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## REVIEW ARTICLE

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### **The Effectiveness of Bereavement Interventions With Children: A Meta-Analytic Review of Controlled Outcome Research**

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*Grief therapies with children are becoming increasingly popular in the mental health community. Nonetheless, questions persist about how well these treatments actually help with children's adjustment to the death of a loved one. This study used meta-analytic techniques to evaluate the general effectiveness of bereavement interventions with children. A thorough quantitative review of the existing controlled outcome literature ( $n = 13$ ) yielded a conclusion akin to earlier reviews of grief therapy with adults, namely that the child grief interventions do not appear to generate the positive outcomes of other professional psychotherapeutic interventions. However, studies that intervened in a time-sensitive manner and those that implemented specific selection criteria produced better outcomes than investigations that did not attend to these factors.*

Losing a loved one through death is a universal human experience. Only a fraction of persons who live a typical life span will avoid the pain of bereavement for the entirety of their lives. Importantly, research indicates that nearly 5% of children and adolescents in the United States experience a crucial loss before the age of 15 (Shneiderman, Winders, Tallett, & Feldman, 1994). Although early clinical theorists raised skepticism about the relevance of grieving for children (e.g., Wolfenstein, 1966), there is now consensus that the majority of bereaved children undertake some sort of grieving process. In fact, even children as young as 4 years will show expressions of grief, though their reactions to the death may not conform to social conventions or closely mirror those of adults (International Work Group on Death, Dying, and Bereavement, 1999).

As with grief phenomena in adults, complications in the grieving process for children are associated with greater vulnerability to a variety of psychological disturbances (see Dowdney, 2000; Tremblay & Israel, 1998; Worden, 1996, for reviews). Research suggests that the detrimental effects on children's acute and medium-term

adjustment include heightened feelings of fear and dysphoria (Weller, Weller, Fristad, & Bowes, 1991), somatic complaints (Kalter et al., 2002), difficulties learning and concentrating in school (Worden, 1996), and an inability to maintain healthy levels of self-esteem or a sense of connectedness to their remaining social network (Silverman & Worden, 1992). Despite the encouraging fact that findings from the Child Bereavement Study (Worden, 1996) indicate that most bereaved children (e.g., 80%) will show resilience in adjusting to loss, a sizable contingent (e.g., 15%–20%) is still expected to display significant emotional and behavior difficulties even at 2 years post-loss.

Although most of the evidence for long-term associations (e.g., depression; see Tennant, Bebbington, & Hurry, 1980, for review) comes from retrospective accounts of adults receiving psychiatric services later in life, it is evident that the experience of bereavement during childhood constitutes a risk factor for concurrent and sometimes chronic distress. In an effort to prevent the onset of more serious manifestations of psychological problems, mental health professionals have grown eager to provide support and comfort to bereaved children and their families. In fact, children who face the death of a loved one nowadays may receive a host of psychosocial interventions

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**Table 1.** Features of Controlled Intervention Studies with Bereaved Children<sup>a</sup>

Study	Published	No. Participants	Random Assignment	Treatment Manual	Follow-Up Data	Selection Criteria	No. Sessions	% Attrition	Assessed for Grief
Adams, 1994	No	69	Yes	Yes	No	None	8	0	Yes
Black & Urbanowicz, 1987	Yes	45	Yes	No	Yes <sup>b</sup>	None	6	43.75	No
Hillard, 2001	Yes	18	No	Yes	No	IDC	8	5.20	Yes
Housely, 1996	No	36	No	NR	No	None	8	0	No
Huss, 1997	No	17	No	Yes	No	None	6	0	No
Loy, 1999	No	61	Yes	Yes	No	None	NR	1.61	Yes
Pfeffer et al., 2002	Yes	41	Yes	Yes	No	EDC	10	45.33	No
Ryan, 1982	No	21	No	Yes	Yes <sup>c</sup>	None	5	8.70	No
Sandler et al., 1992	Yes	54	Yes	Yes	No	None	15	47.60	No
Sandler et al., 2003	Yes	244	Yes	Yes	Yes <sup>d</sup>	EDC	12	3.50	No
Tonkins & Lambert, 1996	Yes	16	No	Yes	No	EDC	8	0	Yes
Wilson, 1994	No	22	No	Yes	Yes <sup>e</sup>	None	8	0	No
Zebrowski, 2000	No	139	Yes	Yes	No	None	NR	NR	No

Note: NR = information not reported in study; IDC = included distressed children only; EDC = excluded distressed children.  
<sup>a</sup>*N* = 13. <sup>b</sup>1 year. <sup>c</sup>6 weeks. <sup>d</sup>11 months. <sup>e</sup>2 weeks.

offered by providers ranging from public health and social service organizations to hospices and traditional psychotherapy programs (Rolls & Payne, 2003). These interventions include a diversity of approaches as well, such as peer counseling, support groups, weekend retreats, and group, individual, and family therapy (Webb, 1993). In the face of this proliferation of grief therapies with children, a mounting clinical literature and an increasing number of professional conferences and workshops have also emerged, all of which assume the effectiveness of these treatments with bereaved children as they are currently practiced.

Among the many priorities for clinical research is establishing the effectiveness of psychological treatments with youth experiencing different types of problems at different developmental ages (American Psychological Association, 2005). Notwithstanding the concern and diligence of the mental health community, questions persist as to whether bereavement interventions actually promote children's adjustment to loss and help to improve their post-loss functioning. Aside from prior narrative reviews of the published literature, a quantitative review that includes all of the available controlled investigations has never been conducted. Earlier narrative reviews of the children's literature concluded that the effectiveness of bereavement interventions with children remains in question (Curtis & Newman, 2001; Shneiderman et al., 1994). However, these earlier reviews did not sample all of the existing controlled outcome studies or quantitatively evaluate the degree to which the interventions truly benefited the bereaved children. Thus, it is the purpose of this article to use meta-analytic techniques to evaluate the overall effectiveness of grief therapies with children

and to explore whether timing and the procedures for selecting bereaved children may influence the level of treatment benefit.

## Method

### Studies

As shown in Table 1, this review was based on a total of 13 studies that examined the effectiveness of grief therapy<sup>1</sup> with children, including six journal articles and seven unpublished dissertations. The studies were identified using two different methods. First, a thorough search of PsychoInfo, PsychArticles, Medline, and Dissertation Abstracts International was performed using groupings of search terms, such as *child*, *children*, *adolescents*, *bereavement*, *grief*, *treatment outcome*, and *evaluation*. Second, reference sections of other reviews (e.g., Curtis & Newman, 2001) were consulted to locate other missing studies.

Five inclusion criteria were implemented to select studies: (a) studies had to compare a bereavement intervention group to a no-treatment control group, thereby lessening the possibility that the simple passage of time accounted for positive outcomes; (b) all of the child participants in the studies experienced the death of a loved one, regardless of study condition (i.e., treatment or control group); (c) interventions were specifically aimed at promoting healthy adaptation to

<sup>1</sup>Though "grief therapy" often denotes a highly specialized and secondary form of intervention that should be kept distinct from the more preventive approaches, such a distinction goes beyond the purview of this review, and the terms *grief therapy* and *bereavement interventions* are used interchangeably.

**Table 2.** *Sample Characteristics*

	<i>M</i>	Range
Age of children (years)	10.1	8–13.6
Percentage of girls	48.2	22.7–63.9
Percentage of parental bereavement	68.9	14.3–100
Percentage of violent loss	37.9	2–100
Percentage White	68.9	0–100
Length of bereavement at start of treatment (months)	17.5	2.5–64.6

bereavement; (d) studies needed to provide quantitative measures of participants' responses to the intervention; and (e) the measures used needed to indicate a clear direction of benefit. Thus, studies that used treatment to no-treatment comparisons were included in the review, regardless of how participants were assigned to conditions. In this sample, the six studies that employed a nonrandom method of assignment produced treatment effects that were, on average, only .10 standard deviations larger than studies that used random assignment. In view of these similarities across studies, no distinctions were made in this review between studies that employed random versus nonrandom assignment.

Although the purpose of this study was not to focus exclusively on group interventions, 12 out of the 13 studies that met the five criteria used group therapy as the primary treatment modality. The interventions were delivered in schools and other community-based organizations, participants' homes, and in the context of a weekend camp. Despite differences in setting, all of the treatments had a strong psychoeducational component and addressed the following therapeutic objectives: (a) improving coping skills, (b) increasing understanding of death and grief, (c) talking about the deceased loved one, and (d) expressing grief-related feelings via verbal and "symbolic" modes (e.g., drawing) of communication. As displayed in Table 2, the typical participant was an older White child<sup>2</sup> who attended around eight or nine weekly group treatment sessions. There was also an almost equal representation of boys and girls in the studies, with most of the participants beginning treatment about a year and a half after experiencing the death of a parent to a natural mode of death (e.g., cancer).<sup>2</sup>

<sup>2</sup>For ease of presentation, the terminology of *child* and *children* is used to describe the participants with average ages of 15 years and under. Ultimately, those individuals at the higher end of the range in the included studies (i.e., 12, 13, 14 years) are more likely to be in the period of adolescence.

## Estimating Treatment Effects

Because this review was exclusively concerned with determining the impact of the interventions on bereaved children's functioning, the outcomes for the parents in the subset of studies that assessed the surviving parent's functioning were excluded from the analyses. The measures of the children's treatment outcomes were converted into a Cohen's (1977) *d*, which is a standardized way of showing the magnitude and direction of an effect. In the 13 studies, the posttest mean of the no-treatment comparison group was always subtracted from the posttest mean of the treatment group. In some cases, high scores on an outcome measure indicated improvement, whereas low scores reflected greater improvement for other measures. When lower scores on an outcome measure indicated improvement, the positive or negative valence of the effect size was adjusted in such a way that a positive *d* always denoted the advantage of the bereavement intervention group over the no-treatment comparison group.

All effect sizes within a study were calculated with few exceptions. In one study, the researchers collected follow-up data 1 and 2 years after treatment (Black & Urbanowicz, 1987). An effect size was only computed for the 1-year follow-up because of far less attrition and much more numerical information provided for this assessment interview. The effect sizes for six of the studies examined in this review were calculated directly from the group sizes, means, and standard deviations of the treatment and control groups as reported in the articles. In all but one (Ryan, 1982) of the seven instances in which the authors failed to report the necessary information for deriving an exact estimate of the effect size, this information was requested via uniform e-mail correspondence to the first and second authors. Of the seven studies whose authors were contacted, additional data were provided for two of the studies so exact estimates of the effect sizes within the studies could be calculated.

Overall, 75 effect sizes were computed across the 13 studies examined in this review (range = .76–2.03, *SD* = .48). Of these effect sizes, 61.3% were calculated either directly from sample sizes, group means, and standard deviation or from *t* statistics, such that estimation procedures were not necessary. In 16% of cases, researchers gave group means and numbers of participants, but the pooled standard deviation had to be estimated from an *F* ratio with more than 1 degree of freedom in the numerator. Also, the researchers failed to report results for their outcome measures in numerical form 9.3% of the

time but discussed finding no differences between treatment and control groups somewhere in the research report. As a way to minimize bias in our review by not excluding findings that disconfirmed the researcher's hypothesis, the corresponding effect sizes for these measures were conservatively estimated to be zero, which could lead to underestimation of study-level effect sizes in some cases. The remaining 13.3% of effect sizes were estimated using other procedures, which have been outlined in earlier work (e.g., Glass, McGaw, & Smith, 1981; Miller & Berman, 1983). On average, effect sizes obtained by estimation procedures were only .10 of a standard deviation larger than those calculated directly from sample sizes, group means, and standard deviations, suggesting that any assumptions made did not appear to introduce systematic bias into the calculation of effect sizes. Because it has been established that estimates of effect size based on small samples tend to overestimate the magnitude of effect sizes (Hedges, 1984), Hedges' (Formula 4) correction was applied to all effect sizes reported in this review.

One of the clear weaknesses in the extant literature involves a shortage of meaningful follow-up data. Altogether, only three of the studies assessed outcome at both posttest and follow-up (Ryan, 1982; Sandler et al., 2003; Wilson, 1994), two of which had time intervals between assessments of very short duration (i.e., 2 and 6 weeks). Because effect sizes assessed at posttest ( $d = .02$ ) and follow-up ( $d = -.02$ ) for these three studies were nearly equivalent, we opted to get the most representative estimates of effect sizes by (a) using the average of posttest and follow-up effect sizes for the three studies that reported results for both time points and (b) to combine the effect sizes for the one study that only assessed outcome at follow-up (Black & Urbanowicz, 1987) with the results from the remaining 12 studies.

## Results

To obtain the overall finding, outcome-level effect sizes were first averaged across the measures to yield a study-level effect size for each of the 13 interventions (range =  $-.15-.95$ ,  $SD = .35$ ). In those instances in which researchers ran analyses on subsets of items from particular measures and reported the results separately, these effects were always averaged for the total measure. Also, for those studies that used overlapping composites of various self-report and behavioral measures to assess outcome, the items were included only once in the derivation of outcome-level effect sizes. Because studies based on larger samples tend to

represent more stable estimates of the effect, a weighted average of the study-level effect sizes was calculated by weighting each study by the inverse of its variance (Hedges, 1982). The mean weighted effect size across the 13 studies was .14. Overall, this analysis failed to show that the overall effect size for the interventions was greater than zero (95% confidence interval,  $0-.28$ ;  $p = .08$ ), which does not support the general helpfulness of these treatments for bereaved children.

The homogeneity of the effect sizes was examined next to determine if the  $d$ s varied beyond what would be expected by chance or sampling error alone. The test for homogeneity of variance also failed to achieve statistical significance ( $Q = 10.82$ ,  $df = 12$ ,  $p = .54$ ) as well, thereby indicating that effect sizes appeared to resemble a homogenous distribution. Because it seemed that this sample of studies represented a relatively homogenous set of effect sizes, there was little empirical warrant to conduct a comprehensive examination of theoretically and clinically relevant factors that might account for systematic variation among the study-level effect sizes.

Nevertheless, when there is limited power to detect significant heterogeneity between studies and sufficient justification for examining specific hypotheses, it is acceptable to test a limited number of carefully selected moderator variables (Hedges, 1994). As discussed in prior narrative reviews (Curtis & Newman, 2001; Schneiderman et al., 1994), problems with how the bereavement interventions with children are commonly implemented could diminish the chance of detecting reliable treatment benefits. For the purposes of this study, studies may have intervened too late after bereavement, at which point children were no longer preoccupied with their losses, as the mean period from bereavement to intervention was a year and a half, and some studies offered therapy as late as 5 years after the loss (see Table 2). A second factor that might have mitigated gains is that therapy could have been offered to children who were not distressed enough to necessitate intervention (see Table 1), a possibility that Jordan and Neimeyer (2003) raised with respect to the literature on grief therapy for adults. To establish the reliability on the ratings of the latter factor, two advanced clinical doctoral students coded the criteria for selecting child participants and achieved perfect agreement as to whether the researchers (a) included only distressed children, (b) excluded distressed children, or (c) did not implement any criteria on the basis of children's pre-treatment functioning.

Thus, the next step in this review was to examine whether these decisions governing treatment

implementation shed any light on the overall effect size. To accomplish this end, we performed two weighted least squares analyses with the study-level effect sizes as the dependent variable and treatment implementation features (i.e., length of bereavement and selection criteria) as the independent variables with weights again defined by the reciprocal of the sampling variances. These analyses confirmed our suspicions. First, a Pearson correlation indicated that treatment effects seemed to differ according to the length of bereavement,  $r(11) = -.56, p = .07$ , with studies that intervened with children whose losses were more distant showing poorer outcomes. Also, an independent samples *t*-test provided some suggestion that the studies that excluded distressed children or did not implement any selection criteria on the basis of children's pretreatment functioning produced poorer outcomes,  $t(11) = 1.93, p = .08$ .<sup>3</sup>

### Discussion

The overall results do not support the assumption that the bereavement interventions with children have a significant influence on adjustment. On average, the treated child did not appear to be better than bereaved children who did not participate in grief therapy (as reflected in an average weighted effect size of .14). This finding contrasts sharply with the large positive outcomes (i.e., overall effect size = .7–.9) typically shown in reviews of general psychotherapy with children (e.g., Casey & Berman, 1985; Weisz, Weiss, Alicke, & Klotz, 1987) or adults (Smith, Glass, & Miller, 1980; Wampold, 2001). Nonetheless, these results accord closely with the findings of earlier reviews of grief therapy with adults. In brief, the bulk of these studies suggest that bereavement interventions with adults produce surprisingly small effects, with those adults who participate in an intervention, on average, tending to look similar to those adults who did not receive any form of grief therapy in the first place (see Jordan & Neimeyer, 2003, for review). The results of our review lead to the same general conclusion, namely that the interventions with bereaved children do not appear to produce the outcomes that are expected from professional psychotherapeutic interventions.

Beyond sounding a cautionary note regarding the helpfulness of these interventions, there are several reasons to consider for the overall lack of effectiveness. For instance, one of the reasons for the overall effect size could be that, on average, too much time passed from the child's loss to the beginning of intervention in many of the studies. In particular, it appears that the children responded more favorably to grief therapy the closer the treatment followed the time of the loss, which indicates that many of the treatments were potentially delivered at a point when they were simply too "weak" to produce measurable effects, perhaps after children and families had already accommodated the loss, whether in an optimal or suboptimal fashion. A corollary to this explanation concerns the possibility that the predominant treatment objectives (e.g., psychoeducation about loss, expression of grief-related feelings) did not address the needs of the vulnerable subset of children who were further removed from their losses, at which time a different form of intervention focusing less on grief and more on other forms of psychological or behavioral problems might have been more appropriate.

Similar to other research that indicates that treatment effects are considerably better with children who manifest a genuine need for treatment, there was some suggestion that the researchers' procedures for selecting bereaved children also made a difference. For example, the overall finding here closely mirrors the overall weighted effect sizes shown in Horowitz and Garber's (2006) quantitative review of preventive interventions for depression (posttest  $d = .16$ ; follow-up  $d = .11$ ). Also, these researchers found that the interventions that targeted "high-risk" children or children already showing signs of difficulty were the most beneficial among those that they sampled (Horowitz & Garber, 2006). In our review, all but one of the studies failed to screen for and select children who were actually displaying adjustment difficulties at the start of treatment. Insofar as there is consensus in the adult literature that most bereavement will follow a "resilient trajectory" (Bonanno et al., 2002) without professional intervention, our results also corroborate other research that suggests that only a minority of children will display lasting grief complications (Dowdney, 2000; Worden, 1996). If it is assumed that only a small subset of the children were distressed enough to achieve measurable gains at the time that treatment was delivered, it follows that a "washing out" of larger positive outcomes for the minority of distressed children would lead to a discouraging overall effect size.

<sup>3</sup>As with other findings reported here, this comparison should be replicated once additional controlled studies are conducted that implement sufficient selection criteria on the basis of children's levels of pretreatment distress. At present, only one study has exclusively selected children who were showing adjustment difficulties at the time that treatment was delivered (Hillard, 2001).

In keeping with this rationale, the lack of effectiveness could derive in part from a more general tendency to “pathologize” grief. Although bereavement makes many children vulnerable to acute and sometimes ongoing difficulties in life, this does not justify the indiscriminate provision of grief therapy to children who show neither clinically elevated distress following a loss or other “objective” risk factors associated with the death itself. Instead, as with Horowitz and Garber’s (2006) findings, our results suggest the potential value of early screening in cases of childhood bereavement and focusing interventions on the high-risk group, such as those showing the beginning signs of “childhood traumatic grief” (see Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002, for review). However, very little effort was made across the majority of the studies to screen clients on the objective circumstances surrounding the death or the level of distress. Thus, some of the children with a higher risk for showing adverse grief outcomes, such as an older boy who witnessed the gruesome murder of his mother a few months before treatment started, might have felt alienated and overwhelmed other group members with his retelling of the death, thereby compromising the cohesiveness and potential effectiveness of the group in the process.

A further consequence of the tendency to pathologize bereavement is revealed in the investigators’ choices of measures, which focused almost exclusively on outcomes defined in terms of psychiatric symptoms or general behavioral disorders. There is now ample evidence, however, that “complicated grief,” understood as a problematic response to a sundered attachment, is irreducible to standard psychiatric symptomatology and requires separate conceptualization and diagnosis (Prigerson & Maciejewski, 2006). Nonetheless, only four of the studies directly assessed grief, per se, and only one of these investigations used a well-established or even standardized measure of grief (see Neimeyer & Hogan, 2001, for review). It is possible therefore that the researchers’ reliance on outcome measures that equated grief with general psychopathology could have limited their chances to detect changes distinctive to bereavement adaptation from the outset. Significantly, this trend highlights the disturbing fact that, with the single exception of a scale to assess the specific domain of adolescent sibling bereavement (Hogan & DeSantis, 1996), there is no single well-validated measure of child grief available for researchers or clinicians to incorporate in their work with this population.

Quantitative reviews are only as sound as the individual studies that are submitted to the statistical procedures. Therefore, many studies were excluded because of shortfalls in research

procedures (e.g., lack of no-treatment control group). Unfortunately, the fact that the total controlled outcome literature on bereavement interventions with children appears to consist of a mere 13 studies restricted the number of questions that could be legitimately examined in this review and reduced the level of confidence that could be placed in the results. For instance, there was a virtual absence of meaningful follow-up data across the studies, which precluded an opportunity to explore if the grief interventions yielded benefits that emerged over time that could not be detected at posttest. Nevertheless, this review assembled and reported the best available information on the increasingly popular area of grief therapy with children, in the hope of providing useful guidance for both clinical practice and future research.

As for future research, the first priority is to develop well-validated and clinically relevant measures of child grief. Second, researchers need to flesh out the theoretical underpinnings and the operational implementation of their interventions. As a starting point, theory would be advanced more by using “dismantling designs” (Wampold, 2001) that could assess the critical mechanisms within intervention programs, thus eliminating treatment components that are not particularly helpful with bereaved children. Also, none of the studies reviewed had a one-to-one ratio of therapist to child or adolescent. Even if the social interaction component of group-based interventions engenders important relational support and validation, a third issue is to examine if a subgroup of high-risk clients will benefit more from individual or family approaches to intervention. Of course, such a determination raises a fourth issue, that of the need for a thorough screening for and selection of grievers who will benefit from professional help. To this point, such a determination has been accomplished only with respect to complicated grief in adults (Prigerson & Maciejewski, 2006). However, in combination, addressing such issues could guide clinicians in selectively implementing grief therapy in a way that will be the most helpful to bereaved children, adolescents, and their families.

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