated interventions in schools designed to assist children who have experienced bereavement. An exception is an Australian study which evaluated ***Seasons for Growth***, an eight-week education programme for young people who have experienced the loss of a parent or significant other through separation, divorce or death (i.e. not only bereavement). Qualitative and quantitative methods were used to measure impact on 186 students aged between 12 and 18 years from eight different schools. Results indicated that the Seasons for Growth programme assisted female students to cope with loss, with a less pronounced effect on coping in male students (Frydenberg et al., 2006).

Specific interventions such as the Seasons for Growth programme are not the only way that schools can support bereaved children. Adults recalling their experiences of losing a parent when children, in the Project Iceberg study (Holland, 2001), reported feeling ignored, isolated, embarrassed or different when returning to school and believed that what would have helped was simply an acknowledgement of their loss and a kind word, with no need for a 'heavier' intervention. Similarly Harrison and Harrington (2001) found that most young people who had experienced childhood bereavement did not feel the need for professional services. This study found that the impact of the loss depended greatly on the young person's perception of how the loss had changed their lives, and that those who did use professional services tended to be those with higher levels of depressive symptoms, suggesting that service use was likely to have been appropriate.

3.2 Other sources of support for bereaved children, young people and their families

Studies by Rolls and Payne (2003, 2004) have described the range of specialist interventions and services for bereaved children and young people in the UK, and there is a growing literature on the nature of the services offered. They can include brief 1:1 and group support, residential camps, memory days, telephone and online support, and interventions for traumatic stress reactions (eg Monroe and Kraus, 2010; Stokes, 2004; 2009). Such services may be offered as a dedicated child bereavement service or as part of a broader host organisation such as a hospice or all-age bereavement service. As well as providing direct services to children and families, many organisations also provide training and support to other children's professionals (Rolls and Payne, 2003).

A survey of 108 bereavement services found that 73% were using a mixture of paid staff and volunteers, who came from a wide range of professional backgrounds including counselling, nursing, social work, medicine, psychology, art and play therapy. These services offered a range of activities to the bereaved child or the whole family, either individually or with others who had been bereaved (Rolls and Payne, 2003). Common service objectives across eight organisational case studies were to provide a secure place for exploration, access unspoken and unconscious feelings, help make sense of what had happened and how the users felt, help users manage those feelings, improve communication between family members, create memory and story, reduce feelings of isolation, and hold the possibility of hope for the future (Rolls and Payne, 2004). Stokes (2009) offers guidelines for practice in helping bereaved children to develop a resilient mindset.

Whole family approaches

Several studies suggest a need for support for parents of bereaved children, particularly for the surviving parent when one parent has died. In Rolls and Payne's survey (2003) 97% of services offered support to bereaved children *and* their families, with only a very small minority supporting children only. Studies have consistently pointed to the significance of the family context in influencing how children respond to the death of someone close to them; particularly the mental health and parenting capacities of the surviving parent after a child's mother or father had died (Christ, 2000; Haine et al., 2006).

Higher levels of warmth and discipline and lower levels of mental health problems in the child's primary caregiver after the bereavement have been associated with better child outcomes in terms of resilience (Lin et al. 2004), while parental unemployment is associated with worse outcomes (Abdelnoor and Hollins, 2004b). "Positive parenting", a measure constructed by Haine et al. (2006), was found to be protective against mental health problems among parentally bereaved children. Positive

parenting had a positive direct effect on such problems, independent of the effect of negative life events and across both genders.

Practice guides emanating from these studies discuss the importance of supporting surviving parents who will be adjusting to their new role as a lone parent and dealing with additional financial and practical stressors brought about by the death, as well as grieving themselves. For example, Haine et al (2008) describe a range of support for parents including reducing parental distress by helping parents to seek support and care for themselves; improving parental warmth by teaching parents listening skills, practising 'one on one time' and encouraging parents to increase their use of positive reinforcement; improving communication between parents and children; increasing effective discipline by normalising parents' difficulties and supporting them to be clear, consistent and calm in communicating their expectations; increasing positive family interactions; and reducing children's exposure to potentially stressful life events.

The availability of services

Among 53 local authorities responding to a survey carried out by the Childhood Bereavement Network (CBN) (Penny, 2010) nearly two thirds reported that they had an 'open access' service working across the whole area with children bereaved in any circumstances, and to which families could refer themselves directly. CBN estimates the figure may be closer to 69% across England. However, even where such services exist, they may only be able to see a very limited number of children due to funding difficulties, and families may need to travel long distances to access support (Ribbens McCarthy, 2006; Penny, 2010).

Additional forms of support may be available to those bereaved in particular circumstances, such as the anticipated death of a patient in a hospice's care. Children and young people facing a parent's serious illness are at increased risk of psychosocial problems and the time before the death may be the time of greatest anxiety and depression for the child (Thastum et al., 2009; Christ and Christ, 2006). Children and young people express a wish for information and communication during this time, but both parents and children describe the barriers to communicating openly in the family (Kennedy and Lloyd-Williams, 2009; MacPherson, 2005). Grace Christ (2006) provides guidance on supporting children at different stages of development, based on her parent guidance intervention which aimed to improve parental competence, communication about the facts of the illness, treatment, death and grief reactions, and consistency in caregiving and planning for the family. Studies of interventions with families where parents are terminally ill suggest positive effects on child and family functioning, including improvements in parenting skill and communication that increase with time (Haine et al. 2008).

Less support may be available to children bereaved through a sudden death such as road traffic accident or heart attack, once the acute involvement of emergency and health services is over (Penny, 2010).

Some groups of children and young people face particular barriers in accessing support for their bereavement, while at the same time being more likely to experience it. This includes those with learning disabilities (McEnhill, 2010), those in public care (Penny, 2007), young offenders (Vaswani, 2008) and those in custody (Penny, 2008).

The majority of bereaved children are unlikely to require referral to child and adolescent mental health services, but for those who do, as for other children requiring such specialist support, waiting lists are frequently long (Department of Health, 2008; Penny, 2010).

The benefits of support

Qualitative studies with bereaved children and young people, including those specifically bereaved by suicide, have explored their reasons for accessing services and the benefits they felt they gained from participation. Children and parents report wanting interventions to help them communicate in the family more about the person who has died (Braiden et al., 2009). Parents also access services because they want reassurance or support for their own emotional needs and their parenting, to meet their children's needs, and support the whole family unit (Braiden et al., 2009; Rolls and Payne, 2007). Children and parents reported better communication and understanding of one another's needs (Braiden, 2009). Children also reported feeling relieved, valuing the ability to talk about things they were worried about and to say what they wanted to someone who wouldn't get upset. Those who had participated in group sessions reported feeling less isolated. Children felt they understood more and were less worried about what had happened to them or the person who had died (Braiden et al., 2009; Rolls and Payne, 2007).

Parents reported finding it helpful to be with others and consoled that they weren't alone, and supported in their own grief. They reported new coping skills and felt more able to cope, release bottled-up feelings and think about the future. They felt more confident and able to support their child, as well as reassured, and noted improvements in communication in the family (Braiden et al., 2009; Rolls and Payne, 2007).

The effectiveness of support

These findings are consistent with evaluations of interventions, which have found that particular programmes can improve children's perceptions of their surviving parent's competence and communication (Christ et al., 2005).

The ***Family Bereavement Program*** is one of the few specific interventions for childhood bereavement that has been subjected to rigorous evaluation. The programme is designed to prevent potential mental health complications (such as depressive symptoms and conduct disorder) that may result from the death of a parent. It is based on a theoretical model which identifies and targets the 'mediating factors' through which any negative impact is thought to operate, such as parental demoralisation, negative life events, parental warmth, and stable positive events in the family. The programme targets the entire family and is designed to educate members about the grief process. It also creates a support network for families by connecting them with others who have experienced the same event, and facilitates adaptive coping through the use of a trained family advisor who has also experienced significant bereavement.

Randomised controlled evaluations have shown that the programme produced immediate improvements in a range of outcomes, including caregiver warmth and discipline, reductions in secondary stressful events involving the children, decreased mental health difficulties in parents, increased positive interactions between the child and caregiver and more positive coping among the children (Sandler et al 2003) as well as reductions in children's intrusive grief thoughts (Sandler et al 2010).

11 months after the end of the intervention, programme effects had emerged on children's mental health: reducing internalising problems among children who had been more anxious and depressed when they entered the programme, and reducing internalising and externalising problems among girls.

When children and young people were followed up six years after participating in the programme, the team found that the programme effects on reducing intrusive grief thoughts had been maintained and new programme effects had emerged on improving children's self-esteem and reducing externalising problems,in comparison with those who did not enter the programme. None of the earlier interaction effects of gender or initial levels of problems on programme outcome were significant at this six year follow up. From this, the research team concluded that the effects of the Family Bereavement Programme on some important outcomes grows over time (Sandler et al 2008a).

Sandler and his colleagues' initial reports of their findings at 11 month follow up were included in a meta-analysis of 13 controlled studies (all from the United States) which concluded that interventions with bereaved children were 'surprisingly small' (Currier et al 2007). A probable reason for this was that many were offered too late (it appeared that children responded more favourably to grief therapy the closer the intervention followed the time of death), and that all but one failed to screen for and select children who were actually showing difficulties at the start of the treatment (2007). This last finding, of greater effects for children who were more distressed, was supported by Rosner et al's analysis (2010) of the outcome literature (both

controlled and uncontrolled research designs), which found small to moderate effect sizes across 27 studies, with particularly promising findings from music therapy and trauma/grief-focused school based brief psychotherapy.

Overall, the evidence to date appears to be strongest for the effectiveness of interventions targeted at those children and young people exhibiting higher levels of distress following parental bereavement. This may not be surprising, since they have more room for improvement. This group is generally referred to in the literature as those with “complicated”, “problematic” or “traumatic” grief, and they are a small proportion of all bereaved children and young people. For example, an evaluation of a twelve-session cognitive behavioural therapy programme for childhood traumatic grief reported significant improvements in children’s grief symptoms and depression (Cohen et al., 2006).

However, emerging findings from Sandler et al’s six-year follow up (published too late to be included in the meta-analyses cited above) suggest that it may be premature to base conclusions about which groups do or do not gain long term benefit from interventions on how the participants are faring immediately or just a year after their involvement.

The results of these meta-analyses may also be influenced by the use of measures of general psychiatric symptoms and behaviour difficulties to measure the effectiveness of services offered to any bereaved child, regardless of their level of difficulty. In these circumstances, such tools can pathologise children’s grief, disguise the improvements made by a subset of children who *were* experiencing clinical levels of distress (Currier et al., 2007), and fail to capture relevant changes (Christ, 2005) such as improving communication in the family, or feeling less isolated.

The conclusions of individual evaluations, meta-analyses and other studies consistently urge the development of clinically appropriate tools to measure the outcomes of interventions on children and families (Christ et al., 2005; Sandler et al., 2008a; Currier et al., 2007; Rosner et al., 2010; Rolls, 2007). It is argued that these should be appropriate to the aims of the intervention: for example Rosner et al. (2010) recommend that the outcome measures used for ‘preventative’ services should reflect these interventions’ goals of ‘providing support and comfort in difficult times’ as well as preventing future symptoms. Developing such measures could also allow the ‘differential merits’ of different interventions (eg prevention, psychotherapy) to emerge, and improve ways of identifying who should be offered different types or levels of service. The challenges of evaluating services are numerous (Rolls, 2011) but this is considered to be one of the most urgent tasks facing the field, and the Childhood Bereavement Network is currently developing an outcome tool for use across services (Rolls and Penny, 2011).

An often-cited study (Neimeyer 2000) suggests that bereavement interventions with adults could be deleterious. However, the validity of evidence for this claim has been

questioned (Stroebe Hansson et al., 2008; Larson and Hoyt, 2007) and other reviews have not found patterns of harmful effects. In relation to children and young people, none of the evaluation studies considered by Ribbens McCarthy (2006) gave evidence of harmful effects.

Other studies have pointed to the benefits associated with residential camps for parentally bereaved children, including reduced symptoms of traumatic grief and post-traumatic stress (Searles McClatchey et al., 2009). In a very small study of children bereaved by suicide, attending a residential bereavement group was associated with children's reports of feeling happier and parents' reports of feeling better able to cope (Braiden et al., 2009).

3.3 A differentiated response

In a comprehensive review of the effectiveness of bereavement services, Schut and Stroebe (2005) suggest that these can be divided into primary interventions, open to all bereaved people (though potentially targeted at particular groups eg bereaved children or parents); secondary interventions for bereaved people at high risk of experiencing a complicated form of grief; and tertiary interventions targeted at people actually experiencing complications in their grief. While asserting that primary interventions are not empirically supported in the case of adults, they suggest that children are likely to be a special case, for whom primary prevention can be effective.

Others have concerns about the validity and reliability of screening tools, given children and families' changing needs over time (Stokes, 2004). If such tools are to be used, emerging evidence suggests the need for further development and testing so that all children and families who might benefit from programmes are included. For example, Haine and Wolchik's findings (2006) suggest that screening families by the number of additional stressors they have experienced since the death to determine their entry into a programme promoting positive parenting would not be helpful, as positive parenting is a protective factor regardless of the level of stress following the death. Sandler et al (2008a) also caution against drawing conclusions about which groups do or don't gain long-term benefit based on premature conclusions.

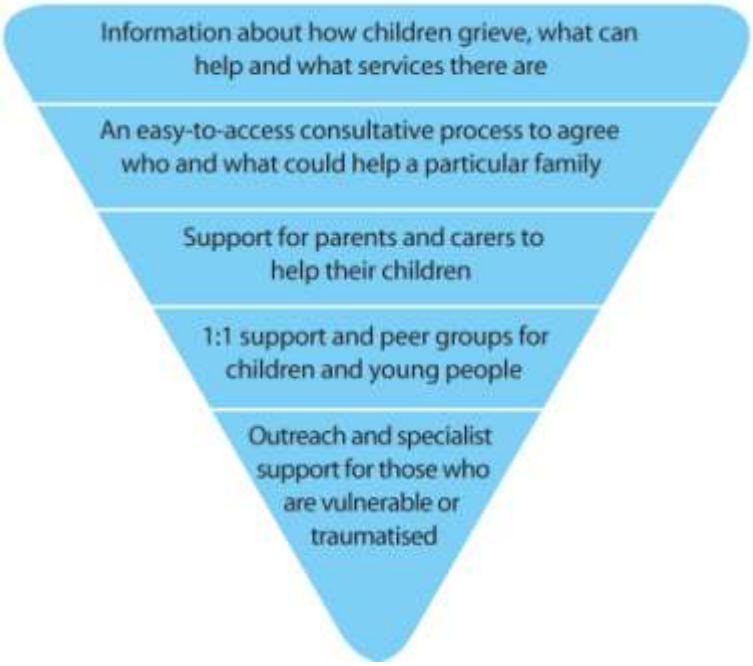
Stokes (2004) instead recommends offering a range of support to any bereaved child and their family, outside statutory mental health provision, although referring on to such provision as necessary. This would include a careful assessment of the family's particular needs so that an appropriate package of support can be offered to them, rather than assuming that one size (or shape) of provision will fit everyone.

Whilst some studies have argued that there is a need for interventions designed for children bereaved by a particular type of death, such as parental suicide (Ratnarajah et al., 2007; Mitchell et al., 2007), others have provided evidence that cause of death

(e.g. violence or suicide) is not necessarily a useful indicator of bereaved children's need for, or likelihood of benefiting from, an intervention (Brown et al., 2007).

A common message from the research reviewed is that effective approaches to supporting bereaved children need to be appropriate to their circumstances, including age and stage of development as well as degree of distress and the presence of protective factors in their environment. A key conclusion from the evidence reviewed is the importance of a differentiated response, and of a strategy to support bereaved children that incorporates both proactive and reactive elements. This suggests the need for a tiered approach, such as that illustrated in the following diagram, taken from a briefing paper produced by the 'Grief Matters for Children' campaign.

Figure 1 What good provision for bereaved children looks like[1]



4. Conclusions

This rapid review has considered evidence for the impact of childhood bereavement on educational and psychological outcomes for children, and the effectiveness of services to support bereaved children.

Most children do experience some negative impact on psychological wellbeing in the short term (up to a year) from bereavement of a parent or sibling. Significant difficulties may continue to emerge - and in some cases intensify - for at least two years following the death. In relation to longer-term outcomes, analysis of data from the 1970 birth cohort study showed that childhood bereavement did have some long-term impact at age 30, but that the effect was limited after family background was taken into account. The quantitative data on long-term outcomes from parental bereavement in childhood from this and other studies present a complex and contradictory picture, and it is likely that polarised responses from different individuals contribute to the complexity of the longitudinal findings.

Grief is a normal response to death, and many children's reactions are below the level that would indicate disorder, although this is a high threshold and milder forms

[1] http://www.childhoodbereavementnetwork.org.uk/documents/CBNCalltoActionbriefing_000.pdf

of distress are likely to remain hidden in studies that focus on clinical levels of difficulty. The evidence suggests that bereavement can be particularly harmful for those who have experienced multiple difficult events or bereavement in disadvantaged circumstances. There is little evidence on the specific impact of childhood bereavement on educational attainment. That which exists suggests that for some children there may be effects on concentration, attendance and attainment, and that these effects are not always short term.

When children do show a significant negative impact from their experience of bereavement, there is some evidence that specialist interventions and programmes can be helpful. Even those not exhibiting clinical levels of distress seem to benefit in the longer term from programmes which normalize their grief and strengthen their coping strategies. A holistic approach which attempts to strengthen the protective factors within a child's life appears to be the most effective, for example providing support not just to the child but also to the surviving parent or other main caregiver, strengthening communication and warmth in the family.

The evidence points to a range of mediating and moderating factors which can affect outcomes of childhood bereavement, such as the child's beliefs about how well they can cope with difficulties and (in the case of parental death) the relationship with the surviving parent. The complexity of children's outcomes highlights the importance of taking account of each child's needs, circumstances and preferences when deciding how best to respond. It also reinforces the need for a holistic approach to promoting children's emotional wellbeing, which aims to reinforce protective factors and address difficulties across multiple areas of children's lives.

Schools, as the place where most children spend a large part of their daily lives, could play an important part in ensuring that the needs of bereaved children are recognised and responded to in an appropriate fashion. Whole-school policies on promoting children's emotional wellbeing could help to increase resilience and thus act as a protective factor for bereaved children, whilst action specific to bereavement might range from raising awareness among practitioners about how to respond when a child has experienced the death of someone close, through the provision of in-school support, to referral for outreach and specialist help when appropriate.

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Research Working Paper 25
Bereavement in childhood: the impact on psychological and educational outcomes and the effectiveness of support services
Rodie Akerman and June Statham

Contact us:
Childhood Wellbeing Research Centre (CWRC)
Thomas Coram Research Unit
Institute of Education
27-28 Woburn Square
London WC1H 0AA

Tel: +44 (0) 20 7612 6957 | fax: +44 (0) 7612 6927
email: cwrc@ioe.ac.uk
www.cwrc.ac.uk