



Grief and trauma intervention for children after disaster: Exploring coping skills versus trauma narration

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ABSTRACT

This study evaluated the differential effects of the Grief and Trauma Intervention (GTI) with coping skills and trauma narrative processing (CN) and coping skills only (C). Seventy African American children (6–12 years old) were randomly assigned to GTI-CN or GTI-C. Both treatments consisted of a manualized 11-session intervention and a parent meeting. Measures of trauma exposure, posttraumatic stress symptoms, depression, traumatic grief, global distress, social support, and parent reported behavioral problems were administered at pre, post, 3 and 12 months post intervention. In general, children in both treatment groups demonstrated significant improvements in distress related symptoms and social support, which, with the exception of externalizing symptoms for GTI-C, were maintained up to 12 months post intervention. Results suggest that building coping skills without the structured trauma narrative may be a viable intervention to achieve symptom relief in children experiencing trauma-related distress. However, it may be that highly distressed children experience more symptom relief with coping skills plus narrative processing than with coping skills alone. More research on the differential effects of coping skills and trauma narration on child distress and adaptive functioning outcomes is needed.

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Post-disaster treatments need to address a wide range of traumatic experiences and be available not only in the immediate aftermath, but throughout the long-term recovery (La Greca, 2007). While childhood posttraumatic stress disorder (PTSD) has been associated with disaster exposure (Goenjian et al., 2001; Roussos et al., 2005) and is an important primary treatment outcome, interventions need to move beyond disaster-related PTSD (Cohen et al., 2009; La Greca, Silverman, Lai, & Jaccard, 2010). Interventions need to address other mental health issues including the reduction of symptoms of depression and grief (La Greca, 2007) and the enhancement of protective factors like social support, which is considered critical to post-disaster recovery (La Greca et al., 2010; La Greca, Silverman, Vernberg, & Prinstein, 1996; Moore & Varela, 2010). In addition, post-disaster interventions need to be easily accessible (e.g. school-based mental health services), address prior and current traumatic events and losses (Jaycox et al., 2010; Salloum, Carter, Burch, Nan Garfinkel, & Overstreet, 2010), and be easily implemented.

One intervention that meets these criteria and also has promising support for its effectiveness is the Grief and Trauma

Intervention (GTI) for children (Rynearson & Salloum, 2011; Salloum, 2008; Salloum, Garfield, Irwin, Anderson, & Francois, 2009; Salloum & Overstreet, 2008). GTI incorporates cognitive behavioral therapy (CBT) and narrative therapy approaches to help children learn coping skills and to construct trauma and loss narratives (Salloum et al., 2009; Salloum & Overstreet, 2008). We conducted a randomized clinical trial four months post Hurricane Katrina in which 56 children (ages 7–12 years) with moderate symptoms of PTSD were randomly assigned to either individual or group GTI. Assessment at three weeks post-treatment indicated that children in both intervention conditions reported significant improvements in PTSD symptoms, depression, traumatic grief, and distress, with medium to large effect sizes (Salloum & Overstreet, 2008).

The current study builds on our earlier research, and the literature on post-disaster interventions, in two ways. First, we sought to examine the impact of GTI on perceived social support. Several studies with children suggest that perceived social support post-disaster is an important buffering factor from posttraumatic stress (e.g. Bokszczanin, 2003; La Greca et al., 1996; Pina et al., 2008). Social support offers emotional validation and opportunities to reduce distressing thoughts and memories about the disaster (Bokszczanin, 2003; La Greca et al., 1996). Furthermore, social support can provide adaptive models for coping with disaster

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exposure and post-disaster stressors (Prinstein et al., 1996). Despite the fact that social support is important in post-disaster recovery (e.g. La Greca et al., 2010), and that a key element of group treatment is building cohesion and support among participants (Yalom, 2005), there are no studies to date that examine social support as a post-disaster treatment outcome. In addition to being a group treatment model, GTI specifically targets reconnecting to others as a coping strategy, making social support an important treatment outcome to study.

Second, we compared the traditional GTI model that includes a structured trauma and loss narrative exposure component to a GTI model that focuses exclusively on grief and trauma coping skills. Developing a trauma narrative as well as cognitively exploring the trauma experience is considered a core component of PTSD treatment (Amaya-Jackson & DeRosa, 2007). Foa and associates have explained that when a traumatic event occurs, pathological fear structures (i.e. memories) develop that are associated with stimulus responses and meaning. To address these pathological fear structures and decrease symptoms, emotional processing theory posits that these memories, responses and meanings can be modified by activating fear structures that have developed, disconfirming these fear structures and confronting trauma reminders. Activating, disconfirming and confronting fear structures are addressed by exposure techniques, trauma processing and the construction of a trauma narrative (Rauch & Foa, 2006).

Most evidence-based CBT treatments for childhood PTSD utilize the construction of a trauma narrative (Amaya-Jackson & DeRosa, 2007) and exposure-based CBT models are highly recommended for adults and children after trauma (Foa, Keane, Friedman, & Cohen, 2009). However, there are challenges to implementing these protocols. First, implementation requires intensive training, adaptations and ongoing supervision whether in post-disaster (e.g. CATS Consortium, 2007) or non-disaster environments (Jensen-Doss, Cusack, & de Arellano, 2008). Second, there are a limited number of trained clinicians in evidence-based CBT practices to meet treatment needs (Becker, Zayfert, & Anderson, 2004). Third, exposure techniques are often not the preferred method of clinicians (Becker et al., 2004; Jenson-Doss et al., 2008; Minnen, Hendricks, & Olff, 2011; Sprang, Craig, & Clark, 2008).

Given these challenges, researchers have begun to explore skill-based interventions versus trauma-focused interventions for children. For example, Layne et al. (2008) conducted a randomized study following the Bosnian war that compared a universal classroom-based psychoeducation and skill-building intervention to the universal curriculum plus a trauma and grief group intervention. Results suggested that although a skill-based curriculum can be effective in reducing PTSD and depression symptoms, trauma and loss focused processing may be necessary for bereaved adolescents. However, it is also possible that the additional therapy sessions, and not the trauma-focused nature of the sessions, contributed to the greater improvements among adolescents who received both treatment components. In another study, Deblinger, Mannarino, Cohen, Runyon, and Steer (2010) randomized 210 children (4–11 years old) who were sexually abused into four TF-CBT groups: 1 & 2) 8 weeks with and without a trauma narrative; 3 & 4) 16 weeks with and without a trauma narrative. Results suggested that TF-CBT was effective with or without the trauma narrative, regardless of the number of sessions, in improving affective and behavioral functioning, child safety skills and parenting. However, the nature of the treatment did differentially impact specific outcomes. For example, focusing on the trauma narrative resulted in less fear and anxiety for children and less abuse-related distress for parents; focusing more on skill-building resulted in more improved parenting skills and externalizing behaviors, especially when more sessions were provided

(Deblinger et al., 2010). Given the mixed findings of these studies, further research on trauma-focused treatments with and without trauma exposure methods is warranted.

The present study contributes to the knowledge about the utility of the trauma narrative for children with posttraumatic stress and traumatic grief. Building on our earlier study of GTI for children four months after Hurricane Katrina (Salloum & Overstreet, 2008), GTI was delivered with and without the narrative processing of traumatic events and losses (see Fig. 1). In addition, we sought to explore the impact of GTI on indicators of distress as well as perceived social support. The purpose of this study was to 1) examine the differential effects of GTI with coping skills plus trauma narrative processing to GTI with only coping skills on distress, behavior, social support, and treatment satisfaction over time, and 2) to determine if treatment gains in both conditions were maintained at 3 and 12 months post intervention.

Method

Setting

This school-based mental health treatment study occurred three years post Hurricane Katrina (August 2008 to April 2009) in four elementary schools in New Orleans, LA. Parental consent forms were sent home with the children. Immediately after the consent forms were sent home, the approach of Hurricane Gustav resulted in a mandatory evacuation of New Orleans and a week-long closure of schools. Due to the disruption, parental consent forms were redistributed and additional evaluators were included in order to screen all of the children. This study was approved by the University of South Florida Institutional Review Board.

Participants

Congruent with community practice and to increase the generalizability of the intervention, participation was open to children who experienced different types of potentially traumatic events, including violence exposure (primarily community violence), hurricane-related exposure, and death (any cause). Inclusion criteria included: (1) parental consent and child assent; (2) enrolled in 2nd through 6th grade; (2) exposure to violence, hurricane-related stressors, or death; and 3) a moderate level of PTSD symptoms indicated by a score of 25 or above on the UCLA-PTSD index (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998). Exclusion criteria included: 1) suicidal ideation (screened by the Mood and Feelings Questionnaire – Child Version (Angold & Costello, 1987), and 2) not clinically appropriate for group participation as determined by the evaluator. Because it is typical for children to receive services intermittently from school counselors or other health professionals, especially after they have been identified for services, children who received such services were not excluded from the study. Randomization resulted in equal proportions of children in each treatment group who had seen a mental health professional over the course of the study (GTI-CN: $n = 1, 6, & 7$; GTI-C: $n = 0, 3, & 8$, pre, 3 and 12 month, respectively).

A total of 587 consent forms were sent home to parents and 131 (22.32%) consent forms were returned by the children. This return rate is consistent with other post-disaster studies (Pullins, McCammon, Lamson, Wuensch, & Mega, 2005; Salloum & Overstreet, 2008). Of the 131 children assessed, 72 (54.96%) children met the enrollment criteria. Using Excel randomization, child participants within each school were randomly assigned to either GTI with coping skills and trauma and loss narrative (GTI-CN) or GTI with coping skills only (GTI-C). There were four sibling sets

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