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**Field trial of a complicated grief psychosocial program for adolescents in occupied
Palestine**

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Abstract

This study evaluated the new ‘Children and Grief’ program for Palestinian adolescents ($n = 158$), aged 10-18, referred to counselors for complicated grief. A mixed methods quasi-experimental design involved non-randomized intervention group ($n = 79$), waitlist ($n = 79$) and measures of program fidelity and cost. Traumatic loss was identified from files. Standardized measures assessed complicated grief, posttraumatic stress and depression at pre and post-test. Interviews of nine adolescents and presenters explored subjective experience. Analysis involved MANOVA and quasi-qualitative analysis of interviews. A large effect size was found for reduced complicated grief. Randomized control trials and longitudinal research are needed.

Keywords: complicated grief, adolescents, trauma, recovery, CBT

Field trial of a complicated grief psychosocial program for adolescents in occupied Palestine

Understanding of complicated grief in adolescence is in its infancy with inconsistent definitions (Barron, Dyregrov, Abdallah & Jindalsnape, 2015). As a consequence, a wide range of prevalence has been identified from eight to 64% (NCTSN, 2009). Around 20% of adolescents have been found to experience severe and enduring symptoms from the death of a parent (Dowdney, 2000). In Palestine, Thabet, Tawahina, Punamaki and Vostanis (2015) report that 10-30 percent of children experience unresolved grief. Within their Gazan study, using a short ten-item Grief Screening Scale with 374 six to sixteen year olds, thirty six participants reported the loss of a parent. Of these, 62.8% reported upsetting thoughts that blocked grieving. Unfortunately, adolescents were not identified. Barron, et al (2015), in a recent West Bank study, used the Traumatic Grief Inventory for Children (TGIC) to assess complicated grief in adolescents aged 10-14 years ($n = 133$) who had experienced a wide range of traumatic losses. Twenty percent reported complicated grief symptoms. The authors concluded, however, that this was likely to be an underestimate because of the strict statistical cut-off. In short, despite the small number of complicated grief studies in Palestine, indications are, a substantial proportion of adolescents experience complicated grief requiring intervention.

Definition

Much of our understanding of complicated grief in adolescence comes from conceptualizations based on adult grief. While there are similarities between adult and adolescent reactions, such as posttraumatic stress (Melhem, Moritz, Walker, Shear & Brent, 2007), Dyregrov & Dyregrov (2012) caution against over-generalisation, as adolescent understandings of loss are influenced by the interaction of social context and cognitive development. Adolescents, for example, worry about who is going to look after them following the death of parents, struggle to cope with intense feelings, and experience anxiety

about their mortality more than adults.

A range of terms are used to describe complicated grief, such as traumatic, disabling, disenfranchised and prolonged grief (Brown & Goodman, 2005). Terms are often used interchangeably and without adequate definition leading to confusion (Stroebe, Hansson, Stroebe, & Schut, 2001). The origins of complicated grief as a phenomenon affecting adolescence emerged from a study of eighty three 8-18 year olds who experienced losing a parent as a result of the September 11 New York terrorist attack (Cohen, Goodman, Brown & Mannarino, 2004). The term used, Childhood Traumatic Grief (CTG), referred to the trauma reaction from sudden, unexpected and violent loss that is understood to block the normal grief response resulting in a combination of posttraumatic stress and grief symptoms. Some, however, question whether complicated grief is sufficiently distinct from posttraumatic stress to warrant its own diagnosis (Melham et al., 2007). In contrast, studies that have explored a wide range of adolescent loss suggest complicated grief often presents in a cluster of symptoms with posttraumatic stress and depression, but as a separate reaction. Intensity of anger and yearning for the deceased, difficulties acknowledging the loss and the meaninglessness of the death are all unique factors (Dillen, Fontaine & Verhofstadt-Deneve, 2009). Prigerson and colleagues (2009) labelled these grief-specific trauma symptoms as adolescent Prolonged Grief Disorder (PGD). The inter-relationship of complicated grief, posttraumatic stress and depression in adolescence, however, is unclear and requires further study (Barron et al., 2015).

Subtypes of complicated grief have also been identified. These include delayed or absent grief with a preoccupation for the welfare of others; chronic grief that is excessive with intense emotions that are limited in range; and inhibited or distorted grief indicating difficulties acknowledging the loss (Dyregrov, 2008). Where there is no body, fantasizing can occur about the horror of what happened (Dyregrov & Dyregrov, 2012). Perhaps not

surprisingly given the confusion of definitions, therapists struggle to define and identify complicated grief in adolescents. Therapists do, however, report intensity, duration and longevity of response as common factors (Dyregrov & Dyregrov, 2013).

Traumatic loss

Adolescents who present with complicated grief experience traumatic loss including acts of war (Barron et al., 2013); terrorism (Cohen et al., 2004); peer or parental suicide, murder, parental imprisonment and siblings taken into care (Barron & Mitchell, 2016). Within contexts of war, adolescents rarely experience single events or clusters of loss, rather they experience cumulative loss over many years (Birman, et al., 2005). In Palestine, such loss is often collective. Parents, friends and teachers are taken into detention, homes are lost through demolition and family members are killed in missile attacks or by sniper fire (Barron et al., 2013). Mannarino and Cohen (2011) suggest that any death can lead to complicated grief if the adolescent experiences the event as traumatic. Further, it is not only the death itself but the circumstances of the death that can be traumatic, for example, witnessing a parent gasping for breath following a heart attack. Cohen and Mannarino (2004), stress the importance of recognising that adolescents who show signs of posttraumatic stress following a death are not following the normal trajectory of grieving and therefore require intervention.

Symptoms

Some adolescents experience death and loss as overwhelming with resultant feelings of helplessness. The trauma response can then block the grieving process resulting in intrusions such as images of the event that led to the death, feelings of terror, numbing and avoidance of triggers. The latter include people, places and situations that are reminders of the death and /or the cause of death (Cohen & Mannarino, 2004). Secondary life changes as a consequence of the loss, such as having to live with extended family, can exacerbate symptoms. Future traumatisation and further loss and life change can also trigger symptoms

(Mannarino, & Cohen, 2011). Adolescents report a wider range of symptoms than posttraumatic stress including embodied trauma (body pains and stomach upsets), depression, anxiety, relational problems, behavior difficulties, self-harm, substance misuse, and violence towards others (Cerel, Fristad, Verducci, Weller & Weller, 2006). A supportive parental response can facilitate recovery, whereas parents struggling with their own grief, who are less emotionally available, and provide little information about the death, can exacerbate symptoms (Scheeringa, Zeanah, Drell & Larrieu, 1995). Culture also impacts on symptoms. In Palestine, where adolescent views are often unheard, more embodied symptoms are reported than in the West (Barron, et al., 2013). In contrast, cultural rituals that emphasise participation provide a context for adolescents to express their sense of loss resulting in better coping (Parkes, Laungani & Young, 2003). The response with age across adolescence is unknown and Palestinian studies suggest no gender difference (Barron et al., 2015; Thabet, et al., 2015). Complicated grief, if not addressed, can lead to long term mental health difficulties (Melhem et al., 2007).

Group-based programs

Group interventions fit well with school contexts. Schools provide the setting to deliver programs to the universal population and enable early identification of mental health difficulties (Topping & Barron, 2009). Group approaches reduce the need for individualised treatment and provide an assessment process for individual therapy (Dyregrov, Yule, Straume, & Kraus, 2011). The main barrier, however, is the lack of group approaches. The only complicated grief group program that has an evidence base is the UCLA Trauma Grief Program for adolescents. The TGPA program includes brief exposure, cognitive restructuring, dealing with reminders, and future planning. Two small empirical studies have found promising results for TPGA in war and community violence contexts. Following the civil war in Bosnian, adolescents reported reduced psychological distress and increased social

adaptation. As the sample size was small ($n = 55$) with no control group, results are preliminary. Adolescents who experienced community violence in Los Angeles also reported reduced complicated grief, posttraumatic stress and improved academic achievement (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001). Again the sample size was small ($n = 26$) with no comparison group. Without the latter there is no way to assess whether change was due to maturation. There is therefore a need for robust program evaluation with larger sample sizes and comparison groups. This field trial then, evaluates a new complicated grief program, Children and Grief (C&G), developed by the Children and War Foundation (Dyregrov, Yule, Straume, & Kraus, 2011) that addresses these methodological issues.

Field trials

Field trials test the effectiveness of programs in real life contexts rather than artificial laboratory settings and have good face validity. The number of controllable variables, however, is reduced (Robson, 2011). Field trials of new programs suggest process-based evaluation as a first step, as assessing outcomes too early can inhibit program development (Barron & Topping, 2011). Designs include a range of methodologies from case studies to randomised control trials (Robson, 2011). Program fidelity is often omitted, yet without assessment of adhering to protocols, it is unknown what is actually being assessed (Barron & Topping, 2011). Field trials seek to identify what works and what needs to be improved. This includes identification of person characteristics of participants and presenters, subjective experience of receiving/delivering the program and situational factors that influence effectiveness (Berlot & James, 2014). Typically, field trials of new programs involve participants who are receptive to the program and what it is trying to achieve. Selection bias may, however, indicate a program is more effective than it is (Berlot & James, 2014). In spite of the importance of finance in sustaining program delivery, it is rare in trauma recovery program efficacy studies to measure the cost of future implementation (Barron et al., 2013).

The current study

As C&G developed from an existing group-based cognitive behavioural program with an empirical evidence base in Palestine (Barron et al., 2013), and other war contexts (Yule, Dyregrov, Raundalen, & Smith, 2013), there was sufficient evidence to suggest the field trial of this untested program include outcome measures as well as evaluation of participant experience. A quasi-experimental design included assessing the situational factors of traumatic loss from adolescent case records and the symptom cluster of complicated grief, posttraumatic stress and depression using standardised measures developed for adolescents. To understand participant experience and learn lessons for future delivery, interviews were conducted with adolescents and school counselors. An assessment of program adherence and calculation of future implementation cost were utilized.

Methods

Field trial design

The current study uses a mixed methods quasi-experimental design with non-randomized intervention and Waitlist comparison, standardized symptoms measures for adolescents and parents, a measure of program fidelity and calculation of future delivery cost. To assess participant program experience interviews were conducted with nine randomly selected adolescents and all presenters ($n = 9$). Prior to the study ethical approval was received from a UK University Research Ethics Committee. Active-informed consent was required from schools, counselors, parents and active-informed assent from adolescents. The Waitlist received C&G a month following post-test completion.

Participants

Participants ($n = 158$) were aged 10-18 years and referred to counseling services in Nablus for symptoms of unresolved grief. Nablus was identified because of high levels of military violence and the availability of counselors previously trained in a psychosocial

trauma recovery program (Barron et al., 2013). Inclusion criteria, identified from referral files was: (i) traumatic losses; (ii) unresolved grief reported by adolescents; and (iii) an absence of co-morbid symptoms contra-indicative of responding to group work, e.g. behavioural difficulties. Half the participants ($n = 79$) were purposefully allocated to C&G (those about to receive support) and half ($n = 79$) to Waitlist (those on the waiting lists). As Palestinian studies found similar levels of complicated grief gender-wise there was no stratification.

Program Presenters

Presenters were school counselors ($n = 9$), from nine Palestinian Authority single sex schools, three female and six male. Counselors had previously trained in TRT (Smith, Dyregrov, & Yule, 2008). C&G is sufficiently similar to TRT to enable transfer of delivery with a familiarisation session. The one and a half day session was delivered by the two researchers who were educational psychologists (one Palestinian, the other British) experienced in delivering psychosocial programs. Content included: boundaries of confidentiality; practice of less familiar complicated grief activities identified by researchers and counselors; and an emphasis on following scripts and listening and responding.

Program

The 'Children and Grief: Teaching Life Skills' program was developed by the Children and War Foundation (Dyregrov et al., 2011). The program aims to reduce adolescent symptoms of complicated grief and reduce the need for individualised treatment. The original TRT program is also based on cognitive behavioural theory and aims to reduce posttraumatic stress symptoms through psychoeducation and the teaching of coping skills. Five sessions cover normalising the trauma response; dealing with intrusions, understanding emotions, relaxation skills, and systematic desensitisation. The C&G program is delivered over seven sessions. The first session normalises the trauma response, introduces the idea of a tool box of strategies, a safe place, feelings thermometer and a memory folder. The next three

sessions mirror TRT in addressing intrusions (visual imagery and dual attention techniques), hyperarousal (relaxation, breathing, and mindfulness strategies and coping statements) and avoidance (regulating grief reminders, distraction and sharing experience). Sessions five and six focus on understanding and coping with feelings (e.g. dozing, postponing worry and sadness, positive self-statements and strong thoughts, managing sleep and participating in the funeral). The final session teaches adolescents how to live with loss over time in terms of meaning making, continuing bonds, and anticipating the future. Homework activities aim to consolidate learning. Because of intergenerational trauma resulting in adolescent short concentration spans, and on the counselors' advice, the first session was a half rather than full day. The subsequent six sessions were two hours each. The program is designed to be delivered at least a month after a significant loss. Within Nablus, however, these losses are cumulative. C&G was translated into Arabic by the Palestinian researcher. Counselors delivered in pairs, one to lead the other facilitate, to ten adolescents in school classrooms.

Program fidelity

Presenters were asked at interview, two weeks following C&G completion, to self-rate and other-rate co-presenter adherence to program protocols on a 0-10 scale (no adherence vs. full adherence) for each sessions Program fidelity is reported as an average rating and percentage. Counselors were asked to report on challenges and adaptations.

Standardized measures

Adolescent traumatic loss events, recorded in case files, were reported by counselors. Four measures were administered two weeks prior to, and after, C&G delivery. The Inventory of Prolonged Grief for Adolescents (IPG-A: 13-18years) and Children (IPG-C: 8-12 years) is a thirty item self-report questionnaire which assesses a range of complicated grief symptoms. The latter has the same statements with simplified language. Questions are on a three point scale (almost never, sometimes, and always). The internal consistency of the IPG-C and IPG-

A is high with a Cronbach alpha of .91 and .94 respectively (Spuij et al., 2011). The IPG-C and the IPG-A were blind-back translated (Chen & Boore, 2010) into Arabic by two Palestinian researchers (educational psychologists). High internal consistency of Cronbach alpha of .84. and .89, respectively, were maintained. The Moods and Feelings questionnaire (MFQ: Angold, Costello, Messer, Pickles, Winder, F. & Silver, 1995) for 7-18 year olds, measured depression in adolescents and has moderate to high criterion validity (.86). The measure contains 13 items each on a 3 point scale. The clinical cut off is 11 with higher scores signifying depression. The Arabic translation maintained a high level of validity (.79). The Children's Revised Impact of Events Scale (CRIES-13: Smith, Perrin, Dyregrov, & Yule, 2003) is a measure of posttraumatic stress. The CRIES-13, for 8 year olds and older, assesses the symptoms of intrusion, avoidance and arousal (13 items on a 4 point scale) with a clinical cut off of 17 for the subtests of intrusion and avoidance. CRIES-13 shows good internal consistency (Cronbach alpha coefficient of .80) as does the Arabic version (.78). The Parent's Report of Posttraumatic Symptoms (PROPS) is a parent-report measure of adolescent posttraumatic stress. The clinical cut-off is 16. The measure has good internal consistency of 0.91 (coefficient alpha) and test-re-test reliability for assessing change over time (Pearson's $R = 0.79$). PROPS was blind-back translated by two Palestinian researchers into Arabic with an alpha coefficient of .72.

Interviews

To explore subjective experience, a semi-structured interview was conducted with nine adolescents two weeks after C&G. Questions covered: what adolescents liked/disliked, what was helpful/unhelpful, what they learned, what difference C&G made in their life and negative consequences. The interviews were translated into Arabic and administered by the Palestinian researcher. Interviews lasted forty minutes on average. A semi-structured interview was held with all presenters two weeks post C&G. Questions mirrored adolescent

interviews and included perception of adolescent experience, program fidelity ratings and adaptations. All interviews were digitally recorded, transcribed and translated into English.

Analysis

Presenter and co-presenter fidelity rating scales were compared across the seven sessions. Traumatic loss was categorised by type of event, counted for frequency (percentage) and rank ordered. Standardised data was logged in SPSS22 and analysed by an omnibus MANOVA for pre-and post-intervention comparison between conditions. Adolescent self-report measures and parental responses were compared for difference. Effect sizes were assessed using partial eta. and compared across complicated grief, depression and posttraumatic stress. Interview data was analysed using Braun and Clark's (2006) quasi-qualitative thematic analysis. This six step process involves: familiarisation of data; initial identification of codes (meanings) from statements; recording statements under codes; identification of themes that captured the main meaning for codes and statements; review of all statements, codes and themes; drafting the report, re-reviewing codes and themes and selecting quotes that exemplifies themes. Inter-rater reliability of quasi-qualitative data involved researchers analysing data separately and then comparing codes and themes. This is reported as Cohen's kappa (Cohen, 1960). Costs included analysis of training, counselor stipends, program material, evaluation questionnaires and counselor subsistence and travel costs. Costs were calculated per school and student and reported in dollars.

Results

Participant characteristics

There were 180 participants in the corpus sample. Eight percent declined to give their consent ($n = 22$). Reasons for non-consent were parental and adolescent misconceptions about counselling, the fear of being labelled crazy and religious beliefs that "all is God's destiny". This was evenly spread across the nine groups. There was no attrition during

program delivery. The resultant sample was $n = 158$, aged 10 to 18, $m = 13.83$ years ($SD = 1.63$). One hundred and two adolescents were male (65%) and 56 female (35%), a function of school gender split. C&G and Waitlist were similar in age. The average C&G age was 13.84 years ($SD = 1.73$), from 11 to 18 years. In the Waitlist, the average age was 13.83 years ($SD = 1.54$) from 10 to 18 years. Gender was similar across condition with 50 males (63%) and 29 females (37%) in C&G and 52 males (66%) and 27 females (34%) in the Waitlist. C&G group sizes ranged from 6 to 10 and Waitlist from 5 to 11.

Exposure to traumatic loss

Adolescents experienced fifteen different types of traumatic loss on average, ranging from nine to 21 ($SD = 2.97$). No significant difference was found between C&G and Waitlist at pre $F(1,156) = 1.519$, $p = .220$ and post-test $F(1,156) = 1.786$, $p = .183$. The five most frequent types of loss in rank order were: death of parents; siblings and extended family member ($n = 21$, 13%); and death of friends; pupils and teachers; house demolitions; extended family and friends by the separation barrier; relatives and friends arrested and in detention; adolescents' own experience of arrest and detention; traumatised parents; and schooling because of settler violence ($n = 20$, 12%).

Pre-test measures

Inventory of prolonged grief-adolescents.

C&G and Waitlist were similar in complicated grief at pre-test $F(1,156) = 2.532$, $p = .907$; $m = 41.30$ ($SD = 12.20$) vs. $m = 41.56$ ($SD = 14.91$) respectively. No significant difference was found for gender $F(1,156) = 2.558$, $p = .112$ and counselor $F(1,156) = 3.561$, $p = .061$. A significant difference was, however, found for age at pre-test $F(1,156) = 10.289$, $p < .01$. Analysis of means indicated younger adolescents (10 to 14 years) reported higher levels of complicated grief than older adolescents (15 to 18 years) in C&G: $m = 46.53$, $SD = 8.90$ vs. $m = 38.54$, $SD = 12.33$ and Waitlist: $m = 44.59$, $SD = 12.47$ vs. $m = 38.58$, $SD = 15.21$.

Table 1 shows the comparison of pre and post-test scores for standardized measures across C&G and Waitlist.

INSERT Table 1

Moods and feelings questionnaire.

C&G and Waitlist were similar in depression at pre-test $F(1,157) = .004, p = .947; m = 10.12 (SD = 6.37)$ vs. $m = 10.05 (SD = 5.73)$ respectively. No significant difference was found for gender $F(1,157) = 0.849, p = .358$, however, significant differences were found for counselor $F(1,157) = 5.004, p < .05$ and age $F(1,157) = 4.728, p < .05$. The counselor result appears to be due to one counselor with low C&G ($m = 0.67, SD = 1.03$) and Waitlist ($m = 0.60, SD = 0.55$) mean scores. Mean depression scores varied across the age range, i.e. scores increased up to fourteen years of age, 11 years ($m = 2.00$); 12 years ($m = 7.88$); 13 years ($m = 13.71$); 14 years ($m = 14.40$); then decreased at 15 years ($m = 8.65$); 16 years ($m = 9.00$); 17 years ($m = 8.00$) and increased again at 18 years ($m = 19.30$).

Impact of events scale.

In contrast to previous measures, a significant difference was found between C&G and Waitlist at pre-test for CRIES-13, $F(1,156) = 23.051, p < .01$ with C&G showing significantly higher scores for posttraumatic stress, $m = 22.62 (SD = 6.0)$ than Waitlist, $m = 17.51 (SD = 7.3)$. No gender effect was found $F(1,156) = 1.129, p = .290$. Significant effects were, however, found for age $F(1,156) = 5.987, p < .01 (22.62, SD = 5.98$ vs. $17.51, SD = 7.31)$ and counselor $F(1,156) = 8.549, p < .01 (22.62, SD = 5.98$ vs. $17.51, SD = 7.31)$. As with the MFQ, the same counselor's scores were significantly lower. Similar to MFQ results, there was a wide dispersal of scores across the age range.

Parent report of posttraumatic stress.

Affirming the CRIES-13 pre-test result, posttraumatic stress in C&G, $m = 26.35 (SD = 10.92)$ was significantly higher, $F(1,156) = 14.933, p < .01$ than in the Waitlist, $m = 20.04,$

($SD = 9.59$). No significant effects were found for gender $F(1,157) = 0.332, p = .571$ and counselor $F(1,157) = 0.579, p = .441$. A significant effect was again found for age $F(1,157) = 4.964, p < .05$ indicated by a range of mean scores similar to MFQ and CRIES-13.

In summary, C&G and Waitlist were similar in complicated grief and depression scores at pre-test. Posttraumatic stress symptoms, however, were significantly higher in C&G. Counselor interviews indicate this may have been a result of counselors' prioritising adolescents showing higher levels of posttraumatic stress for intervention. Younger adolescents reported significantly higher levels of complicated grief, whereas depression and posttraumatic stress varied across the adolescent age range.

Post-test measures

Inventory of prolonged grief – adolescents.

A highly significant difference was found at post-test between C&G and Waitlist $F(1,156) = 37.654, p < .01, \eta^2 = .19; m = 27.99 (SD = 12.09)$ vs. $m = 40.35 (SD = 13.22)$ respectively. A reduction of $m = 13.31$ (C&G) compared to $m = .26$ (Waitlist) was a large effect size. As with pre-test, there was no significant gender $F(1,156) = 11.898, p < .01, \eta^2 = .07$ and counselor difference $F(1,156) = 3.414, p = .067, \eta^2 = .02$. The significant age difference was no longer present at post-test $F(1,156) = 0.232, p = .631, \eta^2 = .002$ indicating C&G may have a protective function for younger adolescents.

Moods and feelings questionnaire.

At post-test, a significant reduction in depression, $F(1,155) = 5.877, p < .01, \eta^2 = .04$ was found for C&G, $m = 4.41 (SD = 4.58)$ compared to Waitlist, $m = 6.28 (SD = 5.06)$. A reduction of pre to post-test of $m = 5.71$ and $m = 3.77$ respectively, was a medium effect size. No difference was found for gender $F(1,155) = 1.180, p = .279, \eta^2 = .006$. The significant difference in depression for age continued post-test $F(1,155) = 4.064, p < .05, \eta^2 = .026$. Counselor, however, was no longer a factor $F(1,155) = 0.026, p = .872, \eta^2 = .000$.

Impact of events scale.

Although, there continued to be a significant difference between C&G and Waitlist at post-test in posttraumatic stress $F(1.156) = 7.110, p < .01, \eta^2 = .04$, the meaning of the difference changed. Posttraumatic stress reduced in C&G from $m = 22.62 (SD = 6.0)$ to $m = 11.97 (SD = 7.19)$ compared to $m = 17.51 (SD = 7.3)$ to $m = 15.22 (SD = 8.06)$ in Waitlist, a medium effect size. No difference was found for gender $F(1.156) = 2.175, p = .142, \eta^2 = .014$ and a reduced level of significance was found for counselor $F(1.156) = 4.613, p < .05, \eta^2 = .029$. An increased level of significance, however, was found for age $F(1.156) = 13.507, p < .01, \eta^2 = .081$.

Parent report of posttraumatic stress.

There was no longer a significant difference between C&G and Waitlist $F(1.156) = 0.111, p = .740, \eta^2 = .001$, a small effect size. As with adolescent self-reports, higher posttraumatic stress in C&G reduced from $m = 26.35 (SD = 10.92)$ to $m = 14.04 (SD = 9.47)$. This compared to a small reduction of 5.5 to $m = 14.28 (SD = 9.17)$ in Waitlist. No significant differences were found for age $F(1.156) = 0.111, p = .739, \eta^2 = .001$; gender $F(1.156) = 0.322, p = .571, \eta^2 = .002$; and counselor $F(1.156) = 0.597, p = .441, \eta^2 = .004$. In summary, C&G achieved a large effect size for complicated grief and medium effect sizes for depression and posttraumatic stress. Parent reports affirmed posttraumatic stress reductions for C&G.

Program fidelity

The average seven session protocol adherence rating was $n = 7.43$. This compared to an observed adherence of $n = 6.9$. Adaptations to protocols were (i) giving adolescents more time to share their stories of loss “Children needed to be given more time to tell their stories”; (ii) more opportunities for skill-based learning, “helping students learn the strategies”; (iii) responding to student anxiety, “time was need to help children cope with reminders” and (iv)

reduced length of some sessions, “some sessions were shorter because of school demands.”

Qualitative interviews

Cohen’s kappa for inter-rater reliability was .82 a level considered appropriate for qualitative studies (McHugh, 2012). Ten themes were identified from 123 statements. There was high commonality between adolescent and counselor themes. Five themes were identified across adolescent and counselor responses: 1. benefit of psycho-education and normalisation ($n = 19$ statements), “I learned it wasn’t only me who had difficulties” and “I noticed that children were feeling with each other as if saying I was not alone”; 2. creation of a context of sharing experiences ($n = 17$), “I learned how to express myself freely without feeling shy” and “It wasn’t just noticeable for me but also teachers noticed students shared more”; 3. lack of negative consequences ($n = 15$), “no negative consequences”; 4. development of skills to increase emotional regulation ($n = 12$), “I learned how to overcome my acute feelings of suffering” and “I noticed that children started to be calmer and listen to each other”; and 5. adolescent and counselor empowerment ($n = 11$). “It helped me recognise my personal strengths” and “I feel more qualified, confident and empowered while dealing with daily difficulties.” Two additional themes were identified from counselor responses: 6. valuing the structure and content of the program ($n = 12$), “I feel that everything in the manual was helpful, how to plan & run a discussion” and “I found it helpful in learning practical procedures in an easy way” and 7. learning about the importance of including teachers and parents ($n = 7$), “I learned the importance of engaging students, parents & teachers in the process.” and “parents and teachers needed to support children.”

A number of problems (five themes) were reported that need addressed for future delivery. A small number of adolescents struggled to achieve a safe place and experienced anxiety ($n = 7$), “I couldn’t find a safe place in my head” and “I was unable to succeed in letting children find secure places.” One counselor wanted more theoretical background to

program content, “I did not find enough theoretical background” and another reported C&G was not designed to address domestic violence, “the manual did not help me in providing students with skills to cope with violence at home.” Counselors ($n = 11$) and adolescents ($n = 8$) mentioned there was insufficient time to share more, “I felt during sessions unable to talk about everything deeply because of the limited given time” and “the time was very short for implementing the sessions.” A number of adolescents asked for sessions more often ($n = 9$). “twice a week” and a small number asked for individual sessions ($n = 3$) “sessions were always in groups” and “I wanted to talk with the counselor on my own.”

Future cost

Costs are based on project spend for training, materials and counselor stipends for delivering C&G but exclude research costs. Costs include a familiarisation session delivered by two experienced C&G counselors: $2 \times \$418 = \836 ; nine counselor familiarisation session stipends: $9 \times \$278 = \2502 ; subsistence for counselors and trainers: $11 \times \$28 = \308 ; counselor and trainer travel: $11 \times \$21 = \231 and nine copies of the C&G manual and evaluation questionnaires at \$28 each equals \$252. Added together this totals \$4129. The cost per school is $4129/9 = \$458.78$. The total cost per student is $4129/158 = \$26.13$. Because there is no training involved, the cost of a counselor running subsequent program delivery reduces to $\$252/9 = \28 per school and \$1.59 per student. The latter costs cover copying the C&G manual and evaluation questionnaires.

Discussion

The current study contributes to the understanding of complicated grief in war-torn contexts. Adolescents experienced a wide range of different types of traumatic loss, with the most frequent, the death of a close relative, friend or teacher. Cumulative violence, unexpected death and the intimacy of relationship with the deceased were significant factors for Palestinian adolescents developing complicated grief. This study highlights the

distinctiveness of complicated grief at pre-assessment as well as complicated grief as a distinct response to focused intervention.

For adolescents living in a context of military violence with multiple and cumulative traumatic loss, findings indicate C&G, is effective in reducing the symptom cluster of complicated grief, posttraumatic stress and depression. Younger adolescents, who presented with higher symptom levels of complicated grief, benefited more than older adolescents. As with previous Palestinian studies (Thabet, et al., 2015), there was no difference in terms of how males and females responded. Parents perceived lower levels of posttraumatic stress and less change. Other studies indicate, however, parents and teachers may have a poor awareness of adolescent internal states and changes (Schechter & Willheim, 2009). As predicted, C&G reduced the number of adolescents who needed individual therapy (scores below clinically significant levels) and functioned as a screening tool for adolescents who needed therapy (scores above clinical levels). In short, C&G fulfils the mental health principle of least intrusive yet effective intervention for a considerable number of children (NICE, 2013).

Seven sessions were sufficient for reducing complicated grief. This is surprisingly few given the enduring nature of traumatic loss in Palestine (Barron et al, 2015). Considering the chaotic context, a high level of program fidelity was achieved (Mowbray, Holter, Teague, & Bybee, 2003). Good outcomes, however, may have been a function of counselor capacity to adapt the program. The latter is an often undervalued part of program fidelity (Daro & Cohn-Donnelly, 2001). In the current study, the main adaptation were to give adolescents more time to share experiences and cope with their emotional reactions. Adolescent requests for longer and more frequent sessions may partly reflect their latter experience as well as their feeling of relief. C&G may, of course, have been more impactful with greater protocol adherence (Mowbrey et al., 2003). Either way, it is important to remember, C&G was delivered by counselors who were experienced in group-based trauma specific programs.

Program adherence, counselor judgment and program adaptation is a complex issue that requires further research. Counselors experienced C&G as empowering with easy to follow scripts and well-structured activities, resulting in increased levels of adolescent disclosure and symptom reduction.

Field trials are helpful in identifying problems to avoid for the future. From the current study, further advice on screening for counselors may reduce bias towards selecting adolescents with high levels of posttraumatic stress. Psycho-education for adolescents and parents on the nature of trauma and healing, set within religious and cultural understandings, may reduce adolescent and family avoidance prior to C&G (Goldston et al., 2008). As found in other types of psychosocial programs, the development of a parent and teacher training component may enhance gains (MacIntyre & Carr, 2000). As younger adolescents experienced higher levels of complicated grief, consideration may need to be given on how programs can be adapted to developmental understandings (Barron et al., 2013). Advice may need to be given for adolescents who, not surprisingly in a context of occupation, struggle to identify a safe place. Finally, individualised therapy needs to be anticipated and planned for a small proportion of adolescents. Finally, following initial program delivery, future sessions run at low cost.

Limitations

This was a field trial with no randomisation which limits generalisation. Counselors had been previously trained in TRT and were positive about the program, it is therefore unknown how effective C&G will be with novice counselors and those less highly committed. Bias towards single sex and particularly male schools may not be representative of adolescent responses in mixed gender schools. Given the compartmentalised nature of the region, Nablus may not be representative of the West Bank and Gaza. It is unknown how those who dropped out prior to the study would have responded to the program. Program

fidelity was assessed retrospectively which is open to memory bias.

Conclusion

C&G is a promising addition to the other group-based approach (TPGS: Saltzman et al., 2001). Within a context of violent military occupation, C&G was effective in addressing adolescent complicated grief and to a lesser but significant extent posttraumatic stress.

Moderate secondary gains were achieved in depression. Student and counselor experience of C&G indicated an emotionally safe and empowering experience. Because of a Palestinian culture of adolescent voice being rarely heard, program adaptation required more time for adolescents to share their stories necessitating further time on counselors responding to feelings that emerged. Adolescents want longer and more frequent sessions, most likely because of the feelings experienced in disclosure as well as the sense of relief experienced.

Recommendations for policy and practice

It is recommended that counselors continue to deliver C&G and familiarisation sessions should be provided for other counselors. C&G training should be developed for counselors new to psychosocial programs along with evaluation. Culturally sensitive advice on program adaptation is needed including consideration of program delivery twice a week and an increased number of sessions. C&G should now be made available to other global war-torn contexts with evaluative research built in to assess impact.

Recommendations for research

There is a need for longitudinal evaluation to assess maintenance of gains and posttraumatic growth. Multiple field trials including randomisation are required to explore the empirical base throughout Palestine and in global war-torn contexts. Novice counselors need included in evaluation samples. An evaluation of C&G with the universal adolescent population would enable an assessment of preventative functions. For reasons of sustainability in a resource dependent context, there is a need for a rigorous cost-benefit

analysis. Despite security-based sensitivities, program fidelity should include at least audio recording of sessions. Despite experiencing traumatic loss, most adolescents are resilient and show no signs of trauma (Luthar, 2006). This requires further research.

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