Utah State University
DigitalCommons@USU

All Graduate Theses and Dissertations Graduate Studies

5-2002

Good Grief Kids: An Exploratory Analysis of Grieving Children and Teens at The Dougy Center in Portland, Oregon

Karen Sorensen
Utah State University

Follow this and additional works at: https://digitalcommons.usu.edu/etd

Part of the Social and Behavioral Sciences Commons

Recommended Citation

Sorensen, Karen, "Good Grief Kids: An Exploratory Analysis of Grieving Children and Teens at The Dougy Center in Portland, Oregon" (2002). *All Graduate Theses and Dissertations*. 2669.
https://digitalcommons.usu.edu/etd/2669

This Thesis is brought to you for free and open access by the Graduate Studies at DigitalCommons@USU. It has been accepted for inclusion in All Graduate Theses and Dissertations by an authorized administrator of DigitalCommons@USU. For more information, please contact digitalcommons@usu.edu.

GOOD GRIEF KIDS: AN EXPLORATORY ANALYSIS OF GRIEVING CHILDREN AND TEENS AT THE DOUGY CENTER IN PORTLAND, OREGON

by

Karen Sorensen

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family and Human Development

Approved:

UTAH STATE UNIVERSITY
Logan, Utah

2002

Copyright © Karen Sorensen 2002

All Rights Reserved

ABSTRACT

Good Grief Kids: An Exploratory Analysis of Grieving Children

and Teens at The Dougy Center in Portland, Oregon

by

Karen Sorensen, Master of Science

Utah State University, 2002

Major Professor: Dr. Marcelo Diversi
Department: Family and Human Development

Every year in the United States, anywhere from 200,000 to 400,000 youths under the age of 19 will experience the death of a parent (or both) or a sibling. The Dougy Center in Portland, Oregon, was established in 1983 to assist grieving children. Support groups are based on principles of nondirective play therapy. During the years 1996-2000, The Dougy Center administered questionnaires to a number of its clients. The results of one of these questionnaires, *The Center for Epidemiological Studies-Depression Scale* (CES-D), showed that 48% of those receiving services were severely depressed at the time of entrance into the program with another 15% showing symptoms of mild-moderate depression. Depression is the most commonly studied outcome of grief and mourning among all age groups (children, adolescents, and adults). Two additional questionnaires measured basic symptomatology at the time of intake into the program. The Child Intake Form showed that those ages 3-12

generally had difficulty being around others since the death and wanted to spend more time alone. The Teen Intake Form showed that those ages 13-18 relied upon friends for support following the death; furthermore, normal patterns of eating, sleeping, and attending school have been disrupted since the death. The only questionnaire to be administered after clients had received services was the Family Self-Evaluation (FSE). Children and teens responded to this questionnaire, reporting that since attending groups at The Dougy Center they are *feeling better*. Many respondents reported that the most helpful aspect of the support groups came from knowing that others were experiencing similar emotions and transitions. Limitations in the reported findings came from too small of a sample size, convenience sampling procedures, administration of an age-inappropriate instrument, and a lack of pretesting and posttesting procedures.

(114 pages)

ACKNOWLEDGMENTS

I want to express deep appreciation to my committee members: Dr. Marcelo Diversi, Dr. Kathy Piercy, and Dr. Eddy Berry. I want each of you to know how appreciative I am that you said "yes" during the most critical period of my entire academic career. Thank you!

I would also like to express my appreciation to Dr. Marcie Goodman for her enormous support throughout this entire journey. I hope you know how much your support and guidance have meant to me. Thank you!

I need to thank the wonderful staff of The Dougy Center, especially Joan Schweizer Hoff, for working with me on this project. Thank you for letting me *set up camp* in your offices while I collected the data. My deepest thanks to The Dougy Center is for the fact that they provide a place of comfort, hope, and healing to grieving children.

I am dedicating this work to my nephew, Kristopher Kerry Osborne (born June 22, 1978, died October 10, 1999). When you were born, my heart learned new depths of love. When you died, my heart learned new depths of pain. I miss you!!

Karen Sorensen

CONTENTS

Page

ABSTRACT . . . iii

ACKNOWLEDGMENTS . . . v

LIST OF TABLES . . . viii

LIST OF FIGURES . . . xi

CHAPTER

1. STATEMENT OF THE PROBLEM . . . 1

2. REVIEW OF THE LITERATURE . . . 5

General Overview of Bereavement Trajectories . . . 5
Childhood Bereavement and Later Depression in Adulthood . . . 7
Childhood Bereavement and Concomitant Depression . . . 11
Summary of Literature . . . 13
Gaps in Extant Literature . . . 13
Purpose of the Study . . . 14
Research Question and Hypotheses . . . 14

3. METHODS . . . 16

The Dougy Center . . . 16
Participants/Sample . . . 17
Instrument: CES-D . . . 20
Validity and Reliability . . . 23
CES-D, Hogan Grief Reaction Checklist, and Validity/Reliability . . . 26
Instrument: FSE . . . 27
Instrument: The Dougy Center Intake Questionnaire, Child Form . . . 28
Instrument: The Dougy Center Intake Questionnaire, Teen Form . . . 29
Procedures . . . 29
Analysis . . . 30
Potential Implications of the Current Study . . . 30

Chapter Page

4. RESULTS 32

The CES-D Questions Evaluated Individually 42
Intake Questionnaire, Child Form 46
Intake Questionnaire, Teen Form 50
Family Self-Evaluation 58

5. DISCUSSION 68

The Center for Epidemiological Studies-Depression Scale 70
Child Intake Questionnaire 72
Teen Intake Questionnaire 73
Family Self-Evaluation 74
Limitations of the Current Project 77
Implications and Recommendations of This Study 79

REFERENCES 81

APPENDIXES 85

A. The Dougy Center Contact Information 86
B. CES-D Scale Scoring 87
C. Institutional Review Board Letter of Approval 89
D. Letters of Permission 90
E. The Dougy Center Population (Entire) From 1996 to 2000 92
F. The Dougy Center for Grieving Children Family Self-Evaluation . . 96
G. The Dougy Center Intake Questionnaire: Child Form 98
H. The Dougy Center Intake Questionnaire: Teen Form 100
I. Independent and Dependent Variables Correlation Matrix 102

LIST OF TABLES

Table		Page
1	Gender and Mean Age for All Samples	18
2	Relationship of the Decreased to the Respondent for All Samples	19
3	Type of Death for All Samples	19
4	CES-D: Format for Self-Administered Use	22
5	Weighting of the CES-D Scoring	24
6	CES-D "Depressive Continuum" Scoring Range	24
7	CES-D by ANOVA	34
8	CES-D by Reliability Analysis (Alpha) and Most/Least Indicative Questions	35
9	CES-D by Reliability Analysis (Alpha)	36
10	Cronbach's Alpha for Each of The Dougy Center Support Groups by Actual Age Group	37
11	Frequencies for Selected Independent Variables and the Dependent Variable	38
12	Frequency Rate of: How Stressful Have the Past Few Months Been for You?	45
13	Frequency Rate of: At This Point in Time, How Well Do You Feel You Are Coping with the Death?	45
14	Intake Questionnaire, Child Form: "Since the Death, I Want to Be By Myself"	46
15	Intake Questionnaire, Child Form: "Since the Death, School Has Been"	47
16	Intake Questionnaire, Child Form: "Since the Death, I Get Along with Friends"	47

Table Page

17 Intake Questionnaire, Child Form: "Since the Death, I Get Along with Members of My Family" 48

18 Intake Questionnaire, Child Form: "Since the Death, My Sleep Is" 48

19 Intake Questionnaire, Child Form: "Since the Death, I Eat" 48

20 Intake Questionnaire, Child Form: "Since the Death, I Sometimes Have Physical Hurts" 49

21 Intake Questionnaire, Child Form: "All the Feelings That Apply to You Now" 49

22 Intake Questionnaire, Child Form: "Do You See a Counselor Now?" . . . 50

23 Intake Questionnaire, Child Form: "Do You See a Counselor Outside of School?" 50

24 Intake Questionnaire, Teen Form: "How Has Your Relationship with Your Parent(s) Been Affected Since the Death?" (Content Analysis, Emerging Themes) 51

25 Intake Questionnaire, Teen Form: "How Have the Areas of School, Grades, and Teachers Been Affected Since the Death?" (Content Analysis, Emerging Themes) 52

26 Intake Questionnaire, Teen Form: "How Have the Areas of Friendships and Social Life Been Affected Since the Death?" (Content Analysis, Emerging Themes) 53

27 Intake Questionnaire, Teen Form: "How Have the Areas of Sleep and Eating Habits Been Affected Since the Death?" (Content Analysis, Emerging Themes) 54

28 Intake Questionnaire, Teen Form: "How Have Your Relationships with Other Family Members Been Affected Since the Death?" (Content Analysis, Emerging Themes) 54

29 Intake Questionnaire, Teen Form: "What Emotions Have You Experienced Since the Death?" 55

Table Page

30 Intake Questionnaire, Teen Form: "Since the Death, Have You Experienced Any Physical Symptoms?" 56

31 Intake Questionnaire, Teen Form: "Are You Taking Any Medications?" . . 56

32 Intake Questionnaire, Teen Form: "Are You Seeing a Counselor?" 57

33 Intake Questionnaire, Teen Form: "Who Are the Supportive People You Talk to about the Death?" 57

34 Family Self-Evaluation: Current Length of Participation at The Dougy Center 58

35 Family Self-Evaluation: "Since Coming to The Dougy Center, I Feel" . . . 59

36 Family Self-Evaluation: Tell about Your Dougy Center Experience (Content Analysis, Emerging Themes) 60

37 Family Self-Evaluation: What Has Been the Most Helpful Aspect of Attending The Dougy Center? (Content Analysis, Emerging Themes) . . . 61

38 Family Self-Evaluation: What Has Been the Least Helpful Aspect of Attending The Dougy Center? (Content Analysis, Emerging Themes) . . . 62

39 Family Self-Evaluation: When Will I Be Ready to Leave The Dougy Center? 64

40 Family Self-Evaluation: The Most Helpful Thing Right Now Would Be? (Content Analysis: Emerging Themes) 64

41 Family Self-Evaluation: What I Need to Do Before Closing at The Dougy Center? (Content Analysis: Emerging Themes) 65

42 Family Self-Evaluation: What I Will Do in the Next 6 Months? (Content Analysis: Emerging Themes) 67

43 Demographic Data Spreadsheet 93

44 Pearson Correlations of Independent and Dependent Variables 103

LIST OF FIGURES

Figure Page

1 Gender of CES-D participants by percentage 38

2 Age (by The Dougy Center support groups) of CES-D participants by percentage 39

3 Relationship of deceased of CES-D participants by percentage 39

4 Type of death in relation to CES-D participants by percentage 40

5 Time between death and administration of CES-D participants by percentage 40

6 Composite scores by depression level of CES-D participants by percentage 41

CHAPTER 1

STATEMENT OF THE PROBLEM

> Do you know the sensation of being a child and being alone? Children can adapt wonderfully to specific fears, like pain, sickness, or a death. It is the unknown which is truly terrifying for them. They have no fund of knowledge in how the world operates and so they feel completely vulnerable. (Katzenbach, 1986, p. 322)

Children grieve. They strongly sense loss when a person close to them dies. In spite of this, many of us like to believe we can protect children and adolescents from loss and death, even though the power to do so is elusive. Kastenbaum (2000) suggested that many adults tend to think of childhood as the "kingdom where nobody dies" (p. 5). Such is not the case, since 5% to 6% of children and teens under the age of 18 will experience the death of one or both parents (Harris, 1995; McLeod, 1991; Zall, 1994). An additional 1% to 3% will lose a sibling through death.

Statistics alone do little to show the real impact of parental and sibling death. According to the 2000 Census, as of April 1, 2000, the population of the United States was 281,421,906. The total population of children and teens—birth through age 19—accounted for 80,472,265 people or 28.6% of the total population. Applying the percentages presented earlier to 2000 Census data, the numbers range from 4 million to 7½ million youths who will have experienced the death of a parent (or both) or a sibling by the time they reach age 19. To break the numbers down even further (using the assumption that equal numbers are affected each year), in the United States, anywhere from 200,000 to 400,000 youths under the age of 19 will experience the death of a parent (or both) or a sibling.

In American society, it seems that many adults have a difficult time dealing with their own responses to grief, to the point of denying that their emotions surrounding grief even exist. With this level of discomfort, seeing children experience the death of a loved one can lead to even further denial—denying the fact that children really are impacted by death and do in fact grieve deeply.

Due to the traumatic nature of events surrounding the death of a loved one, there are many transitions and adjustments to be made at such a time. A panoply of emotions follow this "psychological insult" (Raveis, Siegel, & Karus, 1998, p. 165) such as anger, fear of abandonment, regression, and especially depression—as this has been the most widely recognized and researched emotional response following the death of a loved one. These factors often seriously threaten a child's social and emotional development (Raveis et al.). Support of children and teens as they grieve can help them to make sense of the loss and learn to incorporate the loss into their new life without the beloved person.

Gersten, Beals, and Kallgren (1991) proposed that children ages 8 to 15 were a population potentially at risk due to the experience of the death of a parent. They conducted an epidemiological study examining potential mental health disorders in this target group. The conclusions reached in this study indicated that children who experience the death of a parent are at 6.5 times greater risk of developing depressive symptoms than children who reside in families where both parents remain alive.

The current study examined the pivotal emotional response of depression linked to the death of a loved one, including death of a parent, sibling, grandparent,

or friend during childhood. The goal of this study was to better understand the myriad responses of children to grief, as elicited in a nonprofit organization specifically designed to work with grieving children, *The Dougy Center, The National Center for Grieving Children and Families*, located in Portland, Oregon (see Appendix A). Although the power to prevent the deaths of those our children love is not possessed by anyone, attempts can be made to describe and better understand their reactions in order to provide appropriate services and support.

The goal of this project was addressed by analyzing previously unexamined data generated from the administration of a well-known and widely used questionnaire known as *The Center for Epidemiological Studies-Depression Scale* (CES-D) (Radloff, 1977) (see Appendix B). This instrument was administered to various clients of The Dougy Center from 1996 to 2000 to approximately 140 of their child and adolescent clients (see Appendix C and Appendix D). The use of three ancillary questionnaires administered to subsets of the same population was evaluated through the technique of content analysis to flesh out details of depression and other general findings. Details of all the questionnaires are outlined in Chapter 3.

The current endeavor was primarily investigative and descriptive in nature, designed to provide a baseline for future research concerning bereaved children, depression, and the use of established models of measurements that nonprofit organizations can use in their program evaluations. One of the central goals of this project was to capture the children and teens' perceptions of their grieving processes. Through the use of open-ended questionnaires, answers to matters such as "what has

been the most and/or least helpful thing about coming to The Dougy Center" and "what would now help that child the most" come shining through in their own words. Given that no published studies exist to date that used *these instruments* to look at children's and teens' grieving, this study will help to fill missing pieces in the current literature on grief.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter reviews published literature that focuses on issues of childhood bereavement as it relates to later adult depression as well as concomitant depression. After a summary of the literature is reviewed, the gaps in extant literature are examined. The purpose of the current study, along with the research question and hypotheses, round out the chapter.

General Overview of Bereavement Trajectories

Many theorists, beginning with Freud, have described stages that a person goes through following the death of a loved one. No one theory is promoted in this project; they are being presented only to provide a base of knowledge concerning *normal* responses to grief, bereavement, and mourning. In addition, they are presented in chronological order to prevent any perceived promotion of a particular theory.

Sigmund Freud postulated a *grief work* theory nearly a century ago that has been adopted by many of those working with, or studying, bereaved populations (Kastenbaum, 2001). Freud's theory has the following propositions: (a) Grief is an adaptive response to loss; (b) the work of grief is difficult; (c) the basic goal of grief work is to accept the reality of the death and thereby liberate oneself from the strong attachment to the lost object; (d) grief work is carried out throughout a long series of confrontations with the reality of the loss; (e) the process of grief work is complicated

by the survivor's resistance to letting go of the attachment; and (f) the failure of grief work results in continued misery and dysfunction (Kastenbaum, 2001).

In 1944, Erich Lindemann postulated that normal or ordinary grief would resolve on its own, whereas abnormal grief may require outside help, including, but not limited to, support groups. For Lindemann, there are two tasks for bereaved persons: (a) accept the loss and (b) work through the pain (Kastenbaum, 2001).

Possibly the most recognized theory of bereavement trajectories is from work that was originally done with terminally ill patients and not the people who are left behind after the person dies. The work of Elisabeth Kubler-Ross from 1969 outlines her five stages of dying, and more recently, grieving. The stages include the following: (a) denial, (b) anger, (c) bargaining, (d) depression, and (e) acceptance (Leming & Dickinson, 2002).

Colin Murray Parkes drew upon the attachment theory work of John Bowlby in 1970 to present his four phases of mourning: (a) shock and numbness, (b) yearning and searching, (c) disorganization and despair, and (d) reorganization (Corr, Nabe, & Corr, 2000). Robert Kavanaugh has the longest list of bereavement trajectory behaviors: (a) shock and denial, (b) disorganization, (c) volatile emotions, (d) guilt, (e) loss and loneliness, (f) relief, and (g) reestablishment (Leming & Dickinson, 2002).

The most recent additions to grief work theories come from William Worden in 1991 and Therese Rando in 1993. Worden's four tasks include the following: (a) accept the reality of the loss, (b) work through the pain of grief, (c) adjust to an

environment in which the deceased is missing, and (d) emotionally relocate the deceased and move on with life (Corr et al., 2000). Rando's six processes include the following: (a) recognize the loss, (b) react to the separation, (c) recollect and reexperience the deceased and the relationship, (d) relinquish the old attachments to the deceased and the old assumptive world, (e) readjust to move adaptively into the new world without forgetting the old, and (f) reinvest (Corr et al.).

Childhood Bereavement and Later Depression in Adulthood

Literature related specifically to the time immediately following the death of a loved one in childhood and depression is sparse (Gersten et al., 1991; Raphael, 1982; Worden, 1996; Worden & Silverman, 1996). On the other hand, there is a fair amount of literature that tackles the topic of early childhood bereavement linked to later adult depression (Finkelstein, 1988; Hurd, 1999; McLeod, 1991; Mireault & Bond, 1992; Raveis et al., 1998; Reinherz, Giaconia, Hauf, Wasserman, & Silverman, 1999; Rodgers, Power, & Hope, 1997). Later, adult depression is studied more often than concomitant depression for a number of reasons. One reason is that children lack experience with dying and death. Another reason is the developmental limitations of abstract thought in children that makes fully comprehending the mourning process difficult at best. These limitations have created methodological difficulties for those wishing to study grieving children. These cognitive limitations can also present difficulties in the mourning process and are indicated by persistent anxiety, a desire to die, persistent blame and guilt, compulsive self-reliance, and

aggressive outbursts (Dilworth & Hildreth, 1997).

Since depression represents the most commonly studied outcome of parental loss (McLeod, 1991), it is important to discuss the literature that relates to later adult depression in addition to depressive symptoms immediately following the event of childhood bereavement. Several articles note gender and age factors as they relate to future depression. Finkelstein (1988) conducted an extensive review of the literature that was available concerning the long-term effects of early parental death. He stated that the most consistent findings showed a relationship between losing one's mother during the formative years and later depression, especially severe depression. Finkelstein also pointed out in his review of extant literature that certain studies showed that later depression was *not* highly associated with early paternal death.

In a related article, McLeod (1991) stated that loss of the mother before age 11, but not loss of the father, is one of the social conditions that can be traced to later adult depression. The younger the child is at the time of the parental loss, especially those who lose their mothers, the higher the risk of depression than for those who do not experience parental loss due to death. In addition, Reinherz and colleagues (1999) conducted a study to determine which childhood risks were associated with depression in the transition to adulthood. This study concluded that, for women, one of the major risk factors was the death of a parent before reaching the age of 9.

Raveis and colleagues (1998) looked at factors that predispose certain children to poor outcomes following the death of a parent, with one of these outcomes being later adult depression. Children under 5 and those in early adolescence are especially

vulnerable to early parental death (Raveis et al.). According to Raveis and colleagues, gender also plays a factor in later adult depression following early parental loss. Girls under age 11 whose mother died and adolescent boys whose father died are at increased risk of depression relative to others who have experienced the death of a parent during childhood. An additional risk factor included the fact that the death was sudden (Raveis et al.).

Other researchers (Hurd, 1999; Rodgers et al., 1997) have studied survivors of early parental death and concluded that later adult depression is not necessarily associated with the death of a parent in childhood but could possibly be mediated by healthy strategies of bereavement. There are a number of strategies that are considered to provide healthy support for bereaved children. Bowlby (1980) stated that parental loss could be tempered through the establishment of a secure relationship with another adult. Hurd (1999) outlined several variables that could reduce the likelihood of later depression, including a loving relationship with the deceased person before the death occurred. Additional variables include strong emotional support from the surviving parent, the ability of the family to communicate openly about the death, consultation with the child concerning the family's future, and help from extended family members (Hurd). Healthy adjustment is much more likely to take place in a family environment that promotes open communication about feelings and facilitates the sharing of information about the deceased (Raveis et al., 1998).

Hurd (1999) conducted a study to determine if depression is an inevitable outcome of the childhood bereavement experience, as the Freudians believe, or if

children can experience healthy mourning, as Bowlby predicted. Four types of bereavement outcomes were measured, including (a) *appreciation*, (b) *frustration*, (c) *enmeshment*, and (d) *ambivalence*. Appreciation is characterized by feelings of gratitude for the deceased, whereas frustration is established through feelings of lamenting the short time the child had with the deceased parent. Enmeshment is described as feelings of affection for the deceased parent and a moderate amount of respect for the surviving parent, whereas ambivalence is characterized by feelings of negativity toward the deceased parent. Hurd concluded that depression following childhood bereavement was not inevitable. Of the four types of bereavement that were catalogued by Hurd, those experiencing appreciation were those who most exemplified Bowlby's healthy mourning:

> Healthy mourning is marked by a timely resolution of the loss during which the child reorganized his or her life with appropriate memories and new attachments after a phase of yearning for the lost one characterized by withdrawal and sadness. (Hurd, p. 19)

Of the appreciation group, only 33% reported ever feeling depressed following the death. Of those categorized as frustrated, enmeshed, or ambivalent, 71% reported that they have been or were currently depressed.

Likewise, Rodgers and colleagues (1997) conducted a study whose findings suggest that early parental death was not always connected to later adult depression. These researchers looked at psychological distress following parental divorce, using a comparison group of those who had experienced early parental death. They indicated that depression during adulthood was not an inevitable outcome of childhood bereavement unless it occurs in conjunction with other factors, although such factors

were not mentioned in their work.

Childhood Bereavement and Concomitant Depression

Three articles were found that evaluated children immediately following the death of a loved one (Gersten et al., 1991; Raphael, 1982; Worden & Silverman, 1996). The research conducted by Raphael (1982), while dated, is still valuable in establishing behavioral symptoms in children under the age of 8 between 2 weeks and 2 months from the time of death. Doctors and professional caregivers who had firsthand knowledge of a death in the family recommended the families to researchers. Then, after a letter was sent contacting the families, two psychologists went to the homes of the families and assessment interviews were conducted. One person interviewed the child and the other interviewed the parent.

The assessment of the child consisted of discussion, doll play, drawings, and responses to picture cards. The interview of the surviving parent was conducted in an unstructured way, with the focus on participant demographics, previous bereavement experiences, circumstances surrounding the death, and the parent's perception of his or her child's responses and behaviors. Behavioral symptoms that were manifested by the children included high levels of anxiety, clinging, excessive crying, aggression, sleep disturbances, eating more or less than usual, heightened responses to separation, and regression in toileting practices. Many of these responses are similar to normal grief manifestations in adults and are considered normal responses to grief in children as well (Raphael, 1982).

Gersten and colleagues (1991) focused on how epidemiological principles could be used to justify preventive interventions for parentally bereaved children. The children in this study (n = 92) ranged in age from 8 to 15 years and were believed to be at risk for future mental health problems because of the death of a parent. The youth in the sample group had at least one parent die at least 3 months but not more than 2 years from the beginning of the research. Three more sample groups were collected in accordance with other epidemiological risk factors: (a) parental divorce, (b) parental alcoholism, and (c) childhood asthma. The researchers' conclusions were that children between the ages from 8 to 15 who experienced parental death were 6.5 times (or 650%) more likely to develop major depressive symptoms than children exposed to the other risks measured.

The work of Worden (1996) and Worden and Silverman (1996) in the *Harvard Child Bereavement Study* is the closest to a longitudinal study of bereaved children that could be located. This study was conducted with school-age children and their families 4 months following the death of a family member and at 1- and 2-year anniversaries. In this study, family demographics were gathered, and semistructured interviews were conducted using three measurement tools: (a) *Child Behavior Checklist* (Achenbach, 1991; Achenbach & Edelbrock, 1983), (b) *Perceived Competence Scale for Children* (Harter, 1979, 1985), and (c) *Locus of Control Scale for Children* (Nowicki & Strickland, 1973). The researchers found depressive-like symptoms such as crying, lack of concentration, and disturbances in sleeping patterns at the 4-month interview. Yet, by the 1-year interview, the symptoms had lessened

greatly. Worden and Silverman concluded that, rather than being indicative of depression, these behaviors are really normal responses to grief in the year following a death.

Summary of Literature

Many of the studies presented here concluded that early parental death is a deciding factor in later adult depression, whereas others concluded that this type of experience is *not* necessarily associated with depression later in life. Three articles were evaluated that studied the behaviors of children immediately following the death of a loved one (with the examinations taking place anywhere from 2 weeks to 4 months following the death). These studies suggest that children are likely to experience depression immediately following parental loss due to death. Behaviors displayed by the children studied were similar to behaviors displayed and expressed by adults who were experiencing depression. Therefore, although later depression may or may not be linked directly to early parental death, it is apparent that immediately following the death symptoms of depression are manifest in many children and teens.

Gaps in Extant Literature

Many of those participating in childhood bereavement studies use samples from the clinical realm; in other words, the people being studied have already sought out psychiatric assistance for their problems. The current project will add to extant

literature by including normative/nonpsychiatric participants in the study. The current study sought a baseline of information for the future study of bereaved children and adolescents.

An element that is missing in the current literature is the perceptions of the children and teens themselves. The current study presents additional information on their perceptions of what they are experiencing at the time they seek support and afterwards. Levels of depression were examined against gender, age, relationship to deceased, and cause of death. In addition, content analysis of three questionnaires was undertaken, all in an effort to better understand this small and silent population.

Purpose of the Study

The purpose of the current study was to take previously unexamined data of grieving children and teens and create a picture of what many of these youths were experiencing when they first arrived at a center that supports them in the grief process.

Research Question and Hypotheses

The research question for the current project is: What experiences, emotions, and behaviors do grieving children and teens experience before and while attending a community-based bereavement support group? A review of the literature showed that children and teens who have experienced the death of a loved one do experience symptoms of depression. Therefore, it was appropriate to create hypotheses for this

exploratory study. The null hypotheses for the CES-D in this study are:

1. There is no difference in the CES-D scores for males and females.

2. There is no difference in the CES-D scores for child's age at time of loss due to death.

3. There is no difference in the CES-D scores for type of relationship of child to the deceased.

4. There is no difference in the CES-D scores for type of death.

5. There is no difference in the CES-D scores for time from the death to administration of the test instrument.

Content analysis was employed to explore the wide range of emotions and experiences in addition to depression that this population was experiencing. No hypotheses are presented for the additional three questionnaires as their content is presented in the form of emerging themes.

CHAPTER 3

METHODS

In this chapter, the history and basic tenets of The Dougy Center are examined. The participants as well as the instruments used are carefully outlined. Issues of validity and reliability in addition to the procedures for analysis follow. Rounding out the chapter is a section on the potential implications of the current study.

The Dougy Center

The Dougy Center is a nonprofit organization established in December 1982. It was the first of its type to offer peer-based support groups for grieving children and teens. The Dougy Center was the brainchild of Beverly Chappell, a pediatric nurse. Beverly had the opportunity to work with Doug Turno, a young boy dying of an inoperable brain tumor. Beverly watched as The Dougy Center helped other children deal with their own grief and realized that children can be powerful facilitators in assisting during each other's grief work. Since the doors of The Dougy Center opened, more than 12,000 children, teens, and their adult caretakers have participated. Local community services personnel, school personnel, hospitals and doctors, and funeral directors refer participants to The Dougy Center.

The Dougy Center operates on the belief that grief is a natural reaction to the loss of a loved one. This thinking holds true for children as well as adults. With grief being a natural reaction to loss, there is also a natural capacity in each person to heal:

> Those who facilitate groups at The Dougy Center are regarded not as counselors or therapists but as fellow grievers. Their roles are to honor and be available for each child, trust his or her mourning processes, remain alert for signs of complicated mourning processes, walk alongside, and uphold the vision that each bereaved person will once again be able to find a way in life. (Corr et al., 2000, p. 331)

With the support of fellow grievers (volunteers), children who attend The Dougy Center can focus on the three tasks of grieving children and teens. The first task is to understand that the person is dead, the second task is to feel the feelings about the death, and the third task is to go on living and loving after the person's death (Smith, 1991).

Participants/Sample

Participants were drawn from closed family files (i.e., they no longer attend the support groups at The Dougy Center) for the 5-year period of 1996-2000. A sample of 139 completed the CES-D upon intake into the program. A sample of 102 completed the FSE after having attended support groups at The Dougy Center. A sample of 103 completed The Dougy Center Intake Questionnaire: Child Form upon intake into the program. A sample of 28 completed The Dougy Center Intake Questionnaire: Teen Form upon intake into the program. These instruments were administered to various clients during the 5-year period, albeit through convenience-sampling techniques. Clients signed a *Rights to Privacy and Exceptions to Privacy* agreement during orientation. One of the exceptions to privacy includes the anonymous use of case examples of children or teens in articles (The Dougy Center, 1998).

As shown in Table 1, the gender breakdown for each questionnaire is shown in addition to the mean age of the child or teen who completed the questionnaire. The four samples were drawn from the participants attending The Dougy Center during the 5-year period mentioned above. The total number of children and teens who attended during this period totaled 733.

Additional measurable factors for the hypotheses in this study are shown in Table 2 and Table 3. Table 2 shows the relationship of the deceased to the child with the categories of father, mother, brother, sister, and other. (See Appendix E for complete demographic data.) Table 3 shows type of death. This category was divided into six smaller groups consisting of natural, accident, homicide, suicide, overdose, and unknown. It should be noted that the category of "overdose" was created because in many of the cases it was unclear if the overdose was an accidental death or a death by suicide. The last category consists of persons who had a loved one die, but authorities were unable to discern the causes, creating the category of "unknown cause of death."

Table 1

Gender and Mean Age for All Samples

Sample	Total	Male	Female	Mean age
CES-D	139	70 (50.4%)	69 (49.6%)	10 years, 9 months
FSE	102	48 (46.1%)	54 (52.9%)	9 years, 1 month
Child	103	46 (44.6%)	57 (55.4%)	7 years, 4 months
Teen	28	13 (46.4%)	15 (53.6%)	14 years, 3 months

Table 2

Relationship of the Decreased to the Respondent for All Samples

Sample	Total	Father	Mother	Brother	Sister	Other
CES-D	139	55 (39.6%)	55 (39.6%)	13 (9.4%)	4 (2.9%)	12 (8.6%)
FSE	102	52 (50.9%)	27 (26.5)	12 (11.8%)	7 (6.8%)	4 (4.0%)
Child	103	61 (59.2%)	24 (23.3%)	11 (10.7%)	4 (3.9%)	3 (2.9%)
Teen	28	15 (51.7%)	8 (27.5%)	3 (10.3%)	1 (3.5%)	2 (6.9%)

Table 3

Type of Death for All Samples

Sample	Total	Natural	Accident	Suicide	Homicide	Overdose	Unknown
CES-D	139	84 (60.4%)	27 (19.4%)	17 (12.2%)	5 (3.6%)	6 (4.3%)	0 (0.0%)
FSE	102	57 (55.9%)	22 (21.6%)	11 (10.8%)	3 (2.9%)	6 (5.9%)	3 (2.9%)
Child	103	49 (47.6%)	19 (18.4%)	19 (18.4%)	9 (8.8%)	7 (6.8%)	0 (0.0%)
Teen	28	11 (38.0%)	10 (34.5%)	5 (17.2%)	2 (6.9%)	1 (3.4%)	0 (0.0%)

Instrument: CES-D

The main instrument used in this study is the CES-D (Radloff, 1977). Experts who treat and study depression use a wide variety of tests and rating systems to determine a person's level of depression. The CES-D is one of the most common methods for allowing an individual to determine his or her depression quotient because it is easily understood and simple to score.

The CES-D, which was designed to be self-administered, measures the person's depressive feelings and behaviors during the past 7-day period. Previous researchers who interviewed children following the death of a family member have given a great deal of knowledge concerning behaviors of children in this critical period (Gersten et al., 1991; Raphael, 1982; Worden & Silverman, 1996). Although none of these researchers used the CES-D, many of the items measured on it are similar to behavioral responses observed in children following the death of a loved one. Using information gained from the CES-D scores, results from this project will help to build the informational database regarding childhood bereavement and depression.

The CES-D, although designed and tested on populations over the age of 18, was one of the main instruments used with the 3- to 18-year-old population in the current study. The CES-D contains many questions that require an understanding of, and an ability of, the respondent to think abstractly. Without explicit knowledge to the contrary, I was working from an understanding that two of the four Dougy Center age groups did not answer the CES-D questionnaire themselves but rather were filled out

by an adult who had daily contact with the child. The age group of 3- to 5-year-olds and the age group of 6- to 9-year-olds were the two groups under question. The reason this artificial line was drawn is because it is generally accepted that abstract thinking does not begin to develop until around the age of 10 years old. In summary, for the purpose of this study, it was determined that all respondents ages 9 and younger did not fill out the questionnaire by themselves and that those respondents ages 10 and older did fill out the CES-D by themselves. This distinction is apparent later when results are presented.

The CES-D is an established instrument composed of 20 items that measure the occurrence of activities within the previous week. See Table 4 for the complete listing of all questions and possible responses. The dependent variables for statistical analyses were the 20 CES-D questions.

Scoring proceeds by summing the responses to the 20 items with a possible scoring range of 0 to 60 (see Table 5). These scores are compiled to indicate a rating along the *depressive continuum* (see Table 6). A score below 15 indicates that the person is not depressed. If the score is between 16 and 21, the person may be suffering from mild to moderate depression. If the score is 22 or above, the person may be experiencing severe depression and should consider seeking treatment from a mental health care professional.

Table 4

CES-D: Format for Self-Administered Use

Instructions: Circle the number for each statement that best describes how often you felt or behaved this way—DURING THE PAST WEEK.

DURING THE PAST WEEK:	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that don't usually bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3

Table 4 (*continued*)

Instructions: Circle the number for each statement that best describes how often you felt or behaved this way—DURING THE PAST WEEK.

DURING THE PAST WEEK:	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people dislike me.	0	1	2	3
20. I could not get "going."	0	1	2	3

Validity and Reliability

The CES-D has strong reliability and validity as indicated by a number of projects over decades of use. Weissman, Sholomskas, Pottenger, Prusoff, and Locke (1977) measured the validity of the CES-D and noted that content validity was established because the scale was drawn from former scales measuring depressive

Table 5

Weighting of the CES-D Scoring

Choices of response	Scoring/weighting (Questions 4, 8, 12, 16)	Scoring/weighting (all remaining questions)
Rarely or none of the time (less than 1 day)	3	0
Some or little of the time (1-2 days)	2	1
Occasionally or a moderate amount of the time (3-4 days)	1	2
Most or all of the time (5-7 days)	0	3

Table 6

CES-D "Depressive Continuum" Scoring Range

Range	Depression detected
15 and below	No depression
16-21	Mild to moderate depression
22 and above	Severe depression

symptomatology that were previously shown to be valid. In the same report, Weissman and colleagues found that concurrent validity was established. First, the CES-D differentiated psychiatric participants from community participants. Second, among the psychiatric population, the scores for acutely depressed persons were higher than other psychiatric participants. Third, the patients previously identified by

clinician report as acutely depressed scored higher than those assessed as recovered depressives. Last, there was high correlation between the CES-D scores and scores of other depression scales such as the Hamilton, the Raskin Depression Scale, and the self-report scale (SCL-90) that had been administered by self-report or through clinical interviews. Weissman and colleagues found that discriminant validity was also adequate.

Radloff (1977) wrote the seminal article on the CES-D and reported an internal consistency reliability of alpha .85 for the general population and alpha .90 for psychiatric patient populations. Radloff and Locke (1986) noted that "high levels of internal consistency were found in all groups with a coefficient alpha about .85 and split-halves correlation about .87" (p. 180). For Hann, Winter, and Jacobsen (1999), CES-D reliability was an alpha of .85 when used as a measurement of depressive symptoms in cancer patients. Radloff and Teri (1986) conducted a review of the literature for studies using the CES-D and found adequate reliability and criterion-related validity. No studies were located to verify the validity and reliability of the CES-D as a measurement tool for grieving children's depression levels. One of the purposes of the current study was to begin an examination of the practicality of the use of the CES-D measure for these purposes.

CES-D, Hogan Grief Reaction Checklist, and

Validity/Reliability

The CES-D has been well tested, mainly on adults, for reliability and validity standards. Although the CES-D is the instrument used by The Dougy Center, no available research could be located that used the CES-D among children or among bereaved persons. The Hogan Grief Reaction Checklist, which was *not* administered at The Dougy Center, is an instrument previously shown to be high in both reliability and validity measures (Hogan, 2001). The Hogan Grief Reaction Checklist is an instrument (61 questions) designed to measure 6 factors in the normal trajectory of the grieving process: Despair, Panic Behavior, Blame and Anger, Detachment, Disorganization, and Personal Growth. The items for this measure were derived directly from data collected from bereaved children, teens, and adults. The Hogan Grief Reaction Checklist has an internal consistency alpha of .90 for the entire instrument, a comparative fit index of .94, and *R* values falling between .53 and .83 for each of the 6 factors (Hogan). There are 21 questions on the Hogan Grief Reaction Checklist that overlap with 13 questions on the CES-D. In other words, 34% of the questions on the Hogan Grief Reaction Checklist overlapped with 65% of the questions on the CES-D. Although the current project could not show reliability and validity aspects of the CES-D with children, by comparing its similarities with the Hogan Grief Reaction Checklist, a fair level of confidence could be implied.

Instrument: FSE

The FSE was designed by the staff of The Dougy Center as a tool to help adults and children in families who are receiving services at The Dougy Center to be able to talk about their grief work. The families who were sent this questionnaire were asked to have each family member fill one out and then discuss the questions and answers with the entire family. The questionnaire was designed to serve as a catalyst for family communication concerning each other's grief experiences at The Dougy Center.

The FSE was not designed to be a tool for measurement; therefore, there is no statistical information regarding validity and reliability. The current study used the information gathered from the FSE to create a more rounded picture of grieving children and teens in the months following the death of a loved one. Its usefulness comes from two areas: (a) It has the most open-ended questions of any of the instruments, and (b) it is the only questionnaire administered *after* the child or teen had been attending support groups at The Dougy Center. A copy of the FSE is located in Appendix F.

The FSE and The Dougy Center Intake Questionnaire: Teen Form (as described later in this chapter) are examples of open-ended questionnaires that were evaluated in this project using methods of *content analysis*. Neuman (1994) described content analysis as "a technique for gathering and analyzing the content of text" (p. 261). Of the various sources of information that content analysis is a useful tool for, analyzing answers to open-ended survey questions is one of them. Therefore, it was a

useful tool for analyzing the data gathered from the FSEs and the Teen Intake questionnaires in the current study.

A basic coding system was used to indicate the *direction* of the message with positive, neutral, or negative as possible choices. Then a combination of *manifest* and *latent coding* was used to determine the message being conveyed in response to the question (Neuman, 1994). Manifest coding uses the "visible, surface content in a text, . . . [whereas] latent coding looks for the underlying, implicit meaning in the content of a text" (Neuman, p. 264). The manifest and latent coding system was used to determine emerging themes in the answers.

Instrument: The Dougy Center Intake Questionnaire, Child Form

The Child Form is completed at the time of intake into the program. It is a checklist of items to which the child responds. The purpose of this inquiry is to discern changes in any number of the child's activities since the death occurred. Because the main audience for this questionnaire is children, the adult who is responsible for the child and knows his or her daily activities generally assists in its completion. Although considerable effort was expended to discern the origin of this questionnaire, it is not known how it originated, whether or not staff of The Dougy Center created it, or if it is an adaptation of questionnaires already in the public domain. (The Child Form is located in Appendix G.)

Instrument: The Dougy Center Intake Questionnaire,

Teen Form

Similar to the Child Form, the Teen Form is completed at the time of intake into the program. It is also a checklist of items to which the teen responds. Although all of the Child Form questions are closed-ended, the Teen Form mainly has questions that are open-ended. The purpose of this inquiry was to discern any changes in the teen's activities since the death occurred. It also contains an extensive checklist of emotions that teens are asked to endorse if they have experienced any of them since the death. The teens complete the form without the assistance of any adults. Although considerable effort was expended to discern the origin of this questionnaire, it is not known how it originated, whether or not staff of The Dougy Center created it, or if it is an adaptation of questionnaires already in the public domain. (The Teen Form is located in Appendix H.)

Procedures

Key demographic data were gathered on 733 children and adolescents (in addition to the data gathered for each of the instruments used in this study) who were clients of The Dougy Center in Portland, Oregon, between 1996-2000. The initial demographic data were compiled using the Microsoft Excel spreadsheet program. All demographic data were aggregate to avoid any identifying features and to ensure client anonymity. For an analysis of the CES-D questionnaires, SPSS version 10.0 was used.

Analysis

Since this study was exploratory and descriptive in nature, descriptive statistics were used in the analysis (mean, median, mode, standard deviation, and range). Data gathered from the CES-D were analyzed statistically with the score for the entire scale through the use of one-way analysis of variance (ANOVA) and Cronbach's alpha reliability measures. The dependent variable is the total CES-D score. The independent variables are (a) gender, (b) age, (c) relation to deceased, (d) type of death, and (e) length of time between death and administration of the CES-D.

Information gleaned from three additional questionnaires (FSE, Child Form, and Teen Form) were evaluated using techniques of content analysis to gauge emerging themes and direction of the comments (e.g., positive, neutral, or negative) to create a more complete picture of the study group. The answer to each of the questions on the three forms was compiled, and then a directional classification (e.g., positive) was assigned. Each response was analyzed, looking for emerging themes based upon my knowledge of child development in addition to the specific model of support used by The Dougy Center.

Potential Implications of the Current Study

A review of the literature showed that children and teens who have experienced the death of a loved one are more likely to experience symptoms of depression than those who have not had such experiences. The data gathered from this investigation will add to the current literature on children's grief, which will be

accomplished by showing the levels of depression in the months following the death of a loved one. These results can be combined with previous research stating that specific groups are more likely to experience depression later in life following the death of a loved one.

CHAPTER 4

RESULTS

The results of the statistical analyses for the CES-D and the Child Intake Form are presented in this chapter. In addition, the content analyses of the Teen Intake Form and the FSE are also presented.

The statistics selected for the analysis of the CES-D include one-way ANOVA for each of the hypotheses and Cronbach's alpha for reliability testing. Assumptions for one-way ANOVA are a single independent variable and a single dependent variable. The dependent variable should be at the interval or ratio levels and should be normally distributed. In addition, the groups should be independent of each other. The assumptions of Cronbach's alpha are that all items in the scale should be interval or ratio level, and each item should be normally distributed.

Five null hypotheses were tested for this study. Hypothesis 1 stated that there is no difference in the CES-D scores for males and females. Hypothesis 2 stated that there is no difference in the CES-D scores for the child's age at the time of loss due to death. Hypothesis 3 stated that there is no difference in the CES-D scores for the type of relationship of deceased to the respondent. Hypothesis 4 stated that there is no difference in the CES-D scores for type of death. Hypothesis 5 stated that there is no difference in the CES-D scores for time from the death to administration of the test instrument. None of the one-way ANOVA operations was statistically significant. In other words, none of the null hypotheses was rejected. Therefore, the independent variables of gender, age, relationship, type of death, and time from death until

administration of the test instrument do not appear to be statistically associated with the CES-D scores among bereaved children and teens in this study.

However, given the sample size, statistical significance is unlikely. For greater analytical power with this small sample size, each of the independent variables was recoded into two groups. Gender is male and female. Age is 3 to 12 years old (preteen) and 13 to 18 years old (teenager). Relationship is parent and sibling/other. Type of death is anticipated (natural) and unanticipated (accident, homicide, suicide, or overdose). Time between death and administration of instrument is 1 year or less (0 to 12 months) and more than 1 year (13 months and up). The ANOVA and Cronbach's alpha were run with the recoded independent variables. The reason for these analyses was to ascertain if differences appear between the groups on depression scores. These distinctions are apparent in the analyses of Cronbach's alpha for reliability. See Table 7 for detailed ANOVA information.

Reliability is the degree of consistency in a questionnaire. In other words, the reliability of a test instrument measures the degree to which similar results would be obtained if the questionnaire were to be administered to the same person under the same circumstances. Cronbach's alpha is the most widely used measure of reliability, as it shows how much each item is associated with each of the other items on the instrument. In the social sciences, an alpha rating of .7 is the lowest acceptable level, whereas a rating closer to .9 is preferred for an instrument to be considered useful.

In Chapter 3, the reliability rating for the CES-D among populations over age 18 was .85 for general populations and .90 for psychiatric populations (Radloff,

Table 7

CES-D by ANOVA

Demographics	*SS*	*df*	*F* value
Gender			.142
Between groups	.121	1	
Within groups	116.469	137	
Age			2.726
Between groups	2.275	1	
Within groups	114.314	137	
Relationship			.857
Between groups	.725	1	
Within groups	115.865	137	
Type of death			.228
Between groups	.194	1	
Within groups	116.396	137	
Time from death			.040
Between groups	3.400E-02	1	
Within groups	116.556	137	

1977). The reliability (alpha) of .72 was obtained for the 20-item questionnaire for the 139 clients of The Dougy Center who were administered the questionnaire between 1996-2000. This rating is acceptable, but it is by no means as strong a measure of depression for this population as it is for adult populations. For the entire questionnaire, the single question that was most indicative of depression was: *During the past week, I felt sad.* For the entire questionnaire, the single question that was least indicative of depression was: *During the past week, I enjoyed life.*

Each of the independent variables was recoded into two groups, split, and run with Cronbach's alpha against the *CES-D* scores. For gender, male alpha was .68 and

female alpha was .75. Age alpha was .71 for preteens and .74 for teenagers. Alpha for the relationship variable of parent was .71 and for sibling/other was .77. Type of death produced alphas of .72 for anticipated death and .73 for unanticipated death. Time between death and administration of the questionnaire showed alphas of .73 for the 1 year or less group and .67 for the more than 1-year category. The split group alphas show that the CES-D was more reliable among teens, females, those who experienced the death of a sibling/other relationship, or those who experienced an unanticipated death. The split group alphas also show a better measure when administered within 1 year of the death. See Table 8 for a further breakdown of the reliability measures, and see Appendix I for a correlation matrix of the five

Table 8

CES-D by Reliability Analysis (Alpha) and Most/Least Indicative Questions

Demographics	Alpha	Most indicative question	Least indicative question
Entire	.72	I felt sad	I enjoyed life
Male	.68	I felt sad	I was happy
Female	.75	I could not shake blues	I enjoyed life
Preteen	.71	I felt lonely	I enjoyed life
Teenager	.74	I could not shake blues	I enjoyed life
Parent (death)	.71	I felt sad	I enjoyed life
Sibling/other	.77	I had crying spells	I enjoyed life
Anticipated death	.72	I felt sad	I enjoyed life
Unanticipated death	.73	I felt lonely	I enjoyed life
1 year or less	.73	I could not get "going"	I enjoyed life
More than 1 year	.67	I felt depressed	I'm as good as other people

independent variables and the one dependent variable.

Additional information regarding the reliability measures is presented in Table 9. As can be seen, the average (or mean) score for the entire group of the respondents and for each of the split-halves groups shows depression scores in the range of *severely depressed*. A score of 22 or higher indicates severe depression according to the CES-D.

Alpha's for the three oldest age groups (see Table 10) show adequate reliability, whereas the alpha for the 3- to 5-year-old age group is below the adequate level. That is to be expected, as children ages 3 to 5 are unable to fully comprehend the depth of the concepts measured in the questionnaire.

Table 9

CES-D by Reliability Analysis (Alpha)

Demographics	*N*	Alpha	Mean	Variance	*SD*
Entire	139	.72	25.79	68.57	8.28
Male	70	.68	24.61	68.57	7.76
Female	69	.75	26.98	75.10	8.66
Preteen	93	.71	25.06	69.12	8.31
Teenager	46	.74	27.26	65.66	8.10
Parent (death)	110	.71	25.45	64.87	8.05
Sibling/other	29	.77	27.06	83.28	9.12
Anticipated death	84	.72	25.77	67.40	8.21
Unanticipated death	55	.73	25.81	71.63	8.46
1 year or less	122	.73	25.87	69.89	8.36
More than 1 year	17	.67	25.17	62.40	7.89

Table 10

Cronbach's Alpha for Each of The Dougy Center Support Groups by Actual Age Group

Age groups	*N*	Alpha	Mean	Variance	*SD*
3-5 years olds	14	.63	27.07	47.14	6.86
6-9 year olds	50	.71	24.86	64.73	8.04
10-12 year olds	29	.76	24.44	89.47	9.45
13-18 year olds	46	.74	27.26	65.66	8.10

Four questions on the CES-D were reverse coded to prevent a response set (answering the same choice for each question) on the part of the respondents. The four questions, which do not measure symptoms of depression, were Questions 4, 8, 12, and 16. These four questions were eliminated from the Cronbach's alpha statistical procedure and were rerun to obtain alpha scores for the 16 remaining questions. The reliability (alpha) for the 16-item questionnaire is .88, which is considerably higher than the alpha rating of .72 for the 20-item questionnaire.

Table 11 and Figures 1, 2, 3, 4, 5, and 6 are presented to provide visual information concerning the variables under study from the CES-D. Although the variables were bifurcated for greater analytical power, the figures that follow are presented in the form of how The Dougy Center collects data on individuals for support groups (i.e., age groups, parent or sibling death groups, and suicide or homicide groups).

Table 11

Frequencies for Selected Independent Variables and the Dependent Variable

Variable	Mean	Median	Mode	*SD*	Range
Age (independent variable)	10.73 years	10 years	9 years	3.96 years	15 months
Time between	6.37 months	3 months	2 months	8.54 months	49 months
CES-D score	21.63	21.00	15.00	12.37	52.00

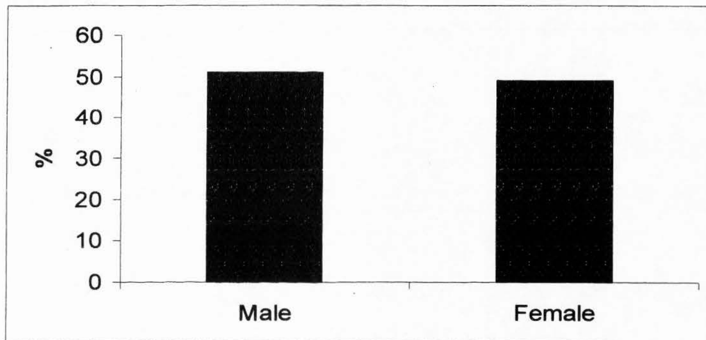


Figure 1. Gender of CES-D participants by percentage.

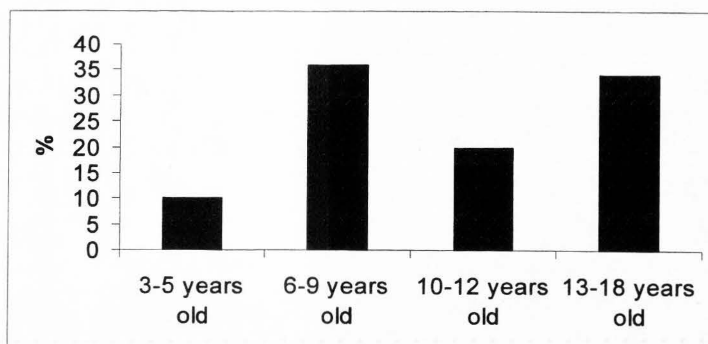


Figure 2. Age (by The Dougy Center support groups) of CES-D participants by percentage.

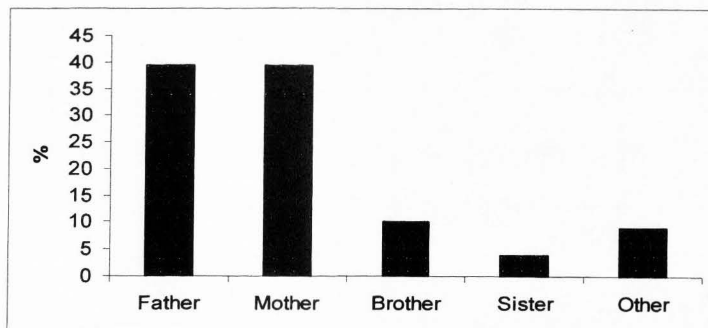


Figure 3. Relationship of deceased of CES-D participants by percentage.

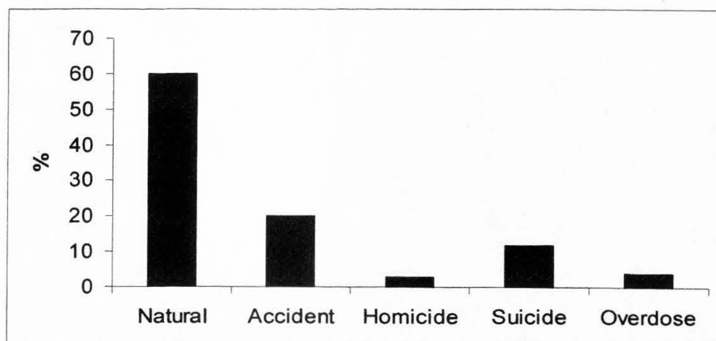


Figure 4. Type of death in relation to CES-D participants by percentage.

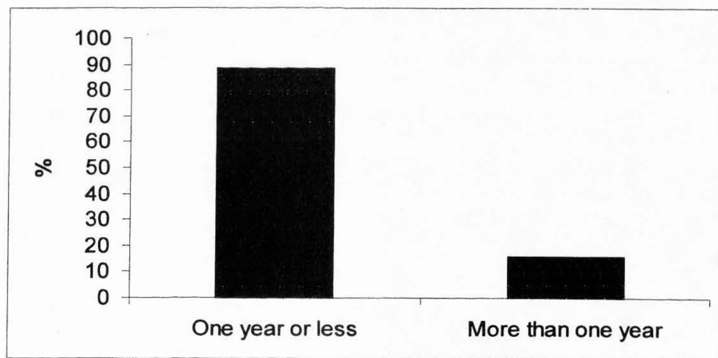


Figure 5. Time between death and administration of CES-D participants by percentage.

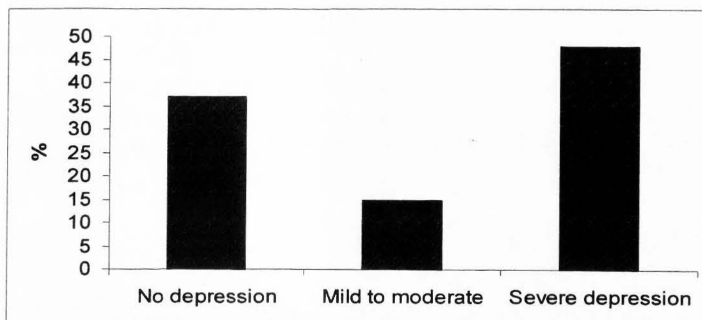


Figure 6. Composite scores by depression level of CES-D participants by percentage.

The chart shown in Figure 6 is a strong visual indicator of the levels of depression being experienced among these children and teens when they entered the program at The Dougy Center during the years 1996-2000. The majority of children when they entered The Dougy Center were experiencing some depression. Of those depressed, 48% scored in the severe depression range, whereas 15% scored in the mild-moderate depression range. Thus, although none of the hypotheses was statistically significant of depression by groupings of independent variables, this is a group of children who was showing signs of significant depression. The CES-D is one of three questionnaires administered upon intake into the program; that is, these are the levels of depression *before* any support services had been provided.

The CES-D Questions Evaluated Individually

The CES-D, while not statistically significant for any of the proposed hypotheses, is substantively significant because it helps to answer the research question of what grief looks like to children and teens. Each question is presented, as it is written on the questionnaire, with the focus being on the symptomatic responses presented. By way of reminder, the questionnaire asks the respondent to answer according to his or her experience of the past 7 days. Choices of responses included: *rarely or never*, *1-2 days*, *3-4 days*, and *5-7 days*.

Question 1: During the past week, I was bothered by things that don't usually bother me. Thirty-one percent of the respondents stated that this was the case 3 or more days during the past week.

Question 2: During the past week, I did not feel like eating, my appetite was poor. Forty-four percent of the respondents stated that this was the case for 1 or more days during the past week.

Question 3: During the past week, I felt that I could not shake off the blues even with help from my family or friends. Twenty-nine percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 4: During the past week, I felt that I was just as good as other people. Seventy-one percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 5: During the past week, I had trouble keeping my mind on what I was doing. Seventy-seven percent of the respondents stated that this was the case for

1 or more days during the past week.

Question 6: During the past week, I felt depressed. Eighty percent of the respondents stated that this was the case for 1 or more days during the past week.

Question 7: During the past week, I felt that everything I did was an effort. Forty-three percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 8: During the past week, I felt hopeful about the future. Eighty-six percent of the respondents stated that this was the case for 1 or more days during the past week.

Question 9: During the past week, I thought my life had been a failure. Twenty percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 10: During the past week, I felt fearful. Thirty-three percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 11: During the past week, my sleep was restless. Sixty-eight percent of the respondents stated that this was the case for 1 or more days during the past week.

Question 12: During the past week, I was happy. Seventy-one percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 13: During the past week, I talked less than usual. Fifty-five percent of the respondents stated that this was the case for 1 or more days during the past week.

Question 14: During the past week, I felt lonely. Forty-five percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 15: During the past week, people were unfriendly. Forty-three percent of the respondents stated that this was the case for 1 or more days during the past week.

Question 16: During the past week, I enjoyed life. Seventy-six percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 17: During the past week, I had crying spells. Thirty-five percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 18: During the past week, I felt sad. Fifty percent of the respondents stated that this was the case for 2 or fewer days during the past week, whereas the other 50% of the respondents stated that this was the case for 3 or more days during the past week.

Question 19: During the past week, I felt that people disliked me. Twenty-one percent of the respondents stated that this was the case for 3 or more days during the past week.

Question 20: During the past week, I could not get going. Thirty-three percent of the respondents stated that this was the case for 3 or more days during the past week.

Two more questions were asked on the CES-D in addition to the standard questions. These questions concerned Likert-type scales with possible responses ranging from 1 through 8 (see Table 12). The average score for the total number of

Table 12

Frequency Rate of: How Stressful Have the Past Few Months Been for You?

	Likert choices							
	1	2	3	4	5	6	7	8
Respondents (n = 139)	Not stressful							Very stressful
Frequency	3	11	17	17	26	23	15	27
Percentage	2.2	7.9	12.2	12.2	18.7	16.5	10.8	19.4

respondents for the past few months was just above the halfway mark of stressful (mean = 5.27), whereas the middle 50% of the respondents scored between 4 and 7. Ironically, the mode (or most frequently reported response) for this scale was 8 (or very stressful.

When respondents were asked how they feel they are coping with the death to this point in time (see Table 13), the mean score was 4.61, just under the half-way

Table 13

Frequency Rate of: At This Point in Time, How Well Do You Feel You Are Coping with the Death?

	Likert choices							
	1	2	3	4	5	6	7	8
Respondents (n = 139)	Not stressful							Very stressful
Frequency	15	9	17	23	25	21	18	11
Percentage	10.8	6.5	12.2	16.5	18.0	15.1	12.9	7.9

mark, whereas the most frequently reported answer was 5. The inner-quartile range for this question was different from the previous question, with 50% of the respondents scoring between 3 and 6 on the scale.

Intake Questionnaire, Child Form

The Dougy Center Intake Questionnaire, Child Form consisted of 12 questions completed by respondents who were 12 years and younger at the time of administration. There were 103 forms completed. The results are presented in aggregate form and percentages.

Respondents were asked how much they wanted to be by themselves since the death occurred. Just over 45% stated that their levels of wanting to be alone had remained the same, whereas nearly 55% reported a change (either a desire to be by oneself more or less than was usual for them) (see Table 14). The next question the children responded to concerned school. More than 50% reported that since the death school had become more difficult for them, whereas only 6% reported that school had become easier since the death (see Table 15).

Table 14

Intake Questionnaire, Child Form: "Since the Death, I Want to Be By Myself"

Respondents (n = 103)	Total	%
More	22	21.4
Same	47	45.6
Less	34	33.0

Table 15

Intake Questionnaire, Child Form: "Since the Death, School Has Been"

Respondents (n = 96)	Total	%
Harder	55	57.3
Same	35	36.5
Easier	6	6.2

As shown in Table 16, the children were asked about their friendships, to which 57% responded that they get along with their friends the same after the death as they did before the death occurred. When asked about how well they were getting along with other family members since the death, 62% of the children in this sample (see Table 17) reported a change (in either direction), with 41% getting along with family members less than was usual for them.

Behaviors such as sleeping and eating were reported by the respondents (see Tables 18 and 19). While more than half reported that their sleep had become worse since the death, just over half reported their eating patterns had remained the same.

Table 16

Intake Questionnaire, Child Form: "Since the Death, I Get Along with Friends"

Respondents (n = 103)	Total	%
More	23	22.3
Same	59	57.3
Less	21	20.4

Table 17

Intake Questionnaire, Child Form: "Since the Death, I Get Along with Members of My Family"

Respondents (n = 103)	Total	%
More	22	21.4
Same	39	37.8
Less	42	40.8

Table 18

Intake Questionnaire, Child Form: "Since the Death, My Sleep Is"

Respondents (n = 103)	Total	%
Worse	59	57.3
Same	36	34.9
Better	8	7.8

Table 19

Intake Questionnaire, Child Form: "Since the Death, I Eat"

Respondents (n = 103)	Total	%
More	18	17.5
Same	54	52.4
Less	31	30.1

The question concerning physical hurts experienced since the death referred to symptoms such as headaches and stomachaches. Concerning physical hurts that were manifest since the death, 55% stated that since the death they had experienced some physical symptoms (see Table 20).

A series of feelings was presented to the child respondents through the question presented in Table 21. In addition, space was provided for "other" feelings that could be written in. Although the great majority of the respondents stated they felt sadness, fear, and anger, only about one third reported feeling shock. The write-in responses to "other" feelings included loneliness, guilt, confusion, denial, a lack of

Table 20

Intake Questionnaire, Child Form: "Since the Death, I Sometimes Have Physical Hurts"

Respondents (n = 103)	Total	%
Yes	57	55.3
No	46	45.7

Table 21

Intake Questionnaire, Child Form: "All the Feelings That Apply to You Now"

Respondents (n = 103)	Total	%
Sadness	90	87.4
Fear	64	62.1
Anger	62	60.2
Shock	32	31.1

feelings, frustrated, forgetful, feeling different, worry, sorry, upset, desire to be with the deceased, and bad dreams about the deceased.

The last two questions on the Intake Questionnaire, Child Form were concerned with the children receiving help in addition to the support groups at The Dougy Center (see Tables 22 and 23). Nearly 42% responded that they see their school counselor, whereas only 22% see a counselor outside of school.

Table 22

Intake Questionnaire, Child Form: "Do You See a Counselor Now?"

Respondents (*n* = 101)	Total	%
Yes	42	41.6
No	59	58.4

Table 23

Intake Questionnaire, Child Form: "Do You See a Counselor Outside of School?"

Respondents (*n* = 92)	Total	%
Yes	20	21.7
No	72	78.3

Intake Questionnaire, Teen Form

The Dougy Center Intake Questionnaire, Teen Form consists of 12 open-ended questions. There were 28 forms completed, and the results are presented in aggregate

form and percentages. Every response was given a *directional category* (in accordance with content analysis protocol) of positive, neutral, or negative. Patterns of emerging themes were documented from the responses, but every response did not fall under a thematic category (as the possibility existed that there could have been a separate theme for every comment). In addition, some comments were classified under more than one thematic category. Percentages presented are based upon the total number of the respondents for that particular question, with the highest percentage themes being presented. This finding accounts for the disparity between the numbers presented in the tables and the total number of the respondents. Discussion concerning the directional aspects of the questions is minimal, although selected direct quotes were used in the presentation of emerging themes.

Most of the comments from the teens concerning conflict with their parents had either a positive or neutral directional tone. Table 24 presents *conflict* with parents through quotes such as: "Can't talk to my mother about a lot of stuff," and "Impatience with my step-dad as well as frustration." The theme of *becoming closer*

Table 24

Intake Questionnaire, Teen Form: "How Has Your Relationship with Your Parent(s) Been Affected Since the Death?" (Content Analysis, Emerging Themes)

Respondents (n = 26)	Total	%
Conflict with	7	26.9
Closer to	6	23.1
Distancing from	2	7.7
Changing family roles	2	7.7

to parents was presented through: "More trusting towards my mom," and "My dad and I have grown really close." Two people reported a *distancing* from their parents: "I am growing up, going away from the nest." Two respondents mentioned *changing roles* within the family since the death: "More of a workload."

Most of the comments from the teens concerning issues of school, grades, and teachers were classified with either a neutral or negative directional tone. Themes that emerged (see Table 25) were that school was a *struggle*: "Sometimes I feel absent minded," and "Less time to complete homework and harder to concentrate." A few respondents stated that they had *supportive teachers*: "Teacher treats me nice," and "Teachers and school staff are sympathetic about the situation because they knew [name of the deceased]." A number of teens experienced their *grades dropping* since the death: "My grades have gotten worse," and "My grades have plummeted because I wasn't there for 11 days." Ironically, two teens reported that their *grades improved* after the death: "My grades have gone up because I realize that my family has less money to pay for college."

Table 25

Intake Questionnaire, Teen Form: "How Have the Areas of School, Grades, and Teachers Been Affected Since the Death?" (Content Analysis, Emerging Themes)

Respondents (n = 28)	Total	%
Drop in grades	6	21.4
School is a struggle	3	10.7
Supportive teachers	3	10.7
Improvement in grades	2	7.1

The directional analysis of the friendships and social life question showed that 82% of the respondents had positive or neutral comments. This question had the highest positive directional percentage of any on this questionnaire, with 32%. Emerging themes for this question (see Table 26) include *help from* friends: "I've gotten closer to my friends," and "My friends seem to talk about it." Two categories concerned with withdrawal emerged: (a) *withdrawing from* friends ("I haven't been as outgoing as I used to be") and (b) *friends withdrawing* from the respondents: ("Some friends lost").

For the sleeping and eating category question, every comment was either neutral or negative in the directional tone. Five themes emerged (see Table 27), including *cannot sleep* ("I can't sleep at night"; "Less sleep—I can't get to sleep at night"; and "Getting to bed late—crying"). For those who could sleep, a few reported *nightmares*: "Sleep is interrupted by nightmares and waking up in sweats," and "I have nightmares often." A few reported *excessive sleeping*: "I mostly sleep or want to sleep," and "Sleep more." Those who reported that they *eat less* stated: "Sometimes loss of appetite," and "I don't eat very much." Almost similar numbers of teens

Table 26

Intake Questionnaire, Teen Form: "How Have the Areas of Friendships and Social Life Been Affected Since the Death?" (Content Analysis, Emerging Themes)

Respondents (*n* = 28)	Total	%
Help from friends	7	25.0
Withdrawing from friends	2	7.1
Friends withdrawing	2	7.1

Table 27

Intake Questionnaire, Teen Form: "How Have the Areas of Sleep and Eating Habits Been Affected Since the Death?" (Content Analysis, Emerging Themes)

Respondents (n = 28)	Total	%
Cannot sleep	8	28.6
Too much sleep	3	10.7
Nightmares	3	10.7
Eat less	7	25.0
Eat more	5	17.9

reported excessive eating since the death: "Eat like a horse," and "A lot of hunger."

Two weak themes emerged from other family relationships (see Table 28), with most positive or neutral and only two responses in each category. The first theme dealt with *problems with "step" members* of the family: "Seem normal, but a little angry with my step-mom," and "Step-dad—bad/okay." The other theme revolved around *extended family members*: "My aunts are a lot nicer and gentle with me," and "Closer to my aunt."

Table 28

Intake Questionnaire, Teen Form: "How Have Your Relationships with Other Family Members Been Affected Since the Death?" (Content Analysis, Emerging Themes)

Respondents (n = 26)	Total	%
Problems with "step" members	2	7.7
Aunts and uncles nicer	2	7.7

A directional analysis of the "emotions" question was not undertaken because I believe that expressed emotions cannot be classified as positive or negative, especially neutral. More than half of the respondents reported feelings of sadness, anger, loneliness, confusion, and shock (see Table 29). Respondents were also allowed to write in any emotions they had experienced that were not currently on the sheet such as a sense of being proud, an intense need to be active, mad, depressed, withdrawn, currently emotionless, and mood swings.

Table 29

Intake Questionnaire, Teen Form: "What Emotions Have You Experienced Since the Death?"

Respondents (n = 28)	Total	%
Sadness	25	89.3
Anger	22	78.6
Loneliness	21	75.0
Confusion	17	60.7
Shock	16	57.1
Fear	13	46.4
Hopelessness	13	46.4
Guilt	12	42.9
Anxiety	11	39.3
Embarrassment	6	21.4
Relief	5	17.9
Happiness/laughter	5	17.9
Shame	3	10.7

Nearly half of the respondents stated that they had experienced physical symptoms since the death such as nosebleeds, vomiting, bed-wetting, ulcers, stomachaches/cramps, headaches, and nausea when thinking about the cause of the death (see Table 30). Table 31 shows that nearly 3 out of 10 respondents were taking some type of medication.

The counseling question did not distinguish between school counselors or private therapists, as the Child Form did. Table 32 shows that 43% of the teens surveyed are receiving outside-of-family support from sources other than The Dougy Center.

Table 30

Intake Questionnaire, Teen Form: "Since the Death, Have You Experienced Any Physical Symptoms?"

Respondents (n = 26)	Total	%
Yes	12	46.2
No	14	53.8

Table 31

Intake Questionnaire, Teen Form: "Are You Taking Any Medications?"

Respondents (n = 28)	Total	%
Yes	8	28.6
No	20	71.4

Table 32

Intake Questionnaire, Teen Form: "Are You Seeing a Counselor?"

Respondents (n = 28)	Total	%
Yes	12	42.9
No	16	57.1

Almost half reported that friends were the supportive people who they talked to (see Table 33). Relatives included mother, sister, aunt, grandmother, and uncle. Support outside the family included counselor, roommate, school counselor, and coach. All other responses to this category included not talking to anybody, God, the walls, and myself.

Table 33

Intake Questionnaire, Teen Form: "Who Are the Supportive People You Talk to about the Death?"

Respondents (n = 28)	Total	%
Friends	12	42.9
Mother	7	25.0
Counselor	4	14.3
Nobody	4	14.3
Sister	3	10.7
Aunt	2	7.1
Grandmother	2	7.1

Family Self-Evaluation

Data from the FSE are presented last because this is the only questionnaire administered *after* the respondent has been attending support groups at The Dougy Center for a period of time, whereas the first three questionnaires were all administered upon intake into the program. This questionnaire is a combination of closed- and open-ended questions. The open-ended questions are presented in a manner similar to the Teen Form, with emphasis on directional analysis and emerging themes from the comments. In addition, at this point, characteristics of The Dougy Center philosophy are presented as needed because the responses are from a base of knowledge of experience with The Dougy Center support groups. Both children and teens completed the responses to this questionnaire.

The Dougy Center offers an open-ended program (versus time-limited) that encourages children and teens to participate as long as they believe it is necessary (see Table 34). The actualization of this philosophy is shown in the fact that exactly one half of the respondents had been attending groups for more than 1 year.

Table 34

Family Self-Evaluation: Current Length of Participation at The Dougy Center

Respondents (n = 102)	Total	%
1-6 months	36	35.3
7-12 months	15	14.7
13-18 months	25	24.5
More than 18 months	26	25.5

When respondents were asked how they are feeling since coming to The Dougy Center, 84% reported feeling better, a little better, or much better (see Table 35). Only 1 respondent reported feeling worse since he began attending groups.

The question of telling about their experience with The Dougy Center was one of the most open to interpretation on the part of the respondents of the entire questionnaire. Yet, 84% of the respondents expressed positive remarks. The themes that emerged from the responses (see Table 36) included the idea of *fun*: "I've had fun spending time with other people that have lost a parent," and "I like it because there are a lot of fun things to do." *Feeling better* was another theme: "I feel better since I've been here," and "It helped me feel better a lot because it takes my mind off my sister dying." Along the same lines is the theme of being *helped/helpful*: "I feel that it has helped me figure out my feelings," and "The Dougy Center is a place to interact with other children, and it has helped me tremendously."

Table 35

Family Self-Evaluation: "Since Coming to The Dougy Center, I Feel"

Respondents (n = 102)	Total	%
Much better	52	51.0
A little better	34	33.3
The same	15	14.7
A little worse	1	1.0
Much worse	0	0.0

Table 36

Family Self-Evaluation: Tell about Your Dougy Center Experience (Content Analysis, Emerging Themes)

Respondents (n = 82)	Total	%
Fun	15	17.1
Helped/helpful	10	12.2
Feel better	9	11.0
Make new friends	7	8.5
Good staff/counselors	7	8.5
Playing	5	6.1
Waste of time	3	3.7

A theme emerged concerning the *staff/counselors* of The Dougy Center (the *counselors* are actually trained volunteers, but sometimes the kids refer to them as counselors or teachers): "I like the art, the kids, and the counselors," and "I like the volcano room because you can tackle the teacher." A few of the respondents reported that they believed their experience at The Dougy Center was a *waste of time*: "I think that it makes it so I can't play with my friends and it's too long," and "We introduce ourselves, say who died, talk, play for a little while, then leave . . . always the same." The last comment is an accurate portrayal of what happens during the support groups. What classified the comment with a negative direction and under the theme of a waste of time was the last part of the comment about the group experience always being the same.

A directional analysis of the question presented in Table 37 was not completed, as the subjects were dealing with things that have been helpful; yet, there were a number of themes that did emerge. When asked what has been the most helpful, the greatest of any theme that emerged from all of the questions was about *talking and sharing feelings*: "Talking about my mom and talking about other people's mom's and dad's"; "It let me talk about it"; "Talking about the death"; "Being able to talk to other teens about my experience and pain"; and "Talking about my brother." The second greatest comment (in total responses) revolved around being with others who are going through the *same experience*: "Knowing I am not the only one who lost someone"; "Talking about the person who died, and people know what you are talking about"; and "Talking and having similarity."

Some respondents stated that it was helpful to talk about and remember the loved one, whereas others found their time at The Dougy Center a chance to take

Table 37

Family Self-Evaluation: What Has Been the Most Helpful Aspect of Attending The Dougy Center? (Content Analysis, Emerging Themes)

Respondents (n = 95)	Total	%
Talking/sharing feelings	39	41.1
Others in similar situation	17	17.9
Support from staff and children	11	11.6
Volcano room	7	7.4
Remembering deceased	4	4.2
Art room	4	4.2
Take mind off the death	2	2.1

their minds off the death. Comments about *remembering* included: "Thinking about my daddy," and "Thinking about grandpa." Comments concerning the chance to *think about something other* than the death were: "I get to play and it takes my mind off my brother for a while." Almost 12% of the respondents mentioned specific activities or rooms at The Dougy Center. The *art room*: "Art . . . because when I get angry, I mess up and then I paint over it." The *volcano room* is a room with padding on the floors, walls, and ceiling and with a large punching bag hanging from the ceiling where kids can express emotions such as anger and rage: "Volcano room because I can get rowdy and crazy there," and "Letting loose in the volcano room."

The question regarding what has been the least helpful had the fewest number of responses given for the entire questionnaire (see Table 38). Of those who did answer, there were a few themes that emerged. Ironically, the two themes with the greatest number of responses were *sitting too long* and *playing*. The statements of

Table 38

Family Self-Evaluation: What Has Been the Least Helpful Aspect of Attending The Dougy Center? (Content Analysis, Emerging Themes)

Respondents (n = 57)	Total	%
Sitting too long	6	10.5
Playing	6	10.5
Opening/closing circles	5	8.8
Acting silly/arguments	3	5.3
Not enough time to play/talk	2	3.5
Talking about deceased	2	3.5
Talking (in general)	2	3.5

those who believed there was too much sitting stated: "Just sitting around," and "Too much sitting." Those who believed that playing was the least helpful part said: "Playing has not helped, but it is fun."

Some respondents stated that the opening and closing circles were the least helpful part: "The circle because I don't like talking about my father because it hurts my feelings," and "Saying our names every time and it's all just review." At the beginning of each of the groups, all of the children, staff, and volunteers meet in an opening circle, and each person states his or her name and says who died and how they died. Anyone who wants to refrain from sharing during this time is allowed to do so. The purpose behind the opening circle is to focus the children's attention on why they are at The Dougy Center and the work the children are doing there (their grief work). It is also designed to give everyone in the group a sense of community with others as everyone, including the staff members and volunteers who share the same information. The closing circle, which takes place in the last few minutes of the group, is designed to help the children rein in their feelings before leaving The Dougy Center. It also provides time for a special going-away ceremony for each child or adolescent when he or she decides to leave the group permanently, which is described later in this chapter: the rock closing ceremony.

One of the mantras of The Dougy Center is to "trust the process." What this means is that whatever situation a person finds himself or herself in to trust that what needs to happen will happen and to remain open to the experience they are in. The fact that the staff and volunteers at The Dougy Center have succeeded in convincing

the children and teens in their groups of this is found in Table 39. With more than 75% of the respondents replying that they do not know how much longer they will be attending groups is an indicator that, at least in their grief work, these children and teens are *trusting the process* and are not trying to force arbitrary ending dates upon themselves.

Three themes emerged from the responses to the question of what would be the most helpful thing right now (see Table 40). One out of five respondents stated that they felt they needed to *continue attending* groups at The Dougy Center: "To

Table 39

Family Self-Evaluation: When Will I Be Ready to Leave The Dougy Center?

Respondents (n = 97)	Total	%
Within a month	11	11.3
3-5 months	10	10.3
6-12 months	3	3.1
Don't know how much longer	73	75.3

Table 40

Family Self-Evaluation: The Most Helpful Thing Right Now Would Be? (Content Analysis: Emerging Themes)

Respondents (n = 73)	Total	%
Continue attending	15	20.5
Talking more	13	17.8
"Understanding"/"incorporation"	13	17.8

continue coming and work on my grief," and "To stay with the group." An almost equal number of the respondents stated that what they needed the most was to *talk more* while at The Dougy Center: "Continue to talk, share, and listen, and I think I'm getting ready to give advice," and "Talk about my anger and feelings." The theme of *understanding and incorporation* deals with comments that conveyed a sense of wanting to understand more about the death and learning to incorporate the loss into their lives. The theme came through in the following comments: "More chances to remember my mom and share her stories," and "To figure out what path I'm going to take in the future."

The question presented in Table 41 asked the respondents to think about what they believe they need to accomplish before they will be ready to leave The Dougy Center. Two themes similar to the previous question emerged in the responses to this question. The theme of *incorporation and understanding* was again apparent: "Work out the issue of losing both my parents—one dead, one gone," and "So it won't be so bad anymore that it just comes into my head and makes me sad." The other emerging

Table 41

Family Self-Evaluation: What I Need to Do Before Closing at The Dougy Center? (Content Analysis: Emerging Themes)

Respondents (n = 73)	Total	%
"Understanding"/"incorporation"	151	25.9
Continue attending	14	24.1
Unsure	7	12.1
Rock closing ceremony	2	3.4

theme that is similar to the previous question is to *continue attending* groups: "Have more time to feel the ways I do which I never know what they are," and "I'm not sure and I really don't want to close at this time."

The theme of being *unsure* of what to do came through, which is part of trusting the process and being comfortable with not knowing the answers to all things right now: "I'm not really sure; this place gives me a great sense of security and friendship," and "I have no idea what I still need to do. . . . I guess I will just know when it is time to leave." Two respondents used terminology unique to The Dougy Center to convey what they need to do to be ready to leave: "Closing ceremony with rocks," and "To come here and smooth out my rocks." Beverly Chappell, the founder of The Dougy Center, developed what is called the "closure and rock ceremony." The purpose behind the ceremony is to give children and teens a chance to say good-bye at the end of their last night of attending groups. The person chooses four rocks and is given a pouch to place them in—three rocks are smooth and one rock is rough. The child or teen is told that the three smooth rocks represent the healing that has taken place inside of himself or herself. The one rough rock represents the part of them that may still hurt and might always hurt. They are reminded that continuing to hurt is okay (The Dougy Center, 1996).

Responses to the question of what the respondent will do in the next 6 months were 95% positive or neutral. One quarter of the comments (see Table 42) again dealt with the theme of *understanding and incorporation*: "Work on the fact that she will not be here for me but not to forget about her," and "Getting better at my grief." The

Table 42

Family Self-Evaluation: What I Will Do in the Next 6 Months? (Content Analysis: Emerging Themes)

Respondents (n = 65)	Total	%
"Understanding"/"incorporation"	16	24.6
The "Non-Dougy Center"-related comments	14	21.5
Close/think about closing	8	12.3
The Dougy Center-specific activities	8	12.3
Helping others	2	3.1

theme of *non-Dougy*-related comments revolved around answers such as: "Go camping," and "Get out of school and have a good summer." Although 75% of the respondents said they did not know when they would be ready to close, a few believed that *closing* was something they wanted to accomplish in the next 6 months: "Try and get myself to the point where I am ready to close," and "Close at The Dougy Center and get on with my life and focus on other things." The theme of *The Dougy Center-specific* activities emerged from comments about playing specific games, the art room, and the volcano room. Two respondents stated that they would like to help others during the next 6 months: "Learn more about getting through it and maybe help others," and "Be a Dougy, maybe."

The findings from each of the four questionnaires were examined in this chapter. A question-by-question analysis was used in conjunction with quantitative and qualitative techniques. Implications of the findings are discussed in Chapter 5.

CHAPTER 5

DISCUSSION

The current chapter discusses a specific type of research known as program evaluation and how it relates to the current project. Then each questionnaire is presented with basic findings and how the findings relate to previously presented literature. The specific principles used by The Dougy Center (and more than 100 centers worldwide based on The Dougy Center model) to assist grieving children and teens are presented. Limitations of the project as well as implications and recommendations are discussed.

Program evaluation is a recognized form of applied research. This type of research most often takes place in academic settings or in social service agencies to determine the effectiveness of the project/program (Patten, 2002). What took place in the current research project is a form of program evaluation, also known as *evaluation research* (Patten, 2002). Program evaluation is similar to experimental research in that programs are given a *treatment* in order to determine the effects; yet, there are major differences (Patten, 2002). These differences include the fact that program evaluation is generally applied research, is based on a needs assessment, and the programs being evaluated are subject to change during the course of the evaluation (Patten, 2002).

During the current research project, four questionnaires were collected with the data being gathered, consolidated, and systematically evaluated. The data collected represents 5 years worth of responses given by grieving children and teens to a series

of questions concerning what their grief experiences have been like for them. The staff of The Dougy Center collected the responses. Program evaluation was the natural form of research for this project because it is research that can immediately be applied to program management.

Although the statistical analyses employed for certain of the data evaluated showed no statistically significant findings, the overall research findings were fruitful nonetheless. The main goal of program evaluation is to determine whether or not programs are achieving the goal of making a difference in peoples' lives. The current project has shown that children do grieve and that they are feeling better after having attended support groups at The Dougy Center. It is unclear from the lack of pretesting and posttesting if the general state of feeling better is directly related to the services of The Dougy Center or if a maturation effect is taking place. Maturation can be viewed as change and bias due to time lapsed since the original event took place, with that event being the death of a loved one as per the current study.

The general state of depression of children and teens at the beginning of participation in the support groups indicates that the majority are experiencing significant levels of depression, with 48% being severely depressed compared to 3% of the general adolescent population (Steinberg, 2002). Although nearly 25% of the adolescents in the general population report regularly feeling depressed (Steinberg, 2002), 15% of the respondents in this study scored in the mild to moderate range of depression in the CES-D (see Figure 6). Levels of depression during childhood are one half as common as they are during adolescence (Steinberg, 2002).

In addition, data from the FSE show that 84% of those participating in The Dougy Center groups are feeling better (see Table 33). Granted, the data used here are based on a research design and instruments that deserve some critiquing. (See the Limitations section later in this chapter.) Still, the data accomplish the purpose of this study in that they offer a detailed picture of children and teens attending The Dougy Center.

In order to create a more detailed picture of what the grief of these children and teens looks like, each of the questionnaires was analyzed on a question-by-question basis. This process provides a breaking down of each questionnaire on an item-by-item basis and then bringing the information together again to create a composite picture. This procedure was done since there were no statistical analyses of three questionnaires. This process also provides a coherent presentation of the findings of all four questionnaires.

The Center for Epidemiological Studies-Depression Scale

Depression is the most commonly studied outcome associated with grief and bereavement. According to Cobb (1998), *adjustment disorder with depressed mood* is marked by the fact that it is brought on by stress and is relatively brief in duration. This may be the type experienced by many of the grieving children and teens in this study, as outlined in previously presented literature (Worden & Silverman, 1996) and corresponding findings in the current study. The depression scores in the current project show *high* levels of depression in the *majority* of the respondents; yet, when

all the data are presented question by question, it appears that time mitigates the depression, as stated by Worden (1996).

A composite picture was created from the CES-D data presented in Chapter 4 that show what the *majority* of the group expressed for each of the questions. Respondents for this particular questionnaire were children and teens. On the whole, this group showed few, if any, problems with a poor appetite, sleep, crying spells, and being able to shake off the blues. In addition, they do not appear to be struggling with feelings of fear, being disliked by others, or feeling that their lives have been a failure. They believe that people are friendly and that they are just as good as other people. Getting going and being bothered by things out of the ordinary do not appear to be problems for this group. This group generally enjoys life, is happy, and feels hopeful concerning the future.

The areas of struggle that emerged from a question-by-question analysis of the CES-D findings appear to be struggles that are similar in many instances of grief and bereavement, regardless of the person's age. Six items appear to be areas of concern and struggle for this group: (a) sadness, (b) depression, (c) loneliness, (d) inability to concentrate, (e) normal activities becoming more of an effort than usual, and (f) talking with others less frequently. These findings are in accordance with previous studies on grieving presented in Chapter 2, reinforcing the notion that children manifest the stress of the loss due to death in ways similar to adults (Gersten et al., 1991; Raphael, 1982; Worden, 1996).

Apparent contradictions may come from the composite scores and the levels of depression presented in Figure 6. However, very rarely are human feelings so bifurcated as to be entirely depressed or entirely optimistic, especially in the target populations under study. In fact, rather than being a red flag, these findings would indicate that the subjects were experiencing a wide range of emotions, including many that are positive in nature. Rather than being a portrait of a group that is nearly suicidal and finding no happiness, joy, or interest, these children and adolescents display grief in some areas of their lives but not in all. These findings are supportive of the results of other grief studies on adult populations previously cited in this work (e.g., Hurd, 1999; Raphael, 1982; Rodgers et al., 1997). What appears to be a contradiction is in fact a spectrum of behaviors. The grief process in most cases, as evidenced from these studies, is not all-encompassing and overwhelming. Findings in this study indicate that grief is evidenced but is not totally debilitating in nature for these children and teens. This explanation of apparent contradictions stands for each of the four questionnaires.

Child Intake Questionnaire

A composite picture was created from the Child Intake Questionnaire data presented in Chapter 4 that show what the *majority* of the group expressed for each of the questions. Respondents for this particular questionnaire were children ages 3 through 12. On the whole, this group struggled with being around others since the death. The desire to be alone was expressed as well as the desire to be around other

people. These children are having challenges getting along with members of their families. Since the death, for the majority of these children, school is more difficult, physical symptoms/hurts are more abundant, and sleeping is a problem. In addition, the children in this group experienced a wide range of emotions with their grief. Variability of emotions during childhood is well-documented, implying that it is not only grieving children who experience emotional variability (e.g., Berger, 1998; Cole & Cole, 1996). Friendships and constancy in their appetite are the two areas that do not appear to have been seriously challenged since the death. These findings are in accordance with previous studies on grieving presented in Chapter 2, reinforcing the concept that children manifest the stress of loss in similar ways to adults (Raphael, 1982; Worden, 1996).

Teen Intake Questionnaire

A composite picture was created from the Teen Intake Questionnaire data presented in Chapter 4 that show what the *majority* of the group expressed for each of the questions. Respondents for this particular questionnaire were adolescents ages 13 through 18. This group appears to be relying heavily on support from friends. Additional sources of support come from extended family members and people outside of the family. The struggles that this group is dealing with include poor appetite and sleep disturbances. School has become more difficult since the deaths, and many respondents reported a drop in their grades. This finding is important, as adolescents already face stress in their school activities. Helping teens to grieve in a context such

as The Dougy Center may help them to deal with dropping grades and the added difficulty felt in school. In addition, the adolescents in this project expressed a wide range of emotions as well as reporting tension in relationships with immediate family members. Although the variability of emotions during adolescence is well documented (e.g., Cobb, 1998; Furstenberg & Cherlin, 1999), the findings in this study suggest that the teens' bereavement shows high levels of emotional distress.

"Nearly half of all adolescents report experiencing some of the symptoms that characterize depression—sadness, crying spells, pessimism, and feelings of unworthiness, fatigue, and poor concentration" (Cobb, 1998, p. 540). In addition, of the teens in this study, many more than half showed significantly higher levels of sadness, anger, loneliness, confusion, and shock, as can be seen in Table 27. Similar emotions were expressed by many of the respondents in this study. Depression during adolescence following a death often is transitory (Worden, 1996) and could possibly be viewed as *adjustment disorder with depressed mood*. This particular type of depression is marked by its brevity and the fact that it is brought on by stress—the death of a loved one being the most stressful event that can occur in a person's life (Kleinke, 1998). Places like The Dougy Center, where grieving is the focus of the intervention, may help teens avoid more severe states of depression.

Family Self-Evaluation

A composite picture was created from the FSE data presented in Chapter 4 that show what the *majority* of the group expressed for each of the questions.

Respondents for this particular questionnaire were children and adolescents. This is the only questionnaire that was administered *after* the respondents had been attending support groups. On the whole, this group reported *feeling better* since attending support groups at The Dougy Center. They were aware that they could attend groups as long as they feel it is necessary and are *trusting the process* as it concerns their grief work. A great deal of the trust comes from knowing that others in the group have experienced similar circumstances. Being able to talk and share their feelings in an atmosphere of commonality is apparent. This group was also looking forward and planning for future events. The greatest struggles for these respondents included a desire to talk more during the sessions, wishing they understood more about the death, and a desire to incorporate this experience into their lives in a manner that is healthy and appropriate.

One of the strongest findings of the data collected for this project was that more than 84% of the respondents reported feeling better after having attended The Dougy Center support groups. Something happens during the support groups that these children and teens attend that affects many of them to such a degree that many report feeling better. The groups are not run in an unstructured fashion but are based on a decades-old technique of assisting troubled children: nondirective play therapy. This technique is used in all of the groups, regardless of age, although teens tend to talk more and play less than the younger children do. Virginia Mae Axline developed this technique during the 1940s and first published her findings in 1947 (Axline, 1969). Nondirective play therapy is based on eight specific principles, each being

critical to the success of the program. The staff and volunteers are trained in the eight principles as they relate to working with grieving children and teens. These eight principles are manifested in the current research findings through comments made in the FSE. Each principle has a quote from the children and teens, showing that these principles appear to be working.

Principle 1, establish rapport: "I like the counselors." The staff and volunteers "must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible" (Axline, 1969, p. 76).

Principle 2, accepting the child completely: "Talking about my anger and feelings" would be the most helpful thing right now. The staff and volunteers "accept the child exactly as he/she is" (Axline, 1969, p. 86).

Principle 3, establishing a feeling of permissiveness: Art is the most helpful "because when I get angry I mess up and then I paint over it." The staff and volunteers "establish a feeling of permissiveness in the relationship so that the child feels free to express his/her feelings completely" (Axline, 1969, p. 91).

Principle 4, recognition and reflection of feelings: Coming to The Dougy Center "has helped me figure out my feelings." The staff and volunteers are "alert to recognize the feelings the child is expressing and reflects back those feelings in such a manner that the child gains insight into his/her behavior" (Axline, 1969, p. 97).

Principle 5, maintaining respect for the child: "I get to play and it takes my mind off my brother for a while." The staff and volunteers "maintain a deep respect for the child's ability to solve his/her own problems if given an opportunity. The

responsibility to make choices and to institute change is the child's" (Axline, 1969, p. 106).

Principle 6, the child leads the way: "Playing hasn't helped, but it's been fun." The staff and volunteers "do not attempt to direct the child's actions or conversation in any manner. The child leads the way." The staff and volunteers follow (Axline, 1969, p. 119).

Principle 7, therapy [support] cannot be hurried: "I still have no idea what I need to do [before leaving], I guess I will just know when it is time." The staff and volunteers "do not attempt to hurry the therapy [support] along. It is a gradual process and is recognized as such by the" staff and volunteers (Axline, 1969, p. 125; brackets added).

Principle 8, the value of limitations: In each group, "we introduce ourselves, say who died, talk, play for a little while, then leave . . . always the same." The staff and volunteers "establish only those limitations that are necessary to anchor therapy [support] to the world of reality and to make the child aware of his/her responsibility in the relationship" (Axline, 1969, p. 125; brackets added).

Limitations of the Current Project

The main purpose of the current study was to provide exploratory findings of what grief looks like to children and teens through the analyses of four questionnaires. This analysis was done to create a more vivid image of how these youth make sense of loss due to death, an image that is sparse in the literature on grieving. Suffice it to

say that each one of the behaviors and emotions presented could be explained in relation to grief and depression. A secondary goal was to determine the usefulness of administering the CES-D to populations under 18 years old.

None of the tests showed any statistical significance between five independent variables and scores on the CES-D. One reason for these findings could be drawn from the fact that the CES-D was not developed for administration among persons under age 18. One reason for this could be due to this population's lack of experience with longitudinal perspective concerning life events. Another reason could be due to limitations associated with processing abstract thought, as many of the concepts measure abstract principles. The most likely factor in these findings could be attributed to sample size. According to Krejcie and Morgan's (1970) table of recommended *sample sizes*, this project would have needed a sample size of 254 to provide an adequate sample from the 733 clients who could possibly have been administered the questionnaire during the time period under study.

The findings of no statistical significance could be attributed to bias in the sampling procedures. Concerning the sample bias in this project, this was a sample of convenience, which is also known as an accidental sample (Patten, 2002). Convenience sampling is a form of nonprobability sampling and relies upon selecting convenient, available subjects. This type of sampling can produce results that are ineffective and unrepresentative and prevents any possibility that the findings could be generalized to a larger population (Neuman, 1994). Finally, the lack of follow-up measures does not allow for analysis of the effectiveness of the intervention (the

intervention being the support).

Implications and Recommendations of This Study

Not too many years ago children witnessed death firsthand in their own homes among extended family members, but the reality of death has been taken out of the home in American society and placed in hospitals and nursing homes. Currently, in American society, adults tend to treat the two concepts of death and children as mutually exclusive. This may be due to the discomfort felt by many adults concerning their own mortality and is then projected onto children as a reason for wanting to protect them from all death-related situations. Complete protection cannot take place, but adults can be of assistance to children when they are curious about loss and death. For those children who are directly impacted by the death of a close family member, services similar to those provided at The Dougy Center can help children and teens make sense of the emotions they are experiencing. Bereavement support groups can help to "normalize" the grief experience that has been shielded from many young mourners.

One of the central implications to be drawn from this study is that literature dealing directly with grieving children and teens is lacking in proportion to the numbers of youth affected each year. There are 200,000 to 400,000 youth each year who experience the death of a parent or sibling. The literature evaluating their perspective has not kept pace with these totals. Second, loss due to death has a significant impact on children and teens. This study has shown that most of these

children benefit from supportive interventions such as the model used at The Dougy Center, with 84% reporting that they *feel better*.

Suggestions for recommendations revolve mainly around the limitations of the current project. Ideally, any organization that relies on a donor base for its funding would conduct program evaluation. For organizations that assist grieving children and adolescents, measures of effectiveness exist and can be utilized. For effective measurement of children and teens' issues, it is of vital importance to use age-appropriate measures. Organizations that decide to use the CES-D could eliminate Questions 4, 8, 12, and 16 and obtain results with high reliability alphas. In addition, sample size and randomness could be taken care of by organizations providing measures of each of their clients. Follow-up studies are critical and should also be conducted to measure change over time and program effectiveness.

The last suggestion for future research is for similar organizations to pool their findings and to create strength that is achieved only in large numbers. With more than 100 organizations in existence that are based on The Dougy Center model, there is no reason why the effectiveness of this type of intervention should remain hidden from grief researchers and from intervention-based organizations. Children grieve. Support helps these children. Research helps organizations provide that support. It is time for the organizations to be more supportive of the research effort.

REFERENCES

Achenbach, T. M. (1991). *Manual for the Behavior Checklist/4-18 and 1991 Profile.* Burlington: University of Vermont, Department of Psychiatry.

Achenbach, T. M., & Edelbrock, C. (1983). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile.* Burlington: University of Vermont, Department of Psychiatry.

Axline, V. M. (1969). *Play therapy.* New York: Ballantine Books.

Berger, K. S. (1998). *The developing person through the life span* (4th ed.). New York: Worth Publishers.

Bowlby, J. (1980). *Loss, sadness and depression.* New York: Basic Books.

Cobb, N. J. (1998). *Adolescence: Continuity, change, and diversity* (3rd ed.). Mountain View, CA: Mayfield.

Cole, M., & Cole, S. R. (1996). *The development of children* (3rd ed.). New York: W. H. Freeman.

Corr, C. A., Nabe, C. M., & Corr, D. M. (2000). *Death and dying: Life and living* (3rd ed.). Belmont, CA: Wadsworth/Thomson Learning.

Dilworth, J. L., & Hildreth, G. J. (1997). Long-term unresolved grief: Applying Bowlby's variants to adult survivors of early parental death. *Omega, 36*(2), 147-159.

Dougy Center (The). (1996). *Waving goodbye: An activities manual for children in grief.* Portland, OR: The Dougy Center for Grieving Children.

Dougy Center (The). (1998). *Policies and procedures manual* (rev. ed.). Portland, OR: The Dougy Center for Grieving Children.

Finkelstein, H. (1988). The long-term effects of early parental death: A review. *Journal of Clinical Psychology, 44*(1), 3-9.

Furstenberg, F. F., & Cherlin, A. J. (1999). Children's adjustment to divorce. In A. S. Skolnick & J. H. Skolnick (Eds.), *Family in transition* (10th ed., pp. 246-256). New York: Longman.

Gersten, J. C., Beals, J., & Kallgren, C. A. (1991). Epidemiology and preventive interventions: Parental death in childhood as a case example. *American Journal of Community Psychology, 19*(4), 481-500.

Hann, D., Winter, K., & Jacobsen, P. (1999). Measurement of depressive symptoms in cancer patients: Evaluation of The Center for Epidemiological Studies-Depression Scale (CES-D). *Journal of Psychosomatic Research, 46,* 437-443.

Harris, M. (1995). *The loss that is forever: The lifelong impact of the early death of a mother or father.* New York: Plume/Penguin.

Harter, S. (1979). *Manual: Perceived competence scale for children.* Denver, CO: University of Denver.

Harter, S. (1985). *Processes of underlying the construction, maintenance, and enhancement of the Self-Concept Scale in Children.* Hillsdale, NJ: Erlbaum.

Hogan, N. S. (2001). Development and validation of the Hogan Grief Reaction Checklist. *Death Studies, 25,* 1-32.

Hurd, R. C. (1999). Adults view their childhood bereavement experiences. *Death Studies, 23,* 17-41.

Kastenbaum, R. J. (2000). The kingdom where nobody dies. In K. J. Doka (Ed.), *Living with grief: Children, adolescents, and loss* (pp. 5-20). Washington, DC: Hospice Foundation of America.

Kastenbaum, R. J. (2001). *Death, society, and human experience* (7th ed.). Boston: Allyn & Bacon.

Katzenbach, J. (1986). *The traveler.* New York: Putnam.

Kleinke, C. L. (1998). *Coping with life challenges.* Pacific Grove, CA: Brooks/Cole.

Krejcie, R. V., & Morgan, D. W. (1970). Determining sample size for research activities. *Educational and Psychological Measurement, 30,* 607-610.

Leming, M. R., & Dickinson, G. E. (2002). *Understanding dying, death, and bereavement* (5th ed.). Fort Worth, TX: Harcourt.

McLeod, J. D. (1991). Childhood parental loss and adult depression. *Journal of Health and Social Behavior, 32,* 205-220.

Mireault, G. C., & Bond, L. A. (1992). Parental death in childhood: Perceived vulnerability, and adult depression and anxiety. *American Journal of Orthopsychiatry, 62*(4), 517-524.

Neuman, W. L. (1994). *Social research methods: Qualitative and quantitative approaches* (2nd ed.). Boston: Allyn & Bacon.

Nowicki, S., & Strickland, B. R. (1973). A locus of control scale for children. *Journal of Consulting and Clinical Psychology, 40,* 148-154.

Patten, M. L. (2002). *Understanding research methods: An overview of the essentials* (3rd ed.). Los Angeles: Pyrczak Publishing.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385-401.

Radloff, L. S., & Locke, B. Z. (1986). The community mental health assessment survey and the CES-D scale. In M. M. Weissman, J. K. Myers, & C. E. Ross (Eds.), *Community surveys of psychiatric disorders* (Vol. 4, pp. 177-189). New Brunswick, NJ: Rutgers University Press.

Radloff, L. S., & Teri, L. (1986). Use of The Center for Epidemiological Studies-Depression Scale with older adults. *Clinical Gerontologist, 5,* 116-136.

Raphael, B. (1982). The young child and the death of a parent. In C. M. Parkes & J. Stevenson-Hinde (Eds.), *The place of attachment in human behavior* (pp. 131-150). New York: Basic Books.

Raveis, V. H., Siegel, K., & Karus, D. (1998). Children's psychological distress following the death of a parent. *Journal of Youth and Adolescence, 28*(2), 165-180.

Reinherz, H. Z., Giaconia, R. M., Hauf, A. M. C., Wasserman, M. S., & Silverman, A. B. (1999). Major depression in the transition to adulthood: Risks and impairments. *Journal of Abnormal Psychology, 108*(3), 500-510.

Rodgers, B., Power, C., & Hope S. (1997). Parental divorce and adult psychological distress: Evidence from a national birth cohort: A research note. *Journal of Child Psychology and Psychiatry, 38*(7), 867-872.

Smith, I. (1991). Preschool children "play" out their grief. *Death Studies, 15,* 169-176.

Steinberg, L. (2002). *Adolescence* (6th ed.). New York: McGraw-Hill.

Weissman, M. M., Sholomskas, D., Pottenger, M., Prusoff, B. A., & Locke, B. Z. (1977). Assessing depressive symptoms in five psychiatric populations: A validation study. *American Journal of Epidemiology, 106*(3), 203-214.

Worden, J. W. (1996). *Children and grief: When a parent dies.* New York: Guilford Press.

Worden, J. W., & Silverman, P. R. (1996). Parental death and the adjustment of school-age children. *Omega, 33*(2), 91-102.

Zall, D. S. (1994). The long-term effects of childhood bereavement: Impact on roles as mothers. *Omega, 29*(3), 219-230.

APPENDIXES

Appendix A

The Dougy Center Contact Information

The Dougy Center: The National Center for Grieving Children and Families
3909 S.E. 52nd Avenue
P.O. Box 86852
Portland, Oregon 97286

Phone numbers:
(503)775-5683
(503)777-3097 (fax number)

Web site:
www.dougy.org
www.grievingchild.org

E-mail:
help@dougy.org

Appendix B

CES-D Scale Scoring

Instructions: Circle the number for each statement that best describes how often you felt or behaved this way—DURING THE PAST WEEK.

DURING THE PAST WEEK:	Item weights			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that don't usually bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	3	2	1	0
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	3	2	1	0
9. I thought my life had been a failure.	0	1	2	3

Table 4 (*continued*)

Instructions: Circle the number for each statement that best describes how often you felt or behaved this way—DURING THE PAST WEEK.

DURING THE PAST WEEK:	Item weights			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	3	2	1	0
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	3	2	1	0
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people dislike me.	0	1	2	3
20. I could not get "going."	0	1	2	3

Score is sum of 20 endorsed item weights.

© National Institute of Mental Health; Lenore S. Radloff (1977).

Appendix C

Institutional Review Board Letter of Approval

UtahState
UNIVERSITY

VICE PRESIDENT FOR RESEARCH OFFICE
1450 Old Main Hill
Logan UT 84322-1450
Telephone: (435) 797-1180
FAX: (435) 797-1367
Email: vpr@cc.usu.edu

4/18/2002

MEMORANDUM

TO: Marcelo Diversi
Karen Sorenson

FROM: True Rubal, IRB Administrator

SUBJECT: Good Grief Kids: An Exploratory Analysis of Grieving Children and Teens at The Dougy Ctr in Portland, OR

Your proposal has been reviewed by the Institutional Review Board and is approved under expedite procedure #7.

X There is no more than minimal risk to the subjects.
There is greater than minimal risk to the subjects.

This approval applies only to the proposal currently on file for the period of one year. If your study extends beyond this approval period, you must contact this office to request an annual review of this research. Any change affecting human subjects must be approved by the Board prior to implementation. Injuries or any unanticipated problems involving risk to subjects or to others must be reported immediately to the Chair of the Institutional Review Board.

Prior to involving human subjects, properly executed informed consent must be obtained from each subject or from an authorized representative, and documentation of informed consent must be kept on file for at least three years after the project ends. Each subject must be furnished with a copy of the informed consent document for their personal records.

The research activities listed below are exempt from IRB review based on the Department of Health and Human Services (DHHS) regulations for the protection of human research subjects, 45 CFR Part 46, as amended to include provisions of the Federal Policy for the Protection of Human Subjects, June 18, 1991.

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Appendix D

Letters of Permission

The Dougy Center

The National Center for Grieving Children & Families

The Dougy Center
for Grieving Children

12/21/01

Karen Sorensen
313 W Concord Drive
Harrisville UT 84404-2745

Dear Karen and The Thesis Committee

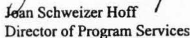
This letter is it confirm our discussion about the data that you have collected and plan to use for the purpose of completion of your thesis.

The Dougy Center has agreed to allow you to copy and have in your possession copies of information collected from closed family files (1996 - 2000). It is our understanding that the information collected will be used in your thesis project and for no other purpose. No names or other identifying information of families will be used. Once the data has been completed the copies will be destroyed.

We further agree that any plans for submission for publication or other public use of the data will be presented to and reviewed by The Dougy Center Staff before the submission occurs.

We look forward to seeing the completed thesis.

Sincerely;



Joan Schweizer Hoff
Director of Program Services

3909 S.E. 52nd Avenue • P.O. Box 86852 • Portland, Oregon 97286 • 503-775-5683
www.dougy.org • Fax: 503-777-3097

National Institute of Mental Health

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857-8030

Dear Colleague:

Thank you for your inquiry regarding the Center for Epidemiologic Studies Depression Scale (CES-D). We are always happy to have the scale used by qualified researchers. The scale is in the public domain and may be used and duplicated without copyright permission.

If you have any questions regarding the CES-D that are not answered by the information in the packet, please feel free to contact me either by e-mail: "kbourdon@nih.gov", or by telephone at 301 443-~~1616~~. 5944

Sincerely,

Karen Bourdon

Karen H. Bourdon, M.A.
Prevention, Early Intervention, and
Epidemiology Research Branch
Division of Mental Disorders, Behavior
Research and AIDS

Appendix E

The Dougy Center Population (Entire)

From 1996 to 2000

Table 43

Demographic Data Spreadsheet

Gender	Age	Age by Desc. %	Person who died	Type of death	Year
The Dougy Center 1996-2000 733 (100%)	The Dougy Center 1996-2000 733 (100%)	The Dougy Center 1996-2000 733 (100%)	The Dougy Center 1996-2000 759 (100%)	Natural 413 (54.8%)	1996 96 (13.1%)
Males 369 (50.3%)	3 years 53 (7.2%)	9 years 74 (10.1%)	Father 389 (51.3%)	Accidental 143 (19.0%)	1997 100 (13.6%)
Females 364 (49.7%)	4 years 40 (5.5)	6 years 69 (9.4%)	Mother 195 (25.7%)	Suicide 99 (13.1%)	1998 181 (24.7%)
	5 years 45 (6.1%)	8 years 58 (7.9%)	Brother 75 (10.0%)	Homicide 56 (7.4%)	1999 158 (21.6%)
	6 years 69 (9.4%)	10 years 57 (7.8%)	Sister 48 (6.3%)	Overdose 31 (4.1%)	2000 198 (27.0%)
	7 years 56 (7.6%)	11 years 57 (7.8%)	Other 50 (6.7%)	Unknown 12 (1.6%)	

Table 43 (*continued*)

Gender	Age	Age by Desc. %	Person who died	Type of death	Year
	8 years 58 (7.9%)	7 years 56 (7.6%)	"Others" Grandfather (23) Grandmother (7) Friend (9) Boyfriend (1) Uncle (2) Aunt (1) Nephew (1) Cousin (3) Father figure (1) Mother's fiancé (2)		
	9 years 74 (10.1%)	3 years 53 (7.2%)			
	10 years 57 (7.8%)	14 years 51 (7.0%)			
	11 years 57 (7.8%)	5 years 45 (6.1%)			
	12 years 43 (5.9%)	12 years 43 (5.9%)			
	13 years 37 (5.0%)	4 years 40 (5.5%)			

Table 43 (*continued*)

Gender	Age	Age by Desc. %	Person who died	Type of death	Year
	14 years 51 (7.9%)	13 years 37 (5.0%)			
	15 years 30 (4.1%)	15 years 30 (4.1%)			
	16 years 27 (3.7%)	16 years 27 (3.7%)			
	17 years 23 (3.1%)	17 years 23 (3.1%)			
	18 years 13 (1.8%)	18 years 13 (1.8%)			

Appendix F

The Dougy Center for Grieving Children

Family Self-Evaluation

Your Name: ______________________________
Group Name: ______________________________
Today's Date: ______________________________

At the Dougy Center, we believe that each person's grief is unique. People work through their grief at very different rates. Please use this Family Self-Evaluation to talk as a family about your experience at The Dougy Center.

Each family member should fill out a separate evaluation form; discuss what works for you, and what else would be helpful for you in coping with the grief process. It is important to remember that you do not have to have the same answers or agree, as each of you may be in different places in your grief process. When you have completed the forms, return them to your group coordinator.

1. I have participated at The Dougy Center for (check one):
   [ ] 1-6 months
   [ ] 7-12 months
   [ ] 13-18 months
   [ ] more than 18 months

2. Since coming to The Dougy Center, I feel (check one):
   [ ] much better
   [ ] a little better
   [ ] the same
   [ ] a little worse
   [ ] much worse

3. Tell us about your Dougy Center experience:
   ____
   ____

4. What has helped me the most is:
   ____
   ____

5. What has been the least helpful is:

____

____

6. I think I will have finished my work and be ready to leave The Dougy Center in about (check one):
   [ ] a month
   [ ] 3-5 months
   [ ] 6-12 months
   [ ] don't know how much longer

7. What would help me most now would be:

____

____

8. To be ready to close at The Dougy Center, I still need:

____

____

9. What I will do in the next 6 months is:

____

____

FOR ADULTS ONLY:

1. Please comment on your experience of the volunteer (or volunteers) who facilitate your group:

____

____

____

2. Please feel free to make any additional comments. Thank you.

____

____

____

© The Dougy Center: The National Center for Grieving Children and Families

Appendix G

The Dougy Center Intake Questionnaire: Child Form

Your Name: ____

What is your relationship to the person who died? The person who died was my:

- [ ] mother
- [ ] father
- [ ] brother
- [ ] sister
- [ ] others: ____________________________

For each question, please check one answer:

1. Since the death, I want to be by myself:
   - [ ] more
   - [ ] same
   - [ ] less

2. Since the death, school has been:
   - [ ] harder
   - [ ] same
   - [ ] easier

3. Since the death, I get along with my friends:
   - [ ] more
   - [ ] same
   - [ ] less

4. Since the death, I get along with members of my family:
   - [ ] more
   - [ ] same
   - [ ] less

5. Since the death, my sleep is:
   - [ ] worse
   - [ ] same
   - [ ] better

6. Since the death, I eat:
   [ ] more
   [ ] same
   [ ] less

7. Since the death, I use:
   [ ] drugs
   [ ] alcohol
   [ ] does not apply

8. Since the death, I sometimes have physical hurts (headaches, stomachaches, rashes, etc.):
   [ ] yes
   [ ] no

Please check all feelings that apply to you now:
   [ ] shock
   [ ] fear
   [ ] anger
   [ ] sadness
   [ ] others: ______________________________

Do you see a counselor now:

at school?	[ ]	yes	[ ]	no
outside of school?	[ ]	yes	[ ]	no

© The Dougy Center: The National Center for Grieving Children and Families

Appendix H

The Dougy Center Intake Questionnaire: Teen Form

Your Name: ____________________
Today's Date: ____________________

How are you related to the deceased?

____

How have these areas of your life been affected since the death:

1. relationship with parent(s)?

____
____

2. school/grades/teachers?

____
____

3. friendships/social life?

____
____

4. sleep/eating habits?

____
____

5. other family relationships?

____
____

6. other?

____
____

What emotions have you been experiencing since the death:

[ ]	shock	[ ]	guilt	[ ]	fear
[ ]	anger	[ ]	hopelessness	[ ]	shame
[ ]	relief	[ ]	sadness	[ ]	anxiety
[ ]	embarrassment	[ ]	loneliness	[ ]	confusion
[ ]	happiness/laughter				
[ ]	others: ____________________				

Since the death, have you experienced any physical symptoms?

[ ] no

[ ] yes; describe: ____________________________________

Are you taking any medications?

[ ] no

[ ] yes; specify: ____________________________________

Are you seeing a school counselor?

[ ] no

[ ] yes; what brought you to the counselor?

____

____

Who are the supportive people you talk to about the death?

____

____

____

© The Dougy Center: The National Center for Grieving Children and Families

Appendix I

Independent and Dependent Variables

Correlation Matrix

Table 44

Pearson Correlations of Independent and Dependent Variables

		Gender	Age	Who died	How died	Time between	CES-D score
Gender	Correlation	1.000					
	Sig. (1-tailed)	. .					
	N	139					
Age	Correlation	.158	1.000				
	Sig. (1-tailed)	.032	. .				
	N	139	139				
Who died	Correlation	-.049	-.022	1.000			
	Sig. (1-tailed)	.282	.396	. .			
	N	139	139	139			
How died	Correlation	.021	.025	.091	1.000		
	Sig. (1-tailed)	.405	.385	.142	. .		
	N	139	139	139	139		
Time between	Correlation	.069	.064	-.084	.012	1.000	
	Sig. (1-tailed)	.211	.227	.164	.164	. .	
	N	139	139	139	139	139	
CES-D score	Correlation	.032	.140	.079	-.041	-.017	1.000
	Sig. (1-tailed)	.353	.051	.178	.317	.421	. .
	N	139	139	139	139	139	139

Note. Gender = male and female; age = 3-12 years old and 13-18 years old; who died = parent and sibling/other; how died = anticipated death and unanticipated death; time between = 0-12 months and 13 months or more; CES-D score = no depression, mild/moderate, and severe depression.