Recent world events have drawn attention to the vast number of children who are mourning or will mourn the death of a parent. Social workers working with parentally bereaved children clearly need to be aware of relevant research on this topic. However, being aware of the perspectives of social work colleagues who regularly work with parentally bereaved children is also essential.

The implications for practice with parentally bereaved children and their surviving caregivers suggest that, while children do indeed grieve, their reactions and grief processes can be very diverse. Knowledge of published research and the perspective from the social worker’s practice experience are both necessary to design individual interventions that fit for each uniquely bereaved child.

Factors Contributing to a Child’s Adjustment to Loss

Many factors affect the adjustment of parentally bereaved children. The most researched factors include the following:

- The bereaved child’s age and gender
- The circumstances of the death
- The adjustment of the remaining caregiver

The bereaved child’s age and gender

Raveis, Siegel, and Karus (1999) found that depressive symptoms were significantly related to a child’s gender, and anxiety symptoms were significantly correlated to a child’s age. Thus, bereaved girls reported higher levels of depressive symptoms than boys, and younger children reported higher levels of anxiety than older children. The authors attributed these differences among girls and younger children to their being more innately vulnerable to bereavement, due to developmental or maturational differences.

Similarly, Worden (2001) found that girls, regardless of age, expressed more anxiety and somatic symptoms than boys, who were more likely to have poor conduct and learning difficulties during the first year of bereavement. Ellis and Granger (2002) also found that parentally bereaved adolescent males tended to experience more delinquent behavior than their female counterparts.
In an exploratory, qualitative study of social workers, participants agreed that the research findings provided useful information; however, they felt it was more important to consider the developmental level of a child rather than age or gender when measuring adjustment (Hope & Hodge, 2006).

More helpful, they stated, was looking at children’s levels of emotional and cognitive functioning and assessing where they lie on a continuum of understanding about death. Participants also responded that each age group displays different reactions, and that it is equally difficult for children of any age to adjust to the death of a parent.

Social workers who participated in the study agreed with the published research showing that male children tended to externalize their grief and exhibit more “acting out” behaviors than females, who tended to internalize their grief. Likewise, participants felt that girls seemed better able to express their feelings verbally, while boys acted them out in art or construction activities.

Several of the participants observed that female children displayed more somatic symptoms. One noted that male and female children might react or adjust differently to parental death because of differences in socialization; in her opinion, grieving openly is more acceptable for girls in this culture than for boys.

The circumstances of the death

In the qualitative study, most of the social workers agreed with research showing that sudden deaths, such as suicide, present a more difficult adjustment task for children (Cerel, Fristad, Weller, & Weller, 2000). Several participants, however, noted that categorizing a death as sudden or anticipated is not always as easy as it sounds.

They also generated support for the research showing anticipated deaths to be no more difficult than sudden deaths in terms of bereaved children’s adjustment (Cerel, Fristad, Verducci, Weller, & Weller, 2006). Several study participants emphasized that—in their experience—sudden and anticipated deaths were equally traumatic for children.

The adjustment of the remaining caregiver

The remaining caregiver’s emotional adjustment to the loss is a very important factor in a child’s adjustment. In an examination of surviving parents’ mental health and parenting styles, Lin, Sandler, Ayers, Wolchik, and Luecken (2004) found that children’s resilience following parental death was positively correlated with parents who provided warmth and discipline, and negatively correlated with parents’ mental health problems. Saldinger, Porterfield, & Cain (2004) measured the “child-centeredness” of surviving parents, and found that more child-centered parenting resulted in less symptomatic children.

The social workers in the qualitative study also agreed that, if a caregiver were making a positive adjustment to the death, it would help his or her child to adjust as well. Nevertheless, participants emphasized the need for caregivers to strike a healthy balance between being able to grieve with their children and being able to mourn alone and take care of their own needs.

While caregivers’ emotional availability and recognition of the need for grieving were important to their children’s adjustment, the caregivers’ own grieving response was equally important to their children’s adjustment. In short, caregivers serve as “grieving role models” for their children. It is also necessary, according to participants, to make sure that a child’s basic needs are being met, and to maintain as much stability as possible in a grieving child’s world.

Helping children to identify their own strengths and how to use them in the coping process is another very important aspect for their healthy adjustment to grief.

One study participant specifically mentioned that having strong connections to people in their communities and strong faith-based belief systems were critical aspects of a child’s adjustment. A child’s participation in memorializing activities
for the deceased parent, such as creating a memory book, was also considered helpful by participating practitioners. Above all, participants emphasized the importance of a good support system with caregivers who are willing to talk with the child about the death.

Implications for Practice

In the research and in the experienced viewpoints of the professional social workers who participated in the qualitative study, it is evident that children do indeed grieve, and that they can be very much at risk for detrimental effects if their grief is not acknowledged and expressed.

Participants stressed the importance of children being given sufficient and accurate information about the death, regardless of age. Worden (2001) found that when children lack sufficient information about a death, they usually make up a story to fill in the gaps. The study participants also related that these made-up details tend to be worse than the actual event, and often involve the children placing blame on themselves for some part of the death.

Overall, these results demonstrate that each child’s grief reaction is unique and should be treated as such. Perhaps the most important factor in a child’s adjustment to the death of a parent is the adjustment of the remaining caregiver. Professional social workers can play a crucial role in strengthening the resiliency of children who suffer parental death by working with the children on their adjustment, while also working with surviving parents to provide their children a sense of security.

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References


Anxiety in the workplace has reached an all-time high. Consider the stressors we deal with daily: the war with Iraq, ongoing global terrorist activities, the human fallout from large-scale natural disasters such as hurricane Katrina—the list seems endless. Add some of the challenges that affect us as social workers, such as reduced funding for key social programs and managed-health care practices that constrain effective service to clients, and you have a sure-fire formula for anxiety levels that can easily outstrip the ability of an organization—and its people—to cope.

Despite the bad rap we give it, anxiety itself is neither good nor bad. It is a normal, natural response to something we know or perceive to be threatening. When we become anxious, we respond in a number of predictable, patterned ways that are variations of our hardwired fight, flight, and freeze responses. If our anxiety is relatively time-limited, it can infuse us with a burst of energy, sharpening our focus and mental acuity. For instance, Jane’s anxiety-based response of jumping out of the way of an oncoming bus protects her from getting hit and possibly injured.

Chronic anxiety, however, is likely to wear us down, resulting in negative behaviors and relationship disturbances. Take the example of Dennis, who lost credibility in an anxiety-driven argument with his supervisor over the question of a discretionary merit increase. The boss, whose own anxiety was piqued by Dennis’ reactivity, dug in her heels and told Dennis there would be no exceptions to the normal salary review schedule, regardless of what she had indicated during the hiring process.

About Organizational Anxiety

Just as individuals become anxious, so do entire organizations. Some of the symptoms of organizational anxiety include:

- **Creating alliances**: people taking sides with other people instead of taking stands on issues; forming clusters and cliques
- **Waging turf battles**: people asserting their territory to the detriment of the organization as a whole; feuding and backstabbing
- **Blaming**: excessive focus on the shortcomings of particular individuals or departments
- **Distancing**: people withholding what they really think in meetings; lack of communication between adversaries; people literally hiding out in their offices or cubicles

The results can be faltering productivity and morale and a sense of oppression on both the group and individual level. Flexibility, objectivity, and creativity give way to tunnel vision, resistance to change, and faulty decision-making.

Anxiety is highly contagious and, when unchecked, will spread across an entire organization in short order. Fortunately, calm is equally contagious. Like a pebble that creates wide ripples when thrown into a pond, one relatively calmer person in an anxious system can have a strong, positive effect for all involved.

Calming Organizational Anxiety

The first step toward becoming calm in the midst of an agitated system is to recognize your own personal anxiety triggers and signals. We may blame disturbing events for setting off our anxiety; however, it is not as much specific events that upset us as our individual reactions to them.
For example, when a client makes angry demands on Stacy that her agency cannot fulfill, she dusts herself off and moves effectively through the rest of her day. In the same situation, Leslie feels rejected and dispirited, and has to recover for a while before attempting further contacts. If you can identify the workplace situations and relationships that trouble you most, you can learn to manage them more effectively just by lowering your anxiety reactions to these issues.

One surprisingly effective method for reducing anxiety is to try to predict exactly how you will behave when a particularly upsetting event occurs. As you engage the logical part of your brain and remember how you have reacted in this situation before and how you are likely to respond this time, you will suppress the domination of the brain structures that initiate and maintain anxiety. Consequently, you will be freer to think your way to a new, and possibly more effective, course of action.

**Shifting Focus**

Focusing on facts rather than feelings will also help reduce anxiety. Feelings can tell us that we are anxious; they can also help us identify the type of internal emotional reaction we are experiencing: mad, glad, sad, confused, stuck, and so forth. What feelings alone do not tell us, however, is how to resolve an unhappy predicament. That takes thinking, not just feeling.

As we shift our emphasis from how we **feel** to how we **understand** the particulars of a challenging issue, we again change the distribution of energy in our brain. By suppressing its more primitive divisions and energizing the more advanced ones, we can better differentiate fact from fear, foresee the consequences of our behavioral choices, and select an approach we believe is likely to work to our advantage.

Another shift in focus that can greatly reduce anxiety is the shift from emphasis on the other to emphasis on the self. As long as we hold on to the illusion: “If only he or she were different, this entire problem would go away,” we do nothing but perpetuate the predicament. Experience tells us there is no way we are going to get others to change, and yet we still see the solution to so many problems as dependent on something the other person must do differently. Relationships are about interactions and transactions among individuals—how they **relate** to each other. When any individual in a relationship makes a change in his or her own way of relating, the total relationship can change.

Consider the case of Sanford and April, social work colleagues in the oncology unit of a large hospital. Sanford, the supervisor, felt that April was underperforming in her role as primary patient contact. Despite superior knowledge in her field, she showed little initiative, had trouble making decisions, and regularly failed to meet paperwork deadlines.

Sanford discussed his concerns with April in several performance reviews, but nothing seemed to change until one day when he overheard her on the telephone, telling her husband she wished Sanford would stop micromanaging and give her some real responsibility. Totally confused, Sanford asked April to lunch to discuss what he had heard. April pointed out that in his zeal for detail and accuracy, Sanford pored over much of her work, holding on to it until the last moment, and then giving it to her for extensive revision of format, style, and minor details.

Sanford took April’s observations seriously and decided to try altering his part of their working arrangement. He would still review her work, but would offer her comments only verbally, allowing her to accept or reject any or all of them. The strategy worked as planned. Sanford was freed from the exhausting burden of a double workload. April paid careful attention to Sanford's input, but made her own decisions and was able to move through her work with greater confidence, efficiency, and pride.

**The Six-second Vacation**

For many people, the greatest workplace anxiety comes from not knowing what to expect next. Allan used to “die a thousand deaths” when his supervisor would summon him into a meeting unexpectedly. He remembers having felt the
same way as a child in school when faced with a pop quiz.

Allan has gained more control over his anxiety in unpredictable situations since he learned a technique called the “six-second vacation.” He likes this approach, since it is quick and can be used in any setting, even while sitting across the desk from his superior. It works like this:

First, inhale for two seconds, sending the air wherever you need a little help. It can be sent to any part of body, mind, or spirit, or you can direct it to a troubling idea, a present worry, a concern, or even a recurring theme.

Next, exhale for two seconds, releasing all muscle tension in your body, starting at the head and moving to the toes. Think of yourself as a calm, still pool.

Finally, do nothing for two seconds.

As you practice the six-second vacation, you will find yourself capable of achieving a much greater degree of serenity in anxious circumstances than you might ever have expected.

Social Workers and Emotional Leadership

Although the events and situations that set off anxiety are often beyond the control of any one individual, everyone in an anxious organization has the opportunity of taking “emotional leadership.” This means managing situations by managing your own reactions when anxiety starts spiraling upward.

In our roles as social workers, we are often placed in the center of highly anxious situations. If we are able to observe ourselves becoming anxious, we can initiate a move from emotional response to principle-based, factual thinking. In so doing, we create a calmer, more flexible environment for our clients, giving them an opportunity to function at their best.

The same principle applies in our interactions with colleagues. An individual can have a significant effect on others beneath them in the pecking order, at their same level, and one or two levels up. Top leaders can have an especially positive influence since they touch more lives within an organization. When they become even slightly calmer, they can calm the entire organization.

The important implication for social workers is that—while some people have a natural talent for managing their anxiety—these are skills that can be both learned and taught.

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Resources

Tropical storms, tornadoes, fires, floods, earthquakes, transportation accidents, mass murders, hazardous material spills, building collapses, nuclear plant malfunctions, terrorist bombings, and many other disasters occur throughout our country each year. In the wake of these events lies a wide path of catastrophic physical and psychological destruction, including many seriously traumatized people who struggle to recover from their losses and rebuild their lives.

Once a disaster occurs, people see things differently. Prior to the event, their lives have order, and they feel like they are in command. In the days and weeks following the disaster, however, people often feel they no longer have control over anything—the event has caused unexpected losses and has taken away their normal routines. They may find themselves awash in a sea of paperwork and bureaucracy (relief agencies and services, insurance claims, etc.) that many refer to as the second disaster. They soon begin to realize it will be some time before they will regain their former sense of stability and control.

Faced with so many changes, people tend to react with fear, anger, anxiety, and depression—all normal stress reactions under the circumstances. Disaster mental health (DMH) workers do not expect people to feel well in the wake of a disaster, yet the victims expect themselves to “get over it,” and to feel better quickly. When they do not, they may fear they are weak or are going crazy. In addition to support, DMH workers need to offer education about “normal” reactions and routine challenges of recovery.

About Disaster Mental Health (DMH)

Disaster mental health (DMH) is a growing field of practice designed to help victims (and the relief workers who rush to their aid) learn to cope with the extreme stresses they face in the aftermath of a disaster. The goal of DMH is to prevent the development of long-term, negative psychological consequences of a disaster, such as post-traumatic stress disorder (PTSD). As noted above, disaster victims and relief workers will be changed by their encounters with disasters, but the majority of them will not be damaged by those experiences.

The basic tenets of DMH begin with this central principle: The target population consists of people who are having normal (and fully expected) reactions to an abnormally stressful disaster/emergency situation. Disaster victims generally will not stop functioning, but they will react in fairly predictable ways (with some differences due to age/maturity).

Psychological first aid, various crisis intervention techniques, outreach services, and psychoeducational approaches allow victims and relief workers to be quickly triaged and briefly counseled (or referred for formal services). This helps them return to pre-disaster levels of functioning as quickly as possible. The goal of DMH is to ensure that the victims become survivors, by doing whatever can be done to prevent long-term, negative consequences of psychological trauma.
Typical Reactions to Disasters

Common feelings and reactions expressed or displayed by victims of disaster include the following:

- Basic survival concerns
- Grief over the loss of loved ones or prized possessions
- Separation anxiety
- Fears about one’s own safety and that of significant others
- Regressive behavior (such as thumb sucking in children)
- Relocation and isolation anxieties
- Need to express thoughts and feelings about experiencing the disaster
- Need to feel one is part of the community and rebuilding efforts
- Altruism and the desire to help others cope and rebuild

Children and Disasters

Disasters often cause behavioral changes and regression in children. Many react with fear and show clear signs of anxiety about a possible recurrence of the disaster event(s). Sleep disturbances are common among children (and adults, too) and can best be handled by quickly returning to (or establishing) a familiar bedtime routine. This often proves difficult following major earthquakes, as frequent aftershocks and displaced residences make it difficult for people to return to regular sleep routines. Many families end up sleeping together in the same bed long after the main quake.

Similarly, school avoidance may occur, and can lead to development of school phobias if children are not quickly returned to their normal routine. In some disasters, schools may be flooded or damaged in another way, making them inoperable. This, and the need to be bussed to other, unfamiliar buildings, will further add to children’s stress. Following a disaster, children may want to stay home, due to fears of leaving their parents’ sides for the length of a school day.

Adults and Disaster

Adults often report mild symptoms of depression and anxiety. They can feel haunted by visual memories of an event, and may experience psychosomatic illnesses. Pre-existing physical problems—such as heart trouble, diabetes, and ulcers—may worsen in response to increased stress levels.

Adult victims of disaster may show anger, mood swings, suspicion, irritability, or apathy. Changes in appetite and sleep patterns are also quite common. Like children, adults may experience a period of poor performance at work or school, and may undergo some social withdrawal. Middle-aged adults, in particular, may experience additional stress if they lose the security of a planned (and possibly paid-off) retirement home or financial nest egg, or if they are forced to pay for extensive rebuilding costs.

Older adults often miss their daily routines, and suffer strong feelings of loss from missing friends and loved ones. They may also suffer feelings of significant loss from the absence of their homes or apartments and the sentimental objects (especially items like paintings, antiques, family bibles, photo albums, films, and videotapes) that tied them to their past.

Adults living in group residential rehabilitation settings (mental health, mental retardation, or drug and alcohol facilities) and institutions (prisons, hospitals, boarding homes, or nursing facilities) may react similarly. In these groups, an overriding sense of isolation and dependence often exists, which they may feel even more strongly during the recovery period. Family members and friends may be lost, as actual casualties of the disaster itself or as captives of a cleanup effort. Either way, those living in residential settings generally receive less social contact following disasters, and tend to feel more forgotten and alone.
Duration of Symptoms

The onset of these changes varies with each person, as does duration. Some symptoms occur immediately, while others may not show until weeks later. Nearly all of the reactions above are considered normal, as long as they do not last for more than several weeks to a few months. Unfortunately, victims and relief workers who are unfamiliar with these normal feelings, emotions, and reactions often fear they are “losing it” or “going crazy” from disaster-related stress.

Returning to feeling “normal” takes far longer to achieve than most people assume. A good way to explain it to others is to draw a parallel to the death of a close family member or friend. Most realize the recovery period will require at least one year (to pass each holiday, birthday, anniversary, change of weather, season, etc.) and the one-year anniversary of the loss (or the disaster event).

Several more years (some estimate two to seven years) may pass before people fully adjust to their losses and the resulting changes in their lives. People who survive disasters tend to mark time differently, referencing events as being before or after the event, even when everything appears to have been successfully resolved.

Moving Forward

The personal impact of disasters tends to be much worse when the events are caused by intentionally destructive human acts rather than by natural causes or accidents. In these instances, survivors often need extra time to resolve their losses and move forward with their lives.

Most trauma victims, however, are amazingly resilient. Disaster survivors often report being stronger or more mature afterwards. Many have taken steps for future personal preparedness. They are often more sensitive to future disasters, and many donate money and/or volunteer to help others who must now go through the same pain they experienced.

Implications for Social Workers

First, social workers need to have a personal family disaster plan. Develop a plan, gather needed supplies, and practice what to do when something bad happens (for example, have a home fire drill).

Then, move beyond personal preparedness and become familiar with ongoing disaster initiatives in your workplace and in your community. Consider becoming an active participant in the local preparedness planning process. Social workers can offer a valuable human-needs perspective that should be considered during disaster preparedness planning and implementation.

Beyond involvement with planning activities, consider volunteering in disaster relief efforts. I have been an American Red Cross volunteer for 16 years. My disaster assignments have all been extremely rewarding, personally and professionally. I alert my clients when I begin seeing them that there may be times when I am activated on short notice. They each have crisis plans and my coworkers will provide backup during my absence.

Even if you have no interest in serving in a disaster relief role, learning some DMH techniques can help you to address the many day-to-day crises encountered in our personal and professional lives. Whenever clients, coworkers, and friends find themselves struggling with the loss of loved ones, crime victimization, job-related stress, or other traumatic events, psychological first aid can provide some relief.

More information about DMH and disaster preparedness can be found at http://www.eyeofthestorminc.com

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