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### The Impact of Camp Erin on Bereaved Youth

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The Impact of Camp Erin on Bereaved Youth

by

Alysondra Duke

A DISSERTATION

Presented to the Faculty of

The Graduate College at the University of Nebraska

In Partial Fulfillment of Requirements

For the Degree of Doctor of Philosophy

Major: Psychological Studies in Education

(Counseling Psychology)

Under the Supervision of Professor M. Meghan Davidson

Lincoln, Nebraska

May, 2013

# The Impact of Camp Erin on Bereaved Youth

Alysondra Duke, Ph.D.

University of Nebraska, 2013

Advisor: M. Meghan Davidson

Approximately 5% of adolescents and children will experience the significant loss of a loved one before the age of 15 (Currier, Holland, & Neimeyer, 2007). Numerous intervention efforts have been utilized to normalize the grief process for youth and to assist in the expression and exploration of loss. Several organizations have created weekend-long camps to serve as an avenue for youth to connect with others who have experienced loss with the hope that this early intervention effort may prevent youth from the onset of depression, chronic anxiety, or other psychological conditions. As well, early intervention has been noted as important in dissuading youth from engaging in activities such as adolescent promiscuity, drug use, or other high-risk behaviors.

The purpose of this study was to examine the impact of Camp Erin, a bereavement camp for children and adolescents, on participant hope, depressive symptoms, and self-perception. Three measures were used to examine these variables: (a) Children's Hope Scale (CHS; Snyder et al., 1997) (b) Children's Depression Inventory (CDI-S; Kovacs & Beck, 1977; Kovacs, 1983; 1992), and (c) subscales of the Self Perception Profile for Children (SPP-C; Harter, 1985). A repeated-measures within-group factorial ANOVA was utilized to examine the impact of Camp Erin on camper experience Pre- and Post-camp, and again at 8-week follow-up.

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## **Chapter 1**

### **Introduction**

Although childhood loss and bereavement is a common occurrence, it remains a relatively understudied area of inquiry. As well, there are some discrepancies in the research regarding the connection between bereavement and psychopathology into adulthood (Cerel, Fristad, Verducci, Weller, & Weller, 2006; Worden & Silverman, 1996). To date, a dearth of research exists on childhood interventions for grief, and there is no published literature on the effectiveness of bereavement camps as an early intervention strategy. Camp Erin is a nationally recognized non-profit camp for children designed to help children and adolescents normalize the experience of death. Camp Erin serves as an early intervention effort, assisting youth to heal from loss by socializing with peers who have also experienced the death of a loved one through a weekend-long camp experience (The Moyer Foundation, 2009). Additionally, the camp aims to provide tools to assist children in more healthful grieving after camp has ended. The current study will examine the potential effectiveness of Camp Erin in terms of evaluating hope, depressive symptoms, and self-perception in areas such as scholastic competency, social acceptance, self-worth, and feelings related to physical appearance. These attributes will be measured through pre-, post-, and follow-up assessment.

Childhood loss of a loved one may contribute to anxiety, depression, and other negative psychological outcomes (Black, 1996; Cerel et al., 2006; Dowdney, 2000; Holland, 2001; Mahon, 2009; Morgan & Roberts, 2010; Weber & Fournier, 1985; Weller, Weller, Fristad, & Bowes, 1991). It has been estimated that approximately 5% of adolescents and children will experience the significant loss of a loved one before the age of 15 (Currier et al., 2007). Likewise Holland (2001) noted that approximately 3% of a

primary school population studied had experienced the death of a parent, and that nine out of ten bereaved children exhibited behavioral disturbances (e.g., difficulty learning and lack of concentration) in the time following the death. Cerel et al. (2006) indicated that these disturbances may last for approximately two years following the loss, while others contend behavioral difficulties were only significantly present in the first year (Dowdney, 2000; Dowdney et al., 1999). Holland's (2001) research also revealed that lack of concentration, as a result of the death of a loved one, impacted schoolwork, while also increasing children's tendency to become more accident-prone. Relatedly, researchers have noted that bereaved children have more arguments with siblings and somatic symptomology after the death of a loved one (Cohen, Mannarino, & Deblinger, 2006; Van Eederwegh, Bieri, Parrilla, & Clayton, 1982; Van Eederwegh, Clayton, & Van Eederwegh, 1985; Worden & Silverman, 1996), as well as angry outbursts and regression of developmental milestones (Downey, 2000). These conflict-related behaviors are likely the exhibition of "the inner turmoil of the child" (Holland, 2001, p. 38).

Research has also indicated that initial reactions to death fade after two weeks, yet 40% of the children studied still exhibited significant disturbance after one year (Black, 1998). This same investigation found that 37% of the children studied met the requirements for a diagnosis of major depressive disorder one year after the death had occurred. Many of the bereavement responses mimic that of a major depressive episode (e.g., diminished interest in activities, depressed mood most of the day, feelings of worthlessness and/or excessive guilt, insomnia and/or sleeping too much) for more than two weeks, causing significant disruption in social interactions or other daily functions (DSM-IV, 1996). However, revisions to the DSM-5 have included a bereavement

exclusion for major depression. According to this change, the diagnosis of Major Depression cannot be given to those who are experiencing grief from a loss if it occurred in the preceding two months (DSM-5, 2006). Additionally, research has consistently demonstrated that children who experience the death of someone significant are more likely to develop a psychiatric disorder in later childhood compared to those who have not had a similar loss (Black, 1998; Cerel et al., 1999; Holland, 2001; Mahon, 2009; Morgan & Roberts, 2010; Weber & Fournier, 1985; Van Eederwegh, Clayton, & Van Eederwegh 1985). Childhood bereavement is highly correlated with later-childhood and adult-onset psychiatric disorders including anxiety, depression, suicidal ideation, attachment issues, and more severe psychological disorders (Black, 1998; Holland, 2001; Mahon, 2009; Morgan & Roberts, 2010; Weber & Fournier, 1985; Wolchik, Tein, Sandler, & Ayers, 2006). Thus, it seems imperative that grief intervention efforts such as Camp Erin are examined regarding their effectiveness to assist youth through their experience of the loss of a loved one.

### **Working with Grieving Children**

The loss of a loved one is traumatic at any age, but is particularly of concern when it occurs during childhood. Numerous authors have argued that children are more acutely impacted by the death of a loved one due to their level of cognitive development (Black, 1998; Christ, 2000; Holland, 2001; Mahon, 2009; Morgan & Roberts, 2010; Webb, 2002; Weber & Fournier, 1985). Because the mind of a child is still maturing, significant loss can cause various impairments such as self-deprecating attitudes, magical thinking and false beliefs about their loved one returning, and long-standing anxiety and

depression (Black, 1998; Fogarty, 2000; Holland, 2001; Dowdney, 2000; Mahon, 2009; Morgan & Roberts, 2010; Weber & Fournier, 1985).

In Jean Piaget's Cognitive Development Theory (1971), it is noted that children develop cognitively in stages that contribute to the manner in which children learn and understand their environment. Piaget proposed four stages of development for children: sensory-motor (birth to 2 years), pre-operational (2-7 years), concrete operational (7-11 years), and formal operational (11 and above). Although Piaget's theory is utilized in the examination of children and adolescent responses to grief and loss, it was not originally designed to explain environmental stressors such as death (Webb, 2002). However, Piaget provides a framework for cognitive development that contributes to understanding child and adolescent response to the loss of a loved one. According to Piaget's theory, concrete operational thinkers are moving from concrete thought to more abstract conceptualizations and creating logical structures to explain physical experiences (Piaget, 1971). Thus, children at this stage may experience feelings such as fear or anxiety about the death, whereas pre-operational thinkers may experience differing emotions due to the lack of comprehension related to the finality of death (Scott, 2004). As well, Webb (2002) asserts that children in this stage may begin to understand the permanency of death, but view it as something removed from them and generally happening only to the elderly or ill and perhaps not occurring if one is strong enough. In the formal operational stage, Piaget contends that cognition is in its final form and youth become increasingly capable of deductive and hypothetical reasoning. As well, youth in the formal operational stage of cognitive development begin to mirror the adult ability to think in abstract ways and no longer require concrete objects to make sense of the surrounding environment

(Piaget, 1971). As a result, formal operational thinkers may view death as more of a fascination, generate ideas about their own mortality, but still remain unaware of the true finality of the death (Webb, 2002). Thus, because adolescents engage in risk-taking behavior and may experience more vulnerability due to their level of development, the experience of a death may give rise to complicated emotions resulting in isolation and loneliness. Adolescents coping with the loss of a loved one may struggle with the same theoretical and philosophical issues as adults, but lack the conceptual framework to fully process the experience (Noppe & Noppe, 1997).

A number of researchers have recommended creating a forum for youth to discuss their feelings in an open and supportive manner in an attempt to further understand and cope with the loss (Bhagwan, 2009; Holland, 2001; Weber & Fournier, 1985). Often, youth need to be reminded that the death is not their fault, as she/he will typically place blame upon themselves in the grieving process (Davies, 1999; Morgan & Roberts, 2010). Bhagwan (2009) noted that children and adolescents have the ability to develop their own spirituality and are open to alternative spiritual experiences; thus, Bhagwan recommends practitioners work diligently to assist them in connection to their own spirituality to further their healing during the grief process. As well, art and creative expression are important in healing for youth, as well as nurturing a sense of mindfulness or remaining in the present moment (Bhagwan, 2009). Bhagwan also emphasizes the importance of being in nature for children and adolescents, noting that it helps to further the connection between the individual, spirituality, and healing.

## **Coping Strategies for Loss**

Children and adolescents utilize a variety of coping strategies to manage their reactions to the death of a loved one. For example, youth may manage their emotions by “numbing out” what is happening and responding in a non-reactive manner to the circumstances (Christ, 2000; Holland, 2001; Kübler-Ross, 1969). For the uninformed parent, this may appear as though their child is disengaged or is not expressing adequate remorse for such a significant loss. Although the appearance of being “numb” may seem counterproductive for the child or adolescent, it is actually a healthy process of healing. The process of becoming numb allows the individual to take in the new information and attempt to process the substantial change that is occurring (Bowlby, 1963; 1973 Christ, 2000; Holland, 2001; Kübler-Ross, 1969). Numbing is also an act of “bracing” oneself for the upcoming emotional outpouring. It is recommended that youth not be criticized with regard to the manner in which he or she is grieving, as this can elicit beliefs for the individual, such as “I don’t feel things like other ‘normal’ people” or “I am doing this wrong.” There is no wrong way to grieve and acceptance of the numb child or adolescent is imperative.

Another common reaction for youth upon losing a loved one is guilt (Holland, 2001; Scott, 2004). It is common for people to feel guilt regarding a death in the family, and it becomes especially visible in children and adolescents. Often youth regret their last words to their loved ones, a fight that occurred, or something the child feels she/he has done to cause the death (Christ, 2000). Whereas guilt may be a typical response to the death of a loved one, Holland (2001) asserts there is a difference between unnecessary guilt and healthy guilt. Healthy guilt may enable a child to find closure; for example, if a

teenager feels guilt for what she said before a parent died, she may decide to make peace with the parent, the world, and within herself by conducting a ceremony in which she is able to voice how she truly felt for her parent or she may offer the world peace by refraining from speaking in that same manner to others. Conversely, unnecessary guilt is related to the feeling that the child has caused the death in some way (e.g., because of a fight, or wishes that the parent was not there) (Christ, 2000; Holland, 2001).

Anger at God and important others have been cited as a healthy way to express grief and feelings of loss, and many children have expressed this (Andrews & Marotta, 2005; The Moyer Foundation, 2007; Worden & Silverman, 1996). As well, anger may be directed outwardly in the form of misbehaving, acting-out, yelling, anger at the parent who died, anger at the parent who lived, and anger at peers who still have the family member (e.g., mom or sister) that is now gone for the child. When anger becomes passive-aggressive and/or a means to seek revenge on others then it becomes problematic (Andrews & Marotta, 2005). Additionally, when children suffer the loss of an important loved one, they may subconsciously believe that revenge is justified, such that they have somehow earned the right to hurt others because they are hurting. Children and adolescents will often “push buttons” of significant people in their lives to cause undue suffering, as well as engage in pranks or other potentially harmful activities such as early promiscuity and drug use (Andrews & Marotta, 2005; Schoenfelder, Sandler, Wolchik, & MacKinnon, 2011).

Holland (2001) asserts that “commotion” is another common behavioral display for youth upon experiencing the death of a loved one. In children this may mimic the diagnostic behavior for Attention Deficit Hyperactivity Disorder (ADHD), including

impaired ability to appropriately engage in conversation, interrupting, inability to fully listen, disorganization, and hyperactivity. The child may be absorbing the chaotic energy of the household created by the loss of a loved one. Even young children without memory of the loved one who has died may experience significant absorption of this negative energy, which may dramatically impact their development and sense of self (Holland, 2001; Morgan & Roberts, 2010). Although the parents or other family members may have resolved conflict within the relationship because of the death, or have moved to a better healing space, the child may still be in significant duress because of what was experienced in the household.

Numerous researchers and professionals assert that the most important recommendation for professionals and families assisting grieving children is to normalize the experience and to allow freedom of expression regarding the loss (Bhagwan, 2009; Holland, 2001; The Moyer Foundation, 2009; Weber & Fournier, 1985). Often, peers and family are unsure how to talk about the death with the child, and may stifle the healing process (Black, 1996; Mahon, 2009; Morgan & Roberts, 2010; Stephens, 2002; Weber & Fournier, 1985). Thus, support networks such as Camp Erin may be beneficial in normalizing childhood grief, providing a forum in which children can discuss their grief with others who have experienced a similar type of loss.

### **Overview of Camp Erin**

In 2002, Camp Erin was established to assist bereaved youth, ages 6-17, learning to grieve and heal in a supportive camp environment with others who experienced similar losses. The organization was established by Karen and Jaime Moyer in memory of Erin Metcalf, a young woman who developed liver cancer at the age of 15. The Moyers met

Erin through the Make-A-Wish Foundation and quickly noted her compassion for other children who were suffering (The Moyer Foundation, 2009). Due to Jaime Moyer's career as a professional baseball player, the Moyers (in conjunction with the already established Moyer Foundation) decided to open a camp in each city associated with a Major League Baseball team. According to the Camp Erin website, there were 42 campers in attendance at the first camp in 2002, and this number increased to 9,745 campers served throughout 2002 to 2012. In 2012, there were 2,166 campers in attendance across the United States and Canada and 1,917 volunteers in participation at various camp locations. Since its inception, Camp Erin has provided grief intervention services for nearly 10,000 youth (The Moyer Foundation, 2012). In order to remove any financial barriers for families, the camps are offered free of charge through The Moyer Foundation.

Camp Erin aims to normalize feelings of loss for children and adolescents by providing an opportunity to socialize with other children who have also experienced the death of someone close to them during a weekend-long camp. Camp serves as an early intervention effort for the grieving experience of youth and provides tools to assist the child in healthful grieving after camp has ended. Although the camp has received informal feedback from campers (e.g., "camp was great!" "I feel like other people feel what I do and this is nice") and their families, to date, no formalized assessment regarding the camp's influence and impact has been conducted (please see Appendix A for an example of current camper evaluations). Thus, the proposed study is a first attempt at gathering quantitative data to examine the efficacy of Camp Erin.

The proposed study enhances research on child bereavement and intervention in three ways. First, by way of an outdoor healing experience, it emphasizes an alternative to traditional grief interventions for children and their families. Second, this research will examine the effectiveness of Camp Erin for children, providing critical quantitative data to support intervention efforts for youth in the grieving process. Third, this study may enhance treatment plans and intervention strategies for professionals working with bereaved children and adolescents. Although several bereavement camps exist throughout the United States, to date, there is no published literature on the effectiveness of bereavement camps for children. The proposed study will examine hope, depression, and levels of perceived competency in scholastic achievement, social interactions, athleticism, and overall feelings of global self-worth and self-esteem. It is hypothesized that children who attend Camp Erin will demonstrate positive gains in these areas as a result of attending the bereavement camp. Should the results of this proposed study demonstrate positive effects for participants, The Moyer Foundation may be assisted in acquiring future funding from prospective donors, and therefore, beneficial for continued success of the program.

This chapter has asserted the need for early intervention for bereaved youth. As well, it has highlighted several of the coping strategies and current recommendations for normalizing childhood loss. In addition, this chapter has provided an overview of the mission of Camp Erin and the ways in which this study seeks to examine the effectiveness of the camp experience. Chapter 2 further discusses current literature pertaining to grief in general, as well as an examination of widely-used grief-related theories. Additionally, Chapter 2 further explores various grief interventions, with

specific attention to grief-related interventions for children and adolescents. Following the review of literature, Chapter 3 details the methods utilized for the study. For this project, campers between the ages of 9-17 were invited to participate in the study. Campers were assessed at pre-, post-, and 8-week follow-up intervals. Chapter 3 also elaborates on the procedures employed in this study and the statistical analyses utilized. Chapter 4 explains the results of the study, and Chapter 5 provides a thorough discussion of the results, limitations, recommendations for future research, and implications of this study for Camp Erin and the broader field of bereavement.

## **Chapter 2**

### **Literature Review**

Grief is an experience that all individuals may encounter at some point in their lives (e.g., Cerel et al., 2006; Currier et al., 2007; Dowdney, 2000; Küebler-Ross, 1969; Maciejewski, Zhang, Block, & Prigerson, 2007; Wolchik, Ma, Tein, Sandler, & Ayers, 2008). The loss of a significant person in an individual's life may result in an array of emotions including anxiety, depression, suicidality, relief, post-traumatic stress disorder (PTSD), disordered sleep and eating patterns, and the onset of more significant pathology (Cerel, et al., 2006; Dowdney, 2000; Schoenfelder et al., 2011). Because of the wide-range of emotions and reactions, death and grief studies have been of focus for numerous psychologists throughout history (e.g., Black, 1978; Bowlby, 1963, 1973; Coddington, 1972). While there has been some disagreement over the ways in which grief impacts potential pathology, numerous studies have indicated that death and consequent grief have a long-lasting impact on the individual (Cerel et al., 2006; Kübler & Kessler, 2005; Schoenfelder et al., 2011; Worden & Silverman, 1996). Thus, early intervention efforts have the potential to lessen the anxiety, fear, sadness, negative coping strategies, and anger regarding death-related concerns (Black, 1996; Black & Urbanowich, 1987; Kubler-Ross, 1969; 1972) and create an opportunity for individuals to openly discuss their feelings in a safe and meaningful way (Christ, 2000; Hung & Rabin, 2009; Morgan & Roberts, 2010; The Moyer Foundation, 2007).

The current study evaluates Camp Erin, an experiential grief intervention for children and adolescents. The potential impact of Camp Erin will be examined by exploring levels of hope, depression, and perceived levels competency in various

domains such as academics, self worth, and social acceptance. The following review of literature will explore several areas related to grieving. First, this narrative examines some of the important grief-related theories utilized to promote understanding related to grief, and provides an exploration of reactions to grieving and dying. Next, information on grief-related concerns as they pertain specifically to children and adolescents will be presented including reactions to loss, duration of grieving, level of cognitive development and the impact of this on the general understanding of death for children, caretaker and/or parental stressors that impact the grieving process for youth, and child and adolescent adjustment related to grief. For the purpose of this study, “children” will be defined as individuals ages 9-12 and “adolescents” will be considered those aged 13-17. “Youth” and “child” will be used interchangeably and will be generally defined as falling into both age groups in the study, including ages 9-17. Additionally, “parent and/or caretaker” will be defined as the adult individual who is either the surviving parent or the current primary caretaker for the child or adolescent. Following the exploration of grief as it pertains to youth, grief-related interventions for children will be discussed. Finally, because Camp Erin is an intervention for grieving children and adolescents, the development, organization, and structure of Camp Erin will be presented, including examples of a camp schedules and mandatory activities.

### **Theories of Grief and Bereavement**

There are several notable grief-related theories to assist in the understanding of death and grieving (e.g., Bowlby, 1963; 1973; Corr, 1993; Horowitz, 1976; Kübler-Ross, 1969; Kübler-Ross & Kessler; 2005; Linemann, 1944; Parkes, 1972; Worden, 1986). Because it is the most widely known grief theory utilized, the work of Kübler-Ross

(1969) and Kübler-Ross and Kessler (2005) will be addressed first. This discussion will be followed by an overview of other stage theories that have either informed, or built upon, the works of Kübler-Ross.

### **Kübler-Ross Stage Model of Grief Theory**

Throughout her work as a psychiatrist, author, and spokesperson, Dr. Elisabeth Kübler-Ross was a passionate advocate for dying individuals, and spoke publicly regarding her perception that the medical model for care of the dying was inadequate and uncaring (Hart, Sainsbury, & Short, 1998). Through information gleaned from her adult patients, Kübler-Ross found the process of dying was a lonely, gruesome, and dehumanizing experience. Thus, Kübler-Ross's five-stage model provided families and friends of the dying with a tangible way to manage interactions, behaviors, and ways in which to respond to the dying, as well as establishing a new way in which to create an opportunity for dialog and understanding with regard to death-related issues (Hart, Sainsbury, & Short, 1998; Kübler-Ross, 1969; Kübler-Ross & Kessler, 2005).

Kübler-Ross's stage model of grief is one of the most commonly used models for understanding grief and loss, and is often included in the education and training of physicians and clinicians (Downe-Wamboldt & Tamlyn, 1997; Hart, Sainsbury, & Short, 1998; Maciejewski, et al., 2007). As well, this model has been used to manage feelings related to a family member struggling with addiction (Sapp, 1985), head injury (Grovesman & Brown, 1985), HIV/AIDS (Kübler-Ross, 1993; Ross, Tebble, & Viliunas, 1989), and employment loss (Blau, 2008). Although this stage model was not initially explored with youth, it has served to inform other theories that more explicitly pertain to children and adolescents.

Kübler-Ross (1969) introduced the five stages of grief in her widely-referenced book, *On Death and Dying*, and this theory has been influential in the death and grief literature (e.g., Andrews & Marotta, 2005; Hart et al., 1998; Maciejewski et al., 2007; Whelan & Warren, 1980). The five-stage theory was introduced as an exploration of the meaning of death and anticipatory grief for terminally ill patients, thereby promoting greater acceptance of the impending death (Whelan & Warren, 1980). A pioneer in the subject of grief and acceptance of death, Kübler-Ross's five stages include: (a) denial and isolation, (b) anger, (c) bargaining, (d) depression, and (e) acceptance.

As well, Kübler-Ross and Kessler (2005) published *On Grief and Grieving*, which builds from Kübler-Ross's prior work, further defining the grief process for individuals who have experienced or are currently experiencing a significant loss of a loved one. Kübler-Ross and Kessler (2005) assert that it is difficult for individuals to fully grasp how the grieving process may impact them as the extent of their grief is unknown. For adults, making meaning of the loss, articulating the meanings that have been made, and incorporating the loss of a loved one into their current life experience are said to be markers of coping effectively (Andrews & Marotta, 2005). However, grief does not always appear to be occurring effectively or in the order suggested.

Often, due to the sensitive and uncomfortable nature of death, bereaved individuals will quickly dismiss their experience of grief while also maintaining hesitancy toward supporting and being present with someone else who may be grieving (Kübler-Ross & Kessler, 2005). Thus, *On Grief and Grieving* attempts to normalize the grieving process for individuals experiencing the loss of a loved one, and examines the myriad ways in which grief manifests in each individual. Kübler-Ross and Kessler (2005)

assert that obtaining information on grief may lessen death-related fear, and also help to create a network of support for the individual. Whereas *On Death and Dying* was more aptly designed for the dying individual to cope with and accept their own loss of life, the intention of the work of Kübler-Ross and Kessler (2005) was to use the five stages Kübler-Ross (1969) had developed in order to assist those who are mourning the loss of the dying. Kübler-Ross's (1969) theory attempts to explain healthy coping, and notes that the stages of coping with death do not necessarily occur in sequence, and that it is possible for an individual to move between stages. In the first stage, denial and isolation include the obvious notion that one is denying the death has occurred or is about to occur. Concomitantly, individuals may isolate from important people in their lives, as well as withdraw from activities they previously enjoyed and in which they demonstrated interest. Kübler-Ross asserted that this period of denial and isolation varies for each individual, and may range from a few moments to several years. Often, denial is the time in which the individual cannot accept that their loved one will no longer be returning home or calling on the phone (Kübler-Ross & Kessler, 2005).

Second, while actively in the stage of anger, bereaved individuals may demonstrate rage toward the person who has died, as she/he is viewed as the responsible party who has inflicted the pain the bereaved are experiencing as a result of the death (Kübler-Ross & Kessler, 2005). This anger may also be targeted at other individuals or things, and may include furiously blaming the person who has died, the world, God, or whomever the individual perceives is the cause of the death (Kübler-Ross, 1969). Likewise, individuals may demonstrate anger toward themselves for "allowing" the death to occur, although there is typically little to nothing that could have been done to prevent

the death. However, Kübler-Ross and Kessler (2005) assert that once an individual has entered the stage of anger, they become aware of their own ability to navigate through this difficult time of loss.

In the third stage, Kübler-Ross (1969) suggested that bargaining may entail activities such as making a “deal” with God to take away the hurt. Often, individuals will ask God if there is a certain act they may be able to engage in to eradicate the experience, or this may be a time in which the bargaining includes thoughts of taking one’s own life to be close to the deceased (Christ, 2000). In their text, Kübler-Ross and Kessler (2005) explore the stage of bargaining as the time of consideration regarding what could have been different, and express significant yearning for the deceased person to return. In Kübler-Ross’s (1969) fourth stage, individuals encounter depression and a sense of feeling “numb” from the experience. To others, this “numbness” may appear as though the bereaved are not adequately processing the death or are doing so unhealthfully (Christ, 2000; Holland, 2001). However, many feelings typically reside below what appears to be numb or indifferent, and these may include residual anger and sadness. As well, depressed feelings are a normal response in order for healing to occur (Kübler-Ross, 1969; Kübler-Ross & Kessler, 2005; Melhem, Moritz, Walker, Shear, & Brent, 2007).

In the fifth and final stage of grieving, Kübler-Ross (1969) suggested the anger, depression, and mourning will have decreased as individuals move into a place of acceptance. In this stage, bereaved individuals are able to fully integrate the loss into their current reality. Kübler-Ross and Kessler (2005) indicate that during this time in the grieving process, individuals can fully recognize and accept the current state of their lives that will continue to exist without their loved one. Once an individual has moved into the

stage of acceptance, it may be easier to live with their new understanding of how life will now be without the deceased (Kübler-Ross & Kessler, 2005; Malchiodi, 2003).

Kübler-Ross's five stages of grieving have been instrumental in understanding and helping individuals cope with and understand grief. Rather than suppressing difficult emotions, the five stages of grief seek to normalize the processing of emotion for bereaved individuals. Again, with any stage theory, individuals may not encounter each stage in order. For example, one individual may feel anger prior to experiencing denial. As well, people can move between stages, and the return to a previously experienced stage is not representative of a regression in healing (Corr, 1993; Maciejewski et al., 2007). Instead of a stringent model in which each individual is intended to fit, Kübler-Ross (1969; 2005) offered a model for which the process of grief and loss can be further understood.

Although there has been limited empirical testing for the sequence of the stage theory of grief, there is significant debate regarding the order of the stages (e.g., Holland & Neimeyer, 2010; Maciejewski et al., 2007). Empirical testing of Kübler-Ross's model continues to support the notion that the stages of grief tend to peak in the order delineated, and often appear within six months after the death (Jacobs, 1993; Maciejewski et al., 2007). Maciejewski et al. (2007) suggest that if the individual remains in any of the stages for longer than six months, therapeutic assistance should be considered. As well, Wortman and Silver (1989) determined that depression was not necessarily a generalized reaction to loss. Additionally, Maciejewski et al. (2007) assert that although denial and disbelief about death are commonly noted as highly influential in the bereavement process, these factors are not the dominant initial indicator of grief.

Instead, these authors suggest that acceptance is the most commonly endorsed stage for those who are grieving, whereas yearning for the deceased to return is the most dominant grief indicator 1-24 months after the loss (Maciejewski et al., 2007).

Although influential in the area of dying and grief, Kübler-Ross has been criticized for oversimplifying the process of death and explaining the complexity of grieving as a series of stages (Corr, 1993; Hart et al., 1998; Maciejewski et al., 2007). For example, Kübler-Ross's work (1969; 1995) has been criticized as being prescriptive in nature with regard for how the dying should prepare for their death (Corr, 1993). Maciejewski et al. (2007) assert that Bowlby and Parkes (1961; 1972; 1980; 1983) were the first to develop a stage theory for grief that included four distinct stages including (a) shock-numbness, (b) yearning-searching, (c) disorganization-despair, and (d) reorganization. Yet, it has been argued that no research can assert how one should navigate her/his own struggle with death (Corr, 1993; Maciejewski et al., 2007). Corr (1993) outlined three major intentions inherent in Kübler-Ross's *On Death and Dying*, and asserted the most important message that can be gleaned from her work, beyond the five stages, is (a) those coping are still alive, something terrible is happening or is about to happen to them, and they should be given due attention and respect for their struggle, (b) one cannot be an effective provider to dying patients without actively listening to the needs of the dying, while also refraining from making generalizations of what they may be feeling, and (c) listening to those who are dying and coping with death can assist the remainder of the population in getting to know themselves better (Corr, 1993; Kübler-Ross, 1969). Corr (1993) argues that Kübler-Ross (1969) would perceive the dying as our teachers from whom to learn about living, however, a stage-based model may be too

limited or rigid to encompass the vast dynamics within the process of dying (Corr, 1993; Hart et al., 1998). For example, a person who recently discovered she/he is dying and are in a state of shock may not necessarily be in denial, just as it may be suitable for an individual to initially, and continually, respond to the death in anger (Corr, 1993). In this case, any stage model has the risk of stereotyping the individual and enhancing the prospect for caretakers to make false generalizations about what the dying individual may need (Corr, 1993). Corr (1993) argues that an adequate model for coping with dying should encompass four traits (a) an improved manner in which to further understand the various complexities and dimensions of those who are dying, (b) empowerment for those who are coping with dying by way of discussing options for the remainder of their time living, (c) emphasized community sharing and assistance, and the creation of meaningful support networks, and (d) guidance for those who are in the provider or caretaker role, as volunteers, professionals, or family members (p. 79). Corr (1993) strongly argued Kübler-Ross's five-stage theory lacked a holistic approach, and suggests more of a task-based model to address aforementioned concerns.

### **Additional Prevalent Theories of Grief**

Beyond Kübler-Ross's five-stage model, other death and grief-related theories have prevailed, and some of the theories will be explored in the following paragraphs. Although these theories primarily focus on adult patterns of grieving, they began to examine childhood loss as it pertained to issues in adulthood. For example, French historian Philippe Aries (1981; 1985) studied historic Western attitudes toward death and describes five dominant and consistent attitudes that sought to enrich the understanding of death for the Westernized individual. These five stages include (a) a tame death (e.g.,

death as expected, waiting to die, death as a public event, and the feeling of a loss for a given community), (b) death of the self (e.g., death creates anxiety in consideration of rewards or punishment in the afterlife), (c) remote and imminent death (e.g., ambivalent feelings about death, death is seen as natural, but effort is made to maintain distance from it), (d) death of another (e.g., main focus is on the survivors, for the dying it is waiting to join with other loved ones in the afterlife, behaviors such as wailing and throwing oneself in the grave may ensue), and (e) death denied/forbidden death (e.g., death viewed as indecent, not to be shared in public, mourning should be private or may be considered pathological). Although much overlap can be found across the patterns Aries discovered and aspects of them may appear in various cultures, it may provide further instruction in the understanding of general response patterns to death (Aries, 1981; 1985). Similarly, Glaser and Strauss (1965) introduced the “dying trajectory,” which provided an idea of what an “appropriate” or “good” death would entail (see Hart, Sainsbury, & Short, 1998). In this manner, all of those involved in the death (e.g., the dying, the family of the dying) would be given appropriate time for meaningful interactions with the family member. This trajectory encouraged families to cultivate a sense of openness regarding the status of the dying and create a shared awareness of the situation. However, the trajectory did not apply to unexpected deaths and the accompanying emotions that ensued (Hart, Sainsbury, & Short, 1998).

In a related death/grief-related theory, Worden (1991) discovered five factors as they pertained to the failure to grieve. These factors were (a) relational (e.g., narcissistic or ambivalent relationships), (b) circumstantial (e.g., general uncertainty about death), (c) historical (e.g., previous complicated loss in life such as childhood loss of a parent), (d)

personality (e.g., how well one copes), and (e) social (e.g., a socially unspeakable death or lack of a positive support system). During periods of grieving, Worden (1986) argues that some individuals may not be able to fully access their feelings about the death, and will remain in a prolonged state of grief. Worden assigns tasks for working through grief, however, the assumption is that one must first work on the more prominent issues (e.g., lack of support system) before tasks directly related to grief can be managed (Worden, 1986).

Additionally, Rando (1993) wrote *Treatment of Complicated Mourning* and asserted that “complicated mourning” relates to the length of time since the death occurred and related “failure” in one of six processes of grieving included in Rando’s theory. The “six R’s” in Rando’s (1993) stage model of grief are (a) recognize, (b) react, (c) recollect and re-experience, (d) relinquish, (e) readjust, and (f) reinvest. These stages assert that first, people must understand and experience the loss that has occurred and subsequently have an emotional reaction to their loss. Beyond these two initial stages, individuals are likely to re-experience memories of the person they have lost, and begin to realize and accept that their world has now changed. At this point in the grief process, the loss may seem more painful as the bereaved is adjusting to her/his life without the loved one, however, she/he will begin to accept the changes that have occurred and establish new relationships and commitments with others (Rando, 1993).

Another highly recognized grief-related stage model was developed by Horowitz (1976) in which he translated Kubler-Ross’ stages of “grief” into stages of “loss.” As with other stage models, they are not specific to every individual who experiences loss and do not always occur in the order suggested. Horowitz’s Model of Loss includes four

stages, (a) outcry (e.g., becoming publicly upset about the death, scream, yell, collapse), (b) denial and intrusion (e.g., distracting self from thinking about the loss, feeling as though they are betraying a loved one), (c) working through (e.g., process the loss more, make plans to date again, develop new friendships), and (d) completion (e.g., life has started to feel normal again, feeling less pain attached to the loss). Horowitz's (1976) stage theory of loss explores the ways in which the initial outcry can only last for a scant amount of time as it requires excessive energy, and maintains that people will oscillate between denial and intrusion. Horowitz (1976) asserts that at one end of the continuum, people will refuse to think about the loss, and at the other end, people will feel the loss as powerfully as it was experienced during the initial outcry. While individuals navigate the working through stage, they spend less time feeling overwhelmed by the loss and more time thinking about the reality that it occurred. A person may begin to develop new hobbies, strengthen existing ones, and engage in new activities while in this stage. Lastly, in the stage of completion, grief may be activated once more by anniversaries and holidays, but the loss no longer negatively interrupts her/his daily living (Horowitz, 1976).

In a study conducted at the end of a workshop given to mental health professionals by Kübler-Ross and Worden (1977), attendees were asked to complete an information form in which they shared (a) who the person was that first died in their life, (b) what the initial response was to the death, (c) what they would do about finding out about their own dying, and (d) what happens after death. This workshop focused on death-related concerns was attended by clergy, physicians, nurses, counselors, and other mental health workers. Kübler-Ross and Worden found the results of the study to be

concerning as the majority indicated they would feel a negative response to learning about their death (e.g., anxious, depressed, avoidant) and this particular group of professionals work with others throughout the dying or grieving process. Kübler-Ross and Worden (1977) questioned how untrained individuals could make sense of death or grieving if this group of trained professionals could not respond to this news in a healthful manner. In this workshop, 32% ( $n = 1,688$ ) noted they would feel anxious and tense upon discovering they had a terminal illness, 3% ( $n = 158$ ) indicated they would commit suicide upon discovery, and 5% ( $n = 263$ ) noted they would not tell anyone (Kübler-Ross & Worden, 1977). Kübler-Ross and Worden suggest that a shift in perspective regarding death and related openness to the topic will not change through publications or through research, as this will only reach a select and small sample of people. Rather, the authors call for a general appreciation of natural resources within and around us including living with contentment in having less, sharing more, and understanding that material “things” decompose but spiritual “things” are eternal (p. 105, 1977).

In a similar study by Whelan and Warren (1980), research indicated that after conducting a workshop exposing participants to the process of navigating the five stages suggested by Kubler-Ross, there was less death-related anxiety than there was prior to attending the workshop. Although the participants were graduate students, and not currently anticipating a death experience in the near future, Whelan and Warren (1980) suggest that with appropriate exposure and discussion about death, anxiety can be decreased (Corr, 2009; Kubler-Ross, 1969). Thus, openness, acceptance, and

communication about death- and grief-related issues may be instrumental in lessening anxiety and other negative outcomes for the individual.

The Hopelessness Theory of Depression (Abramson, Metalsky, & Alloy, 1989) asserts that individual responses to environmental stressors such as death may be mitigated by original levels of hope for each person. In the context of this theory, hopelessness functions as a cause of depression rather than a manifested symptom. Thus, hopelessness depression may be caused when the individual experiences an expectation that a negative outcome will occur with regard to something highly desirable or the assumption that the outcome will be adversarial in some way (Abela & D'Alessandro, 2001; Abela & Seligman, 2000; Abramson et al., 1989). Additionally, hopelessness may include the expectation that the individual would experience a helplessness expectancy due to the likelihood and doubt that she/he may be able to act in some way to change the situation. As well, negative life events may serve as occasions for people to become hopeless (Abela & D'Alessandro, 2001; Abela & Seligman, 2000; Abramson et al., 1989). However, there is a difference in the way that individuals experience adverse life experiences, and Abramson et al. (1989) assert that this variation is due to (a) individual inferences made about why a particular event occurred, (b) conclusions made regarding consequences that may result because the event occurred, and (c) individual inferences with regard to self-perception due to the event. Thus, the inferences an individual creates about her/his own worth, desirability, and personality as a result of a negative life is perceived as highly contributory to hopelessness depression. Abramson et al. (1989) provide an example of a young girl grieving the death of her mother and argue it is her inferences about the negative

consequences of the death, in lieu of inferences about the causes of the death or implications for how she may view herself, that may contribute to whether she becomes hopeless. As well, decrease in self-esteem may be symptomatic of hopelessness depression when the event contributing to the depression is attributed to a stable, internal, or global cause, rather than an unstable, internal, specific cause. Abela and Seligman (2000) conducted a study testing helplessness theory with high school seniors (Study 1) and undergraduate students (Study 2) and results indicated support for the hopelessness theory with regard to immediate mood changes related to a negative event. The inferences of individuals with more depressive personality traits predicted an immediate negative change in mood due to inferential thoughts about the self and inferred negative consequences to the event that has occurred (Abela & Seligman, 2000). Similarly, in a related study employing hopelessness theory with children ages 7-13, Abela and D'Alessandro (2001) noted that symptoms such as sad affect, decreased energy, sleep disturbance, low or no motivation, loneliness, and low self-esteem were significantly correlated with hopelessness. As well, this study indicated that lowered self-esteem had the strongest relationship to hopelessness. This result suggests that low self-esteem may be central to the symptoms of hopelessness depression experienced among younger populations, whereas low self-esteem was not a direct symptom in the work of Abramson and colleagues (Abela & D'Alessandro, 2001). Lowered self-esteem may occur in cases of hopelessness depression when individuals have inferred negative characteristics about the self they view as unlikely to change or be remedied (Abela & D'Alessandro, 2001; Abela & Seligman, 2000; Abramson et al., 1989). Conversely, making the same inferences when a positive event occurs (i.e., attributing event to stable or global factors,

inferences related to positive consequences, inferring positive characteristics about her/himself) may facilitate a positive emotional state and either restore or increase hope. The theory presented by Abramson et al. (1989) attempts to highlight both the manner in which hope may be lost in times of adversity in addition to how hope may endure for the individual.

Although the aforementioned theories explore death and grieving for adults, their insight served to further understand grief and loss as it pertains to children and adolescents. The following section explores some of the theories that are viewed as directly relevant to childhood loss.

### **Grief and Children**

Until recently, child and adolescent grief was not viewed as important or even existent (Bowlby, 1963; 1973; Freud, 1957; Wolfenstein, 1966). In fact, youth were regarded as somewhat of an inconvenience for the family in that they were smaller than adults, susceptible to illness and death during childhood, and limited in their ability to contribute to the needs of the family. In the late 1800's and early 1900's, many young children were viewed as disposable, and parents did not exhibit the same level of interest in their child as they do today (Public Broadcasting System, 2011). Freud (1957) developed a developmental stage theory that was inclusive of children's development into adulthood. The study of child psychology and development did not begin until the late nineteenth century and at that point, there was still some contention regarding grief in children. Initially, some research asserted that children were incapable of mourning (Christ, 2000; Freud, 1957; Malchiodi, 2003). However, Bowlby (1980) asserted that children as young as 6 months grieved when removed from a particular love object

(Christ, 2000; Malchiodi, 2003). According to Bowlby (1980), healthy mourning for children included communication with children about the death that occurred, and its consequential impact on the family. As well, Bowlby emphasized including children in death-related rituals, and adults' demonstration of empathy for children's emotions regarding the death.

Much of the grief and bereavement literature has focused on adult bereavement, resulting in childhood grief as largely understudied (Hung & Rabin, 2009; Wolchik, et al., 2008). This has resulted in parents, peers, and teachers of bereaved children being virtually unprepared and unskilled in discussing the topic of death with children and adolescents (Black, 1996; Davies, 1999; Holland, 2001; Hospice Net, 2011; Mahon, 2009; Morgan & Roberts, 2010). Regarding incidence and consequences, it has been estimated that approximately 5% of adolescents and children will experience the significant loss of a loved one before the age of 15 (Currier, Holland, & Neimeyer, 2007), and that they are three to five times more likely to develop a psychiatric disorder than those who have not (Dowdney, 2000; Schoenfelder et al., 2011). As well, some studies indicate that early loss of a parent may enhance the potential for greater instability later in life, drug use, promiscuity, and serious mental health outcomes such as schizophrenia (Holland, 2001; Schoenfelder et al., 2011).

The majority of research on bereavement and children has been derived from studies on adults (Wolchik et al., 2008) or as retrospective studies of childhood completed by adults (Currier, Holland, & Neimeyer, 2007). This may be due in part to the difficulty in assessing childhood bereavement and there are several reasons this population remains a challenge to study. To begin, it is difficult to gain access to children

as research participants following the loss of a loved one, and to simultaneously gain parental permission for a child to participate in a research study post-loss (Dowdney, 2000). Additionally, childhood bereavement may be impacted by several factors including parental support (Wolchik, 2008), socioeconomic status (SES) (Cerel et al., 2006; Wolchik et al., 2008), level of parental depression (Cerel et al., 2006; Schoenfelder et al., 2011), level of attachment to the surviving parent if the death was of a parent (Schoenfelder et al., 2011), and other adverse life circumstances that may further exacerbate the grieving process (Thompson, Kaslow, Price, Williams, & Kingree, 1998; Sandler, 2001; Wolchik, Tein, Sandler, & Ayers, 2006). As well, it is difficult to assess levels or stages of grieving in children and adolescents as they are consistently growing and changing, and there is scant opportunity for longitudinal study on childhood loss (Worden & Silverman, 1996). Bereavement is a process that occurs over time, and relates to both maturation and the time since the loss. Thus, it is difficult to garner information on children that have not been impacted by a multitude of other factors.

In addition, several studies investigating parental loss for children and adolescents have noted that the depression levels of the surviving parent may impact level of involvement in the child's life, thus cultivating a sense of neglect for the child (Cerel et al., 2006; Dowdney, 2000; Wolchik et al., 2008). Likewise, in lower SES households, the loss of a parent may also mean the loss of significant income. Financial constraints place further pressure on the surviving parent, and this parent may react with more impatience and hostility toward the needs of the child (Wolchik et al., 2008). Thus, there may be a sense of more than one loss for a child in the death of one parent and the absence of another, and these cumulative losses may have adverse affects on childhood adjustment

and development (Schoenfelder et al., 2011; Wolchik et al., 2008). For example, the child may have more difficulty with academics or garnering support to complete assignments (Currier et al., 2007; Worden & Silverman, 1996). As well, the child may become more socially isolated from their peers and other family members (Currier et al., 2007; Wolchik et al., 2008). This may cause a decrease in social competency for the child in self-comparison to their peers (Worden & Silverman, 1996). Relatedly, youth may also display hostility toward siblings or the surviving parent (Van Eederwegh et al. 1982; 1985), disordered sleep or eating patterns (Dowdney, 2000), excessive anxiety or worry (Worden & Silverman, 1996) and overall difficulty in concentrating (Holland, 2001). Additionally, a significant loss for the child may threaten their overall sense of self-worth (Wolchik, 2008; Worden & Silverman, 1996). Likewise, if the surviving parent and/or caretaker is reluctant to seek grief support, this may contribute to a lack of integration of the death into the present lived-experience of the child, and consequently the ability for youth to manage grief appropriately (Wolchik et al., 2008).

Although death is difficult at any age, it can be even more cumbersome for youth as they may not have a full understanding of what death entails (Black, 1996; Christ, 2000; Davies, 1999; Holland 2001). Thus, the ability to fully understand death and the accompanying grief process may look very different in youth due to their cognitive level of functioning (Christ, 2000; Scott, 2004), which will be discussed in further detail later in the chapter. As well, many well-meaning family members wish to protect the child or adolescent by shielding them from the idea of death and will tend to refrain from any “real” discussion about the deceased (Black, 1996; Mahon, 2009; Weber & Fournier, 1985). However, many researchers have noted that discussing death with youth may be

highly beneficial and provide essential information to process the death when the child or adolescent is ready (Mahon, 2009; Weber & Fournier, 1985).

Similar to grief for adults, youth will also navigate through the stages of grief as suggested by Kübler-Ross (1969). Upon learning that the death has occurred, youth have numerous ways in which they display the denial and/or isolation indicative of the first stage. For example, Holland (2001) reported that young children had no recall of the death and will often become numb to feelings related to the loss. As stated previously, many youth will isolate from their peers and perceive themselves as less socially competent (Worden & Silverman, 1996). Additionally, depending on level of cognitive development, children between the ages of 3-5 years may respond with excitement or laughter that the death has occurred. Conversely, early adolescents may refuse to engage in any conversation in which additional information about the death may be obtained (Christ, 2000). In the second stage, where anger is the most dominant emotion, Worden and Silverman (1996) noted increased hostility toward siblings and the surviving parent. Likewise, bereaved adolescent girls have been shown to display aggression toward their peers in school (Schoenfelder et al., 2011), whereas young children may become more argumentative and withdrawn (Christ, 2000). Holland (2001) noted that what may be viewed as conflict for children may be the expression of the “inner turmoil of the child” (p. 38).

When children experience bargaining or “yearning” as part of the third stage of grief, they may perceive the death as somehow reversible (Morgan & Roberts, 2010). Andrews and Marotta (2005) noted that one child participant in their study was told that it was God’s decision whether or not the parent’s condition would have improved; thus,

children may become preoccupied that the deceased will return depending on their interactions with God, or depending on having a “strong enough” desire to keep a loved one alive. Kübler-Ross (1969) asserted that depression is a natural subsequent emotion following the stage of bargaining. In a study of primary school-aged children by Holland (2001), 30% of bereaved children reported crying regularly and 40% experienced withdrawal and depressive moods. Some common depressive symptoms among grieving children that appear at approximately one year post-loss include sleep disturbance, crying, and lack of concentration (Worden & Silverman, 1996). In a study by Black (1998), 37% of bereaved children qualified for a diagnosis of Major Depressive Disorder, whereas Melhem et al. (2007) reported that depression is three times more likely for grieving youth than for those who have not experienced a significant loss. Regarding the fifth stage, children or adolescents may demonstrate acceptance of the loss by openly discussing the death of the loved one, wearing the clothes or other significant belongings (e.g., watch, ring) of the deceased, and discussing dreams in which the deceased appeared (Christ, 2000).

**Duration of Grief.** There is some discrepancy among researchers regarding the duration of grief for children and adolescents. Several studies indicate that demonstrable grieving behaviors (i.e., withdraw, excessive anxiety, hostility) will last between one to two years to fully allow youth to process the loss (Currier et al., 2007; Dowdney, 1999; 2000; Worden & Silverman, 1996). A study by Worden and Silverman (1996) indicated that 19% of children demonstrated serious emotional and behavioral concerns at one year post-loss, and that 22% showed an increase in disruption of behaviors at two years. As well, in cases of parental suicide as the cause of death, Cerel et al. (1999; 2000) noted

that youth will experience anger at six months, shame at one year, and less acceptance by the second year following the death than children or adolescents who are coping with other types of parental-related bereavement (e.g., cancer, car accident). Despite the amount of time in which the initial grieving period takes place, there is notable concern that the impact of childhood loss may be long-lasting and result in damaging negative mental health outcomes into adulthood (e.g., Black, 1998; Holland, 2001; Hung & Rabin, 2009; Mahon, 2009; Morgan & Roberts, 2010; Weber & Fournier, 1985). As well, many patients admitted for psychiatric care for reasons such as Major Depressive Disorder or PTSD reported the loss of a significant loved one during childhood (Pfeffer, Karus, Siegel, & Hang, 2000). Likewise, Tsuchiya, Agerbo, & Mortensen (2005) discovered that childhood experience with maternal suicide was associated with a diagnosis of Mania or a mixed episode upon their first discharge from a psychiatric hospital. However, this outcome was not correlated with paternal suicide (Tsuchiya et al., 2005). In a related study, Schoenfelder et al. (2011) examined the impact of grief for children and adolescents, ages 7-16, six years after the death of a parent had occurred. Thus, at the time of follow-up, the participants were either in adolescence or early adulthood. The authors noted fear of abandonment by the surviving parent and/or caretaker and depressive symptomology experienced within the first year after the death impacted level of anxiety in romantic relationships six years later for youth involved in this study. The anxiety related to romantic relationships was correlated with depressive symptoms experienced six years post-death (Schoenfelder et al., 2011).

As well, Worden and Silverman (1996) conducted a study to provide a comparison between bereaved youth who had lost a parent, and a control group of non-

bereaved youth at four months, one year, and two years. The study indicated that initial differences between the two groups were not apparent, however, after one year, bereaved children and adolescents reported an increase in bad behavior, less scholastic competence, and less empowerment compared to the non-bereaved youth. For the purpose of Worden and Silverman's (1996) study, less empowerment related to the individual's sense that what happened in their life was not under their control. Additionally, at the two-year anniversary of the death, bereaved children and adolescents reported less social competence, less control of their lives, and increased "bad" behavior compared to their peers in the control group (Worden & Silverman, 1996). Overall, self-worth and scholastic competency was perceived as lower in bereaved children and adolescents at the two-year assessment, and differences in social withdrawal between bereaved and non-bereaved youth were greater for pre-adolescent girls and for adolescent boys. As well, increased aggression was noted in pre-adolescent, parentally-bereaved girls two years after the death (Worden & Silverman, 1996).

### **Reactions and Coping Strategies of Bereaved Children and Adolescents.**

Children and adolescents demonstrate their grieving in myriad ways (Bhagwan, 2009; Bowlby, 1980; Christ, 2000; Holland, 2001; Sandler et al., 2010; Stephens, 2002). The manner in which a child may cope with a difficult loss in their life may appear vastly different than the coping strategies of an adult. For example, youth tend to "numb" their emotions by either ignoring what has occurred or pretending it did not exist. Thus, children may laugh, seem apathetic, demonstrate confusion, or continue to ask when their loved one will be returning home (Christ, 2000; Holland, 2001). Children and adolescents may demonstrate a non-reactive stance, and appear to be uncaring or cold toward the

notion that a loved one has died. (Christ, 2000). For some parents and/or caregivers, these initial reactions may create immense worry that the child is not expressing adequate loss, or perhaps, suppressing intense emotions that may potentially be harmful to the child (Holland, 2001). However, the reaction of “numbing out” can be a healthy manner in which to manage tragic news as it allows the child to slowly take in the new information and process the substantial change in her/his life that has now occurred (Christ, 2000). Numbing can also be understood as a “bracing” of oneself for the upcoming emotional outcry (Holland, 2001; Horowitz, 1976). Criticizing the child during this time for the manner in which she/he are processing the grief may be potentially damaging, as it suggests they are failing in some way or are not acting “normal” (Holland, 2001). Thus, it is important to allow the child to process the grief in her/his own way, in an effort to further promote acceptance of the child.

Children and adolescents will often feel guilt about the death, and this is another common reaction for youth to experience (Holland, 2001). This may be demonstrated in children or adolescents who believe they could have done something to prevent the death (Christ, 2000; Fogarty, 2000), engaged in an activity which they believed to have caused the death (Christ, 2000; Holland, 2001), or engaged in a conversation with the deceased prior to dying which they now regret (Holland, 2001). As well, it is common for youth to feel guilty if they were not present during the time of death, as they may have been able to save their loved one in some way (Fogarty, 2000). Although guilt may be a typical response of a child with regard to the loss of a loved one, Holland (2001) suggests there is a substantial difference between unnecessary guilt and healthy guilt. Healthy guilt is understood as feeling a certain level of guilt that may provide impetus to seek closure

with a love one, or hold a personal ceremony to share what the child would have wished to have shared with the deceased (Holland, 2001; The Moyer Foundation, 2009). For example, a teenager may have had an argument with a parent or sibling before the individual died. Healthy guilt may inspire the individual to engage ceremoniously in sharing their true feelings about the deceased, as well as vocalizing a decision to behave differently toward others in the future. In contrast, Holland (2001) contended that unnecessary guilt relates to the strong sense that the child is responsible for the death in some way. Thus, unnecessary guilt may ensue as a result of a disagreement prior to the death, or previous “childish” wishes that the now deceased parent would die (Holland, 2001).

Another common manner of coping for children and adolescents is to display excessive anger. Andrews and Marotta (2005) assert that it may be healthy for youth to express their anger toward God and others who are significant in their lives for “allowing” the death to happen. Anger may be demonstrated in the form of misbehaving, acting-out, and yelling, may be directed at the parent who died, the parent who lived, and/or other youth who still have the family member (i.e., dad or sister) that is now gone for the child. However, anger can sometimes become passive-aggressive and/or used as a means to seek revenge on others (Andrews & Marotta, 2005). In the thick of the grieving process, youth may erroneously believe that revenge is justified. Thus, because they are hurting, others should hurt as well (Andrews & Marotta, 2005). Often, this anger and desire to harm others may be demonstrated in the form of drug use, pranks, bullying, and early promiscuity (Andrews & Marotta, 2005; Schoenfelder, et al., 2011).

Youth may also demonstrate such behaviors as impairment in the ability to concentrate or to engage fully in conversation. As well, it would be common for children or adolescents to be non-attentive, interruptive, and to appear chaotic (Holland, 2001; Stephens, 2002). Youth may also choose to withdraw from friends and family (Stephens, 2002), and will typically disengage in activities and/or hobbies they once enjoyed (Dowdney, 2000). Another common reaction for children is a change in appetite and sleep patterns, as well as regression to “babyish” behaviors and bed-wetting (Stephens, 2002). Children at a certain level of cognitive development may cope with the loss by creating an imaginary “friend” or an imaginary replica of the deceased (Christ, 2000). As well, youth may want to spend time around the loved one’s belongings, such as wearing their clothing or accessories, or describe the feeling that the loved one is still with them (Christ, 2000).

Families, peers, and teachers are often untrained and ill-equipped to discuss death with children and adolescents (Black, 1996; Hospice Net, 2011; Mahon, 2009; Morgan & Roberts, 2010; Weber & Fournier, 1985). This inability to relate to a grieving child may be detrimental, as it further creates the perception that the child is alone in her/his experience. Likewise, if family members are not discussing the death, youth will often follow the adults’ examples, thus, perceiving conversation and questions about the death as “bad” ([www.hospicenet.org](http://www.hospicenet.org)). Normalizing grief, and the encouragement to express grief in their own individual way, is the most important contribution professionals and families assisting youth can make to the process of grieving (Bhagwan, 2009; Holland, 2001; The Moyer Foundation, 2009; Weber & Fournier, 1985).

**Cognitive Functioning and Grief.** The adjustment of children following the death of a significant loved one is strongly related to their level of cognitive development and ability (Andrews & Marotta, 2005; Christ, 2000; Malchiodi, 2003). Andrews and Marotta (2005) noted that stages of grief may not apply in the same manner to children and adolescents as they may grieve repeatedly as they reach each developmental milestone. In his Four Stages of Cognitive Development (1954), Piaget theorized that children develop cognitively through a series of four stages: (a) sensorimotor stage (birth to 2 years of age), (b) preoperational stage (2 to 7 years of age), (c) concrete operational stage (7 to 11 years of age), and (d) formal operational stage (11 years of age through adulthood). Piaget's theory of cognitive development relates to grief and children and adolescents as they are cognitively capable of understanding death. Recent studies have revealed that children ages 3-5 years struggle to understand the irreversibility of death (Christ, 2000; Malchiodi, 2003) as well as the deceased individual as no longer functional (Christ, 2000; Davies, 1999). As well, Davies (1999) noted that during the stage of preoperational thought, children understand the world as largely revolving around them. Likewise, children in this cognitive stage of development may believe they have the ability to create the death. Children in this stage may ask repeatedly where the deceased has gone and the point at which they will return (Christ, 2000). Likewise, children in the preoperational stage of development may worry if their loved one will be able to breathe when they are buried, or if the deceased will be afraid of the dark (Malchiodi, 2003). For some children of this age, they will need a concrete explanation of death as well as an introduction to the emotions people experience when a death occurs. However, Christ (2000) noted that when children are prepared adequately for the death, they may respond

with a mixed array of reactions including excitement, clinginess to the surviving parent and/or caregiver, and somatic symptoms (e.g., stomachaches, headaches).

Unlike many children in the preoperational stage, concrete operational thinkers understand that once the death occurs, the body is no longer functional (Black, 1998; Davies, 1999) and the death is no longer reversible (Malchiodi, 2003). As well, they tend to grasp the finality of death and display appropriate emotions such as sadness, anger, and dejection upon discovery of the loss (Christ, 2000). In contrast to older children, Christ (2000) found that children, ages 6-8, demonstrated more somatic symptoms such as headaches and stomachaches, as well as fearfulness, sleeping difficulties, and separation anxiety. Often, children in this age group wish they could also die in order to join the deceased family member, although these thoughts are generally not indicative of suicidal ideation (Christ, 2000). However, if these thoughts were to become more severe or inflexible, professional treatment would be necessitated. Although considered in the same stage of cognitive development according to Piaget (1971), Christ (2000) reported that children, ages 9-11, required additional factual information regarding the death compared to those children approximately two years younger. As well, children of this age had a tendency to avoid strong emotion, both of their own and of others, and were only able to openly discuss the loss briefly. Rather, the feelings experienced by children in this age range are demonstrated through argumentativeness, messiness, stubbornness, and withdrawal (Christ, 2000).

Youth in the formal operational stage of cognitive development tend to reason in more abstract and idealistic ways (Piaget, 1954). Thus, children and adolescents in this stage who have experienced a significant loss may share dreams in which she/he

communicated with the deceased or felt a strong “sense of presence” (Christ, 2000, p. 77). Fear of abandonment by the parent and/or surviving caretaker may be stronger for girls than boys at this stage (Schoenfelder et al., 2011), and early adolescents may avoid all expressions of grief-related emotion with the exception of their own anger about the situation (Christ, 2000). The process of grief for middle adolescents, ages 15-17, can be characterized as similar to adults. For example, children of this age can describe their feelings of anger, sadness, longing, despair, helplessness, and hopelessness because of the death (Christ, 2000; Malchiodi, 2003). As well, young adolescents can understand the manner in which these emotions are impacting their ability to engage in typical activities such as sports, school, and after-school events (Christ, 2000). Schoenfelder et al. (2011) noted that adolescent girls may seek alternative support from deviant males, and engage in early sexual activity if they are not receiving adequate support in the home. Likewise, adolescents may also turn to drug use to manage feelings of depression, anxiety, or loneliness (Schoenfelder et al., 2011). Morgan and Roberts (2010) assert that although adolescents may sometimes view the notion of death as fascinating or romantic, they may not be fully aware of the finality of death beyond the idealism regarding the concept. Additionally, the family of an adolescent may expect adult behavior throughout the grieving process, and the adolescent child may give the impression that they are coping well without support. However, Morgan and Roberts (2010) note that youth of this age may not be fully equipped to navigate the emotions related to death, and need just as much grief support as other bereaved children and early adolescents.

Overall, Christ (2000) asserts that in order for youth to healthfully adjust to a loss, they must be provided with increased levels of social support, a positive relationship with

the surviving parent and/or caretaker, and the presence of positive attributes in the home such as warmth and family cohesiveness. Childhood adjustment to loss can take many forms, but special emphasis has been placed on the relationship between the child and the surviving parent and/or caretaker (Haine et al., 2006; Hung & Rabin, 2009; Kwok et al., 2005). Some of the stressors experienced by the surviving parent and/or caretaker will be discussed in the following paragraphs.

**Caregiver Stress and Grieving.** The US Bureau of the Census (2001) reported that approximately 3.4% of American youth will experience the death of a parent prior to the age of 18. As well, parentally-bereaved children and adolescents are three times more likely to experience depression than non-bereaved youth (Melhem et al., 2007) and are at increased risk for depression into adulthood (Kendler et al., 2002; Reinherz et al., 1999). There is difficulty obtaining information on bereaved youth who have lost a parent as many cases involve the surviving parent's report of the child which may be tainted by the grief symptoms of that parent (Worden & Silverman, 1996). However, the actions of the surviving parent may be preventative for some of the aforementioned negative outcomes, as parental warmth and consistent discipline may be a factor which fosters resiliency and adaptiveness for the child (Haine et al., 2006, Hung & Rabin, 2009), as well as lessening potential pathology later in life (Kwok et al., 2005).

Numerous authors note that financial constraints become problematic for the surviving parent and/or caretaker (e.g., Hay & Nash, 2002; Institute of Medicine (IOM), 2000; Schoenfelder et al., 2011). In some families living at or below the poverty-level, or in homes of the working-poor, the loss of half of the income in the home compounds the stress already experienced as a result of the death. Financial constraints may impact

several aspects, including the depressive symptoms of the surviving parent and/or caretaker (Hay & Nash, 2002), less time to spend with the child (Schoenfelder et al., 2011), and increased impatience and hostility for the child (IOM, 2000). Unfortunately, these outcomes create further distress toward the child. The changes to the household such as an increase in stress, depression, and hostility may result in neglect for the child. This sense of neglect invites the perception that the surviving parent no longer has time for or interest in the child (Schoenfelder et al., 2011). Although a well-meaning parent may intend to serve the child well by working more hours in order to take care of family financial obligations, the child may view this as a lack of interest in their life or activities. As well, depending on levels of parental depression, there may genuinely be a lack of interest in child concerns or activities (Schoenfelder et al., 2011). If the depression was present for the parent and/or caretaker before the death, it may be further exacerbated by the loss. Relatedly, the loss itself may have evoked symptoms of depression for the surviving parent or caretaker and an inability to cope with work and family stress (IOM, 2000; Schoenfelder et al., 2011), all of which will impact the child.

Youth from lower SES homes may already face issues of instability related to inability to obtain every-day necessities, thus substantially decreasing the likelihood of obtaining bereavement counseling as the parent may not have the time to seek this type of assistance for the child and/or it would be unaffordable (IOM, 2000). Additionally, the feelings of neglect or loneliness experienced by the child, as a result of parent and/or caretaker absence may impact the child in a variety of ways such as withdraw from peers or family situations, depression, anxiety, hostility, and later pathologies (e.g., Black, 1998; Cerel et al., 2006; Holland, 2001; Hung & Rabin, 2009; Mahon, 2009; Morgan &

Roberts, 2010; Weber & Fournier, 1985). Likewise, a study published by the IOM (2000) asserts that children and adolescents from impoverished families have a tendency to experience delays in cognitive development due to lack of parental engagement in dialog. This may increase the potential for depression-related concerns, drug use, early sexual activity, and lower academic achievement for these children (IOM, 2000).

In an article by Hay and Nash (2002), the authors noted that children and adolescents may also be impacted by not having the “ideal family.” Upon comparing themselves to other families, and finding deficiency in one’s own family structure, the surviving parent and/or caretaker may experience a perception of decreased self-efficacy (i.e., the individual may feel failure in the capacity to generate a positive family dynamic). These feelings of diminished self-efficacy experienced by the parent may contribute to decreased self-efficacy for the child, and therefore, may result in lower levels of achievement (Hay & Nash, 2002).

**Fear of Abandonment and Grief.** The experience of loss at an early age may create a sense of fear that the surviving parent and/or caregiver will also leave at some point (Worden & Silverman, 1996). After the death of a parent or significant loved one, there may be a shift in the relationship between the child and the surviving parent and/or caretaker. This shift in the family may create a threat for the child in their sense of control in their lives, and life may seem suddenly unpredictable (Worden & Silverman, 1996). This unpredictability may enhance the potential for lower levels of coping efficacy, and a sense that the child cannot handle their own problems effectively. Additionally, these lower levels of coping are related to decreased efforts from youth to re-engage in activities interrupted by the death and related grief (e.g., sports, hobbies) (Wolchik et al.,

2008). As well, a sudden shift in the relationship may involve decreased attention toward the child resulting in lowered self-worth, which increases grief and decreases involvement in self-esteem elevating activities for the child (Wolchik et al., 2008).

Schoenfelder et al. (2011) suggest that the death of a parent affects childhood adjustment due to attachment level with both the deceased and surviving parent or caregiver. These attachment-related concerns may lead to later depressive symptoms and directly impact relationships with peers, caregivers, and romantic partners (Schoenfelder et al., 2011). For many youth, the loss of one parent may evoke excessive anxiety about the loss of the surviving parent and/or caretaker. In a longitudinal study of children who had lost a parent, fears of abandonment reported in the first year after the death related to the loss of the surviving parent were directly related to fears experienced six years later in their romantic relationships (Schoenfelder et al., 2011). The fears and anxiety experienced with regard to romantic relationships were also correlated to current levels of depressive symptoms.

Schoenfelder et al. (2011) define “fear of abandonment” as the child’s belief that they will not be able to rely on their current caregiver for future care. Wolchik et al. (2006) reported that major disruptions in the family impact the level at which the surviving caretaker is able to provide positive parenting, and thus, the manner in which the family can now manage stress. Schoenfelder et al. (2011) report that the disrupted relationships experienced during childhood with the surviving parent and/or caretaker, as well as disruptions in peer and romantic relationships, may be a pathway to the development of depression. As well, parental bereavement may result in a lesser level of care by the surviving parent and/or caretaker, and this may lead female adolescents to

seek support from alternative, negative, male influences (Schoenfelder et al., 2011). The depression experienced by adolescent females due to the loss of a significant person in their life may result in increased vulnerability and poor coping strategies (Schoenfelder et al., 2011). Because the parent-child relationship may provide a model for negotiating other significant relationships throughout the lifespan, anxiety regarding the loss of the surviving caretaker may evoke fears of abandonment, which would directly impact the quality of future relationships (Schoenfelder et al., 2011). Thus, quality of relationships may significantly impact the lived-experience of the bereaved child thereby increasing the opportunity for the development of depressive and anxiety-related disorders. Some studies have indicated that more securely attached parent-child relationships result in social relationships that are more intimate, an increased ability to both give and receive help from/to their peers, and decreased conflicts with a best friend (Schoenfelder et al., 2011).

**Child Adjustment and Grief.** Social relationships are necessary in meeting the needs of youth for coping with feelings related to trauma or parental bereavement (The Moyer Foundation, 2009; Worden & Silverman, 1996). In a study by Schoenfelder et al. (2011) regarding the importance of social relationships for children, the authors found that depressive symptoms post-death were stronger for younger adolescents than for older adolescents and young adults. The authors assert that emphasizing a reduction in children's fear of abandonment as a result of significant loss will improve social relationship quality and a reduction of later depressive symptomology. Social connections are emphasized throughout the literature on childhood bereavement (e.g., Currier et al., 2007; Wolchik et al., 2008; Worden & Silverman, 1996) as social

competence and connection with peers is important for the healthy development and adjustment of the child. Lack of success in this particular arena may not only cause depressive symptoms, but later internalizing and externalizing of problems as well. Use of drugs may also be utilized as a way to cope with unmet social needs (Cerel et al., 2006; Morgan & Roberts, 2010; Schoenfelder et al., 2011).

According to Worden and Silverman (1996), bereaved children do not experience more illnesses than non-bereaved children, however, other somatic ailments related to grief and bereavement such as headaches and stomachaches may impact adjustment, social functioning, and connectedness (Stephens, 2002; Van Eerderwegh et al., 1985; Worden & Silverman, 1996). At thirteen months post-death of a loved one, Worden and Silverman (1996) reported that children demonstrated a decrease in depressed mood and an increase in conflict with siblings, abdominal pain, and diminished interest in school. As well, bereaved children demonstrated concern for their own safety in this study and for the safety of their surviving parent and/or caregiver at approximately two years post-loss.

In poverty-level families, youth may also be expected to work in order to support the family (Hay & Nash, 2002; IOM, 2000). The responsibility of working may impact the child's ability to connect with her/his peers, thus impacting social-adjustment. Cognitively, the child may not be to fully process the loss, and managing adult-level responsibilities such as work may increase this difficulty. The lack of opportunity for adequate grieving impacts level of social connection, and may contribute to a wide-range of mental health concerns for children and adolescents such as depression, anxiety, social problems, lower self-esteem, and lower self-efficacy (e.g., Black, 1998; Holland, 2001;

Mahon, 2009; Morgan & Roberts, 2010; Weber & Fournier, 1985; Worden & Silverman, 1996). In the time initially following the death of a loved one, the child may struggle to maintain academic competence for their grade-level, or exhibit an inability to connect with peers, thus impacting academic and social adjustment. This inability to connect with others may be displayed by behaviors such as withdrawing from their peers or enacting bullying behaviors upon others (Worden & Silverman, 1996). As well, childhood depression, if left untreated, may create a sense for the child that the world is an unwelcoming and dark place.

### **Grief Interventions for Children and Adolescents**

Childhood and adolescent bereavement has been demonstrated to be highly correlated with later-childhood and adult-onset psychiatric disorders such as anxiety, depression, suicidal ideation, attachment issues, and more severe psychological concerns (e.g., Black, 1998; Cerel & Roberts, 2005; Holland, 2001; Mahon, 2009; Morgan & Roberts, 2010; Pfeffer et al., 1997; Weber & Fournier, 1985). Due to the potentially damaging consequences of grief and bereavement for youth who have lost a loved one, numerous researchers and clinicians have developed interventions to assist bereaved children throughout the grieving process (Hung & Rabin, 2009; Malchiodi, 2003; Stephens, 2002; Wolchik et al., 2008). Early intervention may assist in minimizing some of the immediate and long-term negative impacts on children (Schoenfelder et al., 2011). The following section will explore the need for grief intervention for youth, as well as contradictory research that asserts intervention is not necessarily required in every circumstance. Lastly, examples of current interventions and suggestions for programming will be explored.

Early grief-focused researchers indicated some skepticism regarding the relevancy in studying grief for children and adolescents based on the belief that it did not necessarily exist (e.g., Freud, 1957; Wolfenstein, 1966). However, contemporary researchers note that bereaved youth typically participate in some type of grieving process. Children as young as six months old can demonstrate sadness regarding a loss, whereas children of four years can display expressions of grief, although it may not be congruent with societal expectations for what grief should entail (Bowlby, 1980; Currier, Holland, & Neimeyer, 2007). Thus, many mental health professionals have asserted a need for preventative interventions to assist bereaved children and adolescents in the hope that it may potentially lessen onset of severe pathology into adulthood (e.g., Andrews & Marotta, 2005; Barnard, Morland, & Nagy, 1999; Bhagwan, 2009; Black & Urbanowich, 1987; Cohen, Mannarino, & Deblinger, 2006). A variety of interventions are available for children to assist in the grieving process such as individual therapy, peer counseling, weekend retreats, support groups, and family and group therapy (Currier et al., 2007; The Moyer Foundation, 2007; Webb, 2002). However, the effectiveness of these interventions for children remains questionable as few outcome studies have been conducted (Currier et al., 2007; Maciejewski et al., 1997).

Conversely, in their intervention evaluation study, Currier et al. (2007) indicated that childhood bereavement interventions have no influence on adjustment for children. Likewise, the authors noted that grieving youth who participated in bereavement interventions did not appear to be any higher-functioning than those bereaved children and adolescents who had not participated in a grief intervention. This lack of improvement may be due to a lapse in time between the death and participation in an

intervention program as it is noted that effectiveness was slightly increased when the intervention occurred closer to the time of death (Currier et al., 2007). Many emotions may have waned during the time between the death and the intervention, perhaps creating decreased effects of the intervention. However, the research conducted by Currier et al. (2007) is contradictory to studies that assert grief interventions for youth are paramount for child adjustment and the lessening of negative mental health outcomes into adulthood (e.g., Andrews & Marotta, 2005; Barnard et al., 1999; Bhagwan, 2009; Black & Urbanowich, 1987; Cohen et al., 2006; The Moyer Foundation, 2009). Currier et al. (2006) suggest that some children may not be “high-risk” or in need of services. Therefore, it should not be considered mandatory to participate in a grief intervention if the child seems to be adjusting in a functional manner. As well, treatment plans for grieving children must be provided on a case-by-case basis. Thus, Currier, Holland, & Neimeyer (2007) recommend intensive screening for bereaved youth in order to adequately and objectively decipher if, and what type of, therapy would be beneficial for the child.

**Educational and Creative Interventions.** Several interventions have been utilized in working with bereaved children including use of the child’s spirituality and faith in treatment (Andrews & Marotta, 2005; Bhagwan, 2009), establishing a relationship with and connection to nature (Bhagwan, 2009), and normalizing childhood grief by vocalizing their pain with other youth who have also experienced loss (The Moyer Foundation, 2007; 2009). Likewise, it may be therapeutic for a child to discuss concerns about death or the loss of their loved one with parents, friends, and family (Schoenfelder et al., 2011; Wolchik et al., 2007), as well as a skilled therapist (Andrews

& Marotta, 2005). Some of the recommended activities described by Andrews and Marotta (2005) are to “link objects” to the deceased in order to positively preserve their memory. For example, a child may choose to carry some of the belongings of the deceased with them, or may link objects in nature (e.g., flowers, butterflies, turtles) to the deceased to maintain a connection with that person. As well, play is suitable for working with grieving children as activities may evoke a sense of control over a particular situation and the power to make negative feelings go away (Andrews & Marotta, 2005; Bhagwan, 2009).

Intervention groups with age-appropriate play and structured group activities may be a way in which to appropriately explore grief-related emotions (Andrews & Marotta, 2005; Hung & Rubin, 2009; Pfeffer et al., 2002; The Moyer Foundation, 2012). Andrews and Marotta (2005) suggested that counselors working with grieving children may use items such as drawings, puppets, and sand to engage in expression of their grief. These types of activities appeared to grant the child some level of control over the situation when she/he may be feeling out of control throughout the experience of the death of a loved one (Andrews & Marotta, 2005; Malchiodi, 2003). Similarly, Malchiodi (2003) asserts that drawing is especially impactful for children who have the ability to draw items such as houses, trees, people, animals, and other important components of their environment. This activity may prompt children to discuss some of their feelings related to each item, and may also serve to illustrate their fears and beliefs about death and dying (Hospice Support Care, 2011; Malchiodi, 2003). As well, scribbles can be useful for younger children who are unable to draw, as they may still be able to provide narrative to the creation they have made. In *Helping Children Feel Safe*, Steele, Malchiodi and Klein

(2002) provide several activities for therapists and counselors working with grieving children. For example, the authors invite children to draw their worries and fears, and then ask children to draw a color, line, or shape that would make the worry feel better. As well, drawing an expression on a blank face may be useful for young children in describing emotion (Ryan's Heart, 2009). Steele et al. (2002) also provide suggestions for an activity called "Magic Book" in which children are asked to imagine a magic book that is always a good listener and that has answers to all their problems, worries, and fears. The therapist is then encouraged to ask the child to draw the magic book and ask the magic book about a problem they are experiencing (Steele et al., 2002). Likewise, a "Safe Box" or a "Memory Box" may be used to store important photos, mementos, and toys or other comforting items the child may turn to when feeling down. Children must be allowed to be "experts" of her/his own expressions and experiences, and the therapist working with the child must be comfortable in discussing death in order to promote acceptance of grieving for the child (Malchiodi, 2003).

Utilizing games with youth may also be useful in cultivating grief-related discussion (Hospice Support Care, 2011; The Moyer Foundation, 2009). For example, use of a maze activity in which a child can navigate going from sad to happy may be useful, as well as word finds that contain grief and loss-related items (e.g., soul, support, loss, hope, stress) (Hospice Support Care, 2011). In a workbook entitled, *Just for Me*, numerous activities are provided in the interest of expressing anger, sadness, and a desire for connectedness (e.g., smashing fruit and vegetables, placing a Hershey's Kiss at a grave/memorial site to melt and send a "kiss" to the deceased, and creating a family flag inclusive of their lost loved one) (Ryan's Heart, 2009). Adolescents are encouraged to

create a support system by contemplating ideas such as “three people you are comfortable talking to,” “name three things you can do or three people you can be with to let out sad feelings,” and “name some things that will help get you mind off your loss” (Ryan’s Heart, 2009). In addition to drawing and other artforms for healing, some researchers and organizations have recommended the use of relaxation techniques (e.g., butterfly relaxation, progressive muscle relaxation, guided imagery) (Cohen et al., 2006; Hospice Support Care, 2011). Relaxation exercises can often provide a reprieve from stomachaches, headaches, and muscle tension as a result of grieving (Cohen et al., 2006).

Educational interventions have been noted in the literature. For example, Corr (2009) suggests the use of “teachable moments” with children, as unanticipated events often occur (e.g., September 11, 2011, the death of a pet, or the funeral of a loved one) (p. 8). The four dimensions in death education are related to (a) what people know, (b) how people feel, (c) how people behave, and (d) what they value. Thus, they are the cognitive, affective, behavioral, and value-laden dimensions of the individual encountering death education, and are distinguishable, but interrelated in the educational process. One example of an activity by Adams (2006), “Lessons from Lions: Using Children’s Media to Teach about Grief and Mourning” seeks to provide children with information that normalizes the process of death. In this intervention, children are provided a booklet with 10 slides of scenes from Disney’s *The Lion King*, and are then prompted to discuss several points from the movie including death. As this movie pertains to children and also encompasses death-related themes, this may serve to provide children with preparation for encounters with death in their own life.

**Other Recommendations for Intervention.** Hung and Rabin (2009) suggest that interventions for grieving children should be highly reliant upon referrals. These referrals should come from individuals in the child's life such as doctors, hospitals, and churches. However, the authors note this type of referral system can be highly variable, and sometimes leaves families without the knowledge that there are crisis centers, mental health clinics, and support groups developed to help grieving children and their families (Hung & Rabin, 2009). Andrews and Marotta (2005) advise that it may be helpful for school counselors to assign a family to a child to help initiate a "buddy system" (p. 47). This system enables children to gain additional support from a volunteer family who can help the child while her/his own family is in the midst of grieving (e.g., transportation to appointments, tracking permission slips). It is also advisable for school counselors and teachers to be mindful of children's difficulties with celebrations in school for holidays, especially Mother's or Father's Day. One activity suggested for use on this holiday is the releasing of a helium balloon into the sky with a message to the deceased (Andrews & Marotta, 2005; The Moyer Foundation, 2009). Wolchik et al. (2008) and Schoenfelder et al. (2011) suggest interventions and prevention programs should target the child and caregiver relationship, exposure to potential stressors for that relationship, fear of abandonment, and coping efficacy beliefs. These authors suggest the increase in attention to the child-caregiver relationship will decrease stressful events, thereby reducing grief over time. The reduction of grief may be due to the reduced fear of abandonment and an increased coping efficacy through these conversations (Wolchik et al., 2008). With improvement in the child-caregiver relationship, stress related to the death may decrease, thus, reducing experience of grief over time. This reduction of grief may be correlated

with a reduction in fear of abandonment or general increase in self-efficacy (Schoenfelder et al., 2011; Wolchik et al., 2008)

Early intervention may assist in minimizing some of the negative impacts on children and adolescents long-term. Ultimately, youth need a space in which they can both grieve and still be a child. Interventions that emphasize play, creative endeavors, physical activity, and connections with nature, may be the most effective manner in which to provide youth with an outlet for healthy grieving (Andres & Marotta, 2005; Bhagwan, 2009; Malchiodi, 2003; Morgan & Roberts, 2010; The Moyer Foundation, 2007; 2009)

### **About Camp Erin**

Camp Erin encompasses many of the recommendations researchers suggest including drawing and creative expression, connections with spirituality and nature, normalizing and validation of experience, and an open group forum in which voices of children and adolescents may be heard. The following section will provide an overview of Camp Erin, including information on how the camp began, a brief history on its symbol and logo, how the camp is managed and staffed, and examples of the overall requirements, activities, and schedule.

The mission of The Moyer Foundation (TMF) is to provide empowerment for children in distress through education and support with the hope that they can live inspired and healthy lives (TMF, 2009). TMF is a public, non-profit organization headquartered in Seattle, Washington. Jamie Moyer is a well-known athlete and current pitcher for the Philadelphia Phillies. In 2000, Jamie and his wife, Karen, approached Providence Hospice and Home Care in Snohomish, Washington, with the initial idea to launch Camp Erin. In the following year, TMF partnered with Kumon North America to

raise funds for the establishment of four bereavement camps for children who had experienced the loss of a loved one in the tragedy of September 11, 2011. Soon after, TMF established a partnership with Providence Hospice of Snohomish County, and established the first Camp Erin in Everett, Washington in 2002 (TMF, 2009).

Karen and Jaime Moyer founded Camp Erin in an effort to memorialize Erin Metcalf, a young woman who developed liver cancer at the age of 15. Upon hospitalization, Erin was told she would only have few months to live, and was subsequently granted a wish through the Make-A-Wish foundation (TMF, 2009). Because Erin was an avid baseball fan, she requested a trip to Arizona in order to watch the Mariners spring training. The Moyers met Erin during this trip, and quickly noted her compassion for other children who were suffering (TMF, 2009). Soon after this visit to Arizona, Erin received a liver transplant and the hope that she was now on her journey to recovery. However, the cancer soon returned, and quickly spread to her spine. On June 16, 2000, Erin died at the age of 17 (TMF, 2009). Throughout her battle with cancer and the time she spent in the hospital, Erin noticed the struggle of other sick children and the loneliness that often ensued. Specifically, she indicated concern for the siblings that would be impacted by the loss of their brother or sister. Erin had two sisters and frequently expressed worry regarding the grief they may potentially experience upon her death. In response to Erin's passing, the Moyers wished to open a bereavement camp for children in Erin's name as a tribute to her compassion, love, and concern for other grieving children (TMF, 2009).

Erin's sister, Maria Metcalf, shared that the blue heron (a large, wading bird found predominantly in wetlands) became a significant symbol in their family. She

reported that once Erin began her treatment for cancer, many blue herons began to randomly and regularly appear. Maria shared that each time the family would drive Erin to the hospital, Erin would sight a blue heron on a particular bridge they crossed, and consequently, Erin began to rely on these birds as she navigated the process of chemotherapy (TMF, 2007). On the day Erin died, she had traveled by ambulance to the hospital. Although she was unable to see for herself, she asked her mother to look and check if there was a blue heron as they crossed the bridge. According to Maria, a blue heron was sighted by her mother in this moment. After Erin passed away that evening, Maria and her mother drove home and spotted a large blue heron standing on the side of the road. Maria interpreted this as a sign that Erin was “okay” and “free” (TMF, p. 37, 2007).

As well, prior to her death, Erin and the doctor who was scheduled to perform Erin’s liver transplant had both individually witnessed a shooting star the night before. This sighting happened to come up in conversation between the two of them while in preparation for the surgery. The transplant was a success, and on Erin’s 16<sup>th</sup> birthday, that doctor registered a star in Erin’s name. Maria also shared that upon taking Erin’s ashes to Hawaii as Erin requested, four shooting stars were sighted by the family. Maria stated this was a reminder that “there is beauty and infinite goodness around you and always a reason to be grateful” (TMF, p. 37, 2007). Thus, the blue heron with a shooting star became the symbol and required logo for Camp Erin.

Camp Erin is the largest nationwide network of bereavement camps for children and adolescents (TMF, 2009). Camp Erin is a weekend long bereavement camp for youth, ages 6-17 whose mission is to “offer encouragement, comfort, and support to

children enduring a time of profound emotional, physical, or financial distress and provides opportunities for enhancing overall wellness, stability and quality of life” (TMF, 2007, p. 7). The first camp was held in Everett, Washington in 2002 with 42 campers in attendance. And in 2007, the Moyers gave a \$1,000,000 gift for the national expansion of Camp Erin. In 2010, there were 35 camps held nationwide with 2,031 campers in attendance. In 2012, there was approximately 40 camps in the United States with an additional camp in Toronto, Canada (TMF, 2009).

Camp Erin serves to provide children and adolescents with a way in which to healthfully express their grief. Often, grieving children and adolescents tend to feel a sense of isolation due to the loss, and may not wish to openly discuss the death with surviving relatives, friends, or teachers (TMF, 2009). Camp Erin creates an environment in which loss is normalized and connections may be made with other children who have this commonality. As well, children are given the opportunity to process grief in a camp setting where fun and play are also emphasized (TMF, 2009).

In order for camp to be a free service for children, each camp is established in partnership with a non-profit bereavement agency (e.g., hospitals, hospices). These respective camp locations must also offer local grief counseling and resources for children and families after attending camp. The national Program Manager of Camp Erin visits each prospective camp in person to ensure it is an appropriate fit with adequate resources for the camp (TMF, 2007; 2009). A Camp Erin Partner Request for Proposal (see Appendix B) must be completed by each site, or prospective Camp Director (CD) before consideration of the site will be made. As well, there is a Camp Erin Pre-Camp Checklist that must be completed by each site before camp begins (see Appendix C).

Every site is expected to follow the *Camp Erin Best Practices Guide* (TMF, 2007; 2009) which details four major areas of interest in establishing a Camp Erin at a given location including (a) Start Up, (b) Pre Camp, (c) Camp Weekend, and (d) Post Camp.

**Start Up.** In the “Start Up” recommendations, TMF provides a general outline in selecting a suitable site to host Camp Erin for the weekend. Some examples to consider are provisions for food services and a dining hall for the campers, cabins in lieu of tents, and a location in which campfires and a flag pole may be established (TMF, 2007; 2009). As well, it is advisable to create a timeline for holding the camp, and Camp Erin provides CDs with one year, and nine-, seven-, six-, five-, four-, three-, two-, and one-month suggestions on preparation for camp. For example, CDs are encouraged to host an initial volunteer training six-months prior to camp, send out camper acceptance letters three-months prior, and to schedule a grief training for volunteers one-month before camp begins. The manual provides an example of a camp schedule (see Appendix D), and examples of camp-preparation letters for campers and their families. Additionally, the manual provides a list of items for campers to bring in order to have a positive experience (e.g., pillow, flashlight, sunscreen), as well as what not to bring (e.g., money, gum, alcohol) (TMF, 2007; 2009).

To assist CDs in conceptualizing the set-up for camp, the manual is clear about camper discipline while children are at Camp Erin. TMF notes that a camper may be asked to leave if there is evidence of using alcohol or other drugs, abusive or inappropriate behavior or language, inappropriate physical contact, or any behaviors that endanger the health and safety of others (TMF, 2007; 2009). Campers have the right to decline participation in any activities they wish while at camp, and campers are not

permitted to go to locations or activities without permission of the Cabin Big Buddies, camp volunteers, or camp staff. Some suggested disciplinary “techniques” include setting limits on a child’s behavior, speaking with the camper about negative behavior, or requesting that the camper apologize to someone they potentially hurt due to their behavior (TMF, 2007; 2009). At no point is it acceptable to physically punish a camper or deny food or sleep. Any staff engaging in this type of behavior will be terminated immediately (TMF, 2007; 2009).

Some of the key positions at Camp Erin are the Camp Director (CD), Clinical Director (CLD), Counselors, and Camp Nurse. TMF states that partner organizations may determine their own names and duties of staff and volunteer positions, but are required to meet the goals and intent of the aforementioned positions. Some of the CD responsibilities include interviewing prospective volunteers, development and implementation of volunteer training, and establishing a volunteer recruitment strategy. The responsibilities of the CD are wide-ranging as they are expected to oversee all activities for the camp and manage the needs of volunteers, counselors, staff, and campers (TMF, 2007; 2009). The CD determines the number of campers suitable to attend the camp, and each camper is required to meet with the CD and/or Camp Erin staff to determine a child’s readiness to attend camp.

The CLD oversees all bereavement-related concerns and activities in the planning stages and throughout the camp weekend. Upon receiving camper’s application and bereavement information, the CLD helps to inform the CD of suitability of the child for camp. The CLD retains the right to alter their recommendation of child readiness at any time in the interest of safety and welfare of all campers. As well, CLD works closely with

the Cabin Big Buddies (CBBs) to ensure the CBBs are aware of any specific concerns or if there is a recommendation that one camper pair up with a certain CBB based on individual needs (TMF, 2007; 2009).

Counselors will assist both of the aforementioned individuals with any bereavement-related issues that arise. The Counselor may assist the CLD in determining goodness-of-fit for the camp, and may be asked to assist with volunteer training in children's bereavement issues, effective communication with children, and HIPPA regulations regarding confidentiality (TMF, p. 41, 2007). One licensed Counselor, in addition to the CLD, is required by TMF to attend camp.

The Camp Nurse must be a currently Registered Nurse and is responsible for all health-related concerns at camp. TMF requires the Camp Nurse to be licensed to practice in the state in which the camp is held. This individual will collect any medications or health-related items from the campers upon arrival to camp and store them in the nurse's station for the entirety of camp. In preparation for a potential emergency situation, TMF requires that two nurses attend camp, as one nurse must be present at all times (TMF, 2007).

There are several volunteer and paid positions at Camp Erin. One of the most directly influential staff for campers is the CBBs. The CBBs are trained volunteers responsible for campers in their cabin at all times. Some of their responsibilities are to facilitate group cohesion in the cabin, create and maintain a supportive and fun environment for campers, to eat all meals with campers, and to share a cabin with their campers (TMF, 2007; 2009). The organization hosting Camp Erin is responsible for gathering all personal information and conducting background checks for the CBBs

(TMF, 2007; 2009). Another important contributor to the experience at Camp Erin is the Grief Activity Facilitators (GAFs). The GAFs are responsible for the development of grief activities to be used at Camp Erin, and several ideas are provided in the manual (TMF, 2007; 2009). The GAFs are responsible for campers' safety and location while conducting the grief activity.

There are also several different volunteer committees at Camp Erin, including the Rituals Committee, the Planning and Organization Committee, and the Welcome and Registration Committee (TMF, 2007; 2009). The Ritual Committee works together to provide and create grief-related activities and crafts, including memory frames and personalized luminaries. As well, this committee may facilitate grief-related storytelling or a grief skit to assist in the process of grief for children. The Planning and Organization Committee has the responsibility of planning logistics for the camp, including facility set-up, parking, scheduling, and communications between staff members at camp. As well, the committee creates weather-related back-up plans for campers and emergency protocol and transportation (TMF, 2007; 2009). Finally, the Welcome and Registration Committee plans for the arrival of the campers and assists with check-in, luggage, and cabin set-up (e.g., quilts, Erin Bears).

**Pre Camp.** The "Pre Camp" section of the manual advises management of the camper application process and criteria for campers to attend Camp Erin. In order to qualify, campers must (a) be between the ages of 6-17, (b) have experienced a significant human loss, (c) completed and returned an application packet (see Appendix E for a sample), and (d) have attended an individual meeting with the Camp Erin CLD (TMF, 2007; 2009). During the meeting with the CLD, each camper and her/his parent or

guardian will obtain additional information about Camp Erin, as well as address and questions or concerns. This section of the manual also provides examples of letters to raise funds for Camp Erin as well as suggestions for brochures to use at the partnering organization's facility.

**Camp Weekend.** During the "Camp Weekend," TMF requires that each camp must provide an evening activity on the day campers arrive for the weekend. One example is a flag raising ceremony to officially recognize that camp is now beginning. TMF recommends that volunteers of Camp Erin be prepared to help parents navigate the process of leaving their children at camp. Because it is unclear what the level of difficulty may be for the parent to separate from the camper given the circumstances, TMF suggests volunteers reassure parents of their child's safety at camp and reiterate the positive experience the children will have at Camp Erin (TMF, 2007; 2009). "Comfort Gifts" are given to campers upon arrival to camp, and may include quilts, beach towels, or special pillowcases. Nationwide, all campers will receive a stuffed bear more aptly known as an "Erin Bear" (TMF, 2007; 2009).

To further maintain consistency across camps, each camp is required to hold a "Memory Board" activity (at the beginning of camp) and "Luminary Ceremony/Love Lights" (on the second/final night of camp) (TMF, 2007; 2009) (see Appendix F). The Memory Board provides children with the opportunity to honor their loved one and share a story about the deceased. Each child and/or volunteer attending Camp Erin is asked to bring a photo of their deceased family member to place on the board. Presentation of the board is accompanied by an oral history of Erin Metcalf, and is posted in a prominent location for the remainder of camp. The Memory Board serves several functions such as

providing representation that children are not alone in their grief, fostering communication between children and their peers about the death, and assisting in the bond between campers throughout the weekend and after they leave camp (TMF, 2007).

During the final night of camp, the Love Lights Ceremony is conducted to honor the loss the campers have experienced as well as the weekend spent discussing their related feelings. Typically, each individual will decorate their own luminary prior to the ceremony as a symbol of her/his love for the loved one who has passed away. TMF suggest that staff encourage campers to craft their luminary in a way that provides remembrance of the person that has passed away rather than approaching it as an ordinary craft. The luminaries will then be released out onto a body of water (e.g., pool, lake, alternative water source) to create a “reflection pool” for campers (TMF, 2007). As well, TMF encourages staff to be prepared for a significant release of emotion from campers during this ceremony as this may be one of the first times they have been able to honor their loved one in such a personal manner. Other suggestions for the camp weekend are provided in the manual such as camp songs or chants, activities for cabin bonding, welcome art, and a grief walk.

**Post Camp.** At the conclusion of camp, the campers are offered the opportunity to reflect on their camp experience through a series of prompted questions such as “what part of camp didn’t you like? and, why didn’t you like it?” (TMF, p. 127, 2007). Please see Appendix A for an example of post-camp evaluations currently utilized. In order to provide outreach to campers after camp ends, TMF created a monthly newsletter, *The Blue Heron Reporter*. This newsletter aims to maintain camper connection as well as provide children with a reminder that they are not alone in their grieving. TMF has also

established a blog on their website for campers to access on a regular basis that includes topics such as “Surviving the Holidays and Tips for Moving Forward” and “Back to School—Helpful Tips for the Grieving Student (see <http://camperinworld.blogspot.com>). Additionally, the Camp Erin blog includes pictures, letters, and video from camp. TMF suggests that CDs create a digital photo album that can be shared with campers post-camp. As well, TMF encourages CDs to plan some type of follow-up or reunion for campers in an effort to maintain connection. Finally, CDs must submit a Camp Erin Post Camp Evaluation and Outcomes Report once camp has concluded (see Appendix G).

### **The Proposed Study**

This study was an evaluation of the potential effectiveness of Camp Erin. More specifically, the investigation explored whether levels of hope, depression, and competency in scholastics, close friendships, social acceptance, as well as feelings about physical appearance and self-worth, improve for bereaved children as a result of participation in Camp Erin. It was hypothesized that participant’s hope and self-perception will increase and depressive symptoms will decrease due to participating in the weekend-long bereavement camp intervention. As well, it was hypothesized that age and time since the death occurred will have an impact on the aforementioned variables. Participants were assessed at Pre-, Post-, and 8-week Follow-up intervention intervals. The following chapter provides an overview of procedures and measures used to obtain this information.

## **Chapter 3**

### **Method**

Camp Erin seeks to assist youth, ages 6-17, throughout the grieving process following the death of a significant loved one by providing a weekend of support and healthy coping strategies. Ultimately, Camp Erin aims to enhance well-being, positive coping skills, self-esteem, and social satisfaction for the participants of their program (The Moyer Foundation, Camp Erin Best Practices Guide, 2007; 2009). This Chapter describes the methods used for the current study. Participants, study procedures, and instruments are discussed.

#### **Overview of Present Study**

The current study is an evaluation of the potential impact of Camp Erin on participants' hope, depressive symptoms, and self-perception domains such as scholastic competency, close friendships, social acceptance, self-worth, and physical appearance. It was hypothesized that children who attend Camp Erin's weekend-long bereavement camps would demonstrate increased levels of hope and perceptions of domain-specific competency, as well as decreased depressive symptoms, at both post-intervention and follow-up intervals compared to pre-intervention data collection.

#### **Participants**

Participants in the current study were children and adolescents who attended Camp Erin due to experiencing the death of a significant loved one at some point during their childhood. Of the children who completed the pre-, post-, and 8-week follow-up measures, 48.8% had experienced a death within the last 12 months, 16.9% within the last 24 months, 22.5% had lost a loved one over two years ago, and 11.3% over five years ago. Some participants noted the loss of multiple relatives including father ( $n = 64$ ),

mother ( $n = 38$ ), grandmother ( $n = 21$ ), brother ( $n = 21$ ), extended relative ( $n = 21$ ), grandfather ( $n = 15$ ), sister ( $n = 11$ ), stepfather ( $n = 7$ ), a friend ( $n = 6$ ), stepmother ( $n = 1$ ), and other ( $n = 1$ ). Approximately 30-70 children attended each of these six camps and typically range from 6 to 17 years of age.

A total of 160 youth participated in the study. Of those 160 participants that originally completed the pre-camp measures, 107 completed post-camp measures, and 55 campers also completed the 8-week follow-up measure. Regarding gender, 91 females and 69 males participated. Participants eligible to participate attended Camp Erin at one of six camp locations during the summers of 2011 and/or 2012, and were between the ages of 9-17 ( $M=11.75$ ,  $SD=2.33$ ). If campers attended both years, only their 2012 data was used for this study. Although data from participants ages 6-8 would have been invaluable, children were required to be at least 9 years of age in order to complete some of the measures used according to the author of the instrument. Ethnicity of participants who initially completed measures for the study were comprised of 62.5% Caucasian, 11.9% Biracial/Multiracial, 8.1% American Indian/Alaska Native, 8.1% Black/African-American, 5% Hispanic/Latino, 1.9% Asian/Asian-American, 1.3% Other, .6% Other Pacific Islander, and .6% Unreported or Refused to Report. Finally, 25.6% of the participants had attended camp at least once prior to this study, and 59.4% had experienced at least some counseling prior to attending camp.

Data was collected from participants and their parent and/or caretaker throughout the summer camp seasons of 2011 and 2012. At the onset of the project, the national Camp Erin Program Manager contacted Camp Directors (CDs) of all Camp Erin camps across the nation and in Canada via e-mail to gauge interest in study participation. As

well, the Program Manager included an advertisement for the study in the online newsletter mailed to CDs on a monthly basis. Approximately seven CDs demonstrated interest in participating in the proposed study and six of these CDs successfully collected data from their respective camper families. The camps that participated in both 2011 and 2012 data collection included Detroit, MI, Albany, NY, Anchorage, AK, and Toronto, Canada. In 2012, the camps from Seattle, WA and Kansas City, MO joined this effort and contributed data to the study as well. Across camps, 33.8% of participants attended camp in Anchorage, AK, 27.5% from Albany, NY, 20% from Detroit, MI, 10% from Toronto, Canada, 4.4% from Seattle, WA, and 4.4% from Kansas City, MO. Each CD was required to complete the online Collaborative Institutional Training Initiative (CITI) training in order to obtain approval to collect data through the University of Nebraska-Lincoln Institutional Review Board (IRB).

### **Procedures**

Prior to beginning recruitment for this study, IRB approval from the University of Nebraska-Lincoln was obtained. As well, because many of the camps are housed in partnering organizations, additional review board approval was also mandatory for Albany, NY, Detroit, MI, and Toronto, Canada. In order to obtain approval to conduct research with the Toronto camp, the PI, UNL IRB, and CE representatives from the Toronto camp's partnering organization completed a Data Sharing Agreement, which required that the Toronto CD refrain from sending any identifying information for participants across the national border. For all six camps, packets including parental informed consent forms, youth assent forms, demographic forms, and measures were mailed to the CDs of each participating camp by the primary investigator (PI); please see

Appendices H, I, and J for these documents. The overview of the study, included in the consent and assent forms, provided information regarding the purpose of the study, requirements of participation, time commitment required to participate, and potential benefits and risks to participating. Due to low response levels in the summer of 2011, additional incentive was offered in 2012 for campers to complete pre-, post-, and 8-week follow-up assessments in the form of entry in to a raffle to win an Xbox donated by TMF. This information was included in the initial overview of the study, was approved by UNL IRB (please see Appendices K and L), and campers were notified they had approximately a 1 in 300 chance of winning. Additionally, campers and their parents/guardians were informed that their information would be held in strict confidence and that they had the right to decline or withdraw from participating at any time without penalty. As well, the consent and assent forms explained the benefits of the proposed study to Camp Erin and the Moyer Foundation. Finally, participants and their parents/caretakers were informed that they may contact the PI, the Moyer Foundation, and/or UNL IRB at any time with questions about the study.

As part of Camp Erin's standard procedures, campers are asked to meet with the camp's CD or Clinical Director (CLD) approximately one month prior to attending camp. This meeting serves to further inform the camper and family about what camp will entail and ensures camper readiness and fit (e.g., if the child is not functioning well or the death is too recent for the child to speak about, camp may not be of benefit to her/him at this time). During this initial meeting, CD/CLDs introduced the study to the campers and their parents/caretakers, and some obtained parental consent and youth assent and then administered the pre-intervention questionnaire packet. Other CD/CLDs collected

consent/assent and this same data at a pre-camp group gathering due to time and resource constraints. For both the group data collection and individual meeting collections, CDs/CLDs mailed all of the pre-camp data collected in a self-addressed envelope that was provided by the PI to the office of the PI.

Immediately after each camp ended in 2011, the PI mailed a post-intervention questionnaire packet to each participants' home. This packet of measures included a letter with instructions (see Appendix M) and a self-addressed stamped envelope to return the completed packet to the PI. In 2012, four of the camps administered the post-intervention questionnaire on the last day of camp in lieu of TMF standard post-camp evaluations. For the camps that administered pre- and post-camp measurements, both of the completed measures were then mailed in the same packet to the office of the PI. This change in administration of the post-camp questionnaires was due to low response rate in 2011.

Eight weeks after camp concluded, a follow-up instructional letter (see Appendix N), packet of measures, and a self-addressed stamped envelope was mailed to the homes of participants. In the instructional letter for the measures at post-camp and eight-week follow-up, a deadline was indicated for completion of the measurement packet, as well as emphasis on how their input may assist in the continued success of Camp Erin. As well, a follow-up phone call and/or e-mail from the PI was made/sent to remind participants to return the measurements. In order to enhance camper participation at the eight-week follow-up measurement point, in 2012 two camps held an eight-week reunion party for campers to reunite with one another following their camp experience and complete follow-up paperwork. When the assessments were administered by CDs at the reunion party, the packets were then mailed to the office of the PI.

## Instruments

Three measures were used to assess the effectiveness of Camp Erin on the experience of grieving youth. Because of the wide range of cognitive ability, and age recommendations for appropriate use of measures, participation was limited to campers aged 9-17 years. Additionally, demographic data regarding participants and their parents was collected to further enhance the study.

**Children's Hope Scale.** The Children's Hope Scale (CHS; Snyder et al., 1997) is a six-item self-report instrument that measures the level of agency and pathway hope for children ages 8-19 years (see Appendix O). Agency hope for children is defined as the degree to which children believe they can attain their goals. Pathway hope is defined as the ability for children to identify various means to achieve a desired outcome in their lives (Snyder et al., 1997). Participants are asked to look at each statement and choose the response on a 6-point scale, ranging from 1 (*none of the time*) to 6 (*all of the time*). When administering the assessment to children, this scale is labeled, "Questions About Your Goals," rather than "The Children's Hope Scale" (Snyder et al., 1997). The CHS is scored by summing the items, with higher scores indicating increased levels of hope. The three odd-numbered items on the scale tap agency-related issues, whereas the three even-numbered items tap pathways. Convergent validity was demonstrated by correlations with the Self-Perception Profile for Children (SPP-C; Harter, 1985), the Children's Attributional Style Questionnaire (Kaslow, Tanenbaum, & Seligman, 1978) and the Children's Depression Inventory (CDI; Kovacs, 1992) scales. Good internal consistency reliability has been demonstrated with  $\alpha$  ranging from .72 to .86, with a median  $\alpha = .77$  (Snyder et al., 1997). Good one-month and one-week test-retest reliability has been

demonstrated ( $r = .71$ ;  $r = .73$ ) (Snyder et al., 1997). Internal consistency reliability for scores on the CHS for the current study (pre-test) was  $\alpha = .83$ .

**Self-Perception Profile for Children.** The Self-Perception Profile for Children (SPP-C; Harter, 1985; 1988) was originally designed to measure self-esteem for youth ages 8 and over, and the instrument (Harter, 1988) used in this study includes the following subscales: (a) scholastic competence (SC), (b) social acceptance (SA), (c) close friendships (CF), (d) self-worth (SW), and (e) physical appearance (PA) (see Appendix P). This assessment was developed in order for children to judge their competency in several domains as well as to evaluate their self-worth (Harter, 1985; Meijer, Egberink, Emons, & Sijtsma, 2008). For each subscale, participants choose one of two statements that would apply to him or her, and indicate if this is “sort of true for me” or “really true for me” (Harter, 1985). Responses are indicated on a 4-point scale and scored inversely. Higher scores reflect higher levels of perceived competency in each domain. Convergent validity was demonstrated by correlations with the Roster and Rating Scale (Roitascher, 1971), Iowa Test of Basic Skills (ITBS) scales. In Harter’s (1985) initial use of the scale, internal consistency of the subscales ranged from .71 to .86. Relatedly, Meijer et al. (2008) found internal consistency to range from .68 to .83 on the subscales, and scores only differed slightly between boys and girls (e.g., 5%). Regarding test-retest reliability, Harter (1985) suggests that perceptions of global self-worth will remain stable between the ages of 8 to 11 years, and asserts that global self-worth is linked to competencies in various domains. For the current study, internal consistency reliability ranged from .42 to .70, with SC  $\alpha = .42$ , SA  $\alpha = .59$ , CF  $\alpha = .63$ , SW  $\alpha = .50$ , and PA  $\alpha = .70$ .

**Child Depression Inventory-Short Form.** The Child Depression Inventory-Short Form (CDI-S; Kovacs, 1992; Kovacs & Beck, 1977) is a ten-item, self-report instrument designed to measure the presence and severity of depressive symptoms in children and adolescents ages 7-17 years (see Appendix Q). The CDI was initially conceptualized by Kovacs and Beck (1977) and later appeared as a 27-item inventory (Kovacs, 1992). The CDI-S is an empirically developed measure used to quickly assess a child's current level of depression, and the results are comparable to the full CDI (Kovacs, 1992). The CDI-S measures five factors of depression, including (a) negative mood/dysphoria (e.g., "I am sad"), (b) low self-esteem/self-concept (e.g., "I look ugly), (c) interpersonal problems (e.g., "I get in fights all the time"), (d) ineffectiveness (e.g., "I can never be as good as other kids"), and (e) anhedonia (e.g., "nothing is fun at all").

Participants are given three statements for each item listed and asked to answer which response best describes how they have been feeling during the last two weeks. Total scores range on each item from 0-2 and total scores greater than 7 indicate increased levels of depressive symptoms. Convergent validity was demonstrated by correlations with the Reynolds Adolescent Depression Scale (RADS; Reynolds, 1997, 1988), the Behavior Problem Checklist (BPC; Achenbach, 1992), and the Walker Problem Behavior Identification Checklist (Walker, 1970, 1976, 1983) scales. Internal consistency coefficients range from .71 to .89, and test-retest coefficients range from .74 to .83 (Kovacs, 1992). Internal consistency reliability for scores on the CDI-S for this study (pre-test) was  $\alpha = .78$ .

## **Analyses**

To evaluate the effectiveness of Camp Erin, a within-groups, repeated measures analysis of variance (ANOVA) was utilized via SPSS to analyze Pre-, Post-, and Follow-up data on the CHS, CDI-S, and SPP-C subscales. Total scale scores of the CHS and CDI-S were utilized to determine current levels of hope and depressive symptomology, respectively. Subscale scores for the SPP-C were analyzed to assess levels of domain-specific competency. The participants' age and duration of time between experience of death and attending camp were used as covariates in the analyses to account for within group variance. All participant data were entered and analyzed using SPSS and those with missing data were still included in the overall analysis.

## Chapter 4

### Results

For this study, a repeated-measures within-group analysis was performed using data collected at Pre-, Post-, and Follow-Up intervals. All three time intervals were entered into a repeated-measures ANOVA to reveal changes across time for participants. The following paragraphs describe results for the CHS, CDI-S, and SPP-C subscales. First, information for each scale across the three different time intervals will be presented. Second, results for ANCOVA analyses using age and time since death as covariates will be explained. Table 1 provides information regarding results of the scales at Pre-, Post-, and Follow-Up intervention (please see page 79).

#### **Children's Hope Scale (CHS).**

A within-groups repeated-measures ANOVA with follow-up analysis using the LSD procedure ( $p = .05$ ) was performed to examine the impact of Camp Erin on levels of hope on the Children's Hope Scale over time. Multivariate analysis revealed there was no significant increase in hope over time at the Pre-, Post-, or 8-week follow-up:  $F(2, 53) = 1.375, p = .262, MSe = .312$ . As well, there was no significant linear trend in the data,  $F(1, 49) = 1.866, p = .178, MSe = .210$ , and no significant quadratic trend ( $p = .823$ ).

However, when adding age ( $M = 11.75, SD = 2.33$ ) and time since death ( $M = 1.98, SD = 1.12$ ) as covariates using a within-groups repeated-measures ANCOVA, there was a significant difference over time,  $F(2, 51) = 4.854, p = .012$ . Mean scores increased over time for Pre-camp ( $M = 1.70, SD = .28$ ), Post-camp ( $M = 1.71, SD = .28$ ), and at 8-week follow-up ( $M = 1.78, SD = .24$ ). Participants 13-17 years of age scored somewhat higher in levels of hope ( $M = 4.67, SD = .88$ ) than participants 9-12 years old ( $M = 4.08,$

$SD = .67$ ). In addition, there was a significant linear trend for hope controlling for age and time since death, ( $p = .005$ ) and no significant quadratic trend ( $p = .481$ ).

### **Children's Depression Inventory-Short Form (CDI-S).**

A within-groups repeated-measures ANOVA with follow-up analysis using the LSD procedure ( $p = .05$ ) was performed to examine the impact of Camp Erin on depressive symptoms over time using the CDI-S. As hypothesized, multivariate analysis revealed there was a significant difference across time in measures of depressive symptoms at the Pre-, Post-, and 8-week follow-up:  $F(2, 50) = 4.001, p = .020, MSe = .033$ . As well, there was a significant linear trend in the data,  $F(1, 51) = 5.735, p = .020, MSe = .028$ , and no significant quadratic trend, ( $p = .349$ ). These results indicate that symptoms of depression decreased across time intervals. Post-hoc analysis demonstrated a significant difference between Pre-Camp and Follow-Up CDI-S scores ( $p = .020$ ), and between Post-Camp and Follow-Up CDI-S scores ( $p = .033$ ), but results were not significant for Pre-Camp to Post-Camp scores ( $p = .829$ ).

When adding age ( $M = 11.75, SD = 2.33$ ) and time since death ( $M = 1.98, SD = 1.12$ ) as covariates to the within-groups repeated-measures ANCOVA, multivariate analysis revealed no significant improvement over time,  $F(2, 48) = 1.048, p = .359$ . Additionally, when controlling for age and time since death, there was no significant linear trend ( $p = .377$ ) and no significant quadratic trend ( $p = .188$ ). As well, in examining rate of attrition for participants using a univariate ANOVA, level of depression was not a significant contributor ( $p = .538$ ).

### **Self-Perception Profile for Children (SPP-C).**

The SPP-C scale was designed to score subscale specific items (Harter, 1988). The following results include analyses of the following subscales: (a) Scholastic Competency, (b) Social Acceptance, (c) Close Friendship, (d) Self-Worth, and (e) Physical Appearance as it pertains to participant responses at Pre-, Post-, and 8-week follow-up.

**Scholastic Competency Subscale (SPP-C).** A within-groups repeated-measures ANOVA with follow-up analysis using the LSD procedure ( $p = .05$ ) was performed to examine the effects of Camp Erin on scholastic competency. Multivariate analysis revealed there was no significant difference over time,  $F(2, 50) = 1.471, p = .239$ . Additionally, there was no significant linear trend in the data,  $F(1, 51) = 2.145, p = .149$ ,  $MSe = .220$  and no significant quadratic trend,  $F(1, 51), p = .837$ .

When adding age ( $M=11.75, SD=2.33$ ) and time since death ( $M = 1.98, SD = 1.12$ ) as a covariates to a within-groups repeated-measures ANCOVA, there was no significant difference over time pertaining to scholastic competency,  $F(2, 48) = .976, p = .384$ . In addition, there was no significant linear trend ( $p = .178$ ) and no significant quadratic trend ( $p = .823$ ) as it pertains to age and scholastic competency.

**Social Acceptance Subscale (SPP-C).** A within-groups repeated-measures ANOVA with follow-up analysis using the LSD procedure ( $p = .05$ ) was performed to examine social acceptance on the SPP-C. As hypothesized, multivariate analysis revealed there was a statistically significant difference over time,  $F(2, 50) = 4.270, p = .019$ . Results of the SPP-C social acceptance subscales are significant in the predictive direction for Pre-camp ( $M = 2.76, SD = .66$ ), Post-camp ( $M = 3.02, SD = .61$ ), and at 8-

week follow-up ( $M = 3.05$ ,  $SD = .59$ ). Additionally, there was a significant linear trend in the data,  $F(1, 51) = 2.144$ ,  $p = .005$ ,  $MSe = .249$  and no significant quadratic trend ( $p = .158$ ). Post-hoc analysis demonstrated significance between Pre-Camp and Follow-Up SPP-C scores ( $p = .005$ ) and Pre-Camp to Post-Camp SPP-C scores ( $p = .021$ ), but results were not significant for Post-Camp to Follow-Up ( $p = .670$ ).

When adding age ( $M = 11.75$ ,  $SD = 2.33$ ) and time since death ( $M = 1.98$ ,  $SD = 1.12$ ) as covariates to the within-groups repeated-measures ANCOVA, multivariate tests revealed there was no significant difference over time pertaining to social acceptance,  $F(2, 48) = .352$ ,  $p = .705$ . In addition, there was a no significant linear trend ( $p = .873$ ) and no significant quadratic trend ( $p = .492$ ) as it pertains to age and scholastic competency.

**Close Friend Subscale (SPP-C).** A within-groups repeated-measures ANOVA with follow-up analysis using the LSD procedure ( $p = .05$ ) was performed to examine close friendships on the SPP-C. Multivariate analysis indicated there was no significant difference over time,  $F(2, 50) = .489$ ,  $p = .616$ . Additionally, there was no significant linear trend in the data,  $F(1, 51) = .485$ ,  $p = .490$ ,  $MSe = .282$  and no significant quadratic trend  $F(1, 51) = .503$ .

When adding age ( $M = 11.75$ ,  $SD = 2.33$ ) and time since death as a covariates to the within-groups repeated-measures ANCOVA, there was no significant difference over time pertaining to close friendship,  $F(2, 48) = .954$ ,  $p = .392$ . In addition, there was no significant linear trend ( $p = .986$ ) and no significant quadratic trend ( $p = .170$ ) as it pertains to close friendship.

**Self-Worth Subscale (SPP-C).** A within-groups repeated-measures ANOVA with follow-up analysis using the LSD procedure ( $p = .05$ ) was performed to examine self-worth on the SPP-C. Multivariate analysis revealed there was no significant difference over time,  $F(2, 50) = 1.39, p = .259$ . Additionally, there was no significant linear trend in the data,  $F(1, 51) = 1.702, p = .198, MSe = .347$  and no significant quadratic trend  $F(1, 51) = 1.298, p = .260$ .

When adding age ( $M=11.75, SD=2.326$ ) and time since death ( $M = 1.98, SD = 1.12$ ) as covariates to the within-groups factorial ANCOVA, there was no significant difference over time pertaining to self-worth,  $F(2, 48) = .109, p = .897$ . In addition, there was a no significant linear trend ( $p = .640$ ) and no significant quadratic trend ( $p = .998$ ) as it pertains to self-worth on the SPP-C.

**Physical Appearance (SPP-C).** A within-groups repeated-measures ANOVA with follow-up analysis using the LSD procedure ( $p = .05$ ) was performed to examine feelings about physical appearance on the SPP-C. Multivariate analysis revealed no significant difference over time in tests of physical appearance,  $F(2, 49) = .794, p = .458$ . Additionally, there was no significant linear trend in the data,  $F(1, 50) = .028, p = .867, MSe = .289$  and no significant quadratic trend ( $p = .217$ ).

When adding age ( $M=11.75, SD=2.33$ ) and time since death ( $M = 1.98, SD = 1.12$ ) as covariates to the within-groups repeated-measures ANOVA, there was no significant difference over time pertaining to physical appearance,  $F(2, 47) = 1.403, p = .256$ . In addition, there was a no significant linear trend ( $p = .902$ ) and no significant quadratic trend ( $p = .097$ ) as it pertains to physical appearance on the SPP-C.

Table 1  
*Means and Standard Deviations by Study Variable*

	Pre	Post	Follow-Up
CHS	4.15 (.92) <i>n</i> = 161	4.22 (.80) <i>n</i> = 107	4.33 (.81) <i>n</i> = 55
CDI-S	1.70 (.28) <i>n</i> = 158	1.71 (.28) <i>n</i> = 103	1.78 (.24) <i>n</i> = 53
SPP-C – Scholastic	2.90 (.57) <i>n</i> = 154	2.95 (.55) <i>n</i> = 104	3.03 (.53) <i>n</i> = 54
SPP-C – Social Acceptance	2.76 (.66) <i>n</i> = 154	3.02 (.61) <i>n</i> = 104	3.05 (.59) <i>n</i> = 53
SPP-C – Close Friendship	2.87 (.65) <i>n</i> = 154	2.96 (.64) <i>n</i> = 104	2.94 (.73) <i>n</i> = 53
SPP-C – Self-Worth	2.90 (.61) <i>n</i> = 154	3.05 (.62) <i>n</i> = 104	3.05 (.68) <i>n</i> = 53
SPP-C – Physical	3.01 (.75) <i>n</i> = 152	2.91 (.80) <i>n</i> = 104	3.03 (.70) <i>n</i> = 52

## **Chapter 5**

### **Discussion**

The purpose of this study was to conduct an evaluation of the potential impact of Camp Erin, a weekend-long bereavement camp for children and adolescents who have experienced the loss of a loved one. This chapter presents a discussion of the current study's findings and related implications. First, findings related to the research questions presented in Chapter 1 are presented. Next, limitations to the study are explored. Finally, the chapter concludes with implications for future work in child bereavement and a discussion of overall conclusions drawn from the study.

Campers attending Camp Erin range in age from 6-17 years and participants were required to be 9 years old to take part in the study. The primary variables evaluated were levels of hope, symptoms of depression, and self-perception as it relates to subscales in scholastic competency, social acceptance, close friendships, self-worth, and physical appearance. These variables were assessed at Pre-, Post-, and at 8-week follow-up intervals. The current study offers a quantitative evaluation regarding the impact of Camp Erin on campers and their perceived sense of self-competence and reliance.

**Children's Hope Scale (CHS).** The findings of this study were somewhat consistent with the hypothesis that Camp Erin may improve participants' levels of hope. When accounting for age and time since death, findings for improvement in hope were statistically significant. As well, when adding age and time since death as covariates to the analysis, there was a statistically significant linear trend. However, initial statistical analyses of hope without controlling for any other factors did not reveal any significant findings related to the impact of Camp Erin across the three time intervals.

The significant findings related to hope indicate that campers 13-17 years of age demonstrated slightly more of an increase in hope ( $M = 4.67$ ,  $SD = .88$ ) than campers 9-12 years of age ( $M = 4.08$ ,  $SD = .67$ ). This finding may be illustrative of Piaget's theory of cognitive development in that older campers may potentially be able to think more abstractly about their own life beyond the loss. As well, it may be demonstrative of a certain level of maturity and ability to think about how to achieve certain goals which may enhance feelings of hopefulness.

When examining hope and time since death exclusively, age appeared to positively impact the level of hope across time for participants, but time since death did not have an impact on its own. This may be due to a variety of reasons that can only be speculated. First, youth cognitive development, including the comprehension of death develops and increases over time; thus, the results may indicate that age is a strong component in both understanding the event that has occurred and the level at which they feel hopeful. Second, referring to the Hopelessness Theory of Depression (1989), there may be no significant change in hope due to time since death as a result of the individual's inferences about the event and about themselves as a result.

**Children's Depression Inventory-Short Form (CDI-S).** Consistent with the study hypotheses, Camp Erin may decrease levels of depressive symptoms. Results of the CDI-S indicated that there was a statistically significant change over time in symptoms of depression for youth. As well, there was a significant linear trend in the data and mean scores improved across time. Thus, results indicate that attending Camp Erin may assist participants in feeling a decrease in feelings such as isolation and hopelessness. Although Camp Erin is only a weekend-long camp, it is encouraging to note that campers

experience an improvement regarding their symptoms of depression after involvement in this type of intervention.

However, when accounting for age and time since death, findings were not significant. Thus, age and time since death did not have an impact on change in depressive symptoms over time for participants. These results are surprising, as many authors have noted differences in levels of depressive symptoms based on both age (Scott, 2004; Webb, 2002) and time since death (Cerel, 2006; Dowdney, 2000; Dowdney et al., 1999). Explanation for this outcome can only be speculated, but is perhaps because it was not a longitudinal study over several years or a larger sample, which may have created a more distinct difference across campers. Additionally, in examining whether initial levels of depression at Pre-Camp impacted rate of attrition for the study, results were not significant. Thus, it appears as though depressive symptoms did not have an impact in whether or not participants remained in the study across time.

**Self-Perception Profile for Children (SPP-C).** Self-perception for youth was analyzed using subscales included on the SPP-C, including scholastic competency, social acceptance, close friendship, self-worth, and physical appearance.

Results for the scholastic competency subscale (SC) were not significant and do not indicate a difference across time in SC as a result of attending Camp Erin. Reasons for this lack of significance can only be speculated, but could be due to the brevity of time spent in camp and lack of relatedness in camp experience or activities related to academics. As well, internal consistency reliability for this subscale was low ( $\alpha = .42$ ), demonstrating this scale did not work effectively for this population and provides further understanding for why results were not significant.

Results for social acceptance (SA) yielded significant results in scores across time intervals. There was a significant linear trend in the predicted direction, indicating that feelings of social acceptance improved as a result of attending camp. This may be due to time spent with other youth who have experienced loss and feelings of social acceptance by other peers may influence a more global sense of social acceptance (Bhagwan, 2009; Holland, 2001; The Moyer Foundation, 2009; Weber & Fournier, 1985). However, when controlling for age and time since death, results were not significant.

Findings with respect to close friends (CF) showed no significant change in level of competency in relating to and/or obtaining close friendships. Reasons for the lack of significant results may only be speculated, but may be due again to brevity of camp experience and lack of relatedness in camp experience or activities focused on obtaining close friendships. Additionally, internal consistency reliability for this subscale was low ( $\alpha = .63$ ), indicating this scale did not work effectively for this sample and providing further evidence for why results were not significant.

Regarding self-worth (SW), results indicated no significant improvement in this domain as a result of attending camp. Additionally, there were no significant results when adding age and time since death as covariates. Due to the brief nature of the camp experience, there may not be enough time or interaction to enhance feelings of self-worth for youth. Furthermore, internal consistency reliability for this subscale was low ( $\alpha = .50$ ), indicating this scale did not work effectively for this sample and further assists in understanding why results were not significant.

Scores on the physical appearance (PA) subscale revealed no significant differences over time for campers. Again, reasons for these results can only be speculated, but may be due to a lack of focus on physical appearance at Camp Erin.

As hypothesized, Camp Erin appears to have a positive impact on campers and it is encouraging to note that there were some significant findings. This study highlights the positive impact of early interventions for youth who are grieving. Non-significant findings may be due to myriad reasons and several of these concerns will be addressed. First, findings from this study may reflect the daunting nature of completing the forms for children and adolescents for two reasons: (a) time and attention is difficult for grieving families and each of these packets took participants approximately 20 minutes to complete, and (b) many youth wrote down their own responses to some measurement items (e.g., “I am beautiful!” “I love myself!”) which may suggest the scales utilized in this study do not fully capture the wide variety of potential responses from participants. Second, although the SPP-C scale is a widely used and respected measurement, it demonstrated poor internal consistency on the subscales indicating that the subscales did not work as intended for this sample. Additionally, it may be slightly outdated and difficult for children to complete. Numerous CDs in this study indicated this scale was the most difficult for youth to complete for this study, as there are 29 items on the scale and participants must make two distinct choices for each item and this may create less focus on completing the task. Third, *type* of death was not examined in this study and this may impact level of coping and feelings of self-efficacy. This information may help to further understand the impact of Camp Erin on levels of hope, depression, or self-perception if more knowledge about the loss was available. Although Camp Erin is only a

small piece of the healing process for grieving children and adolescents, positive trends and significant improvements indicate that interventions such as bereavement camps are beneficial in increasing hope and feelings of social acceptance, and decreasing feelings of isolation for youth.

### **Strengths and Limitations**

There are both strengths and limitations with respect to the current study. First, with regard to strengths, it is the first quantitative study to date to evaluate the impact of a bereavement camp on participants and provides a model from which to draw from in moving forward with intervention and prevention for bereaved youth. Second, the PI worked closely with Camp Erin staff to determine the variables of interest and may be the foundation from which other evaluations of this kind may develop. There still remains a wealth of information to be discovered in child bereavement and camp intervention, and this study marks the beginning of such effort. Third, this study provides TMF with valuable data to share with prospective donors while advocating for additional funding for campers and the creation of new camp locations in order to assist future youth in need of services. Overall, this study yielded some positive effects and serves as one prospective model for conducting intervention research with bereavement camps for grieving youth.

Several limitations to this study should also be noted. First, due to poor participation rates, there was no control group used for the study to compare the potential impact of Camp Erin for those who had attended camp and those who had not. Additionally, although there was some improvement over time for participants, this may also be due to the natural course of healing from a loss over time. Thus, results of this

study may be informative to future studies, but caution should be used in making any direct causal interpretations of the data.

Second, many youth and families who have experienced the loss of a loved one may be experiencing increased stress and completing additional forms for research purposes may seem like a daunting task. Throughout the process of gathering data, some CDs noted the difficulty in asking families to complete additional paperwork while in the midst of grieving. As well, although self-addressed and stamped envelopes were provided for families to complete and return Post- and 8-week follow-up packets, numerous participants appeared to have some difficulty in returning the measurements, even with prompting from the CD and the PI.

Third, although Camp Erin requires a certain level of consistency across camp locations, some camps differ with regard to specific planned activities included during the camp weekend and if the CD meets with campers individually or as a group to complete pre-camp evaluations. Although CDs are required to meet certain conditions set forth by TMF, there is some flexibility in activities initiated during the camp weekend. As well, CDs are required to meet with campers before camp begins, but some found difficulty in adding the questionnaire packets from this study with the other paperwork required for camp participation during the individual meeting between camper and CD. Thus, some CDs chose to administer packets for this study at a Pre-camp group gathering rather than during individual meeting sessions.

As well, in analysis of the data, many campers had experienced the death of multiple loved ones at different time periods. In reflection, there should have been a way in which caregivers and campers could note the loved one who died and the time period

since they lost that specific person. Instead, the demographics form allows participants to check multiple loved ones who may have died and multiple time periods and it is unclear which timeframe pertains to each family member lost.

Finally, it is unclear why participants may have initially indicated interest in the study and completed Pre-camp measures and did not follow up with Post-camp evaluation. Reduction in participation occurred again between Post-camp and 8-week follow-up measures and the reasons can only be speculated. As previously mentioned, one of the scales was especially difficult and lengthy for youth to complete and participants may have not realized the time or effort required. Additionally, one may surmise that prior to attending camp, participants may have felt more enthusiastic about completing items related to the upcoming camp experience, but later lost interest. As well, children and families may have many types of measurements and forms they are required to complete and one that is voluntary may not be a priority.

### **Future Directions**

This study ignites several other questions for future research. First, as mentioned in the limitations, a control group should be utilized to further provide support for findings. Although time would impact both groups, it would be important to create a comparison between those who had attended Camp Erin and those who had not. Use of a control group would serve to further support outcomes in future studies. For organizations that regularly work with grieving families, there may be more access to participants who are utilizing their program's services and also participating in camp and those who have decided to use services without camp involvement.

Second, obtaining information on cause of death and expectancy related to the death as it relates to hope and symptoms of depression would be a worthy study. This may serve to further enhance understanding related to levels of depressive symptoms as well as social acceptance. As well, it would be useful to examine the variables of this study when a death was either expected or unexpected. This may be an important factor in understanding the manner in which youth are coping with the death and relating with others.

Third, it would be highly beneficial to garner more participants and CDs to help with future studies to ensure a more comprehensive understanding of the potential impact of Camp Erin. A larger sample size may impact significance of results and create the ability for further examination of variables such as (a) cause of death, (b) level of severity of depressive symptoms and related retention in the study, (c) level of support campers experience either by having a sibling attend camp, or (d) support received from other siblings in the same age living in the home. As well, it may be beneficial to see if there was a response difference in campers who attend grief counseling and those who do not. Campers who have attended or are attending counseling may have already obtained some healthy coping skills and it would be informative to examine whether counseling creates a significant difference.

Additionally, there was not enough participation in the study from 2011 to produce significant results, and because of this, a second year of collecting data was required. Therefore, there are some slight differences in data collection between 2011 and 2012. First, Pre-camp measures were collected in the same manner as previously mentioned for both years. However, in 2012, TMF allowed CDs to administer Post-camp

packets for this study in place of their typical camp evaluations in order to increase retention for the study. Four of the six camps agreed to participate in this new arrangement and collected Post-camp data on the final day of camp. Thus, in 2011 all Post-camp measures were mailed from the homes of the campers to the office of the PI, and in 2012 this same strategy was utilized in addition to 4 of the 6 camps administering Post-camp measures on the last day of camp. Second, in 2011 all 8-week follow-up measures were mailed from the homes of the campers to the office of the PI. In 2012, two camps collaborated with TMF and the PI to provide an 8-week reunion party in order for campers to complete the 8-week follow-up measurements in an effort to increase participation to the follow-up measurement point. CDs for these two participating sites hosted campers at their respective organizations and provided campers with food and an opportunity to socialize with one another.

In collaboration with TMF, 2012 data collection included incentives such as winning an Xbox. The opportunity to win an Xbox was included in informed consent and assent forms and indicated a requirement for campers to complete each of the three measurement points in order to be eligible for the raffle and campers and/or caregivers could still refuse to participate at any time or to not receive an Xbox if they were chosen as the winner. The addition of this incentive was approved by UNL IRB in 2012. This information about potential to win the Xbox was also included in the 8-week follow-up letter. The differences described between 2011 and 2012 were initiated due to poor participation rates in 2011 and should be noted as a caution and suggestion to those moving forward with research in this particular area of study.

Finally, this study was conducted using instruments that most closely gathered information on what TMF requested to know about their camp experience. There are additional variables and scales that would be useful for this population. Measures examining variables such as anxiety, complicated grief, and attachment would also be highly interesting topics to explore. This study provides numerous avenues for future research on child bereavement camps as interventions for youth and may provide the foundation for a more thorough understanding of the positive impact of bereavement camps.

### **Conclusion**

For children and adolescents, the experience of grief at a young age may contribute to anxiety, depression, and other negative mental health outcomes (Black, 1985; Cerel et al., 2006; Dowdney, 2000; Holland, 2001; Mahon, 2009; Morgan & Roberts, 2010; Weber & Fournier, 1985; Weller, Weller, Fristad, & Bowes, 1991). An estimated 5% of youth will experience the loss of a loved one prior to the age of 15 (Currier, Holland, & Neimeyer, 2007). Numerous studies have revealed that children and adolescents who experience grief during childhood are more likely to develop a psychiatric disorder in later childhood or into adulthood than those who have not (Black, 1998; Cerel et al., 1999; Holland, 2001; Mahon, 2009; Morgan & Roberts, 2010; Weber & Fournier, 1985; Van Eederwegh, 1985). Thus, researchers in childhood bereavement have strongly suggested creating an environment for youth to discuss and explore their feelings in an open and supportive manner to fully process and understand the death (Bhagwan, 2009; Holland, 2001; Weber & Fournier, 1985).

Camp Erin was established in 2002 in an effort to normalize youth loss and grieving and provide children and adolescents with a supportive camp environment. As an early childhood bereavement intervention effort, Camp Erin has provided services for nearly 10,000 youth and 2,166 campers attended camp in the 2012 during the most recent camp season (TMF, 2012). Studies have noted that early intervention efforts may decrease the anxiety, fear, sadness, negative coping strategies, and anger regarding death-related concerns (Black, 1996; Black & Urbanowich, 1987; Kubler-Ross, 1969; 1972) and establish an opportunity for individuals to openly discuss their feelings in a safe and meaningful way (Christ, 2000; Hung & Rabin, 2009; Morgan & Roberts, 2010; The Moyer Foundation, 2007).

Myriad interventions are currently available to assist youth in the grieving process such as individual and peer counseling, support groups, family and group therapy, and weekend retreats or camps such as Camp Erin (Currier et al., 2007; The Moyer Foundation, 2007; Webb, 2002). However, few outcome studies have been conducted for these interventions (Currier et al., 2007; Maciejewski et al., 1997) as grieving youth and their families can be a difficult population to assess and retain. The current study served as the first quantitative study on youth bereavement camps to date. This investigation explored whether levels of hope, depression, and competency in scholastics, close friendships, social acceptance, as well as feelings about physical appearance and self worth would improve for bereaved youth (ages 9-17) as a result of participation in Camp Erin. Participants attended the 2011 and/or 2012 camp season at one of six participating camps and were assessed at Pre-, Post-, and 8-week follow-up intervals. Three measures were used to examine these variables: (a) Children's Hope Scale (CHS; Snyder et al.,

1997), (b) Children's Depression Inventory (CDI-S; Kovacs & Beck, 1977; Kovacs, 1992), and (c) subscales of the Self Perception Profile for Children (SPP-C; Harter, 1988). Data were analyzed using SPSS repeated-measures within-group factorial ANOVA to examine the impact of Camp Erin on camper experience. The current analyses revealed a statistically significant increase in hope when controlling for age and time since death, decrease in depressive symptoms, and increase in feelings of social acceptance.

As hypothesized, Camp Erin had a significant positive impact on campers. Although this study demonstrates promise in that it produced some positive effects with bereaved youth, the findings should be replicated with other Camp Erin campsites, with a larger sample size, employing many of the strategies introduced during data collection for the 2012 camp season. Although it is possible that different instruments or varying methods of collecting data from campers would yield additional significant results, it is evident that participants experienced some increase in hope, decrease in depressive symptoms, and increase in self-acceptance as it pertains to self-perception from Pre-camp to 8-week follow-up. It is hoped that this study provides reassurance to professionals who care for bereaved youth, and ignites interest in future bereavement intervention research.

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## Camp Erin 2010 – Camper Evaluation



Your Name: \_\_\_\_\_

Age: \_\_\_\_\_

Please tell us about the person who died.

What was your favorite part of camp?

What were your favorite activities?

What would you change about camp?

Did camp help you understand your grief feelings?  
If yes, how?

Yes

No

Were you surprised by anything at camp?

What is one thing you learned at Camp Erin that will help you cope with your loss?

Are you glad you came to Camp Erin?	Yes	No	Not Sure
Did you feel understood at Camp Erin?	Yes	No	Not Sure
Was it helpful to be around kids your age that had someone they know die?	Yes	No	Not Sure
Did Camp Erin help you talk about your feelings?	Yes	No	Not Sure
Did you learn anything at Camp Erin to help you deal with your feelings?	Yes	No	Not Sure
Did you have a chance to share your feelings at Camp Erin?	Yes	No	Not Sure
Did you make friends & connect with kids your own age?	Yes	No	Not Sure
Did you feel safe & comforted at Camp Erin?	Yes	No	Not Sure

Did you find camp...

	N/A	A little			A lot	
Useful	0	1	2	3	4	5
Fun	0	1	2	3	4	5
Inspiring	0	1	2	3	4	5

What did you learn at camp that was new to you (check all that are true for you)?

All feelings are okay \_\_\_\_\_

We all grieve in our own way \_\_\_\_\_

There are many healthy ways to show my grief

(like arts & crafts, creative writing, movement, play, etc)? \_\_\_\_\_

It is okay to cry and it is okay to laugh again \_\_\_\_\_

Remembering and talking about the person who died is ok \_\_\_\_\_

Lots of kids and adults have experienced a death \_\_\_\_\_

It's okay to have all kinds of memories about the person who died \_\_\_\_\_

We are not alone in our grief \_\_\_\_\_

Anything else? \_\_\_\_\_

If you could, would you come again?

If you could, would you be a Cabin Big Buddy someday?

**Thank you so much for attending Camp Erin!**  
**Welcome to the Camp Erin Alumni Club!**

# Camp Erin 2010 – Camper Evaluation



Your Name: \_\_\_\_\_

Age: \_\_\_\_\_

Share with us who died \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is it easier to talk about the death now, than it was before I came to Camp Erin?



Yes



Maybe



No

Did you learn at camp that it's okay to have all kinds of feelings when someone dies?



Yes



Maybe



No

Was it helpful to meet other kids who have had someone die?



Yes



Maybe



No

Did you like coming to Camp Erin?



Yes



Maybe



No

Do you think other kids would find Camp Erin helpful?



Yes



Maybe



No

What was your favorite part of camp? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What didn't you like about camp? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you think Camp Erin is helpful for grieving kids?



A little



Kind of



A lot

Did Camp Erin make you feel better?



A little



Kind of



A lot

Did you find Camp Erin fun?



A little



Kind of



A lot

Share one thing you learned at Camp Erin? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Thank you so much for attending Camp Erin!**  
**Welcome to the Camp Erin Alumni Club!**



THE MOYER FOUNDATION  
*Helping Children in Distress*



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## CAMP ERIN PARTNER – REQUEST FOR PROPOSAL

---

**CITY:** INSERT CITY

**DATE:** INSERT DATE

---

**RE:** THE MOYER FOUNDATION IS EXCITED TO BRING A CAMP ERIN TO YOUR LOCATION. WE'VE SELECTED YOUR ORGANIZATION AS A POSSIBLE CAMP ERIN PARTNER AND KINDLY ASK YOU PROVIDE THE US FOLLOWING INFORMATION.

PLEASE TYPE ANSWERS DIRECTLY INTO THIS TEMPLATE, PRINT OUT COMPLETED APPLICATION (SECTIONS #1-#5) AND RETURN TOGETHER WITH ALL OF THE REQUIRED APPLICATION DOCUMENTS AS INDICATED ON THE RFP CHECKLIST.

---

### SECTION #1: Organization Overview

#### A. Organization Contact Information

Name of Organization:

Contact Name:

Contact Title:

Address:

City/State/Zip:

Phone (day):

Phone (evening):

E-mail:

#### B. Budget - Actual and Intended

Bereavement Program/Project Budget Size: \$

Organization's Annual Budget: \$

Estimated year one camp budget (please attach): \$

Estimated yearly budget thereafter (please attach): \$

#### C. Description of organization

Please list any additional relevant data relating to the history, goals and accomplishments of your organization:

#### **D. Additional details**

1. Does your organization have a current 501 (c)(3) status?      YES      NO
2. Year founded:
3. Number of employees:
4. Partners or affiliates:
5. List of Organization's Officers and Directors:

#### **E. Bereavement**

1. Please describe your history of service to grieving children:
2. How many grieving children are you currently serving?
3. How many do you serve per year (average)?

Total to date?

4. How specifically do you serve these children? What programs do you offer?

What is the frequency of these programs?

5. Why do you feel your agency would be well suited to partner with The Moyer Foundation?

## **SECTION #2: CAMP PLANS**

### **A. Preparation**

1. How do you plan to prepare for Camp Erin?
  
1. Will you hire staff, if so how many in what positions?
  
2. How will you recruit and train volunteers?
  
3. When do you plan to hold your first Camp Erin?

### **B. Evaluation**

1. How will you determine the impact of Camp Erin? Please explain post-camp follow up strategy and intended follow-up length of time.

### **C. Attendance**

1. What is your target number of children and volunteers attending year one?
  
2. And each year thereafter?

## **SECTION #3: FUNDRAISING + AWARENESS**

### **A. Fundraising**

1. How would you ensure the financial stability of Camp Erin after the first year of funding from The Moyer Foundation?
2. What are your plans to grow funds over the 10 year period? Please give a specific example.
3. Have you identified potential partners that will support with time, talent or treasure? (this can include fundraising, in-kind donations or volunteer support)

### **B. Awareness**

1. How will you create awareness of Camp Erin in your community?
2. How will you reach out to children and families in distress?

## **SECTION #4: REFERENCES**

Please provide reference letters from the following:

1. Community supporter
2. Corporate partner
3. Program advocate

## **SECTION #5: ADDITIONAL REQUESTS**

1. Please find attached the Camp Erin and an example of The Moyer Foundation Letter of Understanding. Review and confirm your organization can comply with what will be required to move forward with this partnership.
2. Please include a copy of your organization's 501(c) (3) determination letter or proof of non-profit status.



THE MOYER FOUNDATION  
*Helping Children in Distress*



**The Moyer Foundation**  
*Camp Erin Partner - Grant Application Checklist*

Please assemble all grant application documents in the following order- **front to back**. Please paperclip everything together- NO staples, please.

- ☐ Cover Letter (on letterhead)
- ☐ Section #1
- ☐ Section #2
- ☐ Section #3
- ☐ Section #4
- ☐ Financial Documents
  - ☐ Most recent audit
  - ☐ Most recent agency budget
  - ☐ Program budget (what grant will help fund)
  - ☐ IRS confirmation letter of 501(c)3 status
- ☐ Signed checklist (this form)

Please check off the items above to confirm they are included in your grants application package. Put the entire package *unfolded* in a 9 x 12 envelope, addressed to:

THE MOYER FOUNDATION  
Attn: Lynette Moore  
Camp Erin Program Manager  
2426 32<sup>nd</sup> Ave. W Ste. 200  
Seattle, WA 98119

By signing below, I confirm the grant application is complete, and all required items are organized as indicated above.

Name\_\_\_\_\_

Date\_\_\_\_\_

## Appendix C



### Camp Erin Pre-Camp Check List

Camp City: \_\_\_\_\_

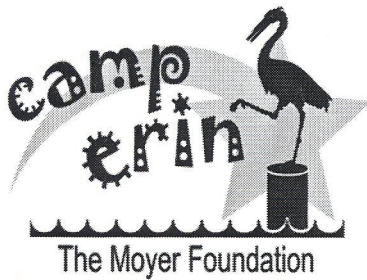
Camp Dates: \_\_\_\_\_

Camp Erin Agency: \_\_\_\_\_

Camp Director: \_\_\_\_\_

- ☐ All staff and volunteers have completed & passed required background checks prior to this camp season.
- ☐ All staff and volunteers have been trained appropriately and substantially for bereavement camp setting.
- ☐ Liability insurance has been obtained in the minimum amount of \$1,000,000 per occurrence, with an aggregated general amount of \$2,000,000, to cover any potential claims or losses arising from the operation of Camp Erin. The Moyer Foundation has been named as an additional insured on its liability policy.
- ☐ All required camper information, liability and consent forms, releases and/or additional requests have and/or will be turned in by all participants, visitors, campers and guardians.
- ☐ If media is attending Camp Erin, contact Rachel Chiechi, Community Relations Manager. Visiting media has been given the 2010 Camp Erin National Media Talking Points from 2010 Communications Toolkit.
- ☐ All Moyer Foundation Camp Erin requirements have and/or will be met.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



## Sample Camp Erin Schedule

### Camp Erin – Seattle

This is an example of a schedule for Camp Erin based off an existing camp. Please note the schedule, activities and all details are the decision of the partner organization.

#### Thursday, August 23

Staff & Committees arrive and set up camp

- Set up of registration & supplies
- Unload supplies to grief activity areas, Dining Hall, Camper Cabins, and main activity areas
- Hang Camp Erin Banners
- Set up Camper Cabins - includes bears, quilts, signs, door hangings, non-perishable foods and any additional items
- Water to cabins and activity areas

#### Friday, August 24

9:00 – 10:00

Volunteers Arrive – Pack In

Set up in Ranch House (Volunteer and staff main meeting area):

- Food
- Message sheets for volunteers and staff

10:00 – 12:00

Challenge Course/Climbing Wall (*Optional*)

12:00 – 12:30

Lunch and Processing of Challenge Course (food provided)

12:30 – 1:15

Volunteer Tour of Camp (*Optional*) – *encouraged for 1<sup>st</sup> yr. vols.*

1:15 – 2:00

- Review of Communication at Camp
- **Volunteer Meeting – All –Flagpole Area (*Required*)**
- Agenda review including any last minute changes
- Synchronize watches

2:00 – 2:30

Prepare Camp for Camper Arrivals - All

- Committees to unload any additional supplies and finish set up
- Final set up camper cabins (Camper Big Buddies)
- Registration/Check In areas, Ritual Table, RN station set up (final)

2:30 – 4:00

Campers Arrive (*Clearly mark Parking Area*)

Camp Arrival Details

- Resident camp staff collect campers gear in parking lot and deliver to cabins.
- Volunteers take places to greet campers at gate, parking lot, registration

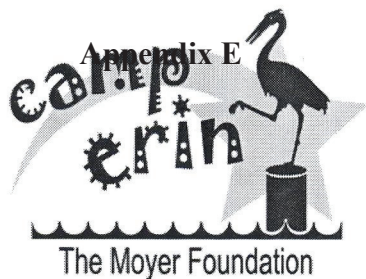
- tables, etc.
- CBB's to watch for and meet up with their campers.
  - Welcome & Registration Volunteers should have walkie talkie & list of all campers/guardians at registration table
  - Campers check in at registration for t-shirts, name tags, goodie bag passport stamp
  - Campers with guardian to check in with camp nurse (note: need 1 table ,1 chair& Canopy) get passport stamp
  - 2 W & R volunteers to escort to picture frame grief activity
  - Campers decorate name tags and picture frames
  - Get acquainted via ice breaker
  - Snack (provided by Camp)
  - Carnival type games (Need 1 card table)
  - Parachute Activity–Guardians Depart
- 4:00 – 5:00
- Opening of Camp - Raising of Camp Flag
- CBB & Campers back to cabins, settle in, create and decorate door hangings
  - **CBBs go over camp guidelines with campers (BBBs can join in)**
  - CBBs ensure camper readiness for evening (i.e., flashlights, bug spray, jackets/sweatshirts, backpacks if desired); **extra bug spray with first aid kit in each shelter**
  - Optional activity for each cabin: create a name, greeting, noise, skit, cheer, etc. to greet other cabins with during tours
  - Games Committee removes Games from field
  - Welcome/Registration volunteers remain at assigned stations until all campers are signed in
- 5:00 – 5:45
- Tour of cabins or scavenger hunt
  - Gathering Song
  - Teen Cabins will have tour in teen area
- 6:00 – 7:00
- Dinner
- Campers and volunteers meet outside dining hall for a circle
  - Welcome – **go over guidelines, check in, introduce some people (e.g., photographers)**
  - Resident camp Welcome & Logistics
  - **Staff check in with CBBs (Clinical Support Staff)**
- 7:00 – 8:15
- Creating Connection
- Icebreaker
  - Corners Game (volunteer will have microphone)
  - **Introduce musician and the harp.** Harp plays to transition to ritual activity
  - Erin's Story
  - **Memory Board** - Campers introduce loved ones to camp (picture frames on magnet board - ) **Director or counselor to facilitate**
- 7:00 – 8:15
- Preparing for evening activity

	<ul style="list-style-type: none"> <li>• Set up campfire - organize a separate campfire for teens</li> <li>• Prepare supplies/set up for S'Mores</li> </ul>
8:15 – 9:30	<p>Campfire</p> <ul style="list-style-type: none"> <li>• Entertainment Committee</li> <li>• Snack Committee</li> </ul>
9:30 – 10:30	<p>Free Time/Games – in cabins</p> <ul style="list-style-type: none"> <li>• Quiet games/stories/CBB's to facilitate sharing</li> <li>• Special teen activity</li> <li>• Get ready for bed</li> </ul>
10:30	Camp Sleeps
<b>Saturday, August 25</b>	
6:30 – 7:00	Self-care opportunity for volunteers (yoga?)
7:00 – 7:30	Rise and Shine
7:30 – 8:15	<p>Breakfast</p> <ul style="list-style-type: none"> <li>• <b>Review Day's Schedule</b> - Schedule will be posted in Dining Hall &amp; Main House</li> <li>• Volunteers set up for day activities (All)</li> </ul>
8:15 – 8:45	<p>Skit in Dining Hall – to prepare campers for activities</p> <ul style="list-style-type: none"> <li>• Facilitate processing of Skit</li> </ul>
8:45 – 9:00	<p>Walk to Activities – CBB's take campers to activities, take a break, and pick up campers at end of each grief activity.</p> <p>Harp plays as campers leave dining hall</p>
9:00 – 9:45	<p>Grief Activity #1</p> <ul style="list-style-type: none"> <li>• Arts &amp; Crafts; Creative Writing; Drumming</li> <li>• Volunteer self-care opportunity</li> </ul>
9:45 – 10:15	Snack and field activity (separate for teens)
10:30 – 11:15	<p>Grief Activity #2</p> <ul style="list-style-type: none"> <li>• Arts &amp; Crafts; Creative Writing; Drumming</li> <li>• Volunteer self-care opportunity</li> <li>• </li> </ul>
11:15 – 11:45	<p>Free time &amp; with possible Bonding Activity</p> <ul style="list-style-type: none"> <li>• Teens may row canoes to main swimming area</li> </ul>
12:00 – 12:50	Lunch

- Barbeque in amphitheater
  - Clown & helpers
  - **Clinical Staff check in with CBB's; Director check in with Grief Activity facilitators**
- 1:00 – 1:45      Grief Activity #3
- Arts & Crafts; Creative Writing; Drumming
  - Volunteer self-care opportunity
- 2:00 – 2:45      Grief Activity #4
- Arts & Crafts; Creative Writing; Drumming
  - Volunteer self-care opportunity
- 2:45 – 3:15      Campers to cabins to change into swimming/free time attire
- 3:15 – 3:45      Snack (*ice cream sundaes*)  
Clown & helpers
- 3:30 – 5:30      Free Time / Swimming / Boating / Nature Hikes/Games/Art Barn open for “free art” time
- Grief Activity Committee - Pack up & Transport love lights to dock/ “reflection pool”
  - Volunteer self-care opportunity
- 6:00 – 7:00      Dinner  
Clinical Support Staff check in with CBBs
- Icebreaker
- 6:30 – 7:30      Evening Preparation
- Set up campfire – Camp Staff
  - Microphone set up, etc.
  - Table for skit props, etc. (can use lots of help)
  - Prepare and set up grief activity
- Alternative rain plan: use dining hall for skits and have love lights ceremony around the windows in the dining hall.
- 7:15 – 8:30      Campfire
- Entertainment committee
- 8:30 – 9:45      Luminary Ceremony
- 9:45 – 11:00      Entertainment (*Dining Hall*)
- Karaoke, pizza, bingo, storytelling, separate Teen Activities?
  - Option of quiet time in cabin areas
  - Optional: Set up of teen campfire or battery-operated candles on labyrinth
- 11:00      Camp Sleeps
- Quiet games/stories/sharing
  - Get ready for bed

**Sunday, August 26**

6:30 – 7:00	Self-care opportunity for volunteers (yoga?)
7:00 – 7:30	Rise and Shine
7:30 – 8:00	Campers and CBBs/BBBs pack and clean up before breakfast. Place gear on tarps in shelters. <ul style="list-style-type: none"> <li>• Remind campers to wear Camp Erin t-shirts (Could Welcome/Reg. Have extra nametag made for each child to identify extra bag for wet clothes/quilts/etc.?)</li> </ul>
8:00 – 8:45	Breakfast <ul style="list-style-type: none"> <li>• Review Days Schedule</li> <li>• Volunteers set up for day activities (All)</li> <li>• Clinical support Staff check in with CBBs</li> <li>• CBBs decide who will supervise each camper during activities; additional volunteers available to assist</li> </ul>
8:45 – 9:15	Picture Taking <ul style="list-style-type: none"> <li>• <i>Campers have time to sign each other's t-shirts or hats</i></li> </ul>
9:15 – 11:15	Climbing Wall/Challenge Course/Nature Walk /Games/Art Barn/Heart Song Hill
10:15 – 11:00	Volunteers / Camp Staff to set up 50 – 60 chairs in Ranch House or in yard; set up tables and (awning?) in yard for parent meeting & lunch <ul style="list-style-type: none"> <li>• Welcome/Reg. Committee go to assigned posts to greet parents</li> </ul>
11:00 – 12:20	Parents Arrive – Meet with staff to de-brief <ul style="list-style-type: none"> <li>• Lunch provided</li> </ul>
11:30 – 12:15	Lunch
12:15 – 12:30	After lunch campers complete evaluation forms/Moyer memory cards –on separate table with markers <ul style="list-style-type: none"> <li>• Practice “Abeyo” song to welcome parents</li> <li>• Clinical Support Staff check in with CBB’S</li> </ul>
12:30 – 1:30	Family Grief Activity/Camp Closing <ul style="list-style-type: none"> <li>• Parents come to main Lodge (escorted by staff &amp; volunteers) for family activity with campers –campers welcome parents with the Gathering Song</li> </ul>
1:30 – 1:45	Shooting Star Procession Campers and parents proceed to flag pole
1:45 – 2:00	Closing Ritual with carabineer Lowering of Camp Flag / Campers depart
2:15 – 2:30	Volunteers gather to say good-bye outside Ranch House
2:30 – 4:00	Clean-up Committee to assist with taking down/packing up camp



## CAMP INFORMATION

CHILD'S NAME: \_\_\_\_\_

Has your child ever:

Attended day camp? \_\_\_\_\_ Yes \_\_\_\_\_ No

Attended overnight camp? \_\_\_\_\_ Yes \_\_\_\_\_ No

Spent the night away from home \_\_\_\_\_ Yes \_\_\_\_\_ No

Is your child a swimmer? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, indicate level: \_\_\_\_\_ Beginner \_\_\_\_\_ Intermediate \_\_\_\_\_ Advanced

Does your child:

Enjoy Music? \_\_\_\_\_ Yes, what kind \_\_\_\_\_ No

Play an instrument? \_\_\_\_\_ Yes, what kind \_\_\_\_\_ No

Enjoy/Play Sports? \_\_\_\_\_ Yes, what kind \_\_\_\_\_ No

Enjoy Arts/Crafts? \_\_\_\_\_ Yes, what kind \_\_\_\_\_ No

What is your child's favorite food (s)? \_\_\_\_\_

What is your child's least favorite food (s)? \_\_\_\_\_

Please list any special interest/hobbies your child has: \_\_\_\_\_

Is there anything we should know to better serve your child? \_\_\_\_\_

Have you and your child talked about the possibility of him/her coming to Camp Erin? \_\_\_\_\_

What would you hope that your child would gain from attending Camp Erin? \_\_\_\_\_

How did you learn about this program?

\_\_\_\_\_ Hospice \_\_\_\_\_ School \_\_\_\_\_ Physician

\_\_\_\_\_ Friend

\_\_\_\_\_ Newspaper \_\_\_\_\_ Other: \_\_\_\_\_

Signature

Relationship to Child



## MEDICAL INFORMATION

Child's Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child have any of the following:	Yes	No
Physical Limitations		
Asthma		
Dietary Restrictions (i.e. physician recommended, religious etc.)		
Convulsions / Seizures		
Diabetes		
Ear Infections		
Hearing Impairment		
Motion Sickness		
Nosebleeds		
Wears Glasses / Contacts		
Recurring headaches or stomach aches		
Other: (please specify)		
Is your child currently under the care of a physician?		
If yes, Physician's Name _____ Phone # _____		
Does your child have any allergies? (i.e. food, medicine, or other)		
If yes, please explain _____		
Any history of operations or serious illnesses?		
Will your child be taking medications at camp?		
If yes, what are the medications treating? _____		
What is the date of your child's latest Tetanus shot?		

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

Is there a hospital that your insurance mandates? \_\_\_\_\_

HOSPITAL OF CHOICE: \_\_\_\_\_



## BEREAVEMENT HISTORY

Please include as many details as possible when answering the following questions. We understand that answering some of these questions might be difficult; however, we want to be able to provide the best possible care for your child.

Child's Name \_\_\_\_\_

1. Full name of deceased \_\_\_\_\_ Relationship to child \_\_\_\_\_
2. Birth date of deceased \_\_\_\_\_ Date of death \_\_\_\_\_
3. Age of deceased at time of death \_\_\_\_\_ Age of child at time of death \_\_\_\_\_
4. Was the deceased receiving Providence Hospice Services at the time of death? \_\_\_\_\_
5. Was the death anticipated or sudden? \_\_\_\_\_
6. What was the deceased's cause of death? \_\_\_\_\_
7. Please check if either of the following statements are true:  
\_\_\_\_ Child/Adolescent has not been told the facts about the deceased's cause of death  
\_\_\_\_ Child/Adolescent does not understand the facts about the deceased's cause of death  
If either is checked, please explain  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Is this your child's first experience with death? \_\_\_\_\_  
If no, please comment on other deaths your child has experienced.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Where did this person die? \_\_\_\_\_  
Was the child present at the time of death? \_\_\_\_\_
10. Did the child see the deceased after the death? \_\_\_\_\_
11. Was there a funeral or memorial service? \_\_\_\_\_  
If yes, did your child attend and what were your child's comments/reactions to the service?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Did the child live with the deceased? \_\_\_\_\_
13. How would you describe your child's relationship with the deceased?  
\_\_\_\_\_
14. How would you describe your family's communication style regarding the death?  
\_\_\_\_ Open \_\_\_\_ Adequate \_\_\_\_ Very little \_\_\_\_ Avoided \_\_\_\_ None
15. Does your child speak openly of the person who died? \_\_\_\_\_
16. Please explain how your child indicates that he/she is grieving.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## REACTION TO THE LOSS

Please place an "X" if your child has exhibited any of the following since the death of the loved one:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Lack of energy  | <input type="checkbox"/> Behavior problems at school                    | <input type="checkbox"/> Peer difficulties                            |
| <input type="checkbox"/> Withdrawn/Isolation                                     | <input type="checkbox"/> Behavior problems at home                      | <input type="checkbox"/> Drug/Alcohol Use                             |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Running away from home                         | <input type="checkbox"/> Causing harm to others                       |
| <input type="checkbox"/> Suicidal thoughts/talk                                  | <input type="checkbox"/> Headaches, stomachaches                        | <input type="checkbox"/> Lying  |
| <input type="checkbox"/> Difficulty with concentration                           | <input type="checkbox"/> Sleeping disturbances                          | <input type="checkbox"/> Stealing                                     |
| <input type="checkbox"/> Causing harm to self                                    | (Please circle: Sleep Walking, Bedwetting,<br>Nightmares, Night Sweats) | <input type="checkbox"/> Destruction of property                      |
| <input type="checkbox"/> Loss of interest in usual activities                    | <input type="checkbox"/> Belief that death was his/her fault            | <input type="checkbox"/> Anger  |
| <input type="checkbox"/> Inappropriate sexual behavior                           | <input type="checkbox"/> Belief that death is a punishment              | <input type="checkbox"/> Disbelief                                    |
| <input type="checkbox"/> Special fears   | <input type="checkbox"/> Changes in attendance at school                | <input type="checkbox"/> Always trying to be in<br>control or perfect |
| <input type="checkbox"/> Sadness   | (Please circle: Increase/Decrease)                                      | <input type="checkbox"/> Changes in how he/she<br>feels about self    |
| <input type="checkbox"/> Worries about his/her safety<br>or the safety of others | <input type="checkbox"/> Changes in weight                              |   |
| <input type="checkbox"/> Hyperactive/Impulsive                                   | (Please circle: Increase/Decrease)                                      |   |

## OTHER IMPORTANT INFORMATION

1. Has your child received any professional support (i.e. school counselor, mental health therapist, peer support group, psychiatrist, pastoral support)? \_\_\_\_\_

If yes, is support currently provided? Please give approximate dates of when support started/ended. \_\_\_\_\_

2. Has there been any other changes/stresses in your child's life (i.e. illness, relocation, divorce, remarriage, finances, other losses)? Please explain  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Has your child ever experienced abuse of any kind? \_\_\_\_\_

If yes, please explain

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4. Please describe your child's personality/character traits.

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5. Are there any language, disability, and/or religious needs that we should be aware of to better serve your child? \_\_\_\_\_

(This information is voluntary and will only be used to help your child with the grieving process).

6. Are there any other special needs, family customs, or cultural aspects to your child's grieving that we should be aware of?

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7. Is your child displaying any behaviors/moods that have you concerned? \_\_\_\_\_  
If yes, please explain

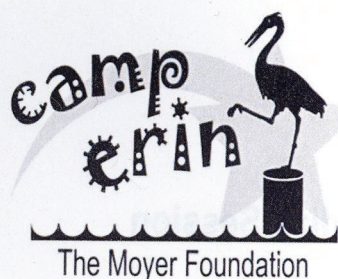
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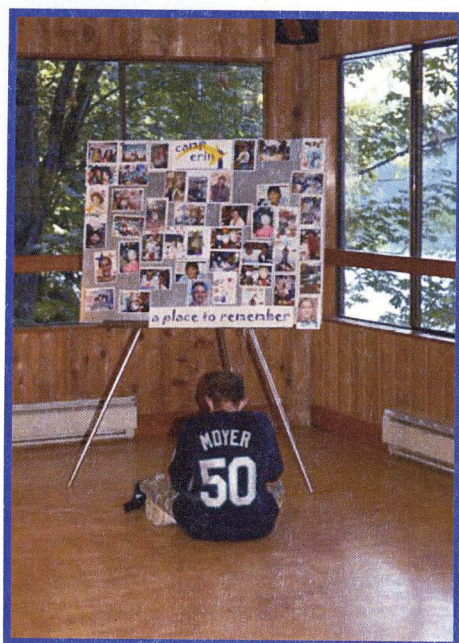
Signature

Date

Relationship to child



## Memory Board

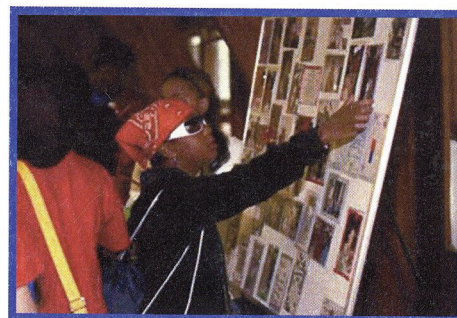
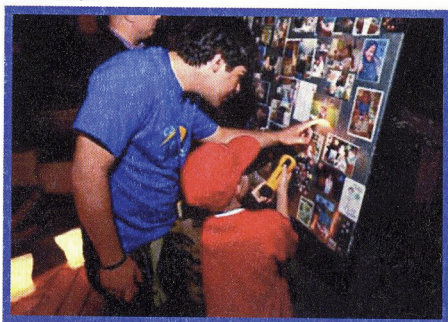


The Memory Board provides a place for children and volunteers to pay tribute at Camp Erin to the memory of the person they lost. Each child and/or volunteer is asked to bring a picture of the person they are honoring to be displayed on the Memory Board for the weekend.

The process for how the Memory Board will be constructed is at the discretion of each camp, but it must be done on the first day of camp. Proven successful at past Camp Erin's is to have each child bring their photo to the first night at campfire and after hearing Erin's Story, each child is given the opportunity to tell a brief story of their loss and place their photo on the Memory Board. A picture of Erin Metcalf is to be placed in the center of the board after her story is told. If there are other influential members specific to your community, the Memory Board is a great place to honor them for the weekend of camp.

The Memory Board serves multiple purposes during Camp Erin weekend. After its creation, the board is to be put on display for the remainder of the weekend in a safe and sheltered location. The dining hall is a great place. Doing this accomplishes many things. It provides a visual representation showing the children they are not alone in their grief. The board also helps to foster discussion between campers and/or volunteers about their losses. Through these discussions, relationships and bonds are formed that last a lifetime and are beneficial to the grieving process.

**\*\*A picture of Erin Metcalf will be provided by the Moyer Foundation to be placed on the Memory Board.**



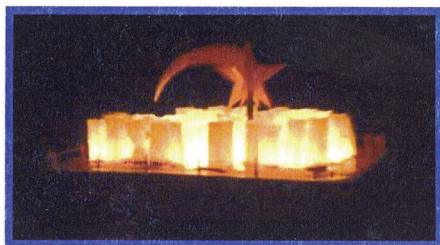
## Lighted Remembrance Ceremony (Luminary / Love Lights Ceremony)



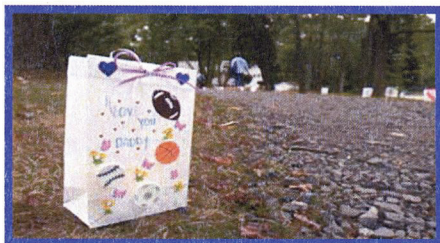
The Lighted Remembrance Ceremony is a time for reflection and is truly inspirational for campers and staff. Each child decorates a special floating memory of their significant loss being honored for the weekend with a candle or light as the centerpiece. The light on their personalized luminary acts as a symbol of the child's love for their loved one – the flame will go out before nights end, but never in their hearts.

Depending on the camp site, the love lights will be released on a "reflection pool" whether that is an actual pool, lake or alternative body of water. This activity provides a unique opportunity for those involved to memorialize or remember the person they lost in their own way. Anticipation of emotion is important. Also important is that the campers understand the process of the remembrance ceremony from the crafty creation of their luminary or love light through the beginning, middle and end of the ceremony.

The ceremony is to take place on the second night of camp. The details of the ceremony are at the discretion of the partner organization and have been successfully accomplished in many different ways at different camp locations.



Shown to the left is an example luminary created at Camp Erin – Philadelphia. A candle is placed inside this version of the luminary, is set upon a raft-like floating device, and released on the water. Other camps create free floating luminaries as pictured above that do not have to be placed on a raft.



\*\*\* Need ideas for your Lighted Remembrance Ceremony? Get connected with established camp locations through the Camp Erin Forum located at [www.moyerfoundation.org](http://www.moyerfoundation.org).



## Camp Erin Post Camp Evaluation and Outcomes Report

The Camp Erin Summary Report is a required part of The Moyer Foundation grant approval agreement. The information/materials provided with this summary will be used to evaluate the effectiveness of the grants and our grants review process and may be used in Foundation collateral to demonstrate/illustrate how grants from the Foundation benefit children in distress through Camp Erin. Thank you for your time in providing us with the requested information and materials.

**DIRECTIONS:** Please fill out the report completely by typing your answers directly into this document. Feel free to use as much room as needed. Please return via email to Lynette Moore at The Moyer Foundation at [lynette@moyerfoundation.org](mailto:lynette@moyerfoundation.org) or send with any additional information or reports to:

Lynette Moore  
Camp Erin – Program Manager  
The Moyer Foundation  
2426 32<sup>nd</sup> Avenue West #200  
Seattle, WA 98199

**Camp City:** \_\_\_\_\_

**Camp Dates:** \_\_\_\_\_

**Primary Contact:** \_\_\_\_\_

Please include all additional support documents with your report. If you have any questions, please don't hesitate to contact Lynette at 206-298-1217.

### Pre – Camp

1. How did you recruit and/or inform children and teens about camp? When did you start recruiting?
2. How did you interview potential campers?
3. What information did you provide to guardians and campers?
4. Did you hold a "pre-camp" pizza party or gathering for campers and volunteers? Please explain.
5. How did you recruit volunteers?

6. How did you train volunteers?
7. How did you fundraise or secure in-kind donations?
8. How did you involve your community?

### **Camp Weekend**

1. Please explain each step of the registration and/or check in process.
2. What information, if any, did you provide caregivers?
3. Were caregivers involved in any camp activities? If yes, please explain.
4. How many campers attended?
5. How many campers applied?
6. How many campers did you have on your wait list?
7. Did you have any returning campers? If yes, how many?
8. Camper statistics
  - a) What were your camper ages – Please list sex and age. (*Example: Boys age 6-8: 8*)
  - b) What percentage of campers are from low income or working poor families (<\$34,999 household income)?

c) What was the racial/ethnic composition of campers:

%	African American
%	Asian
%	Caucasian
%	Latino
%	Other
<b>100%</b>	<b>TOTAL</b>

9. How many cabins did you have and what was the age breakdown?
10. How many volunteers participated?
11. What were the volunteer jobs? Please list each job and how many volunteers in each.  
(Example: Cabin Big Buddies: 16.)
12. Did you have volunteer committees? If so what were the committees? How many volunteers participated in the "pre-planning" for the weekend?
13. How many volunteers per cabin?
14. How many staff attended?
15. Did you have any visitors or VIP's to camp? If yes, please explain.
16. What, if anything, was waiting for campers in their cabins? What did campers take home?
17. Please list each grief activity and length of time.
18. How did your Memory Board and Luminary ceremonies work? Please describe.
19. What was the campers' favorite activity? Were there any that didn't work so well?

20. What food/snacks were provided for campers and volunteers?  
(Example: 3 meals a day for each including 2 snacks and a separate volunteer room with food)

## Post Camp

21. How did you "de-brief" after camp with volunteers and staff?
22. Please attach blank evaluation forms given to staff and volunteers. (if any)
23. Please describe any evaluations/measurement processes that you conducted to assess impact on individual campers.
24. How will you follow/keep in contact with campers and volunteers? What frequency and duration?
25. How many campers have reached out to seek additional services or attend activities (group, events, grief activities, etc.) with your organization after camp?
26. Do you have a "volunteer retention program" if so, please explain.
27. Moyer Foundation Support
- A) Please provide us with a quote from your board president and/or agency executive director stating how this camp helped support your mission or is helping the children you serve. Please include the name and title of the person quoted.
  - B) In what ways can The Moyer Foundation be of assistance to you in planning future camps?
28. What, if any, aspects of the camp did not meet your expectations?
- a. Identify lessons learned, where improvements are needed and/or what changes you plan to make for the next session.

## General

29. Did you receive media coverage of camp or related events/activities?

30. Did you receive in-kind donations for camp? If yes, please explain.

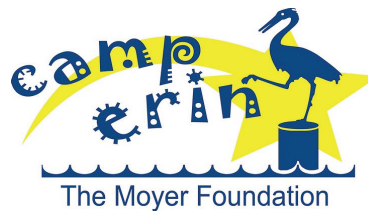
### 31. Required ATTACHMENTS

1. Final program budget – Use Camp Erin template provided.
2. Camp schedule - detailing times, activities and workshops.
3. Fundraising activities or how you raised funds for camp.
4. Photos:
  - 2-3 Photos that showcase your camp and the children who are being helped
    - The photos can be action shots (candid) or portraits
    - Please send high-resolution JPEGs (300 dpi or better) or EPS files
    - These photos may be used by The Moyer Foundation for:
      1. Website
      2. Brochures
      3. Videos
      4. Annual reports
      5. Special event materials (invitations/programs/posters)
      6. Promotional materials

**NOTE: It is the responsibility of your organization to ensure that releases have been received and authorized by those appearing in photographs or by their parent or guardian approving the usage of photos for purposes as stated above.**

5. All consent and release waiver forms for campers, volunteers and staff.
6. Collateral: Photos:
  - If applicable, please send digital copies of any relevant collateral used to help support/promote this program such as annual reports, flyers, brochures, posters, etc.

###



### Informed Consent to Participate in Research

**Title of the Study:** The Impact of Camp Erin on Bereaved Children

**Person in Charge of the Study:** Alysondra Duke, MS

**Sponsor of the Study:** The Moyer Foundation

Hello! My name is Alysondra Duke, and I am conducting a study on the impact of Camp Erin on children's levels of hope, perceptions of self, and depression. I am conducting this project in collaboration and with permission from Camp Erin and The Moyer Foundation. I would like to let you know about the opportunity for you and your child to participate in this research study.

For this study, I am inviting the participation of children, ages 9-17, who are attending Camp Erin. ***In order for your child to participate, your permission is needed.*** Please take your time and read the following information carefully.

The purpose of my study is to evaluate the effectiveness of Camp Erin for children with regard to hope and goals, levels of depression, and perceived levels of scholastic competence, social acceptance, athletic competence, physical appearance, behavioral conduct, and global self-worth. It is hypothesized that children who attend Camp Erin's weekend-long bereavement camps will demonstrate increased levels of hope, perceptions of self, and global self-worth, as well as a decrease in depressive symptoms.

There are no additional costs to participate in this research, and you will not receive any monetary compensation for participating in this study. However, your child's participation in this study will provide important information to assist Camp Erin and The Moyer Foundation in understanding the impact of Camp Erin on children who are grieving the loss of a loved one.

For this study, your child will be asked to complete some questionnaires during your meeting with Camp Erin staff. It will take approximately 20 minutes for your child to complete all of the questions. The responses to these questions will remain **confidential**. Only the Camp Erin staff member with you today and I will have access to the responses. Once I receive the responses from you and your child, an identification number will be assigned to your child's name to ensure that their responses to the questionnaires remain confidential. Once the research study is completed, the confidential responses from each participant will be compiled and this information will be shared with Camp Erin and The Moyer Foundation.

In this study, we want to know how camp impacts children before and after camp ends. Thus, if you agree to participate, this same packet of questions will be mailed to your home for your child to complete after attending camp. Additionally, a follow-up questionnaire packet will be sent to your home for your child to complete 8-weeks after camp. If you decide to no longer participate after camp has ended, you do not need to complete or return the questionnaires that will be sent to your home.



The risks of this study are minimal, and would be similar to those your child might experience when disclosing information about himself/herself, his/her feelings, or the death of a loved one to others. There are Camp Erin counselors available should your child need to discuss any feelings that arise as a result of completing the questionnaires. Please take some time to discuss this with your child. Sometimes people who participate in a study have questions about their rights. If you have questions, please call the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965. As well, you may contact the Principal Investigators (listed below) with any questions you may have.

You and your child's participation in this study are **voluntary**. If you and your child decide to participate in this study, please sign this form. Your child will also need to sign the assent form to participate. You and your child are still free to withdraw at any time, and this decision will not affect the relationship you have with the Camp Erin staff, The Moyer Foundation, or the University of Nebraska-Lincoln.

Thank you for considering this research opportunity.

**I grant my son/daughter, \_\_\_\_\_, permission to participate in this research study.**

(your child's name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Alysondra Duke, M.S.  
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Hello! You are invited to participate in a research study, and your parent and/or guardian(s) know that we are asking you if you would like to participate. Before you agree to be a participant in this study, we want to be sure you understand what the study is about.

**Goal:** We are doing a study to learn about kids who have experienced the loss of a loved one and who are attending Camp Erin. We are asking you to help because we don't know very much about how Camp Erin really affects kids your age. We would like to know how you're feeling now, right after camp, and eight-weeks after camp, so there will be three different times you will answer the same questions about how you're feeling.

**Participation Guidelines:**

- First, we need you to read this letter carefully, and if you want to participate, sign at the bottom of the page.
- Then, if you agree to be in our study, we are going to ask you some questions about some feelings you have about you and about other kids your age. For example, we will ask you if you feel like you are doing pretty well right now or if you feel sad sometimes.
- It will probably take about 20 minutes to finish all of the questions.
- We will have you answer these questions before you start camp, and then we will mail these same questions to you after camp ends because we want to know how you feel before and after going to Camp Erin.

**Participation Benefits and Risks:**

- By participating in this study, you might help others to learn more about how Camp Erin can help kids who are have lost a loved one.
- This study does not involve any risks or discomforts greater than those you feel in your daily life when you talk about your feelings.

**Rights to Refuse to Participate or Withdraw:**

- Your participation in this study is VOLUNTARY.
- Your relationship with Camp Erin staff, the researchers of this study, The Moyer Foundation, or the University of Nebraska- Lincoln will not be affected if you decide not to participate.
- You can decide NOT to participate or to withdraw at any time.
- You can stop answering questions at any time or skip questions you do not wish to answer.

**Rights as a Participant:**

- You may ask the Camp Erin staff member questions about this study at any time. You can also have your questions answered by the researchers of this study.

**Remember!** The questions we will ask are only about what you think and feel. There are no right or wrong answers because this is not a test.



IRB# 20110611807 EX  
Date Approved: 06/09/2011  
Valid Until: 06/08/2016

**Agreement to Participate:**

You should first discuss the study with your parent or caretaker before you decide to participate. If you agree to be a participant, please check that you agree to participate, and print and sign your full name on this form. If you do not wish to participate, you can just give the form back.

\_\_\_\_\_ I AGREE to participate in this research study.

Your printed name: \_\_\_\_\_ Date \_\_\_\_\_

Your signature: \_\_\_\_\_ Date \_\_\_\_\_

Alysondra Duke, M.S.  
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For more information regarding participation in this research, please feel free to contact the University of Nebraska-Lincoln Institutional Review Board office at (402) 472-6965.

**Appendix J**  
**Camp Erin Research Questionnaire**

Thank you for your interest in this study! We appreciate your time. Please answer the following questions below.

Date: \_\_\_\_\_ Camp Erin Location (City and State): \_\_\_\_\_

Child's Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Child's Age: \_\_\_\_\_ Child's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender of child: (Check one) Female \_\_\_\_\_ Male \_\_\_\_\_

What grade will your child be entering in the Fall of 2011? \_\_\_\_\_

Your Name: \_\_\_\_\_ Phone Number (Best one to reach you): (        ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**1. Who is filling out this form? (Check one)**

\_\_\_\_\_ child's mother  
\_\_\_\_\_ child's grandmother  
\_\_\_\_\_ child's stepmother  
\_\_\_\_\_ child's foster mother  
\_\_\_\_\_ child's father  
\_\_\_\_\_ child's grandfather  
\_\_\_\_\_ child's stepfather  
\_\_\_\_\_ child's foster father  
\_\_\_\_\_ other: \_\_\_\_\_

**2. Has this child previously attended Camp Erin? (Check one)**

\_\_\_\_\_ Yes \_\_\_\_\_ No If "Yes," how many times? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

**3. Who was the significant person in the child's life that passed away?**

\_\_\_\_\_ child's mother  
\_\_\_\_\_ child's grandmother  
\_\_\_\_\_ child's stepmother  
\_\_\_\_\_ child's sister  
\_\_\_\_\_ child's father  
\_\_\_\_\_ child's grandfather  
\_\_\_\_\_ child's stepfather  
\_\_\_\_\_ child's brother  
\_\_\_\_\_ other: \_\_\_\_\_

**4. How long has it been since the death of this person occurred?**

\_\_\_\_\_ within the last 12 months  
\_\_\_\_\_ within the last 24 months (2 years)  
\_\_\_\_\_ more than 2 years ago  
\_\_\_\_\_ more than 5 years ago  
\_\_\_\_\_ other

**5. Race of Child: (Check the option that would most apply)**

\_\_\_\_\_ American Indian/Alaska Native  
\_\_\_\_\_ Black/African-American  
\_\_\_\_\_ Asian/Asian-American  
\_\_\_\_\_ Native Hawaiian  
\_\_\_\_\_ Other Pacific Islander  
\_\_\_\_\_ Hispanic/Latino  
\_\_\_\_\_ White  
\_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_ Unreported/Refused to Report

**6. List all of the people living in the child's household (include yourself if you live there and all adults and children\*):**

Use back of sheet if necessary. \*First names or initials can be used to protect confidentiality if you wish to do so.

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Relationship of this person to the child?</u> (father, sister, cousin, etc.)

**7. What is the mailing address we should use for follow up questionnaires?** (You can write "same as above" if it is the same).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**8. Persons to contact for a follow-up address:**

(So we can contact you if you move—follow-up questionnaires, etc. are sent through the mail)

(a) A close relative:

<u>Name</u>	<u>Street Address</u>	<u>City/State</u>	<u>Phone Number</u>
_____	_____	_____	(    ) _____

(b) A friend:

<u>Name</u>	<u>Street Address</u>	<u>City/State</u>	<u>Phone Number</u>
_____	_____	_____	(    ) _____

**9. How did you hear about Camp Erin?** (Check all that apply)

\_\_\_\_\_ Online: Which website?: \_\_\_\_\_

\_\_\_\_\_ On television: A commercial? (Check if this applies) \_\_\_\_\_ Or, other? \_\_\_\_\_

\_\_\_\_\_ From a friend or family member

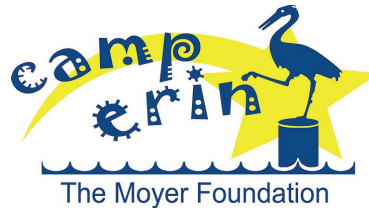
\_\_\_\_\_ Other: \_\_\_\_\_

**10. Has your child previously received grief-related counseling?** Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes," for how long? \_\_\_\_\_

Where? \_\_\_\_\_

**Thank you for your participation in this study!!**



### **Informed Consent to Participate in Research**

**Title of the Study:** The Impact of Camp Erin on Bereaved Children

**Person in Charge of the Study:** Alysondra Duke, MS

**Sponsor of the Study:** The Moyer Foundation

Hello! My name is Alysondra Duke, and I am conducting a study on the impact of Camp Erin on children's levels of hope, perceptions of self, and depression. I am conducting this project in collaboration and with permission from Camp Erin and The Moyer Foundation. I would like to let you know about the opportunity for you and your child to participate in this research study.

For this study, I am inviting the participation of children, ages 9-17, who are attending Camp Erin. ***In order for your child to participate, your permission is needed.*** Please take your time and read the following information carefully.

The purpose of my study is to evaluate the effectiveness of Camp Erin for children with regard to hope and goals, levels of depression, and perceived levels of scholastic competence, social acceptance, athletic competence, physical appearance, behavioral conduct, and global self-worth. It is hypothesized that children who attend Camp Erin's weekend-long bereavement camps will demonstrate increased levels of hope, perceptions of self, and global self-worth, as well as a decrease in depressive symptoms.

There are no additional costs to participate in this research, and you will not receive any monetary compensation for participating in this study. However, your child's participation in this study will provide important information to assist Camp Erin and The Moyer Foundation in understanding the impact of Camp Erin on children who are grieving the loss of a loved one.

For this study, your child will be asked to complete some questionnaires during your meeting with Camp Erin staff. It will take approximately 20 minutes for your child to complete all of the questions. The responses to these questions will remain **confidential**. Only the Camp Erin staff member with you today and I will have access to the responses. Once I receive the responses from you and your child, an identification number will be assigned to your child's name to ensure that their responses to the questionnaires remain confidential. Once the research study is completed, the confidential responses from each participant will be compiled and this information will be shared with Camp Erin and The Moyer Foundation.

In this study, we want to know how camp impacts children before and after camp ends. Thus, if you agree to participate, this same packet of questions will be mailed to your home for your child to complete after attending camp. Additionally, a follow-up questionnaire packet will be sent to your home for your child to complete 8-weeks after camp. If you decide to no longer participate after camp has ended, you do not need to complete or return the questionnaires that will be sent to your home. However, if your child completes the post-camp and follow-up packets and they are returned immediately, he/she will be

automatically entered into a drawing to win an Xbox sponsored by The Moyer Foundation. The odds of winning an Xbox depend on how many campers participate in this study. Your child has approximately a 1 in 300 chance of receiving the Xbox.

The risks of this study are minimal, and would be similar to those your child might experience when disclosing information about himself/herself, his/her feelings, or the death of a loved one to others. There are Camp Erin counselors available should your child need to discuss any feelings that arise as a result of completing the questionnaires. Please take some time to discuss this with your child. Sometimes people who participate in a study have questions about their rights. If you have questions, please call the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965. As well, you may contact the Principal Investigators (listed below) with any questions you may have.

You and your child's participation in this study are **voluntary**. If you and your child decide to participate in this study, please sign this form. Your child will also need to sign the assent form to participate. You and your child are still free to withdraw at any time, and this decision will not affect the relationship you have with the Camp Erin staff, The Moyer Foundation, or the University of Nebraska-Lincoln.

Thank you for considering this research opportunity.

**I grant my son/daughter, \_\_\_\_\_, permission to participate in this research study.**

(your child's name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

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Hello! You are invited to participate in a research study, and your parent and/or guardian(s) know that we are asking you if you would like to participate. Before you agree to be a participant in this study, we want to be sure you understand what the study is about.

**Goal:** We are doing a study to learn about kids who have experienced the loss of a loved one and who are attending Camp Erin. We are asking you to help because we don't know very much about how Camp Erin really affects kids your age. We would like to know how you're feeling now, right after camp, and eight-weeks after camp, so there will be three different times you will answer the same questions about how you're feeling.

**Participation Guidelines:**

- First, we need you to read this letter carefully, and if you want to participate, sign at the bottom of the page.
- Then, if you agree to be in our study, we are going to ask you some questions about some feelings you have about you and about other kids your age. For example, we will ask you if you feel like you are doing pretty well right now or if you feel sad sometimes.
- It will probably take about 20 minutes to finish all of the questions.
- We will have you answer these questions before you start camp, and then we will mail these same questions to you after camp ends because we want to know how you feel before and after going to Camp Erin.

**Participation Benefits and Risks:**

- By participating in this study, you might help others to learn more about how Camp Erin can help kids who are have lost a loved one.
- This study does not involve any risks or discomforts greater than those you feel in your daily life when you talk about your feelings.
- In addition to answering these questions now, if you answer the same questions right away after camp ends AND again 8 weeks after camp is finished when they are given or mailed to you, you will be automatically entered into a drawing to win an Xbox. The odds of winning an Xbox depend on how many campers participate in this study. This means you would have about a 1 in 300 chance of receiving the Xbox.

**Rights to Refuse to Participate or Withdraw:**

- Your participation in this study is VOLUNTARY.
- Your relationship with Camp Erin staff, the researchers of this study, The Moyer Foundation, or the University of Nebraska- Lincoln will not be affected if you decide not to participate.
- You can decide NOT to participate or to withdraw at any time.
- You can stop answering questions at any time or skip questions you do not wish to answer.

**Rights as a Participant:**

- You may ask the Camp Erin staff member questions about this study at any time. You can also have your questions answered by the researchers of this study.

**Remember!** The questions we will ask are only about what you think and feel. There are no right or wrong answers because this is not a test.

**Agreement to Participate:**

You should first discuss the study with your parent or caretaker before you decide to participate. If you agree to be a participant, please check that you agree to participate, and print and sign your full name on this form. If you do not wish to participate, you can just give the form back.

\_\_\_\_\_ I AGREE to participate in this research study.

Your printed name: \_\_\_\_\_ Date \_\_\_\_\_

Your signature: \_\_\_\_\_ Date \_\_\_\_\_

Alysondra Duke, M.S.  
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For more information regarding participation in this research, please feel free to contact the University of Nebraska-Lincoln Institutional Review Board office at (402) 472-6965.

## **Appendix M**

### **Post-Camp Letter**

Hello! I hope your child had a great experience at Camp Erin. My name is Alysondra Duke, and before camp started, you and your child completed a packet of questionnaires for a research study I am conducting in collaboration with Camp Erin and The Moyer Foundation to learn about the impact Camp Erin has on children's levels of hope, perceptions of self, and depression.

We really appreciate your continued participation in this study! As I mentioned in the first letter, we want to know how Camp Erin impacts children before and after camp ends.

Your child's participation in this study will provide very valuable information to assist Camp Erin and The Moyer Foundation in understanding the impact of Camp Erin on children who are grieving the loss of a loved one.

If you have questions about your or your child's rights as a participant, please call the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965. As well, you may contact the Principal Investigators (listed below) with any questions you may have.

Please discuss these questionnaires with your child, have your child complete them, and mail the completed packet back to Alysondra Duke in the self-addressed stamped envelope included with this packet.

We will send one more follow-up questionnaire packet in 8-weeks!

Thank you for your participation in this study!

Warmly,  
Alysondra Duke

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## **Appendix N**

### **Eight-Week Follow-Up Letter**

Hello again! My name is Alysondra Duke, and before camp started and after camp ended, you and your child completed a packet of questionnaires for a research study I am conducting in collaboration with Camp Erin and The Moyer Foundation. It has now been eight-weeks since camp ended and I am contacting you and your child to complete the follow-up questionnaire packet!

We really appreciate your continued participation in this study! As I mentioned in the first and second letters, we want to know how Camp Erin impacts children before and after camp ends.

Your child's participation in this study will provide very valuable information to assist Camp Erin and The Moyer Foundation in understanding the impact of Camp Erin on children who are grieving the loss of a loved one. Especially 8-weeks after camp has ended!

If you have questions about you or your child's rights as a participant, please call the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965. As well, you may contact the Principal Investigators (listed below) with any questions you may have.

Please discuss these questionnaires with your child, have your child complete them, and mail the completed packet to Alysondra Duke in the self-addressed stamped envelope included with this packet.

Thank you so much for your participation in this study! You and your child have greatly assisted Camp Erin and The Moyer Foundation in their mission to help children for future years to come!

Take great care,  
Alysondra Duke

Alysondra Duke, M.S.  
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## Appendix O

### Questions About Your Goals

The six sentences below describe how children think about themselves and how they do things in general. Read each sentence carefully.

For each sentence, please think about how you are in most situations.

Circle the one that describes YOU the best.

For example, circle "None of the time," if this describes you. Or, if you are this way "All of the time," check this circle. Please answer every question by circling only one of the answers. There are no right or wrong answers.

1. I think I am doing pretty well.

None of  
the time

A little of  
the time

Some of  
the time

A lot of  
the time

Most of  
the time

All of the time

2. I Can think of many ways to get the things in life that are most important to me.

None of  
the time

A little of  
the time

Some of  
the time

A lot of  
the time

Most of  
the time

All of the time

3. I am doing just as well as other kids my age.

None of  
the time

A little of  
the time

Some of  
the time

A lot of  
the time

Most of  
the time

All of the time

4. When I have a problem, I Can come up with lots of ways to solve it.

None of  
the time

A little of  
the time

Some of  
the time

A lot of  
the time

Most of  
the time

All of the time

5. I think the things I have done in the past will help me in the future.

None of  
the time

A little of  
the time

Some of  
the time

A lot of  
the time

Most of  
the time

All of the time

6. Even when others want to quit, I know that I Can find ways to solve the problem.

None of  
the time

A little of  
the time

Some of  
the time

A lot of  
the time

Most of  
the time

All of the time

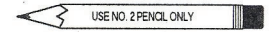
# What I Am Like

Appendix

Init:	
Date:	

C1	C1	C1	C1	C1
C2	C2	C2	C2	C2
C4	C4	C4	C4	C4
C8	C8	C8	C8	C8

**Directions:** For these questions, we'd like you to think about what you are like. You're going to read about two kinds of kids and I'd like you to tell me which kids are more like you.



For each item, decide which side best describes you. Then fill in the circle on THAT side for either "sort of true" or "really true". Don't fill in EITHER circle on the OTHER side.

- 1.) Some kids have trouble figuring out the answers in school, but...

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

Use Only  
One  
Side  
↔

Other kids almost always can figure out the answers.

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

- 2.) Some kids wish that more people their age liked them, but...

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

Use Only  
One  
Side  
↔

Other kids feel that most people their age do like them.

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

- 3.) Some kids are able to make really close friends, but...

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

Use Only  
One  
Side  
↔

Other kids find it hard to make really close friends.

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

- 4.) Some kids are often unhappy with themselves, but...

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

Use Only  
One  
Side  
↔

Other kids are pretty pleased with themselves.

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

- 5.) Some kids find it hard to make friends, but...

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

Use Only  
One  
Side  
↔

Other kids find it's pretty easy to make friends.

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

- 6.) Some kids do have a close friend they can share secrets with, but...

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

Use Only  
One  
Side  
↔

Other kids do not have a really close friend they can share secrets with.

Sort of  
True For  
Me  
C O

Really  
True For  
Me  
C O

7.) Some kids do very well at their classwork, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids don't do as well at their classwork.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

8.) Some kids are not happy with the way they look, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids are happy with the way they look.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

9.) Some kids have a lot of friends, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids don't have very many friends.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

10.) Some kids don't like the way they are leading their life, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids do like the way they are leading their life.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

11.) Some kids find it hard to get along with other kids, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

For other kids it is really easy.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

12.) Some kids wish they had a really close friend to share things with, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids do have a close friend to share things with.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

13.) Some kids wish their physical appearance was different, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids like their physical appearance the way it is.

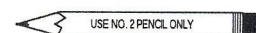
Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Init:	
Date:	



C1	C1	C1	C1	C1
C2	C2	C2	C2	C2
C4	C4	C4	C4	C4
C8	C8	C8	C8	C8

14.) Some kids are popular with others their age, but...

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

Use Only  
One  
Side  
↔

Other kids are not very popular.

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

15.) Some kids feel that they are just as smart as others their age, but...

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

Use Only  
One  
Side  
↔

Other kids aren't so sure and wonder if they are as smart.

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

16.) Some kids like the kind of person they are, but...

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

Use Only  
One  
Side  
↔

Other kids often wish they were someone else.

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

17.) Some kids find it hard to join in when other kids are doing activities, but...

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

Use Only  
One  
Side  
↔

Other kids find it quite easy.

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

18.) Some kids find it hard to make friends they can really trust, but...

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

Use Only  
One  
Side  
↔

Other kids are able to make close friends they can really trust.

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

19.) Some kids think that they are good looking, but...

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

Use Only  
One  
Side  
↔

Other kids think that they are not very good looking.

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

20.) Some kids feel that they are socially accepted, but...

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

Use Only  
One  
Side  
↔

Other kids wish that more people their age accepted them.

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

21.) Some kids are pretty slow in finishing their schoolwork, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids can do their schoolwork more quickly.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

22.) Some kids are very happy being the way they are, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids wish they were different.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

23.) Some kids don't have a friend that is close enough to share really personal thoughts with, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids do have a close friend that they can share personal thoughts and feelings with.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

24.) Some kids really like their looks, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids wish they looked different.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

25.) Some kids don't think that it is important to do well at schoolwork in order to feel good as a person, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids think how well they do at school work is important.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

26.) Some kids think that being popular is important to how they feel about themselves, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

Other kids don't think that being popular is all that important.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

27.) Some kids think that the way they look is important to how they feel about themselves, but...

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )

Use Only  
One  
Side  
↔

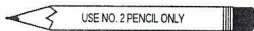
Other kids think that how they look is not all that important.

Sort of  
True For  
Me

( )

Really  
True For  
Me

( )



Init:	
Date:	

C1	C1	C1	C1
C2	C2	C2	C2
C4	C4	C4	C4
C8	C8	C8	C8

28.) Some kids think that having a close friend is important to how they feel about themselves, but...

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

Use Only  
One  
Side  
↔

Other kids don't think that having a close friend is all that important.

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

29.) Some kids think that getting along with other kids is important to how they feel about themselves, but...

Sort of  
True For  
Me  
C D


Really  
True For  
Me  
C D

Use Only  
One  
Side  
↔

Other kids don't think that getting along with other kids is all that important.

Sort of  
True For  
Me  
C D

Really  
True For  
Me  
C D

Client ID: _____		<b>Short Version</b>	<b>Maria Kovacs, Ph.D.</b>
Age: _____ Birthdate: _____ mm/dd/yyyy			
Grade: _____ Gender: Male Female			
Today's date: _____ mm/dd/yyyy			

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group of three sentences, pick one sentence that describes you *best* for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this ☒ next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example of how this form works. Try it. Put a mark next to the sentence that describes you *best*.

Example:

- ☐ I read books all the time.  
☐ I read books once in a while.  
☐ I never read books.

***Remember, pick out the sentences that describe you best in the PAST TWO WEEKS.***

Item 1

- ☐
- I am sad once in a while.
- 
- ☐
- I am sad many times.
- 
- ☐
- I am sad all the time.

Item 6

- ☐
- Things bother me all the time.
- 
- ☐
- Things bother me many times.
- 
- ☐
- Things bother me once in a while.

Item 2

- ☐
- Nothing will ever work out for me.
- 
- ☐
- I am not sure if things will work out for me.
- 
- ☐
- Things will work out for me O.K.

Item 7

- ☐
- I look O.K.
- 
- ☐
- There are some bad things about my looks.
- 
- ☐
- I look ugly.

Item 3

- ☐
- I do most things O.K.
- 
- ☐
- I do many things wrong.
- 
- ☐
- I do everything wrong.

Item 8

- ☐
- I do not feel alone.
- 
- ☐
- I feel alone many times.
- 
- ☐
- I feel alone all the time.

Item 4

- ☐
- I hate myself.
- 
- ☐
- I do not like myself.
- 
- ☐
- I like myself.

Item 9

- ☐
- I have plenty of friends.
- 
- ☐
- I have some friends but I wish I had more.
- 
- ☐
- I do not have any friends.

Item 5

- ☐
- I feel like crying every day.
- 
- ☐
- I feel like crying many days.
- 
- ☐
- I feel like crying once in a while.

Item 10

- ☐
- Nobody really loves me.
- 
- ☐
- I am not sure if anybody loves me.
- 
- ☐
- I am sure that somebody loves me.