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The Benefits of a Grief and Loss Program With a Unique Technological Intervention

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The grief process, difficult for anyone, is especially challenging for children and adolescents because they integrate loss differently from adults both in terms of cognition and emotion (Webb, 2011). Studies have found that bereaved children and adolescents are at high risk for depressive symptoms, anxiety, somatic complaints, and academic difficulties, compared with children and youth who are not grieving (Cohen & Mannarino, 2004; Dowdney, 2000). It is therefore important to provide effective intervention. While researchers have found age-appropriate and developmentally relevant strategies that help children and adolescents navigate the grief process (Rosner, Kruse, & Hagl, 2010; Sandler et al., 2010), additional data-based studies to explore optimal therapeutic services for these youth can provide new choices.

This chapter contains a review of existing developmentally based models used to conceptualize children's grief processes and a discussion of empirical studies concerning child and adolescent adaptation to loss, with a special focus on our recent study of a novel technological intervention. The chapter also includes a discussion of directions for future work.

CHILD AND ADOLESCENT GRIEF MODELS

Webb (2011) offered a developmental conceptualization based on Piagetian cognitive development stages. During the preoperational stage (ages 2–7), children are egocentric; they view death as temporary, and they engage in magical thinking. In the concrete operational stage (ages 7–11), children begin to understand the finality, irreversibility, and universality of death. In the formal operational stage (ages 9–12), more logical and abstract thinking emerges, leading to an increased understanding of the death process. In the adolescent years, children begin to form complex conceptual frameworks for coping with death.

Worden's Task Model

Data from the Harvard Child Bereavement study guided the development of a task model that includes flexibility for youth progressing at developmentally

appropriate rates (Silverman & Worden, 1992, 1993). Their first task is to accept the reality of the loss, a task contingent in part upon the emergence of operational thinking around age 7 (Webb, 2011). The second task is to experience the pain of the loss; the third is adjusting to life without the loved one; and the fourth is to discover ways to memorialize dead loved ones, in a sense relocating them in their lives. Worden (1996) pointed out that each child resolves these tasks developmentally and that resolution occurs most effectively with the help of an adult who can regularly aid in the grief process.

EFFECTIVE INTERVENTIONS

Although therapeutic literature on intervention strategies for bereaved children and adolescents is available, empirically guided research is not so common (Currier, Neimeyer, & Berman, 2008). One exception is a meta-analysis conducted by Rosner, Kruse, and Hagl in 2010 to provide support for treatment models incorporating music therapy and brief school-based psychotherapy focused on grief.

Other researchers have identified several therapeutic interventions for facilitating children's and adolescents' grieving processes. Narrating personal stories and integrating feelings can lead to children understanding death (Cohen & Mannarino, 2004; Scaletti & Hocking, 2010). Art, bibliotherapy, play therapy, and multimedia are also beneficial therapeutic formats (Morgan & Roberts, 2010; Webb, 2011). Relevant support groups can be instrumental in helping grieving youth maintain a sense of connectedness and a positive outlook of the future (McNess, 2007). Cognitive-based interventions can help children who are dealing with more complicated grief adapt: Specifically, family-based programs have yielded positive results over time for parentally bereaved youth who had adopted maladaptive grief responses (Sandler et al., 2010).

The Role of Technology

The current societal trend of using the Internet to obtain information and support has led to research concerning the viability of technological interventions for dealing with grief. Researchers have begun to evaluate the ethical and appropriate use of technology in therapy, and to explore whether technological interventions can be helpful, while also maintaining professional standards of care (McMinn, Bearse, Heyne, Smithberger, & Erb, 2011; Van Allen & Roberts, 2011). Quality research is required to assess the potential benefits of the rapidly increasing number of technological interventions available (Jones, 2014).

Some researchers have suggested that children and adolescents often use the Internet when dealing with stress resulting from the death of a loved

one (Leung, 2007). Children and adolescents increasingly use technology in ways that expose them to risk if they reveal personal information (Livingstone, 2008). The full implications of processing emotions in an online forum are unclear (Williams & Merton, 2009). Adolescents are not always aware of privacy settings—a lack of knowledge that can place them in vulnerable positions if they reveal personal information. Despite the potential dangers, however, the Internet may still be a positive tool for grieving individuals because of its instant availability, information, and support (Gilbert & Horsley, 2011).

Some researchers support the incorporation of multimedia components in interventions for bereaved youth. For example, a review of developmentally appropriate interventions for bereaved adolescents suggests that creative arts, including visual arts, drama, and music provide needed benefits (Johnson & Alderson, 2008; Slyter, 2012). In a recent exploratory pilot study, participants in therapeutic filmmaking activities adjunct to university counseling services reported positive benefits, including increased sense of mastery and changes in perspective (Johnson & Alderson, 2008). Cohen (2007, 2012) and Marsick (2010) suggest that video-based therapies, including Cinematherapy (Solomon, 2001) may yield therapeutic benefit for adolescents within the field of expressive art therapies. In another study, researchers identified the efficacy of mobile phone self-monitoring in decreasing depressive symptoms (Kauer et al., 2012). Ortiz, Cozza, Fullerton, and Ursano (2013) found positive support for the effects of *Talk Listen Connect*, a self-directed multimedia program for children who had lost a parent.

In many cases technological interventions, either incorporated into traditional psychotherapeutic formats (Anderson, Spence, Donovan, March, & Kennedy, 2012) or used as distinct approaches (Kauer et al., 2012), have led to demonstrated positive therapeutic effects. *The Confessional* videotape technique described below is another example of how technology can be used effectively to treat bereaved children and adolescents.

Hope and Resilience

Hope can be conceptualized in terms of *agency*, or motivation towards a goal, and *pathways*, finding ways to reach the goal (Snyder, 2000). Although Cutcliffe (2004) demonstrated that therapists' hope is vital for the reemergence of hope in bereaved adults, research concerning the role of hope in the grief process of children and adolescents has been scant.

Sapienza and Masten (2011) defined resilience in youth as "the capacity of a dynamic system to withstand or recover from significant challenges that threaten stability, viability, or development" (p. 268). Others have conceptualized resilience as a sense of mastery, a sense of relatedness, and moderated emotional reactivity. A sense of mastery includes optimism, self-efficacy, and adaptability. A sense of relatedness includes a sense of trust,

perceived access to support, comfort with others, and tolerance of differences. Emotional reactivity includes sensitivity, recovery, and impairment (Prince-Embury, 2007).

THE CURRENT STUDY

Within this context, we investigated the use of a technological intervention, *The Confessional*, which allows young people to speak to a camera behind a two-way mirror. The Confessional is a creative bereavement intervention tool such as those reviewed by Slyter (2012). It has elements of Gestalt therapy (being rooted in a phenomenological construct, using an empty chair approach, and involving psychodrama) and allows individuals to respond freely to open-ended questions and prompts. We measured the effects of engagement in the Confessional by noting self-reported accomplishment of Worden's grieving tasks (Worden, 1996).

This unique intervention provided a safe, relevant medium for youth to process grief verbally. We examined hope and resilience before and after participants' time in the program, hypothesizing a significant increase in hope, sense of mastery, and sense of relatedness, along with a significant decrease in emotional reactivity. We also expected that the technological intervention would facilitate accomplishing the four grieving tasks (Worden, 1996).

METHODOLOGY

Participants

Participants entered the study through a grief support program facilitated by a grief and loss center for children and adolescents in Pennsylvania. They participated in the program for 8 weeks. Forty-nine children and youth in three separate programs (summer, winter, and spring) were recruited, including 16 boys and 33 girls ranging in age from 6 to 18 years. The majority of the young people in the program had lost their loved ones 3 to 6 months prior. Of the 49 participants, 33 had lost a parent, 4 had lost a grandparent, 5 had lost a sibling, 3 had lost a cousin, 2 had lost a great grandparent, 1 had lost an uncle, and 1 had lost a friend. Causes of death included illness (22), suicide (2), sudden death (12), homicide (8), and accidental death (4).

Instruments

The grief and loss program in this study facilitated children learning healthy ways to express their feelings about bereavement. Coping skills were taught and encouraged through engagement in program activities that included a

visit to a funeral home that provided appropriate information. The program culminated with a review and a celebration of life ceremony that included a balloon release. During this time, children were empowered to be "wisdom givers" to others in their communities who were experiencing grief. These interventions are similar to those that were empirically supported in a bereavement camp where a balloon release, memorial service, and journaling were implemented (McClatchey & Wimmer, 2012).

Children's Hope Scale. The Children's Hope Scale contains six self-report items for children aged 7 to 16 years, resulting in an overall score, a score for pathways, and a score for agency (Snyder, 2000). Administration and scoring took approximately three minutes. Response options followed a Likert format and included the items none of the time, a little of the time, some of the time, a lot of the time, most of the time, and all of the time. The measure was filled out by the children alone or with the aid of readers available to help those without the requisite reading skills (Snyder et al., 1997). Our original study design included using the Adult Dispositional Hope Scale for participants over the age of 16 years and the Young Children's Hope Scale for children under the age of 7 years. However, analysis of data from these two age ranges was precluded by low numbers of participants (only four adolescents and one 6-year-old child).

Resiliency Scales for Children and Adolescents. The Resiliency Scales for Children and Adolescents contain three subscales (20 to 24 items each) that measure (a) sense of mastery, (b) sense of relatedness, and (c) emotional reactivity in youth aged 9 to 18 years (Prince-Embry, 2007). It took approximately fifteen minutes to complete. Respondents answered questions on a Likert scale containing the elements never (0), rarely (1), sometimes (2), often (3), and almost always (4).

Confessional Questionnaire. Study participants filled out five-item questionnaires developed specifically for this study following each use of the Confessional. Four questions related to Worden's (1996) four tasks of grieving and one related to their overall experience. Respondents answered these questions on a Likert scale between not helpful (1) and very helpful (5). See Table 7.3 for specific Confessional Questionnaire items.

Procedure

The 8-week support program in which the children and youth participated was facilitated by a grief and loss center for children and adolescents. Each week, the age groups (elementary: 6–11 years; middle: 12–14 years; and adolescent: 14–18 years) met for 1.5 hours. The participants in these groups were encouraged to cope with their grief by engaging in various activities that were designed to increase their coping skills, enable emotional expression, and encourage memory sharing. The program is not considered formalized therapy, but rather a multifaceted supportive program to help youth navigate grief.

Participants were invited to take part in this study to investigate the efficacy of video-based technology. Parents or caregivers as well as the children provided consent and assent, respectively. All participants responded to the Resiliency Scales for Children and Adolescents and we analyzed answers appropriately for each participant's age. Children aged 7 to 16 years responded to the Children's Hope Scale. We distributed all forms both pre- and post-participation.

The participants had the unique opportunity to confidentially use the Confessional, a room with brightly painted walls, a couch, a television monitor, and a one-way mirror with a camera. They could choose to use the Confessional alone, with a friend, with their entire age group, with their group facilitator, or with the program director. They were encouraged to speak freely, read something aloud, play an instrument, play with toys, or respond to questions on the television monitor. The program director regularly reviewed video footage to ensure the safety of all participants. No other individuals viewed the footage and it has been kept confidential. Each time the participants used the Confessional, they filled out the Confessional Questionnaire described above.

Statistical Analysis

The process described above resulted in the variables in Table 7.1. The first variable, time, was the grouping variable. The two hope measures—agency and pathways; the resiliency measures—sense of mastery, sense of relatedness, and emotional reactivity; and measures related to the Confessional Questionnaire provided the means for close statistical analysis of the program's efficacy.

We performed one-tailed paired *t* tests to measure changes in overall hope, agency, pathways, mastery, relatedness, and emotional reactivity. A one-tailed test was appropriate because we specifically hypothesized increases or decreases in the variables. Pairing was appropriate given that we had two readings (before and after) for each participant. For the Confessional Questionnaire, we examined the mean values for each of the five items on the survey to ascertain how the children responded to the intervention.

Results

Descriptive statistics. Table 7.2 contains the sample sizes (*N*), means (*M*), and standard deviations (*SD*) for each of the hope and resilience scales and Table 7.3 contains the means and standard deviations for each element of the Confessional Questionnaire.

Analysis. We performed one-tailed paired *t* tests to identify changes in the hope and resilience variables from the beginning to the end of the program. The Confessional Questionnaire provided descriptive information that showed to what extent participants who used the tool found it to be helpful.

Table 7.1 Variables used in this study

Variable		Variable Type	Group or Minimum	Group or Maximum	Instrument	Number of Readings
Hope	Overall Hope	Scalar	6	36	CHS*	2
	Agency	Scalar	3	18	CHS	2
	Pathways	Scalar	3	18	CHS	2
Resiliency	Sense of Mastery	Scalar	0	80	RSCA†	2
	Sense of Relatedness	Scalar	0	96	RSCA	2
	Emotional Reactivity	Scalar	0	80	RSCA	2
Confessional		Scalar	5	25	CQ‡	Dependent upon how many times participants used the Confessional

*Children's Hope Scale (CHS)
†Resiliency Scales for Children and Adolescents (RSCA)
‡Confessional Questionnaire (CQ)

Table 7.2 Means and standard deviations for pre- and post-measures

	Pre			Post		
Measures	N	M	SD	N	M	SD
Hope (Ages 7–16)	41	24.95	5.26	41	26.92	5.36
Agency	41	12.44	3.07	41	13.78	3.07
Pathways	41	12.51	2.78	41	13.14	2.96
Resilience (Ages 9–18)						
Sense of Mastery	36	49.25	9.04	36	52.39	10.62
Emotional Reactivity	35	53.43	9.56	35	51.60	11.54
Sense of Relatedness	36	50.06	8.44	36	50.64	7.94

Table 7.3 Means and standard deviations for questions on the Confessional Questionnaire

Question	M	SD
1. My time in the Confessional was helpful.	4.45	0.86
2. My time in the Confessional helped me accept the death of the person who died.	3.74	1.23
3. My time in the Confessional helped me to feel the hurt I have from losing the person who died.	3.63	1.38
4. My time in the Confessional helped me to get used to life without the person who died.	3.93	1.11
5. My time in the Confessional helped me to find ways to remember the person who died.	4.25	1.12

Hope. Using one-tailed paired t tests ($1 - \beta = .93$), we found that overall hope and agency increased during participation in the program with statistical significance, $t(40) = -2.454$, $p = .010$ and $t(40) = -2.820$, $p = .004$. Overall hope increased by 1.97 and agency by 1.34.

Resilience. Again using a one-tailed paired t test ($1 - \beta = .90$), we found that children's sense of mastery increased with participation in the program, $t(35) = -2.128$, $p = .020$. Mastery increased by 3.14.

The Confessional. As shown in Table 7.3 and in Figure 7.1, data indicated that the Confessional aided participants in accomplishing Worden's (1996) four tasks of grieving. Ten participants used the Confessional once, 14 used it twice, 7 used it three times, and 6 used it four times.

Discussion

In this study, we explored factors that could promote healing after the deaths of loved ones among children and adolescents participating in a bereavement program that made use of a unique technological intervention.

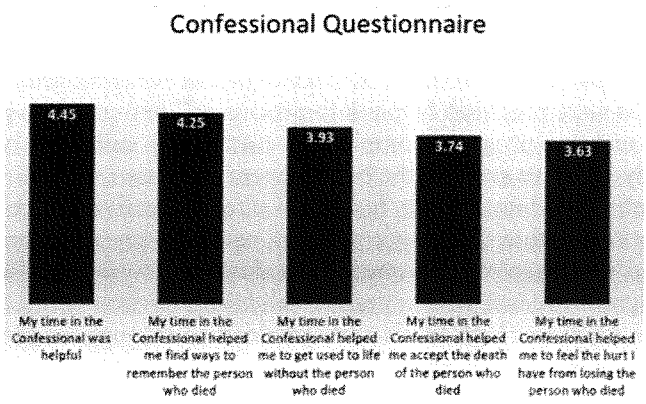

Figure 7.1 Average responses to questions on the Confessional Questionnaire

Overall, the data provided evidence of the clinical utility of the grief program as indexed by multiple therapeutic changes.

Researchers have used empirical studies to identify themes of healthy bereavement, including open communication, peer connection, and emotional catharsis (McClatchey & Wimmer, 2012). A child bereavement camp also has provided evidence that grief is a process that includes coping, empowerment, and hope (Swank, 2013). These themes were congruent with the significant factors that emerged in this study.

Hope

Significant changes were observed in overall hope and in agency for children aged 7 to 16 years. In addition, program alumni offered hope and validation to current participants, and at the close of the program, youth were encouraged to share with others the wisdom and skills that they had gained. It is reasonable to state that the need for hope drew families to the program in this study for various reasons congruent with Snyder's (2000) framework.

Resilience

Sense of mastery. Johnson and Alderson (2008) identified sense of mastery as one of the mechanisms of change that contributed to the positive therapeutic effects of using film as therapy for young adults. The use of the Confessional in this study leads to the new question of whether children might gain a greater sense of mastery when they are able to use tools such as the Confessional to create a narrative for themselves. The use of the Confessional in our program could explain why the children gained a greater sense of mastery than they did a sense of relatedness and why emotional reactivity did not change as much as sense of mastery did.

Emotional reactivity. The lack of change in emotional reactivity over the course of participation in the program may reflect the specific therapeutic goals of this particular program. Rather than discouraging grief reactions, coping skills were taught to help youth process and express their grief effectively. As such, at program completion, youth may still have been in an emotionally sensitive stage in the bereavement process.

Sense of relatedness. High levels of interpersonal connections were quickly formed within the program. Trust, access to support, comfort with others, and tolerance of differences are values that were established early in the program because of the unique validating environment. A sense of relatedness started at high levels and remained so throughout the program but did not change significantly.

Technology: The Confessional

Confessional Questionnaires completed by participants demonstrated that each item was rated with a mean greater than 3 ("above average") out of 5. The young people in this program said that using the Confessional especially helped them to accept the death of their loved ones as well as to remember those individuals. The majority of youth in the program had lost their loved ones 3 to 6 months prior to beginning the program. This passage of time may have affected variables such as emotional reactivity. Furthermore, it may be neither appropriate nor feasible to expect the limited number of variables that can be collected in a temporary setting in front of a camera to encompass the entirety of the complex process of grief.

Nonetheless, this technological intervention was a safe outlet for the participating children and adolescents to communicate feelings about their grief and loss; society provides many less optimal avenues for self-expression. Roberts (2004) said that adolescents used online social networking to communicate feelings that they would not have felt comfortable discussing in person. Cohen (2007) also suggested that some adolescents who are resistant to therapy might prefer the use of video therapy in order to receive help. Young people tend to use the Internet more heavily following the death of a loved one; however, some researchers have raised questions about the safety of this practice (Leung, 2007; Livingstone, 2008; Williams & Merton, 2009). The Confessional is a safe alternative to engage with technology, giving young people a means of verbal and emotional expression without parents or caregivers present (Scaletti & Hocking, 2010). The Confessional also provides youth with the freedom to choose how to use the technology (alone, with peers, or with the program director) and a place to express themselves that is not necessarily face to face.

GLOBAL EXPLANATION OF FINDINGS

While participating in the program, youth were told that all of their emotions were acceptable and were given the skills to manage them. Administrators

told participants that they would not perform therapy; they designed the program to be an educational and supportive milieu, a validating and supportive environment for young people to share their stories verbally with others experiencing similar grief and loss (Cohen & Mannarino, 2004; Scaletti & Hocking, 2010). This study, with others, has shown that hope and a sense of mastery are significant factors related to grief (McNess, 2007). Participants found the Confessional to be helpful overall and in particular by offering ways to help remember deceased loved ones. This innovative tool might give youth the opportunity to share their experiences safely while interacting with an expressive and creative technology within a secure and trusted environment.

IMPLICATIONS

The data in this study show that the youth who used it found using the Confessional helpful as they worked their way through grief as depicted in Worden's (1996) model. Moreover, within the context of the program, hope and a sense of mastery changed significantly for this group of children and adolescents. These findings suggest that utilizing an intervention similar to the Confessional might yield similar effects for clients in other therapeutic settings.

Based on a review of the literature, therapists should consider the development of coping skills in addition to the provision of hope to children as a main goal of bereavement therapy. Interventions could include empowering children to create reasonable goals and ways to achieve them as a way of fostering self-efficacy, optimism, and hope. It also might be appropriate to refer families to grief and loss centers or camps for youth, or to work with them independently in more traditional therapeutic settings. Grieving children should be monitored long-term because of their tendencies to revisit bereavement, manifest symptoms extending beyond 1 or 2 years past the deaths of loved ones, and experience possible delayed or prolonged grief (Melhem, Porta, Payne, & Brent, 2013; Silverman & Worden, 1996).

LIMITATIONS AND FURTHER STUDY

Limitations of this study included a lack of standardization of the Confessional experience, in terms of time and selected activities, and the fact that ethnicity could not be investigated because of incomplete demographic information provided by parents or guardians. In addition, the various types of losses the children experienced might have caused variations in the intensity of the experience; closeness to deceased loved ones, the type of death, and presence at the time of death, for instance, all have possible effects on grief (Draper & Hancock, 2011). Another factor that would interfere with drawing conclusions from the data was that the children and adolescents

in the program received different levels of professional help outside of the program. In addition, the Confessional Questionnaires were not linked to participants or to participants' other survey data. This precluded individual pre- and post-measure comparisons and analysis of how the Confessional related explicitly to hope and resilience measures. The Confessional was only part of a program with other tools available to participants, any of which could have affected the hope and resilience measures or even the efficacy of the Confessional itself. The study also had no control group; although it is therefore possible to identify areas for further study, it is not possible to draw definitive conclusions from these data.

Further studies may be enhanced by the use of a larger sample size, the inclusion of a control group, the expansion of demographics, and the inclusion of long-term follow-up. It also might be useful to conduct studies using a similar technological intervention in other settings such as a private practice office or a school in order to isolate the effects of the tool.

Having a more comprehensive understanding of specific instruments that can be used to evaluate the grief of children and adolescents will facilitate recognition of the changes in processes involved in grief recovery. A growing body of research indicates that bereaved children and adolescents benefit from timely therapeutic interventions that are sensitive to their developmental level and emerging cognitive complexity. In addition to more traditional psychotherapeutic models, innovative approaches, including multimedia therapy, and technological components, such as therapeutic filmmaking and the videotaped Confessional approach described in the current study, may provide youth with specialized opportunities to further process their grief. Researchers should continue to explore the effectiveness of novel technologically based interventions as ways to help bereaved children and adolescents adjust.

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