Effect of a Group-Style Intervention, for Children Suffering Grief and Complicated Grief.

Abstract

A literature review indicated that although activity approaches to child interventions report benefits of significant value, these interventions are largely of an individual nature. Little has been reported relating to group therapy for children using the integrated approach. A longitudinal study was therefore conducted to establish the therapeutic benefits associated with an integrative, group therapy approach to working with children. These children had recently suffered loss due to violent death, incarceration of a parent due to child abuse or marital breakdown. It was found that the approach to therapy made a significant positive impact on the children's behaviour. It was also found that this impact could be considered moderate to high in nature. It is suggested that the level of effect was directly associated with the power attained and associated sample size. This design of intervention may, therefore, be considered to have the ability to add considerably to the literature.

Introduction

It is recognized that issues related to grief and loss represent a significant contribution toward psychological and emotional dysfunction, especially as they relate to children (Baggerly & Exum, 2008). Various interventions have been practiced for many years as individual approaches (Serafica, 1989). For example work sheets may be used to teach social skills, self esteem and education in protective behaviours (Geldard & Geldard as cited in Looker, 2003); and Kaduson and Schaefer center on different models which involve Individual play therapy, Family play therapy, and Group play therapy (Kaduson & Schaefer, 2006). Empirical data to support the practice of multi-modal approaches to grief and loss in children appears to be lacking. Even reports for activity approaches appear unusually sparse, considering their popularity with child therapists (Serafica).

Complicated grief (CG) is, as its name suggests, of a more complicated nature. It is said to produce yearnings, preoccupation with the deceased person and disbelief at the death of the individual (Boelen & Van Den Bout, 2007). Children may experience intrusive thoughts and images related to the loss of the person (Boelen & Huntjens, 2008). These symptoms need also to have been present for at least six months and caused impairment to normal functioning (Boelen & Huntjens, 2008). Ordinary grief may include intrusive mental images (ITM) when fragments of specific autobiographical events, or extensions of these events contain sensory qualities and enter awareness suddenly and without intention (Hackmann & Holmes, 2004).

Over the rainbow

The program under investigation (Over the rainbow) offers children the opportunity to learn to overcome difficulties related to loss, primarily of a loved one through divorce, death and violent death, incarceration of a parent following child abuse, or abandonment (Jones, 2010). It is run over a seven week period and is designed to help children gain understanding of the experience of a loss. They are encouraged to tell their story, grieve the loss and feel the feelings, physically and creatively express their feelings, complete unfinished business, commemorate and move on in life, and, claim a new sense of self and receive permission to move on in life (Jones, 2010).

Each session with the children involves the use of story telling from such books as: *The lonely scarecrow* (Preston, 1999); *The midnight unicorn* (Reed, 2005); *My grandpa is great* (Goldsack, 2001); *Scaredy mouse* (Macdonald & Warnes, 2005); *Oakey's perfect day* (Harker, 2009) and *Badgers parting gifts* (Ref Varley). Because of its recognised association with the relief of anger, discord, and conflict in children (Bowlby-West, 1982); relaxation therapy is a central theme in therapy (Feltham & Horton, 2009).

Whilst children are learning the art of relaxation, music of a calming nature is played. This is because the therapeutic effect of music for such conditions as cancer (Barrera, Rykov, &

Doyle, 2002); depression (Chan, Chan, Mok, & Tse, 2009); and language difficulties (Geist, McCarthy, Rodgers-Smith, & Porter, 2010) among others is well documented. The use of music as a therapeutic tool has long been established and its effectiveness catalogued. However, although Barrera, Rykov and Doyle (2002) found evidence that music therapy had a therapeutic effect, they concede that the measurement of change attributable to music was difficult. As discussed, over the years music has been used in therapy for a range of interventional needs. Another such need is for helping individuals overcome grief and loss. Bright (1999), another pioneer into this approach reports that "music reaches into the person's inner depths more easily that words (Bright, 1999, p. 483). Bright also states that music is more easily expressed by the client, than, the use of words. As words relate to the telling of stories by both the client and the therapist, this form of intervention also has a history of successes (Androutsopoulou, 2001). Music in this program is also utilised whilst children are undergoing Adlerian Art Therapy (AAT) (Froeschle & Riney, 2008).

Children in grief and complicated grief may engage in socially aggressive acts (Froeschle, Mayorga, Castillo, & Hargrave, 2008). It has been shown that this may be linked to a lack of security and a desire to preserve self esteem (Adler, 1956). Thus, by offering alternative solutions to aggressive acts, young people in grief may feel empowered to make constructive changes in their behaviours (Froeschle & Riney, 2008). Art therapy as discussed by such authors as McNamee (2005), and Stephenson (2006), helps to promote self expression and thereby recognize strengths. The use of bi-lateral approaches to art therapy are speculated to incorporate neural integration, thereby affording the possibility for neural change based on the therapy (Stephenson, 2006).

Froeschle and Riney (2008) reported that in the context of social bullying at school, students who underwent AAT were more likely to change their socially unacceptable behaviour into more acceptable behaviour if they engaged in AAT, than if they did not

undergo AAT. In response to the outcomes reported by Froeschle and Riney (2008), it was decided to include AAT as part of the program for *Over the Rainbow*. AAT uses the association between different colours in the mind of the child, with the dimensions of attention, power, inadequacy and revenge. The children are encouraged to discuss times when inappropriate or appropriate responses have been engaged within these dimensions. Following the creation of two drawings from different social spheres such as home and school the children then discuss how their artwork relates to each of the dimensions (attention, power, inadequacy, and revenge). They also discuss how their use of these dimensions relate in these social spheres (Froeschle & Riney, 2008). Later in the programme children discuss positive and negative consequences for behaviours depicted in previous artwork. When a child suggests that a particular behaviour is appropriate he may be asked questions such as “Can it be that you want to fit in better with your peers”. Such questions enable the child to reflect on mistaken goals and defence mechanisms (Froeschle & Riney, 2008, p. 425).

Hypothesis 1

It was expected to be found that over the seven week period that the course is run, that a significant change would occur in the children’s behaviour as it applied to their psychological status. That pre-testing would indicate symptoms that are significantly different to the children in the general population, and that post-testing would indicate symptoms that are similar to children in the general population.

Hypothesis 2

It was further hypothesized that differences between pre-test and post-test results would correlate significantly with the children’s own subjective assessment of their emotional and psychological state.

Background

The literature appears deplete as this applies to multimodal approaches to child interventions for grief and CG. One study conducted by Snow, Hudspeth, Gore, and Seale (2007) in an attempt to examine the relationship between the quantitative and qualitative aspects of play therapy, reported on their findings related to two case studies. They used the Child Behavior Check List (CBCL) (Achenbach & Rescorla, 2001) and the observations of play therapists over a six week period. In order that play therapists observations be standardized, these researchers used the Benedicts Expanded Play Themes (Benedict, 2004). The results from this study, which were according to the researchers possibly skewed due to sample size indicated a strong correlation between the play themes and the CBCL results (Snow et al.). According to Snow et al., the greatest changes were reflected in anxiety/depression, withdrawn/depressed, attention problems, rule breaking behaviour, and internalizing. Slightly reduced changes occurred for somatic complaints, aggressive behaviours and externalizing (Snow et al.). A major concern in Snow et al.'s report, however, is the total lack of statistical evidence to corroborate their statements.

A review of the literature indicates that the choice of therapy by a therapist should be based upon the client's needs and the implicational setting (Prochaska & Norcross, 1999). For example the use of conditioning as described by Nye (1996) may well be appropriate for a given client who wants to stop smoking, when psychoanalytic therapy is not. Prochaska and Norcross (1999) suggest that a single therapeutic approach may not be as beneficial perhaps as an integrated approach. "Integration as a point of view has probably existed as long as philosophy and psychotherapy (Prochaska & Norcross, 1999, p. 459). It is this view that guided the work of authors such as (Page, Werner, Stritzke, & McLean, 2008). Page et al., proposed a model of science-informed practice which suggests that client data (problem, context, history etc) is assessed in light of theoretical and empirical literature and, clinical

training and experience. The results from this data are assessed and a case formulation leading to treatment is planned and measures considered. Treatment is then implemented, monitored and evaluated (Page et al.). According to these authors data are collected from the presenting issues, predisposing factors, precipitating factors, perpetuating factors and potential problems or strengths. Based upon the data collected and the validity of the treatment plan it is then possible to formulate a prognosis for the client (Hunsley & Lee, 2006).

Other researchers who support the integrative approach to therapy include Hollanders (1999), and Strickler and Trierweiler (2006) who report that this approach is based on what is often referred to as the *scientist practitioner approach* otherwise known as the Boulder model, named after the conference in Boulder Colorado where this "bridge between science and practice" was conceived (Stricker & Trierweiler, 2006, p. 37).

The *Over the Rainbow* approach to group therapy with children may also be considered to include a multiple intelligences framework (O'Brien & Burnett, 2000). Multiple intelligences as proposed by Gardener (1993) may be said to include verbal/linguistic intelligence, utilized by *Over the Rainbow* in listening, speaking and writing; visual/spatial used during art work; musical/rhythmical used during art work; interpersonal used in communication, and intrapersonal intelligence which is related to the child's emotional responses, self reflection and awareness of metaphysical concepts (O'Brien & Burnett).

Symptoms related to grief and loss

As identified from the CBCL manual, Achenbach (1991) a number of symptoms may emanate through the experience of grief and loss. Stress, a product of grief and loss, is known to highly correlate with depression and anxiety (Banez & Compas, 1990) and may be defined as an internal cue in the physical, social, or psychological environment, that threatens the homeostasis of an individual (Gray-Toft & Anderson, 1981). Children who suffer from stress are likely to experience fear, hopelessness or horror in its acute form and may feel numb or

detached (American Psychiatric Association, 2000). They may experience a tendency to loose perspective, feel restless, anxious or depressed (Cheng & Hamid, 1998). Or they may experience somatic symptoms such as sore throat, dizziness, blurred vision or sweaty palms or feet (Cheng & Hamid).

A number of moderating variables between potentially stressful events and the products of those events if not attended to have been suggested (Makano, 1991). These have included avoidance of emotionally focused interventions (Makano), High levels of self esteem (Barnett & Fanshaw, 1997), Personality traits such as extroversion (Roberts & Monroe, 1992), and cognitions associated with the events that have the potential to cause stress (Hilsman & Garber, 1995).

Another moderator to psychological health is level of optimism (Huan, Yeo, Ang, & Chong, 2006). Vivian Huan and her associates in their discussion over dispositional optimism argue that even in the face of adversity, individuals may succeed in fulfilling desired goals (Huan et al.). The opposite is true, however, when the disposition is one of pessimism. It is shown that achievement under these conditions has a negative effect on development (Leung, 2002).

Anxious children are apprehensive for more days than not. This apprehension affects their every day performance at school and it makes them irritable, restless, fatigued and tense (American Psychiatric Association, 2000). It also causes them to lose sleep, either through restlessness once they have fallen asleep or, through having difficulty initially falling asleep. Symptoms may also depend on ethnic background (American Psychiatric Association, ; Ang & Huan, 2006; Leung, 2002; Makano, 1991).

Depressed children may feel depressed or have a loss of interest or pleasure (American Psychiatric Association, 2000). They may lose or gain weight without dieting and they may suffer insomnia or hypersomnia nearly every day. They may have no energy, feel worthless or

guilty. They may not be able to concentrate. They may feel agitated or really slowed down. They may also have recurrent thoughts of death, committing suicide or have a specific plan to commit suicide (American Psychiatric Association).

As well as symptoms associated with depression anxiety and stress, children who suffer grief and loss may exhibit other symptoms (Achenbach, 1991). These children may be said to be *Internalizing* and would rather be alone than with others, won't talk, are secretive, shy, may stare, sulk, are under-active, sad and withdrawn (Achenbach & Rescorla, 2001). Children who are said to be *Externalizing* are the opposite. They may feel no guilt, be bad company, lie or cheat, or prefer being with older people. They may run away, set fires, steal, swear, think a lot about sex, truant, use drugs or alcohol or vandalize other peoples property (Achenbach & Rescorla). Other externalizing behaviours are: arguing, bragging, being mean, jealousy, fighting, screaming, showing off, stubbornness, mood changes, talkativeness, teasing, displays of temper, threatening behaviour and being loud (Achenbach & Rescorla).

As well as any of the above difficulties, children who have suffered grief and loss may display many other symptoms including self harm, fear of school, nail biting or thumb sucking. They may sleep walk or suffer from enuresis. They may pick at their skin, be prone to accidents or be too neat (Achenbach & Rescorla, 2001).

The current study

In light of the shortfall related to multimodal approaches to counselling children in grief, the particular approach taken by *Over the Rainbow*, and the lack of empirical data associated with this approach in the English context it was decided to conduct an empirical study. The need for reliable and valid programs designed to help at risk children can not be over-emphasized.

Method

A longitudinal mixed (quantitative/qualitative) survey/semi-structured interview study was conducted. A single parent report questionnaire (X2) was used for the pre-test and post test stages of the quantitative part of the study. For this purpose the Child Behaviour Checklist (CBCL) Achenbach (1991) was chosen. The qualitative part of the study was conducted through the use of a semi-structured interview at post-test only. An explanatory letter introduced the researcher. It also explained the voluntary nature of the research and the rights of the participant to withdraw from the research at any time. This letter also gave an assurance of confidentiality and anonymity and, explained in simple terms, the use of the data. The security and subsequent disposal of the data was explained.

Participants

G-Power (Erdfelder, Faul, & Buchner, 1996), a statistical package designed for assessing sample size was used to compute an *a priori* sample size. An effect size of ή = 0.05 and power = 0.95, was computed. The suggested sample size developed from this computation was n = 22. This was based on the intended use of a multivariate analysis of variance (MANOVA). Because of a crossover of symptomology between complicated grief and Posttraumatic Stress Disorder discussed in an earlier literature review by this author; the Child Post-Traumatic Cognitions Inventory (CPTCI) (Meiser-Stedman et al., 2009) was used to screen participants with PTSD (Appendix A).

The sample was taken from *Over the Rainbow* in Stafford, UK. Based on availability, the questionnaire was administered to a final sample of twenty-one children at pre-test. On week three of the program one child was withdrawn from the program. A breakdown of the remaining 20 subjects consisted of 4 (25%) female and 16 (75%) male. Of this sample, 12 (60%) were of European descent, and 8 (37.5%) were of West Indian descent. The frequency of children's ages indicated that two were aged 7, one was aged 8, four were 9, three were 10

and ten were aged 11. It was also shown that of the twenty children, 4 were from one family, 2 were from another and each of the other children were representative of different families.

Measures

The Child Behavior Checklist / 4-18 (CBCL) (Achenbach, 1991)

The CBCL (Appendix B), is a multiaxial, empirically based assessment for behaviours in children aged from 4 to 18 years. It is constructed in the following formats: written responses to such questions as "Please list your child's favorite hobbies, activities, and games, other than sports", Likert scales of three and four point frequencies, and binary questions. The CBCL may be administered in as little as 10 minutes though a typical administration is said to be 15 to 17 minutes (Achenbach, 1991). It was designed for people who have a minimum of fifth grade reading skills. The CBCL is designed to record in a standardized format, children's competencies and problems as reported by parents or parent surrogates.

In reporting his analysis of the CBCL, Achenbach showed that the CBCL discriminates children who express externalizing and internalizing behaviours from the normal sample. On each of the syndrome scales borderline scores are reported as those between T = 67 and T = 70. Those children that score above T = 70 are said to be in the clinical range. Inter-interviewer reliability on item scores by three interviewers on 241 matched triads of children is reported as 0.927 for the 20 competence items and 0.959 for the 118 problem items. Significance for both scores are reported at $p < .001$. Achenbach reported mean test – retest reliability as between r = 0.70 and 0.92 for the competence scales and r = 0.82 and 0.95 for the syndrome scales. All scores were significant at $p < .001$. Convergent validity for the CBCL is reported through a correlation of r = 0.86 with the Connors Rating Scale (Connors, 1989); and discriminant validity was shown through selective weight prediction between referred and non-referred children in samples that ranged between 740 and 857.

Procedure

Data was collected from parents as part of the intake interview (Pre-test). They were told the background for the study and asked to participate and at this time, issues of confidentiality and discontinuance were explained. Post-test data was collected in a similar fashion at the end of the program. The final session was extended by one hour. During this time short subjective interviews were conducted with the children (Appendix C).

There were nine independent variables (IV's) associated with this project: On the CBCL, the problem scale contained four levels, (1) internalizing, resulting from sub-scales: withdrawn, somatic and anxious/depressed. (2) Externalizing, resulting from two sub-scales: delinquent and aggressive. (3) social/thought/attention problems; and (4) other problems. On the competence scale (5) there were three levels, activities, social, and school. Each of the levels on the problem and competence scales were continuous variables. Ethnicity (6), which has two levels: English (white), Non-English (non-white). (7) Gender which has two levels. On the child interview there were two IV's; feelings and cognitions.

Results

An inspection of the data revealed that prior to engaging in the Course, the average level of internalizing issues reported were M = 10.20 (SD = 6.33). Externalizing difficulties were reported as M = 11.90 (SD = 6.90). The minimum and maximum levels reported were 2.00 and 21.00, and 2.00 and 23.00 respectively. Other areas of interest reported mean scores of 2.90 (SD = 1.91) (social problems), 0.80 (SD = 0.79) (thought problems), and 3.90 (SD = 3.31) attention problems. At post – test, the levels for each of the foregoing were reported as: Internalizing issues M = 4.37 SD = 3.77, Externalizing issues M = 7.25 SD = 4.74, social problems M = 1.87 SD = 1.12, thought problems M = 0.87 SD = 0.83, and attention problems M = 1.87 SD = 2.29. What is referred to as other problems in the CBCL returned scores of M = 5.70 SD = 4.11 and M = 1.75 SD = 1.28 for Pre-test and post-test respectively.

A multivariate analysis of variance (MANOVA) indicated that the main effect was significant F [10.29] = 19, p = 0.015. An analysis of variance (ANOVA) on each dependent variable on the problem scale found that a significant effect occurred between Pre-test and Post-test reports for the following behaviours: Externalising = F [10.294] = 1, p = 0.015; Internalising = F [9.947] = 1, p = 0.016; "Other" = F [9.736] = 1, p = 0.017. It was found that the effect size for each of these measures may be suggested to be very good (R = 0.795, R = 0.787, and R = 0.782). A multiple regression analysis was conducted to investigate the likelihood that effects of the interventions applied may have been influenced by co-variants. When family, gender of the child, age of the child, and cultural background of the child, were considered, it was found that none of these variables influenced the outcome of scores. This indicates that a high likelihood exists that the variation in scores between the pre-test and post-test conditions for the subjects in question were a function of the interventions applied.

A child interview was conducted at post-test containing 7 items. These included questions such as "what sort of things did you like doing best while you were here?" and "tell me how you feel now about daddy (or mummy) not being here. What sort of things do you do to make yourself feel better?"

A Principle Components analysis was conducted on the child interview, looking for Eigenvalues that exceeded 1.00 (Pett, Lackey, & Sullivan, 2003). It was found that two factors existed. A Kaiser-Meyer-Olkin (KMO) statistic revealed that a very high ratio of the squared correlation between variables to the squared correlation between variables existed (0.889). This "meritorious" score (Pett et al., 2003, p. 78) indicating that a factor analysis should yield distinct and reliable factors. A series of PCA and Principal Axis Factoring (PAF) analyses, using both oblique (Oblimin) and orthogonal (Varimax) rotations with Kaiser normalisation, were then conducted to confirm factors within the scale. Two factors were

confirmed, these were identified as relating to feelings (57% - 4 items) and cognitions (43% - 3 items). It was found that items 2, 3, 5, and 6 were associated with feelings; whilst items 1, 4, and 3 were identified with cognitions.

Reliability of the derived factors was assessed using Cronbach's Alpha. From this approach factor one (feelings), showed an alpha level of $\alpha = 0.88$. On factor two (cognitions) $\alpha = 0.76$. Cronbach's Alpha for the whole scale was $\alpha = 0.92$. Validity of the child interview was assessed through Pearson's correlations with the total scores on the CBCL. The relationship between feelings and the CBCL was shown to be, negatively correlated ($r = -0.093$) indicating strong discriminatory power. The relationship between the cognitions and the CBCL was also negatively correlated $r = -0.087$, also indicating strong discrimination. Thus children's feelings and cognitions at post test were reflected by their positive behaviours compared with their CBCL scores at pre-test.

Discussion

It may be seen from the data that the first hypothesis (H1) is supported. It was shown that over the seven week period that the course was run, that a significant change occurred in the children's behaviour as it applied to their psychological status. It was shown at pre-testing, that children's symptoms as identified by parents on the CBCL were significantly different to the children in the general population, and that, post-testing indicated symptoms that are similar to children in the general population. It was also found that children in this sample felt better and understood why they felt better as a result of this intervention.

Further research

The evidence suggests that the group-style intervention strategies espoused by *Over the Rainbow,* has positive utility for children suffering grief and complicated grief. Before this style of intervention is utilized in a broader format, however, it may be suggested that further studies be conducted to include larger samples and diverse therapists. It is suggested that in

this context therapists be drawn from a range of psychological approaches such as clinical, counselling, and educational psychologists; as well as client centered counsellors. It is further suggested that male and female therapists be equally represented within this range.

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