

Spring 2013

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Perceived Social Support and Individual Differences in Childhood Traumatic Grief

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Spring 2013 Senior Honor's Thesis

April 09, 2013

Submitted to the College of Arts and Sciences

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Abstract

Grief has long been a topic of study and debate among researchers, but the concept of Childhood Traumatic Grief (CTG) has only recently been introduced and accepted as a condition in need of better understanding. Childhood Traumatic Grief is defined as occurring "...when children whose loved ones die in circumstances that are subjectively traumatic develop trauma symptoms which impinge on these children's abilities to engage in the typical tasks of grieving" (Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002; Pynoos & Nader, 1990). Social support has been recognized as correlating with grief symptoms in adults, but has never been analyzed in relationship to Childhood Traumatic Grief. The purpose of this study is to determine whether differences in perceived social support in children correlates with self-reported Childhood Traumatic Grief symptoms following a loss. Implications for these results are discussed.

Keywords: Childhood Traumatic Grief, Bereavement, Trauma, Perceived Social Support

Perceived Social Support and Individual Differences in Childhood Traumatic Grief

Death can often times be an extremely difficult concept for young children to grasp. The loss of a loved one can fundamentally change children's view of what is "safe" and "normal" in their lives (Cohen, J., Mannarino, A., & Deblinger, E., 2006). Major life stressors related to the loss of a loved one may even serve to aggravate any posttraumatic or other symptoms that children may experience due to losing the deceased (Cohen, J., Mannarino, A., & Deblinger, E., 2006; Hulsey, E., 2008). The developing psyche of each child handles trauma and bereavement differently with symptoms manifesting themselves in many different ways (Hulsey, E., 2008; Nickman, S., Silverman, P., & Normand, C., 1998). While most children and adolescents progress through grief in unique and diverse ways, one of the determinates of a child's expressed grief is the way in which their surviving caregiver demonstrates their own handling of the death loss (Nickman, S., Silverman, P., & Normand, C., 1998; Cohen, 2004). While most children and adolescents will be able to progress through their respective grief reactions without difficulties that affect functional impairment over time and development, for some, the death loss and the experience of the death loss may put them at risk for such difficulties (Worden & Silverman, 1996; Brent, D. et al. 1999). For some, the loss of a loved one may be a topic that requires discussion and validation of thoughts and feelings to protect the experience from becoming potentially traumatizing for the child (Greenwald, 2002). Additionally, in relation to bereaved adults, social support has been shown to lessen distress following a death loss and the question may be asked whether the same is true for children (Hogan & Schmidt, 2002)

This investigation will center on whether differences in measured perceived social support for bereaved children and adolescents on Intake measures collected at a non-profit bereavement center correlate with self-reported levels of Childhood Traumatic Grief. It is

predicted that higher perceived social support endorsed by a child, will negatively correlate with lower Childhood Traumatic Grief scores.

Bereavement

Contrary to earlier models of grief (e.g, Kubler-Ross' stages of grief), there is no set course for grief, with fixed durations or stages of transition between phases (Hulsey, E., 2008). Everyone grieves at his or her own rate and takes his or her own time to come to terms with certain aspects of grief. Coping strategies that might work for one child or adult might be unimaginable to another. Keeping in mind the idiosyncrasies of children's grief, there are nonetheless some similarities among children and adolescents grief reactions that have been described in the literature.

Grief reactions that have been documented in the empirical literature include an investigation by Cerel, J., Fristad, M., Yerducci, J., Weller, R., & Weller, E. (2006), in which they compared groups of depressed children, bereaved children, and a community control group of children who had neither experienced a death loss or been diagnosed with depression. Bereaved children were found to be less impaired on measures than the depressed group, but more maladjusted on daily coping measures than the controls (Cerel et al., 2006). These researchers found that psychiatric problems were especially associated with bereavement two years post-death, and that children who were suicidally bereaved experienced more psychopathology after the death of a parent than children experiencing depression or the normal control.

Among bereaved children, Cerel et al. (2006) further found greater increases in children's psychopathology among those children who had more psychopathology prior to the bereavement, compared to those who did not display psychopathology before the death of a

loved one. This finding can be interpreted as pointing to the potentially traumatizing effect that a death can have on children, as seen by the emotional dysregulation that especially disturbed children may experience at the time of a death loss (Cohen, J., Mannarino, A., & Deblinger, E., 2006).

Bereavement and Posttraumatic Symptoms: Death and Trauma

Recent understanding of Childhood Traumatic Grief (CTG) is conceptualized as occurring according to the following definition: "...children whose loved ones die in circumstances that are subjectively traumatic develop trauma symptoms, which impinge on these children's abilities to engage in the typical tasks of grieving" (Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002; Pynoos & Nader, 1990). Thus, by definition, CTG involves symptoms similar to those of posttraumatic stress disorder (PTSD): persistent, intrusive, re-experiencing of horrifying aspects of the death; avoidance of reminders of the traumatic event (death), such as death and loss reminders; and hyper-arousal when confronted with traumatic reminders (Cohen et al., 2004). Additional characteristic features of CTG include avoidance of identifying with the deceased for fear that if resemblances to the deceased exist then, one will also experience a premature or horrific death (Brown, Amaya-Jackson, Cohen, Handel, De Bocanegra, Zatta, Goodman & Mannarino, 2008; Crenshaw & Garbarino, 2007; Pynoos, 1992). Those children that suffer from CTG may experience trauma symptoms of estrangement, or emotional numbing, which allows the child to minimize the pain and other negative feelings experienced when exposure to such trauma reminders inadvertently occurs (Brown et al, 2008). This numbing may take the form of extreme estrangement, in which the child feels alienated, different, or set apart from others, even those in the family who also experienced the traumatic loss (Crenshaw & Garbarino, 2007).

Additionally, appraisals of alienation were found to predict PTSD symptoms among children who experienced a traffic accident (Ehlers, A., & Clark, D. M., 2000). Ehlers et al. (2000), also discussed alienation as likely for bereaved children as they may experience themselves as different from other children, because of experiencing the traumatic death event itself as well as the continued absence of the deceased. Such perceptions of alienation in bereaved children as described, furthered evidence for hypothesizing that a child's perceived support socially may correlate with CTG reactions.

As discussed, the death of a loved one induces grief, and those deaths appraised as highly traumatizing may lead grief symptoms to occur together with signs of psychological trauma, which has been characterized in the literature as CTG. Although the construct of PTSD has been found to be separate and distinct from CTG, they are highly correlated and overlap conceptually (Brown & Goodman, 2005; Brown et al. 2008). Namely, at all stages, posttraumatic symptoms include those described in the construct of CTG not specific to grief: *avoidance, intrusive, repetitive imagery and behaviors, hyper arousal, affective distress, and, more rarely, dissociative reactions*. Such distress and avoidance may interfere when reminiscing about a stressor and, in turn, create obstacles to the psychological integration of an event, which is similarly described within the CTG construct in relation to the death and grief (Cohen et al., 2004; Cohen et al., 2006). Thus, deaths due to traumatizing events or perceived as traumatizing may trigger CTG symptoms and generally maladaptive grief outcomes. In addition, such deaths, together with other childhood chronic stressors, such as previous traumas, may be likely to predict elevated CTG. This is seen more generally in the literature when severity of posttraumatic reactions is positively associated with the number of *types* of traumatic events to which individuals have been exposed (Silvern & Griese, 2012). The connections and

correlations between trauma reactions and Childhood Traumatic Grief are important to highlight due to the scarcity of CTG literature. It then follows that trauma literature can be studied to help inform this current investigation.

Trauma

It is generally understood by trauma theorists that in the midst of traumatic events (i.e., “peritraumatic experience”) victims cannot organize the experiences cognitively or emotionally (Kolk, B. A., McFarlane, A. C., & Weisaeth, L., 1996). Greenwald (2002) argues that to avoid posttraumatic psychopathology, children must have opportunities to talk about their traumatic memories. This idea is known as therapeutic disclosure, which refers to detailed recounting of the recall to a listener who is nonjudgmental, and who can remain calm in spite of the arousing nature of the events. Therapeutic disclosure provides children with the opportunity to learn that they can make sense of the traumatizing events without becoming re-traumatized by the memories.

Greenwald (2002) further argued that children’s and adolescents’ experience of grief is often so unbearable that it is traumatic, and healing often requires therapeutic disclosure, just like the requirements for healing from the traumatic effects of other events that are overwhelming due to being terrifying or otherwise unbearable. Not only Greenwald’s argument, but most approaches to healing from grief and terror involve therapeutic disclosure. Such disclosure can occur *informally* in the context of trust relationships among peers or families. Disclosures that meet the necessary requirements can also occur in *formal relationships*, e.g., between victims and professionals. For present purposes, the concept of “social support” can be applied to either formal or informal relationships. An increasing number of bereavement centers are the dominant

community settings in which professional programs are offered for grieving children and their caregivers. Those programs are generally provided for bereaved children and for caregivers.

Social Support and Traumatic Symptoms

For the purposes of the present thesis, “perceived social support” is defined as the overall constructive support that a child or adolescent perceives that they believe that they are receiving from familiar people. In other words, the more that a child recognizes that their feelings and ideas centered on their grief are being validated by a trusted member of their support system, the stronger the sense of their perceived social support.

Rollins claims that the role of parental and other emotional support both at the time of the death and subsequently may be crucial to children's responses to the deaths (1997). Parental emotional support has been found to predict children's adjustment following diverse traumatic events (Pine & Cohen, 2002). Parents and other caretakers can provide a protective shield for children at this vulnerable time, if they are able to contain their own emotional reaction, but for many children this is not the case. Following violent deaths, caretakers and parents tend to be less able to provide emotional support to children (Clements & Burgess, 2002). Lin, Sandler, Ayers, Wolchik, and Luecken (2004) found that children's resilience following a caregiver's death was positively predicted by the surviving caregiver's provision of warmth and discipline, and negatively predicted by caregiver mental health problems.

While there is currently very little research regarding any potential interaction between perceived social support and CTG directly, Bal, Crombez, Van Oost, and Debourdeaudhuij (2003) surveyed 820 students about their perceived social support and experienced general trauma symptoms. They found that it was not peer support directly that correlated with trauma symptoms, but instead that it was the *highly perceived availability* of perceived peer support that

directly related to fewer expressed trauma symptoms (Bal et al., 2003). These findings further call for more research into any possible explicit correlation between CTG and perceived social support.

Hogan and Schmidt (2002) conducted a study using the Inventory of Social Support, which asks grief specific questions about adult's perceived social support. This study found social support enhanced bereaved adults ability to lessen their grief symptoms. Additionally this study found that the bereaved adult's ability to talk openly and honestly about their grief was dependent on the supporting person being able to listen non-judgmentally. Similar to Greenwald (2002), this study demonstrates the importance for adults being able to talk about traumatic memories with others. Hogan and Schmidt's work provides a strong connection between how social support is related to an adult's traumatic grief symptoms. As such, this provides support for the need for more research on the connection between social support and traumatic grief in children.

The central hypothesis of this thesis is that bereaved children who have more perceived social support will report lower Childhood Traumatic Grief scores. It is predicted that increased perceived social support in children correlates with lower self-reported Childhood Traumatic Grief scores.

Methods

Data for the present study were drawn from a prospective study directed by Louise Silvern, Ph.D., concerning child adjustment following bereavement. The study was described in more detail elsewhere (Griese, Giusto, & Silvern, 2012). All data were collected as part of the intake process at Judi's House, a non-profit community bereavement center that provides free grief care services to families in the metropolitan Denver area. Caregivers and children provided

voluntary consent and assent to have an *anonymous version* of their records employed for research. Intakes and subsequent services were identical, regardless of whether participants agreed to the research. Data collection procedures were approved by the Institutional Review Board at the University of Colorado.

Description of the Sample

The final sample utilized in the present study ($N=1129$) included children from age 5.71 years to 18.74 years ($M=11.67$, $SD=3.35$). This sample was relatively evenly split by gender (48.0% male and 51.8% female). In regard to ethnicity, 56.7% of the children were Caucasian, 17.9% were Hispanic, 8.2% were African American, 1.0% were Native American, .5% were Asian/Pacific Islander, and 13.6% multi-racial. On average, children rated themselves as above the clinical cutoff score (30) for Childhood Traumatic Grief diagnosis ($M=38.84$, $SD=19.11$, $SE=.76$). The mean score, standard deviation, and standard error for the Inventory of Social Support are ($M=18.26$, $SD=4.05$, $SE=.16$). Means, standard deviations, and standard errors for Family Functioning Items are as follows: Family Functioning Question 1 ($M=1.83$, $SD=1.12$, $SE=.04$); Family Functioning 2 ($M=1.96$, $SD=1.11$, $SE=.04$); Family Functioning 3 ($M=2.99$, $SD=.99$, $SE=.03$); Family Functioning 4 ($M=1.97$, $SD=1.25$, $SE=.04$); and Family Functioning 5 ($M=1.97$, $SD=1.26$, $SE=.04$). Subjects not included in each measure can be found in Table 1.

Annual Family Income. At the intake assessment (post-death), adult caregivers reported annual family incomes as follow: 10.1% of the sample reported incomes under \$12,000, 38.3% of the sample reported incomes of \$12,000-\$35,999, 23.9% of the sample reported incomes of \$36,000-\$59,999; and 27.9% of the sample reported incomes above \$60,000.

Time Since Death. At intake, the time elapsed since death varied from .2 months to 147.10 months ($M=212.3$, $SD=20.3$). For families who reported more than one death, the time elapsed focused on the death that the caregiver considered the reason they sought services.

Relationship to the Deceased and Nature of the Death(s). The deceased was a parent (dad, mom, stepdad, stepmom) for 72.4% of the children, a sibling (brother, sister) for 10.7% of the children, a grandparent for 8.5% of the children, and another relative or friend (aunt/uncle, cousin, friend, other) for 8.4% of the children.

Procedures

Overview. Research data were collected as part of the usual Judi's House evaluation procedures, conducted prior to decisions about what services should be provided to particular families. If individual adult caregivers consented to research and children assented (see "Informed Consent" below), anonymous copies of their intake forms and measures were forwarded to researchers if families included at least one child from ages six- to 18-years. Adult caregivers typically initiated services with a phone call to Judi's House or a message on the agency's website asking for a phone call. A staff member conducted a brief telephone "Initial Contact" interview, and if the caregiver sought grief support services for a child, he or she received an application by mail. During the phone interview, an appointment was also made for a group orientation meeting. Caregivers returned the applications at that meeting at which staff members introduced caregivers and children to Judi's House and explained the services available. If families remained interested, an appointment for an Intake assessment was made for each family.

Children and adolescents' self-report measures and interviews were individually administered during the Intake assessment prior to the start of bereavement services.

Participant Contacts and Data Sources.

The application that is sent by mail includes questionnaires that the caregiver completes. These questionnaires concern demographics, the nature and dates of the death, family composition, children's ages, etc., and caregiver's concerns about the child(ren). Research Consent Forms and Child Assent Forms are also included. An opportunity to ask questions about the Consent and Assent Forms were provided at the Intake and staff members who administer the Intake are trained to provide information.

Individual child assessments. Self-report measures and a semi-structured interview were individually administered by staff members or specially trained volunteers to each child or adolescent at the Intake assessment. At the beginning of the individual sessions, the purpose of the assessments and the limits on confidentiality were described to caregivers and to each child. The Youth Interview (Child or Teen versions) were administered first. Children seven years and older receive a child Assent Form at the end of the assessment.

Informed consent. If caregivers consented to participate in research based on the form in the Family Application Consent Forms and again verbally at the beginning of their individual sessions, children seven years and older were then given Assent Forms read orally and in writing at the end of the individual assessment. The Youth Assent was not administered if the caregiver did not consent to research. Assent and Consent forms asked for the use of anonymous records for research purposes.

Measures

On all assessment measures, children (or adults) were invited to skip any questions they were uncomfortable answering or had difficulty understanding.

Demographic Variables: Family Application. The Family Application (see above) elicited information about all family members and about the deceased. The caregiver also provided general demographic information about the children, as well as information regarding the death loss, including: time since death and information about each child, such as the child(ren)'s age(s) and gender(s). Information about the deceased and his or her relationship to the child(ren) was also recorded.

Family Functioning Questions and Inventory of Social Support (ISS). The Five Family Functioning Questions adapted from Characteristics, Attributions, and Responses to Exposure to Death (CARED; Brown, Cohen, Amaya-Jackson, Handel, & Layne, 2003), are a measure of support from within the family. The questions were embedded in the "Judi's House Youth Interview" (See Appendix). These five Family Functioning questions take aim to tap an individual child's perception over the last two weeks about their immediate family. For example, Family Functioning Question 1 asks the child to what degree, "People at home fight or get angry and irritable with each other". Each Family item was analyzed separately.

The Inventory of Social Support questions (Hogan and Schmidt's, 2002) ask the child about how well they feel they can get support concerning their grief ($M=18.26$, $SD=4.05$, $SE=.16$). For example, Question 4 of the Inventory of Social Support asks to what degree a child feels, "There is at least one person that I can talk to about my grief". The questions for both of these perceived social support measures are answered on a 5-point Likert scale regarding how well they relate to the question prompt. These Inventory of Social Support Questions are intended to be employed as a single sum of the five items.

CTG: Extended Grief Inventory (EGI; Layne, Savjak, Saltzman, & Pynoos, 2001). The EGI is a 28-item self-report questionnaire that is the only generally available measure

employed to assess symptoms of Childhood Traumatic Grief. Responses to all EGI items are elicited on five-point Likert scales (Brown & Goodman, 2005; Cohen, et al., 2004). The CTG subscale contains 23 items and is intended to tap unique symptoms of CTG, such as yearning and wishing for revenge for the death as well as Posttraumatic Stress Disorder (PTSD) symptoms (e.g. re-experiencing, invasive thought processes, and avoidance). The sum of the CTG subscale items was the focus of the present study.

The questionnaires also elicited considerable clinically relevant information that was not employed in the present study, such as depression and trauma measures. Moreover, children provided their views about the death, their own and their caregivers' reactions to it, as well as their relationships to the deceased, and so on.

Results

Demographics and Other Potential Confounds in Association of Social Support with CTG.

A primary focus of the present study was to test the relationship between children's perceived social support and their CTG scores. Thus, it was important to identify variables that might confound that relationship. For that purpose, statistical analyses were used to test simple relationships of CTG and Inventory of Social Support scores with: children's Relationship to Deceased, and demographic variables, i.e. Age, Gender, Ethnicity, Time Since Death, and Income After the Death.

Gender. Independent samples *t*-tests were used to compare differences between boys and girls. There was no significant gender difference in total Inventory of Social Support, or CTG subscale scores. Independent sample *t*-tests were also used to test gender differences on each Family Functioning item separately; there were no significant differences found. Thus,

gender could not account for associations between social support and CTG, given there was no gender difference on CTG.

Age. Pearson Product Correlation Coefficients were calculated to test the associations of age with CTG scores and with Inventory of Social Support (ISS). No significant association was found between age and ISS scores. However, younger children had relatively higher CTG scores than older children ($r(507) = -.154; p = .000$, two-tailed). Thus, age could not account for any relationship of ISS scores with CTG scores, because as the correlation coefficient showed, age was associated with only CTG, not ISS.

Ethnicity. One-way ANOVA and Tukey's Post-hoc analyses were used to test relationships of ethnicity with participants' scores on CTG and ISS and Family Functioning questions. Ethnicity was *not* significantly related to CTG, perceived social support (ISS), or Family Functioning scores.

Time Since Death. Pearson Product Correlation Coefficients were calculated to test the associations of Time Since Death with CTG, ISS and the Family Functioning questions. No significant associations were found between Time Since Death and CTG scores; Time Since Death and ISS; and Time Since Death and Family Functioning questions. The only exception is the significant relationship that was found with Family Functioning Question 2, i.e., "People at home seem to be sad or depressed," $r(1022) = .099, p = 0.002$. Thus, Time Since Death did not account for any relationship of ISS scores with CTG scores, because as the correlation coefficient showed, Time Since Death was not associated with CTG.

Family Income After the Death. A Pearson Product Moment Correlation Coefficient was used to test relationships of Family Income After the Death with CTG as well as with each perceived social support item. Significant negative associations were found between CTG scores

and Family Income After Death ($r(371)=-.197, p=.000$, two-tailed). Significant negative correlations were also found between Family Income After Death and Family Functioning Question 2 ($r(401)=-.99, p=.047$, two-tailed), and Family Functioning Question 5 ($r(398)=-1.50, p=.003$, two-tailed). The significant relationships among Family Income After Death, CTG, and Family Functioning Questions 2 and 5 will be further clarified in our discussion.

Relationship to Deceased. A one-way ANOVA and a Tukey's Post-hoc test were used to test the participants' relationships to the deceased with their CTG scores as well as with perceived social support, i.e., ISS. Relationship to the deceased was not significantly related to CTG, ISS, nor to any Family Functioning items.

Reliability Analysis

A reliability analysis was conducted on the five Inventory of Social Support questions to determine if they functioned together as an internally consistent scale. This analysis revealed that a scale based on these items was sufficiently internally consistent to justify combining them together into a scale ($\alpha=.70$). A scale score was calculated by summing the five items, and excluding scores if responses to one or more of the five items was missing. This ISS Total score was employed to calculate substantive analyses on perceived social support.

A reliability analysis was also conducted for the five Family Functioning (FF) questions. These were not found to function as an internally consistent scale ($\alpha= 0.037$). Thus, for substantive analyses, individual paired sample *t*-tests and correlations were calculated for each Family Functioning question.

Hypothesis Tests

Inventory of Social Support and CTG. A Pearson Product Moment Correlation Coefficient was used to test the association between CTG Total scores and ISS Total scores.

As hypothesized, a significant negative relationship was found, demonstrating that relatively lower perceived social support for a child's grief was associated with higher CTG scores ($r(625)=-.169$, $p=.000$, two-tailed). We identified no potential confounding variables that might have influenced this relationship (See Above). A paired samples t -test revealed a significant relationship between CTG and ISS $t(624)=25.48$, $p=.000$, two-tailed.

Family Functioning

Family Functioning Question 1. People at home fight or get angry and irritable with each other. A Pearson Product Moment Correlation Coefficient was used to test the association between CTG Total and the rating of the family's fighting and irritability. A significant relationship demonstrated that more fighting at home was associated with higher CTG scores ($r(1014)=.168$, $p=.000$, two-tailed). A paired samples t -test was also calculated to test the relationship between "People fighting or getting angry at home" and CTG. A significant relationship was found between CTG and Family Functioning Question 1 $t(1013)=61.76$, $p=.000$, two-tail, ($M=37.66$, $SD=19.42$, $SE=.61$).

Family Functioning Question 2. People at home seem sad or depressed. A partial correlation coefficient was calculated to test the relationship between CTG and Family Functioning Question 2, controlling for Family Income After Death. This correlation was found to be significant ($r_{\text{partial}}(354)=.347$, $p=.000$, two-tailed), with a direct relationship between perception of family's "depression and sadness" with children's CTG scores. A paired samples t -test was calculated to test the relationship between this item and CTG as well. A significant relationship was found between CTG and Family Functioning Question 2, $t(1008)=62.09$, $p=.000$, two-tailed, ($M=37.55$, $SD=19.21$, $SE=.60$).

Family Functioning Question 3. People at home support and help each other. A Pearson Product Moment Correlation Coefficient revealed no relationship between CTG Total scores and this favorably worded question about support among family members. A paired samples *t*-test was calculated to test whether there was an association between this question about the family and CTG. A significant relationship was found between CTG and this Family Functioning Question $t(1010)=59.10$, $p=.000$, two-tailed, ($M=36.45$, $SD=19.61$, $SE=.62$).

Family Functioning Question 4. At home, we talk openly about what we are thinking and feeling. A Pearson Product Moment Correlation Coefficient revealed no significant association between the CTG Total and this favorably worded question. A paired samples *t*-test was calculated to test the relationship between CTG and this Family Functioning question. A significant relationship was found between CTG and Family Functioning Question 4 $t(1010)=60.74$, $p=.000$, two-tailed, ($M=37.52$, $SD=19.64$, $SE=.62$).

Family Functioning Question 5. At home, we each try to keep sad and angry thoughts and feelings to ourselves. A partial correlation coefficient was calculated to test the association of CTG with this Family Functioning Question, controlling for Income After Death. This coefficient reflected an association between keeping angry thoughts and feelings to oneself and CTG scores was found to reflect a significantly negative relationship ($r_{\text{partial}}(361)=-.204$, $p=.000$, two-tailed). A paired samples *t*-test was run to test the relationship between CTG and this question about the family. A significant relationship was found between CTG and Family Functioning Question 5 $t(999)=61.94$, $p=.000$, two-tailed, ($M=37.65$, $SD=19.22$, $SE=.61$).

Discussion

The primary research question in this study was whether or not a significant correlation existed between perceived social support scores and CTG scores among service-seeking,

bereaved children and teens upon Intake. Results supported our hypothesis to this question that those who perceived relatively lower social support also reported higher CTG scores.

The Inventory of Social Support (Hogan & Schmidt 2002) was found to have a significant negative relationship with children's CTG scores. This result indicates that children who have more perceived support for their grieving in their lives may also have lower CTG scores, as predicted. It is of interest to note though that the correlation, while significant, was small ($r(625) = -.169$). This small correlation may result in certain children having both high levels of perceived social support and clinically high levels of CTG.

As described in the results section, the only demographic variable found to be a confounding factor, was Family Income After Death. This variable had a significant association with CTG and the Family Functioning Questions 2 and 5 scores, which ask about sad and depressed feelings at home and whether these are thoughts that can be talked about at home. Given that lower socioeconomic status can be a major life stressor in addition to losing a loved one, severity of depressive symptoms and family members' willingness to talk about these stressors and related depressive feelings could still be a predictor for reports of increased CTG symptoms. With less income to support the family, many life stressors could be occurring that are not directly addressed in this study (e.g. living in a dangerous neighborhood, improper diet, poor living conditions, etc). With more increased daily and life stressors related to lower income, it follows that more research needs to be done to test the relationship between social support, Childhood Traumatic Grief symptoms, and a number of stressors affecting the family.

For Family Functioning Question 1 (See Appendix), a significant, negative association was found between relatively more in-home fighting and relatively high reported CTG scores. This finding seems understandable, given that a more unstable, unsupportive home setting could

exacerbate CTG symptoms that began with the death. Concerning Family Functioning Question 2, when Family Income After Death is controlled for there is a direct relationship between the rating of depression and sadness of family members and a child's CTG scores, as noted above.

Family Functioning Question 3 and Family Functioning Question 4 are of particular interest, because they are not significantly correlated to CTG. Perhaps a measurement problem exists given that these two questions are worded favorably, and the surrounding items in the FF questionnaire are worded with the unfavorable pole scored higher than the favorable pole.

Additional findings concerned Family Functioning Question 5 about variation in children's perceptions that family members inhibited their expression of emotions, "keeping sad and angry thoughts to oneself". Endorsing relatively high scores on this Family Functioning item was associated with elevated CTG scores, again after controlling for Family Income After Death. It could be the case that by suppressing difficult feelings and thoughts at home, these children have no safe outlet through which to discuss their CTG symptoms.

The present results have potential to influence the field of Childhood Traumatic Grief assessment and intervention. Bereavement treatment centers usually do not assess for perceived social support or Childhood Traumatic Grief when screening participants for trauma. The present findings suggest it might be advantageous for these bereavement centers to further screen for both children's perceived social support and self-reported CTG scores. By further identifying how this relationship may correspond with elevated CTG symptoms, it may potentially point to a possible pathway for intervention by identifying a focus of treatment (poor social support) that can be easily addressed. Barriers that prevent these bereavement centers from currently assessing for perceived social support and CTG may include a lack of time and monetary resources, unfamiliarity with the measures and testing procedures, and a general lack of

familiarity and understanding of Childhood Traumatic Grief. However, these variables have the advantages of being reasonably easy and inexpensive to assess once properly trained.

With a significant relationship present between CTG scores and perceived social support (ISS) scores in this study, it would be advantageous for childhood bereavement centers and programs to make sure to include scales looking at these reported variables to best tailor intervention procedures to an individual. It could be the case that certain children just do not feel like they are experiencing the same base level of support as some of their peers and may need extra attention to meet their needs. This disparate perceived level of support might play a factor into how an assessor might populate a grief support group, make a referral for group work in addition or in lieu of individual work, or provides a context for children that need to be given a bit more preferential attention to help them cope with their Childhood Traumatic Grief.

Limitations

The present study reflects several methodological limitations that are common in community-based studies. The population from which we drew participants cannot be generalized to the bereaved population at large, due to the fact that all of the participants were self-selected and service seeking. The participants were not randomized into treatment groups, and the sample included in this study may not be demographically representative of the entire bereaved population. It may even be the case that these families self-selected for extra professional help from a no-fee organization in the first place *because* they may be experiencing lower perceived social support.

Another limitation to this study is that Judi's House is not a laboratory environment. Processes were not in place to control the environment in which measures are administered, other than administering measures one at a time to the child in a quiet room with only one or two

clinicians present. The questions are sometimes read to the younger children, and often given to older children and teens to fill out for themselves. This could make it difficult to control for outliers due to differing administration methods, but are necessary to address an individual child's needs. The measures themselves present limitations concerning how they may be implemented and interpreted. Most ISS questions addressed grief and grieving specifically, but the Family Functioning questions were not grief-specific, instead assessing how children perceives their family's interactions more generally. This variation in the items may present a potential problem, because we intended to examine how much support a child perceives specifically for their grief.

Although we controlled for families' annual income as a variable that potentially confounded relationships of CTG with perceived support, there are too many potential life stressors to control for every one that could have been important.

These methodological issues should be revisited and resolved in future replications of this study at Judi's House and elsewhere. Other issues that should be revisited have already been touched upon. The need for a more rigorous experimental design is key in understanding what influences manifestations of CTG. The main difficulty lies in how one would ethically develop a randomized sample of grieving children. Without a more rigorous, randomized, experimental design, there can be little generalizing beyond the self-selecting population at Judi's House. More questions asking about potentially confounding variables, such as Change in Income, could further develop the understanding of how CTG correlates with major life stressors. During this difficult period in a child's life, there may be many of these major life stressors taking place that are further acting upon the child's understanding of their grief, family structure/roles, and individual place in their world.

One future study that could be very interesting to undertake would be to look at post-intervention data collected after completion of a grief support intervention to assess whether peer groups may actually increase perceived social support, family functioning, and lower CTG scores. This study would be able to look directly at the effectiveness of Judi's House's Pathfinders programs as an intervention in raising perceived social support scores, while lowering CTG scores. These future studies could in turn potentially lead to a better understanding of assessment and prevention of CTG by targeting family functioning and perceived social support if replicated, but would first need much more empirical support.

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Appendix: Measures

Figure 1: Inventory of Social Support

For the next few questions, please choose the answer that comes closest to describing the way you have been feeling during the past two weeks, including today. Some of the questions ask you about the grief you might have been feeling – those are the sad, painful feelings that people sometimes have after someone special dies.

1. People take the time to listen to how I feel.
_____ Not at all _____ Not quite _____ Fairly well _____ Well _____ Very well
2. I can express my feelings about my grief openly and honestly. _____ Not at all
_____ Not quite _____ Fairly well _____ Well _____ Very well
3. It helps me to talk with someone who is OK with how I grieve. _____ Not at all
_____ Not quite _____ Fairly well _____ Well _____ Very well
4. There is at least one person I can talk to about my grief. _____ Not at all
_____ Not quite _____ Fairly well _____ Well _____ Very well
5. I can get help for my grieving when I need it. _____ Not at all
_____ Not quite _____ Fairly well _____ Well _____ Very well

Figure 2: Family Support Questions

“Now let’s do something a little different. We care about your whole family at Judi’s House and would like to know how you think your family—the people you live with—has been getting along during the past month—about the last 4 weeks.

“I will read you some ways that families are with each other sometimes. Like: “At home we play games together.” Then I will ask you to think about the last four weeks and tell me whether that is something that you have NEVER done together, or NOT OFTEN, or SOMETIMES, or A LOT, or ALMOST ALWAYS. Remember to think about the last four weeks.”

(Place sheet with response options in front of child.)

[After reading each item, initially ask: “is that something you have done NEVER, NOT OFTEN, SOMETIMES, A LOT, OR ALMOST ALWAYS?” until it is clear that child can answer without prompts.]

People at home fight or get angry and irritable with each other.				
Never	Not often	Sometimes	A lot of the time	Almost Always
People at home seem to be sad or depressed.				
Never	Not often	Sometimes	A lot of the time	Almost Always
People at home support and help each other.				
Never	Not often	Sometimes	A lot of the time	Almost Always
At home, we talk openly about what we are thinking and feeling.				
Never	Not often	Sometimes	A lot of the time	Almost Always
At home, we each try to keep sad and angry thoughts and feelings to ourselves.				
Never	Not often	Sometimes	A lot of the time	Almost Always

Figure 3: Childhood Traumatic Grief Subscale of Extended Grief Inventory

NOTE: Questions included in CTG Measure include all of the following,

EXCEPT: #1, 3, 7, 10 & 17

Name _____

[*IMPORTANT: Ask these questions in reference to the loss identified by the child's caregiver as the most significant or recent*]

These are the very last questions. They are some more that have to do with thoughts and feelings you have been having. As you answer, this time think again about your reactions to losing _____ [*deceased identified by caregiver*]. I appreciate your hanging in here with me.

Directions: The following statements are about the thoughts and feelings you have been having. As you answer each question, think especially of your reactions to the loss of your special person who died. This time I will also ask you to circle the number that tells how often the thought or feeling has happened during the last month—the last four weeks.

[*Have child choose a marker; show TV example*]

RATING SCALE

0	1	2	3	4
Never	Rarely	Sometimes	Often	Almost Always

EXAMPLE:

Let's say I ask if you have liked to watch TV during the last month.

Remember that there are no wrong or right answers, so please answer each question as truthfully as you can.

[*Please substitute the name of or relationship to the person who died when reading each question to the child. Emphasize the italicized words when reading the questions.*]

[*If necessary, acknowledge any frustration or boredom, etc.; laugh about repetitiveness.*]

0	1	2	3	4
Never	Rarely	Sometimes	Often	Almost Always

1. I enjoy good memories of him/her.

0 1 2 3 4

2. I try really hard to stay away from things that *remind* me of him/her.

0 1 2 3 4

3. I think that I *see or hear* him/her, or that I can feel him/her nearby.

- 0 1 2 3 4
4. It's very *hard* to go on living without him/her.
0 1 2 3 4
5. I feel *shocked* or *stunned* when I think about his/her death.
0 1 2 3 4
6. I think about him/her *so much* that it's hard to think about things that I *want* to think about.
0 1 2 3 4
7. I have *pleasant* or *comforting* dreams about the person who died.
0 1 2 3 4
8. I *can't* bring myself to accept that he/she is really dead.
0 1 2 3 4
9. I feel more lonely since he/she died.
0 1 2 3 4
10. I feel that even though the person is gone, he/she is still an important part of my life.
0 1 2 3 4
11. I get upset thinking about his/her death.
0 1 2 3 4
12. My life doesn't seem very important since he/she died.
13. It's harder to *trust* other people since he/she died.
0 1 2 3 4
14. I feel that my life is empty *without* him/her.
0 1 2 3 4
15. I don't talk about the person who died because it is too painful to think about him/her.
0 1 2 3 4
16. I don't see myself having a good life without him/her.
0 1 2 3 4
17. I enjoy thinking about him/her.
0 1 2 3 4
18. I feel like a big part of me died with him/her.
0 1 2 3 4
19. Upsetting thoughts about how the person died *get in the way* of enjoying good memories of him/her.
0 1 2 3 4
20. I feel more cranky since he/she died.
0 1 2 3 4
21. I feel angry that he/she died and left me.
0 1 2 3 4
22. I try not to think about the person who died because it brings up *upsetting* memories and feelings.
0 1 2 3 4
23. I find myself wishing that he/she would come back so that we could be together again.
0 1 2 3 4
24. I have upsetting or scary dreams about him/her.

- 0 1 2 3 4
25. I feel *jealous* of other people who haven't lost a loved one.
0 1 2 3 4
26. I don't care as much about other people as I used to.
0 1 2 3 4
27. I keep wanting to *look* for the person who died even though *I know* he/she is not there.
0 1 2 3 4
28. I think about revenge or getting back at someone who *caused* his/her death.
0 1 2 3 4

Updated 10/21/2011

Table 1.

Descriptives Statistics of Variables

<u>Variable</u>	<u>N</u>	<u>Mean</u>	<u>St. Dev</u>	<u>St. Error</u>
CTG	1021	38.84	19.11	.76
ISSrev	680	18.26	4.05	.16
Family Functioning #1	1108	1.83	1.12	.04
Family Functioning #2	1100	1.96	1.11	.04
Family Functioning #3	1105	2.99	.99	.03
Family Functioning #4	1101	1.97	1.25	.04
Family Functioning #5	1090	1.97	1.26	.04