Evaluation of a therapeutic residential intervention for traumatically bereaved children and young people

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Abstract: Child bereavement interventions are rarely subjected to rigorous evaluation, so there is scant evidence in the literature to support their efficacy. This article reports the evaluation of a residential group programme developed by the UK charity Winston's Wish for children and young people and their parents/carers bereaved in traumatic circumstances (murder or manslaughter). A number of validated psychometric measures were taken pre- and post-intervention, and the results indicated positive outcomes for participants. Further research is needed to shed more light on which aspects of bereavement interventions are effective for which children and young people. However, the study does demonstrate that it is possible to conduct scientifically objective and rigorous evaluations of bereavement work with children and young people.

Keywords: Evaluation, children, young people, trauma, group programme

Childhood bereavement services offer various types of support and interventions to bereaved children, despite the fact that little is known about how effective such interventions are.

There are very few high quality studies that are able to demonstrate whether such interventions are effective or not. Indeed, there are very few poor quality studies exploring this particular subject. However, there is a slowly developing body of research that is gradually giving both providers and recipients of such services cause for optimism. Sandler and colleagues have now produced a burgeoning corpus of research using quantitative methods that is not only academically robust but also shows positive results. Their studies consistently indicate that their Child Bereavement Programme is effective at 11 months and six years after the intervention (Sandler *et al*, 2003).

However, two recent meta-analyses of the literature have produced interesting conclusions. Currier, Holland and Neimeyer (2007) concluded that child grief interventions did not generate outcomes that matched other psychotherapeutic interventions for children and young people. In contrast, Rosner, Kruse and Hagl (2010) more recently found that, overall, child grief interventions generated small to medium effect sizes (see box on statistical analysis below).

There is even less evidence to support grief interventions offered to traumatically bereaved children. Cohen and colleagues (2002) suggest that, for some such children, trauma-related symptoms interfere with the child's ability to mourn their loss, making it necessary to offer specifically trauma-focused interventions in addition to grief-focused interventions. The child may need to process the event of

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the death first, before it is possible to support her or him to mourn the loss of the person (Black & Trickey, 2009).

That said, there are a small number of published studies using quantitative methods that demonstrate that such interventions may offer hope to traumatically bereaved children (eg. Cohen, Mannarino & Knudsen, 2004; Cohen, Mannarino & Staron, 2006; Layne *et al*, 2001; Saltzman *et al*, 2001).

This leaves those offering such services in a dilemma. Should they stop providing services until there is an overwhelming weight of evidence demonstrating their effectiveness? Or should they carry on offering a service based on the relatively weak evidence, even if it may be proven ultimately to be less effective than they hoped?

Given that few services have the resources or inclination to conduct such research, at the very least they should ensure that they are taking reasonable steps to evaluate their services. Routine evaluations are likely to become more important as the competition for limited financial resources becomes increasingly fierce. However, it may also be argued that it is unethical to continue to provide a service for which we have little supporting evidence.

This article describes how one UK childhood bereavement service evaluated one of its interventions. The evaluation was not a randomised controlled trial, but it was an attempt to systematically evaluate whether there was any change in the distress and the functioning of the bereaved children and young people following the intervention.

The intervention

Winston's Wish – The Charity for Bereaved Children was established in 1992 and has supported over 50,000 bereaved children and young people following the death of a family member. In 2005 Winston's Wish piloted a weekend residential group offering a variety of therapeutic opportunities to children and young people bereaved through murder or manslaughter, and their parents or carers. The programme for the weekend (and subsequent weekends for murder-bereaved families that Winston's Wish has hosted) was based on existing residential group programmes offered by Winston's Wish for families bereaved through accident or illness and for families bereaved through suicide (see Stokes, 2004; Alilovic, 2004).

The aims of the residential group for families bereaved through murder or manslaughter are to:

- decrease sense of isolation and increase self-esteem through meeting others who are similarly bereaved
- find ways to remember the person who died, not just how they died
- talk about the death and the specific circumstances of the murder in a safe and accepting environment
- create the opportunity for children and families to share their story with others who have had similar experiences
- create an opportunity to acknowledge and express feelings and thoughts and to specifically consider the trauma associated with a death through murder or manslaughter, and
- explore positive strategies for coping with distress, fears and difficulties and consider personal resources and ways of facing the future with greater confidence and hope.

Table 1 (see right) lists the aims of the individual sessions offered to participants.

All children and families receive substantial family and individual support and preparation prior to – and after – attending a residential group. The interventions are delivered in the context of a broader range of services and an open, community-based support programme delivered by qualified practitioners in the Winston's Wish family services team. This model is outlined in a case study by Nugus and Stokes (2007). Details of the therapeutic techniques and approaches used on the weekends can be found elsewhere (see Stokes, 2004, 2009; Nugus, 2009; McIntyre & Hogwood, 2006; Stubbs, Nugus & Gardner, 2008; Nugus, in press).

Is it unethical to continue to provide a service for which we have little supporting evidence?

From the outset it was considered important to evaluate the intervention to ensure that it did indeed reduce distress and increase functioning. Rolls (this issue) highlights the advantages and disadvantages of using someone from within the service to carry out the evaluation: they understand the service and are intimately acquainted with how it works but they may have overly invested in the answers and therefore may not ask more searching questions. Winston's Wish attempted to get the best of both worlds by approaching the first author to lead the evaluation as someone who was independent but also familiar with the service.

Participants

The participants were all the children and families who attended one of two weekend residential groups (weekends 1 and 2) for children bereaved by murder or manslaughter: 39 children in 24 families. The children were aged from five to 17 years, with a mean age of 11.41 years.

Table 1: Weekend for families bereaved through murder/manslaughter

Individual session aims	
Challenges	■ Getting to know each other ■ Having fun ■ Permission to enjoy themselves ■ Building trust
Telling the story	■ To gain confidence in telling story ■ Knowing that it's ok to talk about murder ■ To gain control over story and related thoughts, through being able to 'play' or 'eject' story (including intrusive images/sensory stimuli)
Relaxation activity	■ Experiencing what it's like to be in a relaxed state and learning how to do this themselves ■ Being aware of how grief and difficult thoughts/feelings can be felt in the body and learning how to recognise and control this
Police session	■ The opportunity to ask questions relating to murder/investigations/trials etc that may feel confusing ■ Anonymity of question asking – enabling young people to ask questions they may believe others would think a 'silly question' ■ Having a positive experience of police officers, hearing their perspective and seeing them as humans (who do sometimes make mistakes)
Difficult feelings	■ To voice/externalise difficult feelings (eg. guilt, shame, anger, fear, confusion, sadness) ■ To normalise these feelings and acknowledge it's ok to have them – ie. it's not about 'getting rid' of them ■ To find ways of being in control of difficult feelings, rather than the other way round
Memory jars	■ Exploring range of memories – like memory stones (difficult, everyday, special) ■ Sharing memories and experiences with others to decrease isolation ■ Finding ways to express range of memories ■ Knowing that it is ok to have range of memories together (not feeling guilty about having difficult memories) and important to acknowledge and express them ■ Being in control of difficult/painful memories and experiences
Coping session	■ To acknowledge and validate what young people are already doing/have done in the past to get through difficult days and manage difficult experiences and feelings ■ To give the opportunity for young people to express less safe/harmful ways of coping and acknowledging these without judgment but as a way to open up exploration of safe/positive ways of coping ■ To think about which coping strategies work best for which emotions and situations
Goodbyes	■ To recognise the importance of the group and other young people and to share an ending that befits that importance ■ Experience a positive goodbye and know that these are possible (compared with the difficult goodbyes they will have experienced through bereavement) ■ Think about and acknowledge own and others' achievements ■ To maintain supportive connections as appropriate

The measures

A number of meetings were held between the first author and those directly involved in the provision of the service, to discuss what benefits they would expect to see if the interventions were effective. He then made a number of suggestions about appropriate measures. It was considered important by all concerned that the package of measures was psychometrically robust (ie. valid and reliable), as well as acceptable to the families and the staff who would be asking the families to complete the measures. A package of measures was selected for weekend 1. However, following discussion between the first author and those providing the service, some changes were made at weekend 2.

Measures used only at weekend 1

Trauma Symptom Checklist for Children – Form A (TSSC-A) (Elliott & Briere, 1994)

This is a 44-item self-report questionnaire suitable for 8–16 year olds. The young person simply circles the appropriate number to indicate whether and how often they are experiencing each of the 44 problems (eg. bad dreams, difficulties concentrating) – 'never', 'sometimes', 'lots of times' or 'almost all of the time'. The answers from different items can be combined to generate scores for a number of subscales: anxiety, depression, anger, post-traumatic stress and dissociation. These subscales scores are less accurate at predicting children who would meet diagnostic criteria for a mental health problem. However, for the purpose of this evaluation and for other services that do not aim to diagnose or 'treat' their clients, these subscales scores do correlate well with other established measures of such constructs, and therefore provide a reasonable assessment of a broad range of aspects of psychological distress.

Coopersmith Self-Esteem Inventory – School Short Form (SEI-SSF) (Coopersmith, 1981)

This is a brief, 25-item self-report questionnaire for children aged eight years old and over. It consists of 25 positive or negative personal statements (eg. 'I'm a lot of fun to be with' or 'Most people are better liked than I am'), which are rated as 'like me' or 'not like me' by the respondent. Self-esteem is then measured by the total number of positive statements rated as 'like me' and negative statements rated as 'not like me'.

Measures used only at weekend 2

Although improvement in self-esteem was considered to be an important outcome of the intervention, it was felt that a simple questionnaire might not be a good enough way to measure this complex concept. The SEI-SSF was therefore not included in the weekend 2 assessments, in order to reduce the burden on the participants.

The TSCC-A is quite a long questionnaire for the children and young people to complete, and it was considered that it might not have provided a sufficiently focused measurement. This was therefore replaced with a more specific measure of children and young people's mood, the Short Mood and Feelings Questionnaire.

Short Mood and Feelings Questionnaire for Children (SMFQ-c) (Burleson Daviss *et al*, 2006)

This is a 13-item self-report questionnaire designed for children aged eight years and over, which measures symptoms of depression. The respondent answers either 'true', 'sometimes', or 'not true' to each item. Although there are cut-off scores that indicate a likely diagnosis of depression, in this study the participant's score was used simply to measure their level of sadness or low mood, not to reach a diagnosis.

Measures used at both weekends

Strength and Difficulties Questionnaire (SDQ) (Goodman, 1997)

The SDQ is a set of brief screening questionnaires, each of 25 items. For children aged 3–16, there are versions that can be completed by parents/carers (SDQ-P) or teachers (SDQ-T). For young people aged 11–16, there is a self-report version (SDQ-S). The SDQ provides balanced coverage of children and young people's behaviours, emotions and relationships. The respondent indicates whether each of the 25 statements is 'not true', 'somewhat true' or 'certainly true'. The answers generate a number of subscales: hyperactivity, emotional problems, conduct problems, peer problems and pro-social behaviour. The first four of these can be added up to generate a 'total difficulties' score. Although originally designed for use with large, non-clinical populations, the SDQ is now used routinely as an outcome measure in bereavement and clinical settings, including some childhood bereavement services, and by child and adolescent mental health services (CAMHS) within the CAMHS Outcome Research Consortium (www.corc.uk.net).

Method

The purpose of the evaluation was explained to families at the standard initial assessment. They were then asked verbally and in writing if they would be prepared to be a part of the pre- and post-group evaluation. They were reassured about confidentiality and that any future support they received from Winston's Wish would not be affected by their decision to take part, or not. If they agreed, they were asked to sign consent forms.

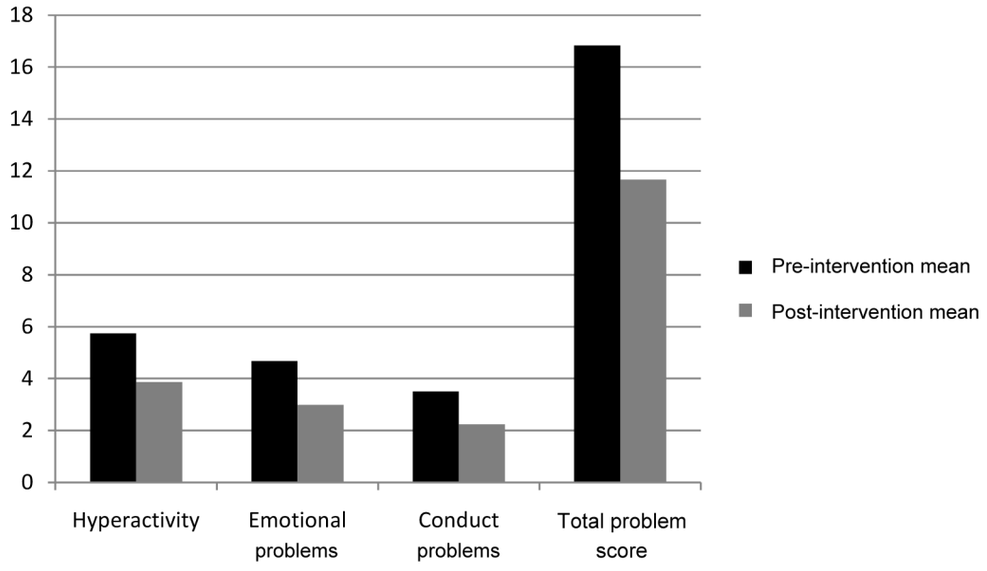
The package of questionnaires was completed by the families at the initial assessment; the post-intervention questionnaires were sent to them approximately six weeks after the residential weekend.

Winston's Wish also devised simple qualitative questionnaires for completion at this initial assessment stage. The practitioners found that this procedure could be used for therapeutic benefit, not simply to record information. For example, completion of the questionnaires could be used to validate and value the uniqueness of each family member's individual experience and ensure that their voices were heard, both by other family members and by the practitioners. Clarifying the individual and collective hopes and expectations of a family about the support they are offered can help to ensure respectful, individualised and responsive support and service provision. Similar qualitative questionnaires were completed immediately prior to and after the residential weekends.

Table 2: Pre- and post-intervention SDQ-P scores, with associated paired samples t-test results and effect sizes

Subscale	Pre-intervention mean (SD)	Post-intervention mean (SD)	*p*	Effect size (*r*)
Hyperactivity	5.73(2.55)	3.86 (1.98)	<0.001	0.38
Emotional problems	4.67 (2.13)	2.98 (2.47)	0.001	0.34
Conduct problems	3.50 (2.74)	2.23 (2.45)	0.006	0.24
Peer problems	2.93 (2.19)	2.59 (2.36)	0.137	0.07
Total problem score	16.83 (7.21)	11.66 (6.50)	<0.001	0.35
Pro-social behaviour	7.14 (2.08)	7.64 (1.92)	0.071	0.12
See statistical analysis note (on following page) for an explanation of how to understand this table				

Figure 1: Bar graph showing pre- and post-intervention SDQ-P scores



Results

Given that the SDQ was the only measure that was appropriate across the full age range and used for both weekends, just the results for that measure are reported here. Results for the other measures that were used on smaller numbers will be reported elsewhere in due course.

Complete data were available for 22 of the 39 young people (56%). Table 2 reports the findings, which are also illustrated in Figure 1.

Without comparing these results with those of a group of similar young people who did not attend the group, it is difficult to know if any of the improvements found are simply due to the passage of time rather than specifically due to the interventions. Likewise, without comparing these results with those from a group of similar young people who participated in other interventions, it is not possible to determine which components of the support are effective.

However, it is possible to draw some conclusions with a reasonable degree of confidence. The first conclusion is that it is possible to systematically evaluate childhood bereavement interventions using psychometrically robust measures and that these can meaningfully identify changes in psychological distress and functioning. That there were more completed sets of data for the second weekend than the first weekend may have been due to the reduction in the number and length of questionnaires.

The second conclusion is that, as reported by their parents or carers after the interventions, the young people who attended these particular residential groups for families bereaved by murder and manslaughter demonstrated measurable improvements in terms of their behaviour and their emotions. Specifically, they were less hyperactive, less emotionally distressed, and had lower levels of problems with their behaviour following participation in the weekend, and these changes were unlikely to be just a chance fluctuation in scores (demonstrated by the value of *p* in Table 2).

A note on statistical analysis

In this article, we have reported just four statistics for each of the six different subscales: the mean score (and standard deviation) before the intervention, the mean score (and standard deviation) after the intervention, the *p*-value, and the effect size.

The mean scores before and after the intervention are simply the average scores of the participants before and after the intervention and the standard deviation is a measure of the spread of the individual scores. You can see that, on average, the participants' scores for the five problem subscales are lower after the intervention than before. Also, the average 'pro-social behaviour' score (ie. the measure of the person's ability to develop appropriate social relationships with peers) is higher after the intervention than it was before. These results are obviously what we would have hoped for – lower levels of problems, and higher levels of pro-social behaviour.

However, it is possible that the observed changes in scores could simply be random fluctuation and that the intervention made no difference. The *p*-value tells us the probability that this might happen. Usually a *p*-value of 0.05 or lower is taken to indicate 'statistical significance' – in other words, there would be a less than one in 20 chance of these observed changes occurring if the intervention had made no difference. You can see that, in this article, four of the *p*-values are well below 0.05. The exceptions are the increase in pro-social behaviour, which has a *p*-value of 0.071 (meaning that there is a 7.1 in 100 chance that this result would be achieved if the intervention did not actually make any difference) and the decrease in peer problems, which has a *p*-value of 0.137 (meaning that there is a 13.7 in 100 chance that this result would be achieved if the intervention did not actually make any difference). These are not considered high enough odds so, although on average the young people were reported to be more pro-social and to have fewer peer problems after the intervention than before, statistically speaking we would not consider these scores to be significant. But we do have four results that have decreased and are statistically significant.

It is also important to know how big the change was. One way of measuring the size of a change is to report effect sizes. In this article we have reported the effect sizes as *r*. This statistic will always be between -1 and +1. A positive effect (ie. between 0 and 1) usually indicates a change in the desired direction. 0 means no effect at all, 0.1 is considered to be a small effect size, 0.3 is considered to be a medium effect size, and 0.5 is considered to be a large effect size. But *r* is not measured on a linear scale so, for example, 0.4 is not twice as big as 0.2.

Discussion

There is a need to balance and complement qualitative research (see, for example, Rolls & Payne, 2007; Rolls, 2008; Brewer, 2009; Simone, 2008; Wood, in press; Brewer & Sparkes, in press), the growing body of practice-based evidence (Dyregrov, 2008; Dyregrov & Dyregrov, 2008; Stokes, 2004; Nugus & Stokes, 2007) and resilience literature (eg. Bonanno, 2004; Calhoun *et al*, 2010; Stokes, 2009) with quantitative methods. Regardless of how childhood bereavement services and the outcomes of interventions are measured and evaluated, it is important to recognise the fundamental distinction between 'satisfaction with', and 'effectiveness of' an intervention (Schut & Stroebe 2010, p5) in determining efficacy.

Even though the results reported here suggest that the children who received these interventions were 'doing better' after the interventions than they were before, it is difficult to be certain what aspects of the weekend groups produced the positive outcomes. The groups were meticulously designed and skilfully facilitated. There were countless practical and intangible therapeutic variables and micro-processes at work, which makes it difficult to draw conclusions about what aspects contributed to the outcomes. Zech, Ryckebosch-Dayez and Delespaux (2010, p105) point out: 'Bereaved people need to get individualised interventions for their own specific problems, to the right extent, and at the right time.' Unpicking what 'works' and what is most or least helpful or effective would require a much more sophisticated and complicated research programme, while bearing in mind that 'scientific progress is not neat or linear' (Larson & Hoyt, 2009). This is an area where qualitative research (eg. Rolls & Payne, 2007; Brewer, 2009; Brewer & Sparkes, in press; Simone, 2008; Wood, in press; Eddershaw, 2006) can offer some insights.

We assume there is a spectrum of efficacy for interventions such as these residential groupwork weekends, and Rolls (2004) highlights the diversity in service provision across UK childhood bereavement organisations. Winston's Wish's residential groups for traumatically bereaved young people (and their families) are based on sound models (outlined in Stokes, 2004). To consider fully what it might be about these interventions and how they are delivered and facilitated that achieved these outcomes is beyond the scope of this article. However, we can highlight what we believe are some of the important attributes of these interventions that may be linked to the positive outcomes for participants. These include:

- pre-planned and well prepared – all participating young people and their families receive preparation and support before attending the residential group

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- family-focused – the interventions support the child within their wider family context, enhancing family communication and empowering caregivers
- clinically sound – the interventions are based on robust clinical evidence and facilitated by experienced, qualified practitioners
- accessible and non-stigmatising – the interventions use a collaborative, community-based, client-led, creative, child-friendly, non-pathologising model of grief support
- specialised – the groups are offered only to people bereaved through murder or manslaughter in order to maximise peer support and understanding
- safe – the groups provide a containing environment for both trauma and memory work and interventions focused on the future
- therapeutic – the environment and interventions are designed to enable emotional expression and sharing of stories; processing of intrusive images; exploration of coping strategies; building of resources, hope, new narratives and a sense of control, and increased opportunities to consider the future, feel normal and have fun.

Conclusion

The evaluation of a therapeutic residential groupwork programme for traumatically bereaved young people described in this paper represents an attempt to redress the shortfall in reliable, outcome-focused research into this area. The findings from this evaluation demonstrate the efficacy of these interventions, although they do not tell us why or how these positive outcomes were achieved.

More research is required to shed more light on which childhood bereavement interventions are demonstrably effective, and what aspects of such interventions are effective for which children and young people. All childhood bereavement services and practitioners need to develop, deliver and refine their specialist services based on feedback from their users, emerging evidence from continued evaluations of their interventions and the published research and practice in this and related fields. Services that are unable to carry out such research should at the very least attempt to routinely and systematically evaluate their interventions. The UK Childhood Bereavement Network (www.childhoodbereavementnetwork.org.uk) is currently undertaking a project to develop a tool that can be used routinely by childhood bereavement services for this purpose (see Rolls & Penny, this issue).

Winston's Wish continues to contribute to the growing body of knowledge, evidence and practice development in the support of traumatically bereaved children and young people (see, for example, the publication Hope Beyond the Headlines (Stubbs, Nugus & Gardner, 2008)). ■

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