BEREAVEMENT AMONG DISASTER AFFECTED CHILDREN

By

BUSHRA KHUDA BUKHSH

Dr. Muhammad Ajmal
NATIONAL INSTITUTE OF PSYCHOLOGY
Center of Excellence
Quaid-i-Azam University, Islamabad

2006

BEREAVEMENT AMONG DISASTER AFFECTED CHILDREN

BY

BUSHRA KHUDA BUKHSH

A dissertation submitted to

Dr. Muhammad Ajmal
NATIONAL INSTITUTE OF PSYCHOLOGY
Center of Excellence
Quaid-i-Azam University, Islamabad

In partial fulfillment of the requirements for the

DEGREE OF

MASTER OF SCIENCE

IN

PSYCHOLOGY

2006

BEREAVEMENT AMONG DISASTER AFFECTED CHILDREN

Bereavement among Disaster Affected Children

BY

Bushra Khuda Bukhsh

Approved by

Supervisor

Director, NIP

External Examiner

CERTIFICATE

Certified that M.Sc Dissertation on **"Bereavement Among Disaster Affected Children"** prepared by Ms. **Bushra Khuda Bukhsh** has been approved for submission.

(Ma'am. Tehmina Saqib)
Supervisor

Dedicated to

My Abu, Ammi & Dadi

CONTENTS

LIST OF TABLES

LIST OF APPENDICES

ACKNOWLEDGEMENT

I am humbly grateful to Almighty Allah. The Most Gracious, and Benevolent, who blessed me to complete this study. I wholeheartedly, pay my gratitude to my supervisor, Miss. Tehmina Saqib, whose concern, constant advice, encouragement, guidance and patience has given great report in the completion of my research work. I appreciate her for encouraging me to initiate such research on this topic and confidence in my potential whenever and needed help.

I pay gratitude to our Director Dr. Naeem Tariq who helped me to build my self, to improve my careless behaviour as well, and to build my understanding towards other people. I learnt very much here. Earlier, I thought I was nothing and couldn't understand the persons and person attitude. But now, I can say that I can understand the behaviour and attitudes.

I am grateful to my Abu, Ammi, my sisters Madiha Khuda Bukhsh and Fadiha Khuda Bukhsh and my brothers, Ali Raza and Mohsin Mukhsh (Moon), who were tolerant and showed kind and affectionate attitude that was necessary for the completion of my work and studies as well.

I am grateful to my best friend Ayesha (Aasho), Shaista (Shusti), Bushra Manzoor, Mussarat Jabeen Khan and Ajmal Khan who were always with me, wherever I had difficulties in studies and especially in my research work. They have always been there to backup me. And especially thanks to Dr. Ghazala Rehman and Adnan Yousaf (my fiancée) who constantly encourage me to do this task and always build my confidence and morale during my research work.

And in the last, it was really a great experience to be a student of NIP. And Thanks to the Library staff and Computer Lab staff of the NIP.

Bushra Khuda Bakhsh

ABSTRACT

The present study aimed at investigating the bereavement among disaster affected children in October 8, 2005 earthquake. A some structured interview schedule was developed on the basis of relevant literature and 30 children were interviewed. The data were collected from the different affected areas. The sample consisted of 30 individuals (15 middle childhood and 15 early adolescents). Qualitative analysis of the interviews was carried out. All participants were takes from different areas, schools, of affected areas. Muzaffarabad and Bagh. An interview schedule was developed on the basis of literature review. Overall, middle childhood children displayed more physiological and psychological symptoms of bereavement. Also, these children had the highest frequency for psychosocial symptoms. The results are discussed in the height of relevant perspectives. Psychological interventions are needed to improve the condition of the children affected by disaster.

INTRODUCTION

INTRODUCTION

Although intellectually we all know that one day we shall die, generally we are so reluctant to think of our death that this knowledge does not touch our hearts, and we live our life as if we were going to be in this world forever. As a result the things of this world - such as material possessions, reputation, popularity, and the pleasures of the senses - become of paramount importance, so we devote .almost all our time and energy to obtaining them and engage in many negative actions for their sake. We are so preoccupied with the concerns of this life that there is little room in our mind for genuine spiritual practice. When the time of death actually arrives we discover that by having ignored death all our life we are completely unprepared.

What is death? Death is the cessation of the connection between our mind and our body. Most people believe that death takes place when the heart stops beating; but this does not mean that the person has died, because his subtle mind may still remain in his body. Death occurs when the subtle consciousness finally leaves the body to go to the next life. Our body is like a guesthouse and our mind like the guest; when we die our mind has to leave this body and enter the body of our next rebirth, like a guest leaving one guesthouse and traveling to another.

The mind is neither physical, nor a by-product of purely physical processes, but is a formless continuum that is a separate entity from the body. When the body disintegrates at death the mind does not cease. Although our superficial conscious mind ceases, it does so by dissolving into a deeper level of consciousness, the very subtle mind; and the continuum of the very subtle mind has no beginning and no end. It is this mind which, when thoroughly purified, transforms into the omniscient mind of a Buddha.

Grief

Grief is the physical, emotional, somatic, cognitive and spiritual response to actual or threatened loss of a person, thing or place to which we are emotionally

attached. We grieve because we are biologically willed to attach (John Bowlby, Father of Attachment Theory).

Grief is a natural dimension of human life. As poet (and undertaker) Thomas Lynch puts it, "Grief is a sign of our humanity. It's the tax we pay on our attachments." Although grief that evolves into clinical depression may demand medical treatment, too often American culture unnecessarily pathologies grief, or tries to fit the most individual of processes into simplistic "stage" models.

The normal process of reacting, both internally and externally, to the perception of loss. Grief reactions may be seen in response to physical or tangible losses (e.g., a death) or in response to symbolic or psychosocial losses (e.g., divorce, losing a job). Each type of loss implies experience of some type of deprivation. Grief reactions can be psychological, emotional, physical, or social.

Grief is Normal. When someone is bereaved, they usually experience an intense feeling of sorrow - grief. People grieve in order to accept a deep loss and carry on with their life. Experts believe that if you do not grieve at the time of death, or shortly after, the grief may stay bottled up inside you. This can cause emotional problems or physical illness later on. Working through your grief can be a painful process, but it is often necessary to ensure your future emotional and physical well-being.

Distinguishing between the following terms is important: grief, mourning, and bereavement. These terms are sometimes used interchangeably, yet often with different intentions.

One author noted 5 characteristics of grief:

1. Somatic distress.
2. Preoccupation with the image of the deceased.
3. Guilt.
4. Hostile reactions.
5. A loss of the usual patterns of conduct.

Mourning: The process by which people adapt to a loss. Different cultural customs, rituals, or rules for dealing with loss that are followed and influenced by one's society are also a part of mourning.

Bereavement: The period after a loss during which grief is experienced and mourning occurs. The length of time spent in a period of bereavement is dependent upon the intensity of the attachment to the deceased, and how much time was involved in anticipation of the loss.

Grief work includes 3 tasks for a mourner. These tasks include freedom from ties to the deceased, readjustment to the environment from which the deceased is missing, and formation of new relationships. To emancipate from the deceased, a person must modify the emotional energy invested in the lost person. This does not mean that the deceased was not loved or is forgotten, but that the mourner is able to turn to others for emotional satisfaction. In readjustment, the mourner's roles, identity, and skills may have to be modified in order to live in the world without the deceased. In modifying emotional energy, the energy that was once invested in the deceased is invested in other people or activities.

Since these tasks usually require significant effort, it is not uncommon for grievers to experience overwhelming fatigue. The grief experienced is not just for the person who died, but also for the unfulfilled wishes, plans, and fantasies that were held for the person or the relationship. Death often awakens emotions of past losses or separations. One author describes 3 phases of mourning:

1. The urge to recover the lost person.
2. Disorganization and despair.
3. Reorganization.

These phases grew out of the attachment theory of human behavior, which postulates people's need to attach to others in order to improve survival and reduce risk of harm.

Different Styles of Grief

There are two types of grief:

- Masculine styles
- Feminine styles

Feminine and Masculine Styles of Grief. Grief energy is converted into emotional, cognitive, physical and spiritual domains of human experience. How much energy is converted into the various domains varies among individuals and situations. The expression of the inner grief experience can be quite varied. Crying, sleep disturbances, loss of appetite or searching behaviors are common expressions of grief. Other observable behaviors might include restless over activity, social withdrawal or a loss of interest in activities that the griever previously enjoyed.

The emotional and cognitive modalities of the grief experience are most useful in discriminating between masculine and feminine grief. These modalities might best be viewed as lying along a continuum. The feminine griever typically invests more energy towards the emotional end of the continuum, while masculine griever allocates more energy towards the cognitive. Note: Your style of grief may or may not directly correspond with your gender. Thus, some women may exhibit a more masculine or cognitive style of grief and some men may exhibit more emotion than cognition while they are grieving.

What are the Stages of Grief?

The grieving process varies from person to person in terms of the order in which one experiences the stages of grief, as well as the time it takes to go through the stages of grief. Persons who are grieving do not necessarily progress in order. Some people may start with anger, while others may start with denial. The stages of grieving are not necessarily one time experience. However, each step helps with the healing process. Grief is usually divided into five stages:

Denial. Denial is a stage where one can try to believe that the death has not occurred. One may feel numb, or in a state of shock. Denial is a protective emotion when a life event is too overwhelming to deal with all at once.

Anger. Anger is a stage in which you are very upset and angry that this tragedy has happened in your family. One of the best ways of dealing with bursts of anger is to exercise or participate in another type of physical activity. Talking with family and friends, other parents who have lost a child, and the hospital staff, may also be helpful.

Bargaining. Questioning God, asking "Why my child?" and "What did we do to deserve this?" are common questions in this stage. Guilt is a primary emotion during this stage. Searching for something that you personally did, which could have contributed to the death, is all part of bargaining. It is important to remember that there is nothing you or your child did which contributed to the death.

Depression or Sadness. This is a stage in which the death of a child can no longer be denied and parents and siblings may feel a profound sense of sadness. This is normal. It may be accompanied by physical changes such as trouble sleeping or excessive sleeping, changes in appetite, or difficulty with concentrating on simple daily activities. It is important to talk about depression with a healthcare professional such as a social worker, or counselor, or meet with a support group to help you cope with these feelings.

Acceptance. Acceptance is the stage in which you have accepted death and are at a point where your child's death has been incorporated as part of your life. You have made an adjustment to the loss. This does not mean that you will never feel other emotions, but usually families find that they are better able to manage their lives overall upon reaching this stage. Some resolution has taken place with the child's death. This may include your religious and cultural beliefs and practices.

Sibling and Peer Grief

The impact of a child's death on their siblings is important to remember and address. Most young children can overcome the trauma of a sibling's death with the

necessary support and time. Many children have strong feelings of guilt and blame when their sibling dies. Often the child that has died is idealized after his/her death, leaving feelings of inferiority and neglect for the surviving siblings. These siblings have often been surrounded by death, illness, and great sorrow from all family members, especially parents, during the dying child's experience. More often, the young siblings of a child with a terminal illness have been protected from some of the experiences associated with the death. They may have not been allowed to visit the dying child, prevented from participating in the religious or cultural rituals, and possibly, even prevented from attending the funeral. All of these experiences may help with closure and can make a sibling's survivor-guilt less burdensome.

For peers and classmates, the grief process may be experienced in a variety of ways. Many children may not have had an experience with any one their age dying from an illness or accident. For any age group, review of our own mortality and purpose in life is evaluated. Young children may fear they will die soon also. They may also have feelings of guilt and blame, similar to the siblings' expression of grief. The peer of a dying child also needs time and emotional support to grieve over his/her loss of a friend, neighbor, and/or classmate. There are many support groups that include non-family members and peers in helping work through the grieving process.

Bereavement and Mourning

Bereavement and mourning are also sometimes used interchangeably when in fact a distinct difference also exists between these two classifications. Bereavement identifies the specific reactions experienced following the death of a significant other whereas, mourning speaks to the way the individual displays his/her grief.

Complicated Mourning and Pathological Grief

Complicated Mourning and Pathological Grief both refer to a description of the normal mourning process that leads to chronic or ongoing mourning. Psychoanalytically, mourning refers to the conscious and unconscious processes and behavior related to:

a) Development of new ties
b) Adapting to the loss (the internal process of redefining one's view of self and the world) and
c) Adaptation to the loss (the external process of relating to the world, people, one's roles, responsibilities etc.)

It has been in this area of complicated mourning and pathological grief that numerous terms came into existence to further clarify different factors of complicated mourning or pathological grief. As stated previously many of these terms were narrowly defined.

Types of Losses

Most of the research and clinical literature on bereavement has focused on the loss of a husband or wife. Very little has been written about the loss of siblings or children in the adult years and even less attention has been focused on the loss of one's friends. Just as each relationship has its own quality and importance, so too, does each death have its own meaning.

Loss of Spouse. The death of one's spouse is a loss in many different ways because marriage has so many different aspects to it. It is the loss of companionship, a sexual partner, co-manager of the household, and partner in decision-making, and for many, it is the loss of one's best friend. The surviving spouse is left alone--alone to make decisions and to perform all household tasks, some of which may be quite unfamiliar. If a couple has lived alone, when one spouse dies the other is often left without anything to prepare a meal for and no reason, other than one that is entirely self-imposed, to adhere to any particular routine. In short, the death of a spouse is not only an emotional loss; it is a social loss often requiring major changes in life style and role performance (Parkes & Weiss, 1983).

For both men and women, the loss of a spouse alters social status. As a single person, the widowed may be less comfortable or less welcome in couples' activities. Previous friendship networks may be less available in an important time of need for social supports than they were when no special need existed. Because the loss of a

spouse alters social status and necessitates learning new roles and tasks, many people refer to bereavement not as a crisis, but as a "transition" (Silverman, 1982). Among the frail elderly, the death of a spouse often results in institutionalization if the survivor cannot manage alone, a traumatic move that is frequently associated with further decline.

In addition to the impact of all of the above on the course of the bereavement process, two types of marital relationships--those involving intense ambivalence and/or excessive dependence--make it harder to separate from the deceased and are likely to lead to difficulties in grieving. Although virtually all relationships are characterized by some mixture of positive and negative feelings (e.g., affection and hostility), high ambivalence appears to complicate grieving. Similarly although most marital relationships involve some dependence on one another, when a person has been overly dependent on his or her spouse (often because they did not complete the separation-individuation process in childhood), bereavement reactions may include exaggerated fear, anger, and distress, which result in particular difficulty in coping (Parkes & Weiss, 1983).

Death of a Sibling. Although there is virtually no literature on the special meaning of sibling death in older life, one can extrapolate from some of the literature on loss of siblings in childhood and from discussions of the nature of sibling relationships to gain some understanding of the special meaning of that kind of loss. Brothers and sisters may be emotionally close or distant. They may live near one another and see each frequently or live far apart and rarely get together. Regardless of emotional closeness or level of involvement in everyday activities, when a sibling dies, it is a powerful reminder of one's own mortality. If the sibling dies of an inheritable disease, it heightens feelings of vulnerability.

The death of one sibling often results in a realignment of responsibilities among the surviving children. Fox example, if the deceased was the one who took responsibility for bringing the family together for special occasions, for looking after an ill family member, or for giving advice about various matters, the survivors will now have to redistribute those tasks (intentionally or unintentionally). Ambivalent feelings are very common among siblings. As mentioned above, such feelings can complicate the grieving process.

Death of a Child. Although a substantial literature exists on parents' reactions to the death of an infant or young child, only one real study has focused on the death of an adult child (Levav, 1982). While some observers claim that the death of a young child is the most stressful, based on his clinical experience, Gorer (1965) believes that "the most distressing and long-lasting of all grief's. . . is that for the loss of a grown child."

Mutual Support. This approach to assisting the bereaved is premised on the belief that "the person best qualified to understand and help with the problems of the bereaved person is another bereaved person" (Parkes, 1980). Typically, mutual support groups provide information about the bereavement process, offer practical assistance, and, by example, reassure the newly bereaved that things will get better. Lay people, may direct mutual support efforts alone, as alternatives to the health care system, or in conjunction with health care professionals.

Most mutual support groups are modeled after the Widow-to-Widow program developed by Phyllis Silverman in Boston beginning in the mid-1960s (Silverman, 1975). Trained widow helpers used an outreach approach to identify new widows. The goal of the program was to assist widows with the life transition by providing information and teaching them the skills they needed to learn to adapt to their altered circumstances. A one-to-one approach was used initially, followed by group interaction. This basic model has been adapted for programs in this country, Canada, and abroad. It has been used extensively for widows, rarely for widowers (for whom few services exist generally), and increasingly for parents of dying or deceased children and other special groups of bereaved people.

One of the most interesting recent adaptations of the mutual support approach exists in hospice programs. Hospices care for terminally ill patients and their families. Because the family is the nit of care, Prebereavement support is offered in addition to help after the death. Hospices have a unique opportunity to observe and assist with family functioning, an opportunity that is lacking in the traditional health care system. Most hospice bereavement programs are directed, and heavily dominated by lay people who have themselves been bereaved, although health professionals, especially nurses,

are also involved. Like other mutual support approaches, hospices vary greatly in the extent of the services offered. Prebereavement support includes emotional support and validation of feelings, information and education, and practical assistance to the family that is often caring for the dying patient at home. "The entire ethos's of hospice are is also likely to lend support through its implicit acceptance of death and willingness to discuss and plan for it" (Osterweis, Solomon, & Green, 1984).

Following bereavement, about 70% of hospices offer support for about one year. The support is often modest--a periodic phone call, social gatherings, or occasional visits. When the patient enters the hospice program, most hospices assign a grief worker to the family to assist during the Prebereavement and post bereavement periods. Some hospices, most notably the Boulder Country Hospice in Colorado, assign a new person to work with the family after the death, believing that one of the most urgent needs for the newly bereaved is to "tell his story" repeatedly and without fear of correction or contradiction. This need id best served by a person with no previous involvement with the case (Lattanzi, 1982).

In fact, some people worry that drugs can interfere with grief work and will ultimately lead to complications. Even those who support the use of psychopharmacologic drugs to relieve symptoms during the intense period of grief caution "the final resolution of loss is better accomplished by psychiatric help than by the use of drugs. Although drugs may be helpful in treating the bereaved, their use is adjunctive, symptomatic, and limited in time" (Hollister, 1972).

Furthermore, all three classes of drugs carry potential risks--they can be lethal in large doses or in combination with alcohol, and some entail risk of drug dependence. Because elderly patients metabolize drugs more slowly than young people (National Institutes of Health, 1983; Solomon et al., 1979) certain anti-anxiety medications and sleeping pills (long-acting benzodiazepines) may cause problems in coordination, alertness, and mood that develop gradually and are difficult to diagnose; this adds new hazards to an older person's period of grieving.

Complicated Grief

Complicated or pathological grief reactions are maladaptive extensions of normal bereavement. These maladaptive reactions overlap psychiatric disorders and require more complex, multimode therapies than uncomplicated grief reactions. Adjustment disorders (especially depressed and anxious mood, or disturbance of emotions and conduct), major depression, substance abuse, and even posttraumatic stress disorder (PTSD) are some of the more common psychiatric squeal of complicated bereavement. Grief that becomes pathologic is often identifiable by the increased duration of symptomatology, the increased disruption of psychosocial functioning due to the symptoms, or by the intensity of subsyndromal symptoms (e.g., intense suicidal thoughts or acts upon the loss).

Complicated or unresolved grief can take many forms. Complications may manifest as absent grief (i.e., grief and mourning processes are totally absent), inhibited grief (a lasting inhibition of many of the manifestations of normal grief), delayed grief, conflicted grief, or chronic grief. Risk factors for pathologic grief include suddenness of loss; gender of the bereaved; and the existence of an intense, overly close, or highly ambivalent relationship to the deceased. Pathologic grief reactions that extend to major depressive episodes should be treated with combined drug and psychotherapeutic interventions, though the efficacy of these combined approaches is untested. The bereaved who maintain long-standing avoidance of any and all reminders of the deceased, who re-experience the loss or the presence of the deceased in illusions or intrusive thoughts or dreams, and startles and panics easily at reminders of the loss might be considered for a PTSD diagnosis (even without meeting all the criteria for a psychiatric diagnosis). Substance abuse in the bereaved is frequently an attempt at self-medication of painful feelings and symptoms (such as insomnia), and can be targeted for drug and psychotherapeutic intervention.

The way in which a person will grieve depends on the personality of the grieving individual and his or her relationship with the person who died. The cancer experience, the manner of disease progression, one's cultural and religious beliefs, coping skills and psychiatric history, the availability of support systems, and one's socioeconomic status also affect how a person will cope with grief.

Grief and Bereavement

Death's closest companion is grief. The aching pain of bereavement can last for years. Fortunately, there are many support resources to help you heal.

Bereavement

'Grief' is the word we use to describe the feelings and reactions that we have when we lose someone we care about or something we value. Grief affects everyone: it is the universal reaction to loss. It is painful and stressful, but also natural, normal and necessary.

This leaflet will focus on the feelings and reactions we are most likely to experience after a death, but feelings of grief and some of the reactions we go onto describe also affect people at the end of an important relationship, or following some other major loss.

Bereavement means, literally, to be deprived by death. After someone close to you dies, you go through a process of mourning. Numbness, anger and sadness can all be part of that process. Bereavement can also cause physical reactions including sleeplessness, loss of energy and loss of appetite.

The period after a loss during which grief is experienced and mourning occurs. The length of time spent in a period of bereavement is dependent upon the intensity of the attachment to the deceased, and how much time was involved in anticipation of the loss.

When we love someone and they die, it can feel devastating. This seems to be a universal part of our human experience.

The Bereavement Process

Whether because of some of the popular literature or because of implicit or explicit cultural attitudes, people tend to think that grieving should be over within a year

and that there are set stages one should go through. People who have experienced bereavement will often tell you that this is not so, and numerous studies confirm that the normal grieving process may be long and uneven (Osterweis, Solomon, & Green, 1984).

Although the acute phase usually lasts only several months, it may take a couple of years for people to resume their normal level of activities and enjoy life again. And in some ways, people never fully get over their feelings of loss.

There are many reactions to loss, including emotional and physiological changes as well as changes in social relations. And the experience of loss differs from person to person. In addition to sadness, a host of other emotions are common during bereavement, including some that may be surprising. Often survivors feel angry--angry for having been left alone, angry at the deceased for dying. Feeling angry at the deceased can heighten feelings of guilt, which is another common emotion following bereavement. People feel remorse about things they did or didn't say, or they wonder whether the death could have been avoided if only they had done something different. Many people experience rapid emotional changes, and even hallucinations about the deceased are not uncommon in recently bereaved people.

The bereaved typically report physical problems ranging from difficulty sleeping and eating to respiratory troubles and even pains and other symptoms that mimic those the deceased person had experienced. Potentially damaging health behaviors such as increased drinking and smoking is common.

Usually these emotional and physical complaints taper off after a while and have no lasting consequences. However, some bereaved people are at increased risk for illness and even death. Bereavement can exacerbate existing illness and appears to have a role in precipitating new illness. Widowed men up to age 75 are about 1-1/2 times more likely to die than married men of the same age (Helsing & Szklo, 1981).

Most bereaved people appear depressed for a few months; after one year, an estimated 10 to 20 percent of the widowed population is still sufficiently symptomatic to be considered clinically depressed (Clayton & Darvish, 1979). Given that there are

800,000 new widows and widowers annually, this means that 80,000-160,000 will suffer true depression each year.

Although it is difficult to predict with certainty who will do well and who will experience lasting difficulty following bereavement, there are several factors that appear to have a significant influence on recovery. Social support has repeatedly been shown to be a reliable predictor of adjustment following a death. People who have no support or feel they have no one to talk to are likely to do poorly. People who are already in ill health, physically or emotionally, are more vulnerable to negative health consequences. This is especially true of people who were depressed to begin with. Concomitant life changes and crises can make the grieving process more difficult. Especially among the elderly, the death of a spouse is likely to result in substantially reduced income and may necessitate significant changes in life style, including moving to a new home, changes which themselves are stressful. The elderly are also more likely to experience several deaths within a short period of time. Finally, the course of bereavement is likely to be influenced by who died and how. It is generally acknowledged that violent and unexpected death, especially suicide, leaves survivors more vulnerable. And, of course, the nature and meaning of the particular relationship that is lost will affect the bereavement process (for detailed discussions of risk factors, see Raphael, 1983; Osterweis, Solomon, & Green, 1984).

According to developmental theory, the stage of adolescence (11-19 years old) presents a number of developmental tasks that must be successfully completed in order to move on to the next stage of the life cycle. Such tasks include forming autonomous lives (Balk, 1998), which involves achieving emotional separation from parents (Balk, 1996). Many factors come into play during this stage that will determine whether these developmental tasks will be successfully negotiated or whether the tasks will be left unresolved and present the potential for adjustment difficulties in adulthood. The great majority of adolescents experience these years as times of relative calm and stability (Balk, 1995). In other words, most adolescents do not experience any major crises or events that completely change their lives. However, some adolescents do experiences some form of trauma or crisis that can create chaos and instability in their lives.

Coping with death and grief is not a normative life transition for an adolescent (Balk, 1996). Therefore, adolescents don't have the luxury of putting developmental tasks on hold while engaging in grief work (Balk, 1998). Grief work, also called bereavement, can be defined as the time it takes and stages one may go through after loss of someone significant in a process of integrating the loss into one's life experience. Significant losses, often coming at a time of rebellious independence against the deceased parent, present special circumstances (Marwit & Carusa, 1998). Resolving bereavement during adolescence involves interplay with the tasks and conflicts of each phase of adolescence (Balk, 1996).

A fact that often goes unrecognized is that adolescent bereavement is more prevalent than many persons realize (Balk, 1996). In fact, 4% of children (1.2 million) have already experienced the death of a parent by age 15 (Sood, Weller, Weller, Fristad, & Bowes, 1992). United States census data indicate that death rates among caregivers rise rapidly from early through middle and into late adolescence (Balk, 1996).

Few events would seem to hold as much potential to disrupt a child's familiar patterns of living, challenge assumptive worlds, or place a child at risk for enduring psychological distress than the death of a parent (Siegel, Karus, & Raveis, 1996). It has been noted that death of a loved one can be life changing for children and that the death of a parent many be the defining moment of a child's life many years after the death (Robinson, 1998).

Using a developmental framework as a driving theory, one might expect debilitating consequences should grief interfere with the normal developmental tasks, given the formative nature of the adolescent years (Balk, 1998). In addition, there is "no single way a child should be expected to react to a parent's death" (Robinson, 1998; p. 71). As a result, it is difficult to make any generalized assumptions about whether grief will actually interfere with the normal developmental tasks of adolescence.

Adolescents have different perceptions and experiences of death that may be as varied as their environments (Morin & Welsh, 1996). Adolescents grieve differently from children and adults and their family and social systems further influence adaptation and vulnerability (Finlay & Jones, 2000). These opinions are based on a

developmental perspective, which states that adolescents, due to their life experiences and level of cognition, react differently to a number of situations than children or adults.

A death in the family results in crisis, and one opinion on this crisis resulting from death is that "every aspect of the daily routine is upset" (Lippincott, Williams, & Wilkins, 2000; p. 1197). Death of a family member can create a profound family crisis by severely disrupting family stability (Kiser, Ostoja, & Pruitt, 1998). Some of the research that has been conducted suggests that children and adolescents may return swiftly to normal levels of adjustment after a parent's death (Balk, 1996). However, one must keep in mind that there can be long-term consequences that manifest themselves later in life (Siegel, Karus, & Raveis, 1996). These long-term consequences may include such problems as ongoing, intense grief reactions, personality disturbances, depression, and difficulty with intimate relationships, or ongoing somatization.

Linda Dowdney (2000) stated in an annotation that grief and disturbance appear to fluctuate over time within and between bereaved children, such that children reported as not depressed at one point can be so at another time point. Even more troublesome is the possibility that some bereaved adolescents may seem to be doing fine, but are actually "quietly disturbed" (Offer, Ostrov, Howard, & Atkinson, 1988), making the world think they are functioning well when they are actually hiding many pains inside. A quote from a teen in a study by Balk (1998) illustrates this point by saying that she has spent most of her college career coping with loss and being sick and trying to hide it.

A further issue to be considered in any discussion of bereavement, and one that can potentially introduce more problems for an adolescent is modern medical interventions. There are numerous medical interventions today that can prolong life, sometimes for long periods of time, and these interventions can extend the terminal phase of many diseases (Siegel, Karus, & Raveis, 1996). This prolonged stage of illness and anticipatory grief carries with it the potential to disrupt such tasks as being able to detach emotionally from one's parents and begin to form an autonomous life. In addition, children's depression and anxiety that may come to exist during this time of illness may remain elevated for extended periods, potentially affecting their relationships with peers and academic performance (Siegel et al., 1996).

What is known is simply that loss of a parent places children at developmental risk (Kiser, Ostoja, & Pruitt, 1998). The proximal outcomes (effects) of the experience of losing a parent in adolescence might include such items as dysphoria, depression, suicidal ideation, anxiety, somatization, guilt, despair, anger, academic problems, attention difficulty, loss of friendships, or aggression (Dowdney, 2000). Distal outcomes might include adult depression, psychiatric disorder, problems with intimate relationships, problems with self-image and confidence, impaired emotional development, or negative attitudes toward religion, doctors or hospitals (Dowdney, 2000; Balk, 1998; Balk, 1991; Geis, Whittlesey, McDonald, Smith, & Pfefferbaum, 1998). However, it is crucial to remind the reader that none of these outcomes are directly a result of losing a parent. All of these outcomes are a result of a combination of factors that collide with the loss of a parent during adolescence.

The purpose of this literature review will be to discuss limitations in causal theories and previous research. In addition, risk and protective factors that may be associated with developmental outcomes will be discussed, and points will be made for how this information on factors should guide research and intervention for adolescents and their families in the future.

What are the Bereavement And Grief?

What is bereavement and what is grief? Bereavement is defined as a state of sadness or loneliness. Grief is the collection of feelings and behaviors associated with the loss of a person. The loss is commonly caused by death of a friend or family member. However, the loss can also be caused by such events as someone moving away or by a divorce.

What feelings and behaviors are associated with bereavement and grief? Some feelings associated with bereavement and grief are numbness, loneliness, sadness, guilt, shock, anxiety, depression, anger, and agitation.

Some behaviors associated with bereavement and grief are crying, insomnia, restlessness, and withdrawal.

What are some of the characteristics associated with grief? It is extremely common for the person who is grieving to be critical of himself/herself for either doing something to or not doing something for the person who has died or left. It is also common for the grieving person to think that he/she should have died instead of the loved one. It is not unusual for the grieving person to be angry toward others, especially other family members or God.

During the grief process many people are surprised to feel the strongest feelings they have ever felt in their lives. Having a depressed mood during grief is quite normal. Insomnia, crying spells and social withdrawal are common. However, a sense of worthlessness, severe guilt, or thoughts of suicide can signal a problem with the grief process. An evaluation and treatment by a professional can often help the person deal with both normal and abnormal feelings of grief.

Grief and bereavement are terms often used interchangeably when in fact there is one major difference between the two. Bereavement is reserved specifically for the response to the death of a significant other whereas; grief can be the result of incidents of loss not involving death such as loss of job, loss of a limb, loss of status.

Psychosocial Reactions

Psychosocial phenomenon includes emotions, disturbed thought processes, hostile reactions, and loss of patterns of conduct. A major problem in describing bereavement is the propensity of writers to use psychological jargon mixed with behavioral descriptions to label bereavement responses. For example Atuel and associates (1988) reported sadness, anger, depression and resolution. While sadness, anger, and possibly even depression, are observable emotions, resolution is a much more complex concept requiring interpretation beyond observational skills. Children's bereavement emotions reported in the literature include:

- Guilt (Jurk, Ekert, & Jones 1981; Atuel, Williams & Camar 1988; Weller et al. 1991);

- Anger (Binger et al., 1969; Jurk, Ekert, & Jones 1981; Atuel, Williams, & Camar 1988);
- Fear (Cain, Fast, & Erikson 1964; Mulhern, Lauer, & Hoffman 1983);
- Sadness (Cobb 1956; Atuel, Williams & Camar 1988; Mahon & Page 1995);
- Hopelessness (Atuel, Williams, & Camar 1988); rejection and self-doubt (Binger et al., 1969);
- Inferiority (Atuel, Williams, & Camar 1988);
- Anxiety (Cain, Fast, & Erikson, 1964; Jurk, Ekert, & Jones, 1981; Atuel, Williams, & Camar 1988);
- Isolation and deprivation (Binger et al., 1969); worry (Michael & Lansdown, 1986);
- Depression (Cain, Fast, & Erikson, 1964; Atuel, Williams, & Camar, 1988; Weller et al., 1991).

These varied emotional expressions reflect the nature of the relationship and the psychological loss experienced. Besides emotions, bereavement thought processes, or forms of impaired cognitive functioning are reported as responses to death.

Bereavement thought processes often fall into Jung's (Hall & Lindzey, 1957) passive thinking category. Jung (1933) articulated the idea that in passive thinking conceptual connections are established and judgments are formed, which may contradict the person's aims. Examples of bereaved thought processes are:

Confusion (Balk 1983); distorted conceptions of

(a) Illness (Cobb 1956),

(b) Death (Cain, Fast & Erikson 1964, Sekaer 1987)

(c) The relationship between illness and death (Cobb 1956; Cain, Fast, & Erikson, 1964; Lauer et al., 1985); frequent thoughts about death (Cobb 1956); trouble concentrating (Jurk, Ekert, & Jones, 1981; Lauer et al., 1985; Hogan, 1988) and death wishes for the ill child or self (Balk, 1983). Distorted conceptions, if temporary are probably of limited concern, it is the prolonged distortion that may lead to mental health problems. Death wishes, frequent thoughts about

death, and trouble concentrating prevent the child from getting on with his/her life.

The passive thought processes discussed above and not under the conscious control of the individual, can create problematic social responses as time passes for the bereaved child. For example, impaired cognitive functioning can result in poor school performance (Cain, Fast, & Erikson, 1964; Stebhens & Lascari, 1974; Kaplan, Grobstein, & Smith, 1976; Tietz, McSherry, & Britt, 1977; Jurk, Ekert, & Jones, 1981; Balk 1983; Lauer et al. 1985) or the more extreme response school phobia (Binger et al., 1969; Tietz, McSherry, & Britt, 1977) and problems in conduct for school-age children or teenagers (Cain, Fast, & Erikson, 1964; Jurk, Ekert, & Jones, 1981; Balk, 1983). Conduct problems may be evidenced as hostile reactions such as sibling rivalry (Cain, Fast,, & Erikson 1964); aggressive conduct with sibling (Baker, Sedney, & Gross, 1992); refusal to comply with parents' requests (Tietz, McSherry, & Britt, 1977); provocative testing behavior (Cain, Fast, & Erikson, 1964); and temper tantrums (Baker, Sedney, & Gross, 1992).

Several other changes in normal patterns of living have been described. For example, social relationships within the family may be strained (Tietz, McSherry, & Britt, 1977; Lauer et al., 1985), as some children blame either themselves (Binger et al., 1969; Lauer et al., 1985) or other members of the family for the death of a brother or sister (Tietz, McSherry, & Britt, 1977). Bereaved children may withdraw into their own world during the day (Cain, Fast, & Erikson, 1964; Mulhern, Lauer, & Hoffman, 1983; Baker, Sedney, & Gross, 1992). At night these children have trouble sleeping (Balk, 1983) and sometimes report nightmares (Stebhens & Lascari, 1974; Michael & Lansdown, 1986; Atuel, Williams, & Camar, 1988). Finally, several authors have reported problems with eating (Cobb, 1956; Balk, 1983; Atuel, Williams, & Camar, 1988). The extent and/ or duration of children's bereavement problems is not well documented. Prospective descriptions of children's bereavement responses over time and development of children's bereavement measures would increase our knowledge and understanding of this human response. Taking into account normal social responses could reduce these highly abstract constructs, so that judgments by parents, teachers, and/or clinicians would be simplified.

While Hogan (1988) has developed a 109-item sibling inventory of bereavement, the development of a more abbreviated measure of bereavement advances the potential to improve clinician's ability to screen children for further treatment.

While most authors view bereavement and anticipatory bereavement from a problematic perspective, other writers have reported positive effects: increased empathy and self-esteem (Iles, 1979; Balk, 1983); greater cognitive mastery (Iles, 1979); co-operation in household tasks; and partial care for the dying child (Iles, 1979; McCown, 1982). Whether these are reactions to the perceived loss, a consequence of the bereavement experience, or are simply normal maturation has yet to be studied. The attempt to measure a positive effect in our study was not borne out (Birenbaum et al., 1988–1989) and therefore will not be included in this description of siblings' bereavement responses.

Physiological Responses

Physiological responses reported in the literature include: enuresis (Cain, Fast, & Erikson, 1964; Binger et al., 1969);

- Headaches (Binger et al.,. 1969; Cairns et al., 1979);
- Abdominal pains (Binger et al., 1969; Cairns et al., 1979);
- Stomach aches (Baker, Sedney, & Gross, 1992);
- Speech disturbance, hysterical pains, convulsive-like state (Cain, Fast, & Erikson, 1964);
- Psychosomatic complaints (Mulhern, Lauer, & Hoffman, 1983), including symptoms similar to the dying child (Stebhens & Lascari, 1974).
- Illnesses such as asthma (Tietz, McSherry, & Britt, 1977);
- Ulcerative colitis (Jurk, Ekert, & Jones, 1981);
- And psychosomatic disease has also been labeled as bereavement responses (Cain, Fast, & Erikson, 1964; Baker, Sedney, & Gross, 1992). While several of these are behavioral descriptions of symptoms, others require professional diagnoses (i.e., hysterical pain, asthma).

While Mulhern, Lauer, and Hoffman (1983) found no differences in bereavement symptomatology by age categories, developmental theorists suggest differences should exist. Baker and associates (1992) suggested that children's grief reactions differed from adults as a result of their cognitive abilities, their coping styles, their need for identification figures, and their dependence on adults for support.

Because a child can lose a sibling to cancer at any time in his/her life, the developmental tasks of that child may have a significant bearing on the symptoms expressed. Any discussion of bereavement behaviors must be made in the context of normal behaviors for a child of that age. That is, bereavement symptomatology must be differentiated from behaviors characteristic of children within a given age group.

Clearly, bereaved children may exhibit many of these symptoms and/or diagnoses described in the literature. Studies that compare the physiological responses reported in bereaved children to the incidence of these responses evidenced in normal children would shed light on whether health professionals need to treat the underlying problem as a function of bereavement. This paper only examines bereavement behaviors from a perspective of frequency and does not identify differences in severity of behaviors at this time.

Phases of Bereavement

The conceptual framework of the attachment theory (the bonds that are formed early in life with parental figures derived from the need to feel safe and secure) and of human information processing (the process used to filter out or let through unwanted information) has been combined to explain loss and bereavement. The bereavement process can be divided into 4 phases:

1. ***Shock and Numbness.*** During this initial phase, survivors have difficulty processing the information of the loss; they are stunned and numb.
2. ***Yearning and Searching.*** In this phase, there is a combination of intense separation anxiety and disregard or denial of the reality of the loss. This engenders a desire to search for and recover the lost person. Failure of this search leads to repeated frustration and disappointment.

3. ***Disorganization and Despair.*** Individuals often report being depressed and have difficulty planning future activities. These individuals are easily distracted and have difficulty concentrating and focusing.
4. ***Reorganization.*** This phase overlaps to some degree with the third phase.

The phases modulate to allow existing internalized, representational figures of safety and security to be reshaped, incorporating the changes that have occurred in the bereaved life.

Bereavement and Developmental Stages

Death and the events surrounding it are understood differently depending on the age and developmental stage of the child.

Infants. Although infants do not recognize death, feelings of loss and separation are part of developing death awareness. Children who have been separated from their mothers and deprived of nurturing can exhibit such changes as listlessness, quietness, unresponsiveness to a smile or a coo, physical changes (including weight loss), and a decrease in activity and lack of sleep.

Ages 2-3 years. In this age range, children often confuse death with sleep and can experience anxiety. In the early phases of grief, bereaved children can exhibit loss of speech and generalized distress.

Ages 3-6 years. At this age children view death as a kind of sleep; the person is alive, but in some limited way. They do not fully separate death from life and may believe that the deceased continues to live (for instance, in the ground where he or she was buried), and often ask questions about the activities of the deceased person (e.g., how is the deceased eating, going to the toilet, breathing, playing?). Young children can acknowledge physical death but consider it as a temporary or gradual event. Death is reversible and not final (like leaving and returning, or a game of peek-a-boo). Children's concept of death may involve magical thinking, i.e., the idea that his or her thoughts can cause actions. Children may feel that they must have done or thought something bad to become ill or that a loved one's death occurred because of some personal thought or

wish. In response to death, children under age 5 will often exhibit disturbances in eating, sleeping, and bladder or bowel control.

Ages 6-9 years. It is not unusual for children this age to become very curious about death, asking very concrete questions about what happens to one's body when it stops working. Death is personified as a separate person or spirit: a skeleton, ghost, angel of death, or bogeyman. Although death is perceived as final and frightening it is not universal. Children this age begin to compromise, recognizing that death is final and real but mostly happens to the elderly (not to themselves). Grieving children can develop school phobias, learning problems, antisocial or aggressive behaviors, can exhibit hypochondriacally concerns, or can withdraw from others. Conversely, children this age can become overly attentive and clinging. Boys may show an increase in aggressive and destructive behavior (e.g., acting out in school), expressing their feelings in this way rather than by openly displaying sadness. When a parent dies children may feel abandoned by both their deceased parent and their surviving parent, since often the surviving parent is preoccupied with his or her own grief and is less able to emotionally support the child.

Ages 9 years and older. By the time a child is 9 years of age; death is understood as inevitable and is no longer viewed as a punishment. By the time the child is 12 years of age, death is viewed as final and universal.

Research on Adolescent Bereavement and Grief

The two areas most widely addressed in the professional literature on loss over the past twenty years are death and divorce (Marwit & Carusa, 1998). However, children are often called "the forgotten mourners" (Robinson, 1998). Although there has been a great deal of interest in adolescent bereavement, adolescents tend to be under-represented in the research (L Dowdney, Wilson, Maughan, Allerton, Schofield, & Skuse, 1999). The majority of research on childhood loss has focused on the younger child and less attention has been paid to adolescents (Marwit & Carusa, 1998). Where only adolescents have been studied, the focus has been on clarifying the grief process during this developmental phase (Van Epps, Opie, & Goodwin, 1997), or on developing theoretical models (Balk, 1996). As a result, any specific effects of parental death on the

mental health of this age group have been largely unexplored (Dowdney, 2000). Much of the research to date is conflicting, and much of the information presented in the introduction of this review was based on opinion, case study, or non-representative samples.

The predominance of research on death has targeted only populations known to have experienced a recent loss (Morin & Welsh, 1996), rather than examining those who are experiencing illness of a parent and anticipatory grief, a concept frequently cited in the literature on death. The longer the passage of time from the death, the more difficult it becomes to disentangle the effects of bereavement from other variables (Dowdney, 2000).

Data from cross-sectional and longitudinal studies have revealed that youth who experience the sudden death of a parent report significantly more depressive, anxious, and disruptive behaviors than their nonbereaved peers (Thompson, Kaslow, Kingree, King, Bryant, & Rey, 1998; Kranzler, Shaffer, Wasserman, & Davies, 1989). For example, the research study by Thompson et al. (1998) revealed that approximately one quarter of the bereaved sample ($n = 80$) scored in the clinical distress range on the Child Behavior Checklist. On the flip side, Balk (1996) found that most adolescents emerge from their bereavement more emotionally and interpersonally mature than unaffected peers. This is typical of the research on adolescent bereavement – some of the findings have detected significant problems in adjustment post-death while others have found no differences and still others have detected significant differences on a positive side as compared to controls. Upon completion of a thorough examination of the literature, one is left with contradicting information about the true nature of the consequences of losing a parent in adolescence.

Cross-sectional designs can lead to problems with analysis of data since it is not possible to say that parental death led to a problem (Thompson et al., 1998).

Furthermore, longitudinal studies can address the question of whether disturbance after parental death will be transient or whether it will persist over time (Dowdney, 2000). However, longitudinal studies lend themselves to major methodological problems, such as attrition, small samples, and enormous cost.

Research has also been mixed in regard to whether boys or girls are more vulnerable to distress or negative consequences following the death of a parent (Thompson et al., 1998). Race has also been scarcely dealt with in the research, partly due to small samples but also due to lack of minority participants altogether (Saler & Skolnick, 1992). This lack of information may have resulted due to overly small numbers of minorities within the sample to make generalizations, or from infrequency of use of the facilities from which participants are recruited for studies.

The studies that have been conducted on adolescent bereavement have often experienced a problem of generalizability due to the types of samples that have been used. Hospitals, Hospice, or other professional or social service agencies have identified many of the participants, which mean samples may not have been random or scientific. The question of generalizability comes into play due to the issue of whether the families who are already seeking professional services or who use hospitals or Hospice may differ in some significant way from those families who do not or cannot use these services. In addition, sample sizes are often focused only on retrospective study, include only child or caretaker for interviews, include only children from two-parent households (Thompson et al., 1998), or neglect the issue of risk or protective factors in the adolescent's life.

Finally, there is a substantial level of refusal by caretakers for their children to participate in these studies. Dowdney (2000) brought up the issue of difficulties facing researchers, stating that identifying samples is difficult, yet equally difficult is gaining access to eligible participants. One could therefore draw the conclusion that, while these studies are definitely breaking ground for increasing the knowledge base about adolescent coping with parental death, most of the research data is minimal in its ability to be generalized.

Another issue that has not received attention in the research is the idea of fostering of positive consequences from loss of a parent. More attention needs to be paid to this idea of restoration, or a positive side of development that can occur after parental loss (Stroebe & Schut, 1995; Balk, 1998).

Morin and Welsh (1996) caution that future research should continue to examine the impact of the environment and level of violence on adolescents' perceptions and experiences of death, make use of larger, more diverse samples, and examine the relationship between death experiences, developmental issues, and attitudes and expectations for the future. In addition, support needs of adolescents in early, middle and late adolescence may be different due to developmental stage, which calls for a division of these populations accordingly in future research (Marwit & Carusa, 1998).

When studying or examining adolescents' experiences of death, it is crucial to consider background environment (Morin & Welsh, 1996). As discovered in the study by Thompson et al. (1998), not all children who experience parental death suffer severe adversity. There may be a subset, however, which does end up with clinically significant problems. Dowdney (2000) stated that the factors associated with bereavement influence adult outcome rather than the bereavement itself. These factors would include quality of parental care, presence of other adverse social and economic sequelae (Dowdney, 2000), individual variables, and situational variables such as participation in the dying process and post-death rituals or nature and timing of the death (Adams, Corr, Davies, Deveau, de Veber, Martinson, Noone, Papadatou, Pask, Stevens, & Stevenson, 1999).

Individual differences in a person's concept of death may be influenced by myriad factors, such as family and cultural background or life experience and environment, which are often related to socioeconomic status and race (Morin &Welsh, 1996). For example, Thompson et al. (1998) argue that minority youth may have developed a repertoire of coping skills to deal with traumatic events or may have a broader kin network that serves to buffer the negative impact of parental death. In other words, certain minority groups may have specific protective factors present in their lives that serve to decrease or wipe out any long-standing negative repercussions of parental death on the developing adolescent.

Whatever the factors may be, they have not been the focus of research studies on child and adolescent grief and bereavement (Dowdney, 2000). In fact, methodologically sound studies have largely ignored potentially important influences on child outcome (Dowdney, 2000). When researchers have looked at factors, they typically focus on the

attributes that allow someone to be "stuck" in grief (Robinson, 1998). This would mean that a person is unable to move through phases of grief and integrate the death into one's life or unable to move forward with the normal activities and responsibilities of one's life. Although this is important information and the risk factor research needs to be evolved, the vital other side of the coin of protective factors also needs to be investigated. It would seem futile to attempt to understand risk factors without the concurrent investigation of protective factors.

On a positive note, risk and protective factors have frequently been cited as influencing outcome following parental death (Dowdney, 2000).

Cross-Cultural Responses to Grief and Mourning

Grief, whether in response to the death of a loved one, to the loss of a treasured possession, or to a significant life change, is a universal occurrence that crosses all ages and cultures. However, there are many aspects of grief about which little is known, including the role that cultural heritage plays in an individual's experience of grief and mourning. Attitudes, beliefs, and practices regarding death and grief are characterized and described according to multicultural context, myth, mysteries, and mores that describe cross-cultural relationships.

The potential for contradiction between an individual's intrapersonal experience of grief and his or her cultural expression of grief can be explained by the prevalent (though incorrect), synonymous use of the terms grief (the highly personalized process of experiencing reactions to perceived loss) and mourning (the socially or culturally defined behavioral displays of grief).

An analysis of the results of several focus groups, each consisting of individuals from a specific culture, reveals that individual, intrapersonal experiences of grief are similar across cultural boundaries. This is true even considering the culturally distinct mourning rituals, traditions, and behavioral expressions of grief experienced by the participants. Health care professionals need to understand the part cultural mourning practices may play in an individual's overall grief experience if they are to provide culturally sensitive care to their patients.

In spite of legislation, health regulations, customs, and work rules that have greatly influenced how death is managed in the United States, bereavement practices vary in profound ways depending on one's cultural background. When assessing an individual's response to the death of loved one, clinicians should identify and appreciate what is expected or required by the person's culture. Failing to carry out expected rituals can lead to an experience of unresolved loss for family members.

This is often a daunting task when health care professionals serve patients of many ethnicities.

Helping family members cope with the death of a loved one includes showing respect for the family's cultural heritage and encouraging them to decide how to commemorate the death. Clinicians consider the following 5 questions particularly important to ask those who are coping with the emotional aftermath of the death of a loved one

In a health care economy frequently limited by financial constraints, identification of those children and teenagers who need bereavement services and those who could benefit from services is a frequent dilemma. When a child loses a sibling to cancer, providers, parents, and insurers make decisions about that child's mental health treatment. Who would benefit from intervention outside the family is not discussed in the literature; rather an assumption is made that services are needed, but the nature of those services and how they are delivered is yet to be addressed., If health care providers are to define bereavement as requiring treatment, then one must first understand what is normal or abnormal (Demi & Miles, 1987).

Bereavement itself is a normal process; mourning the loss of a loved one is a universal experience. Whether treatment is warranted rests on the idea that untoward effects can be prevented alleviated, or the assumption that something is abnormal. Some children may require treatment outside the family; other children will not need services and may find professional treatment to be less than beneficial., The Institute of Medicine reported that most of the childhood bereavement literature is based on observations of disturbed children in treatment, that studies of the long-term effects are

highly controversial because they almost always rely on retrospective data, and many existing prospective studies are methodologically flawed (Osterweis, Solomon, & Green, 1984).

Opie (1992) echoes these sentiments in calling for improved designs and more representative samples. Because of the orientation in these studies, they provide limited information about the normal grief process. The characteristics of the bereavement trajectory in children warrant further investigation (Sekaer, 1987). A description of this trajectory will provide a basis for assessing normal and abnormal bereavement. This knowledge will assist health care providers as they develop bereavement services for children.

Many bereaved children manifest behavior patterns that are more similar to children with mental health problems than to normal children (Cain, Fast, & Erickson, 1964; Birenbaum et al., 1988–1989; Jurk, Ekert, & Jones, 1981).

Prospective studies examining bereavement responses within a theoretical framework are needed in order to better define the needs of bereaved children. This is particularly important, as not only may the child be vulnerable during the bereavement period, but the parents who make decisions for the child may feel incompetent as parents to make these decisions. A better description of bereavement behavior will help parents and professionals make treatment decisions. This paper makes the assumption that psychosocial treatment, like medical treatment, is not always beneficial (Fuchs 1986). Careful consideration must be taken to determine the nature of the problem and the most appropriate approach: professional intervention or self-healing.

Extreme grief has been a criterion for treatment (Demi & Miles, 1987). A consideration in judging the severity of bereavement responses has been to consider the length of time past death that the bereaved remained symptomatic (Lewis, 1967).

In examining the pattern of responses over time, Birenbaum and associates (1988–1989) did not find a decrease in parents' reports of children's problems for the first year after death. In fact, at entry into the study and 12 months after death, parents

reported higher mean scores for the group continuing throughout the study. This is consistent with other reports on bereaved persons (Balk, 1983; Hogan, 1988).

There is limited agreement in the literature as to whether the phenomenon under study is bereavement or grief (Quint, 1967; Rando, 1984).

Theoretical Underpinnings in Bereavement and Grief Research

The complexity of adolescent grief requires models to guide scholars in their interpretations of adolescent bereavement and practitioners in their work with adolescent grievers (Balk, 1996). Furthermore, models are needed that assist in rethinking what "recovery from bereavement" denotes and that afford criteria for assessing recovery from bereavement (Balk, 1996). The major theoretical models represented in the literature are discussed below.

Psychoanalytic Theory. Under the umbrella of psychoanalytic theory, the idea is put forth that bereavement requires a person to sever ties and detach energy invested in someone who has died and that these requirements occur by working through the anguish and loss produced (Balk, 1998). Grief is therefore seen as a process of reviewing and contemplating memories of the dead and is complete when most of the attached libidinal energy is released (Geis, Whittlesey, McDonald, Smith, & Pfefferbaum, 1998).

However, this theory does not account for such issues as environment, risk and protective factors, or developmental phases. In addition, descriptive studies based on psychoanalytic case studies may report a higher incidence of parental bereavement (Dowdney, 2000) and therefore will not be further discussed in the implications for the future.

Attachment Theory. Bowlby was at the center of the use of attachment theory and its use as a framework for grief and bereavement. Bowlby's model suggested that recovery from bereavement occurs in four phases: numbness, craving and searching for the deceased, disorganization and despair, and reorganization (Balk, 1998). This theory does not consider risk and protective factors as mediators in the recovery from

bereavement. Although it does consist of a cyclical model of phases, it does not incorporate the notion of developmental phases, such as times of greatest vulnerability for not completing the four phases.

Ethologic Theory. The ethologic explanation of grief examines the survival value of attachment where one's response to grief depends on how the person was raised and various personality characteristics (Geis et al., 1998). Although this theory incorporates some of the factors that may lead to or protect from negative outcomes, it does not seem to take developmental stages, age, or individual differences into consideration.

Behavior Theory. This conceptualization is based on the premise that behaviors elicit reinforcement from others and that, when a loved one dies, certain behaviors no longer produce the same rewards (Geis et al., 1998). Behavior theory focuses more on depression than grief (Geis et al., 1998). Although it does have application to the study of adolescent bereavement, it also does not consider factors that produce risk for or protection against aversive outcomes.

Cognitive Theory. Cognitive theories for understanding grief focus on learned helplessness, where an individual is helpless to change the situation and experiences a resulting decrease of sense of control (Geis et al., 1998). Although this theory does fit with considerations of outcomes from parental loss, it does not consider factors that might protect an adolescent from losing a sense of control when a parent dies.

Family Crisis Theory (ABCX). Family stress theories consider the involvement of four factors that interact, including the stressor event, family's resources for meeting the demands posed by the event, family's appraisal of the event, and the family crisis precipitated by the first three (Kiser et al., 1998). This theory does not take into account many of the factors that affect outcomes, nor does it consider the notion of a family's place in time or history or developmental stage of the individuals within the system. Finally, this theory does not provide an understanding for individual behavior and differences between individuals.

Coping with Life Crisis Theory. Rudolf Moos and Jeanne Schaefer pursued the coping with life crisis theory and model in the 1980s. The central characteristic of this theory involves coping with crisis, which involves the aspects of factors present in the person's life, cognitive appraisal, adaptive tasks, and coping skills (Balk, 1996). Essentially, adolescents who are faced with the death of a parent must initially accept the loss intellectually and then integrate that loss into their world view (Balk, 1996). This theory has a vital interplay with developmental and sociocultural theories, which also discuss factors in a person's life that can lead to integration or maladaptation. However, Sociocultural and developmental theories consider these factors within a context of stages or development across the life span and the interactions that occur between risk and protective factors and fulfillment of stages or tasks.

Sociocultural Theory. Alexander Leighton put forth a model in the 1940s and 1950s for understanding how people cope with crisis and tragedy. The heart of this theory involves human striving to achieve ten essential human sentiments, stating that bereavement can obstruct the achievement of these sentiments. It is the opinion of this author that the premise of sociocultural theory very closely resembles that of

Developmental theory, which emphasizes stages and life events that can obstruct the successful negotiation of these stages. However, Sociocultural theory tends to avoid the further mediation of stage in the lifespan and how this can also affect the achievement of the sentiments.

Developmental Theory. A model developed by Stephen Fleming and Rheba Adolph in the 1980s utilizes linkages between developmental markers and issues that are faced by adolescents who have lost a parent (Balk, 1996). This theory puts forth the notion that bereavement is handled differently by adolescents depending on whether they are in the stage of early, middle, or late adolescence. The developmental tasks of early, middle and late adolescence differ, as do the quality and focus of primary relationships (Marwit & Carusa, 1998).

As a result, the age and developmental stage of the adolescent influence disturbances. Furthermore, age and stage then interact with family and environmental factors to determine outcome. Family factors would include such issues as when in the

family life cycle the death occurs, nature of the death, deceased person's position in the family, and social issues (Geis et al., 1998). Once all of these factors interact, the resulting outcomes can be negative or positive.

The developmental theory of adolescent bereavement has driven the most empirically based research that is available to date, and will therefore be the theory suggested in the final section of this review for use in future research on the topic of adolescent bereavement.

Theories on Bereavement

- Elizabeth Kubler-Ross: Stages
- William Worden: Four tasks of grieving
- Robert Neimeyer: Rebuilding life and search for meaning

Kubler-Ross Theory. In 1969 **Elizabeth Kubler-Ross** wrote *On Death and Dying*. Research and interviews began in 1965 and encountered problems because (1) There is no real way to study the psychological aspects of dying and (2) Patients were often willing to talk but it was hard to convince the doctors.

- ***Stage Theory:*** From this research, Kubler-Ross saw a pattern emerging that she expressed in the way of stages. These stages begin when the patient is first aware of a terminal illness. While Kubler-Ross believed this to be universal, there is quite a bit of room for individual variation. Not everyone goes through each stage and the order may be different for each person.
- ***Stages of Dying***: It has following contents:
  1. *Denial and Isolation:* Used by almost all patients in some form. It is a usually temporary shock response to bad news. Isolation arises from people, even family members, avoiding the dying person. People can slip back into this stage when there are new developments or the person feels they can no longer cope.
  2. *Anger:* Different ways of expression
     - Anger at God: "Why me?" Feeling that others are more deserving.

- Envy of others: Other people don't seem to care; they are enjoying life while the dying person experiences pain. Others aren't dying.
- Projected on environment: Anger towards doctors, nurses, and families.

3. *Bargaining:* A brief stage, hard to study because it is often between patient and God.
   - If God didn't respond to anger, maybe being "good" will work.
   - Attempts to postpone: "If only I could live to see . . ."
4. *Depression*: Mourning for losses
   - Reactive depression (past losses): loss of job, hobbies, and mobility.
   - Preparatory depression (losses yet to come): dependence on family, etc.
5. *Acceptance*: This is not a "happy" stage; it is usually void of feelings. It takes a while to reach this stage and a person who fights until the end will not reach it. It consists of basically giving up and realizing that death is inevitable.

   - *Hope* is an important aspect of all stages. A person's hope can help them through difficult times.

J. William Worden's Four Tasks of Grief Model. These are the four tasks of grief model:

- Task One: To accept the reality of the loss.
- Task Two: To work through the pain of grief.
- Task Three: To adjust to a different type of environment.
- Task Four: To emotionally relocate the deceased and move on with life.

SEARCHING FOR THE MEANING OF MEANING:

Grief Therapy and the Process of Reconstruction

Robert A. Neimeyer

University of Memphis, Memphis, Tennessee, USA

Abstract:

A comprehensive quantitative review of published randomized controlled outcome studies of grief counseling and therapy suggests that such interventions are typically ineffective, and perhaps even deleterious, at least for persons experiencing a normal bereavement. On the other hand, there is some evidence that grief therapy is more beneficial and safer for those who have been traumatically bereaved. Beginning with this sobering appraisal, this article considers the findings of C. G. Davis, C. B. Wortman, D. R. Lehman, and R. C. Silver (this issue) and their implications for a meaning reconstruction approach to grief therapy, arguing that an expanded conception of meaning is necessary to provide a stronger basis for clinical intervention.

Thoughts and Feelings

There is no right or wrong reaction to death. We all need to grieve in our own way and in our own time. For some this might mean crying, for others not. For some this is likely to take months and years, for others not. Reactions and feelings can change from hour to hour, and day to day. Some days are good while others are bad; some days you'll be up and others down again.

Over time the emotional swings will lessen in intensity as you learn to adapt to your changed circumstances, but to begin with it can be hard.

The following is a summary of the most common feelings:

Shock and disbelief. It can take quite some time for news of the death to sink in. You don't want to believe it - who would? You can't believe it, not at first.

Loss. You've lost so much - the person, their love, their friendship, their companionship; intimacy, opportunities, hopes... and accompanying the loss can be a deep sense of sadness.

Guilt and regret. Maybe you regret having said that hurtful thing or not visiting the previous week as you'd promised. You feel bad for feeling angry. Some will feel "survivor guilt" - to be alive when another is dead. If the death was suicide, feelings

of regret and guilt will probably be heightened. You might also feel shame or blame yourself.

Injustice. Why did s/he have to die so young? Why did this have to happen to me? It's not fair!

Envy. You might envy others for having what you don't have - the friend, lover, and mother, father... that you have just lost. You could also envy others their apparently carefree lives.

Anger. You might feel angry with the world or with people for:

- Causing the death
- Not being able to cure the illness
- Not understanding your feelings
- Making thoughtless remarks
- Carrying on with life and having fun.

You might feel angry with yourself too, for what you did or did not do. But perhaps most difficult of all, you might feel angry with the dead person for dying and abandoning you and for the pain you are suffering as a result of their death.

Loneliness. Grieving can be a lonely process. You may feel that no one can possibly understand what you are going through or that no one cares. And you might have just lost someone who played a big part in your life. See also the UCS leaflet on Loneliness.

Depression. Feeling low is a natural part of the mourning process. For a time you could lose interest in life and feel that there's no point in going on. At worst you might feel despair. See also the UCS leaflet on Depression

Relief. You might feel relieved, especially if the death follows a long illness or if the person's life has been reduced to a shadow of what it once was e.g. through advanced old age.

And finally you might feel as if these reactions will go on forever, which of course they won't.

You might wish to avoid such difficult feelings, but for the process of healing to occur (and it will, given half a chance!) the pain of grief has to be experienced and expressed.

Effect on Behavior

Grief also affects our behavior and functioning. You may find it affects you in some or all of the following ways:

Sleep disruption. You may find that you can't get to sleep, or can't stay asleep, or that you wake early. See also the UCS leaflet on Insomnia.

Loss of appetite. You might not feel like eating, or you may feel sick when you do.

Restlessness. You may find it hard to relax and 'switch off'. Your mind goes into overdrive trying to make sense of what has happened, especially when you are alone or in bed at night. See also the UCS leafley on Relaxation.

Exhaustion. Grief is stressful, and if you are also not sleeping or eating well, you are bound to feel tired and worn down.

Preoccupation. You might be so preoccupied with thoughts of the dead person that you imagine seeing or hearing her/him. (You are not going mad - this is quite common!)

Anxiety and Panic. With so many powerful and unfamiliar feelings aroused, you might become anxious - that you're going crazy (which you're not) or that something terrible might happen. See also the UCS leaflet on Anxiety and Panic.

Inability to Cope. You might find it difficult to cope with ordinary, everyday things like shopping, cooking, and your work.

Loss of Interest. Things that were once a source of great pleasure to you now feel meaningless and tiresome.

Irritability. You might find yourself 'snapping' even if you are not the sort of person who normally reacts in this way.

Tearfulness. You might cry a lot; in fact, sometimes it's all you can do. Crying can bring relief, as it is an outlet for the emotions, tension and strain that have built up.

Other Physical Symptoms. Palpitations, nausea, dizziness, tightness in the throat and digestive problems - all can be experienced during grieving. If you are concerned, consult a college nurse or your GP.

These are all normal and understandable reactions to bereavement and a natural part of the mourning process. Given time, support and understanding they will lessen and eventually disappear.

Disaster

While each disaster is unique, response efforts tend to occur in phases: search and rescue, immediate relief (for immediate medical, shelter, sanitation, and food), reconstruction and recovery, and long-term development. Our focus is on the health needs of victims, and we provide support from the immediate throughout the long-term reconstruction and development phases. Our experience has shown that the outpouring of immediate assistance tends to diminish as the media coverage wanes – resulting in severe hardships as the difficult process of reconstruction and redevelopment begin. While we are often the first organization to respond

The first investigative issue that arises is the characterization of a disaster. This raises the question of "what exactly is a disaster?" Webster's Dictionary defines a disaster as a "sudden calamitous event bringing great damage, loss, or destruction. "

This is a broad classification, and the term may mean different things to different people.

The fatalistic notion of disasters probably arises from the manner in which disasters have been portrayed throughout history. Foremost, disasters have commonly been linked to religion. A popular perception today is that disasters represent an "Act of God". Historically, this notion has strong ties to religious teaching. The flood of 40 days and 40 nights (Noah's Ark) is one example. Another example was the view of many cultures (e.g. Incan, Mayan) that volcanoes represented the power of the gods. Several individuals were sacrificed into volcanoes as an offering of gifts to the gods.

The catastrophic nature of disasters has also led to the evolution of disasters as a part of folklore and mythology. We all have been taught about the destruction of Pompeii in 79AD by a volcano. The myth surrounding the underwater community of Atlantis originates from a disaster.

An overriding consequence of this history is the thought that there is little that we can do to prevent disasters. The goal of this lecture is to put an end to this perception. While it may not be possible to prevent a volcano from exploding, or a hurricane from forming, there are, in fact, several steps that we can take to reduce the likelihood for disasters or reduce the loss of life and injuries associated with disasters when they occur.

Disasters may represent many different types of events. Those related to weather and the earth's geology are the most widely recognized. Recent events, though, point out that several episodes of mass destruction have their links to our own actions. The se may include industrial accidents, many episodes of famine, and significant population displacements.

The common characteristic to each of these events is their severity. These events represent extremes. We normally live with the underlying features of these events present with us every day. They become disasters when the extremes express themselves.

Definition of Disaster

- ***Catastrophe***: A state of extreme (usually irremediable) ruin and misfortune; "lack of funds has resulted in a catastrophe for our school system"; "his policies were a disaster"
- ***Calamity***: An event resulting in great loss and misfortune; "the whole city was affected by the irremediable calamity"; "the earthquake was a disaster"
- An act that has disastrous consequences.
- A disaster (from Greek meaning, "bad star") is a natural or man-made event that negatively affects life, property, livelihood or industry often resulting in permanent changes to human societies, ecosystems and environment. Disasters manifest as hazards exacerbating vulnerable conditions and exceeding individuals' and communities' means to survive and thrive. Most events included herein are compiled from United States Federal Emergency Management Agency and Department of Homeland Security. ...

A condition in which an information resource is unavailable, as a result of a natural or man-made occurrence, that is of sufficient duration to cause significant disruption in the accomplishment of agency program objectives, as determined by agency management.

Simply you can define a disaster is as the "extreme weather event, extreme geological event, industrial mishap, famine or as a major population displacement".

Disasters may represent many different types of events. Those related to weather and the earth's geology are the most widely recognized. Recent events, though, point out that several episodes of mass destruction have their links to our own actions. The se may include industrial accidents, many episodes of famine, and significant population displacements.

The common characteristic to each of these events is their severity. These events represent extremes. We normally live with the underlying features of these events present with us every day. They become disasters when the extremes express themselves.

Types of Disasters

These are the types of disasters commonly named as:

- Floods
- Hurricanes/Cyclones
- Tornadoes
- Volcanic Eruptions
- Tsunamis
- Droughts/Famine
- Blizzards
- Earth Quakes

The most widely recognized types of disasters are listed here. Disasters related to extreme weather events (floods, cyclones, tornadoes, blizzards, droughts) occur regularly. Events related to extremes of the earth's geology (earthquakes, volc anic eruptions) occur less frequently, but result in major consequences when they happen. Tsunamis often result from earthquakes. Avalanches result from massive accumulations of snow.

Disasters are commonly categorized by their origin: natural or man-made. Most disasters investigated in the literature are natural disasters. Recently, however, industrial accidents have been categorized as disasters. The Bhopal gas release and the Chernobyl nuclear accident are two examples of a man-made disaster. Forest fires (initiated by man) may be another example.

Disasters may occur suddenly in time (a quick onset), or they may develop over a period of time (a slow onset). Most occur suddenly and perhaps unexpectedly. However, some events develop gradually, including some floods and famines related to drought.

One of the most difficult concepts in the literature is to arrive at a definition of a disaster. There have been many attempts to define disasters, but all run into the problem of either being too broad or too narrow. Having a definition of a disaster is extremely

important in epidemiological for identifying which events to include or exclude from your analysis. If events are identified with a common definition, then they can also be more easily compared.

In general, most disaster events are defined by the need for external assistance. Perhaps, one reason for this observation is that the disaster relief agencies are often the only organizations with comprehensive and systematic data. There should be some caution applied to data defined in this circumstance. Notably, the decision on which situations require external assistance may differ by country or region. In some situations, it may be a political decision as well.

Hurricanes/Cyclones. The primary health hazard from hurricanes or cyclones lies in the risk for drowning from the storm surge associated with the landfall of the storm. Most deaths associated with hurricanes are drowning deaths. Secondarily, a hazard exists for injuries from flying debris due to the high winds.

Tornadoes. The primary hazard from a health perspective in a tornado is the risk for injuries from flying debris. The high winds and circular nature of a tornado leads to the elevation and transport of anything that is not fastened down. Most victims of tornadoes a re affected by head and chest trauma due to being struck by debris or from a structural collapse. Some individuals are injured while on the ground. Others are lifted into the air by the tornado and dropped at another location.

Floods. Flooding events represent another type of disaster. Floods may originate very quickly following a quick rainstorm, or they may develop over a period of days (sometimes weeks) following an extended period of rain or quick snowmelt. Flash floods are of particular concern because of their sudden onset.

The primary hazard from flooding regards drowning. This is particularly evident for flash floods. One identified risk factor for victims of flash floods is driving in an automobile. Whether a flood overtakes a car, or an operator drives the car into fl owing water, this is not the place where you want to be. Many victims of flash floods drown within their vehicle.

A longer-term health concern from flooding is the development of disease from inundated sanitation stations. Large floods pose a hazard to existing sanitation and drinking water systems.

Volcanic Eruption. Volcanic eruptions are rare, but can be catastrophic when they occur. Data from *CRED* indicate that there were 3 eruptions designated as disasters in the year 1997. Over the 25-year period (1972-1996), there was an average of 6 eruptions per year, causing an average of 1017 deaths and 285 injuries.

Several health outcomes are associated with volcanic eruptions. Most notably, respiratory illnesses are of particular concern following an eruption. This may arise from the inhalation of toxic gases for persons close to the volcano at the time of the eruption. Or, it may arise from the inhalation of ash from the volcano. For individuals in close proximity to the volcano, some danger exists from lava flows, or more likely mud flows.

An overview of the morbidity and mortality patterns of several disaster events provides a clue to the lethality associated with particular weather hazards. In general, disaster events that involve water are the most significant in terms of mortality. Floods, storm surges, and tsunamis all have a higher proportion of deaths relative to injuries. On the other hand, earthquakes and events associated with high winds tend to exhibit more injuries than deaths.

An overriding message of the study of individual hazards is that mitigation and preparedness can be effective in saving lives and preventing injuries. Should disaster strike, be prepared. Areas with established and practiced disaster plans have a marked advantage over areas with no preparations. Planning is particularly important for providing adequate levels of emergency health care, temporary shelter, and preventive health services.

The epidemiological study of disasters is a relatively new area of research. Although there are strong concerns regarding the quality of existing mortality and morbidity data, unique patterns of death and injury have been noted by the type of disaster occurring. The analysis of past disasters provides several clues to the reduction

of mortality and morbidity from future events. Future researches in the epidemiological of disasters will likely focus on improving the surveillance of mortality and injuries related to disasters.

Earth Quake. Earthquakes are a significant global concern. Earthquakes of varying magnitude occur everyday. Most are small, but the potential for a large quake exists. What scientists don't yet know, though, is when a large quake might be expected to occur. In 1997, 13 significant earthquakes were noted in the *CRED* database.

The primary health concerns associated with earthquakes are injuries arising from structural collapse. Most injuries occur amongst individuals trapped within their homes or businesses at the time of the earthquake. Another issue in large quakes is the development of tsunamis. Quite recently, Papua New Guinea was struck by a tsunami following an n earthquake in the Pacific Ocean. Several thousand individuals were swept out to sea by the tsunami.

Earthquakes can occur in several areas of the world. That is because geological fault lines exist worldwide. The Pacific Rim countries are particularly vulnerable to these events. This figure illustrates the areas of the United States (Alaska & Hawaii excluded) at greatest risk for earthquake tremors.

The most well known prevention strategy in earthquakes is the prevention of a building from collapsing. Several jurisdictions in earthquake prone areas require that all new buildings follow certain construction codes. These codes ensure that the building is structurally sound in the event of a significant tremor.

Several areas of research, though, are continuing in the area of earthquakes. Foremost, scientists are seeking better ways of predicting when large tremors will occur. Secondarily, there is a recognized need to develop better rescue strategies for retrieving individuals from collapsed buildings.

Environment of Disaster

There are several factors, which have been linked to the risk for disaster occurrence or the risk for heightened mortality in the event of a disaster. One such factor is the environment. Anecdotal evidence suggests that changes in the environment may have an impact on disasters. For example, deforestation is increasing worldwide. Deforestation, though, increases the risk for landslides and soil erosion. Some believe that deforestation on the hillsides of Central America contributed to the disaster fro m Hurricane Mitch in 1998.

Another example is the increase in consumption of fossil fuels with industrialization. Global climate change from the build-up of greenhouse gases may lead to a greater frequency of extreme weather events (heat waves) in the future, as well as sea level rise. Several existing coastlines may be threatened in this event.

The Impact of a Disaster

The impact of a disaster and its relationship to population and environmental factors are illustrated here. From a human or economic perspective, the degree of calamity associated with a disaster will be associated with the population density of an affected and the level of vulnerability in that area.

The diagram above illustrates the point that hazard events (such as earthquakes, hurricanes, floods, fires, etc.) do not occur in a vacuum. Events occurring in areas with dense population will result in greater harm (by absolute numbers) than events in less dense areas. Similarly, hazards occurring in areas made vulnerable by poor economic development will result in greater harm than those occurring in stable areas. Vulnerable areas include river watersheds, undefended coastal plains, and hillsides prone to landslides (perhaps from deforestation). Many lesser-developed countries have large populations living on vulnerable ground.

In the concentric circles above, areas of greater population density are represented in the outer circle. Similarly, areas of greatest vulnerability are depicted in the outermost circle.

The intersection of a hazard, high population, and high vulnerability results in a major catastrophe. This type of event will be associated with high mortality, high morbidity, and high economic costs (often uninsured).

Significant events can also occur in vulnerable areas with less dense population. Though the loss of human life will not be as great, there will often be similar levels of economic loss.

Disaster and Health

Disasters can influence human health in many ways. The largest impact of disasters on human health lies in the injuries, which occur from the event itself. The types of injuries associated with disasters are discussed later in the lecture. The remaining areas of concern lie in events, which take place after the disaster. Natural and man-made disasters will often destroy sizeable amounts of property, including houses and farms. From a health perspective, one is concerned with the effect of having no she lter (environmental exposure) foremost. In the long-term, this is concern over the ability to feed the population affected adequately.

It is quite common to hear many individuals raise the issue of an increased risk for communicable diseases following a disaster. Certainly, the environment may be right for a disease outbreak to occur. However, several reports suggest that this risk is generally over-estimated.

Another area of interest is the mental health consequences of disasters. It is not uncommon for some victims of disasters to experience what is called "disaster syndrome". The specific nature and pattern of this syndrome is not well defined. Most often the term is used to describe the segment of the population affected by depression and other mental health conditions arising from the disaster.

Recent studies also suggest that mortality from NCDs may be increased in the period of time following a disaster event.

In most disaster situations, however, disease outbreaks are not the primary concern. It is the view of many disaster professionals that the risk for outbreaks will not lay immediately after an event, but 1-2 weeks later. They regard the treatment of the injured as receiving the highest priority, rather than the disposal of dead bodies.

This is not to say that disease outbreaks cannot occur following a disaster. Several changes brought about by a disaster may increase the risk for such an outbreak. These include changes affecting vector populations, changes in housing for humans, the destruction of the health care infrastructure, and the interruption of normal health services geared towards communicable diseases. Relief workers should take a survey of these factors following a disaster to determine if the environment is favorable for an outbreak.

Pakistan's Earthquake

The October 8, 2005 earthquake deprived thousands of all their belongings and livelihoods, and left them traumatized by the sudden and violent loss of loved ones. The tragedy is the worst in the country's history, and has caused the Pakistan people to come together with the international community to find relief for survivors.

In response to this crisis, Give2Asia created the Pakistan Earthquake Fund in collaboration with The Asia Foundation and Pakistan Centre for Philanthropy. In the year following the quake, donors contributed $632,072. With these resources, the Fund helped meet the immediate needs of at least 28,945 affected people and will continue to deliver sustained support to help with the recovery, rebuilding and revitalization of impacted communities.

++A primary focus for the Fund has been to provide resources to local nongovernmental organizations (NGOs) directly. Local groups that are run by people directly impacted by the earthquake make sure that support goes to capable groups and to critical needs.

Established within the first week of the disaster, the Fund has provided support to immediate relief efforts, as well as medical assistance, rehabilitation and reconstruction.

On October 8, 2005, a massive earthquake shook northern Pakistan killing more than 73,000 people, injuring some 70,000 and leaving 3.5 million homeless. In addition to the fatalities, the earthquake did severe damage to the infrastructure. Some 5,857 schools were damaged or destroyed, as were 585 medical facilities and 4,000 miles of road.

METHOD

METHOD

The present study was conducted to explore the different aspects of bereavement. Specially, the study focused on the following objectives:

Objectives of the Study:

1. To carry out extensive literature review with reference to bereavement.
2. To search the bereavement instrument.
3. To investigate the bereavement process in the children.
4. To investigate the symptoms of bereavement.
5. To compare the children belonging to the disaster of two groups of ages, middle childhood and early adolescence.
6. To develop a semi-structured interview schedule.
7. Any other information that is acquired during questioning.

Instrument

The present study is purely a qualitative study, which comes under basic research. Therefore, primarily qualitative data collection technique, "focus group" is used. A semi-structured probing interview schedule is developed in the study, and will be used to facilitate the respondents. A screening questionnaire is also used to identify the demographic variables of the sample included.

Sample

A Sample of 30 children directly affected by earthquake was collected. The sample is from two age groups as middle childhood and early adolescence.

Research Techniques

The technique being used for this study is content analysis. Content analysis is a method of studying and analyzing communication in a systematic, objective, and quantitative manner for the purpose of measuring variables (Kerlinger, 1973). It is a research method, which is popular with mass media researches (Wimmer & Dominick, 1987).

The systematic and objective process through which the communication and its contents are summarized s called coding. The decision about the coding rules gives the final shapes to the research design. These were mainly three decisions, which were taken for adopting the specific coding process (Pervez, 1984).

1. Categories of Analysis. The selection and the definition of the analysis categories can be described as the backbone of the research. The categories should exhaustively and exclusively represent all the elements under investigation (Pervaiz, 1984).

The intention of content analysis in this study was to investigate and analyze the bereavement process. Therefore, the cat3gories of analysis were symptoms and bereavement effects displayed in children since Oct 2005 to present time.

2. Units of Analysis. The second important decision while planning the research is to determine the units of analysis or recording units. The size of the recording unit depends upon the purpose of the research, the scope of the material to be analyzed, and also on the research resources (Pervez, 1984). Such as:

- Fear
- Sleeplessness
- Isolation
- Headache
- Somatic complaints

All answers to the interview questions are the focus and this is also the main content, which is analyzed. Every answer is said thoroughly and a system of enumeration is applied to collect the information about bereavement.

3. System of Enumeration. The main objective of content analysis technique is to quantify the contents of the mesas age. Units of enumeration are time, space, appearance, frequency and intensity (Pervez, 1984).

Units of enumeration selected for this study was frequency, intensity and percentage.

Procedure

30 bereaved children were collected, who faced bereavement from 8th October 2005 to 16th January 2006. Causes of bereavement were analyzed and counted. Factors such as (middle childhood and early adolescence) were counted and analyzed and discussed. The data is arranged in tables in the form of frequencies.

RESULTS

RESULTS

The results of the bereavement analysis are as under in the forms of tables with frequencies and percentages.

Table 1

Frequency and percentage of Psychosocial symptoms of bereavement in children of middle childhood

Rate of Psychosocial Symptoms (Fear)	Total No of Children	Percentage of Total No. of Victims
Middle Childhood (Mild)	3	20%
Middle Childhood (Severe)	12	80%

Table 1 shows severe psychosocial symptoms until now. Research into bereavement process suggested that there are sustained differences in the intensity of the symptoms. The number of symptoms is different but its effects are same. This may reflect the differences of symptoms because of the passage of time.

Table 2

Frequency and percentage of Psychosocial symptoms of bereavement in children of Early Adolescence

Rate of Psychosocial Symptoms (Fear)	Total No of Children	Percentage of Total No. of Victims
Middle Childhood (Mild)	8	53%
Middle Childhood (Severe)	7	47%

Table 2 shows almost some symptoms and same intensity of psychosocial symptoms. In this table, children of early adolescence give same response at some extent. But the percentage level of psychosocial symptoms with mild intensity is rather

high then the severity of the problem. It might be the effective coping strategies, which are developed.

Table 3

Differences of severe Psychosocial symptoms of bereavement between the children of middle childhood and early adolescence

Rate of Psychosocial Symptoms (Fear)	No of Victims (Victims/Total no)	Percentage of Total No of Victims
Middle Childhood (Severe)	12/15	80%
Early Adolescence (Severe)	7/15	67%

Table 3 shows the difference between the symptoms of both age groups, one is middle childhood and other is early adolescence of disable-affected children. Which show that the intensity of the symptoms is high in the children of middle childhood as compare to the children of early adolescence.

Table 4

Differences of mild Psychosocial symptoms of bereavement between the children of middle childhood and early adolescence

Rate of Psychosocial Symptoms (Fear)	No of Victims (Victims/Total no)	Percentage of Total No of Victims
Middle Childhood (Severe)	3/15	20%
Early Adolescence (Severe)	8/15	53%

Table 4 shows the difference between the symptoms of both age groups, one is middle childhood and other is early adolescence of disable-affected children. Which show that the intensity of the mild symptoms is high in the children of early adolescence as compare to the children of middle childhood.

Table 5

Frequency and percentage of Emotional symptoms of bereavement in children of middle childhood

Rate of Emotional Symptoms (Sleeplessness/Isolation)	Total No of Children	Percentage of Total No of Victims
Middle Childhood (Mild)	6	40%
Middle Childhood (Severe)	9	60%

Table 5 shows the severe emotional symptoms of because in the children of middle childhood this research suggested that have are various intensities of emotional disturbances. The number of symptoms is different. It may reflect the ratio and severity of the symptoms the targeted children showed severe emotional disturbances 60% children showed severe symptoms of emotional disturbances.

Table 6

Frequency and percentage of Emotional symptoms of bereavement in children of Early Adolescence

Rate of Emotional Symptoms (Sleeplessness/Isolation)	Total No of Children	Percentage of Total No of Victims
Middle Childhood (Mild)	9	60%
Middle Childhood (Severe)	6	40%

Table 5 shows the frequency and percentage of emotional disturbances in early adolescence, such as sleeplessness and isolation etc. early adolescence has emotional disturbance but there are of mild form. Most of the adolescence has mild intensity of the symptoms.

Table 7

Differences of severe Emotional symptoms of bereavement between the children of middle childhood and early adolescence

Rate Of Emotional Symptoms (Sleeplessness/ Isolation)	No of Victims (Victims/Total no)	Percentage of Total No of Victims
Middle Childhood (Severe)	9/15	60%
Early Adolescence (Severe)	6/15	40%

Table 7 shows the difference of severity of the emotional disturbances regarding bereavement between the children of middle childhood and early adolescence. This shows the severe intensity of disturbance in children of middle childhood. The ratio in 2:3 and the percentage is higher in children of middle childhood.

The attachment of them may be very strong. And they can't easily forget the attachment figures. The young one of early adolescence has too much things to get involve and the children of middle childhood are not yet well developed to think and do any thing by their own. So that's why the younger children have severe symptoms of emotional disturbance then the early adolescence.

Because of the process of bereavement they are still in the conditions of grief and sorrow. And they cannot cope with the trauma till now. And these who were in to stat having mild symptoms also suffer, because they developed certain strategies but yet they are not able to develop those as a whole.

Table 8

Differences of mild Emotional symptoms of bereavement between the children of middle childhood and early adolescence

Rate Of Emotional Symptoms (Sleeplessness/ Isolation)	No of Victims (Victims/Total no)	Percentage of Total No of Victims
Middle Childhood (Severe)	6/15	40%
Early Adolescence (Severe)	9/15	60%

Table 8 shows the difference of intensities of mild symptoms of the emotional disturbances regarding bereavement between the children of middle childhood and early adolescence. This shows the intensity of disturbance in children of middle childhood is low as co9mpare to the children of early adolescence.

Table 9

Frequency and percentage of Physiological symptoms of bereavement in children of middle childhood

Rate of Physiological Symptoms (Headache/Somatic Complaints)	Total No of Children	Percentage of Total No of Victims
Middle Childhood (Mild)	4	26%
Middle Childhood (Severe)	11	74%

Table 9 shows the intensity, frequency and percentage of physiological symptoms of bereavement in middle childhood, which headaches somatic complaints etc.

In which 74% children shared severe symptom of physiological disturbance abnormalities, which is very high rate for any abnormality.

Table 10

Frequency and percentage of Physiological symptoms of bereavement in children of Early Adolescence

Rate Of Physiological Symptoms (Headache/Somatic Complaints)	Total No of Children	Percentage of Total No of Victims
Middle Childhood (Mild)	11	73%
Middle Childhood (Severe)	4	27%

Table 8 shows the same measure in the children of early adolescence mostly showed very mild symptoms and few showed severe symptoms of such disturbance.

Table 11

Differences of severe Physiological symptoms of bereavement between the children of middle childhood and early adolescence

Rate of Physiological Symptoms (headache/somatic complaints)	No of Victims (Victims/Total no)	Percentage of Total No of Victims
Middle Childhood (Severe)	11/15	73%
Early Adolescence (Severe)	4/15	27%

Table 11 shows the difference in the severities of children, in middle childhood age group and early adolescence. The number of frequencies of intensity and severity the ratio between them is 3:1.

Table 12

Differences of mild Physiological symptoms of bereavement between the children of middle childhood and early adolescence

Rate of Physiological Symptoms (headache/somatic complaints)	No of Victims (Victims/Total no)	Percentage of Total No of Victims
Middle Childhood (Severe)	4/15	27%
Early Adolescence (Severe)	11/15	73%

Table 12 shows the difference in the mild symptoms of children of middle childhood age group as compare to the children of early adolescence, who showed the high ratio of mild symptoms. The ratio between them is 1:3 respectively.

Table 13

Severity of severe Psychosocial, Emotional & Physiological symptoms of bereavement between the children of middle childhood and early adolescence victims by showing the frequencies and percentage

Age Groups	Psychosocial Symptoms		Emotional Symptoms		Physiological Symptoms		Total Sample
	f	%	*f*	%	*f*	%	
Middle Childhood	12	80%	9	60%	11	28%	15
Early Adolescence	7	47%	6	40%	4	27%	15

Figure 1

Severity of severe Psychosocial, Emotional & Physiological symptoms of bereavement between the children of middle childhood and early adolescence victims by showing the percentage

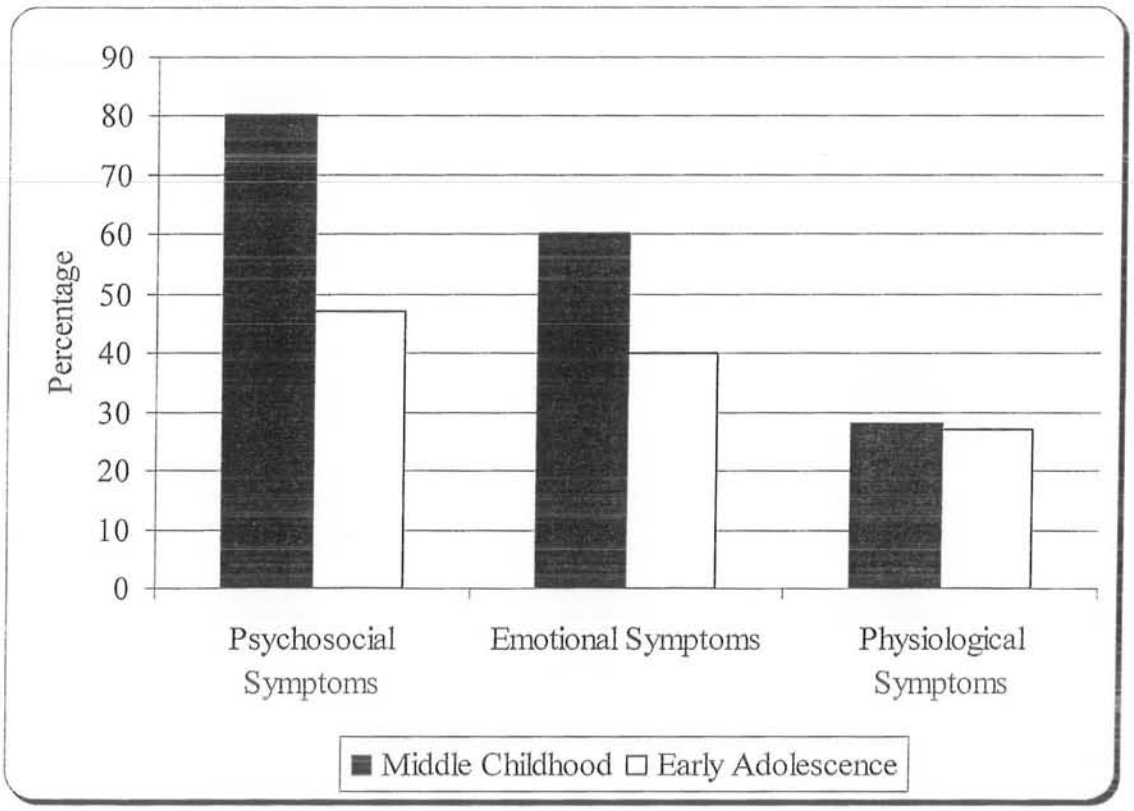

Table 13 and figure 1 show the comparison between the severities of the psychosocial, emotional and physiological symptoms of bereavement. Also the symptom s and percentage of children of middle childhood is compared to all the symptoms of early adolescence.

Which shows lot of disturbances and abnormalities are still there in the children of middle childhood age group. Early adolescence showed low prevalence routes on well on the symptom as compare to the children of middle childhood.

So in the end, by comparing the frequencies and percentage of the both groups showed that children of middle childhood are facing higher rates of problems as compare to the children of early adolescence and they are facing the severe bereavement process effects after the passage of the time of one year and two months.

Table 14

Intensity of mild Psychosocial, Emotional & Physiological symptoms of bereavement between the children of middle childhood and early adolescence victims by showing the frequencies and percentage

Age Groups	Psychosocial Symptoms		Emotional Symptoms		Physiological Symptoms		Total Sample
	f	%	*f*	%	*f*	%	
Middle Childhood	3	20%	6	40%	4	27%	15
Early Adolescence	8	53%	9	60%	11	73%	15

Figure 2

Intensity of mild Psychosocial, Emotional & Physiological symptoms of bereavement between the children of middle childhood and early adolescence victims by showing the percentage

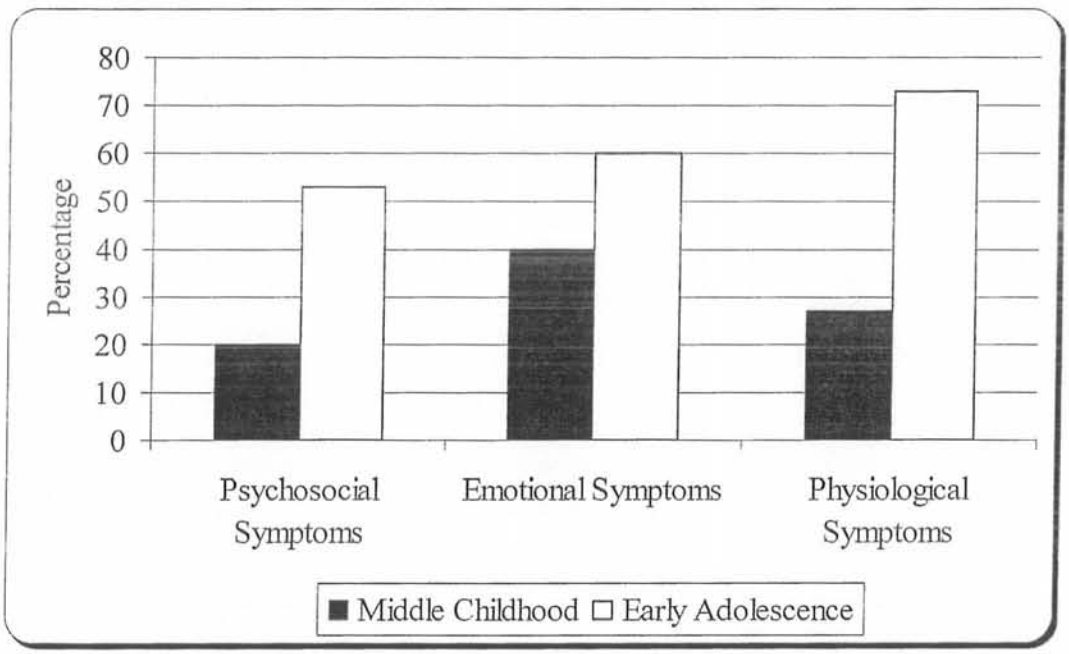

Table 14 and Figure 2 show the comparison between the intensities of the psychosocial, emotional and physiological symptoms of bereavement. Also the symptoms and percentage of children of middle childhood is compared to all the symptoms of early adolescence. So in the end, by comparing the frequencies, intensities and percentage of the both groups, it is that children of early adolescences are facing mild symptoms of bereavement process as compare to the children of middle childhood.

DISCUSSION

DISSCUSSION

The present study was carried out to explore the extensive literature review and to explore the different aspects of bereavement among disaster affected children. According to developmental theory, the stage of adolescents (11-19 years old) presents a number of developmental tasks that must be successfully completed in order to move on to the next stage of the life cycle. Such tasks include forming autonomous lives (Balk, 1998), which involves achieving emotional separation from parents (Balk, 1996). Many factors come into play during this stage that will determine whether these developmental tasks will be successfully negotiated or whether the tasks will be left unresolved and present the potential for adjustment difficulties in adulthood. The great majority of adolescents experience these years as times of relative calm and stability (Balk, 1995). In other words, most adolescents do not experience any major crises or events that completely change their lives. However, some adolescents do experiences some form of trauma or crisis that can create chaos and instability in their lives.

A qualitative research approach was adopted for exploring the term bereavement among disaster affected children of middle childhood and early adolescents. Data was collected from the disaster affected areas like Balakot, Bagh, and Muzafarabad. The interview was conducted by the focus group method. In which the research technique was content analysis. Content analysis was used of analyze the bereavement among the children of sample.

The results indicated according to Table 1 severe psychosocial symptoms until now. Research into bereavement process suggested that there are sustained differences in the intensity of the symptoms. The number of symptoms is different but its effects are same. This may reflect the differences of symptoms because of the passage of time. From the given information we understand that only 20%has the mild symptoms and 80% has severe symptoms.

According to Table 2, there is almost same symptoms and same intensity of psychosocial symptoms. In this table, children of early adolescents give same response to some extent. The percentage of children of early adolescents is 53% and 47%. This indicates that the intensity is high in the mild symptoms.

According to Table 3, the difference between the symptoms of both age groups, in which the intensity of the symptoms is high in the children of middle childhood as compared to the children of early adolescents.

According to Table 4, the difference between the symptoms of both age groups, in which the intensity of the mild symptoms is high in the children of early adolescents as compared to the children of middle childhood.

According to Table 5, the severe emotional symptoms of because in the children of middle childhood are discovered. This research suggested that have are various intensities of emotional disturbances. The number of symptoms is different. It may reflect the ratio and severity of the symptoms. The targeted children showed severe emotional disturbances 60% children showed severe symptoms of emotional disturbances.

Table 6 shows the frequency and percentage of emotional disturbances in early adolescents, such as sleeplessness and isolation etc. Early adolescent's children have emotional disturbance but these are of mild form. Most of the adolescents have mild intensity of the symptoms.

Table 7, this shows the severe intensity of disturbance in children of middle childhood. The ratio in 2:3 and the percentage is higher in children of middle childhood.

According to Table 8, the difference of intensities of mild symptoms of the emotional disturbances regarding bereavement between the children of middle childhood and early adolescents. This shows the intensity of disturbance in children of middle childhood is low as compare to the children of early adolescents.

According to Table 9 the intensity, frequency and percentage of physiological symptoms of bereavement in middle childhood are headaches somatic complaints etc. In which 74% children shared severe symptom of physiological disturbance abnormalities which is very high rate for any abnormality.

According to Table 10 the same measure in the children of early adolescents mostly showed very mild symptoms and few showed severe symptoms of such disturbance.

Table 11 the difference in the severities of children, in middle childhood age group and early adolescents. The number of frequencies of intensity and severity the ratio between them is 3: 1.

According to Table 12 shows the difference in the mild symptoms of children of middle childhood age group as compared to the children of early adolescents, who showed the high ratio of mild symptoms. The ratio between them is 1:3 respectively.

Table 13 shows the comparison between the severities of the psychosocial, emotional and physiological symptoms of bereavement. Also the symptoms and percentage of children of middle childhood is compared to all the symptoms of early adolescents.

This shows lot of disturbances and problems are still present in the children of middle childhood age group. Early adolescents showed low prevalence rates on the entire symptom as compare to the children of middle childhood.

Table 14 shows the comparison between the intensities of the psychosocial, emotional and physiological symptoms of bereavement. Also the symptoms and percentage of children of middle childhood is compared to all the symptoms of early adolescents.

So in the end, by comparing the frequencies and percentage of the both groups showed that children of middle childhood are facing higher rates of problems as compare to the children of early adolescents and they are facing the severe bereavement

process effects after the passage of the time.

Most children and adolescents, if given support such as that described above, will recover almost completely from the fear and anxiety caused by a traumatic experience within a few weeks. However, some children and adolescents will need more help perhaps over a longer period of time in order to heal. Grief over the loss of a loved one, teacher, friend, or pert may take months to resolve, and may be reawakened by reminders such as media reports or the anniversary of the death.

In the immediate aftermath of a traumatic event, and in the weeks following, it is important to identify the youngsters who are in need of more intensive support and adolescents who may require the help of a mental health professional include diminished emotional response or lack of feeling toward the event. Youngsters who have more common reactions including re-experiencing the trauma, or reliving it in the form of nightmares and disturbing recollections during the day, and hyper arousal, including sleep disturbances and a tendency to be easily startled, may responds well to supportive reassurances from parents and teachers.

Early adolescents are considered the most difficult time due to profound physical, cognitive, and the contextual changes. These changes occur simultaneously, affecting various areas of the young adolescent's life in a manner that can be overwhelming (Cooke, 1999).

Researches in this areas has been devoted to document that changes in the behaviour of family members during the transition period to adolescents are linked to pubertal changes (Holmbeck & Hill, 1991).

Middle Adolescents: According to the American Academy of Child and Adolescent Psychology (1996), this stage encompasses of self-involvement, alternating between unrealistically high expectations and poor self-concept. However, intellectual interest gain importance and some sexual and aggressive energy are directed into creative and career interest. Middle adolescents occur during the high school years (Cooke, 1999).

Late Adolescents: According to Kenistion (1962) calls the period of late

adolescents "youth". He suggests that the experiences of older adolescents differ in many respects from those of younger ones, and at the same time their experiences differ profoundly form those of adults as cited in. Keniston argued that in this stage the peer group no longer such a dominant intluence, the individual has a new freedom to develop individually to shape a personal perspective on life and a sense of direction before tacking the challenges of the adulthood. The structural and external factors, which keep on influencing the individuals (Muuss, 1968).

After the disaster which occurred in Pakistan, the family is the first line resource for helping. The psychologists can do work in collaboration with a mental health professional to improve the condition of effected children by following these patterns. Among the things parents and other caring adults can also do are:

- Explain the episode of violence or disaster as well as you are able.
- Encourage the children to express their feelings and listen without passing judgment. Help younger children learn to use words that express their feelings. However, do not force discussions of the traumatic event.
- Let children and adolescents know that it is normal to feel upset after something bad happens.
- Allow time for the youngsters to experience and talk about their feelings. At home, however, a gradual return to routine can be reassuring to the child.
- If your children are fearful, reassure them that you love them and will take care of them. Stay together as a family as much as possible.
- If behaviour at bedtime is a problem, give the child extra time and reassurance. Let him or her sleep with a light on or in your room for a limited time if necessary.
- Reassure children and adolescents that the traumatic event was not their fault.
- Do not criticize regressive behaviour or shame the child with words like "babyish".
- Allow children to cry or be sad. Don't expect them to be brave or tough.
- Encourage children and adolescents to feel in control. Let them make some decisions about meals, what to wear, etc.
- Take care of yourself so you can take care of the children.

Limitations

Despite the best efforts put to this research work, it cannot be without flaws. The present research study was done to find the personal domain of adolescents. But there are always some limitations and following are some of the limitations of this study.

1. Due to the limited time allowed to conduct the research, it was not possible to explore the wide of other variables related to phenomenon of adolescents.
2. Convenient sampling technique was applied it carry out the research, which cannot yield much appropriate results.
3. Sample was collected only from Rawalpindi and Islamabad cities and due to shortage of time more cities have not been studied as if variation in responses can be obtained if data was collected from other cities.
4. The personal domain of adolescence was not studied in Pakistan before this so any scale or instrument was not available to carry out the research.
5. No information was available to understand the condition of personal domain in Pakistan.

Suggestions

When violence or disaster affects a whole school or community, teachers and school administrators can playa major role in the healing process. Some of the things educators can do are:

- Sample size should be increased to increase the generalizability of the research.
- If possible, give yourself a bit of time to come to terms with the event before you attempt to reassure the children. This may not be possible in the case of a violent episode that occurs at school, but sometimes in a natural disaster time will be several days before schools reopen and teachers can take the time to prepare themselves emotionally.
- Don't try to rush back to ordinary school routines too soon. Give the children or adolescents time to talk over the traumatic event and express their feelings about it.
- Respect the preferences of children who do not want to participate in class

discussions about the traumatic event. Do not force discussion or repeatedly bring up the catastrophic event; doing so may re-traumatize children.

- Hold in school sessions with entire classes, with smaller groups of students, or with individual students. Theses sessions can be very useful in letting students know that their fears and concerns are normal reactions. Many counties and school districts have teams that will go into schools to hold such sessions after a disaster or episode of violence. Involve mental health professionals in these activities if possible .
- Offer art and play therapy for young children in school.
- Be sensitive to cultural differences among the children. In some cultures, for example, it is not acceptable to express negative emotions. Also, the child who is reluctant to make eye contact with a teacher may not be depressed, but may simply be exhibiting behavior appropriate to his or her culture .
- Encourage children to develop coping and problem solving skills and age appropriate methods for managing anxiety .
- Hold meetings for parents to discuss the traumatic event, their children's response to it, and how they and you can help. Involve mental health professions in these meetings impossible.

Suggestions & Limitations:

These are the suggestions and limitations for the research work.

1. A large sample can be taken to explore the phenomena further.
2. Other psychological measures can be used to investigate the conditions of children.
3. Families of children should also be studied in the detail.

REFERENCES

REFERENCES

Achenbach, T. M. & Edelbrock,C. S. (Eds.). (1983). *Manual for the Child Behaviour Checklist and Revised Child Behaviour Profile*. Burlington, VT: Queen City Inc.

Achenbach, T. M. (1991). *Manual for the Child Behaviour Checklist/4–18 and Profile*. Burlington, VT: University of Vermont Department of Psychiatry.

Adams, D. W., Corr, C. A., Davies, B., Deveau, E., de Veber, L. L., Martinson, I. M., Noone, M., Papadatou, D., Pask, E., Stevens, M.M., & Stevenson, R.G. (1999). Children, adolescents, and death: Myths, realities, and challenges. *Death Studies, 23*(5), 443-464.

Atuel, T. M., Williams, P. D., & Camar, M. T. (1988). Determinants of Filipino children's responses to the death of a sibling. *Maternal Child Nursing Journal, 17*(2), 115 134.

Baker, J. E., & Sedney, M. A. (1992). & Gross, E. Psychological tasks for bereaved children. *American Orthopsychiatry, 62*(1), 105 116.

Balk, D. (1983). Effects of sibling death on teenagers. *Journal of School Health, 53*, 14-18.

Balk, D. E. (1991). Death and adolescent bereavement: Current research and future directions. *Journal of Adolescent Research, 6*(1), 7-27.

Balk, D. E. (1995). *Adolescent development: Early through late adolescence*. Pacific Grove, CA: Brooks/Cole.

Balk, D. E. (1996). Models for understanding adolescent coping with bereavement. *Death Studies, 20,* 367-387.

Balk, D. E. (1998). Psychological development during four years of bereavement: A longitudinal case study. *Death Studies, 22*(1), 23-36.

Binger, C. M., Ablin, A. R., Feuerstein, R. C., Kushner, J. H., Zogu, S., & Mikkelsen, C. (1969). Childhood leukemia: emotional impact on patient and family. *New England Journal of Medicine, 280*, 414 418.

Birenbaum, L. K. (1987). *Effect of family nursing on sibling response to dying*. Final Report. Division of Nursing. Health and Human Services, Oregon Health Sciences University, Portland, OR.

Birenbaum, L. K., Robinson, M. A., Phillips, D. S., Stewart, B. J., McCown, D. E. (1988–1989). The response of children to the dying and death of a sibling. *Omega, 20*(3), 213 228.

Birenbaum, L. K., Yancey, D. A., Phillips, D. S., Chand, N., & Huster, G. (1999). Children's adjustment when a parent has cancer. *Oncology Nursing Forum, 26*(10), 1639 1645.

Cain, A. C., Fast, I., Erickson, M. E. (1964). Children's disturbed reactions to the death of a sibling. *American Journal of Orthopsychiatry, 34*, 741 752.

Cairns, N. U., Clark, G. M., Smith, S. D., & Lansky, S. B. (1979). Adaption of siblings to childhood malignancy. *Journal of Pediatrics, 95*, 484 487.

Cobb, B. (1956). Psychological impact of long illness and death of a child on the family circle. *Journal of Pediatrics, 48*, 736 751.

Davies, E. B. (1982). *Behavioural responses of children to the death of a sibling.* Unpublished Doctoral Dissertation, University of Washington.

Demi, A. S., & Miles, M.S. (1987). Parameters of normal grief: A Delphi study. *Death Studies, 11*, 397 412.

Dowdney, L. (2000). Annotation: Childhood Bereavement Following Parental Death. *Journal of Child Psychology and Psychiatry, 41*(7), 819-830.

Dowdney, L., Wilson, R., Maughan, B., Allerton, M., Schofield, P., & Skuse, D. (1999). Bereaved children: Psychological disturbance and service provision. *British Medical Journal, 319,* 354-357.

Finlay, I.G., & Jones, N.K. (2000). Unresolved grief in young offenders in prison. *British Journal of General Practice, 50,* 569-570.

Fuchs, V. R. (1986). *The health economy.* Cambridge, MA: Harvard University Press.

Geis, H. K., Whittlesey, S. W., McDonald, N. B., Smith, K. L., & Pfefferbaum, B. (1998). Bereavement and loss in childhood. *Stress in Children, 7*(1), 73-84.

Hall, C. S., & Lindzey, G. (1957). *Theories of personality.* New York: John Wiley & Sons, Inc.

Hogan, N. S. (1988). The effects of time on the adolescent sibling bereavement process. *Pediatric Nursing, 14*(4), 333 335.

Iles, P. (1979). Children with cancer: Healthy siblings' perception during the illness experience. *Cancer Nursing, 2,* 371 377.

Jung, C. G. (1933). *Psychological types or the psychology of individuation.* New York: Harcourt, Brace.

Jurk, I. H., Ekert, H., & Jones, H. J. (1981). Family responses and mechanisms of adjustment following death of a child with cancer. *Australian Paediatric Journal, 17,* 85 88.

Kaplan, D. M., Grobstein, R., & Smith, A. (1976). Predicting the impact of severe illness in families. *Health and Social Work, 1*(3), 71-82.

Kiser, L.J., Ostoja, E., & Pruitt, D.B. (1998). Dealing with stress and trauma in families. *Stress in Children, 7*(1), 87-103.

Kranzler, E., Shaffer, D., Wasserman, G., & Davies, M. (1989). Early childhood bereavement. *Journal of the American Academy of Child and Adolescent Psychiatry, 29*, 513-520.

Lauer, M. E., Mulhern, R. K, Bohne, J. B., & Camitta, B. (1985). Children's perceptions of their sibling's death at home or hospital: The precursors of differential adjustment. *Cancer Nursing, 8*(1), 21 27.

Lewis, I. (1967). Leukaemia in childhood: its effects on the family. *Australian Paediatric Journal, 3*, 244 247.

Lippincott, Williams, & Wilkins (2000). Bereavement follow-up after critical illness. *Critical Care Medicine, 28*(4), 1196-1208.

Mahon, M. M., & Page, M. L. (1995). Childhood bereavement after the death of a sibling. *Holistic Nursing Practice, 9*(3), 15 26.

Marwit, S.J., & Carusa, S.S. (1998). Communicated support following loss: Examining the experiences of parental death and parental divorce in adolescence. *Death Studies, 22*(3), 237-256.

McCown, D. E. (1982). *Selected factors related to children's adjustment following sibling death.* Corvallis, OR: Oregon State University.

Michael, S. A., & Lansdown, R. G. (1986). Adjustment to the death of a sibling. *Archives of Disease Childhood, 61*, 178 283.

Morin, S.M., & Welsh, L.A. (1996). Adolescents' perceptions and experiences of death and grieving. *Adolescence, 31*(123), 585-596.

Mulhern, R. K., Lauer, M. E., & Hoffman, R. G. (1983). Death of a child at home or in the hospital. subsequent psychological adjustment of the family. *Pediatrics, 71*(5), 743 747.

Neimeyer, R. A. (Ed.). (1994). *Death anxiety handbook.* Washington, DC: Taylor & Francis.

Neimeyer, R. A. (Ed.). (2001). *Meaning reconstruction & the experience of loss.* Washington, DC: American Psychological Association.

Neugarten, B. L. (1968). *Personality in middle and late life* (2nd ed.). New York: Atherton Press.

Nunnally, J. C. (1976). *Psychometric theory.* New York: McGraw-Hill Book Company.

Offer, D., Ostrov, W., Howard, K.I., & Atkinson, R. (1988). The teenage world: Adolescents' self-image in ten countries. New York: Plenum.

Opie, N. D. (1992). Childhood and adolescent bereavement. In J. J. Fitzpatrick, R. L. Taunton & A. K. Jacox (Eds.), *Annual review of nursing research* (Vol. 10). New York: Springer Publishing.

Osterweis, M., Solomon, F., & Green, M. (1984). *Bereavement: Reactions, consequences, and care.* Washington, DC: National Academy Press.

Quint, J. C. (1967). *The nurse and the dying patient.* New York: The Macmillan Company.

Rando, T. A. (1984). *Grief dying, and death: Clinical interventions for caregivers.* Champaign, IL: Research Press Company.

Robinson, F. (1998). Children: The forgotten mourners. *Healthplan,* 69-72.

Saler, L., & Skolnick, N. (1992). Childhood parental death and depression in adulthood: Roles of surviving parent and family environment. *American Journal of Orthopsychiatry, 62,* 504-516.

Schultz, K. (1999). Bereaved children. *Canadian Family Physician, 45*, 2914-2921.

Sekaer, C. (1987). Toward a definition of 'Childhood Mourning'. *American Journal of Psychotherapy, 41*(2), 201 219.

Siegel, K., Karus, D., & Raveis, V. (1996). Adjustment of children facing the death of a parent due to cancer. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(4), 442-456.

Siegel, K., Mesagno, F.P., Karus, D., Christ, G., Banks, K., & Moynihan, R. (1992). Psychosocial adjustment of children with a terminally ill parent. *Journal of the American Academy of Children and Adolescent Psychiatry, 31*, 327-333.

Sood, B., Weller, E., Weller, R.A., Fristad, M.A., & Bowes, J..M.(1992). Somatic complaints in grieving children. *Comprehensive Mental Health Care, 2*(1), 17-23.

Stebhens, J. A., & Lascari, A. D. (1974). Psychological follow-up of families with childhood leukemia. *Journal of Clinical Psychology, 30*, 394 397.

Stewart, A. L., & Ware, J. E. Jr (1992). *Measuring functioning and well being medical outcomes study approach.* Durham, NC: Duke University Press.

Stroebe, M., & Schut, H. (1995). Adolescent responses to the death of a parent. In C.A. Corr and D.E. Balk (Eds.), Handbook of adolescent death and bereavement (pp.15-172). New York: Springer.

Thompson, M. P., Kaslow, N. J., Kingree, J.B., King, M., Bryant, L., & Rey, M. (1998). Psychological symptomatology following parental death in a predominantly minority sample of children and adolescents. *Journal of Clinical Child Psychology, 27*(4), 434-441.

Tietz, W., McSherry, L., & Britt, B. (1977). Family sequelae after a child's death due to cancer. *American Journal of Psychotherapy, 21*, 417 425.

US Bureau of the Census. (1984). *Statistical abstract of the United States 1984* (104th ed.) Washington, DC: US Department of Commerce, US Government Printing Office.

Van Epps, J., Opie, N.D., & Goodwin, T. (1997). Themes in the bereavement experience of inner city adolescents. *Journal of Child and Adolescent Psychiatric Nursing, 10,* 25-36.

Weller, R. A., Weller, E. B., Fristad, M. A., & Boles, J. M. (1991). Depression in recently bereaved prepubertal children. *American Journal of Psychiatry, 148*(11), 1536 1540.

APPENDIXES

Annexure 1

ہدایات:

قومی ادارۂ نفسیات، قائداعظم یونیورسٹی، اسلام آباد ایک ایسا ادارہ ہے ، جو تدریس کے ساتھ ساتھ انسانی اور معاشرتی نفسیا
سے متعلق مختلف موضوعات اور مسائل پر تحقیق بھی کرتا ہے-موجودہ تحقیق اسی سلسلے کی ایک کڑی ہے ،جس کے لئے ہمیں آپ کا تعاون درکار

ہم بچوں سے متعلق ایک تحقیق کر رہے ہیں، جس میں ان کے جذبات واحساسات کو جاننے کی کوشش کی جائے گی-اس سلسلے میں ہم آپ
مختلف سوالات کریں گے-یہ سوالات زلزلے کے بعد کے حالات سے متعلق ہیں-

آپ سے گزارش ہے کہ ان کا جواب تفصیلی طور پر مہیا کریں - آپ کی معلومات کو صیغہ راز میں رکھا جائے گا اور صرف تح
کے مقاصد کے لئے استعمال کیا جائے گا-

آپ کی توجہ اور بھرپور تعاون کے لئے ہم آپ کے بے حد ممنون ہیں-

نام : ✓ _____

عمر : _____

جنس : _____

ولدیت : _____

تعلیم : _____

رہائش : _____