# Grief and Trauma Intervention (GTI) for Children

Grief and Trauma Intervention (GTI) for Children is designed for children ages 7 to 12 with posttraumatic stress due to witnessing or being a direct victim of one or more types of violence or a disaster, or due to experiencing or witnessing the death of a loved one, including death by homicide. The purpose of the intervention is to improve symptoms of posttraumatic stress, depression, and traumatic grief. The intervention is conducted with children in a group or individual format in 10 sessions of approximately 1 hour. One session is conducted with parents. Children participating in group sessions attend an additional session conducted one on one. The intervention uses developmentally appropriate methods, including art, drama, and play; an ecological perspective; and culturally relevant approaches, especially in regard to death rituals, spiritual beliefs, coping strategies, historical occurrences, and the child's language. Sessions address topics that are common to children who are experiencing grief and trauma, such as dreams (nightmares), questioning, anger, and guilt. The techniques used in the sessions are grounded in cognitive behavioral therapy (CBT) and narrative therapy and include narrative exposure to the trauma (through drawing, discussing, and writing), development of an indepth, coherent narrative while eliciting the child's thoughts and feelings, development of positive coping strategies, and making meaning of losses.

GTI for Children has been used in various community-based settings, including schools, afterschool programs, and community centers. It can be implemented by mental health clinicians. It is recommended that implementers have a master's degree in a mental health-related field and participate in a 2-day training on the intervention.

In the studies reviewed for this summary, the intervention was implemented in a group and individual format as well as with and without the trauma narrative processing component. These studies involved primarily African American children.

## Descriptive Information

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| **Areas of Interest** | Mental health treatment |
| **Outcomes** | **Review Date: November 2011**<br>1: Posttraumatic stress symptoms<br>2: Depression symptoms<br>3: Internalizing and externalizing behaviors |
| **Outcome Categories** | Mental health<br>Social functioning<br>Trauma/injuries |
| **Ages** | 6-12 (Childhood) |
| **Genders** | Male<br>Female |
| **Races/Ethnicities** | American Indian or Alaska Native<br>Black or African American<br>Hispanic or Latino<br>White |
| **Settings** | Home<br>School |
| **Geographic Locations** | Urban |
| **Implementation History** | The Children's Bureau of New Orleans first implemented GTI for Children in 1997 and has delivered the intervention to about 1,000 children to date. The intervention also has been used in California, Florida, and Texas, as well as in Ethiopia. Training on the intervention has been conducted in Israel, Lebanon, and Turkey. |

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| **NIH Funding/CER Studies** | Partially/fully funded by National Institutes of Health: No<br>Evaluated in comparative effectiveness research studies: Yes |
| **Adaptations** | No population- or culture-specific adaptations of the intervention were identified by the developer. |
| **Adverse Effects** | No adverse effects, concerns, or unintended consequences were identified by the developer. |
| **IOM Prevention Categories** | IOM prevention categories are not applicable. |

## Quality of Research

**Review Date: November 2011**

### Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

**Study 1**

Salloum, A., & Overstreet, S. (2008). Evaluation of individual and group grief and trauma interventions for children post disaster. Journal of Clinical Child and Adolescent Psychology, 37(3), 495-507.

**Study 2**

Salloum, A., & Overstreet, S. (2012). Grief and trauma intervention for children after disaster: Exploring coping skills versus trauma narration. Behaviour Research and Therapy, 50(3), 169-179. (NOTE: At the time of the NREPP review, the manuscript of this article had been submitted for publication but not yet accepted.)

**Supplementary Materials**

Baggerly, J., & Salloum, A. (2010). Deaths connected to natural disasters. In N. Boyd Webb (Ed.), Helping bereaved children: A handbook for practitioners (3rd ed., pp. 240-260). New York, NY: Guilford Press.

Salloum, A. (2008). Group therapy for children after homicide and violence: A pilot study. Research on Social Work Practice, 18(3), 198-211.

Salloum, A., Garside, L. W., Irwin, C. L., Anderson, A. D., & Francois, A. H. (2009). Grief and trauma group therapy for children after Hurricane Katrina. Social Work With Groups, 32, 64-79.

### Outcomes

| **Outcome 1: Posttraumatic stress symptoms** | |
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| **Description of Measures** | Posttraumatic stress symptoms were assessed by parents using the 22-item UCLA Posttraumatic Stress Disorder Index for DSM-IV (UCLA-PTSD-Index). Using a scale from 0 (none) to 4 (most of the time), respondents indicate the frequency of the child's symptoms, such as inability to concentrate; angry outbursts and physical fights; intrusive, distressing thoughts; guilt; diminished interest in activities; attitudes toward the future; difficulty sleeping; avoidance of trauma reminders; and distressing feelings. The instrument was administered in one study at pretest, posttest, and 3-week follow-up and in another study at pretest, posttest, 3-month follow-up, and 12-month follow-up. |
| **Key Findings** | In one study, children in New Orleans who reported moderate to severe levels of posttraumatic stress 4 months after Hurricane Katrina were randomly assigned to receive the intervention in either a group or individual format. Both treatment groups had a decrease in posttraumatic stress symptoms over time ($p < .001$). Specifically, both groups had a decrease in posttraumatic stress symptoms from pre- to posttest ($p = .001$) and from pretest to 3-week follow-up ($p = .001$). There were no significant between-group differences in posttraumatic stress symptoms.<br><br>A second study, conducted in New Orleans 3 years after Hurricane Katrina, involved children who were exposed to hurricane-related stressors and often other potentially traumatic events (e.g., community violence, death of someone close) and who had a moderate level of posttraumatic stress symptoms. The children were randomly assigned to one of two groups: one receiving the group format of the standard intervention using cognitive behavioral skill-based methods plus trauma narrative processing and one receiving the group format of the intervention using only cognitive |

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| | behavioral skill-based methods. Both treatment groups had a decrease in posttraumatic stress symptoms over time ($p < .001$). Specifically, both groups had a decrease from pre- to posttest ($p < .001$), pretest to 3-month follow-up ($p < .001$), and pretest to 12-month follow-up ($p < .001$). There were no significant between-group differences in posttraumatic stress symptoms. |
| **Studies Measuring Outcome** | Study 1, Study 2 |
| **Study Designs** | Experimental |
| **Quality of Research Rating** | 3.1 (0.0-4.0 scale) |

| **Outcome 2: Depression symptoms** | |
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| **Description of Measures** | Depression symptoms were assessed by parents using the 33-item Mood and Feelings Questionnaire--Child Version (MFQ-C), which assesses how a child felt or acted during the past 2 weeks. This instrument includes statements assessing suicidal ideation (e.g., "I thought my family would be better off without me" and "I thought about killing myself") and other symptoms of depression (e.g., "I felt miserable or unhappy" and "I didn't enjoy anything at all"). For each symptom, the response options are "true" (scored 2), "sometimes true" (scored 1), and "not true" (scored 0). The instrument was administered in one study at pretest, posttest, and 3-week follow-up and in another study at pretest, posttest, 3-month follow-up, and 12-month follow-up. |
| **Key Findings** | In one study, children in New Orleans who reported moderate to severe levels of posttraumatic stress 4 months after Hurricane Katrina were randomly assigned to receive the intervention in either a group or individual format. Both treatment groups had a decrease in depression symptoms over time ($p < .001$). Specifically, both groups had a decrease in depression symptoms from pre- to posttest ($p = .001$) and from pretest to 3-week follow-up ($p = .001$). There were no significant between-group differences in depression symptoms.<br><br>A second study, conducted in New Orleans 3 years after Hurricane Katrina, involved children who were exposed to hurricane-related stressors and often other potentially traumatic events (e.g., community violence, death of someone close) and who had a moderate level of posttraumatic stress symptoms. The children were randomly assigned to one of two groups: one receiving the group format of the standard intervention using cognitive behavioral skill-based methods plus trauma narrative processing and one receiving the group format of the intervention using only cognitive behavioral skill-based methods. Both treatment groups had a decrease in depression symptoms over time ($p < .001$). Specifically, both groups had a decrease from pre- to posttest ($p < .001$), pretest to 3-month follow-up ($p < .001$), and pretest to 12-month follow-up ($p < .001$). There were no significant between-group differences in depression symptoms. |
| **Studies Measuring Outcome** | Study 1, Study 2 |
| **Study Designs** | Experimental |
| **Quality of Research Rating** | 3.1 (0.0-4.0 scale) |

| **Outcome 3: Internalizing and externalizing behaviors** | |
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| **Description of Measures** | The Child Behavior Check List (CBCL) for children ages 6 to 18 was used to assess parent-reported internalizing behaviors (i.e., anxious, depressive, overcontrolled) and externalizing behaviors (i.e., aggressive, hyperactive, noncompliant, undercontrolled). Using a 3-point rating scale from 0 (not true) to 2 (very true or often true), parents indicated the extent to which each item described their child's behavior within the past 6 months. The instrument was administered at pretest, posttest, 3-month follow-up, and 12-month follow-up. |
| **Key Findings** | A study conducted in New Orleans 3 years after Hurricane Katrina involved children who were exposed to hurricane-related stressors and often other potentially traumatic events (e.g., community violence, death of someone close) and who had a moderate level of posttraumatic stress symptoms. The children were randomly assigned to one of two groups: one receiving the group format of the standard intervention using cognitive behavioral skill-based methods plus trauma narrative processing and one receiving the group format of the intervention using only cognitive behavioral skill-based methods. Both treatment groups had a decrease in internalizing symptoms over time ($p = .015$) but no change in externalizing symptoms. |

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| | In additional analyses conducted using an intent-to-treat approach, both treatment groups had a decrease in internalizing behaviors over time ($p < .05$). In addition, there was a significant between-group difference over time on externalizing behaviors ($p = .026$). The group receiving the standard intervention using cognitive behavioral skill-based methods plus trauma narrative processing had a greater decrease in externalizing behaviors from pretest to 12-month follow-up ($p = .044$) than the group receiving the intervention using only cognitive behavioral skill-based methods. |
| **Studies Measuring Outcome** | Study 2 |
| **Study Designs** | Experimental |
| **Quality of Research Rating** | 3.0 (0.0-4.0 scale) |

### Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

| Study | Age | Gender | Race/Ethnicity |
|---|---|---|---|
| **Study 1** | 6-12 (Childhood) | 62% Male<br>38% Female | 91.1% Black or African American<br>3.6% American Indian or Alaska Native<br>3.6% White<br>1.8% Hispanic or Latino |
| **Study 2** | 6-12 (Childhood) | 56% Male<br>44% Female | 100% Black or African American |

### Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

| Outcome | Reliability of Measures | Validity of Measures | Fidelity | Missing Data/Attrition | Confounding Variables | Data Analysis | Overall Rating |
|---|---|---|---|---|---|---|---|
| **1: Posttraumatic stress symptoms** | 4.0 | 4.0 | 3.1 | 3.0 | 2.1 | 2.5 | **3.1** |
| **2: Depression symptoms** | 4.0 | 4.0 | 3.1 | 3.0 | 2.0 | 2.5 | **3.1** |
| **3: Internalizing and externalizing behaviors** | 4.0 | 4.0 | 3.3 | 2.3 | 2.0 | 2.5 | **3.0** |

#### Study Strengths

For all outcome measures, reliability and validity were well documented and at acceptable levels. Clinicians completed an adherence checklist, documenting whether each planned topic was addressed, and the checklists indicated there was high adherence. The attendance rate of sessions was high. Supervision meetings were held at least weekly. Both studies employed random assignment to condition and use of multiple longitudinal data collection points. Evaluators and children were blind to treatment condition at pretest, and evaluators continued to be blind to condition through posttest and follow-up assessments. Data analyses were appropriate.

#### Study Weaknesses

Information was not provided on the reliability and validity of the fidelity instruments. The clinicians' self-reported adherence was not corroborated by an independent observer, and sessions were not audiotaped or videotaped for review. Neither study included a no-treatment control group, raising concerns that results could have been due to nontreatment factors. In both studies, a small sample size limited data analyses.

# Readiness for Dissemination

**Review Date: November 2011**

### Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Grief and Trauma Intervention (GTI) for Children PowerPoint training slides

Program Web site, http://www.childrens-bureau.com/gti.html

Salloum, A. (with Children's Bureau of New Orleans). (2010). Grief and Trauma Intervention (GTI) for Children: A manual for practitioners. New Orleans, LA: Children's Bureau of New Orleans.

### Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

| Implementation Materials | Training and Support Resources | Quality Assurance Procedures | Overall Rating |
|---|---|---|---|
| 3.8 | 3.5 | 3.9 | **3.7** |

#### Dissemination Strengths

The program manual is detailed and straightforward in the presentation of session content, the flow of the sessions, and implementation guidance for staffing and participant selection. It describes the structure of the intervention and contains guidance for clinicians on conducting the sessions so they proceed smoothly. It also includes procedures for missed sessions. All session worksheets and handouts are provided. Program developers offer a 2-day, on-site training as well as ongoing consultation on site and via phone, email, and the Web. A variety of fidelity tools and assessment instruments are provided to support quality assurance. The manual includes a brief section for program evaluators with recommendations for specific standardized assessment instruments that can be used to measure child outcomes.

#### Dissemination Weaknesses

Little guidance is given on how to adjust session content and materials to accommodate the developmental differences across participants of varying ages in the same group. Some sessions rely heavily on clinician experience and knowledge, and supplemental resources are not provided for less experienced clinicians. Some evaluation tools are recommended for use but not provided to implementers.

## Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

| Item Description | Cost | Required by Developer |
|---|---|---|
| Program manual, including all worksheets, handouts, fidelity tools, and assessment instruments | Free if downloaded from Web site, or $25 for hard copy | Yes |
| 2-day, on-site training | About $150 per person for up to 25 participants, plus travel expenses | No |
| On-site consultation | $100 per hour, plus travel expenses | No |
| Phone, email, or Web-based consultation | $100 per hour | No |

## Replications

No replications were identified by the developer.

## Contact Information

**To learn more about implementation or research, contact:**

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

**Web Site(s):**

- **http://www.childrens-bureau.com/gti.html**