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Bereavement support groups for elementary school-aged children: The impact on grief related problematic behaviors

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BEREAVEMENT SUPPORT GROUPS FOR ELEMENTARY SCHOOL-AGED CHILDREN: THE IMPACT ON GRIEF RELATED PROBLEMATIC BEHAVIORS

A Project

Presented to the

Faculty of

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In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

This study investigated the impact of bereavement support group participation on the problematic behavior of elementary school age children. It hypothesized that bereavement group support and counseling would provide increased ability to understand and cope with the emotions of grief thereby reducing the trauma and the resultant acting out behavior. A preliminary interview plus completion of pre-test and post-test by both parents and children was used to collect the data. The researchers used the Social Skills Rating Scale developed by Gresham and Elliott. Also the Home and School Behaviors Questionnaire developed by the researchers was used.

Analysis was performed utilizing both EPI6 and SPSS computerized analysis program. The researchers found that the bereavement support group was effective in impacting the emotional and behavioral functioning of the participants. The support group appears to have had a positive influence in reducing the problematic behaviors of the children and increasing the desired positive behaviors and social skills. Use of bereavement groups to increase the positive emotional development of a child who experienced the death of a significant other has numerous practice, research and policy implications.

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Introduction

Families facing death and loss frequently are unaware of the impact of grief related issues on children. Masterman and Reams (1988) report that one in 27 children will lose a parent by death before the age of eighteen. Linda Goldman (1994) reported that 20% of today's children will have experienced the death of a parent by the end of high school. Trauma of this magnitude poses the potential for psychologically harmful long lasting effects. Yet, children in our society are often ignored, overprotected, or misinformed about the death situation (Davis, 1989).

Due to shock of the surviving parent and family system the grief of many children is overlooked until problematic behaviors occur. Often it is only when the children's behaviors become disruptive that the family realizes the reaction of the children has been overlooked. This behavior may surface initially in the school setting and is reported on a regular basis by elementary school teachers. In a study by Greenberg (1975) presenting symptoms included academic deterioration, depression, anxiety, withdrawal, and somatic complaints. In Wolfeld's work (1991) he adds information regarding the expression of the pain of grief through acting out behavior including becoming unusually loud and noisy, temper outbursts, fighting, defying authority, running away from home and general rebellion against everything.

While bereavement groups are diverse and available in most communities they seldom specifically target the elementary school age population. Current groups for children, though few in number, are often geared toward strengthening emotional control while allowing for the grieving process to be identified, defined, and safely expressed.

Many children will blame themselves for the death with unresolved guilt. Others express confusion and uncontrolled anger at their perceived abandonment.

Arguments in the psychoanalytic literature continue to debate the ability of children to mourn. Buirski and Buirski (1994) argue that children are not structurally equipped to mourn and are only affected by the emotions of their surroundings. The responses of adults in their lives is seen as an important contributing factor by other researchers. An absence of grief, however, is uncommon with sadness, crying and other affective and behavioral symptoms being more the norm (Wolfelt, 1991, Via & Grizenko, 1989). Children are seldom aware that they are not alone in their grief and that other children may be experiencing similar problems. Verbal expressions of loss cease being accepted by their peers, long before the grieving process is completed. Peers soon become intolerant of a seemingly extended grief process and most children are then unable to locate appropriate resources to vent and heal.

For these reasons participation in a bereavement support group is advisable. Such participation would permit the child expression of emotive content, considered taboo in other settings, so the child could grieve without fear of disapproval or rejection. The focus of group work promotes the reduction of problematic behaviors through the development of the child's awareness and expression of feelings and their ability to make knowledgeable choices. The group process provides a setting for the child to become aware of the appropriateness of these feelings and to learn healthy methods for dealing with loss and grief issues.

Segal (1984) states that group methods can be used to break down communication barriers that prolong the grieving process and delay problem resolution. Blank (1975) further states that the longer treatment is deferred the less successful it becomes. Group treatment programs are primarily time-limited, interventive and educational. These are designed to reduce current and future problematic behaviors through the use of catharsis. The use of support groups is limited primarily by the individual therapist's philosophy towards the psychosocial needs of their client. In some cases the mission of support group programs is to address the cultural and spiritual needs through physical, emotional, and social interactions within a safe and nurturing environment.

Research on bereavement support groups for school age children evaluates their effectiveness in reducing negative reactions related to loss and grief (Greenberg, 1975, Davis,1989, Wolfelt, 1994). Such studies may reveal that children are and need to be curious and to express their feelings, whether they be feelings of guilt, hurt, anger, or pain. Often children need outside permission to do this.

Unresolved grief issues can be expressed in numerous ways. Children mourn through behaviors rather than through communication (Goldman, 1994). Denial of the event, guilt and self blame for the event, withdrawal or isolation, separation anxiety, and anger are the most frequently reported behaviors (Goldman, 1994). Also reported are breakdowns in communication including selective mutism, helplessness, feelings of being overwhelmed, confusion, depression, aggression and other acting out or acting in behaviors (Goldman, 1994). Apparent lack of feelings, fear, regression, physiological

changes, disorganization and panic as expressions of grief are still other reported behaviors (Wolfelt, 1991).

Traumatic experience may leave lasting marks on a child. Adjustment and functioning problems can continue into later life when the child is left without support during the grieving process (Van der Kolk, 1987). Bereavement groups provide an avenue for this support. With the opening of communications the child can move forward to confront painful feelings. Through mutual sharing the group develops as a support system and as an educational forum for learning appropriate, acceptable behaviors. Currently there is insufficient evidence to determine the impact of this modality on the reduction of problematic behaviors in children with loss and grief issues. There is a need for more studies to examine the effects of children's bereavement support groups on children's behavior following the death of a significant other.

Social workers in direct practice face many issues in working with the bereaved. They must be able to discuss the issues surrounding death and to intervene in a sensitive manner. There must be an awareness of the meaning of loss to the client and social workers must confront their own issues related to loss. Social workers require knowledge of age specific concepts and perceptions of death. Personal attitudes and experiences with death may influence the social workers ability to lead and the ability to use openness and a non-judgmental approach in the conduct of bereavement groups.

All human beings experience loss and grief differently. These differences are based on life experience, coping skills, past experiences and the relationship to the deceased (Goldman, 1994). McIntyre (1990) in her review of case reports states "child

bereavement was an experience of uniqueness and sameness." In working with grieving children group leaders must be aware that children's experiences and reaction to grief are as varied and unique as any adult (Davis,1989).

A group counselor working in this field must have a thorough understanding of children's perceptions of death at each developmental stage. A child under five years of age has an emotional response to the death of someone they have bonded with but may believe death to be a reversible state. Children may believe the person is "sleeping" and will awaken shortly. Children between the ages of fine and nine years old personify death as evidenced by their perception of their own negative behavior having a direct bearing on the death. Usually those over age nine realize death is a definitive state, inevitable, irreversible, and universal (Bertman, 1984). Although these views are not widely accepted they are a helpful tool for those working with clients dealing with bereavement issues. Awareness of these various developmental stages, however, are vital for group work success. "There are two choices when a loved one dies - to live in grief, remorse, and guilt covered thinly by a facade, or to face those feelings, work them through, and emerge with an acceptance of death and a commitment to living (Mize, 1975)."

Problem Focus

Children who experience unresolved loss and grief face many problems in their activities of daily living. Often reported are lack of impulse control and anger management skills, causing disruption in both home and educational settings. School officials report reduced academic achievement including inability to concentrate and complete assigned tasks, increased challenge of authority figures, and increased

absenteeism. Behaviors also include increased severity in fighting with peers requiring intervention by adults with heightened emotional response to otherwise normal activities.

Other emotional aspects of grief include denial of the death, repression of the death, and withdrawal from social situations including family and peers. These coping mechanisms may be carried to the extreme causing difficulty in daily functioning. The child also may cope through use of projection involving a distortion of reality regarding the death, or may regress to an earlier developmental stage including separation anxiety. Adults often overprotect children from the realities of death or are unaware of the needs for the child to receive assistance and/ or permission to express feelings regarding the loss and grief.

The authors for this study chose a positivist' paradigm as the underpinning to their research. Paradigms serve as lenses not blinders (Phillips, 1989). It is the world view the researcher uses and not all researchers agree on the "proper" format. The positivist paradigm assumes a realist ontology stating there exists a reality driven by immutable natural laws which can be quantified and is measurable to test the cause and effect between the phenomenon and certain variables. This objective paradigm assumes the elimination of bias and is traditionally accepted and respected. Questions and hypothesis are stated in advance, established as facts, tested, and statistically analyzed. Deductive logic will provide for a set belief and a propositional frame will determine the question by assuming that the hypothesis is correct. The derivation of this world view is based in part on our personal previous experiences and what we accept as knowledge (Tyson, 1992).

Using the realist ontology this study was committed to an objectivist epistemology as though looking through a one way mirror. According to Theodorson and Theodorson (1969) ontology is defined as dealing with the nature of reality, and epistemology as the study and theory of knowledge and the nature of the relationship between the researcher and that knowledge. Methodologically the use of quantitative data surveyed documented behavior problems of the sample population prior to and upon the completion of the bereavement support group. The data was primarily descriptive in nature. For these reasons, the authors felt the traditional positivist view emphasizing deductive, value-free inquiry, and objective observation was optimal choice. The researchers began with rational thinking that led to goal specific tasks which dictated the methodology. However, it required the researchers voice remain that of the disinterested scientist (Eisner, 1990). The primary focus was on the dependent variable which is the topic of interest and the resultant changes to it. Also of importance was the independent variable which is item which will influence the change or solution to the problem or is the cause of the problem.

For this study the role of the direct practitioner was evaluated for relevance as a benefit to children facing loss and grief issues. How the interventions and services impacted the client's functioning was a major area for review, as the outcome had a direct bearing on the group format selected for use. Children require the opportunity to recognize and work through the grief process in a safe setting. Bereavement groups for elementary age children are seldom offered. Research reviewed showed only one report on concurrent groups for children and surviving parents (Zambelli, Clark, & Hodgson,

1994) with a greater number of reports of successful intervention groups for children only Davis, 1989, Goldman, 1994, Greenberg, 1975, Healy-Romanello, 1993).

Due to the guilt often associated with the death and the child's view of their role in the causality it is important that negative feelings be identified and normalized. Previous studies show not only is it important to identify the feelings and symptoms but to assist in the alleviation of these symptoms. This population also has a need to develop self acceptance and to develop a healing capacity.

The children need to deal directly with any specific obstacles interfering with their effort to function such as anger management and impulse control. The use of the bereavement group setting allows for limit setting, support, protection, and linking in developing the ability to resolve conflicts. This setting also provides a safe haven where the social worker can impart information, develop social skills, instill hope of return to normal functioning and provide an avenue for the cathartic experience.

Research Question

The question this study was concerned with was: "What is the effect of a bereavement support group on the emotional and behavioral aspects of grief in children?" The study proposed to examine if bereavement support group activities would produce positive results in both the behavioral and emotional areas of the children's daily function. The study also examined the use of a group setting as the modality for interaction.

Content Specific Terms

Bereavement - a state of psychological stress caused by loss such as death

(Kastenbaum, 1991).

Bereavement Groups - groups formed to assist in the process of expressing and dealing with grief (Goldman, 1994).

Grief - An emotional response to a real or perceived loss, an emotional suffering caused by death or bereavement. A process with a constellation of feelings that can be expressed in many ways. It is the internal meaning given to the external event (Wolfelt, 1983).

Grief work - the activities, behaviors, and rituals used in thinking through the loss, facing the reality, expressing the feelings and emotions and becoming reinvolved with the life process (Goldman, 1994).

Mourning - taking the internal emotions of grief and expressing these outside of ourselves. Traditional methods include funerals and memorial services. Creative methods include letter writing to the deceased and then disposing of the letter (Goldman, 1994).

Literature Review

Resolution of grief is a difficult process for most people. We live in a society that tends to avoid the topic of death, although, current census records show an increase in death rates (U.S. Bureau of Census, 1993). Our children, for the most part, are often ignored or over protected in the area of grief and bereavement (Costa, Holliday, 1992). We avoid evidences of aging as well as dying yet allow our children to learn about this sensitive subject through violent experiences on TV. Goldman (1994) states that it is

estimated that by age fourteen a child will see 18,000 deaths on TV, the majority usually violent murders.

Identification of children's needs to resolve grief often surface in negative behaviors in the school setting. As negative behaviors manifest the family may become aware for the first time that children also need assistance to complete the grieving process. Presenting symptoms may include academic deterioration and well as depression, anxiety, withdrawal, somatic complaints, and fantasies about death (Greenberg, 1975). Studies show school children who experience a loss display anger and guilt with frequent notations of nightmares and dreams (Terr, 1987). Van der Kolk (1987) proposes that without the support during the grieving process the traumatic experience may leave lasting marks on a child with adjustment and functioning problems continuing into later life.

Children are seldom given permission to feel grief and are often misinformed or uninformed about the death situation (Davis, 1989). Davis (1989), in his pastoral counseling of bereaved children, states that many of the same tasks apply to both adults and children. Modifications are based upon the cognitive, personal, social, and emotional development of the child. Children are and need to be curious and to express their feelings whether they be feelings of guilt, hurt, anger, or pain. One common mistake, however, is for adults to assume children think like adults (Giblin & Ryan, 1989).

While children's views and the methods in which they grieve is as diverse as that of adults they also have a different approach to grieving than adults (Giblin & Ryan, 1989). Children generally have a limited ability to verbalize their feelings. Many children fear being considered "different" or being pitied (Webb, 1993). During latency most children

attempt to gain control over their feelings and may over react or be more resistant to discussion of grief related, painful feelings. Many children in this age group also consider display of grief behaviors such as crying to be babyish adding to there resistance to share their grief publicly (Furman, 1974). According to Webb's work (1993) grief of children differs from that of adults as follows:

1. Children's immature cognitive development interferes with understanding about the irreversibility, universality, and inevitability of death.
2. Children's limited capacity to tolerate emotional pain.
3. Children's limited ability to verbalize their feelings.
4. Children's sensitivity about "being different" from peers.

Arguments in the psychoanalytic literature continue to debate the ability of children to mourn. Several authors who write on the phenomenology of childhood bereavement feel that there is an absence of grief in children. This is based on the concept that children are unable to tolerate the intensity of mourning. Buirski and Buirski, (1994) argue that children are not structurally equipped to mourn and are only affected by the emotions of their surroundings. They state that situational factors can inhibit or preclude the unfolding of the mourning process. Vida and Grizenko (1989) disagreed and found the absence of grief to be uncommon, with features such as sadness, crying, becoming irritable, and other affective and behavioral symptoms the norm. Wolfenstein (1966) found children did not have an absence of grief but displayed a low tolerance for acute pain. This is in agreement with Rando's work (1988) which found children were likely to express grief intermittently rather than deal with the entire problem at one time.

In addition research shows a need to understand the emotional stability of the child prior to the loss and the importance of the relationship of the child and the deceased

parent, including the issue of same sex child/parent versus opposite sex child/parent (Heath, 1985) Hawener and Phillips (1975) propound the most important factor determining how well a child copes with parental loss is the quality of their interactions with other significant adults following the death.

While limited resources have been reported in the area of bereavement groups specializing in the younger population there is no limit on the methodologies presented. These include art therapy, play therapy, psychodrama, story telling, music therapy, sand trays, journals, role playing, and memory books with individuals and groups (Allan, 1978, Davis, 1989, Goldman, 1994, Healy-Romanello, 1993, Masterman,). In his article on serial drawing as a therapeutic approach Allan (1978) reports dramatic changes of a moderately disturbed youngster in only 10 sessions. Group advocates agree support is crucial during the grieving stage and previous research reports success with the use of various modalities for the remission of negative reactions to loss and grief (Davis, 1989, Fox, 1985, Greenberg, 1975, Lohnes & Kalter,1994).

The group modality allows for the expression of emotive content without fear of disapproval or rejection. Used by social workers, psychologists, recreation therapists, and school counselors this modality is limited primarily by the philosophy towards and emphasis on psychosocial needs of the client. The therapist's creative participation is recommended in individual or group setting as a means of assisting the child to cope with the trauma and stress of the death experience (Segal, 1984).

In work at the Dougy Center, Smith (1991) reports on the play activity of three to five year old children. She contends the children, in a supportive relationship with other

children and adults, will create the precise "play" experience required for healing themselves. Her research has also identified three tasks essential to process grief and integrate losses in the young child. These are understanding the person is no longer there, feeling the feelings, and reinvesting in life (Smith, 1991).

Group work can assist the children to express overwhelming feelings and is of value as a means to opening communication. Several researchers stress the need to break down communication barriers that prolong the grieving process and delay problem resolution whether in individual or group settings. Play, as the accepted language of children, is a medium which can often unlock communications and allow the child to work through deeply painful feelings (Webb, 1993).

Research indicates that while the families appear resistant to grief intervention for children the longer the delay in obtaining treatment the less likely the treatment will be successful (Blank, 1975). Zambelli, Clark, and Hodgson (1994) report success in parallel groups for children and the surviving parents promoting relationship for healing of both children and parents and education of the parents regarding the needs of the children in this sensitive area.

Advantages of groups include the commonality of shared experiences and the reduction of isolation. All participants have experienced a loss (Schwartz & Zalba, 1971) and many are in crisis. The school setting is often one where support groups can be beneficial and impact everyday activities. The group setting also allows for interaction of children at various stages of grief. The children in later stages will be able to provide assistance to more recently bereaved peers (Yalom, 1985). This provides a two way

benefit as the children in the earlier stages are able to see through example that it is possible to survive the pain of loss. The children in the later stages of bereavement are able to become a support system to peers increasing healing and additional growth in their own lives (Schiffer, 1984, Schwartz & Zalba, 1971, Hickey, 1993).

Davis (1989) in his discussion of the objectives of bereavement work as in the development of awareness, expression of energy and feelings, problem solving, spontaneity, creativity, and joy prefers active methods to cathect feelings. This allows constructive channeling of destructive energies. He concludes "art therapy (which is his preference) is an excellent resource for children struggling with a loss". Segal (1984) agrees and adds that the arts involve tactile, visual, aural, and kinesthetic senses. Most of these are related to the involuntary nervous system arousing and transmitting messages to the brain. This creates an unplanned response to the images and sounds encountered in this methodology. This allows the child to tap natural feelings in a spontaneous expression if the group atmosphere is non-critical, non-judgmental and accepting (Davis, 1989).

The researchers agree that all participants experience activities differently based on varying life experiences including coping skills, past experiences and the relationship to the deceased. Also important to successful intervention is the understanding of the cultural implications with care taken in defining the normality of responses to death (McGoldrick, 1991). McIntyre, (1990) in her review of case reports, states "Child bereavement was an experience of uniqueness and sameness". Through the use of grief groups emotional growth and competence in relating to the outside world were evidenced by improved changes in behavior.

Regardless of the primary modality researchers agree it is vital for the group facilitator working with bereaved children to have a solid understanding of children's perceptions of death based on the developmental level of the individual child (Webb, 1993). While the child under five may view death as a reversible state, the child between five and nine may personify death with guilt for their part in the death being a major issue to be addressed (Bertman, 1984, Bluestone, 1991). Bertman (1984) continues that most children over nine realize death is a definitive state, inevitable, irreversible and universal. These guidelines are only a portion of the many variables that affect children's views of death and loss. While disagreement continues as to the exact age breaks, most researchers agree there are three basic stages. These include death as a reversible state, the child's view that they are responsible for the death, and death as a definitive irreversible state. Lonetto's work (1980) however, reveals that although the majority of prepubertal children understand the finality of death they continue to relegate death to the domain of the aged. Additionally with distorted perceptions based on views portrayed in some films, an increase in death rates (U.S. Census, 1993), and a decline of philosophical and religious views death has become a mystery rather than a normal segment of life (Brennan, 1983).

With the differences in the developmental views on death it may be beneficial to work with similar age group children. Preschoolers and young children may respond more readily to play therapy, stories, and role plays (Giblin & Ryan, 1989). In groups for older children discussions may more appropriately include perceptions of death, reaction to last rites, denial of the death, current fears regarding stressors in the family, with peers, and in personal needs, and changes expected in the future (Masterman, Reams, 1988)

Decisions to allow the child to attend and participate in the funeral are strongly reacted to in our society. Despite popular opinion to the contrary research has shown that most children were emotionally controlled during the services and participation itself was not detrimental to the child's functioning (Weller, Weller, Fristad, & Cain, 1988, Rando, 1988/1991, Wolfelt, 1983, Kastenbaum, 1991). Wolfelt (1991) found that involvement of the child in family group decisions helped establish a sense of comfort and promote the understanding that life goes on despite the loss. He emphasized the importance of allowing for participation by the child but not forcing it and preparing the child for what they will experience (Fox, 1985). Children should be made aware that some people may express emotions differently than others and some may cry. This provides a setting for natural expression of good bye (Krementz, 1981,1991).

McGlauflin (1990) further discusses phases and common themes and symptoms unique to children including the circumstances of the death, and how adults in the child's life handle the grief. In her discussion of counseling strategies she includes the need to address the quality of the counselor's knowledge, the need for parental consultation and involvement, and the ability of the family to respond to the child's grief. Her research supports the need for significant adults in children's lives to be knowledgeable about grief issues and counseling techniques. This would enable involved adults to provide a base for both identification of symptoms and the development of a support base for children experiencing loss.

Another area to be addressed is the child's memories of the deceased and what is missed most about that person (Warmbrod, 1986). One area of caution noted by Salladay

and Royal (1981) is the use of explanations that lead to confusion of reality with young children. One example cited is "God reached down and took Daddy to heaven while he was sleeping" again showing unrealistic overprotection of children in our society.

Unresolved grief issues are expressed in numerous ways. The issues reported most often in the literature are denial of the event, guilt and self blame for the event, withdrawal or isolation, separation anxiety, and anger (Wolfelt, 1994, Webb, 1994, Goldman, 1994). Also noted were breakdown in communications including selective mutism, helplessness, feelings of being overwhelmed, confusion, depression, aggression, and other acting out or acting in behaviors. One primary objective, therefore, is the opening of communications allowing the child to move forward to confronting the painful feelings (Segal, 1984). Additional objectives required are the normalizing of children's reaction to death and development of functional coping strategies as children appear to struggle with death related stress beyond the normal time of loss (Lohnes, Kalter, 1994). Through mutual sharing the group develops as a support system and as an educational forum for learning appropriate, acceptable behaviors (Segal,1984, Hickey, 1993).

Based on the sensitivity required the group facilitator must be aware of their own personal attitudes regarding death and experiences with death and grief (Tait & Depta, 1993). Such attitudes will impact their ability to allow the children to openly discuss their loss, to be aware of the more subtle responses of or delayed responses of grief, and provide reassurance to children's unexpressed guilt (Hare, 1984). The group facilitator can assist by using less threatening loss issues such as the loss of a pet in understanding the death concept, using child appropriate language when providing information, and

creating an open, continuous opportunity for the expression of grief (Hare, 1984). In addition Hare (1984) advocates the education of parents regarding the children's needs to participate in the death rituals and the issues of unexpressed or delayed responses and guilt.

Maslow and Freud both suggested discussion can reduce anxieties about death and increase coping with this topic. Currently there is insufficient evidence to determine the impact of any one modality on the long term reduction of problematic behaviors in children with loss and grief issues. Additionally longitudinal studies need to be done. From the early studies by Nagy (1948) to the current studies on children's grief many issues remain to be addressed whether by art, dance, music, or discussion. If children are our future we must identify methodologies to assist in their development towards healthy, functioning adulthood.

Purpose and Design of the Study

The purpose of this study was to evaluate the impact of bereavement support groups on children who have lost a significant other. The study investigated two primary areas of concern: the reduction of problematic behavior and the increase in social skills. In professional experience with elementary school age children the researchers found many of the problematic behaviors and depression reported by teachers and administrators were exhibited after the child's loss of a significant other. In discussion with school staff and with family members it was discovered these children were not involved in any bereavement support program. Most families, teachers, and school administrators were not aware of the availability of bereavement groups for children despite the fact that many

of the adults had availed themselves of the service. The questions arising from this knowledge are:

1. "What is the impact of a bereavement support group on the emotional aspects of grief in children?"
2. "What is the impact of a bereavement support group on the behavioral aspects of grief in children?"

The researchers hypothesized:

1. Children who participate in bereavement support groups will show a greater increase in social skills than non-participants
2. Children who participate in bereavement support groups will show a greater increase in positive behavioral functioning than non-participants.
3. Children who participate in bereavement support groups will show a greater decrease in negative behavioral functioning than non-participants.

Strengths of the study include the all inclusive client population, the access to hospice records and the brevity of the intervention program. An additional strength was the fact that the families involved initiated the contact. One possible weakness identified was the lack of knowledge of the mortality rate of participants. This was addressed by the implementation of two groups concurrently in an attempt to provide an adequate starting sample to provide for a sufficient data base.

Threats to Internal Validity

Threats to internal validity were addressed. History was reviewed in the

initial interview with caretaker and child. Change of caretaker, relationship of the deceased, and additional variables that could affect the behaviors of the children were assessed in the interviews and survey instruments and questionnaires and analyzed for probability utilizing statistical analysis. It is noted, however, that history is an unknown. It is impossible to identify in advance any specific events that may occur during a child's participation in the group. Protection against this threat was attempted by regular contact with the primary caregiver and through group discussions with the children. Maturation was assessed by the age variable and the length of time since the loss. In addition the brevity of the intervention period reduced a possible bias in this area and also reduced the threat of mortality. The current research shows, however, that the passage of time increases the problems and decreases the likelihood of successful treatment (Blank, 1975).

Testing instruments remained unchanged for pre-tests and post-tests for both the experimental and control groups. The pre and post-tests were given eight weeks apart which should have reduced the possibility of repeat test bias influencing the results. Since the test documents and questionnaires developed by the researchers may have inadvertently contained biased or confusing terminology, feedback was solicited from knowledgeable professionals prior to use, to identify required corrections in this area.

All data was gathered by the researchers which eliminated problems with interpretation of test data. Selection bias was reduced as all referrals were offered the intervention. Those clients applying for but declining the service were used as a control group when agreeable to the family. The results remained confidential and available only

to the researchers and should not have, therefore, created a threat to the anonymity of the participants in the study.

Several strengths of the study were identified. The researchers had control of group content for their program which allowed for flexibility. Another area identified was the gathering of current data regarding behaviors of the children from both parents and the children themselves. This provided different viewpoints and reduced the problem of memory of events. Another identified strength was the reputation of the hospice facility used for the study. Their reputation in the community for services in this area provided a base of clients voluntarily seeking the service thus providing a cooperative study sample. The facility also had adequate meeting space to allow for implementation of both indoor and outdoor play activities, art project, and discussion groups. Weaknesses would include the time frame for the study and limited sample size. A full year for additional groups and follow up would be desirable. A full year follow up might provide information regarding immediate benefit response versus reduction of benefits over time

Orientation

Using a positivist orientation this study was evaluative and explanatory. The study evaluated the impact of the bereavement support groups on the behavioral and emotional changes of the participants. Parental permission and permission of the child was obtained prior to the child's participation in the program.

The positivist paradigm, using a realist ontology, states that the study must be observable, measurable, and free of biases, prejudices, and values. This paradigm accepts only one dependable way of gaining knowledge which is through the scientific method

(Eisner,1990). According to Lincoln (1990) it must be "possible for more than one observer to agree on its existence and characteristics". Solomon (1989), addressing this issue, believes that knowledge is independent of personal experiences which would allow for more than one observer to agree on the findings. This belief also gives support to the use of quantitative analysis as a means of obtaining truth.

Study Sample

The study population consisted of all elementary school age children referred to the Bereavement Support Group offered by Hospice of East San Gabriel Valley. This program was offered through the parent corporation known as Citrus Valley Health Partners and was held at one of the company's hospital sites. Children ranged from six to twelve years of age with emotional and/or behavioral issues connected to the loss and grief of a significant other. This facility was selected because of its history for providing bereavement services for children as well as for adults. The researchers concluded this setting would provide a sufficient study sample.

A non-probability purposive sample was drawn from the referrals by using hospice records, maintained at the main office, located on the grounds of the clinic and hospital site. This provided an all inclusive population framework as all children participating in the program for the entire eight weeks were studied. Those refusing the program were used as a control group. It is not possible to guarantee that the control group and experimental group will be identical, however, by using all applicants the primary demographic data was significantly similar.

From a previous review of facility records of children's participation in bereavement groups it was anticipated that there would be six to ten children per group with two concurrent groups weekly. This would provide a base of twelve to twenty children. The maximum limit set by the facility was twelve children per group with all groups conducted for an eight week period.

Data Collection and Instruments

Data was collected through a preliminary interview with the child and primary caregiver. A pre-test questionnaire and a post-test questionnaire were administered to both the child and the primary caregiver independently. The questionnaires and interview format were designed specifically for the study by the researchers. The social skills of the children were assessed by use of an existing and accepted instrument for children of this age group (Social Skills Rating Scale by Gresham and Elliott), administered to both the parents and the children, at pre and post-test sessions. Questionnaires designed specifically for this study were not tested for reliability or validity.

Reliability and Validity of Instruments

The Social Skills Rating Scale (SSRS) by Gresham and Elliott is an accepted instrument with published reliability and validity results. Reliability refers to the consistency of test scores which were gathered through repeated testing of an instrument under comparable circumstances. The SSRS used internal consistency (coefficient alpha), test-retest, and interrater. The median coefficient alpha reliability for the Social Skills Scale was .90 and for the Problem Behavior Scale was .84 . The internal consistency ranged from .83 to .94 for Social Skills and from .73 to .88 for Problem Behaviors. These

coefficients indicate a relatively high degree of scale homogeneity. The test-retest reliability coefficients ranged from .77 to .84 for parents reports and .52 to .66 for students reports on Social Skills Scale. Problem Behaviors ranged from .48 to .72 for parents reports.

Validity refers to measurement of the variable it purports to measure. The social validity was promoted by allowing users to select behaviors perceived as socially significant by parents and students. Frequency ratings were used to compare "before intervention" and "after intervention" patterns of social skills with national normative samples. Overall the correlation of .70 between the Problem Behaviors scales and the results from the CBCL -PRF (Children's Behavioral Checklist, Parent Report Form) should be taken as strong evidence of validity for the SSRS Problem Behaviors Scale. The SSRS Scale median internal consistency reliabilities (coefficient alpha) of .90 for Social Skills and .84 for Problem Behaviors suggest good scale homogeneity indicated that the scales assess unitary underlying constructs. Correlations among the subscales were also found to be highly consistent. Social Skills Subscales correlated positively with each other and negatively with the Problem Behaviors Subscales. This is highly consistent and provides additional evidence for construct validity of the SSRS.

Convergent validity is the relationship between two or more measures of the same trait using different measurement methods such as different raters as in use of both parents and children. One measure of reliability is the extent to which different raters make similar ratings and may be viewed as one aspect of convergent validity. Convergent validity coefficients show a median correlation range of .26 with a $p < .001$ to .30 with $p <$

.0001. A total of 14 of the 16 convergent validity coefficients are significant at least at the .05 level.

Procedure

Data gathering was initiated through a preliminary interview with the primary caregiver and the child. This required approximately one hour per family. Initial appointments were set by the clerical staff and the interviews were conducted by both researchers approximately two weeks prior to the beginning of a new group. The interview assessed the families knowledge and attitudes regarding death, loss, and bereavement issues. Upon completion of the interview the child and caregiver independently completed a pre-test questionnaire addressing the current social skills, emotional, and behavioral functioning of the child. An in-depth assessment by the researchers was completed based on the information obtained at the preliminary interview. Additional data regarding the impact of the bereavement support group was obtained at the completion of the program through a post-test and closing interview with the child and caretaker. Final data for the control group was gathered through telephone interviews and completion of the questionnaires. The estimated time for gathering data was approximately three to four months.

Bereavement support groups were designed as eight week sessions facilitated by two M.S.W. interns. The facilitators have training in counseling with emphasis in problematic behaviors with elementary school age children, mental health treatment groups, parenting groups, family groups, art and play therapy, and grief work. New participants were enrolled prior to or no later than the second group session. Late

enrollments were placed in the next available group. All groups consisted of no more than seven children with ages ranging from six to twelve years and were not separated by gender. Enrollment was voluntary with agreement for participation by both the parent and the child with regular attendance.

The bereavement group sessions were designed to promote communication, allow for a variety of modalities, and provide for both quiet and animated activities. Each session included a discussion period, an activity period, and an active play session. Group rules and behavioral expectations were developed through a team effort between the group leaders and the children. This increased compliance and promoted group cohesiveness. The group format was developed based on the facilitators previous experience and group work reviewed in the literature (Masterman, Reams and Redmond 1988, Goldman, 1994, Lohnes, 1994).

Although often painful, discussions reviewed feelings, fears, memories of the deceased, and changes in the children's current lives. Sharing of experiences developed awareness that other children were facing similar situations. An attempt to normalize feelings through open communications assisted in the development of a peer support system. Fears regarding death were explored and cultural differences discussed including differences in death rituals such funerals.

Initially children were hesitant to share memories of the deceased. However, with encouragement from group leaders and peers the children were able to openly discuss special times without hesitation, sharing drawings, pictures, and other personal

memorabilia. Many were surprised to find peers had similar memories and experiences in the past which enabled the children to be more open to discussions of current life changes.

Activities were carefully selected to provide an outlet for emotions, creativity, and fun. The children participated in cooking, baking, clay, coloring, painting and other art projects. Puppet play provided a stage for safe disclosure of previously taboo feelings and statements. Collages were created based on happy memories of activities they enjoyed with the deceased and sadness they no longer had to hide. Paintings, completed by the children, showed sadness, broken hearts, happy memories and dreams.

With the large outdoor yard at the group site, active play was enjoyed outside. Children in crisis often have difficulty with concentration, focus, or remaining seated for prolonged periods. Exploration of the gardens also provided a safe venue for discussion of death as related to nature. Dinosaurs, cars, and other assorted items played out scenes these children were unable to verbally discuss. Bubble blowing was a favorite activity and allowed for a range of movement from sedentary to extremely active participation. The researchers found this was a beneficial release of the energy created during the discussion periods.

Protection of Human Subjects

The human subject selected for this study had their confidentiality and anonymity protected at all times. All names and identifying information was eliminated and interview sheets and questionnaires marked with numbers assigned in numerical order by the researchers. All data was further reported on a group basis rather than on individuals participating in the groups. A participant consent form was issued at the beginning of the

interview. In addition an informed consent and debriefing statement was provided for each participant which briefly introduced the researchers and explained the purpose of the study. The consent was signed by both the primary caregiver and the child and was stored separately. All written research data was available only to the researchers and was destroyed upon completion of the project.

Results of Data Analysis

Central to this study was the question concerning the effect of bereavement support groups on the emotional and behavioral aspects of grief in children. The concept of bereavement is a multifaceted issue which can be viewed as a process rather than as an event. Definition will differ based on the cohort viewing the process. Cohorts of age, ethnicity, race, gender, and religion will all observe evidence of the bereavement state from a variety of constructs. The constructs this study addressed included social skills, negative behaviors, and positive behaviors. The investigation examined the relationship between childhood bereavement and problematic behaviors in both the school and home settings. The problematic behavioral issues were the dependent variables. The intervention, defined as participation in the bereavement support group, was the independent variable.

Two questionnaires, a social skills survey, and a preliminary interview were used to gather data. An initial interview with parents and children provided demographic information including age, gender, living arrangements and relationship to the deceased. Social characteristics of the child and family and information regarding bereavement activities were also obtained. The Social Skills Rating System by Gresham and Elliott

reviewed social skill in the following areas: cooperation, assertiveness, empathy, responsibility, self control and extroverted, introverted, and hyperactive negative behaviors. The Home and School Behaviors questionnaires reviewed positive and negative behaviors in areas of activities of daily living, leisure, affective behaviors (including fears), aggressiveness, attentiveness, disruptive behaviors and defiance of authority. The completion of these instruments by both parents and children yielded multiple outcomes. The researchers determined frequencies and other appropriate statistics on all variables for both the experimental group and the control group.

Demographic Characteristics of the Sample

According to the results from the preliminary data analyses the following describes the demographics of the sample. The age range for both groups was from six to twelve years of age. In the both the experimental and control groups, however, only one child was in the six to nine year range. In the control group the remaining children were evenly distributed between the ten to eleven age group and the twelve year old age group. In the experimental group the ten to eleven age group represented 50 % of the population with the remaining 45% in the twelve year old age range.

Table 1 also shows other similarities between the experimental and control groups. A higher percentage of male participants was noted. The incidence of Hispanic clients was higher in both groups and the predominant religion was protestant. Differences were noted in birth order with the oldest children the majority in the experimental group and the minority in the control group. This information is further represented in Table 1.

TABLE 1.

DESCRIPTIVE STATISTICS FOR DEMOGRAPHICS

		EXPER. GRP		CONTROL GRP	
		N	PERCENT	N	PERCENT
AGE	6 - 9	1	5%	1	14%
RANGE	10-11	10	50%	3	43%
	12	9	45%	3	43%
GENDER -	FEMALE	9	45%	3	43%
	MALE	11	55%	4	57%
BIRTH ORDER -	YOUNGEST	8	40%	3	43%
	MIDDLE CHILD	3	15%	3	43%
	OLDEST	9	45%	1	14%
ETHNICITY -	CAUCASIAN	5	25%	3	43%.
	HISPANIC	12	60%	4	57%
	AFRICAN AMERICAN	3	15%	0	
RELIGION -	CATHOLIC	9	45%	2	29%.
	PROTESTANT	11	55%	4	57%
	OTHER			1	14%

Table 2 describes the social characteristics of the sample. According to the figures 50% of children in the experimental group and 57% of children in the control group reside in single parent households. The majority of the children in both experimental and control groups were in homes where the parents were married at the time of the death of the significant person in each of their lives. Results on the experimental group indicates 90% of the children sustained the death of a parent. In contrast the control group showed that for 86% of the children death came to someone other than a parent.

Further results showed that causes of death for the majority of significant others was from other means than illness for both the experimental and control groups. Other

means of death included accident, suicide and homicide. Results showing family attitudes regarding the death indicated both groups had a higher percentage of families engaged in "facts only " discussion. Open discussion of death issues were practiced by families with 35% of the children in the experimental group and 29% of the children in the control group. The lowest percentages represented families where no discussion took place with 20% in the experimental group and 14% in the control group in this category. Further information is represented in Table 2.

TABLE 2.

DESCRIPTIVE STATISTICS FOR SOCIAL CHARACERISTICS

	EXPER. GRP		CONTROL GROUP	
	N	PERCENT	N	PERCENT
CHILD RESIDES WITH				
SINGLE PARENT	10	50%	4	57%.
BOTH PARENTS	4	20%	2	29%
OTHER	6	30%	1	14%
PARENTS MARITAL STATUS (AT TIME OF DEATH OF SIGNIFICANT PERSON)				
MARRIED	12	60%	5	71%
DIVORCED/ NOT MARRIED	8	40%	2	29%
DECEASED PERSON - PARENT	18	90%	1	14%
OTHER RELATIVE	2	10%	6	86%
DEATH BY - ILLNESS	8	40%	3	43%
OTHER- (ACCIDENT, SUICIDE OR HOMICIDE)	12	60%	4	57%
FAMILY ATTITUDE TOWARDS DEATH				
OPEN DISCUSSION	7	35%	2	29%
FACTS ONLY	9	45%	4	57%
NO DISCUSSION	4	20%	1	14%

Results from the data on bereavement activities are represented in table 3. According to the figures only one child in the experimental group was required to attend the funeral. In the experimental group 75% of the children were allowed a choice to attend the funeral. Only 30% chose to attend. The results from the control group showed that of the 86% of children allowed a choice of attending 57% chose to attend.

The length of time since the death of the significant party varies between the two groups. According to the results 55% of the children in the experimental group experienced the loss prior to twelve months previous to entering the support group. The results on children in the control group showed that in 86% of the cases the loss was of less than twelve months duration. None of the children in the control group had previous bereavement counseling and only 10% of children in the experimental group had previous bereavement counseling. (Additional findings are represented in Table 3)

TABLE 3.

DESCRIPTIVE STATISTICS FOR BEREAVEMENT ACTIVITIES

	EXPER. GRP		CONTROL GRP	
	N	PERCENT	N	PERCENT
BEREAVEMENT ACTIVITY OF CHILD				
REQUIRED TO ATTEND FUNERAL	1	5%	0	
NOT ALLOWED TO ATTEND FUN.	4	20%	1	14%
ALLOWED CHOICE OF ATTENDING	15	75%	6	86%
CHILD ATTENDED FUNERAL				
YES	6	30%	4	57%
NO	14	70%	3	43%
BEREAVEMENT TIME FRAME				
LESS THAN 12 MOS SINCE DEATH	9	45%	6	86%
MORE THAN 12 MOS SINCE DEATH	11	55%	1	14%
PREVIOUS BEREAVEMENT COUNSELING				
YES	2	10%	0	
NO	18	90%	7	100%

Means and Standard Deviation for Social Skills

Table 4 and Figure 1 show the results according to the social skills measurements. Means and standard deviations for pre and post test are displayed for both groups. Figure 1 represents the results in bar graph format. These scales included areas of assertiveness, cooperation, responsibility, empathy, and self control in the behaviors of the children.

According to the figures social skills for the experimental group indicated an increase from pre test to post tests in both parents (Mean 65, sd 14 to Mean 82, sd 17) and children (Mean 73, sd 14 to Mean 95, sd 17) with the children showing higher scores than the parents on both tests. The control group scores showed a decrease in both the

parent (Mean 69, sd 20 to Mean 68, sd 21) and the children from the pre-tests to the post-tests respectively (Mean 68, sd10 to Mean 70, sd11). (Table 4 and Figure 1)

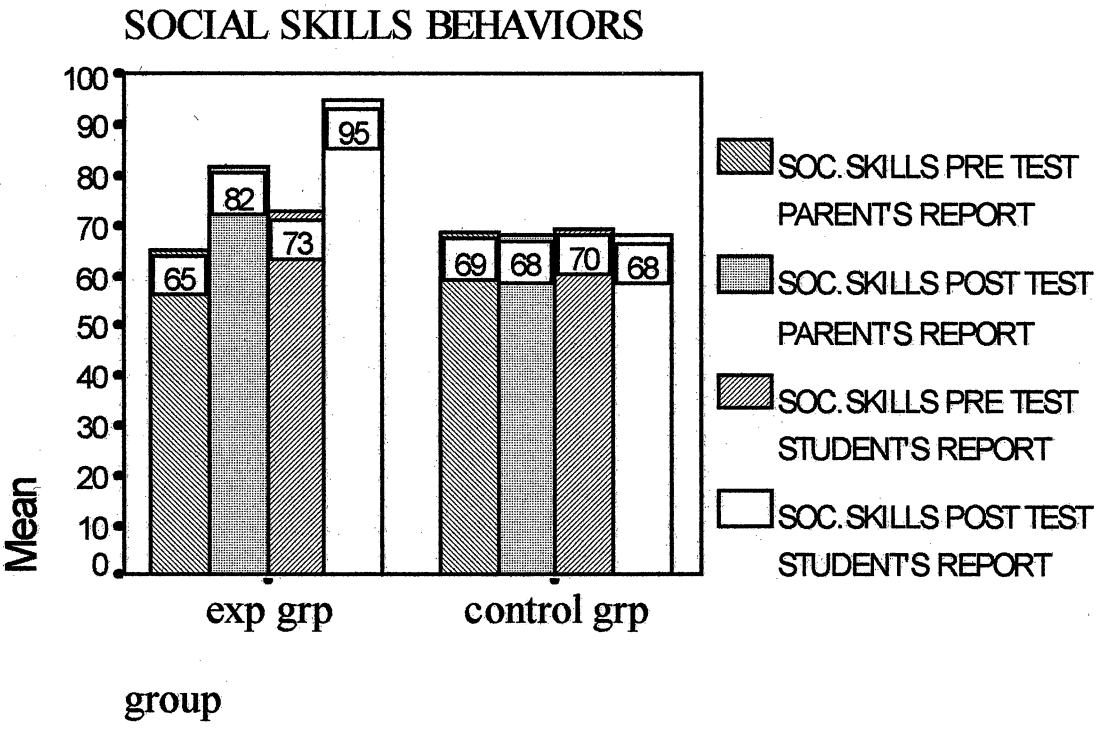
TABLE 4.

MEANS AND STANDARD DEVIATION FOR SOCIAL SKILLS FACTORS

INCLUDING: ASSERTIVENESS, COOPERATION, RESPONSIBILITY, EMPATHY, AND SELF CONTROL

	EXPER. GROUP		**CONTROL GRP**	
	M	SD	M	SD
SOCIAL SKILLS PARENTS REPORT - PRE TEST	65	14	69	20
SOCIAL SKILLS PARENTS REPORT - POST TEST	82	17	68	21
SOCIAL SKILLS STUDENT REPORT - PRE TEST	73	14	70	10
SOCIAL SKILLS STUDENT REPORT - POST TEST	95	17	68	11

Figure 1.



Means and Standard Deviation for Positive Behaviors

In Table 5 and Figure 2 the results show information on outcomes for positive behaviors. These results were based on both parent's and student's reports on the Home and School Behavioral Questionnaires. The findings are displayed for pre and post-tests of both the experimental and the control groups. The results indicate a marked difference between the two groups. The reports for the experimental group show an increase in positive behaviors by the parent (Mean 35, sd 10 to Mean 50, sd 8) and the children (Mean 31, sd 9 to Mean 45, sd 12) from the pre test to the post test scores. However, the

results for the control group show a decline in positive behaviors from parent and children from the pre-test to post-test scores respectively (Mean 38, sd 14 to Mean 35, sd 15). (Table 5, and Figure 2)

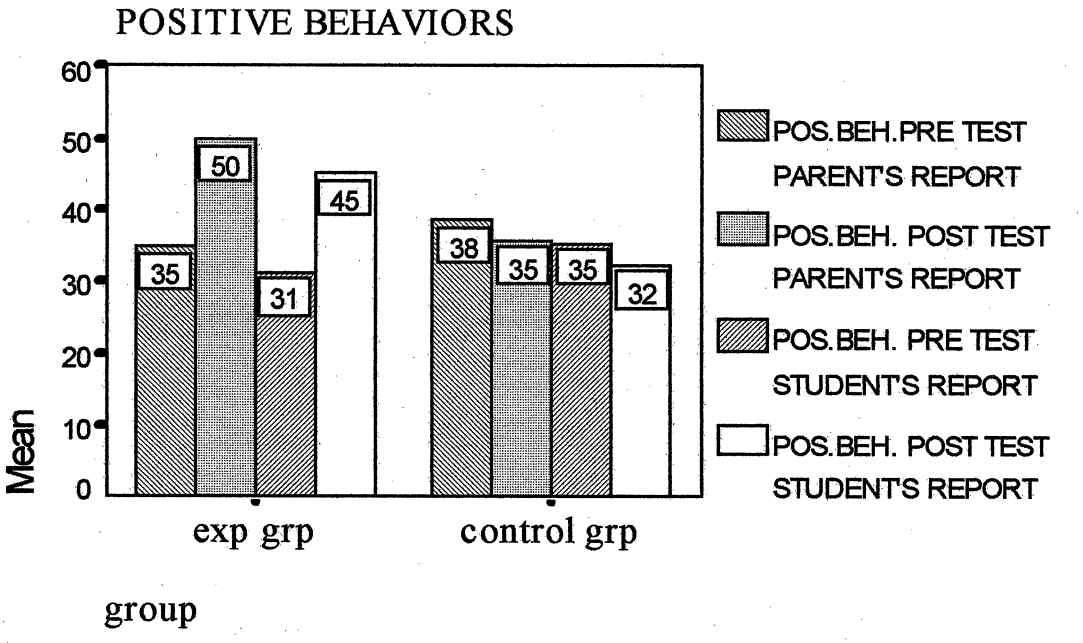
TABLE 5.

MEANS AND STANDARD DEVIATION FOR POSITIVE BEHAVIORS

INCLUDING: ACTIVITIES OF DAILY LIVING, HOME CHORES, ATTENDING, COMPLIANCE, EMOTIONAL EXPRESSION, LEISURE ACTIVITIES.

	EXPER GRP		**CONTROL GRP**	
	M	SD	M	SD
POSITIVE BEHAVIOR PRE TEST PARENTS REPORT	35	10	38	14
POSITIVE BEHAVIOR POST-TEST PARENTS REPORT	50	8	35	15
POSITIVE BEHAVIOR PRE-TEST STUDENTS REPORT	31	9	35	13
POSITIVE BEHAVIOR POST-TEST STUDENTS REPORT	45	12	32	15

Figure 2.



Means and Standard Deviation for Negative Behaviors

Results from the analysis of negative behaviors are reported on Table 6 and Figure 3. The results for the experimental group showed a decrease in negative behaviors for parents (Mean 37, sd 10 to Mean 22, sd 8) and for children (Mean 41, sd 9 to Mean 27, sd 12). The Social Skills Scale Negative Behaviors also displayed a decrease for the experimental group (Mean 130, sd 9 to Mean 106, sd 14). These results are based on reports from parents only.

Results from the analysis of control group data indicate a minimal increase in negative behaviors in all areas. Parents (Mean 34. sd 14 to Mean 37 sd 15),(students

Mean 37, sd 13 to Mean 38, sd 15), and, parents Mean 95, sd 81 to Mean 96, sd 81) .

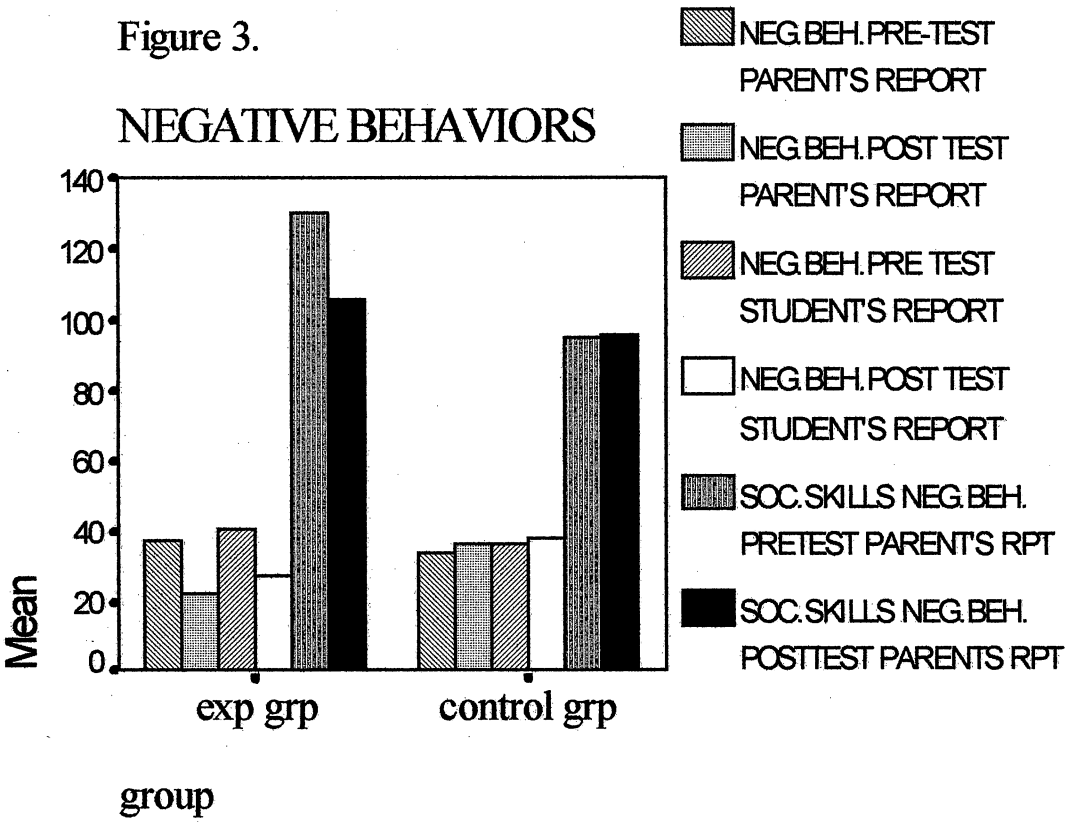
(Table 6 and Figure 3)

TABLE 6.

MEANS AND STANDARD DEVIATION FOR NEGATIVE BEHAVIORS

	EXPERIMENTAL GRP		CONTROL GRP	
	M	SD	M	SD
INCLUDING: ANGER, CRYING, IRRITABILITY, AGGRESSIVENESS, DISRUPTIVENESS, DEFIANCE OF AUTHORITY, NON-COMPLIANCE, AND NEGATIVE AFFECTIVE BEHAVIORS.				
NEGATIVE BEHAVIORS PRE-TEST PARENTS REPORT	37	10	34	14
NEGATIVE BEHAVIORS POST-TEST PARENTS REPORT	22	8	37	15
NEGATIVE BEHAVIORS PRE-TEST STUDENTS REPORT	41	9	37	13
NEGATIVE BEHAVIORS POST-TEST STUDENTS REPORT	27	12	38	15
EXTROVERTED, INTROVERTED AND HYPERACTIVE BEHAVIORS.				
NEGATIVE BEHAVIORS ON SOCIAL SKILLS PRE-TEST PARENTS REPORT	130	9	95	81
NEGATIVE BEHAVIORS ON SOCIAL SKILLS POST-TEST PARENTS REPORT	106	14	96	81

Figure 3.



Discussion and Implications

The researchers found that the bereavement support group was effective in impacting the emotional and behavioral functioning of the participants. Reports indicated a reduction of negative behaviors for both home and school settings. This was noted by both parent's and children's reports. Conversely the positive behaviors showed an increase in reports by both parents and children. Results of the social skills scales including self-control, empathy, responsibility, assertiveness, and cooperation showed an increase in the level of behaviors with social skills negative behaviors (externalized,

internalized, hyperactivity) showing a decrease. The support group appears to have had a positive influence in reducing the problematic behaviors of the children and increasing the desired positive behaviors and social skills.

Studies suggest that children will manifest a wide variety in their approaches to grieving. This was noted by Giblin and Ryan (1989) in their studies on children's perceptions on death. Reviews of children's home and school behaviors also identified academic deterioration, anxiety, withdrawal, somatic complaints and death fantasies present in the majority of cases in agreement with the studies completed by Greenberg (1975). Also consistent with Greenberg's research, this study showed participants displaying a wide range of emotions such as sadness, crying, irritability, and anger as documented on the Home and School Behavioral Questionnaires. These results though, are not consistent with findings by Buirski and Buirski (1994) stating children are unable or structurally unequipped to grieve. The results of this study were more consistent, instead, with results of the work by Vida & Grizenko (1989) showing the manifestation of grief to be common.

Hawener and Phillips work propounds the importance of the child's interaction with significant adults following death, particularly of a parent. Interviews with parents and children and bereavement group observations by these researchers supported their statements. Children with little or no discussion of the bereavement issues displayed withdrawal and anxiety at a more severe level than children with supportive home environments. Open verbalization of emotive content increased as the participants became aware of peers with similar situations. The group setting provided for normalization of

fears and increased the ability to share with others the trauma and stress they experienced. This was not unexpected by these researchers as the work by Segal (1984) and Davis (1989) also found this to be representative of the group experience. The improvement in emotional and behavioral growth was dramatically noted in all participants of the study. However, one six year old perhaps told the whole story when at the initial session the child was aggressive and verbally abusive with his mother. His behavior alternated between crying, yelling, hitting, and kicking. The initial group session found him sitting in the doorway with no communication with other participants. Allan (1978) found art to be a significant medium for change in brief group work with aggressive children and the dramatic changes in this participant were also noted in response to art based modalities. Unable to participate in any way initially, the child was fully involved in the group by the end of the eight week session.

In reviewing Table 2 it was noted that 90% of the children in the experimental group lost a parent and only 70% of these children attended the funeral. Their lack of closure may have been one variable responsible for the decision of the family to have the child participate in the support group. It is also noted 85% of the children in the control group lost someone other than a parent yet 43% attended the funeral. Again absence of the opportunity for closure may have been a contributing factor in declining services.

Implications for further research are numerous. The findings of this study are only a beginning examination of the factors affecting the adjustment of bereaved children. With time limited groups a minimum one year follow up would be recommended as previous research shows a regression pattern with children reverting to earlier levels of

deleterious grieving which appears to stabilize within that time frame (Lohnes & Kalter, 1994).

Researchers disagree as to the impact of bereavement support groups for children on adjustment and functioning in the adult years (Masterman, 1989). Long term studies would determine the long range benefits and the rate of retention of improved functioning. Further, the optimal number of group sessions is not agreed upon by group facilitators in bereavement work with intervention groups ranging from six to twelve weeks or longer (Warmbrod, 1986). There is a need for studies to examine the impact and retention of benefits based on the number of sessions provided.

The abilities and training of researchers or group facilitators, and the intervention modality used are other areas in need of review. Difference of response by participants to male only, female only, or male and female facilitator teams was another area where data was not available. Additionally larger population samples would provide additional issues and needs which may not have been addressed in this study.

These bereavement groups were provided free of charge, through a coalition between the hospice and the medical center, as a community service. This service has been available for approximately ten years and yet remains relatively unknown. Little marketing has been done and advertising has not reached the target population. Doctors, schools, churches, and most counseling service agencies in the area are not aware of the program and often at a loss for resources for their clients.

Provision of these support groups benefited the entire family. The child's participation allowed for respite for the surviving parent or caretaker. Education of the

families as to the normal grief reactions of children alleviated the levels of anxiety. Weekly family contact provided information to the researchers regarding any additional areas of concern or traumatic impact to the child. This team effort also provided a support base for the families in accessing additional resources in the community. Lastly, the research showed a decrease in problematic behaviors and an increase in positive behaviors and social skills for the participants. While not "curing" all the problems encountered by the children and families the change in behavioral patterns was a positive step reducing anxiety and stress and allowing for the gradual return to normal functioning levels.

Significance for Social Work Practice

Social work direct practice is impacted by increasing client referrals and decreasing funding. Many insurance companies limit the number of visits they will cover and with managed care any problem in the emotional arena is under tighter scrutiny than in the past. Few HMO's provide bereavement support groups and individual sessions are limited and usually require a co-pay. This is often substantial and not affordable to families often overburdened with burial and medical expenses.

With the limited resources and time frames imposed on direct practitioners modalities can be implemented in time limited group settings to provide benefits to the treatment team as well as to the client. Group work is one area that can provide increased benefits to our clients while controlling staff costs. Social workers have the opportunity to study this process at many workshops and conferences. Knowledge of bereavement support group work would allow the social worker increased choices for treatment. With

continual increased referrals, time constraints, and reduced financial resources it is important to develop modalities that will fulfill the needs of the client while providing long term benefits. Research, as previously stated, shows that delay in treatment implementation decreases the possibility of successful resolution of grief and loss issues and the reduction of the accompanying problematic behavior with resulting impact on later adult functioning (Goldman, 1994). As shown by Tables 4,5, and 6 and Figures 1,2, and 3 control group members showed increases in problematic behaviors with decreases in both positive behaviors and social skills, thereby indicating that providing early prevention could save lives, time and financial burdens.

APPENDIX A:

DEMOGRAPHIC QUESTIONNAIRE

Demographic statistics

AGE: 6-9YRS _____ 10-11 YRS _____ 12 YRS_____

GENDER: MALE_____ FEMALE_____

BIRTH ORDER: YOUNGEST _____ MIDDLE_____

OLDEST_____ OTHER_____

ETHNICITY: CAUCASIAN_____AFRICAN AMERICAN_____

HISPANIC_____ASIAN_____ OTHER_____

RELIGION: CATHOLIC_____ PROTESTANT_____

JEWISH_____ISLAMIC_____OTHER_____

Demographics of Social Characteristics

CHILD RESIDES WITH: MOTHER_____ FATHER_____

BOTH PARENTS_____ OTHER _____

PARENTS MARITAL STATUS AT TIME OF DEATH OF SIGNIFICANT OTHER

MARRIED_____ DIVORCED_____

NOT MARRIED _____ OTHER_____

RELATIONSHIP OF DECEASED PERSON TO CHILD

MOTHER _____ FATHER_____

GRANDPARENT_____ SIBLING_____OTHER_____

DEATH DUE TO: LONG TERM ILLNESS _____

SHORT TERM ILLNESS_____ ACCIDENT_____

HOMOCIDE_____ SUICIDE_____ OTHER_____

FAMILY ATTITUDE TOWARDS DEATH

OPEN DISCUSSION_____ FACTS ONLY_____

NON-FACTUAL DISCUSSION (FANTASY) _____

NO DISCUSSION _____ OTHER_____

Demographics of Bereavement Activities

BEREAVEMENT ACTIVITY OF CHILD - ATTENDING FUNERAL

REQUIRED TO ATTEND _____NOT ALLOWED TO ATTEND ____

ALLOWED CHOICE TO ATTEND OR NOT _____

CHILD ATTENDED FUNERAL: YES_____ NO_____

LENGTH OF TIME SINCE DEATH

LESS THAN 12 MONTHS_____OVER 12 MONTHS_____

PREVIOUS BEREAVEMENT COUNSELING: YES_____ NO_____

APPENDIX B:

SCHOOL BEHAVIORS QUESTIONNAIRE

SCHOOL BEHAVIORS	SELDOM	SOME TIME	OFTEN
AGGRESSIVE BEHAVIORS			
FIGHTING AT SCHOOL			
.FIGHTING IN CLASSROOM			
GET SENT TO TIME OUT CLASSROOM			
LOOSE TEMPER - HIT, YELL			
BREAK OTHER PEOPLES THINGS			
GET SENT TO OFFICE			
GET SUSPENDED			
TRIED TO KILL MYSELF			
ATTENTIVE BEHAVIORS			
HAVE TROUBLE PAYING ATTENTION			
NOT FINISHING WORK IN CLASS			
DAYDREAMING IN CLASS			
STAY IN MY SEAT			
DISRUPTIVE BEHAVIORS			
MAKE LOUD NOISES LIKE BURPING, ETC.			
MAKE SIGNS OR GESTURES WHEN I SHOULDN'T			
DISTURB CLASSMATES			
FORGET THINGS AT HOME I NEED FOR SCHOOL			
CHEAT IN CLASS			
AUTHORITY DEFIANCE BEHAVIORS			
DON'T FOLLOW TEACHERS RULES			
DON'T LISTEN TO PRINCIPAL OR VP			
DON'T LISTEN TO TEACHER			
TELL THE TEACHER OFF			
SKIP SCHOOL WHEN I'M SUPPOSED TO GO			
STEAL THINGS			
LIE			
AFFECTIVE BEHAVIORS			
OTHER PEOPLE MAKE ME MAD			
FEEL LIKE CRYING			
CRY AT SCHOOL			
DON'T UNDERSTAND HOW TO DO THE HOMEWORK			

APPENDIX B - CONT.

	SELDOM	SOME TIME	OFTEN
WANT TO BE ALONE			
FEEL LIKE NOTHING MATTERS			
FEEL LIKE I WOULD RATHER BE DEAD			

APPENDIX C

HOME BEHAVIORS QUESTIONNAIRE

	SELDOM	SOME TIME	OFTEN
ACTIVITIES OF DAILY LIVING			
BRUSH TEETH			
TAKE A BATH/SHOWER			
EAT MOST OF MY FOOD			
PICK UP BELONGINGS			
HELP AROUND THE HOUSE			
HELP AROUND THE YARD			
LEISURE ACTIVITIES			
WATCH TV			
PLAY VIDEO GAMES			
PLAY WITH FRIENDS			
PLAY WITH FAMILY			
FEARS			
AFRAID TO BE AWAY FROM HOME			
AFRAID OF THE DARK			
AFRAID OF GOING TO SLEEP			
HAVE NIGHTMARES			
AFRAID OF GETTING SICK			
AFFECTIVE BEHAVIORS			
CRY			
CAN'T STOP CRYING			
GET ANGRY EASILY			
FEEL LIKE PEOPLE ARE PICKING ON ME			
HATE THE PEOPLE AROUND ME			
GET MY FEELINGS HURT EASILY			
FEEL SAD			
FEEL PAIN WHEN I GET HURT			
HAVE STOMACH ACHES			
HAVE HEADACHES			
FEEL I'M TO BLAME FOR SOMEONE DYING			
FEEL LIKE I WANT TO HURT SOMEONE			
DEFIANCE OF AUTHORITY			
ARGUE WITH MY FAMILY			
ARGUE WITH MY FRIENDS			
FIGHT, HIT, KICK			
DON'T PAY ATTENTION TO THE RULES			

APPENDIX C: CONT.

	SELDOM	SOME TIME	OFTEN
CAN'T UNDERSTAND THE RULES			
BREAK OTHER PEOPLES THINGS			
BREAK MY THINGS			
TRY TO GET EVEN WHEN I GET UPSET			
LIKE TO DO EXCITING THINGS EVEN IF THEY ARE DANGEROUS			
CALL PEOPLE BAD NAMES			
HIT SMALLER KIDS IF NO ONE IS LOOKING			
DRINK ALCOHOL			
USE DRUGS			

APPENDIX D:
INFORMED CONSENT AND DEBRIEFING STATEMENT

The Bereavement Support Group you are applying to for your child may be used as a base for research. The study you are about to participate in is designed to investigate the impact of bereavement support groups on the behaviors of children who have lost a significant person in their life. This study is being conducted by Marlen Kellas and Lynette Wheeler under the direction of Dr. L. Cardona, Assistant Professor of Social Work at California State University, San Bernardino. This study has been approved by the Institutional Review Board of the University.

The child will participate in an eight week bereavement support program. You and the child will be asked to participate in an interview and complete a questionnaire prior to the beginning of the program and again at the completion of the program. There are no risks from the research project. Please be assured that any information you provide will be held in strict confidence by the researchers. All information collected will be identified only by a case number. At no time will your name be reported along with your responses. All data will be reported in group form only.

Please understand that your participation is voluntary and you are free to withdraw at any time during this study, without penalty.

I acknowledge that I have been informed of, and understand, the nature and purpose of this study, and I freely consent to participate _____

Signature of participant/age/date

I acknowledge I have the authority to give permission for this child to participate in the program.

_____ _____

Signature of Authorized Adult Date Signature of Researcher Date

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