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The Effectiveness of Group Therapy in Decreasing Symptoms of Depression in Children Experiencing Loss/Grief.

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Acknowledgments

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Abstract

An opening to the topic of children experiencing grief and loss is introduced. Definitions of loss, grief, bereavement, reconciliation, and mourning are described. Examples of grief and loss that children experience are outlined, such as death of a parent, death of grandparent, death of a sibling, death of a pet, and divorce. Everyday losses, such as having a new baby in the family, moving to a new home, and parent incarceration are also explained. A section on depression is discussed, following interventions for children dealing with grief and loss. A closing of the literature review is summarized. Lastly, sections on method, results, and discussion are concluded.
The Effectiveness of Group Therapy in Decreasing Symptoms of Depression in Children Experiencing Loss/Grief.

Children are exposed to loss and death more frequently than what many people would like to believe (Fox, 1985). An estimated 90% of school aged children have personally experienced the death of someone who they cared about, such as the loss of a family member, friend, or pet (Ewalt & Perkins, 1979; Harrison & Harrington, 2001; Stewart & Sharp, 2007). They proposed that the most frequent experiences of death are the deaths of parents and grandparents, followed by deaths of siblings and friends.

Children learn much more from society about loss and death than they are intentionally taught (Anthony, 1971). Anthony stated that the way children conceive death and loss depends on their age and maturity level, as well as what they are taught.

Children lack the built-in support systems that many adults depend on in times of stress and loss (Auman, 2007; Webb, 2002). Auman continually stated that an alarming lack of understanding about childhood bereavement and children’s need for bereavement services continues to exist among the general public, as a lack of awareness exists of the inner suffering experienced by children. Most adults are reluctant to talk with young children about such an emotional event as death for fear of saying the “wrong thing” and creating unnecessary anguish (Fox, 1985). As nurturing adults, we try to soften the definition of death and try to spare children the necessity of facing tragic circumstances, which is well intentioned but inhibits children’s understanding (Jackson, 1965; Trozzi, 1999). Some adults think that children are too immature and too young to share anything pertaining to death and loss and are therefore, reluctant to do so (Rochlin, 1967).

Children often appear to suffer more from the loss of parental support or overprotection
than from the intimacy of the death or loss experience itself (Wolfelt, 1983). Children cannot and should not be spared knowledge about loss and death (Grollman, 1967). Our culture does not have an understanding of how hurting is a part of the healing journey (Wolfelt, 1996).

Children are often referred to as “forgotten mourners” because society often does not encourage children to mourn (Wolfelt, 1996). Bereaved children have high levels of emotional disturbance and symptoms following a loss (Auman, 2007; Fox, 1985; Webb, 2002). Children’s coping skills are not fully developed and they end up feeling frighteningly helpless and out of control, as though their world has been turned upside down (Keyser, Seelaus, & Batkin-Kahn, 2000). When bereaved children internalize messages that encourage repression, avoidance, denial or numbing of grief, they become powerless to help themselves in their own healing process (Wolfelt, 1996). Wolfelt stated that children may instead learn to act out their grief destructively, and so will learn not to mourn well, resulting in not loving or living well. Therefore, it is imperative for children to mourn their losses, and they need help from adults in order to do so (James, 1994).

Adults must listen to the information children have when experiencing a loss or death (Fox, 1985). Providing honest information that children can understand will significantly increase the chance of their coping in times of a crisis and will help in reducing stress (Fox, 1985; Lonetto, 1980; Wolfelt, 1983). Children can handle honest answers more than dishonest avoidance (Jackson, 1965). Parents experience frustration and hopelessness when faced with questions about death or other losses from their children, whether healthy or fatally ill (Hoffman & Futterman, 1971; Karon & Vernick,
Parents often feel it is unwise to appear confused, uncertain, or frightened in the presence of their children (Lonetto, 1980). Lonetto stated that discussions are necessary and children’s reactions and choices to loss or death should be recognized and respected.

Children need to repeat their questions over and over again in order to better understand what is happening or what has happened (Wolfelt, 1983). He added that children need to be given the opportunity to feel that their questions are welcomed. In addition, Wolfelt stated that the process of repeating questions aids in the child’s healthy adjustment, as each time it is discussed, it becomes more bearable. Furthermore, he discussed that adults can demonstrate sensitivity to children by being aware of tone of voice, maintaining good eye contact, being aware of what is being said verbally and also what is being communicated nonverbally, being empathic, patient, and loving.

Review of the Literature

Definitions

Loss

Fiorini and Mullen (2006) described loss as a universal experience and that the causes and manifestations of it are unique to each individual and may change over time. They additionally stated that the experience of loss is different for each person. They suggested that loss does not necessarily have to be death or the end of a relationship, but can also be a result of a change or disruption in someone’s life, such as a divorce or moving.

There are many losses experienced by children. These include loss of significant relationship, death of a loved one/pet, a decline in one’s health, capabilities or
opportunities, loss of safe/familiar environment with home and/or school, incarcerated parent, and loss of belongings/finances. Losses can be personal or material, tangible or symbolic, specific or general, sudden or gradual, real or imaginary, minor or major, partial or total, personal or corporate, single or multiple, expected or unexpected, private or public, local or global, and individual or communal (Abi-Hashem, 1999).

Loss of significant relationships places extraordinary demands on a child (Monahon, 1993). Monahon reported that the closer the child’s relationship was to the one who passed away, the more difficult the mourning process is. James (1994) discussed that the steps necessary for acceptance of the loss of a relationship are to protest the loss, internalize the loss, say goodbye, grieve, and create meaning. Monahon stated that grieving for children normally involves a long and gradual process and that grief can be complicated in many ways.

Following a major loss, the bereaved survivor needs to go through a long process of readjustment, renegotiation, reorganization, and readaptation to normal living without one’s loss (Abi-Hashem, 1999b). This process is called the relearning of the world (Attig, 1996). In the absence of children’s attachment figures, children give themselves what they need to live (James, 1994). James continually discussed that this includes a viable relationship with the missing relationship through idealization, splitting, bargaining, magical thinking, and reunion fantasies.

A life event dealing with death is considered to be a crisis (Fox, 1985). In addition, Fox stated that crisis for children is a developmental interference that results in the suspension of their ongoing growth. Furthermore, she discussed that the goal of crisis
intervention for children is to get them “unstuck” and out of their temporary barrier to a more normal and healthy place.

**Stage models.** A famous stage conception of normal grief and bereavement is Kubler-Ross’ five-stage sequence for the dying person: denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1969). She discussed that when individuals are hit with tragedy, these coping mechanisms to deal with difficult situations kick in. Grief is described as a process comprised of distinct stages that mourners pass through, in which the stages are not necessarily in the same order, differ in the degree of intensity, and vary in duration (Kubler-Ross, 1993). Stages are meant to be general guidelines and do not speculate where an individual should or must be in the grieving process (Shuchter & Zisook, 1993). Stewart and Sharp (2007) stated that denial, anger, bargaining, depression, and acceptance are steps along the bereavement process that children may need help navigating, depending on their cognitive, emotional, and behavioral experiences in each stage.

Kubler-Ross (1969) and Kubler-Ross (1993) described children in the denial stage as unable to view the death as permanent and real, and are therefore unable to exhibit behavioral and emotional responses consistent with reality, causing greater distress. She discussed that the anger experienced is a result of the lack of acceptance of reality and the maintenance of beliefs, such as thinking the loss should still be around, that it is not fair, or that they do not deserve such pain. She further proposed that children in the bargaining stage make assumptions based on beliefs that they have influence over the situation; that the loved one’s death is within their control. She continually mentioned that the depression stage is based on dysfunctional beliefs, such as thinking that they will
never feel normal again. Lastly, she concluded that the acceptance stage involves more realistic thinking about the loss and what that means for the grieving child.

Another stage model is Kavanaugh’s (1972) seven stages of shock, disorganization, volatile emotions, guilt, loss and loneliness, relief, and re-establishment. Rando (1984) proposed that instead of stages, three phases of reactions can be seen: avoidance, which encompasses shock, denial and disbelief; confrontation, the highly emotional state; and re-establishment, when grief reactions diminish and there is a re-entry into the everyday world. According to Shuchter and Zisook (1993), the grief process has three overlapping phases, which consist of an initial period of shock, denial, and disbelief; a mourning period of acute somatic and emotional discomfort and social withdrawal; and a period of restoration. They discussed that the first phase of shock can last anywhere from hours to weeks and is characterized by disbelief, and feeling numb and paralyzed. They added that the second phase of acute mourning begins when death or other losses are acknowledged cognitively and emotionally. Lastly, they stated that the mourning stage can last for several months before entering the period of restitution or restoration. Furthermore, they concluded that in the third stage of restoration, the bereaved has the ability to recognize they have grieved and can return to work, re-experience pleasure, and seek companionship of others.

Bowlby (1980) described the grief process in four phases. He outlined his phases as the phase of numbness, the phase of yearning and searching, the phase of disorganization and despair, and the phase of reorganization. He described these phases like so: the phase of numbness involves being stunned and in denial; the phase of yearning and searching is when individuals encounter strong urges to reunite with their
loss; the phase of disorganization and despair entails giving up the attempt to search for the loss, depression is present, and failure to realize purpose in life exists; and phase of reorganization incorporates establishing new ties to others and returning to interests and appetites.

Engel (1964) described the normal sequence of grief as follows: shock and disbelief, developing awareness, restitution or performing rituals to initiate recovery, resolving the loss, idealization, and the outcome. Parkes and Weiss (1983) believed that three tasks must be completed for recovery and grief to take place. They proposed their tasks as intellectual recognition and explanation of the loss, emotional acceptance of the loss, and assumption of a new identity. Overall, the intensity and duration of feelings may vary with children experiencing grief, but they tend to go through similar stages of grieving to cope with loss (Mack & Smith, 1991).

Grief
The Center for the Advancement of Health (2004) defined grief as the distress resulting from bereavement and is seen by some researchers as a complex set of cognitive, emotional, and social difficulties that follow a loss. Grief is a highly charged emotional state and a risk factor for the development of a wide range of negative outcomes, including mortality and major physical and mental health disturbances (Gallagher-Thompson & Thompson, 2007). Corr, Nabe, and Corr (2000), Rando (1984), and Stroebe et al. (2001) defined grief as the person’s reaction to the perception of the loss. Corr, Nabe, and Corr (1997) indicated that grief is the response to loss; grief signifies one’s reaction both internally and externally to the loss. Rando added that grief allows individuals to let go of what was and gets people ready for what is to come in the future. Grief refers to personal expression, thoughts, and feelings associated with loss
Individuals vary in the type of grief they experience, its intensity, its duration, and their way of expressing it (Christ, et. al., 2003). Grief can be emotionally exhausting with many similarities to clinical depression and is normative in circumstances of loss (Tedeschi & Calhoun, 2008). Klass, Silverman, and Nickman (1996) and Stroebe, et. al. (2001) described that for most people, their loss is always an issue, and that missing their loss and remaining connected to such loss is part of the bereaved person’s typical experience throughout life. Moreover, Clegg (1988) proposed that grief is almost synonymous with sorrow, and is a series of reactions to the perception of loss.

Grief can be defined as deep sorrow, heaviness of heart, and agony of the soul, and can be understood as mental anguish and emotional suffering (Abi-Hashem, 1999). Abi-Hashem also described grief as an acute and overwhelming sense of loss, in which children become helplessly engulfed with strong waves of emotions. Grief is an inevitable, never-ending process that results from a disruption in a routine, a separation, or a change in a relationship that may be beyond a person’s control and causes pain, discomfort, and impacts the person’s thoughts, feelings, and behaviors (Fiorini & Mullen, 2006). They explored that grief can be expressed in an infinite number of ways.

Gallagher-Thompson & Thompson (2007) described bereavement in its narrowest sense as the reaction or process that results after the death of someone close. Wolfelt (1983) suggested that grief is a process, rather than a specific emotion like fear or sadness and that it can be expressed by a variety of thoughts, emotions, and behaviors. Grief is both a process and an outcome, as it is a mental, emotional, and behavioral response to loss (Wolfelt, 1988). Grief is the reaction to bereavement that may be thought of as the
mind’s natural healing process, triggered by loss (Shear, Zuckoff, Melhem, & Gorscak, 2006).

According to Fox (1985) and Willis (2002), children grieve differently than adults. Grieving children have frequent anger, mischievous, boisterous, and noisy behaviors (Simos, 1979). Fox added that grief work with children should include dealing with the reality of the death, pain, and emotional adjustments in order for them to continue living, loving, and trusting.

When grief is being dealt with well, grief occurs in two phases (Shear, Zuckoff, Melhem, & Gorscak, 2006). They stated that initially there is disbelief, anguish, social withdrawal, and preoccupation with the loss. They discussed that overtime; disbelief is superseded by acceptance of the finality of the loss. They described that the intensity and frequency of painful emotions subside and they are gradually replaced by positive, comforting feelings when thoughts return of the loss. Furthermore, they indicated that interest in daily activities is regained and problems that arise from the loss are able to be resolved. Moreover, they concluded that eventually the thoughts of the loss will still be present, but will no longer control the bereaved person’s mind.

**Anticipatory grief.** Anticipatory grief refers to grieving that occurs prior to the actual loss (Corr, Nabe, & Corr, 1997; Worden, 1982). “Many deaths occur with some forewarning and it is during this period of anticipation that the potential survivor begins the task of mourning and begins to experience the various responses to grief” (Worden, 1982, p. 92). Worden argued that the awareness of inevitability of death can alternate with experiences of denial that the event will really happen. He also indicated that for many people experiencing anticipatory grief, anxiety increases and accelerates the closer
the person comes to death. For example, Hindle (2006) proposed that with parents’ preoccupation of illness and a natural tendency to use denial as a defense, children face overwhelming feelings of anxiety.

*Complicated grief.* Normal, uncomplicated grief is known as a dynamic process with overlapping stages, which include shock, painful emotional and somatic symptoms, and then resolution (Bowlby, 1980; Engle, 1961). However, the inability to deal with losses and the crippling fear of future losses could interfere with the psychological functioning of the person (Abi-Hashem, 1999). Complicated grief reactions are unusual and abnormal in the sense of being deviant and unhealthy (Corr, Nabe, & Corr, 1997). There are many documents of mental and physical health complications associated with bereavement (Lichtenthal, Cruess, & Prigerson, 2004). Some of these symptoms include depression, anxiety, interpersonal problems, substance abuse, hallucinations, physical illness, and even death (Sable, 1992; Stroebe, Schut, & Finkenauer, 2001). According to Cohen and Mannarino (2004), children with complicated grief are unable to complete the tasks of reconciliation because remembering the loved one typically serves as a trauma reminder. Cohen, Goodman, Brown, and Mannarino (2004) explained that when children experience trauma and death, chaos, anger, and sadness are created. Prigerson, Frank, et al. (1995) and Sanders (1989) defined complicated grief as an unresolved nature of the disorder, in which symptoms are related to complications in normal functioning.

Lichtenthal, Cruess, and Prigerson (2004), proposed that the symptoms of complicated grief are associated with mental and physical dysfunction that can persist for years if left untreated. Grief can remain unresolved for long periods of time and when such disturbances become chronic or increase in time, the bereaved then may develop
serious psychological conditions and will qualify for a psychiatric diagnosis, like major clinical depression, anxiety or panic disorders (Abi-Hashem, 1999; Middleton, Raphael, Martinek, & Misso, 1993). Abi-Hashem concluded that when this happens, it is referred to as complicated or pathological bereavement. Chronic depression with persistent grief, anxiety, depressed mood, and social impairment that spans over years or a lifetime is when grief would become a disorder (Maercker, 2007).

Worden (1991) described four types of complicated grief reactions: chronic grief reactions, delayed grief reactions, exaggerated grief reactions, and masked grief reactions. Worden explained chronic grief reactions as reactions that are prolonged in duration and do not lead to appropriate outcomes. He defined delayed grief reactions as grief that is postponed, suppressed, or inhibited. He suggested that exaggerated grief reactions are excessive and disabling and can lead to a phobia or irrational fear. Lastly, he stated that masked grief reactions are behaviors or symptoms that are experienced that cause difficulty to the person grieving, in which this person does not realize their behaviors or symptoms are related to the loss.

_Grief_ reactions. There are many reactions to major and sudden losses that are part of the normal grieving and bereavement process (Abi-Hashem, 1999). Abi-Hashem (1999) and Shuchter and Zisook (1993) summarized the most common reactions as sense of shock and disbelief, numbness, sadness, irritation and anger, guilt and self criticism, anxiety, shortness of breath, hollowness in the stomach, tightness in the throat, fears and apprehensions, physical aches and pains, loneliness and helplessness, crying, tearfulness, distress, confusion, fatigue, exhaustion, regressive tendencies, blaming and complaining, frustration, restlessness, sleep and appetite disturbances, mental preoccupation, disturbing
dreams, clinging to familiar objects and reminders of the lost, or completely avoiding reminders, social withdrawal, isolation, preoccupation of the deceased person or lost object, feeling overwhelmed, and changes in conduct and behavior. Emswiler and Emswiler (2000) added that some common physical reactions are grinding teeth, heart palpitations, numb or tingling sensations, diarrhea, cold and clammy hands, dry mouth, and nervous tics.

Abi-Hashem (1999) proposed different levels of functioning after a loss. He suggested that on the emotional-affective level, symptoms of anxiety and depression are present, as well as fluctuations of mood, deep anguish, loneliness, crying spells, and being constantly drained. He stated that on the mental-intellectual level there is usually confusion, disorientation, poor concentration, states of metal fog, poor school or job performance, loss of intellectual sharpness, and feelings of “going crazy.” He discussed that on the physical-biological level, there are changes in health-related habits and physiological functioning that did not exist prior to a loss, such as high blood pressure, diabetes, severe headaches, ulcers, joints or respiratory problems. He mentioned that on the behavioral-habitual level, bereaved individuals often engage in unhealthy behaviors because to them, life stops having the same meaning as it did before the loss. He described such destructive behaviors as excessively eating, drinking, working, smoking, or playing. He explored these behaviors as possible gambling, using drugs, or engaging in any activity that seems to soothe pain or help to cope with the harsh reality of the loss.

On the social-interpersonal level, there may be disruption of meaningful relationships, break of long term alliances, or overdependence on remaining survivors for comfort and support (Abi-Hashem, 1999). He reported that at times, children try to
protect the surviving parent or other grieving family members by stepping up and assuming roles and responsibilities around the household. Lastly, he concluded that on the spiritual-existential level, there are often serious doubts, crises of faith, over-spiritualizing, under-spiritualizing, blaming self or others, and feeling angry with society, life and God in general.

Bereavement

According to the Center for the Advancement of Health (2004) and Stroebe, et al. (2001), bereavement refers to the loss of a loved one. Attig (1996) and Rando (1984) proposed that bereavement is the state or condition of having suffered a loss. Corr, Nabe, and Corr (1997) and The Oxford English Dictionary (1989) indicated that bereavement is the state of being deprived, robbed, or stripped of something. Bereavement is also explained as a broad term that encompasses the entire experience of family members and friends in the anticipation, death, and adjustment to living following the death of a loved one (Christ, et. al., 2003). Webb (2002) described bereavement as the status of the individual who has suffered a loss and who may be experiencing psychological, social, and physical stress because a meaningful person has died. Abi-Hashem (1999) and Wolfelt (1983) suggested that bereavement is a state caused by loss or is the state of having suffered a loss. Bereavement is explained as the state which follows an actual or perceived loss, which may involve changes in psychological, behavioral, and/or physical dimensions to any valued object or relationship (Clegg, 1988). Bereavement is a global term that describes the immeasurable arrangement of experiences, changes, and conditions that take place following a loss (Sanders, 1989).
During bereavement, the process of regression is a common response and adaptation of children when experiencing an emergency situation, such as loss (Kliman, 1968). Kliman described regression as the turning back of psychological development to earlier stages of adaptation. Furthermore, he stated that when children are under distress they regress to previous behaviors, such as wanting to be cuddled or even slept with as if they were a baby, for temporary comfort and satisfaction.

The American Psychiatric Association (2000) utilizes the term *uncomplicated bereavement* in reference to the “typical” grieving process through which children and adults adjust to loss of a loved one. Uncomplicated bereavement is described as having much in common with depression, such as great sadness, appetite and sleep problems, difficulty concentrating, and lack of interest in activities (American Psychiatric Association, 2000; Gallagher-Thompson & Thompson, 2007). Uncomplicated bereavement was defined in the DSM-III-R (1987) as follows:

This category is used when the focus of attention or treatment is a normal reaction to the death of a loved one. A full depressive syndrome frequently is a normal reaction to such a loss, with feelings of depression and such associated symptoms as poor appetite, weight loss, and insomnia. Morbid preoccupation with worthlessness, prolonged and marked functional impairment, and marked psychomotor retardation are uncommon and suggest that the bereavement is complicated by the development of a major depression (American Psychiatric Association, 1987, p. 361).

“In *complicated bereavement*, the traumatic nature of the loss is due to the security-enhancing nature of the relationship and the bereaved’s dependency on that
relationship” (Cohen & Mannarino, 2004, p. 819). Cohen and Mannarino stated that children’s understanding of death varies according to their developmental level. Furthermore, they reported that uncomplicated bereavement in children is also evidenced in varying ways depending on the family’s modeling and support of emotional expression, cultural and religious beliefs, and mourning rituals, as well as the child’s own expressive and cognitive style. The DSM IV (1994) described symptoms that are not considered to be characteristics of “normal” grief:

- guilt about things other than actions taken or not taken by the survivor at the time of death,
- thoughts of death other than the surviving feeling that he or she would be better off dead or should have died with the deceased person,
- morbid preoccupation with worthlessness,
- marked psychomotor retardation,
- prolonged and marked functional impairment,
- hallucinatory experiences other than thinking that he or she hears the voice of, or sees the image of the deceased person (American Psychiatric Association, 1994, p. 684-685.)

Gallagher-Thompson & Thompson (2007) stated that there are various forms of individual and group therapies that have been used to treat patients with complicated bereavement. Rapheal and colleagues (1993) included that psychodynamic approaches, behavioral therapies, and cognitive therapies are the most useful in helping such individuals.

*Reconciliation*

Wolfelt (1996) described reconciliation as the process of the child adjusting to and accepting the reality of life without the loved one and re-involving oneself in daily activities. Wolfelt (1996) and Worden (1996) proposed that these following tasks are
imperative to the reconciliation process: accepting the reality of loss, fully experiencing the pain of the loss, adjusting to an environment and self-identity without the loved one, converting the relationship from one of present interacting to one of memory, finding meaning in the loved one’s death, and experiencing comfort of a continuing or new supportive adult presence in the child’s life. These tasks help the child to tolerate sustained thoughts about the deceased love and the child’s past interactions with the deceased, to remember the person and manage regret or guilt felt about unsaid words or things left undone in the relationship, and to overall face the pain and suffering associated with the loss (Cohen & Mannarino, 2004). Wolfelt proposed that reconciliation brings a renewed sense of energy, confidence, and a capacity to become reinvolved in the activities of living.

*Mourning*

Mourning refers to the family, religious, and cultural rituals through which bereavement and grief are expressed (Stroebe, et al., 2001). Fiorini and Mullen (2006) described mourning as a task that required detaching from a lost love one or object. Mourning has been referred to the external expression of the internal experience (Abi-Hashem, 1999). Freud (1917) proposed that mourning is the reaction to the loss of a loved person, or the loss of some abstraction which has taken place of one, such as one’s country, liberty, and ideal. Freud further explained that children experience extreme psychological pain which follows death or loss of a love-object. In addition, Freud suggested that such an experience of pain relates to the necessity for recognizing that the object no longer exists in external reality.
Wolfelt (1983) stated that mourning is emotional processes and resultant behavior which come into action following the death of an important person in one’s life. Wolfelt (1996) defined mourning as taking the internal experience of grief and expressing it outside oneself. Abi-Hashem (1999), Wolfelt (1983), and Wolfelt (1996) concluded that mourning is also known as “grief gone public” or “sharing one’s grief with others.” Wolfelt (1996) discussed that bereaved children mourn more through their behaviors than words, and is expressed differently than for adults. Worden (1982) and Worden (1991) defined mourning as a process of separating from the loss and adapting to it. Recent findings suggest that people mourning do not just move on and relinquish the relationship to the lost person, but instead continue to have a relationship with the lost person or object throughout their lifetime (Webb, 2002). Fiorini and Mullen discussed that this concept is hopeful and satisfying for counselors working with children and adolescents experiencing grief and loss. Moreover, they concluded that instead of insisting children “get over” their feelings of grief, counselors are able to help them redefine their lost loved one or object and hold on to meaningful memories.

The inability to mourn leads to personal disintegration (Grollman, 1967). He added that the intensity of symptoms divides what is normal and neurotic. He explained that continued denial of reality months after a funeral, or an extended guilt, or an enduring anxiety, or an unceasing hostile reaction are all distorted mourning reactions. Complicated mourning is defined as absent, distorted, converted, or chronic responses to death (Wolfelt, 1996).

Fox (1985) outlined four tasks for children to work through as they mourn a loss, including understanding, grieving, commemorating, and moving on (Fiorini & Mullen,
During the task of understanding, children strive to understand what caused the loss and why it happened (Trozzi, 1999). Worden added the importance of this task is to fully face the reality and the loss. Worden (1996) suggested that a funeral is a good place to begin acknowledging the reality of the loss. The presence of a child at a funeral allows the child to recognize that death has occurred (Fulton, 1967). Fulton stated that by being present at a funeral, children can realize they are not the only one who is experiencing loss, as they are surrounded by other family members and friends.

Trozzi (1999) stated that the task of grieving involves children to experience the painful feelings associated with their loss. Fiorini and Mullen (2006) further discussed that in order for children to process their experience, they need to be allowed an opportunity to feel and express their emotions about their loss. Furthermore, they proposed the task of commemorating as children being encouraged to develop a meaningful way to affirm and remember the lost person or object. Worden (1996) mentioned the importance of adjusting to the new environment after a loss. Finally, Trozzi suggested that during the task of moving on, children discover new ways to “maintain an inner connection with and representation of the deceased as they develop other friendships, attend school, play, and perform all things that shape their daily lives” (p. 67). Worden (1991) and Worden (1996) viewed task four as not giving up the relationship with the deceased but finding a new and appropriate place for the dead in one’s emotional life.

**Gender and mourning.** Based on society and culture, there are certain expectations for males and females in dealing with death and other losses (McGoldrick,
2004). McGoldrick described that women are more likely to seek social support, mourn actively, cry and show their grief and sorrow, talk about their feelings, focus less on the financial aspects of funerals, focus on comforting others, find rituals of mourning to be comforting, seek support from spouses, family, friends, and professionals, and find comfort in remembering the deceased person. She explained that men, on the other hand tend to feel a sense of powerlessness and loss of control, fear losing control of their feelings, seek comfort through keeping busy, take refuge in work, withdraw and deal with their grief in private, become angry and act out aggressively, over-focus on financial aspects of the funeral, underestimate the emotional needs of their children in the aftermath of loss, have more physical illnesses, as well as a higher death rate and higher suicide rate, seek comfort exclusively from the wife or new sexual partner instead of their friends, become uncomfortable with wives’ or partners’ expressions of grief, not knowing how to respond, and engage in the misuse of alcohol, risk-taking behavior, or sexual acting out.

_Grief and Loss in Children_

_Death_

Death is an example of a traumatic event which threatens the safety of all the surviving members of the family (Grollman, 1967). “For most children, the natural evolution of their ability to think rationally leads gradually to a mature understanding about death” (Webb, 2002, p. 4). Webb discussed in detail Jean Piaget’s developmental phases and made connections with children’s ideas about death in each phase. The first stage is the sensorimotor stage, from birth to age two, where children think in egocentric terms and they begin to use symbols, words, and mental images to represent reality to
themselves (Fiorini & Mullen, 2006). Prior to age three, children may sense an absence among someone and may miss an individual familiar to them, but they are not likely to understand the difference between a temporary absence and death (Emswiler & Emswiler, 2000). Webb suggested the next phase as the young child, ages 2-7, also called Piaget’s preoperational stage. In this phase, Webb stated that children have magical thinking and that they believe they possess powers that permit them to control the world by thinking. Webb proposed that children in this stage are still egocentric and are unable to see other people’s viewpoints. Children in this phase do not differentiate between thoughts and deeds, and therefore a child may believe that when his sister dies accidentally, that his anger towards her caused her death (Fiorini & Mullen, 2006; Kaplan & Joslin, 1993). Children cannot understand that death is irreversible and a child this young will think if he or she screams loudly enough that one’s deceased father will awaken, who the child believes is sleeping (Saravay, 1991). Webb described that even if a child has witnessed a burial, he or she may not realize that the dead body in the casket no longer feels anything or carries out its usual activities. Children may wonder how the person in the casket will breathe with dirt on him or how he will go to the bathroom (Fox, 1985). Nagy (1948) concluded that children this age deny that death is permanent.

Webb (2002) described Piaget’s second phase for children ages 7-11, also known as Piaget’s Concrete Operational stage. These children begin to comprehend that the dead is dead and at some point in time, each of us will die (Fox, 1985; Webb, 2002). Fox (1985) and Webb (2002) stated that children this age gain a sense of power and control, which makes it hard for them to believe that such a thing as death could ever happen to
them. Children see death in a personified way, such as a ghost, angel, or space creature that can come get you (Fox, 1985; Nagy, 1948; Webb, 2002).

The third phase that Webb (2002) reported is the pre-pubertal child, ages 9-12, also known as Piaget’s Formal Operational Stage. She stated that the youngster’s thinking becomes truly logical, able to handle many variables at once, and capable of dealing with abstractions and hypotheses. Children acquire a realistic perception of finality and irreversibility by the age of 9 or 10 (Anthony, 1971; Grollman, 1967; Kastenbaum, 1967; Lonetto, 1980; Nagy, 1948; Wolfelt, 1983; Webb, 2002). Lonetto concluded that children from nine to twelve years of age are capable of perceiving death as biological, universal, and inevitable.

Lonetto (1980) summarized that death for the child from six to eight years of age is personified, externalized, and can be avoided if one sees death in time. He stated that death is not yet finalized but instead assumes various external forms, as skeletons or ghosts. He concluded that death for the child from nine to twelve years old is inevitable; no one escapes or recovers from death. Children from 9 to 12 years of age may not differ from adolescents in the content of death conceptions; the main difference may lie in the significance these concerns have for their total cognitive development (Kastenbaum & Aisenberg, 1972).

Wolfelt (1996) described grief responses for infants and toddlers as “I’m upset” behaviors, such as crying, sucking thumb, or biting, and that change in sleep patterns may occur. Additionally, children may shake and throw themselves about (Bowlby, 1980). Wolfelt suggested that offering physical comfort and accepting changes while still adhering to a routine would be most beneficial for this age group. Children 2-3 years of
age have little understanding of the meaning of death and they live in the present, not understanding concept of time (Jackson, 1965). Jackson indicated that for this age group, it is necessary to hold the child in one’s arms and talk to the child about what he or she knows. Children between the ages of 2 of 5 years do not have the ability to put thoughts into words, which makes caregivers assume they are not grieving (Zambelli, Clark, & De Jong Hodgson, 1994). They proposed that this age group may ask when a deceased parent will return home; even after being told numerous times that the parent is dead and will not return home. They concluded that children this age may experience immediate reactions as sleeping, eating, bowel, and bladder disturbances.

For preschoolers, aged 3-6, children may not understand their new scary feelings and may not be able to verbalize what is going on inside them; they may ask questions about the death repeatedly or may reenact the death during play (Wolfelt, 1996). He stated that they may regress and cling to parents, suck thumbs, revert to baby talk, and lose potty training. He explained that this age group can be helped by providing them with terms for feelings, answering concretely and lovingly to all questions, allowing and/or joining in the death play as it is fine and normal, and offering presence and support for the short-term regressive behaviors. Children ages 5 to 8 years have more of a cognitive understanding of death, and denial is this age groups chief form of defense (Zambelli, Clark, & De Jong Hodgson, 1994). Children in this age group may experience maladaptive bereavement responses as becoming phobic, hypochondrial, withdrawn, or excessively care-giving behaviors (Krupnick, 1984).

Wolfelt (1996) mentioned that for grade schoolers, ages 6-11, children continue to express their grief primarily through play, may “hang back” socially and academically,
and may act out due to not knowing how to handle their feelings of grief. He provided
tips for helping this age group, such as engaging in “older kid” play therapy techniques,
giving them time to concentrate on mourning before they are expected to carry on with
other activities in their lives, and offering “venting” alternatives or support groups.
Children ages 8-12 are moving toward independence and children this age use denial as a
means of defense to avoid mourning (Zambelli, Clark, & De Jong Hodgson, 1994).
Death of a parent or loved one shakes the growing sense of autonomy and instead
invokes feelings of helplessness and loss of control (Rando, 1984). Instead of sadness,
displays of aggression may be observed, especially in boys (Krupnick, 1984).

Lastly, Wolfelt explained that adolescents, ages 12 and up may protest the loss by
acting out and/or withdrawing, may feel life has been unfair to them and will act angry,
may act out a search for meaning, and may test one’s own mortality. He concluded that
acting out behaviors should be tolerated if no one is being harmed, withdrawal is normal
in the short-term, encourage the search for meaning as teens begin to explore the “why”
questions about life and death, and after the teen explores the effect of death and his or
her future, encourage him or her to consider the death’s impact on the larger social group,
instead of the individual impact. Moreover, it is typical for children to displace feelings
about their real loss onto one that is secondary (Wolf, 1973). Wolf added that such
actions and behaviors are an attempt to push the real problem away and to also come to
grips with it.

Death is such a tragedy and thus, can bring about many symptoms (Grollman,
1967). Such symptoms include denial, bodily distress, anger, hostile reactions to the
deceased, guilt, hostile reactions to others, replacement, idealization, anxiety, panic, and
assumption of mannerisms of deceased (Goettemoeller, 2008; Grollman, 1967). He explained that during replacement, the child seeks affection of others as a substitute for the person who has died. Idealization involves fighting off unhappy thoughts and becoming obsessed with the dead person’s qualities: “How dare you say anything against daddy! He was perfect (Grollman, 1967, p. 20). Grollman suggested that assumption of mannerisms of deceased involves children attempting to take on characteristic traits of the dead person, by walking or talking like him or her, or by trying to take over the role of the person: “Do I look like daddy?” (p. 20). Children may have hostile reactions to the deceased and blame the deceased person for leaving: “How could daddy do this to me? Why did he leave me?” (p. 19). Children may act out their grief through behavior because feelings can be difficult to handle (Jackson, 1965).

Anticipatory death. If death is anticipated, it is crucial that adults help children toward a realization of what is coming (Wolf, 1973). Wolf stated that when a death of a loved one comes as a complete shock or surprise, a child may feel left out and resentful, or taken advantage of. Even when death is expected, when the death occurs, there is an intense degree of death anxiety that accompanies the reaction (Sanders, 1989). Wolf additionally discussed that explaining the anticipatory death to children depends on their development; older children may want some medical facts while younger children may want to hear that their loved one is sick and that he or she may not always be around. Furthermore, he concluded that there should always be much more in a child’s life besides preoccupation with the anticipatory death; the child should focus on his or her own world when the impending loss is forgotten.
Death of Parent

Upon learning the death of a parent, children feel lied to, frightened, angered, guilty, anxious, shocked, and stunned as such a tragedy is unbelievable and hard to face (Worden, 1996). The world will never again be as secure a place as it was before and family life is completely disrupted (Grollman, 1967). Most children feel as if their world has come to an end (Le Shan, 1976). An example from a 9 year old girl from a Child Bereavement Study stated, “When mother called me to tell me dad died, I told her she was a liar. I was frightened. I started shaking.” (Worden, 1996, p. 18-19.) Worden discussed that many children feel sad and confused, even when the death is expected. He stated that the most frequent expression of sadness when a parent dies, is crying. He suggested that children feel sad because they miss activities previously shared with the parent, have missed opportunities to show the lost parent new accomplishments, sometimes regret not telling the lost parent that they loved them, could no longer receive advice from the dead parent, or could no longer share the presence or touch of the dead parent. Furthermore, he concluded that in general, the loss of a mother tends to be worse for most children than the loss of a father. He explained that this may be because the death of a mother represents the loss of the emotional caretaker for the family.

After the death of a parent, children experience many changes. Children may act out due to feelings of abandonment and anger, health may decline, and school performance can decrease (Worden, 1996). Worden stated that in the early months after a parent’s death, many children experience some type of learning disability and report difficulty in concentration. Worden discussed that the death of a parent can affect children’s self esteem and can be associated with more behavior problems, high levels of
anxiety, social withdrawal, and a lower sense of self-efficacy. After a parent dies, many bereaved children wonder if they are still part of a family (Wolfelt, 1996). Wolfelt added that children may question what their meaning in life is without the dead parent.

The greatest fear of all for a child who lost a parent to death is that something terrible may happen to the surviving parent (Le Shan, 1976). She stated that this fear may start immediately due to the surviving parent being so grief-stricken, and so unable to help, that the child may feel he or she has already been abandoned by both parents. Le Shan reported that feeling angry at the living parent is also very common and normal among children. In greater detail, she explained that when a parent dies, children tend to forget the unhappy times, as when the parent got angry and yelled at them. She proposed that children think, “Dad never yelled at me about those things- I wish mom had died instead” or “Daddy is just no good at taking care of me when I feel sick- it would have been better if my mom had lived and daddy had died” (p. 26).

Surviving parents need to keep the following in mind as they help their children mourn deep losses (Trozzi, 1999). Trozzi outlined these important tips: do not deny the truth when explaining a parent’s illness or death, as honesty is the foundation of trust and helps to build healthy coping skills; answer children’s questions and answer truthfully, as avoidance keeps both children and the parent in pain; do not gate-keep or keep kids away from the dying parent or from discussions; make sure the parent expresses anger or sadness, but assures children that they are cared for and together survival will exist; and lastly, do not ask children to take on the role of the deceased parent and act like an adult.

Elizur and Kaffman (1982) examined grief reactions in children whose fathers had died. In their findings, they stated that children suffered from depressive symptoms,
such as sleep disturbance, social withdrawal, and restlessness. Similarly, Van Eerdewegh, et al, (1982) concluded in their study that children encountered depressive symptoms following death of a parent. Furthermore, they reported the depressive symptoms as dysphoria, withdrawal, sleep disturbance, and anhedonia.

“DSM-III-R suggests that in bereavement, ‘thoughts of death are usually limited to the person’s thinking that he or she would be better off dead or that he or she should have died with the deceased person’” (Weller, et al., 1991, p. 1539). Weller, et al and Wolfelt (1996) suggested that in bereaved pre-pubertal children, suicidal ideation represents a longing to be with the deceased parent (reunion fantasy), rather than wanting to harm one’s own life. Moreover, in this study, a considerable number of bereaved children developed clinical symptoms of a major depressive episode immediately following the death of a parent. Wolfelt stated that it is imperative that children are helped to prevent potential long-term effects, such difficulties with future intimate relationships, vocational success, and general joy of life.

Death of grandparent

The child’s reaction to death of a grandparent varies depending on the quality of the attachment relationship (Crenshaw, 1991; Raphael, 1983; Wolfelt, 1996). Sometimes grandparents are very important figures in the child’s life as sources of love and caregiving, while in other situations the death of a grandparent is a non-event (Hatter, 1996). Wolfelt stated that in families where grandparents were strong matriarchs or patriarchs, there is often a ripple effect across generations as the family unit struggles to redefine itself. In addition, he mentioned that the personality of grandparents also influences a
child’s response as some older adults are naturals with children, while others have a difficult time relating to young children.

Death of sibling

Grieving children experience sadness, irritability, feelings of being alone, complaints of bodily discomforts, sleep disorders, and loss of appetite (Webb, 2002). Webb stated that some children feel they matured as a result of a sibling death, as they feel good about their abilities to handle adversity. One mother described her daughter as, “She has learned a lot from her brother’s death. It hasn’t been easy, but she has gained such insight about life and death. She has been exposed to things that most kids of her age are not. She had to grow up faster, and she is very sensitive and patient. She is so much more tolerant of others as well” (Webb, 2002, p. 97).

Webb (2002) outlined four general responses of a child’s death of a sibling: “I hurt inside,” “I do not understand,” “I do not belong,” and “I am not enough.” Webb concluded that the surviving children are often left with unanswered questions about what happened and oftentimes about their role in and responsibility for what happened. The death of a sibling can be complicated by strong feelings of guilt because of past anger or jealousy toward the dead sibling or because of failure to make the deceased sibling happier while he or she was alive (Grollman, 1967). Children may also have feelings of relief, fear, and confusion (Wolfelt, 1996). Wolfelt gave examples of such feelings. He described confusion as not knowing one’s role: “Am I still a big sister?” Wolfelt suggested that out of fear, children will wonder if they will die too and out of relief, children may be glad to have a bedroom to oneself or that the deceased sibling can no longer take one’s belongings.
Death of a pet

Childhood bereavement may have immediate and long-lasting consequences such as depression, anxiety, social withdrawal, behavioral distances, and school underachievement (Abdelnoor & Hollins, 2004; Christ, Siegel, & Christ, 2002; Kaufman & Kaufman, 2006; Sanchez, et al., 1994; Sandler et al., 1992; Worden & Silverman, 1996). Kaufman and Kaufman explained that this is also true for childhood pet bereavement because a pet is often considered a member of the family by the child. Children may feel guilty when a pet dies because they feel they did not care well enough for the pet and was in some way responsible for its fate (Grollman, 1967). Grollman stated that children may conduct burial services to work things out for themselves and play out their feelings, anxieties, and fears.

In order to help children grieve, adults can model their own feelings about the death of the pet, when appropriate, explain the pet’s illness and death was no one’s fault, use simple and direct language in sharing facts about death, encourage involvement in rituals, encourage creative outlets for feelings, openly discuss what will be done with the pet’s body, do not attempt to replace the dead pet before the child has an opportunity to mourn, and if euthanasia is used, do not describe it as putting the pet to sleep because children need to know that sleep and death are not the same thing (Wolfelt, 1996). Pets mean a great deal to children and if children are provided with fiction about the pet’s death, there is always a danger that they will discover the truth for themselves, feel deceived, and will be unable to talk it over with their parents (Wolf, 1973).
Death of a friend

It is difficult to describe the profound and unique meaning of friendship or the emotions experienced when a close friend dies (Werner-Lin & Moro, 2004). They stated that friends often share similar beliefs and values and serve many social and emotional roles. They discussed that friends usually are unconditionally accepting and allow individuals to fully be themselves. They described that friendships are distinct because they are chosen by individuals and are actively maintained because they improve lives (Silverman, 2000). Werner-Lin and Moro explained that following the loss of a friend, the closer the friendship was, the more profound the loss is, as individuals may feel that they lost part of themselves. They additionally suggested that bereaved friends experience a range of emotions, such as sadness, anger, and guilt, and they may not be able to fully function at school or work. They indicated that some individuals may feel like they are going crazy or that life no longer makes sense to them.

Death of a friend varies depending on age and gender (Werner-Lin & Moro, 2004). They suggested that girls may be more upset by the loss of emotional intimacy with the death of a best friend, whereas boys may miss the loyalty or solidarity of a friend or teammate. The death of a friend or classmate is so out of the normative life cycle expectations that it causes shock and disbelief as the bereaved realize people their age can die (Oltjenbruns, 1996). Werner-Lin and Moro discussed that the death of a friend, particularly for children and adolescents, affects the whole family. It is imperative for clinicians to help parents in talking to their children about death in an age-appropriate manner (Toray & Oltjenbruns, 1996).
Divorce

Children of divorce comprise an increasingly growing population in the United States (Fassler, 1978). Since the divorce rate is highest in the first few years of marriage, the affected children tend to be young and the major disturbances tend to focus on separation anxiety (Anthony, 1974). In helping children through divorce and guiding them to a happier future, parents need to understand their children’s emotional needs and find healthy ways of meeting them (Despert, 1962). Despert added that the most serious danger to children lies in depriving them of emotional support.

According to Trozzi (1999), divorce represents the “death” of the family that a child has known. She stated that parents are the agents of grief and stress in the divorce process. Trozzi (1999) and Worden (1996) argued that divorce is the grief that keeps “giving,” meaning that kids often long for or fantasize about their parents’ reunion for many years. Worden reported that when the various strategies that a child uses to bring about this reunion fail, a lower self esteem can result. Children may feel personally responsible for the conflict in their homes (Fassler, 1978). Trozzi reported that just as adults vow that their marriage is “forever,” kids expect their family union to be “forever” as well. Worden discussed that hopes for reuniting the family may keep the reality of the loss at a distance for some time. Furthermore, Trozzi suggested that even though a parent, usually the father, leaves the home, a child’s emotional ties to each parent remain strong. Moreover, Worden concluded that children whose parents divorce may feel the need to hide their mourning and that their mourning may not even be supported by other family members.
In many divorce situations the ongoing tension between parents can carry on for some time (Worden, 1996). He continually stated that children in this situation often feel conflicted as each parent strives to gain the child’s loyalty. Wallerstein and Blakeslee (1989) discussed that even when children are encouraged not to take sides, they often feel they need to. In addition, Worden discussed that if a child sides with one parent over the other, the child feels less hope that a reuniting of parents will ever occur. He suggested that divorce is a choice and the fact that one’s parent has chosen to leave the family can leave the child feeling abandoned and feeling less about oneself and angry at the parent who has left. Children may even feel hostile toward a parent who remains, missing the other meaningful relationship (Despert, 1962). Healy et al. (1993) stated that while children try to understand the process of divorce, they often believe they are part of the cause and feelings of self blame arise.

The major affect during divorce is grief associated with guilt, and the affect after divorce is shame coupled with resentment (Anthony, 1974). Anthony proposed that when children first learn of the divorce, their first response is often denial to such an extent that the parents may question his or her affection and involvement. Despert (1962) believed that the time before a divorce is finalized, is the most destructive time emotionally for a child. Despert added that the time following a divorce may precipitate new disorders or struggles, involving regression, somatic disturbances, sleep difficulties, and feelings of guilt, anger, withdrawal, and fear of abandonment. Anthony continually suggested that even when a child is repeatedly told that the divorce is final, he or she may still quietly go on asking when the missing parent will return or why the missing parent has not come back yet.
Anthony (1974) explained that in “bad” divorces, parents seem to have more to fight over than when they were married, and visitation rights provoke endless animosity, leaving children to be pulled into two directions. He concluded that when divorces end badly, children become badly disturbed. He described that in the “good” divorce, the child has two parents that speak well of each other, relate well to each other, and place no blame on one another. This may confuse the child and make it difficult for one to understand why his or her parents like each other and get along, yet they have decided to separate (Despert, 1962).

Children of divorce fear repeating their parent’s mistakes and therefore might turn away from marriage themselves (Anthony, 1974; Kliman, 1968; Wallerstein & Blakeslee, 1989). More children experience the loss of parent through divorce than through death (Worden, 1996). Worden stated that children do not like to feel or appear different than their peers but do so with parental divorce. Children of divorce may develop psychiatric disturbances in childhood and then psychiatric disorders in adulthood. (Anthony, 1974). Some symptoms of disturbed children after experiencing a divorce involve possibly running away from home, becoming delinquent, having poor behavior at school and at home, or becoming depressed and therefore, becoming more accident prone (McDermott, 1970). A child who has been able, with parents’ or outside help, to weather the divorce has a better chance for a healthy maturity (Despert, 1962).

*Everyday losses*

Trozzi (1999) explained that there are losses experienced during the normal course of development that need to be grieved. Such losses Trozzi described are becoming a sibling when parents bring home a new baby brother or sister, moving to a
different part of the country, not making the team, not getting into the college of choice, breaking up with a girlfriend or boyfriend, and adjusting to future realities and vocational choices. Other losses include losing a talent or mental faculty, natural disasters, loss of childhood innocence, and giving up a social role or status (Abi-Hashem, 1999; Corr, Nabe, & Corr, 1997). Corr, Nabe, and Corr concluded that losses that are not related to death can be complicated in their own ways and can be equally as hurtful as some losses that arise from death, or perhaps even more hurtful.

New baby. Children’s reactions to the arrival of a new baby can include feelings of jealousy, resentment, ambivalence, and pride and will therefore; need reassurance and attention at this time (Fassler, 1978). A child expecting a new sibling may feel resentment toward his or her mother and toward the expected or newborn baby (Wolfenstein, 1947). Fassler discussed that children’s reactions to a new baby fluctuate, as one day a child may feel angry and another day the child may feel eager to help with the baby’s care.

Moving to a new home. The National Education Association (1958) indicated that 40 million Americans move every year and that an average one out of four families’ changes homes every year. A family’s move to a new home can put a strain on a child’s concept of himself and the world (Fassler, 1978; Kliman, 1968). Children, at least temporarily, suffer from an impairment of the ability to cope with the life change associated with a move (Switzer, et al, 1961). Switzer, et al. added that children experience this decreased capacity, as well as have feelings of abandonment, loss, helplessness, isolation, and the fear of the unknown.
Whether or not a child is completely happy or not in his or her home setting, he or she has invested a considerable amount of psychological energy into thoughts and feelings about one’s surroundings and when there is a move, such energy must be reinvested (Kliman, 1968). A child may suffer from loss of a parent’s time and attention more than from the actual move itself due to a parent having less emotional energy or of one’s own eagerness to become adjusted to the new community (Switzer, et al., 1961). Fassler (1978) suggested placing items important to the child in positions similar to those in the old home to help the child orient him or herself to new surroundings. Fassler also reported that a family move does not have to be a stress-producing experience and children may take pride in realizing they have mastered a difficult situation.

**Parent incarceration.** When a parent is sent to prison, children are exposed to a departure that is sudden and stigmatizing for those left behind (Sack, Seidler, & Thomas, 1976). When a parent goes to prison, children’s homes are disrupted, family relationships are interfered with, separation anxieties occur, loss of respect in the community exists, children become socially isolated from peers, and children endure conflicted attitudes towards their parents (Fassler, 1978). Fassler suggested that when a father is in jail, children frequently experience depression, aggressiveness, and school performance declines. Sack, Seidler and Thomas reported that children, both girls and boys, are susceptible to antisocial behavior following a father’s incarceration and are subjected to peer teasing. They additionally indicated that children are often given a vague or deceptive explanation as to why their parent is in jail, in which many children learn to cope with the reactions of their peers by practicing their own deceptions or avoidance. Furthermore, they argued that the problem is intensified because society does
not offer children the means to justify their loss. Moreover, Fassler concluded that there is a need at the time of parental imprisonment for children to be provided with supportive services to help them cope with such stresses.

Secondary losses

When someone experiences a loss, we may lose other connections to ourselves and our world (Wolfelt, 1996). He stated that some secondary losses include loss of self, loss of security, and loss of meaning. In addition, he discussed that losses linked to loss of self include loss of identity, self confidence, health, and personality. He outlined losses pertaining to loss of security as loss of emotional security, physical security, fiscal security, and lifestyle. Furthermore, he added that losses relating to loss of meaning include goals, ideas, hopes and dreams, faith, will/desire to live, and joy. Other losses, such as developmental losses can include the loss of a bottle for an infant, loss of early childhood for an adolescent, loss of a last child moving away from home for a parent, and the loss of role function at work for a retired individual (Wolfelt, 1988).

Depression in Children

Depression is among the most common of psychological disorders, such that it is known as the “common cold” of psychopathology (Gotlib & Hammen, 2002). The World Health Organization suggested that depression is the number one cause of disability and will be the second most important disorder by 2020 in terms of burden and disease (Murray & Lopez, 1996). Gotlib and Hammen stated that an estimated 5 to 25% of the population will experience depression at some point in their life and up to 15% of severely depressed individuals will commit suicide. Due to the dramatic rise in depression through transition from childhood to adolescence, which then remains at high
prevalence levels throughout adulthood, these facts are particularly true (Lakdawall, et. al., 2007). Hankin, et al. (1998) reported a 10-year study showing that rates of depression raise six fold during adolescents, for example. Weisz, McCarty, and Valeri (2006) also concluded through a longitudinal study that substantial continuity of youth depression was shown into adulthood. Furthermore, they discussed that impaired functioning in work, social, and family life, and an elevated risk of suicide attempts also carried on into adulthood.

Childhood experience of bereavement can contribute to a psychiatric illness (Kliman, 1968). The bereavement process has been related to clinical depression, anxiety, physiological changes, academic functioning, and social functioning (Hogan, Greenfield, & Schmidt, 2001; Stewart & Sharp, 2007). Depression in children and adolescents is a significant, persistent, and recurrent public health problem that weakens social and academic functioning, generates high levels of family stress, and prompts significant use of mental health services (Angold, et al, 1998; Clarke, et al., 2003).

Depression tends to affect a small number of youth, wherein 5-8% are adolescents and fewer are pre-adolescents (Angold & Costello, 2001; Birmaher, et al, 1996; Cohen, et al, 1993). Just about twenty percent of youth may experience a depressive disorder by the end of adolescence (Lewinsohn, et al., 1993). Angold and Costello reported that depression in girls increases during adolescence and that childhood depression may be more common in boys. Youth depression is associated with severe disruption in social, academic, and family functioning and has been connected with higher risk for depression and other psychiatric disorders, substance abuse, and suicide in adulthood (Angold &

In a study conducted by Weller et al. (1991) 37% of children suffered from major depressive disorder one year after bereavement. They indicated in their study that guilt/worthlessness was a symptom of 21% of the children studied. They also proposed that 89% of depressed children in the study had suicidal ideation and that 42% of them were admitted to the hospital for at least one suicide attempt. They suggested the hypothesis that in bereaved children, suicidal ideation represents a longing to be the deceased rather than a depreciation of one’s own life. Rutter (1966) explained that childhood psychiatric disorders with bereaved children are increased five-fold when compared with the general population.

A study performed by Beck, Sethi, and Tuthill (1963) showed correlations between the incidence of childhood bereavement and the degree of adult depression. They found that out of the 297 inpatients and outpatients that were studied, 100 were “very depressed,” showing a higher incidence of orphan-hood before age 16 (27%) than did the 100 “least depressed” patients (12%). They also concluded that there was also a predisposition for the very depressed group to have had more early-life parental death before the age of four, than the least depressed group. Similar findings reported by Brown (1961), suggested that about 41 percent of 216 depressed adults had lost a parent through death before the age of 15. Brown implied that the loss of a mother was significant at all ages and the loss of a father was more noticeable between ages 5 and 14. He suggested that bereavement in childhood is an important factor in the causation of depression.
Most of the time depression is displayed through behaviors as expressions of sadness, social withdrawal, psychomotor retardation, apathy, and nonverbal language (Rando, 1984). She stated that children oftentimes mask their feeling of depression with agitation or restlessness.

Behavioral techniques for depression, such as in Cognitive Behavior Therapy, make use of common learning and conditioning principles (Chu & Harrison, 2007). The cognitive therapy targets irrational beliefs, guilt, hopelessness, and worthlessness, while the behavioral therapy targets social withdrawal, impaired interpersonal interactions, and anhedonia (Clarke, DeBar, & Lewinsohn, 2003). Gotlib and Hammen (2002) concluded that CBT interventions reduce depressive symptoms in school and community samples of children. In addition, Chu and Harrison stated that strategies for depression emphasize pleasant activity scheduling and behavioral activation. Through such strategies, the therapist encourages activities that are individually gratifying for the child to increase availability of natural reinforcement in the child’s life and improve the child’s sensitivity to natural rewards (Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972).

**Interventions**

**Group Therapy**

Group therapy helps children to know that what they are feeling is predictable, that they are not alone, and that other children have similar experiences (Fox, 1985; Schoeman & Kreitzman, 1997). Schoeman and Kreitzman additionally proposed that group therapy breaks the sense of isolation and weakens the feeling of being different or strange. Members of a group are given the opportunity to vent feelings of pain, anger, guilt, and other strong feelings, while normalcy of reactions can be acknowledged (Corr,
Nabe, Corr, 1997). Groups provide a safe, supportive context in which children can express feelings without worrying about the presence of other family members (Worden, 1996). Being separated from parents can help children develop a peer group that can provide nurturance (Freud & Dann, 1951). Worden stated that group interventions provide an environment for children to learn about death or loss and to confront faulty beliefs about such losses. Corr, Nabe, and Corr also indicated that other group members can serve as role models, which can help members to determine how to live one’s life. Schoeman and Kreitzman discussed that as children observe others in the group expressing feelings, they can gain greater confidence in taking risks of expressing their own feelings. Most children find group therapy to be a natural environment in which to play, grow, and express their physicality (Keyser, Seelaus, & Batkin-Kahn, 2000).

Fox (1985) explained that games are very useful in group settings, in that games are a good way to normalize discussions of death and loss. He additionally reported that games give children new ways of coping and relating to other children. Fox added that therapists who work with children must make sure that they have the opportunity to grieve and that their grief is good grief, which is grief that helps them stay psychologically healthy and strengthens their ability to cope with future losses. Fox (1985) and Wolfelt (1996) outlined the mourning needs necessary in bereaved children’s healing, which can be facilitated during the group therapy process.

Trozzi (1999) stated that understanding, the first task of mourning, means knowing what happened and why, in death or non-death losses. She added that children cannot feel the pain of grief until they have an honest understanding. The bereaved child must receive an honest and open explanation to a loss in order to confront the reality of
such loss (Wolfelt, 1996). Wolfelt discussed that children cannot cope with what they do not know.

Grieving, the second task of mourning, means experiencing the painful feelings related with death or other losses (Trozzi, 1999). Children need to be allowed and encouraged to embrace their feelings and thoughts that result from their loss (Wolfelt, 1996). Commemorating, the third task in the mourning process, is remembering the person who has died or other non-death losses (Trozzi, 1999). Trozzi explained that commemoration confirms the reality of death or loss. Commemorating is a way to express the grief children experience and can be done both formally and informally. Wolfelt (1996) added that children are encouraged to move from the “here and now” of the relationship of the person who died to the “what was.” Wolfelt suggested that the child should remember such loss, but should also alter the loss from one of presence to one of memory.

The fourth task or need, as described by Wolfelt (1996) is to develop a new sense of identity on a life without a loss. He stated that the fifth need in grieving is to relate the experience of death or loss to a context of meaning. Furthermore, he added that children need to find meaning after a loss. Lastly, Wolfelt provided that the sixth need is experiencing a continued supportive adult presence in future years. He concluded that grief is a process, not an event and children, therefore, will need adult “stabilizers” throughout their lives.

*How adults/parents can help*

There are many ways for adults to help children who are grieving. Fox (1985) reported that in order to help children experiencing loss, adults need to recognize their
own feelings, monitor vulnerable children, address children’s fears and fantasies, be honest and open, be supportive as children grieve, remember the loss and commemorate, and establish an ongoing loss or death education program. Trozzi (1999) suggested that to ensure that children master emotional skills as they process loss, caregivers need to foster honesty and open relationships with children, provide a safe and secure space in which children can mourn, and be role models of healthy mourning. At first, it is common for a child to refuse to accept our view of death as final and the child may go on believing what he or she wants to (Wolf, 1973). Wolf added that it is important to let the child do this because one’s denials are one’s way of coping with such a difficult situation. Childhood imagination can be a major asset in dealing with fears, and children can use fantasy to help change unpleasant situations (Mills & Crowley, 1986). It is important to assist the child to unburden feelings though catharsis, confession, remembrance, and release (Grollman, 1967). Accept the child or adolescent’s feelings as real, important, and normal (Corr, Nabe, & Corr, 1997). Grollman stated that children need to talk and not just be talked to, they need to be loved, their personalities need to be respected, and they should be encouraged to accept the reality of the loss or death. Corr, Nabe, and Corr indicated that it is very critical to use supportive responses that reflect acceptance and understanding of what the child or adolescent is trying to disclose. As a caregiver, it is also important to encourage a child to play, as play is an important tool for healing (Willis, 2002). Willis described that play is a natural method for self-expression and communication. Willis concluded that play promotes the development of emotional and motor skills and provides a safe, non-threatening environment for the child to act on one’s feelings.
It is the parent’s job to help a child discover and face the truth without fear, rather than to hide unpleasant realities from their child (Wolf, 1973). When truth is hidden or not provided, children may imagine something worse than the actual truth (Le Shan, 1976). Le Shan described an example of this as a little boy losing his newborn sister due to prematurely being born. She added that his parents had his sister cremated and buried but failed to fill him in on this fact. Furthermore, she proclaimed that the boy’s lack of understanding gave him severe anxieties; he was afraid of the dark, afraid of opening the closet or a drawer, and even began vomiting every morning. Moreover, Le Shan suggested the reason for his anxieties is because the boy thought his sister was in the house somewhere and was unaware that she was actually cremated and buried.

There are many things that children bereaving may need. Davidson (1984) suggested that there are mainly five things that any bereaved individual needs. Davidson outlined these five essentials as: social support, nutrition, hydration, exercise, and rest. Social support is perhaps the main post-death variable in determining high versus low grief (Corr, Nabe, & Corr, 1997). They discussed some other variables that make a difference in bereavement and grief as, the nature of the prior attachment, the way in which the loss occurred, and the coping strategies the bereaved individual has learned in dealing with previous losses. Corr, Nabe, and Corr (2000) pointed out that three elements are crucial in bereavement: a relationship with some person or thing that is valued; the loss- ending, terminating, separating- of that relationship; and a survivor deprived by the loss.

There are many myths about death, mourning, and protecting children. Trozzi (1999) described a few myths as, death is not a part of living; children do not mourn; and
we can protect children by shielding them from loss. Trozzi concluded that in our efforts to protect our children from sadness or trauma, we tend to shield them from it, which is not wise. Due to these myths and society’s lack of knowledge about children and loss, it is imperative that children grieve losses to cope and live a healthy life.

Berg and Daugherty (1972), Best (1948), Fassler (1978), Galen (1972), Grollman (1967), Hoffman and Futterman (1971), Jackson (1965), Kavanaugh (1972), Le Shan (1976), Lonetto (1980), Vernick and Lunceford (1967), and Wolf (1973) summarized guidelines for “telling” children about loss and/or death and are outlined as follows: children are ready and capable of talking about anything within their own experience, use the language of the child, do not expect an immediate and obvious response from the child, be a good observer and listener, do not try to explain and discuss all in one conversation, make certain the child knows that he or she is part of the family especially when death has occurred, and lastly, one of the most valuable methods of teaching children about death and loss is to allow them to talk freely and ask their own questions at their own pace. These guidelines are important for parents and/or adults to follow when a child is experiencing loss, as they help to explain how to meet the child’s needs.

Too often, society conveys unhelpful messages to individuals grieving (Corr, Nabe, & Corr, 1997). They described these unhelpful messages as minimizing the loss, warning or cautioning not to feel or express feelings in public, and suggesting that one get back to living and not disturb others with one’s bereavement. They outlined some suggestions of phrases not to say to others: “Be strong,” “You’re the big man of the family now,” “What you need to do is to keep busy and forget her,” “Don’t be so upset always,” and “After all, your grandfather was a very old man.” (p. 255).
Other interventions

There are other interventions that are not pertinent to this research, but are useful and effective in helping children experiencing loss and grief. Some of these interventions include individual therapy, play therapy, art therapy, music therapy, word therapy, and family therapy. Although all interventions are seen as helpful, this specific research emphasizes the importance of group therapy. Other interventions listed are mentioned and described briefly.

Individual therapy. Grief is a complex but perfectly natural and necessary mixture of human emotions (Wolfelt, 1996). Wolfelt stated that it is not up to the therapist to cure the grieving child, but instead create conditions that allow the bereaved child to mourn. When mental health professionals facilitate bereaved children in the grieving process, many components are necessary for effective treatment. Worden (1996) suggested that providing adequate information, addressing fears and anxieties, providing reassurance that they are not to blame, listening carefully, validating feelings, and modeling grief behaviors are all essential components to effective treatment for children in the grieving process. Individual counseling allows for maximum attention to the child’s needs and allows the therapist to move at the child’s pace (Webb, 2002). Wolfelt stated that when a nurturing environment is provided, bereaved children not only heal, but grow. Therapy helps to change overwhelming feelings to more manageable ones (Trozzi, 1999). Worden stated that individual counseling frequently uses nondirective play activity in which children play with various toys and games and interact with the counselor. Furthermore, he discussed that this approach is helpful
because children process conflict and anxiety through play, imagination, and creative activity.

Play therapy. The natural means of communication for children is play and activity (Landreth, 2002). Play is the bereaved child’s natural method of self-expression and communication (Wolfelt, 1996). Wolfelt believed that children use play in response to losses because they try to learn about what no one can teach them. He also mentioned that “for bereaved children, “playing out” their grief thoughts and feelings is a natural and self-healing process” (Wolfelt, 1996, p. 150). Furthermore, he reported that play is helpful in providing a way for children to bring their feelings out safely and at their own pace. Landreth indicated that play represents the attempt of children to organize their experiences, fully express themselves, and may be one of the few times in their lives when they feel more in control and thus more secure.

Art therapy. Direct access to a child’s world is often achieved by the use of his or her imagination, where thoughts, ideas, and feelings interact freely with the facts (Webb, 2002; Wolfelt, 1996). Wolfelt added that art allows for explosive emotions in an acceptable framework. Wolfelt (1996) and Worden (1996) both stated that while the bereaved child may be hesitant to talk about their emotions, they can spontaneously be expressed through forms of art. Webb stated that images have the capacity to capture and confront private, unpleasant, and confusing feelings. Moreover, Wolfelt suggested that feelings can be expressed through such forms of art as painting, drawing, clay, collages of feelings, and photography. Worden explained that in both drawing and in clay sculpting, the colors selected may reflect the child’s feeling tone. Worden also suggested puppet activities as an effective approach in helping children grieve and creatively
express themselves. Children often draw pictures reflective of grief, such as pictures that include clouds, coffins, flowers, tears, rain, rainbows, tombstones, cemetery gates, angels, and wakes (Zambelli, Clark, & De Jong Hodgson, 1994). They indicated that children who are grieving will produce symbols in their art that are reflective of their grief process. It is important that the art be fun for the child and not something being demanded or pressured (Willis, 2002).

**Music therapy.** Music is an effective way to help children deal with their grief (Willis, 2002). Some children benefit from spending time alone listening to self-selected songs, while other children enjoy listening to music with a group of others (Wolfelt, 1991). According to Hilliard (2007), results from his study concluded that music therapy groups improved children’s grief symptoms and behavioral problems.

**Word therapy.** Language, in various forms, can be healing for bereaved children through journals, letters, poetry, essays, bibliotherapy, storytelling, sentence completion inventories, wishes and fears inventories, and hypothetical situations that pertain to the child’s experience (Wolfelt, 1996). Wolfelt described these techniques as helpful for children mourning to express themselves in various ways. Webb (2002) stated that stories can provide information, provide distractions from the burden of sorrow, encourage imagination, give validation, provide alternatives, give sudden bursts of insight, and provide awareness. Storytelling can involve reading books to children and having them discuss how the story made them feel or they can draw their personal reaction to the story (Worden, 1996). A more indirect approach may be to read the story to children and then ask how the bereaved character in the story might have been feeling (Fleming & Balmer, 1991).
Family Therapy. Family interventions are designed to give bereaved children an opportunity to work through grief within the context of their family (Worden, 1996). Worden explained that family interventions allow family members to converse together about the death or loss and to readjust the family as a working system after the loss. Family therapy acknowledges that all the members have experienced the same loss and also points out that different people in the family will respond differently to such loss (Webb, 2002). The goals of a therapist working with a bereaved family are to help the family understand grief, offer an outside perspective, help adults understand the grieving child’s behavior, point out discrepancies in communication within the family, build self esteem, help delineate changed roles within the family, reconstruct the family’s loss history, act as a family advocate, provide hope for healing, validate all members for the courage to mourn, and facilitate rituals as a means of healing (Wolfelt, 1996).

Summary

There are many losses that children can experience. Such losses can include death of a loved one, loss of significant relationship, parental divorce, having a new baby enter the home, moving to a new home, and parent incarceration. Such losses can lead to feelings and symptoms of depression in children, as losses can be devastating and overwhelming. There are many interventions that can be helpful in facilitating children through the grieving process. Group therapy is one intervention in particular that helps children to express and explore their thoughts and feelings, and to learn to cope with loss.
Research Experiment

Method

Setting

This research study was completed at a community mental health agency in northeastern United States. The agency is in a city that comprises approximately 219,773 people, making it one of the largest cities in this region (Municipal Reference Guide, 2001). The Municipal Reference guide estimated that the racial makeup of the population of the city involved 106,161 Caucasians, 84,717 African Americans, 1,033 Native Americans, 5,047 Asians, 28,032 Hispanics, and 22,815 individuals from other races. The Municipal Reference guide further suggested that the city population consists of 61,735 individuals aged 17 and under, in which this research and agency specifically targeted and serves. The County and City Data Book (2007) stated that the median income for a city household was $26,650 and the median family income was $28,387. The County and City Data Book indicated that the number of violent crimes committed in the city average about 1,974, while property crimes are around 13,828 per year.

The mental health agency itself is only a branch of the overall health care system, as many other services are offered. The agency as a whole seeks to make a positive difference in the lives of individuals in the growing city (Unity Health System, 2008). Unity Health System also indicated that the highest quality of care is provided to all members of the community, especially those who are underserved and most vulnerable. Unity Health System described that the mental health services provided through the agency focus on children, adolescents, adults, and families to develop self awareness, confidence, and coping skills during difficult times.
Participants

The purpose of this study was to determine if group therapy was effective in decreasing symptoms of depression in children experiencing loss. The study involved both male and female participants between the ages of 8 and 12 years. All participants had experienced some sort of loss/grief. There were no more than 10 children permitted in the group. All participants were referred to the group by their primary therapist, as it was up to the therapist’s discretion, the child, and the child’s parent/guardian for the child to attend the group. The group was open, as participants joined after the group initially started. The group therapy sessions lasted approximately one hour in duration for eight consecutive weeks.

This study relied on specific criteria for admission into the group. All participants were between ages of 8 and 12 years of age. They were currently experiencing loss that had occurred within the last two years. It was necessary for children to exhibit the ability to verbalize thoughts and feelings, and to show a willingness and availability to participate. Some losses that were included but were not limited to, were loss of significant relationships, loss of safe or familiar environments, death of a loved one or pet, incarcerated parent, and loss of belongings and/or finances.

Evaluation

The participants were given the Beck (2001) Depression Inventory for Youth (BDI-Y) (See Appendix A) as a pre and post-test measure, which consists of twenty questions. Of the twenty questions on the inventory, items 3, 11, 13, and 15 measure a negative view of the self; items 1 and 20 measure a negative view of the child’s world, and item 20 also measures hopelessness, or the child’s negative view of one’s future
(Beck, Beck, Jolly, & Steer, 2005). They also proposed that items 5 and 9 measure vegetative and somatic symptoms; items 2, 4, and 16 measure motivational aspects of depression; and the remaining items measure the emotional symptoms of depression. The children participated in activities which included making a memory book, sharing stories and items relating to their loss, drawing pictures and memories of their loss, and participating in a feelings exercise (Keyser, Seelaus, & Batkin-Kahn, 2000). They also wrote a letter to their loss (Fiorini & Mullen, 2006). In the group, there was discussion of the different types of loss, feelings associated with loss, and the individuals who are affected by loss.

The internal consistency of the BDI-Y has a reliability of above .9 for males and females ages seven to eighteen (Beck, Beck, Jolly, & Steer, 2005). They stated that the test-retest reliability was .81 for females ages 7-10 and .79 for males ages 7-10, while reliability was above .9 for both males and females ages 11-18. They discussed validity of the Beck Depression Inventory for Youth in terms of relatedness to other instruments. They proposed that the validity of the inventory was assessed with respect to the Child Depression Inventory (CDI). They therefore, indicated that the validity in comparison with the CDI had a total score of .72 for children and a .67 for adolescents.

Confidentiality was maintained within the agency. The pre and post-tests were coded by numbers for each child in the group. After the pre and post-tests were given, they were placed in the client’s files, available for other therapists and doctors to view within the agency. Registration and secretarial staff also had access to these files as they manage all client files in the agency setting. All files were kept in a locked room and were not accessible to non-employees. Signed consent forms (Appendix B), allowing
children to participate in this research study were also placed in the individual’s file, which were kept in a Medical Records office that is kept locked and secure.

*Review of assessment.* The Beck (2001) Depression Inventory for Youth contains 20 statements for which the child indicates the frequency in which he or she experiences having that thought, feeling, or behavior (Bonner, 2001). The time required to complete the inventory is reported to range from 5-10 minutes, depending upon the child's reading ability or other circumstances (Beck, Beck, Jolly, & Steer, 2005). They suggested adjusting the time period to meet the special needs of the children being tested. Bonner discussed that the inventory is written at about a second grade level, meaning most children covered by the norm group should be able to read the items and directions. He additionally stated that instructions may need to be verified for individual children, particularly those who are younger or with language- and reading-related difficulties. Bonner continually mentioned that the manual states that significant variability was encountered with the reading level for young children. He proposed that if necessary the inventory can be read to children. Furthermore, he proposed that the administration procedures are outlined for the examiner to read the instructions to the child, after introducing the general task demands. Moreover, Bonner described that the child is asked to rate statements related to how often they think or feel consistent with the item, particularly during the past two weeks.

The manual for the BDI-Y describes the development of the inventory as following pilot studies for initial item selection in clinical settings, produced from statements children provided in therapy (Beck, Beck, Jolly, & Steer, 2005; Bonner, 2001; Stephenson, 2001). Bonner (2001) and Stephenson (2001) indicated that item selection is
not described in great detail, but that it consists of 20 items categorized by four criteria: low item to total correlation, higher inventory alpha with item deleted, clinical judgment, and non-significant factor loading across or within inventory factor analyses. Stephenson proposed that raw score totals are calculated in the test booklet and moved to the profile sheet. He also suggested that the child's raw score can be changed to T-scores and percentile ranks.

The internal consistency was calculated for the BDI-Y across the gender-age norm group stratification (Bonner, 2001). Bonner proposed that the depression scale coefficients were strong at .91 for girls and boys. He also stated that test-retest was computed using a sub-sample of 105 children and a median retest interval of 7 days. He concluded that no further information has been reported on the methodology. He reported that corrected correlations for the younger children (7-10 years) ranged from .74 to .90 and for the older children (11-14 years) ranged from .84 to .93. He summarized that although these are reputable coefficients for a self-report scale with children, the reader is warned that these are limited data (sample size, only one study) with which to fully consider reliability. Moreover, Bonner explained that examining the coefficients for the individual scales demonstrates that they are variable across age and gender.

According to Beck, Beck, Jolly, and Steer (2005), Bonner (2001), and Stephenson (2001), the BDI-Y is likely to be popular among school and clinical professionals due to conciseness, flexibility, and purported construct measures. They indicated that as a result of the test being preliminary, interpreting the scale as direct evidence of a single construct presented is not warranted, as more evidence is necessary. Bonner (2001) and Stephenson (2001) also stated that an even larger problem of the inventory is the
undetermined reliability and validity associated with decisions practitioners will make regarding differential diagnosis, treatment, screening, or evaluation using data generated from this scale. They mentioned that despite this, use of the BDI-Y rating scale guides diagnostic decision making and remains popular. Both Bonner and Stephenson argued that they expect applied clinicians will quickly add this scale to their collection of inventories and assess the added utility of the scale in the context of their clinical experience. In conclusion, they discussed the anticipation that the BDI-Y will be popular with researchers, which should then add to the understanding of the technical properties, including decision reliability and incremental validity, of these measures.

The response format of the inventory is Likert-type with participants asked to indicate how frequently they have certain behaviors, thoughts, and emotions (Stephenson, 2001). He recommended that the scale be used in schools, outpatient, forensic, residential managed care, and medical settings. He discussed the importance of the manual, stating that the administration of the inventory may be conducted by a variety of people under supervision, but that the individual responsible for the overall administration and interpretation of the inventory should be trained in clinical assessment procedures. He suggested that the manual be utilized for proper implementation of guidelines for clinical application and interpretation.

Although a detailed discussion of the BDI-Y is included, the manual notes that the scale should not be used for diagnosis, as other assessments are also necessary for accuracy (Stephenson, 2001). Bonner (2001) and Stephenson (2001) stated that the BDI-Y is a brief screening tool that can evaluate a variety of childhood concerns within the normal population of children aged 7-14. They also declared that it is appropriate for use
in a wide range of settings for both group and individual administration. In addition, they suggested that there is some evidence that the high scores on the BDI-Y call for further assessment and that more research is needed. They argued that the inventory may be read to participants but that it provides no pertinent normative or validity data to support this use. Furthermore, Stephenson discussed that it is reasonable to assume that responses may change when a child is read an item such as "I wish I were dead" or "I like being mean to others" and asked to respond to it versus reading it.

Procedure

All participants ranging from 8 to 12 years of age were involved in a group therapy study that lasted for eight consecutive weeks. Every week, each session lasted for an hour in duration. Each session and week is detailed below. Icebreakers were used during these sessions, as they helped the participants get to know each other and become more comfortable (Schoeman & Kreitzman, 1997).

Group one. The first group included six children, which consisted of 2 girls and 4 boys. The children came in, sat down at the table, signed in, and ate snacks. Food is of great importance to children and it initiates talk (Keyser, Seelaus, & Batkin-Kahn, 2000). Providing refreshments is an integral part of a group therapy program and is a necessity (Rachman, 1995; Schleidlinger, 1982). They all participated in an icebreaker and introduced themselves. After the introduction, the pre-test was given to the children, which was read out loud to them. Confidentiality was reviewed with the group. The group members created their own rules for the group and then signed the poster with all the rules written on it. Singing the poster indicated that the participants agreed to follow the rules they made up and also to maintain confidentiality. Having the children establish
the group rules and define confidentiality is important and necessary to gain group identity (Schoeman & Kreitzman, 1997). At this time, the first group came to a close and all the members lined up tallest to shortest, while walking out to the waiting room.

**Group two.** The second group consisted of eight members, of which three were new. The members comprised 3 girls and 5 boys. They entered the group room, ate snack, and signed in. A discussion on loss was formulated. Such topics on loss that were discussed were why the children were there, what types of loss there are, what loss and death means, and who is affected by loss. The group members shared the losses they endured and their feelings associated with such losses. During the time of this discussion, the three new members were taken to another room to complete the pre-test. Once they returned, they were filled in on the discussion and they participated as well.

After the discussion activity, the children participated in an icebreaker. They played the name game, where they have to match a food of the same letter of their name and attach it after their name. For example, Anthony Apple, Carrie Cookie, or Terry Taco. They would then have to go around the circle and say everyone’s name with their matching food attached to it. The members enjoyed picking the food that attached to their name and had fun with this activity. After this icebreaker, the group returned to the discussion on loss. When the children finished talking about loss, the project of the upcoming memory books was introduced to the members. Since there were three new members in the second group, the group reviewed for them the rules they made up the week prior. The new members all signed the contract of following the rules and confidentiality. The group came up with a cheer before leaving.
Group Therapy

Group three. Group three consisted of only three people, comprised of two boys and one girl. There were no new members this week. The members came into the group room, ate snack, and signed in. The co-leaders checked in with the members about how their weeks were going and how they were doing. Reviewing the past week and issues that may have come up with the group members is helpful to group cohesion and helps children get to know one another and to learn about their current lives (Schoeman & Kreitzman, 1997). While checking in with the members, one of them decided to share with the group, a picture of her mother who had recently passed away. Discussion on this was initiated. After the member shared about her loss, the group participated in an activity together. They drew pictures of what their loss looks like and then shared with the group their pictures and losses. One member drew a picture of his cat, which had passed away, while another member drew a picture of his old home that he missed. Group then came to a close, as the group cheer was implemented.

Group four. Group four had eight members, which consisted of six boys and two girls. All members came into the group room, signed in, and ate snack. Co-leaders checked in with group members about how they were doing and how their weeks were going. While checking in with members, one member chose to share an item of loss. He shared a picture album of his father, who is in jail, his sister who lives in another state, and his grandpa who died. He showed many pictures of all three of these losses and explained his pictures in detail. After this member shared his picture album, the whole group participated in the next activity of drawing a picture of their favorite memory of their loss. Some members decided to share their drawings afterwards, while others
respectfully chose not to. Upon completion of the drawing activity, the group did their good bye cheer and group four ended.

(Group five) This group involved three people, of which two members were girls. One of the girls was a new member. Members came into the group room, signed in, and ate snack. Co-leaders checked in with the members on how their weeks were going and how they were doing. The two members introduced themselves to the new member. The planned feelings activity was postponed during this group due to lack of attendance. Instead, the group worked on their memory books, drawing pictures to add to their books and held conversation. The members reviewed the rules for the new member, while they were working on their memory books. Stories and losses were disclosed between members. Members ended session with their good bye cheer.

(Group six) Group six consisted of three members; two boys and one girl. They entered the group room, sat at the table, ate snack, and signed in. Co-leaders checked in with the members on how they were doing and how their weeks were going. They participated in a feelings exercise, which four out of eight feeling words were explored. Eight feeling words of fear, sad, grateful, angry, empty, confused, guilty, and shame were on paper strips on the floor (Keyser, Seelaus, & Batkin-Kahn, 2000). The children were asked to pick one of the feeling strips that they had felt before and explain what it was like. The strips chose in group six were fear, sad, grateful, and angry. All members disclosed what those feelings meant to them and shared times when they felt that way. They ended group with their good bye cheer. This was a very effective group, as they all took turns, and explored and processed meanings, feelings, and losses.
**Group seven.** Group seven consisted of four members, comprised of three boys and one girl. They entered the group room, sat at the table, signed in, and ate snack. Co-leaders checked in with the members on how they were doing and how their weeks were going. The feelings exercise from the week prior was continued, as the other four feelings of empty, guilty, shame, and confused were explored and disclosed by members. After this activity was completed, members participated in another activity and wrote letters to their loss. After writing their letters to their loss, some members decided to share with the group, which began conversation. The group ended with their good bye cheer.

**Group eight.** Group eight was the final group for this experiment. The group consisted of six members, of which two were girls and four were boys. They entered the group room, sat at the table, and all took the post-test. The post-test was also read to the children, just like it was for the pre-test. After the post-test was finished, the members ate snack and engaged in discussion. Co-leaders checked in with the members on how they were doing and how their weeks were going. The children worked on their memory books, finished them, and put their pages together. The members in the group all shared what they had learned, liked, and disliked from the group. Group then terminated, as they all took their books home, and ended with their good bye cheer for the last time.

**Scoring of assessment.** Each item on the BDI-Y was scored individually for each participant. On the inventory, the likert-type rating scale ranges from 0 (never), 1 (sometimes), 2 (often), and 3 (always) (Beck, 2001). In assessing the data for each participant during this research, the likert-type rating scale was reversed from 4 (never), 3 (sometimes), 2 (often), and 1 (always) for visual purposes. The reasoning behind this
was to show the results and changes from pre and post-test data in a positive skew versus a negative skew. The score taken from the pre-test was compared to the score taken on the post-test. The pre-test score was subtracted from the post-test score, indicating the difference between the scores and therefore, presenting the change.

**Results**

The two charts that are utilized explain the results of the pre and post-test data, which are shown below. The first chart is a pie chart, which shows the difference by color where the participants were with pre-test answers, post-test answers, and then the change that resulted between both measures. The yellow color describes the amount of change the participant encountered throughout the group process, displaying that their answers improved in the post-test measure and that symptoms of depression did decrease over time from the first group to the last group. The bar graph, on the other hand, displays more than just the overall picture. The bar graph details how each question improved or worsened from the pre-test measure given on the first group, to the post-test measure given on the last group.
The above graphs display the outcome of the group as a whole, combining all six members’ data. The pie graph shows there was change between the pre and post-test data, as indicated by the color yellow. The red color, representing the post-test data consumes most of the pie chart, signifying that there was improvement and that
symptoms of depression decreased. The bar graph displays the average scores of the six participants according to each question. In each of the twenty questions, there was an increase in the post-test responses, which is concluded by viewing the blue color of the pre-test average with the red color of the post-test average. The red post-test bar is greater or taller than every blue pre-test bar, making it visible to determine that progress was made overall by group members on all twenty questions on the inventory. The change between the pre and post-test average of all participants is noticed by the yellow color, stating that there was indeed change and showing the difference between the pre and post-test responses.

*Participant One*
Within the pie chart, data shows that there was quite a bit of change from the pre and post-test data. The pie chart mostly comprises change and post-test data, which displays an increase in positive responses over the course of the group process.

Participant one’s data, in the bar graph, shows a decrease of depressive symptoms in eighteen out of the twenty questions of the inventory. This participant, however, did not improve with symptoms of depression on two questions. The chart shows negative change and displays that there was not improvement with questions number two and number fourteen. Question item two was “I have trouble doing things” and question item fourteen was “I feel bad about what I do” (Beck, 2001).
The pie chart shows no change, as participant two’s responses to the pre and post-test averaged the same. In the bar graph, change is shown between questions two, five, eight, ten, sixteen, and eighteen. The change between these questions was positive, as this participant had a decrease in depressive symptoms over the eight week group process. The amount of change for these questions is evident by the color yellow. All
other questions were rated the same on both the pre and post-test and no change with these questions occurred.

*Participant Three*

The charts for participant three indicate that there was positive change and that symptoms of depression decreased from the time of the pre-test to the time of the post-test. Only three questions for this participant address change, while the majority of the responses remained consistent from pre and post-test data. The questions and symptoms
this participant improved on were item number one, “I think that my life is bad,” item number nine, “My stomach hurts,” and item number fourteen, “I feel bad about what I do” (Beck, 2001).

**Participant Four**

![Pie chart showing participant four's pre and post scores](image1)

![Bar chart showing participant four's pre and post scores](image2)

Participant four shows change between pre and post-test data. Change occurred within three of the twenty questions on the inventory. Of these three questions indicating change, there was only one question that this participant did not improve on, which is
shown with number nine, “My stomach hurts” (Beck, 2001). There was only improvement for this participant in two questions. Question number one shows little change, while there is significant positive change in question number seventeen. Beck specified that item one is “I think that my life is bad” and item seventeen states “I feel like crying.” For all other questions on this inventory, data for both pre and post-test measures equaled the same, making this participant neither improve nor worsen on the majority of the questions.

*Participant Five*
These graphs display positive change and improvement in depressive symptoms for 9 out of the 20 questions. There was only one question that participant five did not improve on, which is number, eighteen, “I feel sad” (Beck, 2001). For this participant, change occurred for half of the items on the inventory.

*Participant Six*
Participant six showed change in 12 of the 20 questions. There was only one out of these 12 questions that did not change positively. Item number seven, “I think bad things happen because of me” (Beck, 2001), was the only question that this participant did not improve on from pre and post-test measures. Eleven of the questions had improved, as symptoms of depression decreased for those responses from the pre to post-test data. Six items from the inventory showed neither improvement nor worsening of symptoms for this participant.

Discussion

The purpose of this study was to determine if group therapy would facilitate a decrease in depressive symptoms for children experiencing loss. The intent of group therapy was to address issues of loss that were experienced by the children and to help them confront, explore, and cope with such feelings and thoughts surrounding the loss.

Interpretation of findings

The outcome of the research study proves the need for children to express themselves after experiencing losses. Children need to be allowed and encouraged to
embrace their feelings and thoughts that result from their loss (Wolfelt, 1996). The results reveal that with the help of group therapy, children can decrease their symptoms of depression and can learn to cope more effectively with loss. Grief can be emotionally exhausting with many similarities to clinical depression and is normative in circumstances of loss (Tedeschi & Calhoun, 2008). During group therapy, children can talk about their losses and can learn to handle their stressors and symptoms relating to grief and depression successfully. Members of a group are given the opportunity to vent feelings of pain, anger, guilt, and other strong feelings, while normalcy of reactions can be acknowledged (Corr, Nabe, Corr, 1997). Children who are not able to express their thoughts, feelings, and questions may not have the ability to resolve their grief, which can remain disturbing and unsettling for long periods of time, and may lead to the development of serious psychological conditions that may qualify as a psychiatric diagnosis, like major clinical depression, anxiety or panic disorders (Abi-Hashem, 1999; Middleton, Raphael, Martinek, & Misso, 1993).

All participants included in the research study had a decrease in depressive symptoms over the eight week period of group therapy sessions. The most improved symptom on the depression inventory was item number five, “I have trouble sleeping,” followed by items one, “I think that my life is bad,” and seventeen, “I feel like crying.” Bereavement has much in common with depression, such as great sadness, appetite and sleep problems, difficulty concentrating, and lack of interest in activities (American Psychiatric Association, 2000; Gallagher-Thompson & Thompson, 2007). Symptoms of depression were decreased with the children in the group and are evident by improvement on all questions. Some examples of other questions the children improved on are, “I feel
empty inside”, “I feel sad,” “I want to be alone,” “I hate myself,” “I feel sorry for myself,” “I feel lonely,” “I feel no one loves me,” “I feel that I am a bad person,” “I have trouble doing things,” and “I feel like bad things happen to me” (Beck, 2001). The outcome of this research study is not statistically significant due to such a small sample size.

The outcome of this research experiment is the result of children having a decrease in depressive symptoms because through group therapy, they were given the opportunity to express themselves, be heard, have questions answered, and explore meanings. They were listened to, supported, taught, and were given a safe environment to face their losses and grow from them. Grief work with children should include dealing with the reality of the death, pain, and emotional adjustments in order for them to continue living, loving, and trusting (Fox, 1985). The children in the group were able to discuss their losses, share stories and memories, and gain insight into themselves and their losses. Fiorini and Mullen (2006) discussed that in order for children to process their experience, they need to be allowed an opportunity to feel and express their emotions about their loss. They proposed that children are then encouraged to develop a meaningful way to affirm and remember their loss.

Limitations

This study was designed to find out if group therapy was an effective intervention in decreasing symptoms of depression in children experiencing loss. Although all group members did benefit from the group and their symptoms of depression decreased, there was always a possibility that their symptoms could have worsened. When reminded of and faced with devastating losses, the children could have been re-traumatized and
symptoms of depression might have escalated. Individuals, who were quiet, reserved, and withdrawn might feel have felt intimidated in the group where disclosure occurred and therefore could have shut down in such a setting. Other children at times were hyperactive and distracted, which could have been their way to get comfortable with the loss or to avoid the hurt the loss was bringing; in any case hyperactivity caused other members not to focus at times. Children may act out their grief through behavior because feelings can be difficult to handle (Jackson, 1965). Having distractions in the group postponed activities or gave the children less time to complete them. In group therapy interventions, information is revealed and confidentiality cannot be guaranteed between participants.

While the pre and post-tests were administered, some children were going ahead to the next statement before it was read out loud and some children seemed to circle any answer to get the test over with. Taking the pre-test took about 30 minutes, as some children monopolized the time and had to comment on every statement, which made some other members impatient.

Throughout many of the groups, it seemed as if the children were distracted on many occasions. It would have been more effective if at those times, that was reflected to the children more frequently for them to explore and be aware of. Children get uneasy dealing with loss and many feelings come from being faced with their loss. It would have been facilitative for co-leaders to explore the children’s behaviors and to explain to the children on the many occasions that it is normal to feel and act that way. Most of the time depression is displayed through behaviors as expressions of sadness, social withdrawal, psychomotor retardation, apathy, and nonverbal language (Rando, 1984).
Rando stated that children oftentimes mask their feeling of depression with agitation or restlessness.

Another limitation of the group as a whole was the number of participants that attended weekly groups. Some members missed some sessions, some never came back, and some missed important activities. The number of participants in the weekly groups varied, as one group consisted of three participants and another group had eight. The lack of consistency might have thrown off the group dynamic. Some members who took the pre-test initially did not complete the post-test, and therefore data was not able to be included. There was only one member from the collected data who had participated in all eight sessions. Due to the group being open, and participants joining after the initial first group session, progress was limited at times, as the group had to review or “catch up” the participants joining at that time. Having new members join after the group has already started can stunt the group’s growth and may prevent them from taking the group seriously and from trusting the members in the group.

Implications for counseling

The concept of grief work has continued to influence a wide variety of counseling and therapy programs (Raphael, Middleton, Martinek, & Misso, 1993; Stroebe, 1992; Worden, 1991). Grief work conveys the need to confront the pain and work through losses (Stroebe & Schut, 1999). Children lack the built-in support systems that many adults depend on in times of stress and loss (Auman, 2007; Webb, 2002). Auman stated that an alarming lack of understanding about childhood bereavement and children’s need for bereavement services continues to exist among the general public, as a lack of awareness exists of the inner suffering experienced by children. It is imperative for
children to have support and encouragement when experiencing devastating losses. Parents, guardians, teachers, and mental health professionals need to let children grieve and mourn in their own ways. There are many ways for adults to help children who are grieving. Fox (1985) reported that in order to help children experiencing loss, adults need to recognize their own feelings, monitor vulnerable children, address children’s fears and fantasies, be honest and open, be supportive as children grieve, remember the loss and commemorate, and establish an ongoing loss or death education program. Trozzi (1999) suggested that to ensure that children master emotional skills as they process loss, caregivers need to foster honesty and open relationships with children, provide a safe and secure space in which children can mourn, and be role models of healthy mourning.

It is critical that mental health professionals have an understanding in the grieving process for children and how to manage sessions in a clinical setting, in order to be helpful to children. By listening, having empathy, and unconditional positive regard, children will have the nurturing environment to heal and grow. Wolfelt (1996) described the essential qualities that counselors need in helping bereaved children as having empathy, a desire to understand, sensitivity and warmth, acceptance, genuineness, trust, spontaneity, flexibility, and a belief in the child’s capacity to heal. Professionals also need to acquire knowledge on the group process and what to expect in a group setting with grieving children. Lastly, comprehension on depression is necessary for effective treatment and understanding in how to handle children experiencing such symptoms. Research should be completed on helpful activities and games that can facilitate the healing process for children experiencing loss. Games are very useful in group settings,
in that games are a good way to normalize discussions of death and loss (Fox, 1985). He reported that games give children new ways of coping and relating to other children. Many activities can be found throughout literature; one in particular is a book written by Fiorini & Mullen (2006).

*Implications for future research*

Bereavement in children and adolescents has not been extensively studied as in adults (Weller et al., 1990). However, this research focused on bereavement in children and adolescents. As concluded from the experimental results, group therapy can be effective in decreasing symptoms of depression in children experiencing grief and loss. Future research may take a step further and compare the same activities used in both individual and group therapies and can assess which therapeutic intervention is shown to be most effective.

*Conclusion*

Society is unaware of the need for children to express themselves after experiencing a loss. Society also lacks the knowledge on how to communicate with children experiencing loss. It is crucial that adults gain understanding in childhood grief and bereavement, so that children can gain the necessary support from adults and are given the opportunity to grieve. Not dealing with losses can lead to faulty beliefs and possible long-term psychiatric diagnoses. Group therapy is an effective strategy in helping decrease symptoms of depression dealing with the loss.
References


Minneapolis: Augsburg.


Appendices

Appendix A

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<tr>
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<tbody>
<tr>
<td>1. I think that my life is bad.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<tr>
<td>2. I have trouble doing things.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<tr>
<td>3. I feel that I am a bad person.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<tr>
<td>4. I wish I were dead.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>5. I have trouble sleeping.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>6. I feel no one loves me.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>7. I think bad things happen because of me.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>8. I feel lonely.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>9. My stomach hurts.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
</tr>
<tr>
<td>10. I feel like bad things happen to me.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>11. I feel like I am stupid.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>12. I feel sorry for myself.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>13. I think I do things badly.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>14. I feel bad about what I do.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>15. I hate myself.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>16. I want to be alone.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>17. I feel like crying.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>18. I feel sad.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<td>19. I feel empty inside.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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<tr>
<td>20. I think my life will be bad.</td>
<td><strong>Never</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
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Introduction:

As a member of the Unity Child/Adolescent team at St. Mary’s, your child is being invited to participate in a research study. It is being conducted as part of Elena Pilato’s (Principle Investigator/Student Researcher) master’s thesis for the Department of Counselor Education at The College at Brockport. The research study was approved by Unity Health System’s Institutional Review Board and is being conducted through Unity’s Department of Psychiatry and Behavior Health. It is recommended that you read this from carefully before deciding whether or not you wish for your child to participate in this study.

Purpose of the Research Study:

The research study is being conducted to determine if group therapy is an effective intervention in decreasing symptoms of depression in children experiencing loss. The investigator will assess children’s symptoms of depression before the group begins and after the group has ended to see if their symptoms of depression have decreased.

Confidentiality and Voluntary Participation:

The participation of this study is voluntary. There will be no effect on your child’s present and future treatment if s/he chooses to participate or chooses not to participate. If s/he does choose to participate in this study, s/he may leave at any time. If your child does choose to leave this study, any information that s/he has provided will be kept confidential.

Imminent threat of harm to self or others is required to be reported to your child’s primary therapist. Findings suggestive of abuse or neglect of a child must be reported and investigated.

During the interview, the Principle Investigator/Student Researcher will record the responses to the pre and post rating scales with number codes in order to compare data. All of the information gathered by the Principle Investigator will be placed in your child’s file and will be kept in a locked room.

Description of the Study Procedures

Your child will be invited to participate in a loss/grief group, lasting eight consecutive weeks. All eight sessions will last for an hour. Your child will be asked to complete a
pre and post rating scale that involves his/her feelings dealing with loss/grief. The rating scale has 20 questions and should take no longer than 10-15 minutes to complete. The purpose of the test is to measure symptoms of depression. S/he will participate in activities that will explore her/his loss and will hopefully help in coping. There will be no more than ten children participating in the group.

Risks and Benefits of Participants

There are no anticipated risks or benefits to your child because of her/his participation in this research study. In group therapy interventions, information is revealed and confidentiality cannot be guaranteed. If your child’s symptoms worsen during the group intervention, you or your child should let the primary investigator know.

Payment

There will be no payment for your child’s participation in this research study.

Contact Persons

Principle Investigator/Student Researcher: Elena M. Pilato
Intern
Child/Adolescent Outpatient
At St. Mary’s Site
(585) 368-6550

Faculty Advisor: Thomas Hernandez
Department of Counselor Education
The College at Brockport
(585) 395-2258

Unity Health System, Department Of Psychiatry and Behavioral Health:

If you believe your child has suffered a research related injury, contact Elena Pilato at 368-6550 who will give you further instructions.

If you have any questions about your child’s rights as a research subject, you may contact the Office of the Institutional Review Board at Unity Health System at (585) 723-7056, Monday through Friday, 8:15 AM to 5:00 PM.

Signature and Date

You are being asked whether or not you will permit your child to participate in this study. If you wish to give permission to participate, and agree with the statement below, please sign in the space provided. Remember, you may change your mind at any point and
withdraw your child from the study. Your child can refuse to participate even if you have given permission for her/him to participate.

I understand the information provided in this form and agree to allow my child to participate as a participant in this project. I am 18 years old or older. I have read (or had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I have received a copy of this form for my records and future reference. If you have any questions, you may contact:

Primary Researcher: Elena Pilato 368-6550

__________________________________________________________
Parent/guardian Signature:

__________________________________________________________
Parent/guardian print:

__________________________(Date)