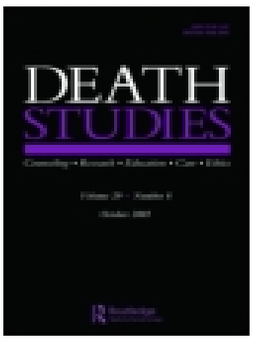

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Outcomes of the grief and communication family support intervention on parent and child psychological health and communication

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ABSTRACT

Parents and children risk developing psychological health problems following the death of a partner/parent and may need professional support. This study used the reliable change criterion and clinically significant change to examine the outcomes of the Grief and Communication Family Support Intervention, comprising three family meetings with a family therapist, among 10 parents and 14 children, using pre–post outcome scores. The results provided preliminary evidence that the Grief and Communication Family Support Intervention may improve self-esteem and reduce anxiety in some parents and may improve communication and reduce internalizing and externalizing problems in some children.

Parentally bereaved children are at increased risk of developing internalizing problems such as depression, anxiety, emotional problems, or difficulty forming relationships with peers. Externalizing problems, including aggression, delinquency, hyperactivity, and conduct problems, are also common (Ayers et al., 2014; Stikkelbroek et al., 2016). These children may also develop prolonged grief, which has been associated with increased suicidal ideation in children and adolescents (Melhem et al., 2007; Spuij et al., 2015; Spuij et al., 2012). At the same time, the child's surviving parent may develop similar psychological health problems, such as depression, anxiety, and prolonged grief (Kristiansen et al., 2019; Prigerson et al., 2009; Sandler et al., 2016; Stroebe & Stroebe, 1993). Furthermore, low self-esteem has been shown to be a risk factor for developing prolonged grief following the death of a spouse (Dellmann, 2018). Similarly, communication between the surviving parent and their child(ren) has been shown to be a protective factor for child and adolescent psychological health following the death of a parent (Howell et al., 2015; Shapiro et al., 2014; Weber et al., 2019b). Such communication is considered to be one of the most important factors in adjusting to the death of a family member (Kamm & Vandenberg, 2001). Bereavement may affect parent and child psychological health, self-esteem, and communication in both the short and long term (Ayers et al., 2014; Bergman et al., 2017; Pfeffer et al., 2000; Worden & Silverman, 1996). Thus, interventions are needed for bereaved children and parents who experience negative psychosocial outcomes.

Many types of interventions have been tested and implemented around the world for parentally bereaved children, including group, family, and individual therapy, as well as support groups, cognitive behavioral therapy, camp activities, expressive arts or music therapy, parental guidance, and trauma-/grief-focused school-based brief psychotherapy (Bergman et al., 2017; Chen et al., 2015; Rosner et al., 2010). Support programs including brief psychosocial interventions seem to be effective in preventing the development of more severe psychological health problems in parents and children (Bergman et al., 2017; Sandler et al., 2010a, 2016, 2010b) and are likely easier and less expensive to implement in a community or healthcare setting.

The intervention that has been most extensively evaluated is the Family Bereavement Program (FBP)

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which has 14 sessions in all: 12 two-hour sessions where parent and child groups meet with trained therapists, and two meetings for individual families. FBP has been shown to be effective at reducing parent and child psychological health problems following participation in FBP and at 15-year follow-up, as well as improving parenting skills (Ayers et al., 2014; Sandler et al., 2003, 2010a, 2018, 2016). However, despite the positive results of FBP studies, an obstacle to the FBP is that the group sessions have been difficult to implement in real-life settings (Sandler & Center for Complicated Grief, 2020), as they may not be convenient for participating families. The Grief and Communication Family Support Intervention was adapted from the FBP and aims to reinforce open family communication, provide psychoeducation on grief, and promote healthy adaptation to bereavement. We adapted the Grief and Communication Family Support Intervention from the FBP to be more feasible for implementation in a community healthcare setting. It was modified to include only family meetings and shortened to three 90-minute sessions with a family therapist. We have previously described the adaptation of the Grief and Communication Family Support intervention in detail (Weber et al., 2019a). Parents and children previously reported that they had learned new communication skills and gained new knowledge regarding other family members' personal experiences through participation in the Grief and Communication Family Support Intervention (Weber et al., 2020). The current study aimed to expand upon these results by examining the change in parent self-ratings of depression, anxiety, prolonged grief, and self-esteem and in child (via parent proxy) ratings of internalizing and externalizing problems, prolonged grief, and communication after participation in the Grief and Communication Family Support Intervention.

Methods

Grief and communication family support intervention

The Grief and Communication Family Support Intervention is comprised of three 90-minute sessions where the surviving parent and child(ren) meet with a family therapist. The three sessions provide the family with opportunities to talk about its current situation, to learn about grief and communication, and to practice communication skills. Family therapy methods which focus on family relationships and emotional processing through family discussion are combined with cognitive behavioral methods, including skills training and roleplay. The contents of each session have been described in more detail in a previous study (Weber et al., 2019a). In brief, session one focuses on establishing a therapeutic alliance while providing the family with psychoeducation on grief and communication. Session two uses skills training exercises to teach communication skills such as "I" messages, sharing feelings, and active listening. During the third session, family members learn a problem-solving strategy and use the communication skills they have practiced in previous sessions in an exercise where each family member shares a memento of the deceased parent with the rest of the family and the therapist.

Design

This study used a pretest–posttest design and was part of a pilot of the Grief and Communication Family Support intervention. All participants were given the opportunity to participate in all three sessions of the Grief and Communication Family Support Intervention. Quantitative data for the parents and children were collected at baseline, one-month follow-up, and one-year follow-up. Additional quantitative data for the children were collected via parent proxy at a six-month follow-up.

Participants

Participants were recruited from a larger questionnaire study which aimed to explore and describe family communication, grief, and psychological health in parentally bereaved families. Deceased persons aged 25–65 years were identified using the Swedish National Causes of Death Register and were then linked to surviving children, between the ages of 1 and 18 years at the time of their parent's death, using the Multi-Generational Register at Statistics Sweden. If the deceased had been living in Stockholm county with a partner, the surviving partner and children were eligible for the questionnaire study. Participating families were required to reside in Stockholm county at the time of data collection and be able to understand written and spoken Swedish. These families were sent an information letter by post, with information regarding a questionnaire study and a request for participation. Upon completion of the questionnaire study, parents were asked if they were interested in participating in the current intervention study. In total, 42 parents (24 mothers and 18 fathers), average age 48.1 ($SD = 5.9$) years old with a mean time since

loss of 3.5 years ($SD = 0.9$) participated by completing the parent self-report questionnaire while 39 parents completed parent-proxy questionnaires for a total of 55 children (25 girls and 30 boys), with a mean age of 12.78 years ($SD = 4.42$). Parents needed to have completed the parent self-report questionnaire as well as a parent-proxy questionnaire for at least one child to participate in the intervention. Ten of those 39 parents, five mothers and five fathers (ages 39–56 years) with a mean age of 48.00 ($SD = 5.27$) years, agreed to participate in the intervention, along with 14 children (ages 6–20 years at baseline), with a mean age of 11.42 years ($SD = 4.05$). Of the 10 parents, four had two participating children. Mean time since loss at baseline was 3.10 years ($SD = 0.87$). All of the deceased parents died of various forms of cancer, including skin cancer ($n = 1$), stomach/colon cancer ($n = 3$), pancreatic cancer ($n = 1$), sarcoma ($n = 2$), lymphoma ($n = 1$), ventricular cancer ($n = 1$), and acute leukemia ($n = 1$).

Specific inclusion criteria from the National Board of Health and Welfare included: the deceased parent and surviving parent must have lived at the same address, and children and adolescents must be registered at the same address as their parent at the time of the study. This effectively excluded families with separated or divorced parents and adolescents who had moved from the family home. There were no inclusion or exclusion criteria regarding mental or physical illness or having previously sought any type of psychosocial support.

Procedure

The study was registered at clinicaltrials.gov (Identifier: NCT03351582) and approved by the Regional Ethics Committee of Stockholm (Dnr 2016/1192/31/1). Parents completed an online baseline self-report questionnaire which included four instruments measuring self-esteem, anxiety, depression, and symptoms of prolonged grief, as well as a similar parent-proxy questionnaire for each of their children, with instruments measuring prolonged grief, communication, and strengths and difficulties. At the end of the parent questionnaire, a brief description of the current intervention study was given in writing and parents could respond by indicating if they would like to participate, would like more information, or declined participation. Parents who indicated that they were interested in participating or would like more information regarding the intervention were sent information by e-mail. The research team contacted these families by telephone a few days later to explain the study in greater detail, answer questions, and obtain verbal consent for participation. If a family wanted to participate, their contact information was given to one of two licensed family therapists who would be conducting the intervention. Which therapist they were allocated to was based on where the family lived. The therapist contacted the family to schedule the three sessions, which were held at the therapist's private practice.

Written informed consent was collected at the beginning of the first session. At one month and one-year post-intervention, parents completed a self-report online questionnaire which contained the same instruments as the baseline questionnaire. Parents were asked to complete a similar proxy questionnaire on behalf of each of their children aged 3–20 years at one-month follow-up, six-month follow-up, and one-year follow-up.

Therapist training and fidelity

Family therapists with similar credentials and experience were recruited to help develop and provide the intervention. Both therapists were present for all development and training sessions. During the training sessions, the therapists roleplayed the modules, asked questions, discussed how best to execute each module, and gave each other feedback. Therapist skills and confidence were monitored throughout the study in coaching sessions with the first author.

Each session was audio recorded with the family's permission. The first author listened to the audio recordings of completed sessions and provided feedback and coaching to the therapists, both individually and together. The therapists engaged in peer-to-peer supervision as needed. As reported in a previous study, the Grief and Communication Family Support Intervention was provided with a high level of fidelity (Weber et al., 2020).

Measurements

Self-esteem

The Rosenberg Self-Esteem Scale (RSE) was used to measure parents' self-reported self-esteem (Rosenberg, 1989). The RSE has 10 items on a 4-point scale (1 = strongly disagree to 4 = strongly agree), with total scores ranging between 10 and 40. Suggested cutoff scores based on previous studies (Isomaa et al., 2013; Lundberg et al., 2018) are as follows: 10–24 low self-esteem, 25–35 normal self-esteem, 36–40 high self-esteem. The internal consistency of the RSE in this sample was high (Cronbach's $\alpha = 0.96$), with a mean score of 18.00 ($SD = 8.32$) at baseline.

Generalized anxiety

Parents' self-reported symptoms of anxiety were measured with the Generalized Anxiety Disorder 7-item Scale (GAD-7), which has seven items rated on a 3-point scale (0 = not at all to 3 = nearly every day), with a maximum score of 21. Cutoff scores were: 5–9 indicating mild anxiety, 10–14 moderate anxiety, and ≥15 severe anxiety (Spitzer et al., 2006). The internal consistency for reliability of the GAD-7 was high in this sample (Cronbach's $\alpha = 0.95$), with a mean score of 12.60 ($SD = 6.48$) at baseline.

Depression

Parents' self-reported symptoms of depression were measured using the self-report version of the Montgomery–Åsberg Depression Rating Scale (MADRS). The MADRS has nine items on a seven-point scale (0–6 points), rating sadness, inner tension, reduced sleep, reduced appetite, concentration difficulties, fatigue, inability to feel, pessimistic thoughts, and suicidal thoughts. Higher scores indicate a greater risk of depression. The maximum score is 54 points (Montgomery & Asberg, 1979). Scores between 13 and 19 points indicate mild depression, 20–34 points moderate depression, and ≥35 points severe depression (Svanborg & Asberg, 2001). The internal consistency for reliability of the MADRS was high in this sample (Cronbach's $\alpha = 0.91$), with a mean score of 18.5 ($SD = 8.70$) at baseline.

Prolonged grief

The Swedish version of the Prolonged Grief Disorder-13 (PG-13) was used to measure parents' self-reported symptoms of prolonged grief (Prigerson et al., 2009). Parents also completed the PG-13 Child for each of their participating children. The PG-13 Child is based on the PG-13 for adults but has simpler language. The PG-13 and the PG-13 Child each contains 13 items with 11 items assessing cognitive, behavioral, and emotional symptoms related to grief, which are rated on a 5-point scale (1 = not at all to 5 = several times a day/overwhelmingly, range 11–55). Two items assess duration and impairment and are answered "yes" or "no." A higher score indicates more symptoms of prolonged grief. A score of ≥ 35 indicates possible prolonged grief disorder (Pohlkamp et al., 2018). The internal consistency for reliability of the PG-13 was high in this sample (Cronbach's $\alpha = 0.93$), with a mean score of 23.40 (SD = 9.95) at baseline for parent reports. For proxy reports, reliability was also high (Cronbach's $\alpha = 0.89$), with a mean score of 16.59 ($SD = 6.99$) at baseline. This is similar to our earlier study from which the participants in the current study were recruited where internal consistency for the PG-13 parent report for children was high ($\alpha = 0.88$). To our knowledge, there are no studies examining the validity or reliability of PG-13 child when used as a parent-proxy or self-report.

Parent and adolescent communication

The Parent and Adolescent Communication (PAC) scale has 20 items, administered through a parent-proxy form or an adolescent self-report form. Only the parent-proxy form was used in this study. The PAC measures family communication on two subscales (open family communication and problems in family communication). Each subscale has 10 items that have been validated using factor analysis (Barnes & Olson, 1985). The two subscales are added together to get a total score for parent-adolescent communication, with higher scores indicating a better quality of communication (Barnes & Olson, 1985, 2003). Cutoff categories are as follows: 70 and below signifies low communication, 70–79 moderate communication, 80–85 high communication, and 86–100 very high communication. Internal consistency for the proxy reports in this study was found to be high (Cronbach's $\alpha = 0.79$), with a mean score of 77.16 ($SD = 9.71$) at baseline.

Strengths and difficulties

Parents completed the parent report of the Strengths and Difficulties Questionnaire (SDQ). The SDQ has 25 questions that are divided into five subscales: emotional symptoms, conduct problems, hyperactivity, peer relationship problems, and prosocial behavior. The total difficulties score is calculated by combining the scores from all the subscales except prosocial behavior. The SDQ total score is used in this study as it provides an overall score for children's internalizing and externalizing problems. Each item is scored on a scale 0–2 with 0 indicating "not true," 1 indicating "somewhat true," and 2 indicating "certainly true." Questions 7, 11, 14, 21, and 25 are inversely scored. Higher scores indicate more problems. Cutoff categories for the SDQ total score are: 0–13 average, 14–16 slightly high, 17–19 high, 20–40 very high. The SDQ's five-factor structure has been supported in large-scale surveys (Goodman, 2001; Malmberg et al., 2003; Smedje et al., 1999). Internal consistency was high for the parent-proxy reports of total problem score (Cronbach's $\alpha = 0.85$), with a mean score of 8.88 (SD = 6.17) at baseline.

Analysis

Reliable change (RC; Christensen, 1986; Jacobson et al., 1984; Jacobson & Truax, 1991) was calculated using an

online html calculator (https://www.psyctc.org/stats/rcsc1.htm) to determine whether an individual participant's reported score on an instrument changed sufficiently. Here, this meant that the change in score was greater than what the unreliability of the measure would suggest might be seen for 95% of participants and was checked by reviewing if the difference between the follow-up and the initial scores exceeded a certain level. Cronbach's α is the parameter of internal consistency with the most theoretically consistent approach, since it is based on classic reliability theory (Evans et al., 1998).

The calculation of reliable change requires estimates of a scale's internal consistency and standard deviation for a given population. The threshold for reliable change is calculated as 1.96 times the standard error of the difference between scores of a given measure administered on two occasions. Standard error of the difference (SE_{Diff}) was calculated using the Jacobson and Truax (1991) formula.

Jacobson and Truax (1991) also discussed the assessment of clinically significant change, meaning that an individual's score following the intervention moves from the dysfunctional to functional range, as indicated by each instrument. Since each of the instruments used in this study had recommended cutoff points, clinically significant change was assessed by checking if an individual's change in score resulted in a change in cutoff category. The change in category was then compared with the criteria for assessing clinically significant change; that is a change of at least two standard deviations, as proposed by Jacobson and Truax (1991) and Evans et al. (1998).

Using the above criteria, parent and child (proxy) outcomes were classified as *Recovered* (significant change in score as measured by RC and significant clinical change as measured by a change in score of two standard deviations or more), *Improved* (significant change in score as measured by RC, but no clinically significant change), *Unchanged* (neither a significant change in score as measured by RC nor a clinically significant change), or *Deteriorated* (significant change in score as measured by RC, but in a direction indicating increased severity of symptoms rather than improvement of symptoms) (Wise, 2004).

Results

Parents

All but one participating family completed all three sessions of the Grief and Communication Family Support Intervention. The tenth family completed only the first session. Nine of the ten parents completed the questionnaire at baseline and at least one of the follow-ups. Seven parents completed the one-month follow-up and seven completed the one-year follow-up. Five parents completed the questionnaire at all three timepoints.

One-month follow-up reports for self-esteem showed that four parents were classified as improved and one was classified as deteriorated. At one-year follow-up, two parents were classified as recovered, three were improved, and one was deteriorated. Both parents classified as recovered and the three parents classified as improved at one-year follow-up were in the clinical range (score $<$ 24, low self-esteem) at baseline (Table 1).

With regard to anxiety, the one-month follow-up showed that one parent was classified as improved. At one-year follow-up, two parents were classified as improved and one as deteriorated. Both parents who were classified as improved were in the clinical range (score $>$ 15, severe anxiety) at baseline (Table 1).

There were no significant changes for depression at one-month follow-up. At one-year follow-up, one parent was classified as improved and one as deteriorated. The improved parent was not in the clinical range (score $>$ 35, severe depression) at baseline (Table 1).

One-month follow-up reports for prolonged grief showed that one parent was classified as improved and two were classified as deteriorated. At one-year follow-up, two parents were classified as improved and two were classified as deteriorated. One of the improved parents was in the clinical range (score $>$ 33, possible PGD) at baseline (Table 1).

Children via parent proxy

Parent-proxy reports were completed for thirteen children at baseline, nine children at one-month follow-up, eleven children at six-month follow-up, and six children at one-year follow-up. Parent-proxy questionnaires were completed at all four timepoints for a total of three children (Table 2).

One-month follow-up reports of children's prolonged grief showed that one child was classified as deteriorated. No significant changes were evident at six-month follow-up. At one-year follow-up, one child was classified as deteriorated. All the children scored below the cutoff for probable prolonged grief disorder (score $>$ 33) at all four timepoints (Table 2).

One child was classified as having improved communication at one-month follow-up. At six-month follow-up, one child was classified as recovered. This child was not in the clinical range (score $<$ 70, low

Table 1. Parents' scores at baseline, one-month follow-up, and one-year follow-up.

	Rosenberg Self-Esteem Scale RC = 4 SD = 8.32			Generalized Anxiety Disorder 7-item scale RC = 4 SD = 6.48			Montgomery–Åsberg Depression Rating Scale RC = 7 SD = 8.77			PG-13 Adult RC = 7 SD = 9.95		
One-year follow-up	Baseline	One-month follow-up	One-year follow-up	Participant	Baseline	One-month follow-up	One-year follow-up	Baseline	One-month follow-up	One-year follow-up	Baseline	One-month follow-up
1	34			26			40			47		
2	22	21		8	7		11	13[1]		20	18	
3	11	22*	20*	8	7	10[1]	12	16[1]	17[1]	20	27[d]	29[d]
4	29	23[d1]	15[d1]	21	14*[1]	13*[1]	20	24	29[d]	45	34*[1]	29*[1]
5	12	25*[1]	28[+1]	11	10	7[d1]	14	13	13	22	29[d]	18
6	15	25*[1]	21*	17	19	21*	23	21	22	28	33	29
7	10		29[+1]	9		7	11		11	15		24[d]
8	10	22*		10	7[1]		18	14		14	15	
9	21	24	20	9	7	8	14	11[1]	17	28	27	23
10	19		26*[1]	7		7				27	26	19*

*Improved.
[+]Recovered.
[d]Deteriorated.
[1]Change between cutoff categories between baseline and follow-up, per accepted scoring instructions.

Table 2. Parent proxy-reported scores for children at baseline, one-month follow-up, six-month follow-up, and one-year follow-up.

	PG-13 Child RC = 6 SD = 6.99				Parent and Adolescent Communication scale RC = 12 SD = 9.71				Strengths and Difficulties Questionnaire RC = 6 SD = 6.58			
One-year follow-up	Participant	Baseline	One-month follow-up	Six-month follow-up	One-year follow-up	Baseline	One-month follow-up	Six-month follow-up	One-year follow-up	Baseline	One-month follow-up	Six-month follow-up
1	28		29		79		100[+1]		25		7[+1]	
2	12	15			75	81			8	8		
3	12		14		82		80		5		5	
4	12	13	13		63	69	73		4	8	3	
5	11	12	11		86	83	82		3	9	2	
6	22	22	17	19	69	66	76	66	18	10*[1]	4[+1]	14
7	14		13	21[d]	92		86	94	3		1	0
8	13	13			100	98			8	5		
9	11	17[d]	12	13	70	83*[1]	80	81	16	12	17	13
10	19		19	13	79		82	88	5		10	3
11	11		14	13	78		70	87	5		6	6
12		11	14			82	82			4	10	
13	17	20	19	21	78	77	75	78	4	11[d]	8	8
14	19	16			79	83			18	10*[1]		

*Improved.
[+]Recovered.
[d]Deteriorated.
[1]Change between cutoff categories between baseline and follow-up, per accepted scoring instructions.

communication) at baseline. No significant changes were evident at one-year follow-up with regard to communication (Table 2).

One-month follow-up responses to the Strengths and Difficulties Questionnaire showed that two children were classified as improved and one as deteriorated. At six-month follow-up, two children were classified as recovered, one of whom had scored in the clinical range (score > 20, very high total problem score) at baseline. No significant changes were evident at one-year follow-up (Table 2).

Discussion

Due to our small sample size, the results are preliminary. However, our findings suggest that the Grief and Communication Family Support Intervention may have a positive effect on self-esteem and anxiety for parents and on internalizing and externalizing problems, as measured by the SDQ, as well as on communication for children, when assessed using a parent proxy. These results are in line with the results from the FBP, from which the Grief and Communication Family Support Intervention was adapted (Weber et al., 2019a). Results from the FBP showed reduced conduct problems, depression, internalizing problems, and externalizing problems for children (Ayers et al., 2014; Sandler et al., 2002, 1992, 2010b). Furthermore, parents who participated in the FBP had reduced general psychiatric distress and problematic grief at six-year follow-up when compared with a control group (Sandler et al., 2010a, 1988, 2016). These results were still evident at a 15-year follow-up (Sandler et al., 2018). However, results from the FBP randomized trial versus a literature comparison condition showed decreased parental depression and grief at posttest and over time, whereas there were limited effects on parental depression in the current study.

Parents reported improved self-esteem following their participation in the Grief and Communication Family Support Intervention. Prior research has shown that self-esteem is one of the strongest predictors of life satisfaction and happiness and that it may be a protective factor for psychological health following the death of a partner (Dellmann, 2018). Many older widows and widowers have reported reduced self-esteem following their partner's death, which has been associated with loss of self-identity, increased emotional loneliness, and higher symptom levels of prolonged grief (Dellmann, 2018; Van Baarsen, 2002).

Parents also reported reduced anxiety following their participation in the Grief and Communication Family Support Intervention. Anxiety is common in bereavement and symptoms of anxiety are often severe (Shear et al., 2011; Zisook et al., 1990). Anxiety can derail the grieving process and may even prolong grief (Shear et al., 2011). Previous research has shown that young widows and widowers who experience a loss of income due to their partner's death, and those who do not have adequate social support, are at a greatest risk of developing anxiety (Zisook et al., 1990).

Parent-proxy reports showed reduced internalizing and externalizing problems for children following their participation in the Grief and Communication Family Support Intervention. A main factor associated with the development of internalizing and externalizing problems in children and adolescents is the quality of the parent–child relationship. In an earlier study of the Grief and Communication Family Support Intervention (Weber et al., 2020), parents and children reported improved family relationships, which may explain the reduction in internalizing and externalizing problems for some of the children in the current study. If left untreated, internalizing problems may lead to disability retirement in adulthood due to persistent and pervasive symptoms of depression or anxiety. Similarly, externalizing problems in childhood and adolescents increase the risk for internalizing problems, as well as somatic health problems in adulthood (Narusyte et al., 2017).

Parent-proxy reports also showed improved communication for children following their participation in the Grief and Communication Family Support Intervention. Higher quality parent-child communication has been associated with lower occurrence of conduct problems in parentally bereaved children and adolescents (Weber et al., 2019b). Family communication is considered a protective factor for child and adolescent psychological health following the death of a parent, as communication is the primary process through which children and adolescents receive social and emotional support, as well as information (Houck et al., 2007; Howell et al., 2016; Shapiro et al., 2014).

The Grief and Communication Family Support Intervention is meant to be a preventive intervention. Participants did not need to have high symptom levels to participate, which makes our assessment of clinical improvement more complex. As most participants had mild to moderate symptoms to begin with, their capacity for improvement was limited. Most participants were unable to achieve an improvement in the score of two or more standard deviations, thus limiting our ability to achieve clinically significant results. Another proposed measurement of clinically significant change is

the use of a change in score of one standard deviation, moving closer to the normal population (Wise, 2004). Had we used a criterion of a change of one standard deviation for clinically significant change, rather than two or more standard deviations, many more of our participants could have been classified as recovered. While the results of the current study show that the Grief and Communication Family Support Intervention may be beneficial, we cannot be sure that the observed individual improvements in psychological health are a direct result of participation in the intervention. One hypothesis suggested by researchers working on the Family Bereavement Program is that preventive interventions such as the FBP and the Grief and Communication Family Support Intervention may have delayed effects on psychological health outcomes, as psychological health is likely mediated by proximal outcomes such as family communication, family functioning, and family coping. For children, another proximal outcome may be their surviving parent's psychological health. Once processes related to these proximal outcomes have stabilized, they may in turn affect secondary outcomes, such as psychological health (Sandler et al., 2003). This hypothesis could help explain why significant changes to scores, which resulted in a change of two standard deviations, were only evident at six-month and one-year follow-ups. This highlights the importance of following intervention participants over the course of several years to better understand the long-term impact of participating in preventive interventions.

The results of this study suggest that scoring in the clinical range (i.e., the highest or lowest possible cut-off category per accepted scoring instructions) at baseline may predict improvement or recovery for parents. Since so few children scored in the clinical range at baseline, yet still improved, it is not possible to say if the same holds true for children as well. When bereavement counseling or therapy are offered to all families or individuals who have lost a loved one—often called a universal approach to service delivery—there is little evidence that therapy interventions are effective or beneficial when compared with control groups receiving informal community-based social support (Aoun et al., 2012; Schut, 2010). On the other hand, bereavement counseling and therapy can be highly effective when sought out by the individual or when selectively offered to families or individuals at high risk of developing psychological or somatic complications as a result of bereavement (Aoun et al., 2012; Neimeyer, 2015; Schut, 2010; van der Houwen et al., 2010). Parentally bereaved children are considered a risk group for developing psychological health problems (Ayers et al., 2014; Berg & Hjern, 2016; Spuij et al., 2015; Worden & Silverman, 1996) and may benefit from the Grief and Communication Family Support Intervention, despite low levels of symptoms.

Future studies of the Grief and Communication Family Support Intervention may need to have stricter inclusion criteria, so that only families where at least one family member rates their symptoms as being in the clinical range are included. However, more research is needed with a larger sample to better understand the short- and long-term outcomes of the Grief and Communication Family Support Intervention on parent and child psychological health, self-esteem, and communication. A larger scale open trial might be the preferable next step to better understand which families may or may not benefit from the intervention.

Methodological considerations

RC, combined with a measurement of clinically significant change, has withstood rigorous debate and despite some methodological limitations has altered the paradigm of clinical outcome research from a group focus to an individual one. This method ensures that the recovery and improvement rates of participants in intervention trials or psychotherapy are very conservative, which provides some certainty that those classified as "recovered" are truly examples of treatment or intervention success (Jacobson et al., 1984).

Early formulas for RC were criticized and several researchers attempted to improve them. However, after comparison of several different ways to calculate RC, most researchers agreed that the method proposed by Jacobson and Truax (1991), used in this study, was the superior method (Wise, 2004).

On the other hand, how best to determine clinically significant change has been debated (Lambert & Ogles, 2009). Criteria such as improved functioning, reduced negative impact on others, or improved quality of life are alternative, perhaps superior methods of establishing clinically significant change (Kazdin, 2001; Wise, 2004). However, by defining clinically significant change as a change in two or more standard deviations, we reported conservative results regarding participant recovery which, given the already subclinical scores at baseline, may mask the actual improvement experienced by participants.

Strengths and limitations

Our findings offer preliminary evidence of which aspects of psychological health that may be affected by the Grief and Communication Family Support Intervention. The use of several follow-up questionnaires over the course of one year helps show how participant psychological health changes over time. Similarities between the findings of the current study and the findings from trials of the FBP may help validate those of our current study, as the Grief and Communication Family Support Intervention was adapted from the FBP.

A limitation of this study was the use of a parent proxy rather than child self-reports. Adolescents were asked to complete self-report questionnaires as part of this study, but none of the participating adolescents did so. Attrition was also a limitation, as not all parents completed assessments at all timepoints. In some cases, parents completed the parent-proxy assessment for their child, but not the parent self-report. One parent completed none of the parent self-report follow-ups but did complete the parent-proxy follow-ups. The small sample size and problems with attrition limit the generalizability of our findings and our ability to draw conclusions from the findings of this study. Furthermore, it is not possible to be sure that the observed changes in participant psychological health are a direct result of the intervention, rather than other confounding factors such as time or participant characteristics.

Another limitation is that only five parents completed assessments at all time points. We could speculate that the non-completers are parents who showed less benefit from the intervention. Also, only 7 of the 10 parents who started the program completed the assessment at 1 month or 1 year, indicating a 30% rate of attrition. Furthermore, by including a fairly homogenous group of participants, all of whom had experienced the death of a partner/parent due to cancer, the findings may not be transferable to families experiencing the death of a parent due to other causes. Lastly, having only two therapists pilot the intervention limits generalizability; thus, a large effectiveness trial with multiple sites and therapists providing the intervention with children experiencing grief due to different causes of death are needed.

Conclusions

This study provides preliminary evidence that the Grief and Communication Family Support Intervention may improve some aspects of psychological health and communication for some bereaved children based on parent-proxy reporting and parents following the death of a parent/partner due to cancer. The parents had improved self-esteem and reduced anxiety, but symptoms of depression and prolonged grief were not improved. Furthermore, the results showed improved communication and reduced internalizing and externalizing problems in participating children. Parents who reported more symptoms at baseline showed more improvement than those who reported fewer symptoms at baseline, which is in agreement with previous research. While this study suggests a potential for promising outcomes for the Grief and Communication Family Support Intervention, more research is needed using a randomized controlled trial design.

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