Art therapy with grieving adolescents in an inpatient setting:

An exploration of media and materials

A Capstone

Submitted to the Faculty

Of

Drexel University

by

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In partial fulfillment of the

Requirements for the degree

of

Master of the Arts in Art Therapy and Counseling

June or May 2018
DREXEL UNIVERSITY
Graduate College

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Dissertation/Thesis Title:  Art therapy with grieving adolescents in an inpatient setting: An exploration of media and materials

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(Last Updated 3/1/2016)
Dedications

I dedicated this paper to my mother, Veronica Staar. Her guidance, wisdom, and being a inspirational role model has motivated me to keep pursuing my passions. She has shown me strength, compassion, and sacrifices that have encouraged me to try and not be afraid to make mistakes. Thank you, you are all a daughter could ask for.
Acknowledgements

I would first like to thank my thesis advisor Natalie Carlton of the Creative Arts Therapy department at Drexel University. Natalie was always available whenever I felt stuck and needed help. She has steered me in the right direction whenever I needed guidance. I would also like to acknowledge Courtney Murphy as the second reader of this thesis, and I am grateful for her time and valuable comments on this thesis. I must express my gratitude to my mother, my friends, and my boyfriend for providing me with support and encouragement throughout my journey at Drexel. Your support has made it possible to finish my capstone. Thank You.
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Abstract

This capstone thesis explored loss and how art therapy can help the grieving process for adolescents in an inpatient setting. The literature review compared foundational and contextual models of grief and loss, while integrating cultural considerations. This included topics such as adolescence and bereavement, how adolescents understand death, how they can react, and what factors affect an individual’s bereavement process, that are often not linear. The literature review also contextualized the plethora of treatment settings available to adolescents in need of support. Typical therapies available to adolescents included cognitive behavioral therapy, trauma informed care, and meta-verbal therapies such as expressive, dance/movement, music, and the focus of this capstone, art therapy. Examples of art therapy utilized with adolescents for their wide bereavement responses were shared to conceptualize specific media and materiality uses.

This capstone researcher actively investigated how four different types of materials and directives may be used with bereaved adolescents in an inpatient setting. Specific media materials and processes explored were collage, postcards, memorial boxes, and old books for black out poetry. Conclusions noted how these specific media worked in both direct and indirect ways with bereavement and that all types of losses, not just death of a loved one, can trigger serious signs of grief for adolescents, especially those with low protective factors. Moreover, and via working in an inpatient setting, this researcher surmised that every adolescent is at a different point of their grief journey and that structured art therapy materials use and adaptation can allow for safety and autonomy, wherein the adolescent can decide what and when they were willing to share within a group of their peers. The capstone concluded that topics of grief and bereavement can be applied ethically and creatively in inpatient settings to encourage social connection to shared themes and enhanced self-awareness for adolescents.
CHAPTER 1: INTRODUCTION

Death, a natural part of life, can be a difficult topic to talk about. At some point in everyone's life, they will experience grief in response to loss of life, whether it be family members, friends, and pets and metaphorical deaths from life-disruptions such as divorce, moving, or termination of relationships. Unfortunately, some individuals' first experience of death is during their childhood and adolescent years. Adolescents who experience death early in their lives experience bereavement and grief differently than adults and have a plethora of factors that affect how they grieve and certain ‘protective factors’ of resiliency. Some factors can be what understanding of death an adolescent has, how they react, the type of significant loss, and the kind of support systems available. The overall purpose of this development of a method capstone was to explore how art and art therapy can be used to provide the space to express grief with adolescents who have experienced a loss in an inpatient behavioral hospital setting. This author reviewed literature on theoretical and clinical approaches regarding grief, how adolescents respond to loss, what factors affect an adolescent’s grief, and how art therapy and other meta-verbal communication modes are used to help adolescents manage grief.

Key Terms

Several key terms are defined in this next section to clarify their use in the capstone project and writing.

Bereavement. Bereavement is the long-term process of adjusting to the death of a person or persons (Newman & Newman, 2015). It is a period of sadness following the loss experience (MacWilliam, 2017). Bereavement is the fact of loss through death and individuals can have a psychological, physiologic, or behavioral response to bereavement that happens over time (Osterweis, Solomon, & Green, 1984).
Grief. The personal experience of loss that involves a broad range of emotional, behavioral, and cognitive reactions is often defined as grief. Grief responses can range from an immediate or delayed response, the response can be mild or intense, and a person's experience of grief can range from short period to a longer period (Newman & Newman, 2015; Worden, 1991). Grief is an emotional, physical, cognitive, behavioral, social and philosophical response to the loss of someone or something to which a bond was formed (MacWilliam, 2017). There are some subset definitions of grief as well, such as disenfranchised grief, or when there is no opportunity to publically mourn the death of a loved one, and complicated grief, which can occur when that death is violent and/or accompanied by trauma or abuse (Bardot, 2013).

Mourning. Mourning is the adaptation to loss; the process of cultural practices observed by people connected in certain ways to a person who has died (Rosenblatt, 2008; Worden, 1991). Mourning is the way the individual expresses his or her grief in front of others, usually through religious and cultural practices (MacWilliams, 2017). Mourning is the social expression of grief, including rituals and associated behaviors (Osterweis, Solomon, & Green, 1984).

Loss. Loss is a broad term that encompasses real-life experiences such as death, major transition, a romantic heartbreak, loss of a job, or estrangement from a family member (MacWilliams, 2017). Loss is the disruption of one's daily life. Primary loss entails death, divorce, abandonment, and incarceration. Secondary loss is the result of a primary loss such as loss of income, environment, and routine. (Bardot, 2013).

Overview

The problems usually addressed when an adolescent is admitted into an inpatient hospital are crisis behaviors and affect, and not the possible underlying trauma, grief, and loss that they may be experiencing currently or long term. The sole focus of their treatment plan can be to
stabilize the adolescent’s crisis behavior before returning home to caregivers or stepping down to another level of treatment care. Modern day behavioral hospitals are short-term because health care models are not able to support an extended stay in an inpatient setting. Due to these limitations, forms of treatment that explore grief and loss for youth are not considered appropriate, even if there are underlying trauma or grief reasons for their dangerous behaviors. This is a concern because adolescents that do not have the proper space to express their grief through the appropriate treatment tend to not resolve their externalizing and/or internalizing behaviors and are often readmitted (Corr, 2010; Yampolskaya, Mowery, & Dollard, 2013).

Moreover, adolescents may not have support beyond the hospital staff, to discuss grief responses, and they may not receive additional professional help outside of the hospitalization. The inpatient setting may be the only space where they can potentially begin to discuss their loss and also connect to other peers experiencing similar types of grief. The type of acute or sustained grief an adolescent may experience could be the result of a death in the family or of a close friend, parental divorce, separation, or incarceration, and/or abandonment from biological family members or a primary caregiver. This capstone acknowledges that all different types of loss require grieving and going through processes of bereavement.

I explored how a group can process grief when each adolescent is at a different point in their admission and if art therapy can create that common ground for adolescents to begin to talk about their loss. The author learned that most of the adolescents admitted have experienced some type of loss other than death. When the topic was broadened to encompass all loss, the adolescents felt more inclined to partake in the conversation and open up about their own experience. The art materials provided a plethora of opportunities ranging from indirect ways to feel heard, to a more direct discussion of grief and loss. The art making process also encouraged
the adolescents to lower their guard, allowing more conversations to happen. The inpatient setting has many challenges to working through grief and loss, but when the topic is universal, it provides more opportunities to explore adolescent grief.

During the adolescent years (13-17), individuals develop the ability to think in a relativistic way about themselves, other individuals, and their world around them (Newman & Newman, 2015). When a death has occurred, adolescents are capable of understanding death as irreversible and likely to happen to them or anyone in their life but may be unaware or disinterested in the details or how it affects other aspects of their lives (Kleinman, Kaplan, & Weiss, 1984; Robin and Omar, 2014; Rosen, 1991). Adolescents' reactions to death can be observed through internalizing and/or externalizing behaviors. How they work through their grief is determined by their support system and circumstances surrounding the death. When the death is violent or has stigma associated with it, adolescents can feel less inclined to express their loss, which can potentially result in the development of trauma; these factors make it harder for an adolescent to resume and work through his or her grief (Brandell & Ringel, 2012; Walker, 2009).

Communication with trusted others could be an important protective factor for adolescents experiencing bereavement. The quality of communication among family and friends can affect how the adolescent grieves over their loss and/or loved one. This communication can be open and honest or reveal strategies of denial or protection. Surviving family members and friends of the grieving adolescent might become hesitant or confused as to how to discuss the loss of the loved one, and they may try to prevent causing any more pain for the adolescent by restricting or avoiding the subject. Rosen (1991) found that when the people involved in the adolescent's life talk openly about their feelings, adolescents found it more helpful for dealing with grief by having the opportunity to share their fears around death and have them corrected. It
has been reported that when adolescents have supportive family and friends, they feel heard, understood, and comforted (Ringler & Hayden, 2000). In contrast, if adolescents found it difficult to talk about loss, there were complications in their bereavement such as not having the opportunity to correct any misconceptions, conflicts, and/or distorted ideas around the death (Moos, 1995). As a result, adolescents who feel they do not have supports around them to express their grief can feel that they will never get the chance to share how they are feeling (Rosen, 1991).

When adolescents cannot find support enough from their friends or family, other supports can be provided via grief counseling and meta-verbal therapies (expressive arts therapy, music therapy, dance/movement therapy, and art therapy). Unfortunately, these services are usually only provided when an adolescent is admitted into residential, outpatient, foster care, and inpatient hospital settings. These services can provide adolescents with the strength and capacity for healing from loss and mediate what gets in the way of their healing (Kosminsky & Lewin, 2009). Each form of therapy can create the space for discussion and process all aspects of the loss, whether it is the primary loss or secondary loss. Although these services have shown to help (Kazdin, 1993), adolescents may appear resistant to treatment because they prefer using supports other than professional services to work through their grief (Primavera, 1988).

The potential implications and applications of this capstone were to give more credence to contextual treatment models where adolescents have the ability express their grief in safe ways and while they are being treated in an inpatient setting. Another implication is to provide adolescents the opportunity to explore and voice their grief and loss without the pressure of acceptance from other adolescent peers through the art and the art making process. Specifically, art therapy use in group settings allowed several adolescents to express their emotions through
the combination of active art-making (using various media) and the creative process, which can engage cognitive, emotional, and behavioral responses (American Art Therapy Association, 2017; Malchiodi, 2005; Riley, 2001). The use of art provided support for these adolescent who seemed to struggle to verbally express their grief to their family or friends. When rapport was built between this art therapist and adolescent, they seemed to feel safe enough to begin to show emotional risk and explore feelings around the death of their loved one. This was done explicitly through verbal processing, relational negotiations, and through the nonverbal exploration of art materials. Research has explored art therapy use with grieving adolescents and has shown what materials and themes have typically emerged. Kohut (2011) used scrapbooking in a bereavement group as a way to remember the deceased loved one in a group setting. Similarly, Beaumont (2013) saw in her review of the literature that the use of storytelling with art allowed grieving individuals to integrate their experience of loss and move forward. Brandon and Goldberg (2017) used a kinetic sculpture intervention within individual sessions to process the family dynamics after the death of a loved one. Overall, the use of art therapy provided adolescents with a permanent container for their feelings and a record of their experience, as well as a way of structuring and having control over their situation (Brodie, 2007; Junge, 1985).

I struggled to find literature that documented the work of supporting adolescent grief with art therapy within inpatient settings specifically. Thus, my capstone process anecdotally explored and provided insight to media, materials, and directives I used to approach grief and loss metaphorically while working in a setting that might make it challenging for clients and therapists to build rapport. Therapeutic rapport can be challenging to build within the inpatient setting, as there can be limited contact between the therapist and adolescent, and due to the turnover rate of inpatient hospitals, adolescents may feel guarded among unfamiliar peers. The
overall goals of the art tasks I implemented were to support grieving adolescents by giving them validation of loss experiences and allowing space for them to express their feelings. The power of art is that adolescents can choose what to reveal about their artwork, and their forms of expression can be through verbal processing and/or art-making processes. Moreover, the artwork becomes the container to hold their grief and allows them the safety to only reveal what feels comfortable. My objective was to see how art therapy could provide adolescents the space and media structure to express their grief, either by verbal processing or through the art-making process. With several adolescents who reported underlying grief and loss dynamics, I explored direct and indirect tasks with non-traditional mediums to engage them in the art-making process and group discussion, via the use of strategic metaphor for group directives.
CHAPTER 2: LITERATURE REVIEW

For a better understanding of how art therapy in inpatient settings can aid grieving adolescents, this literature review explored four topical areas: 1) an overview of bereavement literature to understand how bereavement has developed over time, and outlined major perspectives and developments while cultural aspects are integrated in bereavement models; 2) a review on how death affects an adolescent’s growth and behaviors, which in turn influences how an adolescent grieves; 3) a review of treatment settings that are typically provided for adolescents as well as how meta-verbal therapies such as art therapy are used with grieving adolescents; and 4) the specific art therapy tasks, materials, and themes used to explore bereavement and grief with adolescents.

Grief, Bereavement, and Loss

The understanding of death and loss has been noted to change throughout human history and geographical locations. Different therapeutic models that have been developed, implemented, and researched over time with client outcomes have also shaped this understanding of death and loss. Research has noted how foundational models and developmental theories have affected bereavement and grief therapy work. Multicultural aspects are explored to provide how different cultural norms in North America view death and bereavement. Western culture’s expectation of grief and homogeneous rituals has made the idea of death and its rituals a taboo topic (Moos, 1995; Shapiro, 1996b). For this literature review, Western culture has been defined as living in Europe currently or having a European decent that migrated to North America. Many grief and bereavement theories and theorists are considered Eurocentric and may not be congruent with culturally diverse families in North America; Therapists have applied broader theories and clinical applications that consider both the origin of their clients’ diverse cultures.
and immigrations statuses (Shapiro, 1995). For this capstone conceptualization, it was important to understand that different ethnic groups have their own ways of grieving that may not fit into Western cultural norms or models.

More contemporary models for art therapy and counseling practices have developed from historical researchers such as Freud (1917), who brought loss to mainstream therapy literature, Kubler-Ross (1969), who created a popular treatment model termed the five stages of grief, and Bowlby (1969-82), whose attachment theory provided a vital lens for bereavement support with youth. Newer models, such as Dual-Process Model and Meaning-Reconstruction Model, have started to conceptualize and implement the many complexities of bereavement and grief (Neimeyer, 1998; Stroebe and Schut, 1999).

**Foundational models of grief and loss.** Freud (1917) created a foundation that allowed the discussion of loss to become a part of mainstream therapy research and strongly influenced subsequent psychoanalysis (Lister, Pushkar, & Connolly, 2008; Shapiro, 1996a). Freud (1917) believed there were two conditions to loss: melancholy and mourning. According to Freud, the task of mourning, the reaction to the loss of a loved one, was to relinquish psychological attachment from the deceased and move on to in essence, let go of any hopes for that relationship in the future (Rothaupt & Becker, 2007; Rubin 1981). When an individual was incapable of relinquishing psychological attachment, then it was considered melancholy. The pathological or maladaptive mourning entailed the loss of interest in the outside world, incapability to love, and restriction of activities, which is essentially depression (Freud, 1914-1916). This left early psychological theorists with two assumptions about grief,

The tendency to pathologize normal grief by describing processes more often observed in clinical populations, and the perpetuation of the belief that normal
bereavement ends with relinquishment of all ties to the lost object. (Shapiro 1996a, p. 549)

These assumptions were also emphasized through Hagman’s (2016) analysis of the standard psychoanalytic model of mourning. This standard model believed that the goal for an individual in bereavement was restoration of psychic equilibrium and then returning to premorbid conditions, which was entirely a private intrapsychic process. Ideally, the psychoanalysis confronted the client’s loss so then the libido could then detach from the loss and be free to invest in other attachments, which resulted in the end of mourning (Hagman, 2016; Lister, & Pushkar, Connolly. 2008). Absence of emotional expression or positive affect like joy and humor were considered a resistance to the mourning and pathological (Hagman, 2016; Lister, Pushkar, & Connolly, 2008). Hagman (2016) believed that the standard model’s preconception of mourning was considered closer to a bodily function than to a person’s worldview, belief system, or emotional language and had normal, predictable characteristics.

Another model that influenced theories on bereavement and loss was Elisabeth Kubler-Ross’ (1969) five-stage model of grief. Kubler-Ross developed this model through researching middle-aged people who had cancer. This model of grief was broken down into five stages of: Denial, Anger, Bargaining, Depression, and Acceptance (1969). In Kontogiannis’ (2000) review of literature, many people took Kubler-Ross’ five stages of grief literally and followed them as linear, sequential steps. In essence, counselors failed to use the stages as a way to contextualize their clients and instead, put these individuals into a theory of linear grief ‘recovery’. Retsinas (1988) conducted a study using Kubler-Ross’ model with elderly patients and concluded that this model could not be universal; therefore the model could not be taken literally. Retsinas stated
that for elderly people, death is not unexpected and it should not be expected that an elderly person would experience all the stages necessarily, nor in a predictable order.

John Bowlby’s (1969-82) attachment theory, with the aid of Mary Ainsworth, also had a great influence on models of grief and loss. This theory was developed through observing abandoned babies in hospitals (Brandell & Ringel, 2012). Through observations there, Bowlby developed a theory that clients would present three attachment styles that developed via interactions with early caregivers: avoidant, anxious-ambivalent, and secured. This was confirmed by the Bowlby, Ainsworth, Boston and Rosenbluth 1956 study of school-aged children who returned from a sanatorium stay and for whom she noted three types of relational bonds with caregivers: those who had positive feelings toward their mothers, those who had ambivalent relationships, and those whose were indifferent or hostile toward their mothers (as cited in Bretherton, 1994). As research developed, early attachment patterns were further correlated with the adult’s beliefs about relationships and affects to how the child developed their attachment patterns (Nesse, 2005). Many of the grief constructs normalize an eventual return to the individual’s normal activities and reengagement in social relationships, wherein the individual who is grieving must reorganize and ‘let go of’ the representation of the deceased (Rothaupt & Becker, 2007).

**Contextual models of grief and loss.** As time progressed, researchers surmised that grief and bereavement had more complexity than what was originally addressed. Researchers started to question “previous notions about grief work, the tasks of that work, and our beliefs regarding grief and mourning” (Rothaupt & Becker, 2007, p. 13). One early idea of grief that was proven inaccurate was the length of acceptable grief; researchers learned that mourning was a longer process and varied in length for each individual (Gray, 1988; Rothaupt & Becker, 2007). Shucet
and Zisook (1993) acknowledged, in their essay on their own staging of the normal grief process, that the duration of grief to be considered “normal” has increased from weeks to months to possibly years. Another misconception critiqued was that unresolved grief necessarily became pathological. Research showed that there are different behavioral and emotional symptoms of grief and that both ‘pathological’ grief and ‘positive’ effects are both meaningful in attempting to preserve connection while dealing with loss (Gray 1988; Hagman, 2016; Rothaupt & Becker, 2007). For example, Unni Wikan (1988) compared bereavement and loss responses for individuals and groups living in both Egypt and Bali, two Muslim communities. Although both communities shared the Muslim faith, they experienced bereavement in different ways; the Balinese community focused on joy and laughter as their expression of sadness, while the Egyptian community believed that expressing unhappiness and anger was necessary for their health. This research demonstrated the complexity of grief for different cultures and worldviews and the importance of not defining what is an atypical or typical grieving response for other cultures.

Some clinical theorists have found that the entire family’s grieving process affected the individual grieving process. Moos (1995) noted that previous models of grief focused on the individual and did not focus on the role of family processes and models of family grief. With family-centered models there is an understanding that each family is different and “within a family system there exist myriad coping styles, patterns of grief, and individual approaches to processing loss” (MacWilliam, et. al, 2017, p. 88). Shapiro (1994) also believed that in order to effectively process the grief, the family structure must reach a stable equilibrium to support ongoing family development. The family structure and previous roles and relations affected how an individual family member grieves. Moos (1995) believed this process is interdependent, and
how flexible the family dynamic is can affect how the individual copes with their loss. How a family is able to communicate about death can be determined by the family’s prior ways of communicating (Goldberg, as cited in Moos, 1995). A rigid family development could prevent a family from openly processing their emotions and grief, which resulted in a harder time for an individual in the family to grieve (Shapiro, 1994).

Moos (1995) perceived a correlation between family grief and individual bereavement and he concluded that bereavement is a complex process that has many other factors that contribute to individual bereavement. Taylor, Hayslip, Kaminski, and York (2003) conducted a quantitative longitudinal study of 66 recently bereaved people to understand grieving family systems. These researchers concluded that affect, communication, and cohesion were all significant predictors of how the participant grieved. Family relationships were an important source of social support and those with high social support had less grief symptoms. Taylor, Hayslip, Kaminski, and York also concluded that families with more communication had fewer grief symptoms due to being able to express their feelings of sadness about the loss. Such critical mediators may be found in how each family member interpreted the circumstances and loss of their loved one and how they affected one another through their grieving interactions. Family-centered models focus on the family sharing information, respecting and honoring differences, partnership and collaboration, negotiation, and care in the context of family and community (MacWilliam, et. al, 2017).

Laurierobert and Neimeyer (2008) conducted a study of bereaved students who experienced their bereavement within the past 24 months by having them complete the Inventory of Complicated Grief-Revised, Continuing Bonds Scale, and additional questions. Thirty-nine percent of the sample was African American and 56.3% was Caucasian. These researchers
concluded that African Americans reported they that maintained some sort of contact with the deceased and compared to other ethnicities, reported higher levels of distress over extended family members (grandparent, aunt, uncle, or cousin). Laurierobert and Neimeyer believed that this was due to the distinction between immediate and extended family being less pronounced. In their study, they found that although the participants claimed to have others to rely on, they were less likely to talk about their loss, which Laurierobert and Neimeyer believed was because talking about the loss was not the primary function of their support. By reviewing literature on cultural aspects of bereavement, this author wanted to acknowledge and emphasize the complexity of death and grief when representing multiple theories and models of bereavement that emerged from Eurocentric viewpoints.

Rubin (1981) discussed the *Two-Track Model of Bereavement* that combined both psychodynamic and personality change models of bereavement. The focus of the two-track model was how personality of the bereaved individual changed and how the bond between the individual and the deceased affected how the individual grieved. Track one of this model focused on the difficulties and competencies in functioning following a loss, while track two of the model addressed the emotional bond with the deceased and what it involves (Malkinson, Rubin, & Witztum, 2006). Unlike Freud’s belief that the individual returned to premorbid conditions, this model acknowledged that the individual goal is to reach a homeostatic functioning that is not necessarily how they functioned prior to the individual’s loss. This starts when the individual loosens their attachment to the deceased, allowing the individual to mourn and retain a level of independence. When the individual has reached homeostasis, they can process their relationship to the deceased and this results in a change in their personality.
In the original work, Rubin (1981) studied 45 married women who were divided into three groups: mothers who lost a child to Sudden Infant Death Syndrome (SIDS) recently, those who lost a child to SIDS two to six years ago, and a group who did not experience the loss of a child. The participants were seen once and were administered a structured personality measure, followed by a semi-structured interview. Rubin concluded that the affective involvement with the deceased continued four and a half years after the death. The mother’s personality change stabilized seven months after the loss and would not change for four years. Rubin concluded that grief is a long process and an individual will not necessarily completely heal from the loss.

Malkinson, Rubin, and Witztum (2006) conducted two case studies demonstrating the application of the Two-Track Model of Bereavement. These researchers concluded that although both tracks of the model needed to be addressed, what was focused on during the initial phase of the intervention depended on the client. One case example was a woman who lost her husband traumatically nine months earlier. These researchers saw that her “pre-loss conflictual relationship resulted in an initial response of relief mixed with guilt feelings… which was expressed as the cause of guilt feelings, depression, anxiety” (p14). Being able to express her thoughts and feelings allowed her to face these feelings and work through them. This resulted in reworking her relationship with her husband and relieved symptomatic difficulties that manifested.

Shuchter and Zisook (1993) developed their own staging of the normal grief process, which was broken into three overlapping phases: an initial period of shock, disbelief, and denial; an intermediate acute mourning period of acute somatic and emotional discomfort and social withdrawal; and a culmination period of restitution. They emphasized that these stages are fluid and overlapping, and should not be taken in a linear process. Their first phase was categorized as
the initial shock of the loss, where the person can feel numb or paralyzed, refusing to believe that the death has occurred. The second phase occurs when the person acknowledges that the death has occurred and often being so absorbed with the deceased that they adopt the deceased’s mannerism and habits. The third phase allows the bereaved person to come to terms with what loss meant to them and begin to look outward into the world, hopefully returning to some daily life activities and seeking out others.

Implementing a study of 350 people who lost their spouse, Shucter and Zisook (1993) explored the many dimensions of grief. The longitudinal study conducted structured interviews with the spouse two months after the death of the partner. Follow-up questionnaires were distributed at seven and 13 months. Researchers found different dimensions of grief that each individual experienced, one being a change in identity. As time went on, the bereaved individual learns that he or she has the capacity to recover from grief and see new ways of the dealing with the world (Shucter and Zisook, 1993). Similarly, Gray (1988) saw that the original major task of mourning was not to move on past death and the relationship with the deceased but by facing the reality of death, the individuals might gain awareness and re-own the meaning of authentic living.

Lister, Pushkar, Connolly (2008) discussed two newer models; Dual-Process Model and Meaning-Reconstruction Model. Both models agreed that bereavement was a life-long process and not a linear one. The Dual-Process Model, proposed by Stroebe and Schut (1999), showed that the process of bereavement was not a phrasal process but an oscillation between two types of stressors: loss orientation and restoration orientation (p 212-213). Loss orientation focuses on the loss itself while restoration orientation focuses on secondary loss like redefining identity, and reorganizing roles of the deceased. Reese (2005) stated that the Dual Process Model was
“successful in organizing grief phenomena with its emphasis on separating attempts to cope with the emotional loss from the attempts to reorganize the instrumental aspects of life after loss” (p 199).

Lister, Pushkar, and Connolly (2008) also noted that there is potential to find meaning in loss through the movement between approaching and avoiding the loss. These researchers described how the Meaning-Reconstruction Model (Neimeyer, 1998) was the process of an individual reconstructing their personal meaning that is constructed around core assumptions that create an individual’s perspective. They also stated that this model actively explored and redefined the individual’s relationship to the deceased over time. Hagman (2016) also believed that the process of mourning was not to relinquish attachment of the death but to preserve and create a meaningful relationship with the loved one. Holland, Currier, and Neimeyer (2006) conducted a study with college students to understand how the Meaning-Reconstruction Model affected grieving. The researchers conclude that, overall, this model helped find benefits from the experience of loss, which resulted in decreased complicated grief. The participants benefited more from sense-making than benefit-finding, and these researchers hypothesized that this could be due to the belief that benefiting from the loss could be selfish in the participants’ eyes.

A major critique for earlier models was that experiencing grief became a one-size-fits-all phenomenon. Both Gray (1988) and Hagman (2016) noticed that the mourning process is unique and influenced by the individual’s understanding of death, and strictly following a model or theory would reduce an individual’s bereavement. One consideration Shapiro (1995) emphasized that families of color are more likely to experience violent or traumatic death, and other catastrophic disruptions of the family cycle in poorer communities. Those discriminated against and those in under-resourced communities are less likely to pursue mental health services for
support due to external barriers like racism, oppression, and poverty (Shapiro, 1996b). Schoulte (2011) also noted that Latin Americans were less likely to seek mental health services due to barriers such as insensitivity, language barriers and lack of effectiveness. Kleinman, Kaplan, and Weiss (1984) noted four aspects of social support that help facilitate recovery when working with culturally diverse populations going through bereavement as, “enhancing self-esteem and a feeling of being loved, problem-solving, networking, and providing relationship resources for meeting life cycle transitions” (p. 203). Social class, immigration status economic, and sociopolitical factors all contribute to how a person grieves and should be taken into account when working with culturally diverse populations (Kleinman, Kaplan, & Weiss, 1984; Shapiro 1996b). Hagman (2016) believed that bereavement theory needed to move toward relationship and relationally based meanings in therapy processes. Hagman critically believed that no matter how withdrawn someone appeared in their grief, they were still struggling to maintain relatedness, whether if it was with the person they lost or the social community surrounding them.

**Adolescence and Bereavement**

How an adolescent expresses bereavement and is affected by loss is varied and dependent on how they developed previously in relationships and due to additional external factors. The next research areas noted explore childhood development and how those critical experiences affect how an adolescent understands grief. The research collated describes how trauma and cultural considerations affect an adolescent’s bereavement. Secondly, critical ideas as to how adolescents exhibit their grief internally and externally, and how circumstances of death and support systems affect an adolescent’s grieving process, are explored. These included examples of other types of losses that approximate grief experiences similar to responses to death of a
loved one. The final section reviews some treatments that are offered to adolescents and issues that come up in each setting.

**Childhood development and bereavement.** The years before adulthood are filled with constant development: physically, psychosocially, and socially. Corr (2010) believed that although there are certain developmental marks, a person’s development during this time could be affected by gender, race, culture, religion, or economic status.

According to Piaget’s theory of cognitive development, during the preoperational years (four to six years of age), children are egocentric and have magical thinking; children believe that death is not a final event and can be reversed or avoided (Hubnik, 2000; Webb, 2002). Hubnik (2000) stated that a child’s magical thinking might include a focus on fear around bodily functions of the deceased. They might believe that death of their loved one is contagious (Brandell & Ringel, 2012). Children at this age cannot differentiate between thoughts and deeds, therefore they believe they are responsible for death—i.e. their anger toward the deceased was the cause of their death (Vollman, 2017; Webb, 2002).

For Piaget’s concrete operational period, children between the ages of seven and 11 begin to comprehend that the “environment is limited to the present and immediate physical realities” (Hubnik, 2000 p. 21). Death is understood in a realistic manner, children understand that this is an event that could happen to them or to others; this is due to the reduced egocentricity and capacity for reasoning (Hubnik, 2000; Vollman, 2017; Webb, 2002). Bardot (2013) stated that children during this age begin to explore what happens after death. They may ask questions in attempt to absorb the significance of the death and loss they experienced (Vollmann, 2017).

The formal operational period occurs during the ages 12 and 18, and adolescents have the capacity for abstract, probabilistic thinking (Newman & Newman, 2015). Adolescents develop
the ability to think in a relativistic way about themselves, other individuals, and their world (Newman & Newman, 2015). Adolescents understand the causes of death and that death is final and inevitable, but also need help in awareness of the types of conflicts that they are experiencing due to the loss (Krupnick, 1984; Rosen, 1991). Death becomes a fascination or a fear that can lead to an increase in risk-taking behaviors to challenge their mortality, and/or may even wonder about their own funeral, who would attend and what they would feel (Morgan & Roberts, 2010; Walker, 2009).

Brandell and Ringel (2012) stated that adolescents struggled between sharing their feelings and in return receiving comfort, and appearing mature and independent. During their early adolescence (12–14 years), they begin to comprehend that death is irreversible but are disinterested in the specific details surrounding the death (Robin and Omar, 2014). They might react in ways that appear selfish or egocentric, as they are more concerned about the impact of how the death will affect them. During middle adolescence (15–17 years), adolescents acknowledged death similarly to adults by being able to confront death more directly. They appeared to be more empathetic, thoughtful, and allocentric than early adolescents but still struggle with their own egocentric desires (Robin & Omar, 2014). Overall, the ability for an adolescent to understand death and the ability to grieve depends on the maturation of his or her emotional and intellectual capacity (Kosmisky & Lewin, 2009).

**Trauma and death.** Adolescents may consider death itself as traumatic and will coincide with inhibiting in addressing the normative task of bereavement (Walker, 2009). Walker (2009) defined the criteria for traumatic grief as how close the individual is to the deceased both emotionally or physically, the stigma associated with the death, and the presence of a violent death. Kosmisky and Lewin (2009) stated that trauma could also result from a death of a long
debilitating illness. Brandell and Ringel (2012) state that those with traumatic grief can have complicated grief and PTSD symptoms and are at risk for substance abuse, major depression, or borderline personality disorder. They can also display other “symptoms such as intrusive thoughts, anxiety attacks, nightmares, and other troubling reminders of the death” (Kosminsky, & Lewin, 2009, p334). If the adolescent feels responsible for the death, it can cause guilt to be intense and lead to suicidal ideation (Kosmisky & Lewin, 2009). Trauma must be addressed first before an adolescent can work through his or her own grief (Brandell & Ringel, 2012).

**Cultural considerations.** It is important to consider an adolescent’s culture or religious background when trying to understand his or hers grief. A Euro-American goal of bereavement is a psychological detachment of oneself from the deceased loved one, which is not the same across cultures where ancestry and its social significance of continuing bonds are important (McCarthy, 2009). Bardot (2013) emphasized the importance to recognizing what expectations are being placed on the adolescent, either by himself/herself and/or by his/her support system. McCarthy (2009) believed an adolescent’s developmental view of death is dependent on social class and societal context. For example,

Adolescents can become more religious after a death of a loved one and there should be consideration for the deceased's body, and honoring the deceased, the beliefs about what happens after death, the characteristics of a normal expression of grief, the roles of family members in coping with death, and whether there are certain types of death which may be less acceptable or especially hard to handle (Robin & Omar, 2014, p.105).

These traditions become important to the adolescent in order to grieve and honor their loved one. When the adolescent is bicultural or multicultural, his or her traditions and practices are blended
and it becomes even more important to understand what the adolescent specifically believes in (Bardot, 2013). An adolescent might pull perspectives from multiple cultures, therefore understanding what their worldviews are and how they are blending, and this might not fit the mold of stereotypical culture.

**Adolescent Responses and Mitigating Factors for Grief and Bereavement**

As an adolescent goes through childhood, they face normative and non-normative life events; non-normative life events are unpredictable and often catch the individual unprepared (Corr, 2010). Death is an example of a non-normative life event that affects an adolescent by providing opportunities for growth but can bring psychological harm (Corr, 2010). Through the lens of Euro-American theories of bereavement, childhood is a period of vulnerability and passiveness; those who appear resilient and active agents are not considered part of the norm (McCarthy, 2009).

The question of how an adolescent has comprehended a death has been explored through literature and research. Bereavement for adolescents has been noted as a long process; every new event or developmental milestone that occurs makes the grieving process continuous and may essentially never end (Corr, 2010). Gao and Slaven (2017) reported that expert interviews in their study saw children under the age of 18, experience grief in short spurts and then return to their daily activities. As an adolescent who grieved the loss of a loved one, he or she can react by displaying internalizing behaviors and/or externalizing behaviors. Internalizing behaviors are when their emotions and feelings are directed inwards while externalizing behaviors are when they are directed outwards, usually onto others (Webb-Ferebee, 2001). The concern is that adolescents are more likely to become depressed and withdrawn (acting in or internalizing) or
become more angry and aggressive (acting out or externalizing) to escape and control their emotions (Baker & Sedney, 1996).

During childhood, an individual can internally process death through a plethora of emotions such as sadness, anger, fear, worry, regret, loneliness, and self-blame (Corr, 2010). Other internalizing behaviors can appear such as fatigue, trouble concentrating, anxiety, depression, trouble sleeping, withdrawing from peers, and losing interest in activities they once enjoyed (Corr, 2010; Horns, 2007; Philpott, 2013). During adolescence, one can take on the role of the deceased caregiver for immediate gratification in the form of appreciation from others for their helpfulness and as a way to deny their inner feelings about their loss (Baker & Sedney, 1996). If a child is unable to process their loss, he or she can develop irrational thoughts such as feeling guilty or feeling responsible for the death of their loved one (Corr, 2010; Webb-Ferebee, 2001).

Some youth’s reaction to death are shown through externalizing behaviors such as irritability, lashing/acting out, getting into trouble, defiance, throwing things and agitation (Corr, 2010; Horns, 2007; Philpott, 2013). Some adolescent-specific behaviors are running away, delinquent behavior, excessive drug use, and risk taking (Baker & Sedney, 1996). Draper and Hancock (2011) conducted a study of the risk or vulnerability to delinquency and factors that compromise resilience in Britain. These researchers concluded that participants who were parentally bereaved before the age of 16 were more vulnerable to delinquency as evidenced by scoring nine or more on the Rutter Behaviour Scale, an approved measure used to quantify and define delinquency. Draper and Hancock believed this was due to the loss of security and protection that shapes how grief is communicated, whether it is withdrawal, regression, or acting out. In contrast, Silverman and Worden (1993) conducted a prospective study with children
between the ages 6 and 17 who lost a parent to death and concluded that a majority did not express their grief through aggression, withdrawal behaviors, or prolong crying periods. There were some cases of sleep disturbances and restlessness, but in excessive measures. Silverman and Worden (1993) reported that the participants showed sadness, confusion, and a high level of somatic symptoms.

Allender (2015) conducted a study that used 1,300 participants from the *Longitudinal Studies of Child Abuse and Neglect Project*. The results indicated that internalizing and externalizing behaviors did not differ based on if the adolescent experienced death before or after the age of nine. Allender (2015) hypothesized that this was because the majority of the participants were in school and could be due to having a more supported environment that promoted support systems and in turn, made it more difficult to be isolated. Some behaviors that appeared in school because of grief might look like forgetfulness and inability to concentrate on their work (Brandell & Ringel, 2012).

**Circumstances of death.** Death of a parent or sibling and how they pass can affect adolescents differently and may dictate how individual adolescents grieve differently as compared to others. Stikkelbroek, Bodden, Reitz, Vollebergh, and van Baar (2016) found in their study that when an adolescent lost a sibling, there was a higher increase in internalizing problems compared to the loss of a parent. Rosen (1991) believed that when a sibling has died, the individual fears that he or she will die like his or her sibling. When a sibling dies, the adolescent’s desire to maintain bonds with the deceased can be through treasuring the sibling’s memory and also by the continuation of the relationship as if they were still with them (Robin & Omar, 2014). Shipkey (2008) conducted a study of 13 participants between the ages of 18 and 20 who lost a sibling between the ages of 4 and 20. She noticed that participants idealized the pre-
death relationship with their sibling; adolescents used a positive lens when talking about their sibling and the only negative comments were about the loss of a future with their sibling. Shipkey also reported adolescents internalizing their deceased sibling’s values, goals, and personalities as a way to maintain the relationship.

A parental bereavement can have an impact on school functioning both academic performance and social behavior and can lead to serious mental health concerns like schizophrenia and major depression (Hubnik, 2000). A loss of a parent can also put the adolescent at risk to be “parentified” as they take on the deceased parent’s responsibilities, become under-responsible, and/or be unsure of which role to take (Brandell & Ringel, 2012; Primavera, 1988). Adolescents in their normal development are forming their own identity by separation and individuation from their parents and will normally act out and be rebellious; adolescents lose the opportunity to experiment with this process by not having the chance to resolve normal defiance and distancing due to the loss of a parent, leaving them with unresolved relational issues and guilt (Rosen, 1991; Stokes, Reid, Cook, 2009; Walker, 2009). Tenenbaum (1997) conducted a study of 60 adolescents (16–24 years old) who experienced a loss of a parent during their early adolescent years. She reported that disruption of the family structure was related to whom the adolescent was closer to; those who were closer with the deceased found it harder and were burdened with urgency and feelings to improve their relationship with the surviving parent (Tenenbaum, 1997).

There are two major types of parental death that affect an adolescent differently: anticipated and sudden. Anticipated deaths are chronic illness or old age, while sudden deaths are caused by external causes such as suicides, accidents, or homicide. Long-term illness, depending on the severity, can bring up guilt from feeling relieved after the death due to possibly dealing
with familial stress caused by the illness (Robin & Omar, 2014). Raveis, Siegel, and Karus (1999) conducted an analysis that used data obtained from 83 families with individuals between the ages of 6 and 16 that were a part of a post death interview of the death of a parent from cancer. They concluded that participants reported relatively low levels of depressive symptomatology and anxiety in comparison with normative samples of children. Raveis et al. believed that the low levels were correlated with a high level of openness in communication with the surviving parent.

Adolescents who lost a parent to suicide experienced more difficulties with peers, siblings, school, and leisure activities. This is due to the stigma associated with suicide such as shame, guilt, and a sense of rejection from others; there is a chance that the adolescent themselves will become suicidal as well (Robin & Omar, 2014, Walker, 2009). Schreiber, Sands, and Jordan (2015) used a qualitative approach to conduct a phenomenological study of how parental suicide affected children under the age of 18. These researchers saw that participants felt guilt for their parent’s death and some felt abandonment. Schreiber, Sands, and Jordan noted that one child who came to a bereaved peer group appeared marginalized due the inability to share that his mother committed suicide. Berg, Rostila, and Hjern (2016) investigated parental death from natural and external causes before the age of 18 and the risk of clinical depression in young adults in Sweden. These researchers concluded that parental loss due to natural causes was associated with small, increased risk of long-term consequences, while children who lost a parent due to external causes, like suicide, accidents, or homicides, were at greater risk. Adults who lost a parent during childhood due to external causes were more likely to have hospital admission and outpatient care for depression (Berg, Rostila, & Hjern, 2016).
Quality of support system. Adolescents during bereavement find their supports in family, friends, or peers. Ringler and Hayden (2000) conducted a study with university students between the ages of 17 and 20 who experienced a type of loss. Ninety-two percent of the participants reported having helpful support from one or two parents, certain family members depending on the type of loss, and most participants reported having multiple peer supports. These researchers reported that adolescents wanted the same three types of supports: being able to listen to the participant talk about the death, having their feelings understood, and having physical comfort. Rask, Kaunonen, and Paunonen-Ilmonen (2002) conducted a study with 89 adolescents between the ages of 14 and 16, exploring how adolescents cope after the death of a loved one. These researchers concluded that 31% of the participants stated that a parent or parents helped them cope, 26% found their support from family as a whole or siblings, 19% found other relatives supportive, and 34% of participants reported that friends were a great support to them. Rask et al. also concluded that there were participants that found parents, siblings, and their social network added challenges to their grief process. During the age where adolescents rely heavily on acceptance from others, the grief process can be stifled in order to preserve the adolescent’s friendship. In Primavera’s (1988) study, she found that the family support system was rated as the most useful and most frequently used in coping with parental bereavement. Primavera also mentions that friends, acquaintances, and neighbors were also relied on and formal support such as counseling was perceived as not being helpful.

Lytje (2017) conducted a study with 39 Danish adolescents between the ages of 9 and 17 that researched loss navigation. What was evident in the study was the adolescents’ fear of being seen differently in class. Many adolescents chose to hide their loss from their classmates due to the risk of feeling discomfort when discussing the loss; this resulted in acting as if nothing had
happened (Lytje, 2017). Stokes, Reid, and Cook (2009) also noted that adolescents feared being rejected or stigmatized by their non-bereaved peers but saw that adolescents found it easier to talk to peers that had also experienced loss. If the community is capable of listening and supporting the bereaved adolescent, the bereavement process can be easier for the adolescent. During this time of grieving, adolescents became closer to peers who were understanding and supportive; these peers wrote letters, always visited, and appeared very caring (Shipkey, 2008).

When a child experienced the death of a parent, there is an emphasis on the surviving parent to play both roles. Regardless of how the parent died, the child’s bereavement depended on how they interacted with the surviving caregiver (Raveis, Siegel, & Karus, 1999). Gao and Slaven (2017) concluded that open communication was best in order for children, under the age of 18, to feel less afraid to express their grief since they feared that talking about it would only add to their caregiver’s grief. This can be due to how the surviving parent discussed the death, which can contribute to the level of avoidance and denial the adolescent experienced for their loss as well (Raveis, Siegel, & Karus 1999). Another influence that parent(s) have over an adolescent’s grief can be in the lack of normalization of the experience. For example, if a parent shows their own discomfort and avoids talking about the death, the adolescent will feel unable to express their own feelings around the loss (Gao & Slaven, 2017). Shipkey (2008) saw that family support varied; some adolescents reported becoming closer to a parent, others felt left out with no one to support them. Other adolescents reported that there was an overall feeling of depression and a loss of family spirit, which left everyone feeling empty. Some parents became over protective, which increased the child’s anxiety by giving special attention to any potential threats or fears in the child’s life; this resulted in them feeling unsafe and needed to be carefully watched if they were to stay safe (Baker & Sendey, 1996).
Other types of significant loss. Grief does not only encompass the death of a loved one but can be in other non-death forms such as incarceration, divorce, and foster care. This type of loss entailed grieving the loss of a parent who is still alive but emotionally and physically absent (Miller, 2006). Miller (2006) noted that adolescents who lose a loved one to incarcerations are hidden victims, and due to the stigmatization of criminal behavior, that causes adolescents to feel conflicted with grieving their loss. The lack of sympathy and support from others due to stigmatization can leave adolescents feeling ashamed, sad, angry, and worried (Miller, 2006; Robertson, 2007). The discrimination and rejection by others due to the family incarceration can also leave adolescents feeling fear, guilt, and having low self-esteem (Miller, 2006; Robertson, 2007). Those who have lost a parent to incarceration often take on new roles in order to provide for the other family members, emotionally, domestically, or financially (Robertson, 2007). Long-term effects can be similar to a death such as depression, anxiety, and other emotional problems; some turn inwards and avoid talking to others about the incarceration while others become defiant and act aggressively toward anyone in defense of themselves or their incarcerated loved one (Robertson, 2007).

Adolescents in foster care experience being taken out of their own established family systems, communities, and relationships. This is an all-at-once loss of parental figures, teachers, friends, places they went to, special rituals or traditions, personal belongings, and family cultures (Foster care & Adoptions Center Resources, 2016). Moreover, as they move through the foster care system, there can be compounded losses around previous caregivers, familiar environments, and established relationships that can reoccur after every new placement (Edelstein, Burge & Waterman, 2001). Samuels (2009) conducted an interpretive study of 29 young adults who transitioned out of foster care. The adolescents in Samuel’s study reported not wanting to be
adopted because of the possibility of being reunified in adulthood and being adopted was a symbolic betrayal of their family origins. Adolescents in foster care typically lack basic trust for their new foster caregiver and can result in superficial interacting to externalizing problems such as acting out and aggression; adolescents in foster care exhibit externalizing problems that become extreme and result in hospitalization (Edlestein, Burge, & Waterman, 2001; Persi & Sission, 2008).

In parental divorce and when marital separation is volitional, blame can occur between spouses. For some adolescents this volatility may come as no surprise but their bystander status can be damaging, especially after witnessing months or years of emotional turmoil—while friends and family members are shocked by the divorce announcement (Schwartzberg, 1980; Somary & Emery, 1991; Sorosky, 1977). Schwartzberg (1980) conducted a study of 30 adolescents who were going to a private psychiatric practice who had experienced divorce. He saw that his participants’ initial reaction to the news was hurt, disappointment, anger, guilt, and a sense of abandonment, while only a few participants showed denial, detachment, and indifference. In some cases, adolescents may fear their own marital failure in their future (Sorosky, 1977). How adolescents cope with separation is based on the type of attachment they have for their parents (Somary & Emery, 1991). Schwartzber (1980) concluded in his study that a majority of his participants reported that the divorce relationship was very difficult or nonexistent. Marwit and Carusa (1988) conducted a study of adolescents between the ages of 13 and 20 comparing parental death and parental divorce. These researchers concluded that those who were faced with parental divorce saw that involvement in social activities was helpful as a way to remove themselves from the stress and conflict that they were experiencing at home.

Treatments for Adolescents Experiencing Grief and Bereavement
Adolescents are provided with other forms of support when their behaviors become concerning and/or extreme. Some treatment options for adolescents are outpatient, residential, foster care, and inpatient services. The focus of these treatment services is to address “at-risk behavior, adverse conditions that promote maladjustment, and clinical dysfunction that affect adolescents” (Kazdin, 1993, p128). Kazdin also noted that, overall, those who received psychotherapy showed more effective results than those with no treatments. Burns (1991) conducted a study researching mental health services used by adolescents between the 1970’s and 1980’s. Burns noticed that minorities had higher populations in partial hospitalization and residential treatments than outpatient and inpatient.

**Outpatient settings.** Outpatient treatment care refers to services that do not require overnight stays and there is a variation on days to attend the program; some adolescents can attend every day while others may attend a couple of days a week. Olfson, Gameroff, Marcus and Waslick (2003) concluded that adolescents between the ages of 15 and 19 had higher rates of outpatient treatment, yet in contrast, these researchers also noted that African Americans, non-Hispanic children, and adolescents were less likely to receive outpatient treatment. Being a less acute form of care, adolescents and their caregivers can drop out of outpatient care whenever they choose. This can happen when an adolescent or family member believes their problem has been resolved and will feel inclined to end treatment (Block, 2009). Haan, Boon, Jong, Hoeve, and Vermerien (2013) conducted a meta-analytic review of treatment dropout in child and adolescent outpatient mental health care. These researchers concluded that higher dropout percentages correlated to programs focusing on efficacy over effectiveness. These researchers believed that clients included in strict selection procedures could be more motivated to complete the treatment. Block (2009) conducted a mix-method study that explored barriers to outpatient
adolescent therapeutic interventions. Adolescents were more inclined to stay in treatment if they believed the therapist was invested in them. These researches also concluded some factors that contributed to dropouts were the stigma behind mental illness. The participants in this study also stated that they prefer individual treatment rather than meeting with their parents due to feeling that they can truly express themselves without hurting their parents’ feelings.

**Foster care.** Foster care settings are placements for adolescents where they live and are cared for by people who are not their biological parents. Placements can be in a group home, a person’s house that is state-certified, or a family relative approved by the state. Chamberlain and Reid (1991) conducted a study using specialized foster care community treatment for children and adolescents leaving inpatient psychiatric hospitals. They concluded that individuals in this type of setting were more likely to stay in their community longer. Kools (1997) conducted a study of adolescents between the ages of 12 to 19 who had at least two years of experience in foster care; the majority of the older adolescents were African American. They faced stigmatization of staying in foster care and resulted in low self-esteem and lack of self-identity. This also caused a lack of future orientation and low self-confidence. Chapman and Wall (2004) conducted a study interviewing children and adolescents in foster care. In contrast to Kools study, Chapman and Wall found that overall, the participants appeared satisfied with their placement except older adolescents living in a group home. Adolescents in group homes had a higher chance of leaving their placement, having visits with family cancelled, and had lower chances of seeing their biological parents on a regular basis.

**Residential settings.** Adolescents that are placed in residential settings are often housed in large dormitory-type facilities that provide mental health services, 24-hour care, and have treatments that emphasize emotional and behavioral concerns (Curtis, Alexander, & Lunghofer,
Adolescents in this type of setting may have difficulties with school, the community that he or she is in, and with peer and family relationships (Blackman, Eustace, & Chowdhury, 1991). Residential settings emphasize routines: relational, regulatory, and coexistence (Palareti & Berti, 2008). These routines provide structure for how to interact with staff and other adolescents, respect shared spaces, and provide structure for activities and commitments that adolescents partake in. Palareti and Berti (2008) conducted a study using self-report questionnaires distributed to 59 adolescents living in residential communities in Italy between one and three years. These researchers concluded that adolescents had overall positive general satisfaction and saw this intervention as an opportunity to rebuild their plans for life. Blackman, Eustace, and Chowdury (1991) conducted a study with 40 teenagers living at Child and Adolescent Services (CASE) houses between 1985-1987. These researchers concluded that using a therapeutic family model helped foster relationships with other peers and provided community supports when they transitioned out of residential care.

**Inpatient setting.** Adolescents in inpatient care are usually admitted to a psychiatric or behavioral hospital and provided with intense, often restrictive, care. Kaltiala-Heino (2010) conducted a study analyzing 187 adolescents between the ages of 11 to 17. Prior to hospitalization, majority lived with their parents (74.3%), 5.7% lived with foster parents, 17.1% lived in child welfare institutions, and 2.9% lived independently. A concern with adolescents who are admitted into an inpatient hospital is the chance of re-admittance. Thirty five percent were hospitalized before while 74% have been treated in other professional services. Out of the 187 adolescent admitted, 45 were in bereavement, and 23 were dealing with divorce or separation. One reason for readmission is correlated to having previous admission; those with a history of hospitalization or other mental health care have a higher chance of readmission (Akin,
et. al, 2010; Pottick, Hansell, Gutterman, & White, 1995). Yampolskaya, Mowery, and Dollard (2013) concluded that shorter lengths of stay correlated with higher readmissions. These researchers believed it was due to the lack of assessment and planning services, and inability to develop appropriate treatment for those who need targeted inventions. Akin, et. al (2010) saw that if the gap between admissions was under 30 days, the adolescent was more likely to have multiple readmissions. Bobier and Warwick (2005) concluded that younger participants with earlier admissions were more likely to be readmitted. These researchers also saw medication non-adherence as a reason for admission to inpatient care.

**Evidenced-based treatment.** Evidenced-based treatment is empirical research about service practices or about the impact of clinical treatments or services for mental health (Hoagwood et al., 2001; Sudhir, 2015). Hoagwood et al. (2001) conducted a meta-analysis of experimental child psychotherapy and concluded that there was consistent beneficial effect of treatment compared to no treatment. Evidenced-based treatment explores how to establish a secure attachment in the therapeutic relationship, honoring the adolescent attachment to the deceased, and develop a narrative, meaning, and perspective (Crenshaw & Hill, 2009). Crenshaw & Hill (2009) believed that individuals working through traumatic grief need to understand that their identity is not formed around the traumatic experience.

An example of evidenced-based treatment is cognitive-behavioral therapy (CBT). Cognitive-behavioral therapy is “a time-oriented and problem-focused psychological therapy” (p. 22) that includes cognitive and behavioral techniques that help with symptom reduction through identification and modification of thoughts (Sudhir, 2015). Working with adolescents, CBT allows adolescents and therapists to work together to set goals, and work on dysfunctional patterns. Rohde (2005) saw that CBT helped adolescents with depression to become aware of
their negative thoughts, and irrational beliefs, and helped adolescents notice successes and not just their failures.

Trauma-informed cognitive-behavioral therapy (TF-CBT) is a strength based and skills model that is about eight to 20 sessions that involve individual parallel sessions with the child and caregiver, along with conjoint sessions (Hanson & Jobe-Shields, 2017; Kosminsky & Lewin, 2009). TF-CBT begins with psychoeducation and teaching of relaxation techniques (Kosminsky & Lewin, 2009). The adolescent learn to express emotions and manage any difficult affective states through affective expression and modulation. Then the adolescent creates their trauma narrative as a process to desensitize the emotionally charged content. Kosminsky and Lewin (2009) believed that this was necessary before addressing other work related to loss. Hanson and Jobe-Shields (2017) emphasized that TF-CBT was not intended to be implemented when caregivers were non-supportive and/or the cause of the trauma, the child has a history of problems that predated the traumatic event, and if the symptoms do not appear to be connected to or enhanced by the traumatic event. Deblinger et al. (2011) conducted a study focused on the trauma narrative in TF-CBT with children and their parents. Overall TF-CBT was effective with affective and behavioral functioning and safety skills. These researchers saw that the trauma narrative was particularly effective with reducing a child’s abuse-related fear and general anxiety and with parental abuse-specific distress.

Trauma-informed care acknowledges the role trauma has on the development of an adolescent’s life and that he or she is the best expert about what is helping or hurting them (Steele & Caelan, 2013; Steele & Malchiodi, 2012). Trauma-informed care principles are: Understand trauma and its impact, establish safety, ensure cultural competence, support client’s control, choice, and autonomy, share power and governance, integrate care, heal through
relationship and that recover is possible (Steele & Caelan, 2013; Steele & Malchiodi, 2012). Overall, trauma-informed care recognizes that survivors need to be respected, informed, connected, and empowered in order to reinforce hope in the recovery process (Steele & Malchiodi, 2012).

Resilience models believe that the treatment should focus on strengths rather than deficits; adolescents are assessed on what ability they have to maintain a stable equilibrium as they are exposed to unfavorable or aversive life circumstances (Bonanno, 2004; Fergus & Zimmerman, 2005). An adolescent’s resilience is determined by looking at the individual’s risks and protective factors, which can be at an individual, family, community, or cultural level (Sandler, Wolchik, & Ayers, 2008). To determine an adolescent’s resiliency after he or she experienced a death, an accumulation of multiple risk and protective factors that precede or follow the death must be taken into consideration (Sandler, Wolchik, & Ayers, 2008). Positive factors can be based on the individual, such as competence, coping skills, and self-efficacy and/or through resources such as community organization, parental support, and adult mentoring (Fergus & Zimmerman, 2005). Zolkoski and Bullock (2012) noted that adolescents with self-confidence and social skills are shown to have more resilient qualities despite the risk or outcome.

**Meta-verbal Therapies**

Meta-verbal therapies use creative outlets as a nonthreatening way to promote spontaneity, autonomy, expression, and feelings of self-worth (Wood & Near, 2010). Where words fail, meta-verbal therapies allow for communication and expression while increasing physical, emotional, cognitive, and/or social functioning (Wood & Near, 2010). Each meta-verbal therapy focuses on specific aspects of creative expression that provide opportunities to
communicate grief and loss when there are no words to describe their experience (Thompson & Berger, 2011). The following section briefly reviewed four specific meta-verbal therapy modalities (expressive arts, dance/movement, music, and art) and how their reflective practices have worked with children experiencing bereavement, grief, and loss.

**Expressive arts therapy.** Expressive arts therapy is defined “as the use of art, music, dance/movement, drama, poetry/creative writing, play, and sand-tray within the context of psychotherapy, counseling, rehabilitation, or healthcare” (Malchiodi 2005, p. 2). Using multiple modes of expression allows an individual to dive deeper and widen the range of expression through the individual’s creativity, sometimes known as integrative approaches (Malchiodi, 2005; Thompson & Berger, 2011). Using expressive art therapy in family sessions allows children, adolescents, and families to relate their grief on an individual and group level (Wood & Near, 2010). Horns (2007) conducted a grounded theory study of therapist perception of using expressive art therapy with grieving young individuals. Interviews over the phone were conducted with 10 to 12 therapists, and then the interviews were coded to find themes. Horn concluded that young individuals are more capable to express themselves through creative artistic modalities rather than just verbal processing. Webb-Ferebee (2001) conducted a pretest/posttest, quasi-experimental control group design, without a control group, of families that attended a weekend camp for families that have lost at least one child to death. There was a variation of groups facilitated for the families: multi-family groups, parents’ groups, developmental age groups for children, total children group, individual family group, mother’s group, and father’s group. Webb-Ferebee concluded that using the expressive arts resulted in parents reporting a reduction in overall behavior problems and family functioning was within range of normal family functioning.
Dance/Movement Therapy. Dance/movement therapy as defined by the American Dance Therapy Association is “the psychotherapeutic use of movement as process which furthers the emotional, cognitive, physical, and social integration of the individual” (2016). Simpkins and Myers (2017) conducted a phenomenological methodology study with three participants from a university who experienced the loss of a parent or caregiver between the ages of 5 and 24. Simpkins and Myers-Coffman (2017) reported that participants remembered their loved ones through bonds that were often through memories; the body itself remembers the past and relives it in the present (Simpkins & Myers-Coffman, 2017). Dance/movement therapy allowed participants to transition the painful memories into more positive memories by creating movements for words they use to describe their loss and paying attention to their bodily sensation; the participant then creates a dance connecting the movements. Philpott (2013) conducted a qualitative study that interviewed a dance/movement therapist who previously worked with children (under the age of eighteen) who experienced loss. Philpott concluded that the playfulness in dance/movement therapy allowed grieving participants to open up and take risks, which created deep emotional spaces. Themes that appeared were, remembering and honoring, feelings about the story, telling the story, learning about mortality and limited amount of time, and resiliency (Philpott, 2013). The modality of therapy allowed young individuals who may not have the words to describe how they are feeling to express themselves through their body and really feel a connection.

Music therapy. Music Therapy, defined by American Music Therapy Association is the use of creating, singing, moving to, and/or listening to music to address physical, emotional, cognitive, and social needs of the individual (2017). Register and Hilliard (2008) discuss how Orff-based music therapy based on cognitive-behavioral music therapy works well with
bereavement children groups. Off-based music therapy believes that music education parallels language learning and is based on the idea that “music can be created out of the natural, inherent rhythms in both movement and speech” (Register and Hilliard, 2007, p. 165). Register and Hilliard (2007) concluded that structured interventions gave participants a creative outlet of expression resulting in positively affecting attendance and on task behavior to the topic. McFerran, Roberts, and O’Grady (2010) concluded in their study that music allowed adolescents to use fun as a way to work through their grieving process. Adolescents found that using instruments allowed for emotional release when participants reported feeling that their emotions were bottled up prior to the study.

**Art therapy.** Art therapy uses the combination of active art making with media and images, the creative process, psychological therapy, and the human experience to enrich the lives of individuals, families, and communities (American Art Therapy Association, 2017; Malchiodi, 2005). Adolescents can feel some sense of mastery as they work with materials, creating artwork that is pleasing to themselves and others, and holds meaning that can be spoken or through metaphors (Gil, 2014). Verbal therapy with adolescents can be difficult due to their developmental age and struggle to verbalize their feelings. Art allows adolescents to express their emotions as they face moodiness, individuation from family, and resistance to authority (Riley, 2001). Art therapy is a vehicle of safe environment to connect their inner world and emotions, offer support, create meaning and hopefully move toward rebuilding their world (Briks, 2007; Miller, 2011). Riley (2004) stated that art therapy gave adolescents the control to reveal only what they wanted to reveal in the art or in the explanation of the art. Although adolescents, at first, would appear guarded, defensive, resistant and apathetic, art therapy
diminished the fear of exposure and pain that is may expected with therapy (Miller, 2011; Riley, 2001).

Power (2016) conducted an arts-based inquiry study in which she created response art alongside her practice with adolescents and reflected on similarities. This researcher noticed themes between her response art and adolescents such as vulnerability, identity development, ritual, and existential issues. Power’s study showed that along with creating a safe space for expression, adolescents become vulnerable and there is a need for a balance between showing this vulnerability while still feeling in control. Rituals can help build rapport and the environment to encourage the adolescent to take emotional risks by creating structure, safety, predictability boundaries, and expectations for the adolescents (Miller, 2011; Power, 2016).

Crawford (2008) conducted a case study meeting with a 16-year-old female for 11 weeks. Themes that appeared in her sessions were resistance, empowerment, assertiveness, and lack of assertiveness. For the 16-year-old girl, empowerment appeared as “I can” statements; as the girl worked with mediums, she gained a sense of mastery, which resulted in an increase in confidence as reported in a better posttest with her teachers. Chilton (2007) used an altered book with adolescents and saw that using a book allowed adolescents to manipulate an object with symbolic meaning filled with text and pictures. Chilton even mentioned the sensory component of using an old book. The altered book provided adolescents with stimulating canvases and the freedom to express themselves. Chilton stated that the metaphor of altering a book is similar to how adolescents’ lives are altered by experiences.

**Art Therapy and Bereavement**

Art therapy provides bereaved individuals a client-centered and expressive approach for addressing their grief (Brodie, 2007). Bereavement art therapy can allow for those who are
grieving to be open, peaceful, clear, free, and social as they move from confusion to clarity (McIntyre, 1990). Simon (1981) conducted case studies with a range of participants who experienced the death of a loved one. Simon concluded that the use of art allowed the acceptance of personal death as a natural part of life, and gave one child the ability to safely remember his brother’s death and talk about his confusion about the loss. As Lister, Pushkar, and Connolly (2008) explored the integration of Dual Process Model and Meaning-Reconstruction Model with art therapy, they stated that art therapy could facilitate ways to cope with sudden negative emotions, creatively brainstorm how to cope with the primary and secondary loss, and integrate the deceased into the bereaved person’s life.

**Interventions for bereavement.** Brandon and Goldberg (2017) used a kinetic sculpture intervention with a college student who lost her mother when she was 10 years old. The kinetic sculpture is a task developed by Kären E. Brandon, which evolved from the family mobile to allow an exploration of losing a family member and how the dynamic changed. Brandon and Goldberg focused on the family structure and how the college student has been affected by the loss of her mother. She created the sculpture of the family dynamic before her mother died and after she passed. Through the art making process, the college student was able to reflect how her and her family adjusted to the loss.

Kohut (2011) discussed case examples on using scrapbooking with a bereavement group. Kohut concluded that the scrapbook was very meaningful for the participants and many kept their book somewhere that was important to them. The participants noted that being in a group with others who are grieving was beneficial because it gave them a sense of not being alone. Kohut stated that scrapbooking helps organize meaningful life events of the deceased so that the individual can begin to assess and accept their loss.
Farrell-Kirk (2001) discussed how boxes are used in art therapy for many different purposes. Boxes provide a spacial physical limitation that allows a client to have the distance to began to investigate and explore they fears and worries. Boxes used to discuss grief and loss can present a safe space from others and guard precious memories. Farrell-Kirk stated that the idea of putting objects into boxes, gives value and newfound importance to the precious content. Larson (2017) used the box form to create a memory box that was a drawer filled with images, collage cutouts, family photographs and colors. She worked with people who were diagnosed with Alzheimer’s and wanted to the individuals to design the box that showed “how the view their life and what they would like to leave it behind” (p 190). Larson reported that the box could hold the story of the individual to suspend those memories in time as it is kept safe and sealed inside.

Rankin and Taucher (2003) discussed how some clients who experienced trauma with their grief must address the trauma before treating their grief. Narrative art-intervention methods are used to address the trauma and enhance the narrative process. A session is divided into three equal-time segments. The first part is a check-in period to allow the client to describe significant events, thoughts, or feelings that occurred between sessions as a way for the therapist to determine if narrative work is appropriate for the session. The second part is the narrative work where the client depicts and verbalizes a portion of the traumatic experience. The last part is to review the session and practice stress-reduction techniques, identify strengths or create self-soothing artwork. Beaumont (2013) provided a review and commentary on perspective and treatment approaches for complicated grief and concluded that Niemeyer’s story-telling incorporated in art therapy sessions helped with addressing grief. Beaumont saw that this process allowed clients to tell their life story and loss, as well as look back on it later. Beaumont also saw the integration of CBT and narrative therapy with art therapy as a way to integrate their
experience of loss so that they can feel a continuing bond with the deceased as well as move forward.

Talwar (2007) discussed the art therapy trauma protocol (ATTP) as a process to address non-verbal, somatic memory of traumatized clients using both sides of the brain. This is done with large sheets of Bristol board that is taped on the wall or easel to allow the client to use his or her full range of body movement. The client’s moves from verbal to visual making allows dual processing and creating control over processing the client’s trauma.

**Themes of bereavement.** Art can provide a permanent, stable container for memories, feelings, and record of their history (Junge, 1985). Goodman (2002) reported that younger children might benefit from more targeted interventions while older children can be involved in elaborate projects and dive into more in-depth exploration that can carry over to other sessions. Brodie (2007) conducted a case study with a 14-year-old girl that she saw as her mother fought and died from cancer. Brodie saw the use of tape as a way her parents limited her and her way of creating structure and control in a situation the adolescent had no control over. Brodie’s use of a non-directive approach allowed her participant to explore meaning making and internalization of her lost relationship with her mother.

**Intersections of the research**

Bereavement is unique to every individual and is a complex process that has shifted over time. The original thought of grieving being an individual, internal process of relinquishing all ties of the deceased loved one has evolved to a process of understanding oneself and the relationship they had with their loved one. Literature that discussed cultural aspects of bereavement concluded that foundational models of grief and bereavement did not encompass cultural diversity. Bereavement could be affected by what resources are available to an
individual, and the cultures’ relationship to health professions; usually people of color and those in poorer communities were more affected than other individuals.

This shift in our understanding of death and grief has aided in researchers’ understanding of adolescent bereavement the multiple factors that affect an adolescent’s grief. Research of the literature has shown that adolescents grieve differently than adults and that these factors need to be taken into consideration in order to work through an adolescent’s grief. Research concluded that adolescents rely heavily on family and friends, which can aid or hinder the adolescent’s bereavement. Being in an inpatient setting, adolescents are surrounded by unfamiliar faces, making it may be hard to genuinely connect with others while trying to impress their peers. Art therapy allows opportunities for an adolescent to explore their grief and loss in a safe environment. They choose what they want to talk about and the art can provide connections and altruism, which may break down the superficial wall to talk about their pain.
CHAPTER 3: EXPLORATIONS OF MEDIA AND MATERIALITY

For this capstone project, I worked on three adolescent units in a behavioral hospital; each adolescent unit was co-ed and had 24 beds. The adolescents admitted to the hospital had either caused harm to themselves, had suicidal ideation, or homicidal ideation. Those admitted to the hospital had experienced a loss in regards to a death, a parent incarceration, and being put in the foster care system. As I settled into my internship, I noticed that adolescents admitted would rather explode or shut down than express their emotions. This was evident when an adolescent brought up loss; either the individual would change his mind and decided to not discuss it or the group would shut it down.

Groups with adolescents can be a challenge due to adolescents’ natural resistance to someone who appears as an authority figure. Those at the hospital also struggled with poor relationships and/or trust issues with adult figures. There is also a pressure to fit in among their peers, and in an attempt to impress them, some adolescents rejected the group and made comments such as “art is dumb” or “this is childish”. There appeared to be unwillingness for some adolescents to engage in the task if it appeared not relatable or too metaphorical to them. Their unwillingness was more evident when the materials were paper, markers, and color pencils as well.

With these challenges presented, I wanted to create engaging tasks that could be relatable and practical for adolescents by the use of nontraditional materials. I was curious to see if direct or indirect approaches to present the topic of loss would provide a space for discussion. I also wanted to see if the art process could provide the space for the expression of grief if verbal processing appeared too overwhelming. I had to keep in mind that due to the quick turnover of adolescents, many adolescents were not familiar with each other and may not feel comfortable
expressing intimate feelings. The following four examples are four different attempts to connect the client with expressing their loss, through specific art therapy materials and task presented.

**Postcards**

The use of postcards was a task presented to target the topic of death more directly and was an attempt to create the space for a group discussion of grief and loss. This idea was inspired by the combination of writing a letter that you never will send and a website that received postcards with anonymous secrets. Both ideas emulated the concept of not being afraid to say honest and true feelings since the recipient would never read it. The use of a postcard instead of a letter format gave the adolescents the challenge of using images and a minimal amount of words to express the essence of their feelings toward the person to whom they wanted to send it. I opened the group by saying that the postcard was to anyone they lost, missed, or had negative feelings toward. I provided blank postcards, markers, color pencils, and collage materials. I emphasized to the group that they did not have to share to whom the postcard was for or what the postcard said, but only about their experience of the process. This was done on two different units, each unit having three different groups; two groups’ reactions stood out to me. Overall, I noticed that the postcards were created for someone they lost by death, those who they have not seen in a while, and to people who were the cause of their loved one’s death or separation.

One group was filled with nine adolescent males, some of which I had met before and had established some type of rapport. This group was filled with many adolescents that had externalizing behaviors that presented aggressively. When presented with the task there was initial resistance by a few adolescents. Out of the nine adolescents, only one refused to do the task but did explore the materials. The rest either completed the task or worked on a piece for the entire group. Some comments during group were about the difficulty of writing everything on a
three by five postcard. Three group members only used markers, two of them attempted to squeeze everything they wanted to say on both sides of the postcard. The other wrote one sentence, folded it up and presented as upbeat and lively for the rest of group. He gave me the postcard and the message was to the person who caused his mother's death and his anger toward that person. One member was fixated on sending the postcard to his mother, who he missed. Another member of the group became emotional and left the group. When he returned, the adolescent mentioned that this task reminded him of his mother whom he lost. While I supported and applauded him for his bravery to express his sadness, the group wanted to shut it down. It brought a conversation about how death happens and that "no one out there cares." The group talked about how sharing about the people who they have lost would not matter to anyone else. They seemed to avoid talking about their own feelings of pain and mentioned that expressing this pain showed weakness.

The next group was comprised of eight adolescents, both males, and females, and compared to the other group, presented with more internalizing behaviors. A majority of the group already used art as a coping skill and this resulted in more engagement in the task. Only one person used a marker to write everything out and needed additional paper to get what the individual was feeling out. This individual mentioned that it was different to write down what she was feeling rather than just speaking it out allowed. After sharing what she wrote, she expressed that it was comforting to have her words heard by her peers. The rest of group spent most of the time creating and used the collage materials to design their postcards. One member talked about how she felt angry with her father for leaving her but still wished that one day they could reconnect. The group talked about how the process brought up some emotions that were buried inside and how having a permanent object to hold the emotions allowed them to sit with
these feelings safely. At the end of the group, I asked what they wanted to do with the postcard. Most wanted to keep the postcard as a memorial of their loved one, and some wanted to eventually give the postcard to the recipient in the future.

**Blackout poetry**

Blackout poetry is writing that is created by using old pages of books or magazines. The individual reads the pages and makes note of the words that resonate with the individual and "blackout" the other words leaving a poetic piece. This was more of an indirect way of discussing grief and loss. Due to artistic nature of poems, I was allowing the chance to let the piece speak for the adolescent and not necessarily talk about the meaning of the poem. Using a surface covered with words can appear less intimidating to an adolescent who is not comfortable with art making. This process also allowed for the projection of their feelings through words that already existed. I allowed the group to work on more than one piece and gave them the choice to share what they created. Those who did share received positive feedback from peers in the form of verbalization and through snapping. This was done on two different units; one unit had three groups while the other had two groups. Overall, I noticed that this piece did not present direct discussion of grief and loss and it was dependent on the group itself. The poetry allowed the adolescent to choose at what level they wanted to reveal their intimate feelings.

One group had 10 adolescents, both male, and female, and this unit had a mixture of externalizing and internalizing behaviors. This group was presented with sharpie markers, and pages of a book that was filled with more vulgar terminology. When the task was presented, there were only two members who had previously used blackout poetry. The first hurdle was the content of the pages; many adolescents were fixated on the words and used it as a distraction from the task. There was also a fixation of permanent markers. Some members of the group used
the markers to draw on themselves or on blank paper rather than for the task. Those who completed the task needed encouragement in the beginning. Some adolescents stated, “this is hard” or “none of these words relate to me.” When group members began sharing their pieces, others felt more inclined to create their own. One adolescent completed three relatively quickly and stated after sharing each piece “now snap for me.” There was no processing of the poetry but the support and encouragement to share their pieces allowed the adolescents to be heard.

The second group was eight adolescent males and females and more group members were aware of blackout poetry. The group was engaged in the process for the entire session, only two members created one piece and created free drawings for the rest of group. Some group members in this group also struggled with connecting with the words on the pages and were able to after seeing other peers’ examples. Some group members shared their connections to the poems they created. One member related her poem to an ex-boyfriend that recently broke up with her. The group talked about how this art-making process allowed some peers to use words that were not naturally in their vocabulary. Many group members commented on how easy and enjoyable blackout poetry is and reported wanting to continue on their own.

**Altered books**

Altered books are when an individual uses an old book to change and alter the pages for their own personal use. Blackout poetry could be a part of the altered book process, or the individual could use the pages as a canvas. Altered books are also less intimidating to those who are not artistic. This project was for an individual who I was seeing struggle to engage in the art-making process. The individual had experienced a death of family members and was experiencing the inability to return home to her parents. The metaphor of creating art on recycled paper appeared to mirror the process of her perception of what she wanted her treatment to be.
When first given the book, the adolescent commented that the author was her father's favorite. When working with the cover, she chose not to paint over the author's name. I introduced blackout poetry to the individual first and she appeared well receptive. She completed a few pages of our session and wanted to continue to work on her own. During our next session, she showed a couple of pages she completed and stated, "this has nothing to do with me." When reflecting what she did create, she was able to see the connection to her own life and the unknown of her new placement. After time, the adolescent became resistant to covering up the words and stated that she wanted to read the book later. I feel that this was mirroring her resistance to going to a group home and not returning home. When the plans kept changing, she wanted her book to remain stable as a way to have something that was familiar to her. This rigidity was tested over and over by a presenting success-orientated task that might appeal to the adolescent. She would find pages with no words to complete the techniques and would usually be pleased with the results. Over time she became more willing to use mediums on pages with words; this mirrored her acceptance to going to a group home before returning to her family.

**Memorial boxes**

Memorial boxes were a more direct task to talk about grief and loss. This was inspired by a project I did myself in a mourning group. The individual decorates the box in memory of their loved one. The permeable object can be taken with them and he or she can put memorial objects, notes, or pictures of the deceased person inside. It creates a safe place to hold the emotions and memories when the individual may not be able to express them openly.

During my first group using this media, I presented the art task as a box they can create on and in, and dedicate to someone they have lost, where they could put his or her emotions that
they may not want to share with others. Everyone appeared eager to use boxes as their canvas, although not everyone wanted to stick to the topic.

Three group members turned their boxes into creatures and were making jokes throughout the session. One responded with "I don't want to be depressed, can I make it something happy instead". Another group member created the box and began to appear agitated as evidenced by stating she was "done" after not being able to find the letters she wanted. She got up and left the group to put her box in her room. When she came back she stated that she did not want to dig up that memory that she had buried away. Her peers supported her throughout the session, helping her out when she became agitated. One group member commented that she has not experienced a death of anyone close to her. She created a box that depicted Puerto Rico, a place she left recently. Group members discussed how loss does not entail just losing a person but could be losing a place, a community, and an environment.

When I presented the task to the second group, I made slight adjustments; I broadened the discussion to encompass all types of losses. The prompt shifted as well; I asked the group to reflect on what they have control over and how they would want others to remember them. I suggested that the outside could be for everyone to know and the inside could share personal qualities that only certain people would have access to. Before I moved to the art making, the group discussed other types of losses besides death. An adolescent male discussed how not winning a game is a loss and getting privileges taken away was a loss for him. Similarly, another male stated that not being able to have control was a loss and described it as not being able to do certain things again which can cause other kinds of losses such as ending of relationships or being kicked off the team. The same adolescent male created his box writing “positive” around the box. He wrote "bad behaviors and sins" on a separate piece of paper and crumpled it up. He
inserted it into the box and closed it up. He talked about wanting to get rid of these qualities by keeping it in the box. In return, only certain people would know this side of him while he wanted everyone to know he is a positive person. Another adolescent male put some traits on the outside of the box such as firefighter, and New York. He talked about how getting caught with illegal substances got him fired from his job as a firefighter and how being at the hospital prevented other future possibilities. One adolescent male became quiet during the group and declined all prompts. He stated that this task had brought up bad memories and he did not want to talk about it.

Project Summary

Overall, these four structured media tasks that supported themes and group discussions of grief and loss with adolescents provided a great foundation to work off and further explore how these topics can be explored in an inpatient setting. Although each intervention varied in materials and approach, all of them explored the use of art as a way to express adolescents' grief. This was important for the adolescents who were not capable or willing to verbalize it. The interventions explored serious themes while providing a safe space where the adolescent each chose at what level they wanted to express or discuss their grief. Those who wanted could verbalize what their art piece was about and others left the art-making process to speak for their grief loss. The art allowed adolescents to feel safe and not exposed to others; in the art making process, adolescents felt comfortable enough to sit in silence as they worked. The adolescents focused more on the art-making process instead of filling the space with superficial conversations, which made conversations more meaningful when started.
CHAPTER 4: DISCUSSION/INTERGRATION/REFLECTION

Discussion

While completing this capstone, many aspects overlapped with literature that I reviewed. Several research findings pointed to how the adolescent treatment environment activates many factors to consider when approaching or opening up a group to therapeutically work with grief, the importance of consistency of support to adolescents, and the use of specific art therapy materials and media with adolescents. An important conclusion that I noted was that the grief evidenced in the adolescents I worked with may not be related to direct experiences of death but circled around other types of critical, primary losses such as incarceration of a parent, familial abandonment, divorce, and foster care. I observed how their processes often entailed grieving a parent who is still alive yet emotionally and physically absent (Miller, 2006). There were also adolescents who then had to be uprooted, face the loss of family systems, relationships, communities, traditions, belongings, and familiar environments—and usually against their will. These types of losses often shape how an adolescent chooses to cope with and express their grief.

Adolescents struggle with balancing being independent and depending on others in times of need. The way they interpret loss is strongly affected by their emotional and intellectual capacities but also with what expectations are being put on them by themselves, society, and/or by their support system (Bardot, 2013; Komisky & Lewin, 2009). This was evident with the adolescents who I saw at my internship site. A lot of the adolescents rejected art therapy because they did not see the value in their treatment. Their focus was what they had to do to become independent and to be able to take care of themselves. When I presented a task or prompt, I could see the adolescent figuring out what value or purpose this had in their lives. If it was not evident immediately, I was faced with resistance. It was interesting that this was their mentality because
most of the adolescents admitted, either had unsupportive parents, no parents, or were placed in residential or foster care. For them, their focus was not depending on adults and caregivers to make a decision for their lives. Therefore, death or loss for them could have been perceived as a barrier or caused complications for their life. Instead of being able to work through their grief, they could have seen it as a burden or reminder to having to take on the role of the absent caregiver. I think this was evident in one of my groups where when one adolescent did share emotions about his loss, the group then appeared indifferent. I believe the group members considered that showing feelings about losing someone was pointless. In some reality, there was truth their thinking; no one in the real world “cares” for what has happened to an individual. This thinking appeared to be a defense, to appear strong and independent became an excuse to avoid processing their loss.

Another interesting observation was how a unit in an inpatient setting acted like its own ecosystem. Each unit was distinctly different, and adolescents changed to fit into the unit’s culture. This environment not only affected the adolescents but also the staff on the unit. How adolescents treated the unit resembled literature discussing the importance of a support system for adolescents. Most literature concluded that peers, family, and the community were important factors in how an adolescent grieved—whether they were supportive and helped an adolescent grieve or made it harder for an adolescent to grieve. One common interaction I saw on the units was adolescent desire to call staff "mom", "aunt", or "sister." Although endearing, I felt that this diminished the authority the staff had in certain instances, and other times made treatment for the adolescent difficult because of the collapsed boundaries. For staff, it made arguments and negative behaviors from the adolescents personal. Since adult figures such as the staff were the examples for the adolescents on the unit, it either aided or made it more challenging for art
therapy. A challenge was how staff interpreted art therapy, which the adolescent mirrored. If they believed it was arts and crafts, adolescents also did not see the importance of art therapy and were resistant. Staff also aided in sessions because they would help some adolescents focus and respect the group and me. When it came to interactions between adolescents, other adolescents on the unit added challenges to his or her grief process because they did not want to appear different from others, even when many peers had experienced something similar. In the times where a peer shared something personal, they either retreated or acted out to shift the attention. I think the blackout poetry excelled in allowing adolescents to express themselves without needing to explain what they were going through. Creating and sharing their poems allowed them to have a level of vulnerability. Structuring the group to compliment and applaud each adolescent after sharing provided validation and support without having to share personal details about their lives. In a way this task allowed them to feel accepted by their peers and not fear rejection.

The power of art therapy and meta-verbal therapies was highlighted through this capstone. Works of literature discussed how art therapy had the ability to safely structure adolescent groups to allow adolescents’ space to process their individualized grief while supporting age-appropriate adolescent communication and personal expression. Regardless of the task, I saw adolescents show vulnerability, either through the art-making process or through sharing their grief with their peers. Art allowed adolescents to create permanent, transitional objects with art media, which were mostly kept with them either as a memento or as something to process on their own time. Grief is something that never ends and usually appears after a milestone (Corr, 2010). Being able to have a permanent art piece, allows adolescents to return to a piece of work that encompasses their grief to either continue their process or remember a sense of meaning that they created in their work. Many works of literature also emphasized the
importance of narration when processing grief. The use of a postcard allowed adolescents to create a permanent record of how they felt about the person they wanted to send it to. Many found the prompt successful and wanted to either keep it as a reminder or eventually send it to the person. While inpatient hospitalization may not be the time and place to dive into their loss, these permanent objects can allow adolescents to return to when they are ready and use it as a platform to explore their grief.

These vital connections between my capstone project and the research literature showed the importance of processing grief in inpatient settings, even if it is not an explicit part of the adolescent treatment goals. Grief and loss are a part of adolescents’ lives and if there is an awareness or acknowledgment of it, adolescents may start to become aware of how it influences their behaviors and their treatment, in the long-term.

**Recommendations**

Completing this capstone has brought an awareness of the impact of grief and loss to my attention and started a discussion with my supervisor of how it can be implemented for this inpatient setting. There is no need for treatment goals to be about processing grief directly, but there should be an acknowledgment of how loss is transformed almost daily in these adolescents’ lives and how to create meaning from it. I believe a trauma-informed practice can emphasize the importance of establishing safety, creating empowerment for adolescents, and focus on the idea that healing happens through relationship. I think that all staff in a hospital setting should be trained in providing trauma-informed care in order to truly create a safe space where adolescents may feel comfortable with the idea of expressing their losses in a safe and empowering way.
When trying to hold a group about grief, a challenge that I was presented with was adolescents’ level of understanding and/or willingness to explore their grief. When I was direct about death, the group would be more resistant. This could be due to being surrounded by unfamiliar peers, which made talking about the topic uncomfortable due to its sensitivity. When I shifted the topic from death to a more general sense of grief, I noticed more interaction and engagement of the adolescents in the group. After discussions with my supervisor at my site, opening the topic to entail all kinds of losses allowed the safety and ability for any adolescent, regardless of what point they are at in their recovery or treatment, to be able to relate and engage in the discussion.

Overall, there needs to be flexible therapeutic approaches implemented with adolescents; each group is affected by who is in the group, and what has happened leading up the group. This flexibility can set an example for adolescents as well. To be able to shift and adjust to what is needed at the moment is important for adolescents because, in life, sudden changes do happen. This also appears in seeing if verbalizing is necessary or if the art-making process is what an adolescent needs at that time.

**Conclusion**

As an individual who lost their father during their childhood, I understand and empathize with the inability to fully communicate and express one’s own grief. Between the fear of fitting in and avoiding peers’ pity, to not wanting to cause more suffering for my mother, I felt unable to find someone to talk to. My outlet was my artwork; I would create and explore any materials I could get a hold on. Now as I work with adolescents in an urban city inpatient behavioral hospital, I have witnessed adolescents be at a loss for words to express their pain. Having the art be an important outlet for my loss, I hoped to provide the same opportunity to the adolescents I
worked with it. My experience working with adolescents has been challenging and offered multiple opportunities to witness the resiliency of adolescents. One of the first realizations I had through learning about my site was that a majority of the adolescents had or were experiencing some kind of loss in their lives. The degree of awareness and willingness to explore their loss varied among the adolescents. Those admitted to the unit and what had happened on the unit prior to the group session determined what capacity the group had to explore grief. It was very interesting seeing how quickly adolescents’ behaviors shifted and I realized how flexible being a facilitator entailed.
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