A FAMILY FOCUSED APPROACH FOR THE TREATMENT OF GRIEF AND LOSS: GROUP AND FAMILY THERAPY

by

LINDA R. McFADYEN CROLL

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Abstract

The purpose of this practicum was to develop a comprehensive family focused program to support children and their caregivers in dealing with the death of a loved one. This practicum involved three treatment modalities: a psycho-educational support group for parents, multiple family group work, and family therapy follow-up. A corresponding practicum offered by Ms. Judy Tozeland included a children's play therapy group. Ms. Tozeland was also the co-therapist in the multiple family group.

Four families, including eight children ages 8 to 12 years and six adult caregivers, participated in an eight week group program. Two families participated in family therapy follow-up. The practicum was conducted from January, 1997 to November, 1997.

The practicum used a combination of systemic and developmental perspectives of family grieving. Some emergent treatment themes related to the primary issue of loss included: attachment issues, secondary losses, grieving tasks, developmental issues, family functioning patterns and parental readiness for treatment.

The four families who participated in this practicum were actively involved during the duration of treatment and a strong sense of cohesion developed between the participants and therapists. All four families indicated that the program assisted in their process of accommodating to their losses.

Acknowledgements

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Thanks to the families who trusted us with their stories and included us in their journey of accommodating to their losses. It was an honour to work with all of them.

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LITERATURE REVIEW

Assisting children and families to cope with the death of a loved one involves a multi-layered clinical approach. Firstly, clinicians need to have a thorough understanding of grieving theories, including the emotional processes and practices necessary to provide support to families seeking assistance. This includes respect for the spiritual dimension that assists individuals and families to make sense of the death and mourn the loved one. This additional factor for grief work has direct implications for therapists in relation to their own belief systems and in terms of the self awareness necessary to work in this area of treatment.

Secondly, clinicians need to be knowledgeable in the area of normal child development, especially the cognitive and emotional domains that are particularly relevant in determining children's abilities to process death.

Thirdly, clinicians need to recognize and understand the importance of family dynamics and the family life cycle stages that existed prior to the death. These factors significantly influence the grieving family's emotional process and interactional coping patterns in adjusting to the loss.

This literature review explores the aforementioned and gives consideration to suggested treatment modalities including group therapy, family therapy and multiple family therapy groups. The information gathered to support this practicum focused on the needs of

the particular client group of four families that included children in the age range of 8 to 12 years inclusive, where there was a loss of a significant family member through death.

A set of definitions supporting the language used in this practicum report were developed. Gathered from a variety of sources they were chosen on universal applicability. An historical overview considers past and present approaches to grief and loss and the impact of social structure on families coping with loss. Grieving responses and mourning tasks are reviewed as they pertain to the population served in the practicum: children, adults, and their relationship configurations.

Definitions

There are several terms that are used in relation to grief and loss issues and many of them are used interchangeably in the literature. Some of the commonly used terminology are as follows:

Grief is usually considered a feeling of deep sorrow (Furman, 1974); a natural emotional and cognitive occurrence, and a normal internalized response to the loss of a significant person, thing or idea (Goldman, 1994). Most families experience a variety of losses in daily living through loss of persons, things or broken dreams resulting from death, divorce, relocation, exposure to violence, personal harm or through environmental disasters (Goldman, 1994). Grieving is the emotional and intellectual process that enables families, and individuals within the family, to adjust to their loss over time. There is no right or

wrong way to grieve. Grieving is described as a personal process that occurs at the individual's own pace and in accordance with their developmental abilities (Goldman, 1994; Shapiro, 1994).

Grief work is often described as "the cognitive process of coming to terms with a loss through confronting the loss and restructuring thoughts about the deceased, the events of the loss and the world as it is without the deceased" (Klass et al., 1996). Grief work is the process that the bereaved enter into, with family, friends or therapists to incorporate the loss into their lives.

Mourning occurs when the internal experience of grief is expressed externally (Goldman, 1994; Furman, 1974). It is also referred to as the mental work following the loss of a love object through death. Mourning is influenced by spiritual and cultural beliefs and expressed through traditional behaviours or rituals such as funerals, wakes and shivas. Some references distinguish between grief and mourning by using the term 'grief' when referring to the initial period of sadness following the loss and 'mourning' as occurring beyond this initial phase (Brooks & Siegel, 1996).

Bereavement is recognized as the state of having lost someone or something, including dreams, dignity or self-respect (Goldman, 1994). Bereavement describes the psychological state that involves renegotiation of the meaning of the loss over time (Klass, et al., 1996).

Historical Overview

Expectations for grieving have changed over time and appear to reflect the social values and mores consistent with the times (Klass, Silverman, & Nickman, 1996; Danbury, 1996). Dating back to the 'romantic age' of the 19th century, the value of love was emphasized strongly, over and above more practical needs. During this period the power of love was all encompassing and eternal; to the degree that 'broken hearts' did not mean 'broken bonds' since love was sustained beyond death. Conversations with deceased were accepted as normal and visions of the deceased were a sign of strong love and commitment rather than pathological hallucinations. Limits to grieving were not defined and mourning could and did last the duration of a lifetime.

The 20th century modernist approach to life stressed "goal directness, efficiency and rationality" over emotion (Klass, et al. 1996, p. 32). Views related to grief work reflected these social values. Emphasis was placed on the need to recover from the intense emotions of grief as quickly as possible and to return to normal functioning and productivity. A good adjustment to loss was deemed possible by breaking the ties between the bereaved and the deceased, thereby decreasing attention to the loss and minimizing its pain.

Psychoanalytic theories related to grieving emerged in the early part of the 20th century as an indirect result of a paper written by Dr. Sigmund Freud, titled "Mourning and Melancholia" (Klass, et al., 1996). Freud's paper focused on narcissism and purported that melancholia or

depression resulted from an inability to relinquish a love object (Danbury, 1996; Furman, 1974). Although that paper was not based on studies of individuals who were mourning a permanent loss suffered through death, Freud's colleagues made the link to permanent loss. This extrapolation was never subsequently challenged by Freud, even though his own personal experience with loss in his life contradicted the suppositions of the model (Klass, et al. 1996). Unfortunately, Freud did not publicize his personal account of grief.

Freud's work was widely accepted as the cornerstone for theories related to grieving a permanent loss through death. Interpretation of the model suggested that the goal of the bereaved was to totally sever attachments to the deceased and form new attachments to other persons or love objects. Freud's theory was accepted with wide acclaim because it also supported society's need to have individuals unencumbered by emotional pain and functioning productively.

Freud's theories were supported by post modernists emerging in the middle part of the 20th century including Erich Lindemann, John Bowlby, and Elisabeth Kubler-Ross. Lindemann (1944) suggested that bonds to the deceased could be severed in 4 to 6 weeks with psychiatric interventions. Bowlby (Klass, et al., 1996) described a sequential response to grieving that included: protest, despair, searching, yearning and detachment. Kubler-Ross (Danbury, 1996) indicated that individuals grieving their own death moved through stages of: denial, anger, bargaining, depression and acceptance. These stages were interpreted as

linear and sequential, although not intended as such by Kubler-Ross.

For most of the 20th century it has been widely accepted in Western cultures that successful mourning involved disengaging with the deceased through severing bonds of attachment. Grieving individuals who did not follow this model and who attempted to retain connections to the deceased were diagnosed as pathologically ill and considered unable to cope (Klass, et al., 1996). Thus, bereavement was made into an illness in the 20th century by Western culture. It was considered a short term illness that was curable through therapy. Aggressive treatment measures were used to heal individuals by confronting denial, encouraging anger, and finally severing all ties to the deceased loved one. Treatment was considered effective if hallucinations or visions of the deceased disappeared and the bereaved individuals were able to function autonomously and productively in society.

Emotional and Physiological Responses to Grief

Grieving Responses of Adults

Adults often react to the loss of a loved one with a combination of physical and emotional responses that are suggested to be normal symptoms of grief (Lindemann, 1944). Some of the physiological symptoms include: sleep disruptions, loss of appetite, chest pains and a depressed immune system. Emotional responses include: shock and denial; a sense of disbelief in the events that have occurred; preoccupation or spontaneous thoughts of the deceased and of the pain,

guilt, and hostility; and impaired patterns of social function. While many adults are able to return to successful external functioning in two or three years, others may take much longer, based on factors related to the death (Danbury, 1996; Furman, 1974; Klass, et al., 1996).

There are a number of factors that influence adult grief reactions: family history of previous losses through death; family of origin relationship patterns; the personality and coping style of the mourner; the mourner's capacity to use external supports; the availability of social supports; circumstances of the death; the degree of trauma related to the death and the degree of responsibility felt by the adult in relation to the death (Shapiro, 1994). Responses to loss are highly individualized and are influenced by one's personality, one's ability to trust and establish intimacy in relationships, and by previous losses that one has suffered (Piper, McCallum, & Azim, 1992). While normal symptoms may be present for a year or two, most symptoms begin to decrease several weeks following the loss.

Pathological grief remains difficult to define based on the number of factors involved. Observing any of the following, however, may be cause for concern: a complete absence of conscious grieving; delayed reactions; chronic mourning; acute or distressful reactions that persist for months or years; or prolonged impaired functioning, separate from cultural or individual differences (Piper et al., 1992). Psychiatric disorders associated with grieving problems can include: depression, post traumatic stress disorder, hypochondriasis, panic or generalized anxiety

(Brooks & Siegel, 1996) .

Most individuals are able to cope with the trauma associated with the loss and do not seek clinical intervention. Family and friends usually provide the support necessary to assist the bereaved. Individuals who lack a strong emotional support system or who are dealing with a highly stressful loss, may seek assistance and work through their grief in therapy.

Grieving Responses of Children

There are a number of myths associated with children and their ability or lack of ability to grieve. These myths suggest that infants and toddlers are too young to grieve a loss and that a child who is able to play is not grieving (Goldman, 1994). Many adults believe that children should be protected from painful experiences and that such topics as death and funerals should be avoided. The research identifies these statements as myths (Goldman, 1994). Children who are old enough to experience attachment can experience grief at the loss of the attachment. Children need to be included in discussions about death and loss and although they grieve differently from adults, they do grieve and require support.

The loss of a significant person is traumatic for a child. The trauma is further intensified if the loss involves a parent or a sibling. Children expect parents and siblings to be around forever (Brooks & Siegel, 1996). A loss of this magnitude requires children to process it

throughout their entire childhood and into adulthood because the loss takes on new meaning and increased understanding with each developmental stage and milestone (Furman, 1974; Shapiro, 1994).

Children respond to a significant loss through behaviours that are usually associated with attachment trauma or attachment disruption (James, 1994). Children who were securely attached to the deceased may respond to the death with anger and severe distress exhibited through tearfulness, anxiety and oppositional behaviour (James, 1989). They may also search for the deceased with intense longing, withdraw from others and reject attempts of comfort (James, 1989). Children often idealize the missing person and engage in a variety of attempts to continue their connection to the deceased, including bargaining, magical thinking and reunion fantasies (James, 1994). Other children may be so overwhelmed by the experience that they show no reactions to the loss, preferring to avoid the reality.

Children who experienced problems in their attachment with the deceased may feel such a high degree of anxiety related to the loss that no amount of reassurance from other caregivers can provide them with comfort (James, 1989, 1994). Their ability to communicate their internal confusion will be limited and resultant behaviours may include extreme clinginess, hostility or oppositional behaviours including refusal, lying and stealing from others. All children attempt to cope as best they can given their developmental understanding and their support systems.

Helen Fitzgerald (1992) cites emotional responses for children's

grieving as including the following: denial or blocking of the death because it is too overwhelming for the child; anger that things 'can't be fixed' and that their life can't return to their sense of normalacy; guilt or regret that is connected to things that they wish they had done or said or wish they had not done in relation to the deceased; depression that is observable with changes in behaviours such as poor concentration, decrease in appetite, withdrawal, somatic complaints; and fears that are related to the shattering of their sense of security.

Goldman (1994) suggests a number of normal symptoms of grief for children. Behavioural symptoms include: sleeplessness, loss of appetite, poor grades, crying, nightmares, dreams of deceased, sighing, listlessness, forgetfulness, clinging, withdrawal, verbal aggression and bedwetting. Emotional responses include: anger, guilt, sadness, depression, relief, helplessness, fear, hysteria, loneliness, anxiety, rage, and feeling unreal. Some of the physical symptoms may include: headaches, fatigue, shortness of breath, dry mouth, dizziness, pounding heart, hot or cold flashes, empty feeling, tightness in throat or chest and stomach aches.

Some of the common feelings, thoughts and behaviours of grieving children may include: retelling events of the deceased's death and funeral; dreaming of the deceased; feeling the deceased is with him or her in some way; seeking new friends who have experienced a similar loss; needing to call home during the school day; inability to concentrate on school work; bursting into tears frequently; seeking medical

information on the death of deceased; worrying about their own health; appearing unfeeling about loss; becoming 'class clown' to seek attention or the child may take on a role of caretaker of others (Goldman, 1994).

The grief of children is also affected by a number of socio-emotional factors including: the nature of the relationship with the deceased, the quality of the relationship with the deceased, the availability of emotional support to the child following the death, the circumstances of the death, the personality and coping skills of the child, gender, economics and religion (Lohnes & Kalter, 1994,).

These factors suggest that the closer the relationship between the child and the deceased, the more affected the child will be by the death. If the relationship was a loving connection, the child will be strongly affected through the loss of the attachment. If the relationship was significant, but conflictual or harmful, the child will also be strongly affected by confusing feelings of love, anger and longing towards the deceased (James, 1994). If the death occurred following a long term illness, or if the death was sudden or violent, the impact on the child will differ. It is more difficult for children to process sudden and violent death, especially if the child witnessed the event.

Regardless of the nature of the relationship or the cause of death, children who have access to positive emotional support and strong attachments to others will fare better than those who are left to grieve in isolation (Fitzgerald, 1992; Furman, 1974; Shapiro, 1994).

Developmental Implications for Grieving Children

The ability of children to grieve the loss of a loved one is predominantly dependent on two factors: the child's cognitive ability to process the death and the socio-emotional support that the child receives within the familial caretaking environment (James, 1994). Erna Furman (1974) suggests that in addition to these two factors a child's previous experience with loss and longing will impact his/her ability to cope with death. Children who have suffered a series of severed attachments, or who have a history of inconsistent, unpredictable or abusive caregivers, will have great difficulty in coping with a permanent loss through death (James, 1994).

The concept of death requires the cognitive ability to understand that death is irreversible, universal and inevitable (Christian, 1997). As the child's developmental understanding increases, she/he may grieve intermittently for years. These abstract qualities are beyond the cognitive abilities of most children until they are about school-age, and even then the ability to deal with these concepts are in the early stages of development. Children are more likely to deny a loss at first because of their limited ability to understand death.

Developmentally, children are not able to tolerate the same kind of emotional intensity that adults can and they grieve in 'spurts' (Furnam, 1974; James, 1989). Play serves a variety of purposes for children, particularly in providing methods to practice their daily life experiences and express their interpretations and feelings related to these

experiences. Grieving children particularly use play to work through such a painful and confusing experience like death. Play can also offer the child intermittent periods of relief from the overwhelming experience of death and loss. Unlike adults, children need to move from grief to play on an ongoing basis using play rather than language to express their feelings of grief and to give them respite from the intensity of the feelings.

School-age or middle years children of 6 to 12 years, have an increased cognitive ability over younger children to understand and process death. They are at the cognitive developmental stage that is termed 'concrete operational thought' (Ashford, Lecroy & Lortie, 1997). The cerebral cortex of the brain has developed to the degree that higher functioning is present in language, perspective taking, problem-solving and self control (Ashford, Lecroy & Lortie, 1997). The child in this age group is able to engage in thought that is reversible and logical. Thought is based on what is real for the child through tangible observation. Thinking is cause and effect focused with an ability to generalize knowledge or learning from one area to another. The child is able to consider two thoughts simultaneously and has a good understanding of space, time and dimension. Short term memory is strong and long term memory has increased to include significant events of a few years earlier. Most magical thinking has disappeared and the child is able to understand the difference between concepts of 'real' and 'pretend'.

Language can be used as a tool for expression and to promote

mutual understanding. Children in this age range are able to engage in conversation, actively listen, ask questions, consider others, describe events logically and sequentially and discriminate between relevant and irrelevant information. They are able to understand the difference between behaviour and intent and can be helped to understand that they are not to blame for certain events in their lives.

Emotionally, children in this age range have the following abilities to process death: they are able to understand finality but can be confused with causality; they may appear unaffected as they can maintain an image of the deceased as present in their lives; or they may feel a sense of shame or stigma related to being different from others (Shapiro, 1995, p. 89).

Emotional development in this age group focuses on the task of industry versus inferiority (Ashford, et al., 1997). Self esteem is dependent on the child's ability to perform and produce in relationship to peers and to meet the expectations of adults in their environment. Emotional tensions can be released through physical play in this age group especially given the child's high need to be physically active.

It is not uncommon for children in this age group to appear unaffected or non-caring about a death. Some may continue to retain a close connection to the deceased, including illusions that the deceased is still present or will return (Christian, 1998) . Children in this age range strive to be the same as others their age and any sign of differentness, such as loss of a family member, may result in feelings of shame (James,

1994). Death may be perceived as punishment for bad behaviour based on cause and effect thinking. The importance of rules make rituals very necessary at this stage in development. Concrete thinking and general curiosity leads to detailed questions regarding the death itself and what will happen next for the child.

The resiliency and the coping abilities of the child, including the child's personality, have a strong impact on the child's grieving process (Bedard, 1992; Danbury, 1996; McFarlane, van der Kolk, & Weisaeth, 1996). Some children are insular and highly sensitive and have less ability to withstand the shock of a death related trauma. Children who are more adaptive by nature are better able to cope with loss. Those who have siblings with whom they can share the trauma of loss are better able to cope than children dealing with the loss in isolation. Children who have strong emotional connections to adults other than the deceased are more protected in event of trauma such as death. Social factors that can have a strong negative impact on the child's ability to cope with a significant loss include: oppressive living conditions, family violence, alcoholism, few family supports or resources and little hope for the future.

In summary, children respond to the death of a loved based on their attachment to the deceased, their ability to comprehend the meaning of the death and the availability of an emotionally supportive environment that is able to give them a sense of hope for their future.

Tasks of Mourning

Mourning Tasks of Children

There are several models to consider for tasks of grieving and mourning. Baker, Sedney and Gross (1991) have developed a model that organizes tasks of grieving and mourning for children in three phases:

1. Early tasks begin at the time that the child learns about the death. This phase involves the child attempting to understand the loss and using denial mechanisms to protect her/himself against the full force of the emotional impact of the loss.
2. Middle phase tasks include accepting the loss and feeling the full intensity of the emotional pain involved in the loss.
3. Late phase tasks involve a re-integration of the child's identity and resuming normal developmental growth and progress.

Children need to feel safe and emotionally secure before they can begin to mourn (Furnam, 1974). Children may fear that they will die, or that their family will fall apart, especially if a parent has died. Adults who withhold information from children to protect them from death are likely to increase the child's fears and anxiety as the child is left to use her/his imagination to process the events taking place (Baker et al., 1991) .

The model described by Brooks and Siegel (1996) outlines emotional responses experienced by children and adults in mourning: sadness, denial, guilt, anger, shame or stigma and acceptance. Similar to the tasks suggested for adults by Elisabeth Kubler-Ross, the process is not

linear and movement through the stages is individually motivated. Children move in and out of these responses based on their ability to understand the death and to tolerate the feelings related to the loss. Children also re-experience the loss during significant events or developmental milestones where they are reminded that the loved one is not present.

During the period of sadness children often exhibit symptoms related to depression. They may briefly withdraw from friends, lack interest in toys or games, experience poor school performance due to lack of motivation or poor concentration, or show marked changes in eating and sleeping patterns. Some children may feel such pain that they express wishes to go to heaven or never wake up. If these symptoms persist or escalate to the point of the child being at risk, the responses may be considered pathological.

Denial is a normal response of children to a traumatic event. Children have a limited ability to tolerate intense emotional distress and easily move into a world of fantasy. Children can be helped to cope with the reality by gentle reminders from adults and through reminiscing about the deceased. Children need the adult caretakers in keeping their memory of the deceased alive (Klass et al., 1996).

Children and adults experience similar feelings of guilt following the loss of a loved one. Children need help exploring their feelings and they need reassurance that they were not responsible for causing or preventing the death. If children are not encouraged to explore their

guilt feelings following the death, the feelings can negatively impact their memories of the deceased as well as their feelings about themselves.

Adults experiencing anger following a death usually find themselves angry with the deceased for abandoning them. Children's feelings of anger result from the overwhelming confusion and disorientation that they experience in relation to the loss (Brooks & Siegel, 1996). They act out these feelings through disruptive behaviour, having neither the cognitive or emotional language to express themselves in other ways. The disruptive behaviour can leave children feeling guilty for causing parents difficulty when they are already upset. Children may experience a loss of emotional support during the period that the adult caregivers are consumed by their own grief. This additional loss increases anxiety for children and leaves them feeling very isolated. When parents, or other adults are able to offer the children emotional support and reassurance, the disruptive behaviours usually decrease.

Grieving adults find comfort and solace in the support extended to them by family and friends. Children, however, prefer to be like others their own age and do not want to be reminded of the difference that the death has made for them (James, 1994). If the deceased was a parent or sibling, children may feel stigmatized and excluded at the times that the child needs the deceased to fulfill their role in the child's life. Children can also feel a sense of shame if the death resulted in any publicity for the child or family. Children need both sensitivity and support during these times.

There is ongoing controversy about the meaning of acceptance in the process of mourning. The Freudian psychoanalytical approach suggests that, for adults, acceptance of the death involves detachment from the deceased and commitment to another person. This particular view is challenged in current literature, and research suggests that acceptance may mean accommodating to the reality of the loss and establishing a changed relationship with the deceased (Klass et al., 1996). Children carry the image of the deceased throughout childhood and into adulthood. Children accommodate to their loss continually, because the loss takes on new meaning and understanding as the child grows and develops. It may be quite possible that children are able to retain attachments to deceased loved ones and continue to form new attachments to others simultaneously.

Mourning Tasks of Adults and Couples

According to Dr. Paul Montgomery (1979) there are four major grief areas that couples work through as they are processing the loss of a loved one. These areas are identified as: being able to allow and express individual feelings to one another related to the loss; the resumption of work and daily couple activities; relating to things that trigger memories of the deceased and sharing the emotional process with each other; sharing in the searching for a meaning to what has happened to them and their family.

Montgomery has observed that the individual grieving style of

each person determines how the couple relationship will cope with each task area. Grieving styles tend to operate on a continuum that ranges from total immersion and preoccupation at one end of the continuum to avoidance of intimacy at the opposite end. Most individuals will fluctuate on the continuum as the couple relationship seeks a balance between the partners' styles. When one partner is operating in avoidance mode, the other may be feeling the full intensity of the grief and strive to share their feelings with the partner.

The stages suggested by Montgomery do not appear to be linear and couples will move from stage to stage as they struggle to come to terms with their loss. Each partner of the couple will move in and out of the stages as individual needs require. Some individuals are comfortable immersing themselves into expression of feelings very soon following the loss. Other individuals need to use avoidance initially, and are more comfortable with the distractions offered by the work environment and daily routines. Some individuals seek comfort in the reminders or memory triggers of the deceased while others want them removed as quickly as possible. The spiritual search for meaning may become important soon after the death, or remain neglected until several months later.

It is normal for grieving couples to feel distant from one another (Montgomery, 1979; Shapiro, 1994). Couples who expect to either retain intimacy or increase emotional closeness during the period of mourning may find themselves highly conflicted and questioning the quality of the

relationship. Couples anticipating 'oneness' may find themselves feeling disappointed and isolated. External supports are very important to ensure that individuals within the couple relationship are receiving enough emotional support to contribute to the couple system.

Mourning Tasks of the Family

Death of a loved one interrupts relationship bonds that assist in defining the sense of self for all family members (Shapiro, 1994). As individuals within the family struggle to absorb and integrate the loss, the normal flow of family functioning and the course of family development is redirected towards coping with the crisis of the loss. Over time, families and individuals within the family unit process the loss to the degree that family functioning is restored. Many sources indicate, however, that it is not possible to fully recover from major losses such as a child's loss of a parent, a parent's loss of a child or a child's loss of a sibling (Dansbury, 1996; Furman, 1974; Shapiro, 1994). Again, the concept of accommodating to the loss appears more realistic than recovering from such a loss.

Healthy family bereavement requires that family members recognize and respect individual differences in response to their grief and in their ability to cope (Shapiro, 1994). This task involves: permission for family members to share personal experiences with one another, the ability of family members to understand and feel understood by others, and the re-establishment of a coherent sense of

past, present and future for the family system (Shapiro, 1994). It is important that family members feel a sense of permission to share their thoughts and memories of the deceased and not withhold these for fear of overwhelming others. Communication is key to the emotional sharing that needs to occur within the family system. It is important that communication occurs in a manner that is respectful of each individual's needs within the system in order for members to feel understood and cared about. As the family system copes with the present and considers the future, the system shifts to adapt to the loss of the role of the deceased.

The degree of disruption in the family system following a death is affected by "the timing of the death in the life cycle of the family, the nature of the death, the openness of the family system, and the family position of the deceased"(Walsh, 1982, p. 172). Knowledge of the stages in the family life cycle and the corresponding tasks are important in the treatment of grieving families. The family life cycle begins with the unattached young adult, where the primary goal is to complete the individuation process begun in adolescence of parent-child separation. The degree to which this goal is accomplished determines the ability of the young adult to resolve past childhood issues, separate from the family of origin and engage in a primary relationship in preparation for establishing a new system. The next stage involves the newly married couple and their commitment to a new system. Completion of this tasks requires the couple to have reached a level of individuation that allows

for the successful resolution of issues within the couple relationship separate from the families of origin. The couple need to have the skills to retain their individual separateness combined with an ability to operate as one team. The family with young children is the following stage in the family life cycle. The task for this stage is the couple's acceptance of a new generation into the system. The couple is required to set many needs aside to successfully tend to the demands of a young family. The couple is also expected to create a boundary around its family system that protects and nurtures the new family unit but allows for selective permeation by extended family systems. The family with adolescents generally upsets the stability achieved in the former life cycle stage as the adolescent begins the process of separation from the system. The task of the system is to create a parental management shift that provides flexible boundaries needed to promote and encourage individuation and independence of the children. Stability in the family system, particularly in the couple relationship, is important in the personal development of the adolescent. Limit setting requires consistent yet flexible boundaries with strong communication and problem-solving skills within the family system. The stage that follows the adjustment to adolescence involves the launching of children from the family system. This is a gradual process that requires the acceptance of a series of exit and entries into the system until the young adult achieves emotional, social and financial independence. The last life cycle stage is the family in later life where the primary task is the acceptance of the shift of

generational roles between parents and children. This tasks involves the ability to balance the need for continued nurturance and support with the young person's need for independence and autonomy (Walsh, 1982).

For the purposes of this practicum, the relevant family life cycle stages include the family with young children and the family with adolescents. During the 'family with young children' phase, the parents assume shared responsibility for the children and establish their roles as authorities or executors in the system. Parents learn to manage and balance the needs for nurturance and limit setting within the system. Clear roles and boundaries are necessary to define the structure of the family system and expectations for individuals within the system. The clear and consistent structure of the system provides children with the emotional safety and security necessary for their growth and development.

The physical and or emotional loss of a parent seriously affects the management of the family system and the security of children within it. The result of such a loss may involve changes in roles and expectations, especially for eldest children who often assume a more parental role (Shapiro, 1994). Shifts may also occur in daily routines, parental availability and their limit setting functions. The emotional and physical safety and security of all family members is affected by the loss of a parent.

The family with adolescents is also significantly affected by the loss of a parent. The task of parents in this stage is to readjust

boundaries in the system to the degree that there is some flexibility and permeability while retaining realistic expectations and encouraging responsibility, independence and co-operation. Disruption of this cycle through the death of a parent can seriously affect the adolescent's ability to become independent and individuate from the family. The family system may shift to discourage the adolescent's need for independence by keeping her or him firmly entrenched in the system as a substitute parent, or promote the independence prematurely by forcing the adolescent out of the system altogether. Neither of these extreme responses meets the adolescent needs for the emotional safety and security that provide the foundation for both attachment and individuation.

To stabilize family structure and promote growth in the life cycle development of the family Shapiro (1994, p. 16) identifies the following resources as helpful: supports for individuals within the family to manage intense emotions, strategies to deal with the stress of the crisis, extended family and community supports to assist with daily basic tasks and encourage searching for the meaning of the loss and cultural rituals that assist with interpreting the meaning of the death and the meaning of life for survivors. She also suggests that grieving families may lack the resources necessary to support them through losses. Treatment interventions need to assist with resourcing the system to ensure that both individual needs are met and that the developmental needs of the system are addressed. Treatment that focuses on increasing the ability of

parents to support and care for children may decrease the negative chain of events for children and also reduce further disruption in the family life cycle and parent-child relationships.

Assisting the Grieving Family

Assessment of Family Functioning

Loss through the death of a significant person stresses the family system. The family's ability to cope with the loss and reorganize to restore balance is dependent on the strength of the family as a healthy, functioning unit (Byng-Hall, 1995). In healthy families, the loss of a significant individual through death is dealt with openly and honestly (Byng-Hall, 1995; Walsh, 1982). Parents give permission for their children to express feelings through a variety of techniques such as verbalization and role modelling (James, 1994). Parents receive adequate support through their own resources enabling them to focus on the needs of grieving children (Shapiro, 1994). All family members feel supported in resolving the impact of the loss on the system (Shapiro, 1994).

The McMaster Model of Family Functioning (MMFF) (Walsh, 1982) was chosen as a method to assist in determining how the family systems were coping with the loss of their loved ones. This model addresses family functioning in a manner that is consistent with the factors outlined in systems theory and considers areas of both strength and weakness in the family system. The model evolved through clinical and empirical testing over a period of 25 years. The current model was

developed at McMaster University in the 60's and 70's using Canadian subject families. In the MMFF family functioning is determined in relation to three task areas:

1. Basic tasks include maintenance in the areas of food, clothing, shelter, money, transportation and survival needs.

2. Developmental tasks address those functions that result naturally over time in families, such as: infancy, childhood, adolescence, middle and old age; marriage, children, loss of children through emancipation, and retirement.

3. Hazardous tasks involve unpredictable crisis for the family and result from illness, death, accident, loss of income and so forth.

The research conducted by Epstein and Westley (Walsh, 1982) found that the emotional health of children is closely related to the emotional relationship between the parents. It was found that even in families where the parents individually were deficient, a positive relationship between the parents produced emotionally healthy children. This research supports the need to consider the parental relationship in grieving families to ensure that parents are able to nurture and support one another through the loss. This will be particularly important if the loss has occurred through the death of a close family member or a child.

Death of a loved one is included specifically in the hazardous task area of this model. The family needs to be able to function adequately in the six dimensions described below in order that it continue to

function in a healthy manner. The format for considering the tasks and functions of families in the six distinct areas are identified by Froma Walsh (1982, p. 119-129) as follows:

a. Problem-solving: considers the ability of the family to identify the problem, communicate the problem effectively, seek possible solutions, make decisions, follow through and evaluate success of solution. It also considers the emotional content of the process. (Most effective when all steps in process are completed. Least effective with problem cannot be identified.)

Death of a family member immediately presents a variety of problems to the family system including: care of the body of the deceased, funeral arrangements, notification of important others and the immediate needs of surviving individuals. Longer range problems tend to focus on the role that the deceased played in the family system and redistribution of the tasks associated with the role. Each problem needs accurate identification by family members in order that effective solutions can be found. The problem solving process also needs to consider the highly charged emotional field within the family system.

b. Communication: considers patterns of communication within the family system and the effectiveness of communication to express both content and emotional meaning to events, and requests. (Most effective when patterns are clear and direct. Least effective with they are masked and indirect.)

Communication between family members often becomes difficult

following the death of a loved one. Respecting the various needs of individual members for emotional closeness or distance can only be achieved if the needs are expressed clearly and directly to one another. Problem solving is also dependent upon the ability of members to communicate effectively with one another.

c. Roles: family roles are viewed in two categories, necessary and other. Instrumental roles ensure that basic resources are in place for the system. Affective roles ensure that needs are met for nurturance and adult sexual gratification. Mixed roles provide life skills development and management of the family system. (Most effective when all necessary functions are clearly and appropriately allocated and accountability is ensured. Least effective when necessary functions are not addressed or allocated and there is no line of accountability.)

Meeting the needs of the family system following the death of a loved one requires that at least one or more adults assume responsibility to manage the process, especially in the short term during the crisis. If there are no members available to manage, the system runs the risk of chaos and immobilization. Members need to work co-operatively within their roles and complete necessary tasks as required.

d. Affective Responsiveness: ensure that a wide range of emotional responses are available to all members for welfare and emergency occasions and that responses are congruent with events and meet the emotional and social needs of family members. (Most effective is wide range of responses. Least effective is limited range and quality is

distorted.)

All members need permission to express feelings openly following the death of a loved one. Grief and loss encompass a variety of emotions as the loss is processed over time. The healthy expression of feelings needs to be modelled by the adults in an accepting and respectful family environment.

e. Affective Involvement: is the range and degree of involvement between members with six styles identified: absence of involvement, involvement devoid of feelings, narcissistic involvement, empathic involvement, over-involvement and symbiotic involvement. (Most effective is empathic involvement. Least effective is absence of involvement or symbiotic involvement.)

Grieving families work to establish a comfortable degree of emotional closeness as they process the loss of their loved one. Healthy families can tolerate some degree of emotional distance between members for brief periods of time but they work towards the emotional closeness that provides empathy and support for all members as need requires. Healthy families are able to openly share their deep emotional feelings with one another in a climate of trust and understanding.

f. Behaviour Control: applies to three types of situations: dangerous, meeting and expressing needs and drives, and socialization behaviours inside and outside of the home. Four predominant styles describe the types of control: rigid, flexible, laissez-faire and chaotic. (Most effective is flexible. Least effective is chaotic.)

Healthy families understand the connection between feelings and behaviour and have the ability to be flexible in meeting the emotional and behavioural needs of grieving children in the family system. The adults are able to continue to provide a nurturing and supportive environment for children, in spite of their own grieving process. The adults are able to identify their own needs and have those needs met by other adults.

Assessing bereaved families involves paying particular attention to the family's communication styles, affective responses and degree and quality of involvement. Functioning in these particular areas can determine the family's general ability to cope with the loss. It is also helpful to know the family's level of functioning prior to the death. This information assists the clinician to develop a baseline of 'normal' functioning for the bereaved family and assess overall coping skills.

Despite Western cultural prohibitions, grieving families continue their involvement with the deceased through memories. Many families say that, " you don't get over it - you get used to it" (Shapiro, 1994, p. 24). An illness model suggests that the bereaved 'recover' in a defined space of time but these models may not be helpful in assessing all bereaved individuals. Families accommodate to their loss over time using the coping skills available to them.

Treatment Interventions

Many families are able to accommodate for the loss of a loved one

by relying on previously developed coping skills and the supports of an established, caring network system. For other families, the impact of the loss exceeds the strength of their skills and supports. In such cases, professional interventions may prove helpful as a means to increase or enhance coping.

Interventions that have proven helpful to grieving families include the following modalities alone or in combinations: group therapy, family therapy, couple therapy and individual therapy. For the purpose of this report, the focus will be on group and family therapies.

Group Therapy

Group therapy is considered as effective a treatment modality as individual therapy and may be a more effective treatment modality for both children and parents when resolving issues that can benefit from mutual aid or support (Fox, 1985; Hartford, 1971; Toseland & Rivas, 1995; Yalom, 1985). Hartford supports the use of group work for children who are developmentally able to participate and to the degree that they feel a sense of belonging. This developmental stage begins for most children between the ages of 7 to 9 years. Feelings of belonging increase trust and emotional sharing with one another.

Time-limited or short term groups are often specialized groups with a specific focus and purpose that can be achieved quickly. Members come together to address a specific issue and focus primarily on the issue itself rather than dynamics within the group. Yalom (1985) and

Corder (1994) indicate benefits in the short term group for problem solving in areas such as eating disorders, while Piper (1997) suggests this form of group specifically for grief and loss related issues. Short term groups are also less threatening to resistant clients and therefore experience lower rates of drop out. Structured or semi-structured formats assist in goal attainment for the short term group (Corder, 1994). Membership for short term groups needs to be closed because each time there is a change in membership, the group must return to the initial stage of formation (Corder, 1994). Time is not available for this regression in the short term group.

Groups provide a sense of hope for members that cannot be duplicated in individual treatment (Yalom, 1985). As group members share feelings and experiences with one another, members feel more hope for themselves in relation to the growth of others. Coping with the loss of significant others through death requires that individuals examine their spiritual dimension of self that gives meaning to life (Shapiro, 1994). Hope for the future adds meaning to life and many families derive hope through spirituality and accompanying beliefs. Group work offers opportunity for the sharing of the essence of hope in a manner that is non judgmental and respectful.

Group work offers mutual support when members focus on a common problem or issue (Shulman, 1979; Toseland & Rivas, 1995; Yalom, 1985). Grief work provides such a commonality. Groups can also offer opportunities for vicarious learning as members share their

experiences with one another (Toseland & Rivas, 1995). Children coping with a significant loss can use the group as a source of support and as a means to decrease isolation and to reduce feelings of stigmatization. Parents benefit from support, education and therapy. A treatment group that offers a combination of these may increase parents' abilities to cope with the loss and increase their abilities to assist their children in coping with the loss.

Parents supporting grieving children in the family system have an additional focus and responsibility that can be addressed in a group context: the need to understand that children's needs and responses to the loss of a loved one will differ from adults. Psychosocial interventions at the parental level are often most helpful for children coping with the loss of a loved one. Adams-Greenly and Moynihan (1983,) refer to four areas that are important to address in the process of assisting parents to help children cope with loss. Parents need information and support to understand that the child's experience of loss differs from the parent's loss experience. If parents suffered a loss in childhood, they may need help in separating their feelings from their child's present experience. Parents usually strive to protect their children from pain. They need reassurance that the child's painful feelings experienced from the loss are normal and that they can help their child to bear the pain. Parents need reminding that children have shorter attention spans, that they feel more secure with routines and that they need reassurance that they won't be abandoned. Under stress, children also need more physical

comfort. Parents' feelings of competency can be increased when they are given direct examples of things to say for support and comfort.

Parents need support and assistance to understand that daily living is often a vivid reminder of loss for children (Furman, 1974). It intensifies their feelings of longing for the deceased, especially if the deceased was a parent. Children require support through words and affection to encourage sharing the feelings and memories of the deceased. Memories are often linked to material objects that belonged to the deceased and adults need to be sensitive to the child's attachment to these material possessions.

In dealing with the death, children need adults to help them distinguish between reality and fantasy. Parents also need to understand that children identify with the deceased and will have fears about dying themselves. They will also fear losing other loved ones and will need ongoing reassurance that they and others are safe. Children cope more effectively when they remain in their home, when their needs are met and when routines are consistently maintained (Furman, 1974). Group therapy can assist parents' understanding of these principles and support parents to enhance the child's ability to cope.

Group process is generally described in three stages or phases. The first phase of group is the orientation phase or the beginning of the process (Corder, 1994; Shulman, 1979; Yalom, 1985). The goal of this phase is to define the purpose for the group and develop group cohesion and trust. The second stage or middle phase of group is often

referred to as the challenging stage of the group. Members may begin to challenge the therapist and one another. As group members become more comfortable in the setting group roles may emerge. Shulman (1979) refers to possible roles as: the deviant member, the scapegoat, the internal leader, the gatekeeper, the defensive member, the quiet member and the overly talkative member. The third stage or phase of group is the work phase. By the time the group reaches this stage members have developed sufficient trust and cohesion to accomplish the tasks that are necessary to achieve the purpose of the group. Members share openly with one another and emotional intimacy develops. Members are able to strongly identify with the group and feel good about their participation in the group. Support groups need to allow time for members to give and receive support from one another. The therapist needs to act as the gatekeeper to ensure that individual members of the group are involved and receiving adequate support within the environment.

Group termination is occasionally seen as a separate stage or phase of the group process. However, Yalom (1985), Corder (1994) and Shulman (1979) regard termination as an on-going part of the group process that begins with the first session and culminates in the last session. Termination offers opportunities for planned farewells and celebration of successes. It is a time to evaluate individual and group growth.

Cultural sensitivity is an important component of group leadership. Culture influences group behaviour and can impact the

group process on a variety of levels. Culture affects how individuals feel about themselves, their feelings about belonging and their feelings about society in general (Toseland & Rivas, 1995). Culture influences gender and power related issues in group settings and can affect an individual's ability to relate to other group members and the group leader.

Spiritual and cultural beliefs provide the foundation for grieving traditions and rituals (Shapiro, 1994). The climate of the group needs to provide the sensitivity and acceptance necessary to allow for diversity in cultural beliefs and practices in the area of grief and loss. Members need to feel valued and their beliefs respected in order to actively participate in the group and process the loss in their lives.

Family Therapy

Bowenian Family Systems Theory (Bowen, 1978; Walsh, 1982; Piercy & Sprenkle, 1986) provides a framework with a variety of opportunities to assist grieving families. Dr. Murray Bowen understood that the family context shaped the life of the family. The goal for therapists using this model is to assist families in recognizing and changing contextual patterns of interaction that are dysfunctional to the family system. Family members are encouraged to communicate their needs and thoughts to one another, assisting in the differentiation of members within the system. Bowen also recognized that interactional family patterns are often repeated from past generations to the present and that these 'family of origin' patterns could be the most important

unresolved issues in a family's present functioning.

Bowen's model evolved from the psychoanalytical principles of Freud and the study of mother-child dyads. The early psychosocial task of attachment is recognized as crucial to both the adolescent and adult processes of differentiation of self. Differentiation of self is a cornerstone for the Bowenian model. It supports the need for the individual to be able to think and feel for one's self, irrespective of pressures from others (Piercy & Sprenkle, 1986). Individual needs for closeness or distance in relationships are included in the differentiation process, stemming from early attachment issues. Differentiation plays a key role in the family life cycle. The relational system of the family needs to expand and contract to readjust to the entry, exit and on-going developmental needs of individuals within the system (Walsh, 1982). Many families experience difficulty with realignment at transition points in the family life cycle. Resultant patterns often include emotional cutoffs such as tremendous distance between members or emotional fusion, an attempt at oneness with another. These patterns of emotional intimacy often become intergenerational.

Systems issues and patterns are particularly relevant for families coping with grief and loss issues. Individual members within the system need to have the skills to communicate their needs, thoughts and beliefs with others in a manner that is supported and respected. Family members need to be able to give and receive support from one another. These tasks require a system that allows differentiation of individuals

within a climate of intimacy that is nurturing and supportive. Goals for Bowenian therapy are consistent with the needs of the grieving family: decrease anxiety within the system, increase differentiation of self for members within the system, re-open closed ties between members and decrease triangulation in the system (Karpel & Strauss, 1983; Shapiro, 1994; Walsh, 1982).

Specific techniques to achieve these goals include some of the following: using genograms to identify significant family members and patterns of interaction;, asking circular questions; encouraging stories about similar families and situations; assigning tasks to shift dysfunctional or ineffective patterns; and supporting and teaching effective communication skills (Piercy & Sprenkle, 1986). Family therapy addresses the needs of the individuals in the family system and works towards improving the patterns in the system to provide maximum support to all members. Past issues of familial loss and legacies related to loss are explored. Emotional needs are identified and the system is supported to meet those needs. Family members are encouraged to share their thoughts, feelings and beliefs related to the death of the family member. Death means that a family member has exited the system and the system needs to realign to incorporate that loss. Therapy can assist with this realignment.

Structural and strategic therapy models were incorporated in the family therapy follow-up sessions for this practicum. Both of these models view the family as a system and give consideration to the

normal developmental stages of individuals and families. Treatment is focused on present rather than past issues, which allows for effective short term intervention (Stanton, 1981). Process is more important that content in both of these models, with the therapist actively involved and acting as a director or coach for the system. Structural and strategic therapists emphasize the development of rapport with families to reduce guilt and defensiveness. Reframing of problems is a common technique used to open the system to change. Reframing of problems can also decrease blame and tension within the family system, creating more openness to change within the system.

Structural therapy pays particular attention to boundaries, subsystems and qualities of involvement (Minuchin, 1974). The functioning of the parental or executive subsystem is paramount to the functioning of the family system as a whole. Structural therapists often align with the executive subsystem as a method of supporting parents and reinforcing their management functions. Strategic techniques are designed to promote change through the use of directives and tasks given to the family by the therapist. The strategic therapist assumes a direct role as a problem-solving resource to the family. Strategic methods are often used when structural methods have not proven successful in promoting change.

Grieving families often seek counselling services during the crisis period or a few months after the death of a loved one (Warmbrod, 1986). For many families, this can be their first experience with a significant

loss and with therapeutic services. Parents requesting treatment may be primarily concerned about children's reactions to the loss or they may be feeling confused and overwhelmed by their own reactions. Intervention strategies need to pay particular attention to decreasing loneliness and isolation within the family system as well as assisting the bereaved to cope with their loss individually (Warmbrod, 1986).

Children need to have opportunities to participate in the grieving of the family and in the rituals that accompany the death (Fitzgerald, 1992). Parents need to ensure that children have opportunities to express their thoughts and feelings with trusted adults. Talking about the loss openly and directly in front of the child and with the child indicates that parents are able to deal with their emotional pain and also gives the message that they are able to deal with the child's pain. There are many resources available to parents to assist them in talking and sharing with their child. These resources, readily available in the form of books and videotapes, provide parents with additional opportunities to nurture their child and strengthen their relationship through positive interaction (see Appendix A).

Child Psychotherapy (Play Therapy)

Beverly James (James, 1989) suggests that a number of critical aspects can be addressed with a grieving child through play therapy. Play therapy affords opportunities for the following: to acknowledge and explore the child's pain as a means of integrating the experience

cognitively, spiritually, physically and emotionally; to provide treatment that is sequential over time and which adjusts to the child's developmental abilities; and to include caregivers as part of the treatment team. Play therapy offers an active and direct approach to the trauma.

Play therapy has the ability to attend to the individual child's needs in treatment, as suggested by James (1989). She also outlines techniques and strategies such as throwing balls, dance, soccer, storytelling, metaphor, art, drama, music, poetry and observing nature as means to share feelings and integrate experiences. Tasks in the child's therapy need to focus on the development of coping strategies, understanding the loss, feeling the feelings and saying goodbye to the deceased (Roberts & Johnson, 1994).

James (1989) also supports direct parental involvement in the treatment process as a means of enhancing treatment. Such involvement decreases secrecy and shame and increases security. It promotes self acceptance for the child and strengthens existing attachments.

Parents can support the work that their child is doing in therapy through developing an understanding of how the death has affected their child and increasing their awareness of the child's needs. Parents can help him/her by acknowledging the loss and the feelings associated with the loss both for themselves and the child. Openness and honesty assist the child in dealing with denial. Providing the child with reassurance and security prepares the child to face the loss. Children

need to know that they are loved and that they will be taken care of before they are able to accept the death of someone special (Fitzgerald, 1992).

Treatment for children needs to consider primary and secondary losses in relation to the death of a significant individual (Goldman, 1994). What else disappeared for the child when they lost this person? All losses may need to be mourned by a grieving child (Goldman, 1994).

Multiple Family Therapy Groups

The literature for multiple family therapy groups (MFTG) provided information that was of interest for this practicum. Criteria for this intervention requires that: two or more families, consisting of two or more generations, are present in the therapy room, that all members share a common problem or concern, and that MFTG is used as the primary intervention (Cassano, 1989). This intervention does not separate families across generational lines. H. Laqueur is regarded as the founder of multiple family therapy group through his work with schizophrenic patients and their families in the 1970's (Kaplan & Sadock, 1993). MFTG has recently been used with a variety of other populations including: multiproblem inner city families, families with children and adolescents in outpatient settings and battered women and their children (McKay, Gonzales, Stone, Ryland, & Kohner, 1995).

MFTG follows the principles of general systems theory (Cassano, 1989). The individual is regarded first as a subsystem of a higher system,

the dyad, then part of the next subsystem, the family, and finally as part of the subsystem of kinship or the community. The group offers a community context in the therapeutic environment. Cross-generational process moves from interfamilial to intrafamilial as cohesion develops within the group setting.

MFTG suggests the following therapeutic advantages: the ability to gain insight into family interactions through discussions of 'real life' issues, 'mirror imaging' as families observe similarities in their interactions, meetings are highly active and less depressing and there is less transference between families and therapists because the roles of the therapist become more akin to that of a mediator or observer, and competition between families can stimulate the treatment process (Cassano, 1989; Kaplan & Sadock, 1993; McKay et al., 1995). Members often to look to peers for input and support. Group composition usually involves a move away from family members sitting together to peers sitting next to one another. The role of the therapist becomes less active as members increase their level of activity to offer feedback and support to one another (Cassano, 1989).

Some of the themes identified in MFTG include the following: the use of families as co-therapists, mutual recognition of problems, learning through observing others, learning through the experiences of others, increased cohesion through identification with others, increased awareness and insight through identification with others, practice learning experiences with one another, healthier aspects of each family

available as models for others, 'piggy-back' on feelings and experiences of others to promote change and increased opportunities for self awareness related to past issues. Multiple family therapy groups can be a source of support and skill building for parents through combined feedback from therapists and other parents (McKay, et al., 1995). They can enhance the group climate through a reduction of barriers related to racial, economic or power differences between clients and therapist (Sue, 1977; Acosta, 1980). They also provide an opportunity for children and parents to listen to one another in a context outside of the family system.

Multiple family therapy group offers increased opportunities for change within family systems through the combination of professional and natural helping procedures (Cassano, 1989).

Therapist and Co-therapist Issues Related to Grief Work

Special issues exist for therapists when counselling the bereaved family. The depth of feeling that results from a permanent loss is often expressed in therapy. The role of the therapist is to listen to the client as the pain related to an unchangeable situation is expressed and the client works towards adapting to this situation (Warmbrod,1986).

The pain expressed in therapy, especially by children, may be difficult for the therapist to support, particularly if the therapist's own feelings of pain or helplessness surfaces. Therapists who are most comfortable working with problem and solution focused methods may

become frustrated when these methods prove less than successful with the complicated relationship issues of the bereaved family (Warmbrod, 1986). Death presents a problem that does not have a solution that will take the pain away.

Bereavement counselling brings therapists face to face with issues related to their own mortality and the mortality of their loved ones. It means examining personal spiritual beliefs including one's reasons for living and the meaning of death. Consequently, a heightened sense of self awareness is necessary to assist bereaved children and families in coping with grief.

Co-leadership in the combined child and adult group was an essential component of this program and required a positive, collaborative working relationship between the therapists (Corder, 1994; Toseland & Rivas, 1995). In addition to providing the advantage of a strong source of support and feedback, co-therapy also allowed for sharing of leadership knowledge and skills. An important component of effective co-therapy required the time necessary for planning, debriefing and sharing any co-therapy issues as they surfaced. The co-therapists also needed to be consistent in their philosophical approach to the group to ensure a workable partnership (Toseland & Rivas, 1995). Direct supervision and consultation assisted in developing and sustaining an effective co-therapy partnership.

Summary

This practicum and accompanying literature review supported the hypothesis that treatment goals for children and families coping with the death of a family member needed to focus on assisting individuals within the system to accommodate to the loss of the loved one rather than to sever emotional ties with the deceased. Treatment modalities supported in this practicum included combinations of group and family therapy to decrease stress on individual members and to provide the maximum amount of support and education to all members.

Grief was valued as a family process dependent on the strengths and coping abilities of the adults in the system to heal individuals and the system as a whole. Identification and treatment for adult issues was seen as key to assisting children in their healing process. Educating adults to the needs of grieving children and involving adults in the children's therapy process was considered an important component of this practicum program.

DESIGN AND IMPLEMENTATION OF INTERVENTIONS

Treatment Design

Practicum and Clinical Objectives

Loss is a common theme in clinical practice with children and families. As a social worker with a treatment background of approximately 20 years in residential youth care, foster care, child welfare and currently in children's mental health services, I have had the opportunity to work with countless children and families grieving a wide variety of losses in their lives. I have observed the positive difference that an understanding and nurturing parent or caregiver can make for a grieving child. Often, my ability to meet the needs of the adult caregivers has been paramount in my ability to treat the child. Conversely, when I have neglected the needs of the caregivers I have been faced with treatment issues related to split loyalties, triangulation, and confusion of roles and boundaries for family members. I now conduct my clinical work in a manner that recognizes the needs of adults as key to a child's treatment process.

This practicum was set up in two phases and afforded me the opportunity to further explore comprehensive clinical options for parental involvement in the treatment of children, particularly related to issues of familial loss. The first phase consisted of group interventions with co- therapist Ms. Judy Tozeland. Ms. Tozeland facilitated the children's play group which ran concurrently with the parent psychoeducational support group; she was also co-therapist in the

multiple family group session time. The second phase of this practicum offered short term follow-up family therapy to the families participating in the group program.

The clinical hypothesis for this practicum was that parental support to grieving children in therapy could be increased by providing emotional and educational support to the parents and by involving parents in their children's treatment process.

The goal for this practicum was to develop a comprehensive family focused program to support the group play therapy for children ages 8 to 12 years who were coping with the loss of a family member.

Specific intervention objectives for parents supporting the treatment for the children included the following:

1. To ensure that parents were fully informed about the therapy their children were receiving as a means to increase their support to their children.
2. To provide opportunities for parents to be directly involved in the therapy that the children were receiving as a means to increase both understanding and support.
3. To offer the parents opportunities to consider their own needs related to the loss in the family, thereby increasing emotional support to parents.
4. To provide the parents with information related to the on-going developmental needs of children experiencing loss to increase both present and future parental effectiveness and support.

5. To provide opportunity for family participation in the treatment process to ensure that no family members were excluded, and to offer additional assistance to support the child's healing process as needed.

6. To evaluate treatment methods through the use of case studies and pre-test/post-test assessment.

Therapeutic learning objectives for this writer included the following:

1. To expand group theoretical and practical skills.

2. To enhance the use of the parent-child relationship to assist the child in therapy.

3. To enhance treatment techniques to decrease parental stress levels and reduce parental anxiety.

4. To increase family assessment skills through interview and test measures.

5. To increase family therapy and develop multiple family therapy skills.

6. To strengthen co-therapy skills.

7. To increase knowledge and skill in relation to grief and loss issues for children, parents and for family members.

While the topic area chosen for this practicum was specifically directed to grief and loss work, the learning gained through the family focused treatment approach will be transferable to other treatment areas for children and families where loss is a factor.

Criteria for Membership

The target population for this practicum was initially designed for 8-10 year old children who had suffered the loss of a significant individual through accidental death or terminal illness. A parent or primary caregiver was required to participate in the parent group and to agree to have his/her family assessed pre- and post-treatment. Client families were also encouraged to participate in a family therapy follow-up program. Clients needed to be developmentally and physically able to participate in group therapy and participation had to be voluntary. Client families needed to be beyond the immediate crisis of the loss, and ready to begin to process the impact of the loss.

Referral Process

Memorandum letters were drafted outlining the purpose, criteria and format for the the program (see Appendix B). The letters were circulated to the following organizations: Community Service Program (M.A.T.C.), Child Guidance Clinic of Winnipeg #1 School Division, New Directions for Children and Families, Compassionate Friends, Health Sciences Centre, St. Boniface Hospital, The Family Centre of Winnipeg and The Elizabeth Hill Counselling Centre. These organizations were selected on the basis of their involvement with children and families in the city of Winnipeg.

Participants were directed to self-refer to Ms. Croll or Ms. Tozeland. Participant information was gathered directly from the clients and

information was not sought or shared with other sources unless directed or approved in writing by clients. Group members were selected on the basis of the criteria stated previously and on a first come basis. Completed referral forms was the first step for client selection.

The Setting

The setting for this practicum was The Community Service Program (C.S.P.) of The Manitoba Adolescent Treatment Centre at 228 Maryland St. in Winnipeg, Manitoba. The C.S.P. staff are mental health clinicians that provide acute and long term treatment services to children, adolescents and their families in the City of Winnipeg.

The space used for this practicum included two large group rooms on the lower level for the group and multiple family therapies. Follow-up family therapy occurred in a large family room on the second floor. The group rooms were equipped with two-way mirrors and video cameras. Flipcharts were available for all rooms as necessary. The group room used for the children's play group was also equipped as a play room with a variety of toys and activity related materials. All rooms contained a variety of tables and chairs conducive to comfort requirements for all members.

Supervision

Clinical consultation for this practicum was available through Dr. Laura Mills, Consultant to the Community Services Program and Faculty

Advisor through The School of Social Work, University of Manitoba. Dr. Diane Hiebert-Murphy, Social Work Faculty, University of Manitoba, and Ms. Kim Clare, Director, Winnipeg Education Centre, University of Manitoba, provided feedback as advisory committee members. Ms. Joan-Dianne Smith, Group Consultant to M.A.T.C. was also available for consultation.

Dr. Mills provided supervision for the group and family interventions outlined in this practicum report. Supervision was available through consultation, written reports and video taped sessions. Discussion focused on group process, emergent themes and intervention strategies.

Methods of Intervention

Initial Screening Interviews

Family assessment interviews occurred prior to the commencement of the group therapy program with each interview lasting approximately one and a half to two hours. These meetings were conducted by the two co-therapists of the group programs, Ms. Croll and Ms. Tozeland. They included all immediate family members in order to assess general family functioning, parental stress levels, communication patterns, roles and responsibilities, affective responses, behaviour control, and task skills. This assisted in determining the impact of the loss on the family system as a whole including established coping patterns. Information gathered from the clients was used to give the therapists sufficient social history

and current family status to proceed with treatment.

The practicum program was explained in detail to each family, including informed consent and confidentiality (see Appendix C). All participants were fully informed of treatment procedures and practicum requirements prior to commencement of treatment. This included a description of the practicum, supervision methods (recording, observation and videotape), published evaluations and any information gathering procedures necessary for this practicum. Participants were required to be emotionally and developmentally capable of understanding procedures in order to give informed consent. Parents or legal guardians consented to treatment for children, but children were also expected to enter into treatment on a voluntary basis, given a developmentally appropriate understanding of treatment. Participants had the freedom to terminate treatment at any time with no penalty.

Confidentiality of participants was respected to the degree possible given group treatment process. It was discussed prior to group, during the assessment interviews and during group sessions. Names of participants and identifying information were withheld from published results, and other pertinent information shared for supervision purposes only.

The FAM III and Parenting Stress Index pre-tests were administered during the assessment interviews. These were the selected pre- and post-tests for the parent psychoeducational support group.

Children's Play Group

A children's play group was facilitated by co-therapist Ms. Judy Tozeland to provide the children with opportunities to express their thoughts and feelings related to the death of a close family member. Eight children participated in this group. Six of the children were members of two sibling sets, three children from each family unit. Although the criteria for group membership was based on ages 8 to 10 years, a decision was made to accept two older children into the group, based on extenuating circumstances related to the sibling configurations and the concerns about potential negative impact if these children were omitted.

Information related to the children's play group is outlined in a separate report completed by Ms. Tozeland.

Parent Psychoeducational Support Group

The parent psychoeducational support group ran concurrently to the children's play group. A group needs assessment was conducted in the first session and assisted in determining the focus for sessions. The format for the parent group included: a brief weekly lecture with a specific focus, socializing and discussion opportunities. Group structure assisted parents in identifying and processing their own issues related to the loss of the significant family member. Parents were also given opportunities to increase their knowledge in child development and children's grieving processes.

Multiple Family Group

The term 'multiple family group' has been used to describe the multiple family group time that occurred during each group session. Parents and children were together for fifteen to twenty minutes at the beginning and end of each session and for the complete final session. This did not meet the designated criteria for MFTG which suggested that the primary modality must be multiple family therapy group without separation of the generations used in this practicum (McKay, et al., 1995). The multiple family group time provided opportunities to increase parental understanding and offer direct support to the children. Shared activity time helped to decrease parental stress and to strengthen attachments between parent and child.

Family Therapy Follow-up Sessions

Seven family sessions were conducted from mid-August to mid-October with a parent session including L. and B. in early November. The sessions were conducted at the Community Services Program of The Manitoba Adolescent Treatment Centre at 228 Maryland St., Winnipeg, Manitoba. Sessions were recorded in client charts on a regular basis, using methods approved by hospital accreditors. Supervision was provided by Dr. Laura Mills. The FAM III General Scale was re-administered to L., and R. following the family sessions.

Follow-up family therapy sessions were designed to enhance family functioning in the areas identified as problematic for the family in the

assessment process. Attention was given to issues directly related to the treatment of grief and loss issues and assisting all family members in the process of grief adaptation and resolution thereby increasing support and understanding for the child in therapy. This part of the program also provided opportunities to incorporate family members who had not participated in the group program. It provided the therapist with opportunities to observe the family as a complete system, increasing her ability to assess patterns and dynamics. Couple and parent-child sessions were necessary to address the complicated issues of one family during the the follow-up process.

Duration of Treatment

Family assessment screening interviews were conducted in January, 1997. The group program began February 5, 1997 with weekly sessions ending March 25, 1997. The sessions ran from 7:00 p.m. to 8:30 p.m. Family therapy follow-up began July 28, 1997 and ended November 24, 1997. Evening sessions occurred on a weekly basis as much as possible and moved to bi-weekly sessions prior to termination.

Treatment Implementation

Treatment Interventions

Client Screening and Selection

The majority of families identified for the practicum were referred through Child Guidance Clinic of Winnipeg #1 School Division, with one

family involved in the Community Services Program. Of five families who responded, four were selected to participate.

Five families participated in the screening interviews conducted prior to the beginning of the group program. The interviews were held during the month of January, 1997 and were conducted in the homes of the referred families and were facilitated by the two therapists, Ms. Croll and Ms. Tozeland.

The guideline followed for each of the screening interviews was:

- initial telephone contact to schedule home interviews
- introductions of facilitators and family members
- purpose and overview of the practicum program described
- brief information gathering of the family's situation related to their loss
- Ms. Tozeland met with the children to further explain the program and complete pre-test measures
- Ms. Croll met with caregivers to further explain the program and begin the process of gathering information to begin family assessments. The process of pre-testing was begun during these interviews but time constraints prohibited completion of the FAM III and the Parenting Stress Index. These were completed by the parents and forwarded to Ms. Croll during the first session of the group program.
- Practicum consent forms were explained and signed by parents. (see Appendix C)

- Treatment consent forms were explained and signed by parents. (see Appendix D)

Decisions regarding family inclusion were made jointly by the two therapists following the completion of the screening interviews. Families were quickly notified of the decision. One family was refused acceptance into the program because the loss issues for the caregiver were so great that she felt unable to participate in the parent group. This caregiver was offered an alternate service for the two children in her care. Two of the families interviewed requested that siblings, including older siblings be allowed into the program. The older siblings were ages 11 and 12 years, slightly beyond the 10 year old limit set for the program. Following discussion and consultation with advisors, the therapists decided to include the children and extend the age range of 8 to 10 years to 8 to 12 years. In making this decision, developmental issues entailed in extending the upper age limit and the possible impact on the dynamics within the family units by excluding the older children were considered. The ensuing decision regarding age was based on 12 years being part of the middle years stage in child development and therefore in keeping with developmental concepts used in the program. In discussions related to sibling groups, it was decided that inclusion of the children would be more helpful to the families than exclusion and sibling groups would enhance the overall objective of the program to offer a family focused approach.

All the families who participated in this practicum program had

suffered the loss of a family member. Six children had lost a parent and two of the children had lost an aunt. In the adult group one parent had lost a spouse, two parents had lost former partners and one parent had lost a sibling and was now parenting the surviving children. Two adult participants were present partners of two of the grieving parents. Non-identifying labels will be given to the participant families selected.

Family Profiles

Family A. (see Appendix E)

This family consisted of single parent mother B. (age 29) and daughter L. (age 8). The referral to the group program was supported by the school. L.'s father had died several months before due to illness. Father and daughter had regular contact prior to the death. L. had a younger sibling, aged 4 years, who did not participate in the group. Information gathered during the screening interview indicated that B. was from a large family that had suffered the loss of several siblings due to illness. There had also been several deaths of extended family members in the past five years. The family was originally from a small rural setting. Both of L.'s parents had an extended family history of alcoholism, although B. was not affected. B. expressed difficulties in parenting L., particularly following the death of L.'s father, K. A family pet had also died very soon after the death of K. B.'s relationship with K. had been very conflictual, but had improved prior to the death. B. was involved in another relationship that was quite supportive of L. L.

responded to the news of her father's death with disbelief. Since the death she had become very oppositional at home and at school. She appeared to be having extreme difficulties in coping and the attachment between L. and her mother, B. was strained. Both B. and L. were looking forward to the group program as a means to help them feel better about their current situation.

Family B. (see Appendix E)

This family included a single parent mother J. (age 26) and son T. (age 8). This family was referred to the group through the school. T.'s father had also died several months earlier but T. had no communication with his father until shortly before the death. T. also had a younger sibling, age 4 yrs., who did not participate in the program due to age. J.'s relationship with T.'s father, S., had been highly conflictual and J. had had two unsuccessful relationships since. J. was feeling very negative towards S. and men in general. J. did not describe T. as being greatly impacted by the death of S. however T.'s behaviour had been difficult at home and at school for some time. J. experienced difficulties managing the behaviour of the two boys during the screening interview. J. was willing to participate in the group program but unclear regarding how the program would benefit her or T., due to his lack of connection to S.

Family C. (see Appendix E)

This family included mother L. (age 38) and current partner B. (age 45). L.'s husband had died suddenly in early 1996. The referral for

this family was supported through the school. Three of four daughters participated in the program: C. (age 11), K. (age 9) and J. (age 8). The other sibling, R., was 16 years old and not eligible for this program. During the screening interview, L. was very open about the death of her husband, T. who had died suddenly from cancer. The loss had a serious impact on the entire family system. L.'s relationship with T. was described in very positive terms. They were partners in marriage and also in business. T. was described as especially close to the eldest daughter, R., with whom L. was experiencing the most difficulty parenting. The secondary losses were very evident in this family system. Following T.'s death, L. coped by immersing herself in the business to keep it viable and to meet the financial needs of the family. R. was left in charge of the younger siblings and the household tasks. The younger children were experiencing difficulties at home and at school. Extended family were fairly helpful and supportive of the system. L. and the children were very interested in the group program and B. wished to participate as a support to the family system.

Family D. (see Appendix E)

The D. family included mother R. (age 35) and father K. (age 32). The family had received acute treatment intervention in the past through the C.S.P. The school was also supportive of the referral. R.'s sister had died a sudden and violent death a few months prior to the practicum program. R. and K. were parenting R.'s sister's children. One of the children, S. (age 10) participated in the group. Two of R. and K.'s

children also participated, A. (age 12) and D. (age 8).

During the screening interviews the therapists observed the hectic lifestyle of parenting six children, including a preschooler and two toddlers. The parents were very open in offering information related to the death of R.'s sister M. and the impact of the death on the family and extended family systems. R. continued to be emotionally upset about the death, but was looking forward to participating in a supportive group environment. Although only child S. had been directly impacted by the loss of M., children A. and D. were part of the secondary losses as the configuration of their family changed to accommodate the needs of two more children. R. and K. seemed to share a close and intimate relationship based on shared values and respect. Although their direct support from extended family was limited, they receive community support from a variety of levels. The family was also connected to a community church and received emotional and spiritual support through that source.

Group Process and Summary

Group agendas were developed for the eight week program (see Appendix F). There was flexibility in the following of these agendas.

Session One

One family was unable to attend the first session. Family B. had a prior commitment that could not be changed. All other members

attended, although family D. was late arriving.

The objectives for the first session were related to engagement. The therapists worked to develop comfort and rapport by introducing participants to one another and to the group experience. Many of the clients had no past experience with group participation. The additional objective for the parents' group was to complete a group needs assessment and jointly outline the preferred weekly focus for the sessions to follow.

The purpose of the group was restated to provide a common ground for members supported by the theme of grief and loss. The families were given information regarding the structure and format of the sessions including the movement from multiple family group sessions to the children's and adults' groups and back to the family sessions for closure. A session time frame of 1 1/2 hours was structured to allow for weekly coming together time, separate child and parent groups, coffee and snack time and closing rituals. Participants were also given information related to the following week's session to provide emotional bridging or transition from week to week.

General group rules were discussed and negotiated with the families. Primary rules were established dealing with issues related to confidentiality, respect and time frames for operation. Parents were requested to notify therapists as soon as possible if they were unable to attend a session.

The group process for session one met the objectives for

engagement. At the beginning of the session the children were quite subdued during the multiple family time with minimal interaction between the adult members. Problems in starting the group on time became a theme throughout the program, and although a variety of interventions were tried by the therapists, there was little success in this area.

The families were welcomed to the group program and parents were invited to introduce themselves and their children to the group. The parents were asked to share with the group who the deceased family member was and when the death had occurred. This established the commonality for the group and began the development of group cohesion around the loss issues.

During the parents' group, members were given further opportunities to engage with one another by sharing more information about the deceased and in particular, how the death had impacted on them and their family system. Coffee and cookies were served during this portion of the meeting to further facilitate communication. Members responded and began to compare their situations with one another in a search for more common ground. There were obvious gestures of support given to one another through attentiveness, facial gestures, body posture and verbal comments.

The latter part of the parents' group focused on their needs in relation to this program. The parents were asked, "What do you need to help your child cope with his/her loss?" The decision to focus on the

needs of the children was made until group cohesion was sufficiently strong to address more personal needs. The needs identified and agreed upon were:

1. Assistance in answering questions asked by the children in areas related to: violent deaths, fears of illness, fears of their death or death of others close to them.
2. How to deal with the children's comparisons of the deceased to these parent(s) or new partners.
3. Assisting parents in understanding future needs of their children in relation to the loss of the deceased.

The parents also accepted the group topics suggested by the therapist, indicating that these additional topics correlated with their needs:

1. How children's grieving differentiates from adult grieving.
2. Mourning tasks of children according to developmental stages.
3. Signs and symptoms of grieving for children and adults.
4. Helping children through their grief at various stages in their development.

The group consensus was to begin the group educational content with children's grieving and the stages of grief with a request from R. to include adult grieving processes. The next area of interest was the differentiation between children's and adults' grieving, followed by mourning tasks of children according to developmental stages, helping children through their grief, and signs and symptoms of grieving

including those that suggest concern. The planned 'question bag' activity was considered a helpful option in assisting parents to answer their children's questions related to death. The last identified parental need to be addressed was related to the comparison of new partners to the deceased. This issue would be responded to at an opportune moment or at the end of session seven.

The needs assessment was accomplished using a flipchart. The information recorded on the flipchart sheet was used as a weekly guide to ensure that sessions were meeting the identified needs of the participants.

Participants R. and K. and L. were the most communicative members with R. and K. initiating much of the discussion. R. and K. appeared open and caring towards one another and the group appreciated their sense of humour. Parent B. was reserved but involved throughout the session. She had volunteered early in the group that she was shy and uncomfortable in group settings but would participate to her degree of personal comfort. Her comments were respected by the group and there was no pressure placed on her either by group members or by the therapist. L.'s partner B. was also less verbal, but appeared to be involved and willing to participate as much as he was able. He also volunteered that his work schedule may interfere with group attendance over the next few weeks. L. found his attendance supportive and it was hoped he would be a regular participant.

By the end of the needs assessment activity, the group was very

interactive. Members were visibly and verbally disappointed that closure for the parent group was necessary. The children were ready to enter the room to rejoin their parents for family session time. Parents commented that forty-five minutes was too brief a time frame for the parents session of the program. The children, however were unable to sustain their involvement in their group beyond this time frame.

The children were very animated upon returning to their parents and the energy level was high as they vied for leftover cookies and parental attention. The multiple family group time was an opportunity to share with the parents the work accomplished by the children during their session. The children had volunteered a number of questions that each of them had in relation to the death of the deceased. The questions were written anonymously on separate pieces of paper and placed in a colourful gift bag referred to as 'the question bag'. The question bag would become a weekly ritual for the group. During the initial portion of each session one child would select a question from the bag and the parents would have an opportunity to respond to the questions, with assistance from the therapists.

The story read at closure of the first session was I Wish I Could Hold Your Hand (Palmer, 1994). The story was read by Ms. Tozeland to the children and the adults in the group. A brief discussion followed the story. Parents were asked to assist their children in bringing a picture of the deceased to the next session for an activity they would be starting.

The session ended on a positive note for all members. Following

the session, parent B. was privately informed that her daughter had been quite upset during the children's group as she remembered her father. B. was open to the information and shared that she was experiencing difficulties with her daughter and felt unsure about how to respond to her. It was suggested to B. that her daughter may require more nurturing following this session and that we would follow up on the situation next week.

The therapists had directed and carried most of the first group session as planned. The participants, particularly the parents, soon became comfortable with one another and were very involved in discussions from the end of the first session to the completion of the program.

Session Two

Participants in session two included all members except L.'s partner, B. Families C. and D. arrived to the session late.

The objectives for the parent's group were: to increase the cohesiveness and support among members; to include parent J. who had been unable to attend the first session; and to increase the parents' general understanding of children's grieving by providing information on the differences between children's and adults' grieving processes.

Start-up time for this session was again delayed due to late arrival by families C. and D. Discussion ensued to determine if the 7:00 p.m. start time needed readjustment. Both families with sibling sets indicated that it would always be difficult to coordinate their families sufficiently

to arrive on time. The therapists agreed to start the sessions with those who were in attendance at the agreed upon time.

During the check-in time for session two, parents indicated that their children were spending more time talking about the deceased person. Parent B. volunteered that she had a very good week with her daughter and was encouraged by these results. As the discussion ensued between the families, it seemed that there was increased comfort within the family systems to talk about the deceased. The families also expressed a wish that some of the non-attending siblings could have participated in the group program. Families were assured that the siblings would be included in the family therapy follow-up portion of the program.

The group needed to incorporate two new members in this session. Parent J. and child T. were welcomed to the group and introductions were repeated. There were no obvious difficulties incorporating the new members because the group process was still in the formative, or first stage (Corder, 1994; Yalom, 1985).

The questions from the question bag this week provided opportunity for the families to share cultural and spiritual beliefs and rituals. The questions asked by the children were: "Why do people die and why do we have to bury people?" Parents and therapists provided responses related to the cycle of life and different ways that people die. The discussion also included the families sharing their sources of beliefs and spiritual meanings of life. The group showed acceptance in the

diversity of spiritual and religious affiliations of members. All families related to some form of spiritual connection, although most were not strongly connected to an organized religion.

The parent group for session two continued to incorporate J. into the group by updating her about the last week's session and giving her an opportunity to be included in the needs assessment process.

The focus for the educational portion of the session was the grieving processes for children. Adult grieving was discussed in relation to the grieving child. The parents raised the issue of expectations placed on them by others. The idea of 'good grieving' was discussed, with parents openly sharing their feelings about how others responded to them following the death and for the many months afterward. The parents were able to show empathy and concern for one another as their stories were shared.

Families C. and D. included circumstances that were complicating the grieving process for individuals within their family systems. Family C. was dealing with a rebellious adolescent and the introduction of a new partner into the family. Family D.'s configuration had been drastically altered following the violent death of R.'s sister. The discussion that followed considered that the process of grieving a significant loss is a lifelong process for many and could not be rushed. The notion of accommodating to loss rather than recovering, provided relief and reassurance to all the members. A 'changed relationship' with the deceased eased pangs of guilt related to loyalty issues where family

structure was now altered. It also eased feelings of 'being crazy' for those who were continuing to have conversations with their deceased loved ones.

The discussion moved to focus on the grieving of the children with parents considering both the children in the group and those at home. They were also very interested in understanding the future needs of their children in relation to the loss of the deceased. This information was interjected into subsequent sessions. A brief discussion began on gender related issues for parents and children, particularly for mothers parenting boys who had lost their father. This discussion was interrupted by the entrance of the children into the family portion of the session.

The parents were highly involved in the discussions of this session. In addition to the issues of grief and loss, the parents found other commonalities to one another. Parenting issues were shared, especially related to the middle years and adolescence. Empathy and limit setting were lively topics interwoven in their discussions.

The multiple family group portion of the session gave the children's group therapist, Ms. Tozeland, a chance to inform the parents that the children were sharing memories of the deceased through art work and may continue to remember more things in the next few days.

The children and parents listened to the story When Uncle Bob Died (Althea, 1982). The circumstances in the story were related to similar events and feelings generally shared by families in the group. In

particular, families shared their experiences of being informed that their loved one had died and the events that followed that news. Family B. was aware that T.'s father was dying and family members were able to emotionally prepare for the death. Families A., C., and D. were unprepared for the sudden losses they encountered. Family C. had believed its loved one was on the road to recovery from cancer when he took a sudden turn for the worse and died very quickly. Family D. was struggling to cope with the violent death of its loved one and the additional pain that was prompted by media attention to the circumstances of the death.

The objectives of this session were met through the information and discussion related to grieving processes for children and adults. Cohesion was developing in the group as families shared information about their situations and their grieving responses.

Session Three

All members attended this session but L.'s partner, B., needed to leave early, and L. left briefly to drive B. to his appointment.

This session again started late because families C. and D. arrived late. The therapists found it difficult to begin the session until the two large families arrived. These families were the bulk of the group membership and their absence was highly significant.

The family portion of this session was very lively. The children were now comfortable with the group setting and routines and they began to initiate engagement with the therapists through caretaking, or

'helping' tasks. Parents initiated interaction with one another unassisted by therapists. During the routine check-in, parent L. began to share distressing events in her family system caused by the adolescent not participating in the group. Therapists intervened to hold further discussion in the parent group. Parent L. was able to accept this and contained her anxiety for the remainder of the check-in.

The question selected from the question bag was "What is evil?". This generated an active discussion with all family members as children and adults alike attempted to respond from their knowledge base, life experience and spiritual beliefs. A decision was made to give a concrete answer by referring to a dictionary the following week.

The parent group shifted its focus to support parent L., who was encountering serious difficulties with her adolescent daughter. Group members offered support and advice to parent L. Parent J. was able to identify with the daughter and offered parent L. much reassurance that the situation was not hopeless and would in fact improve over time. Parent B. identified with parent L., sharing worries that she would experience similar difficulties with her daughter in the future.

Parents L. and B. also shared with the group the impact that the deaths of fathers had on their daughters who were both closely aligned with the deceased prior to the death. These mothers shared common frustrations in parenting linked to weakened attachments and feelings of being overwhelmed by the needs of their children. Parent R. was able to closely identify with this since she was attempting to parent a child

other than her own, and deal with her large family and extended family in the process.

This session provided opportunity for the parents to consider their personal needs for care and support as they struggled with the needs of their grieving children.

Parent L. and partner B. left the session prior to the children joining the parents group. As the children joined the session, L.'s children were noticeably anxious that she was absent. They did not seem prepared for their mother's brief departure from the group and they required reassurance from the therapists to decrease their anxiety.

All members settled for storytime and the reading of Sunflower Mountain (Foster-Morgan, 1995).This story was longer than previous stories and the children became very fidgety during the story. Parent L. returned during storytime and the group was interrupted by the children challenging her about leaving. Parent L. was defensive with the children and seemed unaware of the anxiety that her absence had caused.

In closure, the therapists recapped this session and bridged to next week, specifically to decrease the anxiety level of the children.

Session Four

The participants in session four included mothers and children only. Both men were unable to attend. L.'s partner B. was working and K. was providing childcare because the sitter was unavailable.

Check-in time with the families was high energy with a great deal

of input from children and adults. Child L. had brought her favourite book, a dictionary, to share with the group and to follow-up on the discussion of evil, generated from last week's question bag.

The highlight in session four occurred during the parenting group as parent B. shared that she was in the midst of a crisis with her daughter, L., and was seriously questioning her ability to continue to parent. Parent B.'s external supports were weak and there was little respite available to her from extended family or friends. She also shared a strong need to do things on her own and not ask for help. The group moved in to offer B. support, reassurance and hope for the future. They also openly shared their need for support as parents, challenging B.'s belief that she must do everything on her own or risk feeling like a failure. It was a very emotional interchange between mothers and was well received by parent B.

With group consent, the session shifted to focus on common myths about grief and loss for children. The myths were tied into the initial group goals established by the parents and also to some of the current described behaviours and perceived needs of the children.

In the multiple family group portion of the session, parents were informed that the children had completed their collages of the deceased and were now ready to share them with their parents. The children eagerly shared their collages that depicted their memories of the deceased.The families were invited to take them home following this session. L. quietly indicated that she did not want to take her collage

home.

Storytime with Badger's Parting Gift (Varley, 1984) produced an increased showing of affection between parent B. and child L. L. remained very close to B. during the story, placing her head on B.'s shoulder. B. stroked L.'s hair during the story evoking smiles and tears from the mothers in the group.

Following group closure L. was encouraged to explain her refusal to take her collage home. In a private discussion with this therapist she volunteered that her collage would not be safe from destruction at home. She was worried that a younger sibling or pet would rip it apart. Given this information, parent B. agreed to find a safe place in the home for L.'s collage. Parent B. was also given a list of resources to assist her if her parenting situation went into crisis during the following week.

This session highlighted the trust that members were placing in one another and also in the therapists. The gentle challenging of beliefs that occurred in the parent group suggests movement to the middle phase of group.

Session Five

This session began a half hour late due to recurring childcare problems for family D. Parent K. remained home with the younger children. L.'s partner B. was also absent. Family B. was absent due to illness.

Check-in time found that parent B. had a much improved situation with child L. and was considering the use of resources to

support her parenting. This was considered a significant sign of progress for parent B. Parent L. indicated on-going issues with her adolescent and that power struggles were a daily problem. Parent R. informed the group that their family had moved to a larger home in the country and group members shared in the family's joy. Mixed with the happiness was the loss of the former home with all its memories of good times and sadness. This prompted a family discussion related to mixed feelings about events and the need to acknowledge the sad feelings with the joy. Time did not permit the question bag ritual in this session.

The parent session focused on the tasks for grieving children including the need to commemorate the death and learn to go on without the deceased. Parent R. continued to share feelings with the group related to the family move and the feelings of loss evoked by the move. It was suggested that child S. in particular, may be experiencing similar feelings of loss. R. was encouraged to engage with S. to explore this further. R. was also able to share ambivalent feelings related to the deceased as there had been much conflict between them prior to the death.

During the discussion parent L. became upset as she shared her story about the family conflict ensuing over the commemoration ceremony for her deceased husband. Other group members shared feelings related to their losses and offered support and advice to parent L.

This topic also provoked a lively discussion from other group

members who had little positive feelings toward the deceased and their anticipated difficulties in assisting their child(ren) with commemorating activities. Parents challenged the therapist when it was suggested that the parents try to assist the child with positive memories of the deceased. Some parents thought they were being asked to tell untruths about the deceased.

Storytime in the family group was appropriate for the parent's group. "Annie's Story" from a book titled Hurt (Amos, 1991) focused on hurt feelings and how difficult it is for adults and children to share these feelings. The parents and children were able to relate to this story about separation and divorce and they shared their thoughts and feelings about it with each other.

Session Six

All participants, with the exception of partner B., were in attendance for session six. During check-in time the group was reminded that termination would occur in two more weeks. Children and adults were verbally resistant to ending the group.

The parent group focused on the goal of increasing knowledge and understanding related to developmental differences and abilities of children. All the parents were very involved in this topic area. While the main focus was on middle years children and future adolescent issues, several of the parents requested information related to toddlers and preschool children and this was also discussed. Parent L. found the adolescent information to be particularly helpful.

The discussion period moved again to the need for children to have positive memories of their parents. For children who had no actual memory of a parent, a suggestion was offered that caregivers could give them remembrances through stories. The impact of positive and negative legacies, or family stories, provided an animated discussion for the parents as they considered their own family of origin legacies.

Parents began to openly share feelings of stressors in day to day life. The single parents in particular, felt overwhelmed by the tasks of parenting and received a great deal of support and admiration from those parenting in a couple relationship.

Parents began to wonder how to recognize when their children were suffering from too much stress in their lives. It was agreed that the next week's session would consider signs and symptoms of stress for children, in conjunction with symptoms of grief and loss.

In the family session, children shared pictures with their parents depicting how they felt when their loved one died, and how they would like to feel. The children were energetic during this time and provided an opportunity for Ms. Tozeland to share with the parents some information about limit testing.

The storytime was "Billy's Story" from the book Hurt (Amos, 1991). It was significant as it dealt with a young boy being teased and not accepted by his peer group. It was a chance to talk about the universality of children needing acceptance and not wanting to feel different or stigmatized and the group related well to this message.

Session Seven

Both male participants, K. and L.'s partner, B., were absent.

Check-in time with the group suggested that families were maintaining some stability, although the situation with L.'s adolescent continued to be difficult and stressful. Group termination and the family therapy follow-up sessions were discussed by the therapists. A termination activity would begin during the multiple family therapy portion of the group.

This week's question from the question bag was "Why did F. kill my mom ?". This question provided opportunity for the affected family to share with all families present, the impact of the crime and their losses in relationship to the crime. One of the older children, A. was quite upset when she discovered she was not privy to a piece of family information. This suggested the need for access and control of information in the family system. Another theme that surfaced was the issue of forgiveness. Group members discussed their feelings and beliefs about the importance of forgiveness.

In the parents' group, the educational focus was on signs and symptoms of grieving and discussion related to troubling behaviours. Parents were given a chance to share their particular concerns related to their children and to have those concerns responded to directly or with suggestions for further resourcing. Parents began to joke with one another about group termination. They began to make plans to continue their contact with each other. The parent's group time was decreased in this

session to provide time for the family group termination activity.

The multiple family group session involved a joint parent-child activity referred to as 'the flower and the tear'. Children worked alongside their parents during the activity. Child D. had much difficulty getting down to task and was eventually assisted by parent R. Competition between siblings was evident as they vied for materials and for parental attention. The activity would move to completion in the last session. The story Hug Me (Stren, 1977) provided a positive emotional ending to this session with parents giving their children spontaneous hugs following the story.

Termination was the major theme in this session. It was evident that group members had made strong connections to one another in the past seven weeks.

Session Eight

The last session was again characterized by the very late arrival of family D. Parent K. and partner B. did not attend this session. Although they were missed, their sporadic attendance did not affect the group process.

While waiting for all families to arrive, Ms. Tozeland began post-measures with the children individually, while the other parents and children socialized. Ms. Tozeland required some assistance from this co-therapist to complete the measures with the children.

This group session remained in the multiple family group format and was the most emotionally intense of the sessions. Parents and

children formed a circle on the floor and took turns sharing the symbolism of the flower and the tear to the loss of the deceased and to the ending of the group. The activity occurred with active participation and tears shed by many group members. The group members were all given two stones, one rough and one smooth, to commemorate the happy and the difficult times in the group experience. A celebration followed the termination rituals, including a large cake decorated for the occasion.

In closure, the parents were given post-test measures including client satisfaction surveys, to complete with the knowledge that a family follow-up home visit would occur to provide at least one family follow-up session with completed post-tests returned (see Appendix G). Families were contacted to schedule appointments and to request participation in the family therapy follow-up portion of this practicum.

Family Therapy Follow-up Sessions

In April, 1997 letters were sent to all participant families thanking them for participation in the group program (see Appendix H). Certificates were also sent to the family members who participated in the groups (see Appendix I). The letters were a means of reminding parents of the family therapy follow-up program with notification that they would be contacted in the near future to schedule a home visit. The purpose of the contact was to assess the family's current needs, pick up the completed post-test measures and discuss the family therapy

follow-up sessions.

The family therapy follow-up schedule did not proceed as quickly as initially planned. The spring flooding of the Red River affected three of the four families who had participated in the group program. Families C. and D. were directly affected with additional work demands placed on the men, K. and B. Family B. required mother J. to assist her rural parents in sandbagging efforts. Therefore, flexibility was needed to accommodate the families' schedules for follow-up planning.

During the family follow-up visits, parent B. in family A. stated that her relationship with daughter L. had improved significantly following the group program. B. also indicated an improved perception of 'helpers' and stated she was much more willing to reach out for professional support should the need arise. She thanked us for the information and support received through the group and commented that she was never made to feel inadequate or incompetent by the therapist or group members. B. was receiving adequate support from a family member and boyfriend and did not feel a need for further treatment.

Parent J. in family B. felt that her family was quite stable prior to group but that she enjoyed the group and felt that she learned a lot as a parent. She was most impacted by the issue related to providing son T. with some positive memories of his deceased father, and that she was continuing to consider this. J. and her family were well supported by extended family members and she did not feel a need for further

treatment.

Families C. and D. continued with complicated circumstances following the losses within their family systems. The complicating factors and the lack of resourcing made accommodating to the losses difficult in these cases. Both of these families agreed to participate in the family therapy follow-up program.

Family C. Case Study

Assessment Information

Initial assessment of this family in January, 1997, indicated that the family system had suffered a major upheaval following the death of the father, T., in 1996. The mother, L., was left to care for three daughters ages 6 years to 14 years. She was also left to manage a family business. The financial and social resources of the family were limited, placing secondary loss stressors on the system. Survival needs of the family were dependent on members shifting roles and responsibilities to accommodate to the losses. L. became the sole financial support of the family system and was not as physically or emotionally available to the children as she had been prior to the death of her husband. The adolescent daughter, R., shifted her role from child to adult to accommodate the gap left by her mother.

The system appeared to be in a state of chaos much of the time. The family was trying to manage in housing that did not meet its needs for personal space and organization of belongings. The limited space was

a frustration for all family members. Physical and emotional organization presented difficulties especially with the decreased availability of L. to function as household manager. There was a high degree of conflict between the children, particularly between the two eldest, R. and C. The children were also exhibiting problematic behaviours in the school system. K. had difficulty concentrating in school and was highly impulsive in her verbal and physical interactions. C. presented as oppositional and aggressive towards others.

Shortly before the group program, L. formed a relationship with another man, B. This seemed to be a warm and supportive relationship for L. and there appeared to be a high degree of acceptance of this relationship by all the girls in the family. B. had parented several daughters in a previous relationship and seemed very comfortable with the girls. His presence was relaxed and he was slow to react to potentially difficult interactions between the girls. His confidence as a parent assisted in enhancing the stability of the system in spite of introducing another change factor in a stressed system.

A post-group family follow-up visit was arranged with family C. and conducted in early May, 1997. Information indicated that R. had been absent from the home for a brief time and had only recently returned. R. chose to acknowledge the interviewer but would not engage in conversation. The other three children were eager to talk, especially C. The three younger children referred to the group experience in a positive and animated manner. B. was only briefly involved in this meeting as he

was needed to transport the younger children to evening activities. Mother, L., openly expressed need and interest in the family therapy follow-up with specific hopes to impact a change in R.'s negative behavioural patterns. L. agreed to contact the interviewer when R. was ready to participate.

The family contacted the therapist for the family therapy follow-up program in early August, 1997. R. reluctantly agreed to join in the therapy sessions. R. had spent most of the summer in the country caring for an ailing grandparent. The younger sisters had joined her for a portion of the summer and this appeared to have been a positive experience for all family members. The respite had been particularly helpful to L. and B.

B. was unable to participate in the family therapy due to work related commitments following the flood. L. and R. completed a FAM III test measure prior to the therapy. R. indicated high scores in the areas of: task accomplishment, role performance, communication, affective expression, involvement, control and values. These scores appear to reflect R.'s dissatisfaction in the family system.

The family's functioning was assessed using the FAM III results to determine common areas of concern (Skinner, Steinhauer, & Santa-Barbara, 1983). Probe questions were used in the initial family interview to expand upon the family's desire for change and to give a voice to the younger children who had not completed the FAM III due to age inappropriateness. General concerns were raised by the family during

the assessment interview related to behaviour management, particularly with respect to the adolescent daughter, R. Parent, L., and younger children viewed R.'s behaviour as beyond the control of the family system. Role performance was identified as an area of conflict in the system with differing perceptions and expectations amongst family members. Parent L. believed that all the children, particularly R., should contribute more to household tasks and responsibilities. R. perceived that she was contributing more than was reasonable and that parents were not contributing enough to household maintenance. Communication was reported as problematic, especially during times of stress and conflict. Control was identified as an issue and power struggles were frequent. Family members proceeded to use blame and force to resolve conflict. Members did not listen to one another and feelings were rarely shared. Co-operative skills appeared limited. Patterns of communication described to influence behaviour involved sarcasm, belittlement, name calling and threats to withhold privileges or of harm. Time with parents appeared to be limited and this raised questions related to the quality of involvement between parents and children.

Treatment Process and Summary

The primary goal identified by all family members during the first session was to reduce the amount of conflict in the system. L. also identified a need to increase the trust level between members within the family.

Information gathered regarding details of the conflicts described by the family indicated verbal and physical aggression towards the younger children by older child, R. It was also indicated that L. would be verbally and emotionally aggressive when angered or upset. The first intervention involved an agreement from all members for physical safety. The family also agreed to work on communication patterns to decrease the verbal and emotional aggression. Problem solving skills were taught by the therapist (Walsh, 1982). Brainstorming and role playing were used to enhance skills and practice alternate methods of relating to one another.

Respect for personal space and belongings was at the core of the trust issue. Limited household space and organizational problems were identified by all members. L. and B. were working towards solving this problem by developing additional living space for the girls. A reframe for an interim agreement was negotiated in the family whereby the children were encouraged to practice 'borrowing' rather than refer to their behaviour as 'stealing' (Karpel & Strauss, 1983).

Subsequent sessions provided follow-up to the issues of trust and safety. The therapist worked to provide emotional and physical safety for all family members during therapy sessions. In alliance with parent L., rules of conduct were made explicit and neither verbal nor physical abuse was accepted in the therapy setting (Karpel & Strauss, 1983). The younger siblings became more relaxed and animated as the safety in the sessions increased. The stress level on the sibling subsystem seemed reduced in proportion to the increased confidence of parent L. as she

defined safety limits.

The family system continued to experience difficulty with conflict, but the issues moved from within the nuclear family system to extended family. The effects of the death of T. continued to be felt by the family system as cross-generational conflict patterns emerged. The conflict and tension decreased between L. and daughter R. as they aligned together in this conflict. The conflict was precipitated by plans to commemorate the deceased family member, T., and this family's needs in the process of commemoration. L. experienced feelings of disempowerment in relation to the extended family, in spite of numerous exchanges where she had shown a strong assertive and non-aggressive response. R. was drawn into a triangulation dynamic to fight a battle on behalf of the family. R. was able to achieve the desired result during a highly heated and aggressive interchange with extended family. R. clearly enjoyed the special status given her and the power that accompanied the status. The therapist used genograms to assist the family in understanding the dynamics between the extended family system of deceased father, T., and their present system. The genogram was used as a tool to consider the interactional patterns between family members and the importance of the roles that members played in the systems patterns (Bowen, 1978).

Family sessions moved to work through issues related to roles and responsibilities in the system (Walsh, 1982). The therapist maintained a structural approach to align with the parent and assist in clarifying and supporting the parent's management role in the family system

(Minuchin, 1974). R. challenged parent L.'s authority on numerous occasions and the therapist encouraged L. to define her expectations clearly and outline consequences for inappropriate behaviour. R.'s special status role was openly identified and challenged by the younger children. The therapist used circular questions and probes with family members to discover how the other children felt about this issue and how they met their own needs for special status (Karpel & Strauss, 1983). The family identified C.'s earlier muteness and K.'s distractibility as adopted behaviours to meet needs for special attention. J. seemed to be the least affected child with no identified disturbing behaviours. The therapist acknowledged the universal need for attention and encouraged the system to consider methods to provide the attention in a more effective manner.

Strategic interventions were used by the therapist to alter ineffective parental responses to the children's needs for attention and involvement (Piercy & Sprenkle, 1986; Walsh, 1982). L. was directed to assume a more active role in attending to the daily needs of the the children. This was accomplished through task assignments and allowance charts. L. and the children negotiated the tasks with L. assuming the role of manager. L. monitored the system on a daily basis .

Prior to the death of T. it appeared that the parents balanced the nurturing and limit setting in the system with father being the nurturer and mother, the limit setter. The system needed increased nurturance time together to compensate for the gap left by T. The therapist worked

to improve family functioning through creating more positive experiences within the family system (Walsh, 1982). Family activities were encouraged as a method of regular interaction. The hectic schedules of all members limited time available for activities, therefore regular routines were considered as times when the family could interact in less stressful ways.

The system appeared to be functioning more positively until the second last session. R. was directly challenged by L. for her perception of the amount that she contributed to the family system. During the interaction with L., R. became angry with C. and moved from behaving in a verbally aggressive manner to physically kicking her sister. L. had been ineffective in limiting R.'s behaviour during this interchange and the therapist intervened at that point and insisted that R. leave the session. A debriefing with L. and the younger siblings indicated that R.'s aggression in the home was escalating again. The children's feelings were acknowledged and they were reassured that parents would intervene to provide safety in the family system. A subsystem meeting was scheduled with L. and partner, B. and the therapist to address the safety issues in the home (Karpel & Strauss, 1983).

R. refused to return for therapy. During the parent session in early November, the family was offered individual counselling for R. and additional family work. The parents chose to focus on a strategy to manage the behaviour of R. and put family work on hold. R. did not accept the offer for therapy. The therapist assisted the parents to

develop a strategy that would ensure the safety of the younger children by prohibiting R. from being left alone in the house with them. They considered a variety of consequences that limited her power and manipulation of the system. The parents were in full agreement with the need to protect the younger children and for them to manage the environment rather than focus on controlling R. The parents left the session feeling in charge and empowered, with the option to schedule other sessions as needed.

A follow-up discussion with L. approximately three weeks later indicated that R.'s behaviour had changed dramatically, for the better. There had been no incidents since the intervention in the therapy session, and parents had not needed to implement the strategies decided upon. L., using humour, seemed almost disappointed with the results because she had been prepared for the worst. Other strategies implemented during the sessions continued to be in effect and L. verbally indicated that the initial goals for therapy were met. Conflict had decreased in the family system and L. felt more in control.

Family D. Case Study

Assessment Information

Initial assessment of the D. family in January, 1997 suggested that the system was under stress following the death of R.'s sister and the subsequent incorporation of the deceased's two children into the D. family. Parents R. and K. had difficulty gaining custody of the children

following the death, but were supported by a variety of systems as the best parenting option for the children. R. and K. lived in a modest three bedroom bungalow with their six children, A. aged 12yrs., S. 10yrs., D. 9 yrs., J. 3yrs., M. 18 mons., and G. 16 mons. K. was employed full time and R. remained a full time parent. In-home support services were in place a few hours a week to assist in meeting the needs of the children. Both parents presented as highly committed and actively involved in meeting the on-going needs of the children.

R. indicated that parenting demands had prevented her grieving the loss of her sister and surrogate mother. R. openly shared the numerous losses in her life as a child growing up in a very difficult environment. Her sister had replaced her mother as a caregiver, and she now felt deeply committed to caring for her sister's children. K.'s family of origin system seemed less chaotic and more available to children than R.'s family had been. K. was R.'s second partner and had happily adopted the two eldest children, A. and D.. Despite the stressors on the system, R. and K. seemed to be coping quite well, given their commitment to their family and a strong religious belief system that they shared as a couple.

Both parents expressed concerns about the children, S. and M. and the impact for both of them regarding the loss of their mother. The mother had died suddenly and the case was a high profile event in the community. The circumstances of the death made the loss and the resultant stigma an even greater burden to the family. However, none of

the children in the family seemed to be exhibiting any signs of disturbance, in spite of the losses and changes that the system had incurred.

Information to assess the family's functioning and desire for change was gathered through FAM III tests completed by the parents and eldest child, A. The therapist asked a series of probe questions during the initial family therapy session to ensure that all family members, including the younger children, were given opportunity to participate (Karpel & Strauss, 1983).

Treatment Process and Summary

Family members volunteered the following areas that they wanted improved in their family system: communication, problem-solving, roles and responsibilities and conflict resolution. It was agreed that the family would direct the course of therapy determined by these current needs.

Communication was a consistent theme throughout the therapy as members worked at being more direct in asking for what they needed, and in sharing feelings with one another. Child D. shared feelings of loss in the sibling group, as A. spent more time with S.; A. shared frustrations related to feeling held responsible for others; S. felt sad a great deal of the time. Parents shared their feelings of anger and frustration with the demands placed upon them and the lack of time individually and as a couple.

Strong couple issues surfaced in the second session and the

emotional tension was sufficient for the therapist to move to contain them to the parental subsystem and defer them to a separate session (Karpel & Strauss). It was the third couple session that motivated the parents to honestly voice the discontent in their relationship. The session was highly emotional but revealed deep seated issues of trust and identity that both individuals carried from family of origin patterns. The couple found it difficult for move from the venting to continue to work on these issues. Family life cycle issues emerged and were discussed to give the couple permission to grieve the lost stages in their relationship (Walsh, 1983). The therapist supported the couple to consider all possibilities to address the needs in their relationship, including other sources of therapy to address specific individual and couple issues. The couple made a decision not to pursue the issues in their relationship. They did not feel that they had the time or the energy to explore these issues at the present time. The demands of work, home and children were exhaustive and overwhelming. A previous relationship crisis had lead to a marital separation, and neither R. nor K. seemed prepared to face the pain involved in that prospect (Karpel & Strauss, 1983). Following couple sessions focused on more pragmatic tasks of childcare and family management.

In September, one of the younger children was diagnosed with a neurological disorder that would have long-term ramifications for her care within the family system. During a family therapy session, the therapist assisted the family in reviewing its commitments to this child.

The parents reviewed their strong commitment to all the children. A few weeks later another child was diagnosed with attention deficit hyperactivity disorder. The family was also emotionally preparing for a court case related to the death of R.'s sister, M. The system was overwhelmed. The therapist worked with the family to manage the stress in the system. Family sessions continued to address the feelings of loss in and supported family members in improving affective expression and responsiveness with each other. A commemorative ceremony was planned on the anniversary of M.'s death and all family members participated in mourning her death.

The parent-child subsystem sessions with R. and S. focused on attachment issues (Karpel & Strauss, 1983). Attachment problems were evident through the lying and stealing behaviours of the child and escalating concerns of the parent (James, 1994). The therapist supported the parent to engage with the child's emotions, especially the confusion of feelings related to the losses and changes of the past year (Brooks & Siegel, 1996). The parent and child planned a commemorative ceremony to mark the one year anniversary of the deceased. S. displayed little emotion during the ceremony but the process was important for her and the family system. The therapist encouraged the parent to create a life book with the child. With all the demands on the mother's time, however, this was not a feasible task.

The family requested termination to decrease the demands on their family time. The problems within the system had improved

slightly and the parents felt that they were able to manage for the time being. Consideration was given to use of daycare services to decrease some of the demands on R. during the day. The family was offered resources on an as needed basis. This therapist was prepared to re-engage with the family upon request. A list of additional community couple and individual therapy resources were provided for the parents to consider at a future time such as Inter-Faith Pastoral Institute and The Family Centre of Winnipeg.

Families C. and D. completed client satisfaction surveys upon completion of the family therapy interventions (see Appendix J).

EVALUATION

The purpose of the evaluation for this practicum was to determine the efficacy of a comprehensive family focused approach in the treatment of children experiencing grief and loss issues. A case study method with pre- and post-test measures was used to determine change in family functioning and parent-child relationships. This involved a combination of client self-report and clinical observations to determine the achievement of objectives.

Standardized test measures were implemented pre- and post-group and included the FAM III General Scale and The Parenting Stress Index. The FAM III was administered for a third time following the completion of the family therapy program. Data was collected throughout the program and recorded on progress notes in client charts in accordance with hospital policy. Data was also collected through the use of video taped sessions. Client satisfaction questionnaires were completed for the group and the family therapy programs.

Standardized Test Measures

Family Assessment Measure III General Scale

The FAM III (Skinner, Steinhauer, & Santa-Barbara, 1983) is based on a process model of family functioning that considers both strengths and weaknesses of the family system (Steinhauer & Tisdall, 1982). It is a self-report measure that provides information about individual

self-report measure that provides information about individual perceptions of the family system. It considers the family's ability to accomplish a variety of basic, developmental and crisis tasks. It also considers the family's ability to differentiate and perform the roles necessary for task accomplishment. The process of direct and effective communication, including the expression of feeling or affect, critical to healthy family functioning is assessed by the FAM. The degree and quality of involvement between family members which determines both task accomplishment and individual satisfaction within the system is also assessed. Behaviour control, essential to the internal and external operations of the system and which is based on members' ability to influence each other is measured by the FAM. Healthy functioning requires responsible management of the system in a manner that is flexible, consistent and predictable. There are generally four styles of family functioning noted in the FAM including: rigid, flexible, laissez-faire and chaotic. The FAM measures values and norms within the family system which provide the foundation for all processes determining the rules and expectations for the system.

The FAM III General Scale contains 50 items that consider the health of the family as a system. It uses a rating scale for seven measures plus response styles to determine social desirability and denial of responders. Overall reliability of this measure is high, for adults it is .93 and for children .94. It has been determined effective in rating both problem and non problem families, with problem families more likely to

indicate higher scores in role performance and affective involvement. It has been determined to be effective as a method of evaluation of case study results when used as a pre- and post-treatment measure (Skinner, Steinhauer, & Santa-Barbara, 1995).

In determining the diagnostic power of the FAM, sample populations included "problem families". These were described as including families where one or more members were seeking professional help for a wide range of difficulties, including psychiatric or emotional problems. Treatment for issues related to grief and loss would be consistent with emotional problem areas. Role performance and affective involvement were cited as areas of family dysfunction consistent in this sample population. These are two areas that are of specific interest to this practicum.

The FAM III is also cited as an effective instrument for pre - post testing and was therefore of interest for this practicum. It could be administered pre- and post-group and post-family therapy to determine changes pre-, mid- and post-treatment and to provide information for treatment in the follow-up family sessions.

The FAM is completed by the individual responding to questions in the booklet by marking an X on the response with which they are in most agreement. The mark transfers through specially treated copying paper to the appropriate category on the score sheet. These scores are transferred to total columns on the reverse side of the score sheet and plotted on the graph. The graph plots indicate the T or raw scores in

each category and the percentiles given. The directions are easy to follow and the procedure is quick and efficient.

Scores in the FAM are normalized with a mean of 50 and standard deviation of 10. Most scores will range from 40 to 60. Below 40 indicates very healthy functioning and above 60 suggests disturbance. The more the score deviates from 50, the more it is unusual or outside the range of normal. Individual scores elevated beyond 60 indicate that a disturbance is likely in the elevated area. The more family members that indicate high scores in a particular area, the greater the likelihood of a problem in that aspect of family functioning. The greater the number of elevated scores by family members, the more severe the disturbance in the family pathology. Scores that exceed 50 in social desirability or defensiveness suggest questionable validity of results. Noticeable discrepancies between spousal results may suggest marital discord. Different scale scores for individuals in the system suggests the problems are perceived differently. Scale scores that are consistently high while other family members are considerably lower likely suggests conflict between that member and the rest of the family system.

The Parenting Stress Index, Third Ed.

The PSI (Abidin, 1995) was designed as a measure to assist in identifying stressful parent-child systems to support interventions to reduce stressors that may account for behavioural and emotional disturbances in children.

The scale measures family stress levels in the parent and child domains and is very suitable for pre-post testing with high scores for test-retest reliability (between .77 for child domain and .69 for parents and .88 for total scores). Validity for this measure has been proven in areas related to developmental issues, behaviour problems, disabilities and illness, in cross-cultural situations and with at risk families. Additional psychometric properties are included in the manual and readily available. Normative data was based on responses by female parents with an adjustment table for male parent respondents who typically score slightly lower than female responders. Normal scores range from 15% to 80% with high scores at 85% and above.

The PSI is efficient, easy to administer and quick to score. This measure can be administered and scored by individuals who do not have formal training in psychology or social work. Interpretation of the scores is provided in the accompanying manual. Specific areas of functioning addressed in this instrument include categories in both child and parental domains. Subscales in the child domain are: distractibility/hyperactivity (DI), adaptability (AD), reinforces parent (RE), demandingness (DE), mood (MO), acceptability (AC) and a total stress score for Child Domain. The parental domain includes: competence (CO), isolation (IS), attachment (AT), health (HE), role restriction (RO), depression (DP), spouse (SP) and total stress in the Parent Domain. The raw scores in the child and parent domains are added to consider the the Total Stress Score. A life stress (LS) score is also

measured. The Defensive Responding category indicates whether or not an individual is responding in a defensive manner and affecting the validity of the measure. A score of 24 or less may suggest that the results of the test are questionable.

High scores in the Child Domain suggest that the qualities of the child make parenting difficult. If the score in the Child Domain is elevated compared to the score in the Parent Domain and Life Stress scale scores, it may suggest that the child characteristics are a major factor in the parent-child relationship. Higher scores in the Child Domain are often indicated by mothers over fathers. This appears to reflect the greater amount of time with the child rather than the gender of the parent. It is also noted that mothers experiencing marital dissatisfaction, or depression, often perceive more difficulties in the child. The Child Domain score is typically higher than the Parent Domain score for parents of disabled children, including learning disabilities. In extreme cases many of the categories in the child related area can appear in the 90% or above range. In crisis situations or families at risk for abuse, both child and parent domain scores are elevated. Child neglect profiles often show scores in the 90% to 95% range for acceptability, mood and reinforces parent subscales.

Higher scores in the Parent Domain suggest that stress may be related to dimensions of the parent's functioning. The subscales scores may assist in determining the sources of major stress for the parent. The potential for child abuse increases if the scores are elevated in the

Parents with high scores in the Life Stress category may be experiencing stress that is external to the parent-child relationship and beyond the control of the parent. If the Total Stress raw score is over 250 and the Life Stress raw score is 17 or above, professional assistance should be considered. If the parent's health raw score is 16 or more, referral is necessary, even if the total stress score is below 250.

The PSI offers a profile of the child, as perceived by the parent, and a self perceived profile of the parent. It also offers information related to the stressors on the parent and the degree to which the stress is experienced. This measure offers an opportunity to assess the parent-child relationship in a variety of categories. It also offers an ability to determine children at risk.

Both of these standardized measures were selected for their overall ability to assess quality of family functioning and parent-child interactions. They also met the criteria for pre- and post-test measures related to this practicum.

Analysis of Data for the Group Intervention

Parenting Stress Index (PSI) Third Edition Group Scores

The PSI was administered as a pre and post test measure for the group intervention program. All the completed PSI forms indicated Defensive Responding scores of over 24, suggesting valid profiles.

Family A.

Child L.

Parent B.'s perception of child L. from pre- to post-test showed the most noticeable change of the eight children in the group program. Scores suggest that this child was extremely high risk (95%+) in four of the six subscales (distractibility/hyperactivity, demandingness, mood, acceptability; see Table 1). Scores were in the high range (80% +) for adaptability and reinforces parent. The Child Domain score was at the 99th percentile. L. was considered at high risk for child abuse with scores in this range. The high scores suggest that she was a child who B. saw as distractible and hyperactive, who had difficulty adapting to change, did not positively reinforce her parent, placed extreme demands on the parent, exhibited distressing affect and appeared a poor match for the parent. The profile closely matched those indicating conduct disorder, poor attachment, or depression.

The parent profile for child L. indicated these subscales scores in the high range: competence, isolation, attachment, health, and depression. The Parent Domain, Total Stress and Life Stress scores were also in the high range. The parent and child domain scores were identical in the pre-test. This parent's profile closely matched those of parents with a depressive disorder, or who have weak parenting skills, are socially and economically isolated, and lack empathy for the child (Abidin, 1995).

Table 1

Parenting Stress Index Scores

(in percentiles)

Pre-Post Group Intervention For

Family A. - Child L.

	Pre	Post	Change
Variable			
Distractibility/Hyper	95	85	10
Adaptability	92.5	50	42.5
Reinforces Parent	87.5	87.5	0
Demandingness	99	70	29
Mood	97	60	37
Acceptability	98	85	13
Child Domain	99	71	28
			0
Competence	90	87.5	2.5
Isolation	85	70	15
Attachment	80	75	5
Health	80	50	30
Role Restriction	75	75	0
Depression	82.5	60	22.5
Spouse	35	80	-45
Parent Domain	83	77	6
			0
Total Stress	94	79	15
Life Stress	85	0	85
Defensive Responding	44	40	4

Post-test results indicated improvements in the child profile. There were no subscales scores in the 95%+ range. Scores improved, but remained in the high range for distractibility/hyperactivity, reinforces parent, and acceptability. In conjunction with the improved child scores, the parent profile post-test scores indicated few concerns in the high range. Feelings of parental competence (CO) remained high, but showed improvement from pre-testing. An increase in the Spousal subscore from 35% to 80% suggested increased dissatisfaction with the ex-partner of the youngest child in the home. All other scores moved below the high range to the normal range for this measure.

Factors that may account for the positive changes in the PSI profiles could be related to the group process. There were no known external factors contributing to the change. Both L. and B. experienced the group program as a positive and informative support resource. B. was given a great deal of verbal support and reassurance from members regarding her child and her ability to parent.

Family B.

Child T.

J.'s parent and child profiles for this family indicated few areas of concern, although most subscales scores improved from pre- to post-test results (see Table 2). The child profile showed no pre-test subscales scores in the 95%+ range. Scores in the high range included mood only. This score was not supported by other high range scores in the child profile or

Table 2

Parenting Stress Index Scores

(in percentiles)

Pre-Post Group Intervention For

Family B. - Child T.

Variable	Pre	Post	Change
Distractibility/Hyper	35	15	20
Adaptability	35	15	20
Reinforces Parent	45	55	-10
Demandingness	15	15	0
Mood	85	60	25
Acceptability	20	15	5
Child Domain	24	15	9
			0
Competence	45	40	5
Isolation	75	25	50
Attachment	25	10	15
Health	85	50	35
Role Restriction	80	10	70
Depression	20	5	15
Spouse	65	80	-15
Parent Domain	60	17	43
			0
Total Stress	38	14	24
Life Stress	90	85	5
Defensive Responding	38	27	11

for attachment in the parent profile, therefore it is not suggestive of a major dysfunction.

The parent profile did not show subscales scores of 95%+. Three subscales scores did fall in the high range: health, role restriction, and Life Stress. There were no known medical concerns for this parent. Factors affecting the role restriction and life stress categories may have been related to employment. This parent was seeking to return to the workforce, and was successful during the group program.

Post-test scores showed no subscales scores in the high range for T. All pre-test scores positively decreased with the exception of a slight increase in reinforces parent. The parent profile showed only two scores in the high range, spouse (80%) and Life Stress. Life Stress decreased slightly but was still at the 85th percentile. The increase in spouse may have indicated a lack of support in childcare resources and employment may have been the factor. Parent J. appeared to find group a positive experience and was a regular attender with active participation. Group involvement may have been a factor in the change in scores from pre-test to post-test.

Family C.

Child C.

This child was profiled in the pre-test by her parent as high risk (95%+) in subscales adaptability, reinforces parent, and acceptability (see Table 3). The Child Domain score was in the high range. The scores

Table 3

Parenting Stress Index Scores

(in percentiles)

Pre-Post Group Intervention For

Family C. - Child C.

	Pre	Post	Change
Variable			
Distractibility/Hyper	75	35	40
Adaptability	95	95	0
Reinforces Parent	96	85	11
Demandingness	55	55	0
Mood	75	75	0
Acceptability	96	97	-1
Child Domain	90.5	85	5.5
			0
Competence	85	65	20
Isolation	50	50	0
Attachment	65	85	-20
Health	35	35	0
Role Restriction	45	55	-10
Depression	50	70	-20
Spouse	85	90	-5
Parent Domain	67	71	-4
			0
Total Stress	80	78	2
Life Stress	60	40	20
Defensive Responding	32	36	-4

in the parent's pre-test indicated subscales in the high range for competence, spouse and Total Stress. As the parent scores in the Parent Domain were lower than the scores in the Child Domain, it suggests that the parent saw the child as the problem. Although attachment scores were not in the high range of the pre-test, the scores suggest that the parent saw the child as unable to adapt to change, not reinforcing the parent or meeting the parent's expectations. This parent was not having her needs for competence met by this child and may have also felt a lack of support in caring for this child.

Post-test results showed few positive changes in child C.'s profile. Subscale scores for adaptability and acceptability remained in the high risk area. Reinforces parent and Child Domain scores were in the high range. Parent scores improved to the degree that spouse and attachment were now in the high range, with decreased scores in other areas.

Factors impacting on the relationship between parent and child C. may have been characteristics of the child that did not meet parental expectations. C. had exhibited serious oppositional behaviours in the past and this may have continued to factor into a parent-child relationship that was unsatisfying for both parent and child. Additional factors in the family system included a high degree of conflict between the parent and other members of the family system. There was also a high degree of conflict between this child and the older sister, R., who was replacing the deceased father in the system. Recently, the mother's dating relationship progressed to a common law situation. Although

scores in the Parent Domain and Life Stress categories do not reflect high demands on the parental system, there were a number of demands placed on this mother of four including extended family and job related pressures. Also, this parent is continuing to adapt to the loss of the father and his role in parenting the children. This may be a factor in the Spouse scores for all three children in this system.

Child K.

Pre-test child profile scores for child K. included three subscale scores in the 95%+ range of high risk: reinforces parent, mood, and acceptability (see Table 4). Other scores were within the normal range. Parent pre-test scores for child K. indicated no subscale scores in the high risk area, but two subscale scores in the high range: competence and spouse. Similar to child C., the parent did not appear to feel reinforced by this child and also found this child did not meet her expectations. In addition, this child displayed signs suggesting unhappiness.

Post-test results indicated no subscale scores in the high risk range and scores in the high range for subscales; distractibility, reinforces parent and the Child Domain. Although the reinforces parent score improved from pre- to post-testing, the other two scores increased. The distractibility/hyperactivity increased from the 45th percentile to the 90th percentile. Parent subscale scores continued to show no scores in the high risk range, but subscales spouse and attachment were in the high range. These scores reflected change for child K. The attachment

Table 4

Parenting Stress Index Scores

(in percentiles)

Pre-Post Group Intervention For

Family C. - Child K

	Pre	Post	Change
Variable			
Distractibility/Hyper	45	90	-45
Adaptability	50	65	-15
Reinforces Parent	96	87.5	8.5
Demandingness	65	75	-10
Mood	95	60	35
Acceptability	96	70	26
Child Domain	79	82.5	-3.5
			0
Competence	85	60	25
Isolation	50	50	0
Attachment	65	85	-20
Health	35	35	0
Role Restriction	45	55	-10
Depression	50	50	0
Spouse	85	85	0
Parent Domain	67	65	2
			0
Total Stress	74	75	-1
Life Stress	60	40	20
Defensive Responding	34	34	0

scores for K. and C. had both elevated from the 65th percentile to the 85th percentile pre- to post-test. These scores suggest attachment problems for both of these children, particularly as they are accompanied by higher scores in categories of acceptability and distractibility/hyperactivity.

K. may have been experiencing a parent who lacked energy or who had unreasonable parental expectations. K.'s behaviours may have been related to increased distractibility, overactivity, short attention span or anxiety.

Child J.

L.'s pre-test scores for child J, indicated subscale scores greater than the 95th percentile in reinforces parent and mood (see Table 5). Adaptability and Child Domain scores were in the high range. Parent profile pre-test scores indicated high range scores for competence and spouse, with no scores in the high risk range.

Post-test scores for child J. showed high risk scores in the area of mood and high range scores in adaptability, reinforces parent, acceptability and the Child Domain. Parent profile post-test scores indicated the following scores in the high range: competence, attachment, spouse and Total Stress. The scores in the Parent Domain remain lower than the scores in the Child Domain for this child and the other two children tested. This suggests that the parent sees the children as the problem and is not reflecting on her role in the difficulties with

Table 5

Parenting Stress Index Scores

(in percentiles)

Pre-Post Group Intervention For

Family C. - Child J.

Variable	Pre	Post	Change
Distractibility/Hyper	45	55	-10
Adaptability	80	90	-10
Reinforces Parent	96	85	11
Demandingness	70	75	-5
Mood	97	98	-1
Acceptability	70	85	-15
Child Domain	86	89	-3
			0
Competence	85	85	0
Isolation	50	50	0
Attachment	75	80	-5
Health	35	35	0
Role Restriction	45	55	-10
Depression	50	70	-20
Spouse	85	85	0
Parent Domain	69	73	-4
			0
Total Stress	77.5	84	-6.5
Life Stress	60	40	20
Defensive Responding	34	34	0

the children. Increased attachment scores for the three children suggest that the problem may not be child specific, but related to the parenting. The quality of time available between the parent and the children could be a factor. Additional factors that might be affecting the parent-child relationships may include the elevated position of the adolescent daughter in the home who has assumed a parentified role with limited skills. Another factor may be the extra demands on the parent's time in running a business and engaging in a new romantic relationship. The social and emotional needs of the three children identified here may not be met adequately.

Family D.

Child A.

The father, K., completed the pre- and post-tests for this child unlike the other children in this study where the testing was completed by mothers. The PSI suggests that a bias exists for forms completed by fathers that is generally related to lower scores especially for behavioural problems. Pre-test profile scores for child A. indicated no subscale scores in the high risk area and only reinforces parent in the high range at the 80th percentile (see Table 6). Pre-test scores for father indicated Life Stress in the high risk area and high range scores for role restriction, attachment, spouse, and the Parent Domain.

Post-test scores showed that reinforces parent remained in the high range area. Parent post-test scores indicated Life Stress remaining in the

Table 6

Parenting Stress Index Scores

(in percentiles)

Pre-Post Group Intervention For

Family D. - Child A.

Variable	Pre	Post	Change
Distractibility/Hyper	20	15	5
Adaptability	65	70	-5
Reinforces Parent	85	90	-5
Demandingness	55	10	45
Mood	75	35	40
Acceptability	50	60	-10
Child Domain	50	35	15
			0
Competence	55	92	-37
Isolation	85	94	-9
Attachment	90	80	10
Health	70	75	-5
Role Restriction	80	65	15
Depression	70	90	-20
Spouse	90	80	10
Parent Domain	81	90.5	-9.5
			0
Total Stress	74	77	-3
Life Stress	96	99	-3
Defensive Responding	37	41	-4

high risk area and high range subscale scores now including isolation, competence, attachment, depression, spouse and Parent Domain. Parent Domain scores are quite elevated to the Child Domain, suggesting that this child is not the reason for the parent's stress. Factors affecting these scores may be related to the child's emergence into adolescence or to the other stressful factors in the family system. Some of these factors include: a recent family move from the city to the rural area, increased financial and job responsibilities for this parent, increased demands on parental time with two toddlers and a preschool child in the home, and court proceedings for guardianship of two of the children in the home.

Child S.

Pre- and post-tests were completed by the mother, R., for this child. All subscale scores of the PSI pre-test showed high risk, greater than the 95th percentile, with the exception of distractibility/hyperactivity, which was within the normal range (see Table 7). Pre-test results for the parent profile showed high risk scores in the following subscales: isolation, attachment, spouse, Life Stress, Parent Domain and Total Stress. Depression and health were in the high range.

Post-test scores for the child profile did not change. Post-test scores for the parent showed some improvement. Subscale scores in the high risk area included attachment, spouse, Life Stress. and Total Stress. High range scores were found in competence, role restriction, depression and the Parent Domain. Parent Domain scores remained elevated over Child

Table 7

Parenting Stress Index Scores

(in percentiles)

Pre-Post Group Intervention For

Family D. - Child S.

	Pre	Post	Change
Variable			
Distractibility/Hyper	60	55	5
Adaptability	99	99	0
Reinforces Parent	99	95	4
Demandingness	97	96.5	0.5
Mood	99	97	2
Acceptability	95	98	-3
Child Domain	99	96.5	2.5
			0
Competence	75	80	-5
Isolation	99	50	49
Attachment	99	95	4
Health	80	70	10
Role Restriction	75	90	-15
Depression	82.5	92.5	-10
Spouse	99	99	0
Parent Domain	65	93	-28
			0
Total Stress	98.5	96	2.5
Life Stress	99	99	0
Defensive Responding	50	48	2

Domain scores in the pre- and post-tests. The high scores in the child profile, however, are of concern and suggest crisis in the relationship.

Factors affecting the scores in this profile are likely related to the loss of this child's birth mother and her subsequent absorption into a new family system. Some degree of uncertainty may be related to placement. There are also external stressors and marital stressors on this parent. The high stress level on this parent and questions regarding the possibility of depression are cause for concern.

Child D.

Child D.'s PSI form was completed by the mother. Pre-test results for this child indicated scores greater than the 95th percentile in reinforces parent, demandingness, acceptability, and the Child Domain (see Table 8). The subscale scores for distractibility/hyperactivity, adaptability, and mood were in the high range greater than the 80th percentile. Pre-test scores in the parental domain were greater than the 95th percentile for competence, spouse and Total Stress. Scores were in the high range of greater than the 80th percentile for isolation, attachment, role restriction, depression, Life Stress and Parent Domain.

Post-test scores for the child profile remained in the high risk range for demandingness and acceptability. High range scores included adaptability, mood, and the Child Domain. Post-test scores for the parent profile showed high risk scores for spouse and Life Stress. High range scores were shown in subscales isolation, attachment, role

Table 8

Parenting Stress Index Scores

(in percentiles)

Pre-Post Group Intervention For

Family D. - Child D.

Variable	Pre	Post	Change
Distractibility/Hyper	90	20	70
Adaptability	90	92.5	-2.5
Reinforces Parent	96	65	31
Demandingness	96	95	1
Mood	85	90	-5
Acceptability	97	98	-1
Child Domain	96	88	8
			0
Competence	98	60	38
Isolation	85	80	5
Attachment	85	90	-5
Health	80	20	60
Role Restriction	87.5	80	7.5
Depression	70	82.5	-12.5
Spouse	85	95	-10
Parent Domain	93.5	84	9.5
			0
Total Stress	96	90	6
Life Stress	91	99	-8
Defensive Responding	49	47	2

restriction, depression, Parent Domain and Total Stress Score.

The scores for D. may be associated with poor individuation related to age, separation anxiety, lack of involvement with peers, or the eventual diagnosis of attention deficit hyperactivity disorder. The death of the aunt could be a factor for her anxiety. Child Domain scores were elevated to the Parent Domain suggesting that the parent saw the child as the problem. This could be further supported with the high risk score in acceptability indicating that the child is not a good match for the parent. This could suggest a lack of empathy between the parent and this child. This child struggled in sibling and peer relationships and was later diagnosed with attention deficit hyperactivity disorder.

Family Assessment Measure (FAM III) - Group Scores

This measure was administered pre- and post-group to participating parents. It was also administered as a pre-post test for the family therapy follow-up and was completed by three parents and two adolescents. Social Desirability and defensiveness scores were below T-60, that is, within normal range.

Family A.

Parent B.

Pre-test results of the FAM indicated Family A. was functioning within the mid range (T score of 50 to 60) in the areas of task accomplishment, communication, control and values and norms (see Table 9). There were three scores of 60 or more suggesting weakness in

Table 9

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Group Intervention

Family A. - Parent B.

Variable	Pre	Post	Change
Task Accomplishment	54	58	-4
Role Performance	70	56	14
Communication	54	54	0
Affective Expression	64	54	10
Involvement	60	54	6
Control	56	62	-6
Values & Norms	56	52	4
Overall Rating	67	56	11
Social Desirability	48	50	-2
Defensiveness	54	46	8

role performance, affective expression, and involvement.

Post-test results showed improvements with all of the scores falling to the mid range. One area was assessed as slightly more problematic following the group intervention: control moved from 56 to 62. None of the scores improved sufficiently to fall in the area of strengths. The overall FAM scores for B. moved from 66.85 to 55.71, indicating improved overall functioning.

These scores suggest that the respondent, B. perceived improved functioning in: adapting roles to meet family needs, expressing feelings and nurturing and supportive involvement. This is consistent with results from the PSI, which indicated improved parent-child relationship, and with observations of the parent and child in the group.

Family B.

Parent J.

Pre-test results completed by parent J. indicated no concerns in family functioning (see Table 10). All FAM scores were between 40 and the mid line of 50, except affective expression with a T score of 54.

Post-test results showed an improvement in all areas of functioning with several scores below 40, indicating strength in task accomplishment, role performance, communication, involvement, and control. Scores for affective expression and values and norms were only slightly above 40. Overall scores moved from 47.42 to 36.85 suggesting improved functioning.

Table 10

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Group Intervention

Family B. - Parent J.

Variable	Pre	Post	Change
Task Accomplishment	48	34	14
Role Performance	48	38	10
Communication	46	32	14
Affective Expression	54	44	10
Involvement	42	34	8
Control	46	36	10
Values & Norms	48	42	6
Overall Rating	48	36	12
Social Desirability	42	50	-8
Defensiveness	46	50	-4

Another factor that may have affected the scores for this family, apart from involvement in the group program, may have been related to J.'s employment. J. reported an increase in her emotional well being upon obtaining employment. She was looking forward to using her skills as a home care worker and to the increased financial freedom that accompanied employment. There were no other known factors.

Family C.

Parent L. and Partner B.

Parent L. indicated that the family was functioning within the normal range (50-60) in the areas of task accomplishment, affective expression, control and values and norms (see Table 11). Scores of 60 -70 suggested weakness in role performance, communication, and involvement. These scores are consistent with areas of difficulty expressed in parent child relations on the PSI, which suggested problems in parental expectations and quality of time spent with the children. L.'s Partner B. indicated weakness (60+) in communication and control (see Table 12). The fact that both parents are suggesting that communication is weak, strengthens the argument that there are difficulties in this area.

Post-test scores for parent L. indicated no change in task accomplishment, control and role performance. Communication and affective expression improved to the mid range while values and norms decreased, moving to 60 and suggesting weakness. Partner B. noted improvements in communication, affective expression and control. With

Table 11

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Group Intervention Measures

Family C. - Parent L.

Variable	Pre	Post	Change
Task Accomplishment	54	54	0
Role Performance	66	66	0
Communication	64	50	14
Affective Expression	54	50	4
Involvement	60	54	6
Control	56	56	0
Values & Norms	73	60	13
Overall Rating	58	56	2
Social Desirability	42	42	0
Defensiveness	42	46	-4

Table 12

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Group Intervention Measures

Family C. - Partner B.

Variable	Pre	Post	Change
Task Accomplishment	54	54	0
Role Performance	56	60	-4
Communication	64	50	14
Affective Expression	58	54	4
Involvement	54	54	0
Control	62	56	6
Values & Norms	56	56	0
Overall Rating	58	54	4
Social Desirability	42	48	-6
Defensiveness	46	46	0

both parents noting improvement in communication and affective expression, there is a stronger possibility of change having occurred. Overall scores for parent L. and partner B. indicated minimal change.

L.'s improved scores for values and norms may have been related to a shift in family conflict that moved from within this family system to the extended family system as adolescent R. directed her anger and hostility towards her paternal grandmother and away from her mother. Changes may have resulted from the group intervention or from the increased spousal support to the system with partner B. moving into the family.

Family D.

Parents R. and K.

Pre-test group intervention FAM III results for parent R. indicated scores between 60-70 in role performance, communication, involvement, and values and norms (see Table 13). Post-test measures indicated no change in task accomplishment, communication, control and values and norms. Changes were negative in role performance, affective expression and involvement. The Overall Rating increased from 60.5 to 64.

Parent K.'s FAM III pre -test results scored all areas of functioning in the 50-70 range, with scores of 60+ for role performance, communication, involvement and values and norms (see Table 14). Post-test results following group intervention indicated a positive change in

Table 13

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Group Intervention Measures

Family D. - Parent R.

Variable	Pre	Post	Change
Task Accomplishment	58	58	0
Role Performance	60	70	-10
Communication	64	64	0
Affective Expression	58	68	-10
Involvement	64	68	-4
Control	56	56	0
Values & Norms	64	64	0
Overall Rating	60	64	-4
Social Desirability	40	42	-2
Defensiveness	36	46	-10

Table 14

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Group Intervention Measures

Family D. - Parent K.

Variable	Pre	Post	Change
Task Accomplishment	58	64	-6
Role Performance	60	66	-6
Communication	60	70	-10
Affective Expression	54	58	-4
Involvement	64	72	-8
Control	52	46	6
Values & Norms	60	64	-4
Overall Rating	58	62	-4
Social Desirability	42	42	0
Defensiveness	40	40	0

control from 52 to 46, and a negative change in all other areas, with involvement scoring highest at 72. The Overall Rating for K. moved from 58 to 63, suggesting a similar increase in dissatisfaction as spouse R. The area of greatest difference between the parents was noted as control, where K. viewed this as a family strength and R. perceived need for improvement.

Factors that may have contributed to the increase of dissatisfaction for the parents could have been increased stressors on the family system. Prior to group termination, the family underwent a major move from the city to the rural area. Although housing space increased, there were additional demands placed on the system financially and in the area of transportation. A second vehicle was necessary and, since finances did not permit the purchasing of a reliable vehicle, ongoing repair costs were an additional source of stress. Changes in schools were required for the children. K. had additional work demands and was less available to the family system. The home and property required time from both parents. R. was faced with increased isolation as a full time mother, at the same time that the two youngest children became mobile. Homemaker supports were less reliable in the rural area, and K. often missed the group sessions to provide care for the three youngest children. Marital dissatisfaction was increasing in the family system.

Analysis of the Data for Family Therapy Interventions

FAM III Family Therapy Scores

This measure was administer pre- and post-family therapy to participating families C. and D. including parents and adolescents. Social desirability and defensiveness scores were scored below T-60 which is within the normal range.

Family C.

Parent L.

FAM III pre-test scores indicated all functioning was within the normative range (50-60) with the exception of role performance and values and norms (see Table 15). FAM III post-test results indicated a marked decline in functioning within the family system. All the scores were 60+ with the exception of affective expression.

Factors influencing the family system were numerous. Timing was likely a key factor in the results since family members spent time away from one another prior to the pre test. Another factor may have been denial of problems on the part of the parent. The PSI results had indicated more difficulties in the system that the FAM III results were acknowledging. These results were child focused. The family therapy addressed specific issues in the functioning of the system, and the post-test results may be a positive sign that the system, especially the parent, was recognizing the difficulties. Another important factor may have been the involvement of the adolescent daughter in the family therapy

Table 15

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Family Therapy Intervention

Family C. - Parent L.

Variable	Pre	Post	Change
Task Accomplishment	54	64	-10
Role Performance	66	70	-4
Communication	50	64	-14
Affective Expression	50	58	-8
Involvement	54	60	-6
Control	56	66	-10
Values & Norms	60	64	-4
Overall Rating	56	72	-16
Social Desirability	42	42	0
Defensiveness	46	32	14

sessions. She had no difficulty voicing her opinions about the system and generated a high degree of conflict in the process. Family members appeared to respond to one another in a very honest manner during the therapy sessions and this may have encouraged increased honesty in reporting.

Child R.

Pre- and post-tests completed by R. suggested serious family dysfunction in all areas (see Table 16). Pre-test scores were all 70+ with the exception of affective expression which was scored at 64. The post test results showed negative movement with all scores above 80 except Role Performance which scored 78.

Factors affecting R.'s scores may have been related to honesty, or to the high degree of conflict between her and other family members. Her daily functioning was weak: she was not attending school on a regular basis and her behaviour was beyond control of the family system. She was verbally and physically abusive towards her younger sisters. R.'s need for power and control had existed prior to the death of her father, but the death seemed to have escalated these issues. The family system was also experiencing serious difficulties with the life cycle stage of adolescence coinciding with the romantic stage between L. and B.

Family D.

Parent R. and Parent K.

Pre-test FAM III results completed by parent R. indicated a

Table 16

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Family Therapy Intervention

Family C. - Child R.

Variable	Pre	Post	Change
Task Accomplishment	90	90	0
Role Performance	86	78	8
Communication	84	88	-4
Affective Expression	64	86	-22
Involvement	84	92	-8
Control	76	90	-14
Values & Norms	70	84	-14
Overall Rating	79	74	5
Social Desirability	24	28	-4
Defensiveness	18	18	0

generalized dissatisfaction in the system with most results in the range of 60-70 (see Table 17). Post-test results indicated no change in values and norms and negative change in all other areas of functioning. Several scores moved to greater than 80, including role performance, communication, and involvement. The Overall Rating moved from 64 to 74. The generalized dysfunction in the system shown by R. may have reflected the problems in the marital subsystem, her diagnosed depression, a series of additional stressors faced by this parent during the course of family therapy. Family of origin issues related to the death of the sister were also evident. The elevated scores may also have been related to R.'s increased sense of comfort and honesty with verbalizing difficulties. Parent K. stated similar feelings.

Parent K. indicated pre-test scores showing dysfunction in areas related to role performance, communication, involvement and values and norms. Post-test results following family therapy indicated no change in role performance, affective expression, involvement and values and norms. Control and task accomplishment showed a negative change. The Overall Rating showed little change (63 to 64).

The greatest degree of dissatisfaction indicated by parent R. was that she did not feel adequately supported or understood by parent K. The parenting demands were overwhelming for parent R., and the diagnoses of two children with special needs placed long term care implications on this family. An additional source of emotional stress for R. was the court case related to the her sister's death.

Table 17

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Family Intervention

Family D. - Parent R.

Variable	Pre	Post	Change
Task Accomplishment	58	74	-16
Role Performance	70	80	-10
Communication	64	84	-20
Affective Expression	68	68	0
Involvement	68	80	-12
Control	56	72	-16
Values & Norms	64	64	0
Overall Rating	64	74	-10
Social Desirability	42	42	0
Defensiveness	46	32	14

Table 18

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Family Therapy Intervention

Family D. - Parent K.

Variable	Pre	Post	Change
Task Accomplishment	64	68	-4
Role Performance	66	66	0
Communication	70	64	6
Affective Expression	58	58	0
Involvement	72	72	0
Control	46	56	-10
Values & Norms	64	64	0
Overall Rating	62	64	-2
Social Desirability	42	42	0
Defensiveness	40	36	4

Child A.

Pre-test results for A. indicated scores between 60-70 in areas of role performance, communication, affective expression, control and values and norms (see Table 19). The problem areas were generalized across the system, similar to the results of the parents. Post-test results showed positive change perceived by A. in all areas of functioning with most scores indicated near the mid range of 50. The Overall Rating showed a positive change from 62 to 56.

In addition to her involvement in the family therapy process, other factors that may have had a positive impact on change for A. included the couple therapy which provided a separate arena to address the parental issues and A.'s social life outside of the family system.

Consumer Feedback Results

Separate self-report client satisfaction surveys were designed and then administered following the group intervention and the family therapy follow-up intervention. Overall client satisfaction was high in the feedback from all respondents. Six surveys were completed in total, four from the group program and two from the family intervention.

Group survey respondents n=4 indicated that the quality of service received was excellent n=3 or good n=1. Family respondents n=2 indicated the quality of service was excellent n=2. Group respondents indicated that the service was definitely what they wanted n=3 or

Table 19

Family Assessment Measure (FAM III)

(T scores)

Pre-Post Family Therapy Intervention

Child A.

Variable	Pre	Post	Change
Task Accomplishment	58	52	6
Role Performance	64	56	8
Communication	70	62	8
Affective Expression	60	56	4
Involvement	54	50	4
Control	60	64	-4
Values & Norms	66	54	12
Overall Rating	62	56	6
Social Desirability	34	42	-8
Defensiveness	36	40	-4

generally what they wanted n=1. Family respondents indicated that the service was definitely what they wanted n=2. All 6 group and family respondents indicated that they would definitely recommend this service to a friend in similar need. Group respondents indicated that this service helped to understand their child a great deal n=2 and somewhat n=2. Family responses were also evenly split with 1 response for helped a great deal, and 1 response for somewhat helpful. All 6 group and family respondents indicated that the setting was definitely appropriate for this service.

Participants' comments related to the group intervention indicated that it was helpful to hear how others coped, to interact with others, to share the same situations, and to learn about the stages of grieving. They suggested changes in lengthening the group program. One respondent supported the need to start the groups on time. There was one response to the least helpful part of the service being to speed up the grief. Comments in the family intervention survey indicated that it was helpful to listen to others vent their feelings and to develop a better understanding of the problem. Two respondents from each survey used the feedback forms to express their appreciation for the service offered and their wish to participate in a similar service in the future.

OBSERVATIONS AND CONCLUSIONS

Treatment Themes

Attachment and Loss

During the screening portion of this practicum, the first theme to emerge was that the impact of the trauma of the loss reflected the relationship, or the attachment, of the individual to the deceased (Lohnes & Kalter, 1994). Child T. had no significant relationship with his father prior to the death. At this stage in T.'s life, the loss had not impacted on his day to day existence. Therefore T. did not appear to be in a state of grieving. T. may grieve the loss of a 'father figure', or the dream of a father, as he grows older and attempts to individuate as an adolescent male.

In contrast, child L. was very connected to her father prior to his death. He had treated her as 'special' and had spent time with her on a regular basis. Consequently, she appeared to be overwhelmed by his death and projected her feelings of anger towards her mother.

Secondary Losses

Child S. had a most complicated set of circumstances. She suffered both primary and secondary losses following the death of her mother, M. Not only had she lost her only primary caregiver, she had also lost her home, her friends, her school and community contacts. Since she was absorbed into an extended family system, she lost her birth position of

eldest child with the move into the new system. The functioning patterns of the new family system were very different from those of her family of origin. These included changes in tasks, roles, values, norms and general expectations placed on S. In addition, S. was faced with the media notoriety that ensued following the high profile death of her mother.

Children C., K., and J., were also strongly affected by the sudden death of their father. These children lost a caregiver with whom they were well connected. They also suffered secondary losses with the sudden financial change in the family system and the emotional and physical loss of their mother as she attempted to cope. The eldest sibling, R., was left to replace the mother, L., however, R. was ill equipped to manage three young siblings. Shifted patterns in task accomplishment, roles, behaviour control and involvement increased the complicated issues affecting the children within this system.

Children's Grief Tasks

In relation to grieving tasks for children, all the children in the group were continuing to process their understanding of the deaths and why they had occurred (Baker, Sedney, & Gross, 1992). This was evident in the questions asked by the children during their first group activity, 'the question bag'. Even A., the eldest child was trying to make sense of a violent act that led to the death of her aunt. The second task relating to acceptance of the loss and bearing the subsequent pain differed for the

children based on their attachment to the deceased. Children in the C. family, child L. and child S., continued to experience difficulty with this task. Their questions about why this had to happen to their parent, the tears shared in group, and the reports from the parents indicated that these children were experiencing their loss on an on-going basis.

The task of commemorating and memorializing the deceased had not been completed by any of the families (Fox, 1994; Worden, 1996). Parents J. and B. were unaware of the importance of this task. Family C. was engaged in a highly conflictual situation with extended family related to this task. Family D. could not proceed with this task until legal issues related to the death were complete.

Children's Developmental Issues

The developmental issues facing the children in the group were in keeping with expectations for middle years children. Parents were provided with information to increase their understanding of children in this age range, especially related to shorter attention spans, the need for structure and routines and physical comfort for reassurance (Adams-Greenly, & Moynihan, 1983). These children responded positively to language that was simple, clear and direct and to structure, routine and predictability, including rules and expectations. The weekly rituals were important to the children and they quickly learned what was expected of them. Structure was important for the multiple family group as well as the children's group. Rules were tested on a number of occasions, but

the children were able to comply with them when they were restated firmly by adults. The children also responded well to positive attention from parents and therapists. They tended to exhibit clingy, aggressive or attention seeking behaviours when anxious. It was difficult for the children to express feelings verbally, and most of their feelings were communicated through behaviour. In contrast, the adult participants used talking and sharing of feelings to decrease anxiety. Children from the C. family demonstrated this during the session that mother left for a brief period of time. These children became withdrawn or hyperactive, asked detailed questions about their mother's whereabouts and became tearful. Child L. showed anxiety through clingy behaviour during session four when she was experiencing attachment problems with B.

Parental Feelings Towards the Deceased

Parents J. and B. were not emotionally invested in the deceased prior to the deaths. Consequently, they were not faced with the overwhelming feelings of loss and sadness that affected parents R. and L. Both J. and B. acknowledged feelings of ambivalence to the deceased for actions prior to the death. R.'s partner K. was faced with feelings of ambivalence as he attempted to process the loss and the changes to his family system. R. and K.'s relationship to the deceased D. prior to the death was conflictual and they were often in a position of rescuing the children for brief periods of time. Since R. saw her older sister D. as a surrogate mother, these feelings of loss tended to override the negative

feelings following the death. Both R. and K. did, however, acknowledge feelings of anger towards the deceased M. for lifestyle choices that were oppositional to their values and beliefs.

Continued Bonds

Another theme that surfaced in the parent group related to the continued bonds to the deceased (Klass, et al., 1996). During the second parent session, discussion moved to parents having conversations with their deceased loved ones and their fears of 'being crazy' for retaining these connections through behaviours. The group members expressed universal relief when they learned that relationships change, but do not end following a significant loss. L. was also encouraged to realize that there was nothing wrong with her for being able to form an attachment to new partner, B., while still retaining her love for her deceased husband. This was also a powerful theme for R. who was working to attach to child S. but remained respectful of S.'s on-going attachment to her deceased mother.

Parental Readiness for Learning and Change

The importance of parental understanding of the needs of the children was evident throughout the group process (Adams-Greenly, & Moynihan, 1983). Parents were open to new information and to learning; they specifically requested direct examples for responding to their children. They did not exhibit feelings of being threatened by the

information shared during the mini lectures or discussion portions of the group. The parents interpreted any current difficulties within their family systems as responses to the death of the deceased, and not something for which they felt personally responsible or able to control. They did not feel that their competency as parents was challenged by the group. They all felt immersed in a new experience brought on by the deaths of their loved ones. In addition to expressing interest in new information, the parents took risks by following directives to change their behaviours in relation to the children. Evidence that stronger attachments were being made between parents and children during the course of the group, was provided by the decrease in crisis situations for the children in group, the outward displays of affection between parents and children, and the language used when parents discussed their children in the groups.

Quality of Involvement in Parent-Child Relationships

Group provided participants with an opportunity to increase involvement in the family unit. The group was a shared weekly activity for the families that attended. It ensured that parents were informed and actively involved in their children's therapy process (James, 1994). The time spent and the quality of that time increased positive feelings between parents and children. This was particularly evident during the last two sessions as parents and children focused on a joint commemorative activity for the deceased. The interaction between

family members as they worked on this task provided increased ability to assess dynamics with the family systems. It also provided time for families to observe one another and learn from one another as parents worked on their project and assisted children as needed. Parents R. and B. showed artistic ability and patience with their own children. Child L. was very involved in this task and exhibited strengths of artistic ability and self motivation that had not been observed previously. Child D. was unable to organize this task without assistance from mother R. Child D. was not resistant, she was just unable to settle into the task. Child D. was later diagnosed with attention deficit hyperactivity disorder. Child A. became impatient when her younger sibling appeared to be copying her design. These two siblings were able to problem-solve without parental intervention.

Family Support Systems and Networks

This theme involved the impact of the loss on individuals in the family system, and the ability of the system to respond to individual needs. The needs of the children were so great in family D. that adult needs went unattended, to the detriment of each adult and the couple subsystem. In family C., the needs of the adult were partially met, to the detriment of the children in the system. The needs of these adults were in conflict with the needs of the children and balancing individual needs would have required considerable external support from extended family and friends. Neither family had adequate supports to ensure that

all family members were able to cope with their losses (Shapiro, 1994). Parent R. did not feel that she had been given time or permission to grieve the loss of her sister. Family demands kept her focused on survival tasks within the family system. The demands of three young children and three slightly older children also limited her ability to seek support through other adults. She was in a position of relying on her husband for much of her support, and that source was not adequate to meet her needs. R. was also faced with a legacy of losses in her family of origin that made grieving this death even more difficult. The previous losses may have been contributors to her need to parent her sister's children, because that sister had been her surrogate parent as a child.

Individuals in family C. were also faced with survival needs that overrode the emotional needs of grieving individuals. The children were faced with the loss of the deceased father and the unavailability of their mother as she worked to ensure the family's survival. Neither of these two families had the advantage of social and economic resources that would have provided for increased opportunities to address individual needs during their time of grief.

Couple issues affected the family system's ability to support grieving. These issues surfaced during therapy for family D. and required attention separate from the family system. Differing individual needs and expectations of one another, demands of the children, and limited resources were stressing the couple beyond their capacity to cope. Their expectations for intimacy and 'oneness' with one another were

unrealistic during this stage in the family cycle. Family of origin issues came to light particularly in the areas of trust, intimacy and conflict resolution, further complicating their process of adjustment and growth.

Family Life Cycle Development

Life cycle issues also emerged as a strong theme in therapy. The parents of younger children shared concerns about the impact of the loss of the deceased on the family system. They worried about the impact of the loss on future development, especially as L. shared her difficulties with adolescent daughter R. in session two. The dependency needs of the children in the family with young children stage were seriously affected as the death posed a real threat to emotional safety and security (Walsh, 1982). Roles, boundaries, structure, routine, nurturing needs were all also impacted in these families. Family C. had just entered the 'family with adolescents' stage at the time of the father's death. As this family still had young children to raise, adolescent R. was prematurely vaulted from her duties as a young adolescent to those of substitute parent. The complications that followed this premature shift skewed the dynamics in the family system to the point of breaking the family apart. Daughter R. left the family system for approximately two months prior to family therapy, staying with grandparents to provide some relief to the tension in the system.

Life cycle issues were also evident for family D. The couple had missed the early stages in the family life cycle that would have provided

time and attention to the development of the couple relationship., particularly in the area of trust. R. and K. began their first tasks together as parents when K. joined R. and her two children. Two more children were born within two years, followed by the addition of sister M.'s two children a year later. With R.'s eldest child A. starting adolescence, this system is approaching another major shift in less that a five year time frame. Life cycle issues had not been effectively addressed in this family system from the beginning.

Family Functioning

Both families C. and D. were managing to function adequately in most task areas. Basic tasks were accomplished to the degree that these families were able to maintain an adequate lifestyle with basic needs met. Developmental tasks that addressed the emotional and social growth needs of the family system were strained in both families. This was due to the crisis following the death. The families had managed to deal with the initial crisis following the death, but the long term effects continued to stress the system. Difficulties were observed in both families in the following areas:

1. Communication patterns were often ineffective, particularly when the adults were stressed. Patterns tended to be critical and blaming and this resulted in aggression or noncompliance from others.

2. Roles and boundaries were not always clear in the family systems. Expectations were not fulfilled in the couple relationship and boundaries

were often blurred between the parents and older children, as they leaned on the children to provide more support to the system.

3. Affective expression and response was determined by the amount of stress on the couple subsystem and the emotional availability of the adults.

4. Involvement, or the quantity and quality of time together was cited as an issue needing improvement in both families.

The therapist used a variety of intervention strategies during the family therapy follow-up to improve family functioning. Both families responded positively to support and reduction of guilt and anxiety. Genograms were used to reframe current problem areas and increase understanding of difficult issues. The need for families to blame was defused and effective communication strategies were role modelled and encouraged during sessions. Expression of feelings, especially anger was problematic for both family systems. Role plays and tasks assigned between sessions were also helpful interventions. The therapist aligned with the couple as executives in the family system and worked to support enhancing their relationship and their effectiveness in the system. Flexibility was needed in both the group and family interventions. The therapists needed to be able to adjust agendas, time frames and strategies based on the needs of the families.

A sequential treatment approach that moved from a least intrusive to most intrusive approach allowed the therapy to move from general issues to core couple and individual issues. The trust developed

gradually and led to very open and honest communication by the end.

Conclusions

Family A. appeared to benefit from the group program to the greatest degree. They entered into the program with a low level of trust for professional helpers and left the program willing to seek professional intervention in the future as needed. Prior to the program, parent B.'s support network was weak, her feelings of competency in relation to child L. were low and the attachment between them was weak. Parent B.'s feelings of parental competency increased during the program and the attachment between parent and child strengthened noticeably. Both mother and daughter indicated a high level of trust and satisfaction with the program and the positive improvements in their relationship were evident on many levels. Parent B. responded very positively to the support, information and direction that she received in this program. The program also provided an opportunity for mother and daughter to positively experience a shared activity, separate from other distractions.

Family B. entered the program reporting no strong concerns in any of the pre-test materials or assessment interview. Post-test scores appeared to reflect a positive change in most areas and this may have been related to parent J.'s active participation in the group. Although J. appeared a younger parent than other group members she was well resourced with extended family support. Her son T.'s resiliency was

strengthened by his strong athletic ability and his mother's pride and support of these talents. J. received positive affirmation from other parents and was able to feel helpful on a number of occasions when a younger perspective on adolescence was needed. Although J. was hesitant to enter into the program she was well connected to the group by the midpoint and would feel confident about entering a similar type of group in the future.

Family C. appeared to benefit from both the group and family interventions of this program. Parent L., in particular, responded to the support, information and sense of hope that she was given by the group. This parent had strong survival skills prior to the group and her support system contained a number of positive resources. During the course of group and family therapy L. was able to understand how the death of her husband had affected the family system as a whole and specifically the degree to which family roles had been altered. Parent L. with the support of new partner, B., moved to realign the power dynamics within the family structure to ensure that the adults were back into managing the system. Child R., had been most affected by the loss of the father and was given more power in the system than she was able to manage. Shifting the power back to the parents was initially very difficult for R. However, following termination of the program, parents reported significant improvements in her functioning. This family made use of all the resources offered and sustained a commitment to the program in spite of busy schedules and multiple commitments.

Family D. entered the program appearing very strong as a system and well resourced in the community. As reflected in post-test results, this family's functioning appeared to deteriorate during treatment. A key component to this system was timing. The couple subsystem had unresolved issues prior to the crisis of the loss they encountered. During the crisis, the issues were set aside to meet the immediate needs of the two children who were absorbed into the system of four children. This family system of two young parents and six children was attempting to stabilize at the time of entry into this program. A series of additional stressors was placed on the system during the course of treatment including a major move, court involvement, diagnosis of two children in the system as neurologically impaired, additional employment responsibilities on K. and homemaker responsibilities on R., and an emergent adolescent. Supports provided to the family were also found to be stressful. The parents in this system were highly intelligent, resourceful people and they engaged well in the treatment offered. They responded very positively to the information and support offered in the group program and were a strong source of support and hope to other members. The couple issues surfaced in the family therapy portion of the program and were addressed in subsequent couple sessions to the degree that the system could tolerate. The couple was referred to other therapy resources following the termination of this program. The program appears to have benefited the children in the family system, although child S. continued to struggle with attachment issues.

In this therapist's opinion the group therapy intervention was helpful in addressing the psychoeducational needs of the participant family systems related to the issues of grief and loss. The group modality gave families permission to talk about the deaths and provided parents with support related to family grief. The group also provided a less intrusive entry into a formal helping process and offered an opportunity for families to begin to build a trusting relationship with this therapist.

The family therapy intervention was a helpful modality for families to explore the impact of their loss on a deeper level. It was an emotionally charged experience for the families as they considered the more vulnerable aspects of their relationships with one another. The complicated issues of the two participant families required a longer term intervention than initially proposed. The issues in the couple relationship of family D. superceded all other issues in the family system. The families determined their direction in therapy and the emotional intensity that they were able to tolerate during this process.

The transition from group to family therapy was an interesting and helpful practice for this therapist. The engagement process established in the group therapy program allowed the family therapy process to move to deeper emotional issues very quickly. This is a process that this therapist would repeat in the future. In considering changes for future practice, this therapist would continue the parent group beyond the eight week sessions described in this practicum. The parents in this program would have appreciated more time together.

SUMMARY

This practicum was a very challenging and rewarding experience. It provided opportunity to research issues of grief and loss for children and adults. It was also an opportunity to reflect on personal losses in my life and re-examine my spiritual beliefs in this area. It offered an opportunity to provide a family focused, multi modal treatment approach. It enhanced therapeutic skills in group and family therapy and added a new dimension of treatment through family group work. Although the family group time did not meet the designated criteria for multiple family therapy group, it offered a new experience for this therapist. There are a number of specific things that I would suggest in attempting to implement a similar program in the future.

Initially, we were concerned that the groups may not be large enough to be effective. This was only an issue when the two large families experienced problems being on time. Attendance, generally, was not a problem, although the two males were not able to complete the group program due to work and family related issues. This program could incorporate more families, but this would require additional therapists in the children's group.

It was helpful to meet the participant families in their home settings prior to group. This enhanced the ability of the therapists to understand the demands on each family system and the effort required for them to participate in this program. The information gathered

during these meetings began the process of assessing family functioning and also assessing functioning prior to the death in their family.

Cohesion in the parenting group developed much more rapidly than anticipated. The group moved back and forth from the educational mode to one of psychological processing and mutual support. Initially, the only common theme that brought the families together was the loss of a family member. Several other areas of commonality surfaced to pull the members together. Families openly shared their spiritual and cultural beliefs and diversity was respected within the group setting. The importance of the beliefs was recognized.

The parent support group needed more time. The children's play group had a limited capacity for focus, and could not have extended beyond the time frame of 45 minutes. I would repeat the structure of this group program and offer additional group sessions for parents on a longer term basis. The parents appreciated the information related to their children's grieving processes and could have benefited from more attention paid to the specifics of parenting a grieving or hurt child. Some of the families' parenting skills were being strained by the demands of the children, and alternate, practical parenting techniques were found to be useful. Short term group seems to be a comfortable format to introduce participants to longer term treatment interventions.

I would definitely repeat the idea of family groups. The children required a high degree of structure during this process but they responded well to activities and the time shared with the parents.

Interactions between group members were high during the activity time and interactional dynamics moved freely from parent to child, child to child and parent to parent. The last activity in the family group, 'The Flower and the Tear', was highly emotionally charged and a very positive experience for all group members and the therapists as well.

The implementation of this program required the therapists to be very flexible and sensitive to the needs of the families. Flexibility was needed in the area of time keeping and group agendas. Both the children's play group and the parent's group required that the primary focus of the group be processing the current needs of the clients within the group. Flexibility and a wide range of treatment techniques and strategies were essential in the family therapy component of the program. A co-therapist would have been helpful during the family therapy sessions.

The sequencing of the treatment interventions for this program was very beneficial. The group program provided opportunity for me to develop a relationship with the families in a very supportive environment. There was an established element of trust prior to the family therapy. The family therapy sessions moved naturally to couple work as the issues surfaced quickly in the family setting.

As therapists, we developed a tremendous respect for the client families' abilities to cope under much adversity. In conclusion, I believe that a family focused multi modal treatment approach can be helpful to grieving families as they accommodate to their loss.

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APPENDIX A

ANNOTATED BIBLIOGRAPHY

For Young Children

Althea. (1982) When uncle Bob died.. London: Dinosaur Publications.

A story about a young boy who's uncle dies. This book examines many of the fears and feelings that children experience following the death of a loved one. It also explains many facts and rituals associated with death.

Dombrower, Jan. (1990). Getting to know your feelings. Livermore, CA.: Heartwise Press

This book teaches children to identify feelings by reading their bodies. It also suggests ways to express feelings with their bodies.

Sanford, Doris. (1986). It must hurt a lot. Portland, Oregon: Multnomah Press.

A young boy's pet dies accidentally and he feels very hurt and alone. As the boy moves through his grief he learns to understand the reactions of other people to his grief. Remembering his own sadness, he is eventually able to help a friend who experiences a death.

Viorst, Judith. (1971). The tenth good thing about Barney. New York: Aladdin Books, Macmillan Publishing Co.

A young boy's cat, Barney, dies. The boy's mother tries to help him through his grief by asking him to remember ten good things about Barney. As the young boy struggles with the tenth good thing, he recognizes a greater purpose for his pet. The book also includes a

discussion between children about heaven .

Wilhelm, Hans. (1985). I'll always love you. New York: Crown Publishers.

This story describes a young boy's sadness when his pet dog dies of old age. The boy is comforted by his memories of love for his dog and that each night he had said to the dog, "I'll always love you."

For School-Age Children

Aliki. (1979). The two of them. New York: Mulberry Books.

This is a story of a special love between a grandfather and his granddaughter. When the grandfather becomes ill, the granddaughter cares for him. As she mourns the death of her grandfather, the young girl finds ways to continue in her love for her grandfather by continuing the activities they shared together.

Amos, Janine. (1991). Hurt. Austin Tx.: Stech-Vaughn Company.

This book describes real life experiences that result in hurt feelings for children. The book encourages participation between the child and the reader as the stories are told.

Carrick, Carol. (1976). The accident. New York: Clarion Books, Ticknor and Fields: A Houghton Muffin Co.

Christopher's dog, Badger, is accidentally killed. This story describes Christopher's intense feelings of grief following the death of his pet. This book also shows the importance of commemorative rituals for children.

Holden, Dwight. (1989). Gran-gran's best trick. New York:

Magination Press.

This story describes many of the thoughts and feelings that children experience as they watch someone whom they love die. This story emphasizes the growth and learning that takes place as children cope with death.

Kubler-Ross, Elisabeth. (1982). Remember the secret. Berkeley, California: Celestial Arts,

Suzy and Peter share a secret spiritual world with their older friends, Theresa and Willy. This book gives a child's account of heaven. As the children are faced with death, they are comforted by their sense of heaven.

Mellonie, Bryan. (1983). Lifetimes. New York: Bantam Books.

This book describes and illustrates the cycles of life including birth, death, and the in between time that we call living.

de Paola, Tomie. (1980). Now one foot, now the other. New York: G.P. Putnam's Sons,

Grandfather Bob was little Bobby's best friend. When grandfather suffers a stroke Bobby helps him to recover through the use of memories.

Simon, Norma. (1989). I am not a crybaby. New York: Puffin Books, The Penguin Group.

This book relates a series of situations where children or adults feel sad and cry. The book gives a strong message that it helps to cry when you feel hurt or sad.

Varley, Susan. (1984). Badger's parting gift. London: Picture Lions,

Harper Collins Publishing.

Badger is old and preparing to die. This book describes Badger's feelings about death and the feelings of his friends following his death. His friends remember all the wonderful things that Badger had given them, and they are comforted in knowing that they will never lose the gifts that Badger taught to each of them.

Wells, Rosemary. (1985). Hazel's amazing mother. New York: Dial Books for Young Readers.

The power of a mother's love rescues Hazel from a very frightening situation. This book can be a good catalyst for discussing the power of parents and the limits of that power.

Resources for Parents and Counsellors

Byng-Hall, John. (1995). Rewriting family scripts. improvisation and systems change. New York: The Guilford Press.

Grieving 'scripts' are discussed in Chapter Thirteen of this book. Many families operate with generational patterns of unresolved mourning. This book offers suggestions to assist in the change of family patterns.

Chazan, Saralea, E. (1995). The simultaneous treatment of parent and child. New York: Basic Books, A Division of Harper Collins Publisher.

Unresolved relationship issues, particularly related to separation and loss, are significant areas to assess in parent-child difficulties. Chapter Three of this book begins the process of assessment, followed by suggestions for simultaneously treating parent and child to improve the

affective qualities of the relationship.

Fitzgerald, Helen. (1992). The grieving child: A parent's guide. New York: Simon & Schuster.

Helen Fitzgerald wrote this book following her own experience in assisting her children to cope with the death of their father. This book offers practical suggestions for parents as they help their child to cope with their feelings and adapt to the loss of a loved one.

Furman, Erma. (1974). A child's parent dies. New Haven and London: Yale University Press.

This book provides a detailed account of the impact of a parent's death on a child. Using developmental levels, and the emotional and cognitive experiences of a group of twenty-three children studied, understanding is enhanced and practical treatment suggestions are given.

Goldman, Linda. (1994). Life and loss: A guide to help grieving children. Bristol, PA.: Taylor & Francis Group.

Goldman has developed a manual that provides practical resource information and material for clinicians working with bereaved children and parents.

James, Beverly. (1989). Treating traumatized children: New insights and creative interventions. New York: Lexington Books, A Division of Simon & Schuster.

In Chapter 12 of this book, James deals specifically with attachment disturbances resulting from unresolved loss due to separation or death of a parent. Descriptions of presenting behaviours and specific

interventions provide clinicians with resources for treatment of these children.

James, Beverly. (1994). Handbook for treatment of attachment-trauma problems in children. New York: Lexington Books, A Division of Simon & Schuster.

Chapters 11 and 12 of this book dealing with assisting children to say good-bye in relationships and reinvest in new attachments. James offers both assessment and practical treatment suggestions for clinicians.

Klass, D., Silverman, P.R., & Nickman, S.L. (1996). Continuing bonds: new understandings of grief. Bristol, PA.: Taylor & Francis.

Continuing Bonds provides an in depth look at the evolution of grief work theories and models through the ages to current times. It offers the reader an understanding of current theories that support the establishment of a new relationship with the deceased rather than an abrupt severance to that relationship. This book examines a complete range of losses through death and adoption. It considers developmental levels, cultural differences, gender factors and relationship issues for the bereaved.

Piper, W.E., McCallum, M., & Azim, H.F.A. (1992). Adaptation to loss through short-term group psychotherapy. New York: The Guilford Press.

A psychoanalytic approach to losses suffered in childhood is outlined in Chapter Two of this book. The writers address the differences between traumatic losses and tragic losses and the ensuing implications for

children. The treatment focus offered is short term group therapy.

Shapiro, Ester R. (1994). Grief as a family process: A developmental approach to clinical practice. New York: The Guilford Press.

Shapiro's book is based on a systemic developmental framework for working with bereaved families. Bereavement in childhood (Chpts. 5-6) and the impact of the death of a child (Chpt. 10) are fully examined within the context of the family and the sociocultural environment. Current theories are supported by case studies and offer direction for treatment.

APPENDIX B

MEMORANDUM

Masters of Social Work Practicum
University of Manitoba

"Helping Children Cope With Grief and Loss"
Ms. Judy Tozeland, Social Worker, Child Guidance Clinic of Winnipeg
"A Family Focused Approach For Supporting The Treatment of Children Dealing With Grief and Loss"
Ms. Linda Croll, Mental Health Clinician,Community Service Program, Manitoba Adolescent Treatment Centre

Ms. Tozeland and Ms. Croll are seeking referrals for overlapping practicums to provide treatment services to children aged 8 - 10 years of age who have experienced a significant loss through death of a parent, grandparent, sibling or someone whom they have shared a close attachment.

Services offered will include:

a. **Childrens' Grief and Loss Group:** 8 weekly sessions
Therapist: Ms. Judy Tozeland
This group will consist of approx. 6-8 participants, 8-10 years of age who have incurred a significant loss in the past 6 months. The group will provide opportunities for the children to work towards resolution of the death through play.

b. **Parent Group:** 8 weekly sessions
Therapist: Ms. Linda Croll
Parents or caregivers of members of the Childrens' Group will meet simultaneously to address issues related to the grieving needs of parents and children.
Parents will also be given opportunity to support their children's treatment through active participation in the childrens' group at the beginning and end of each session.

c. **Family Therapy Follow-up:** 4-6 sessions
Therapist: Ms. Linda Croll
Family therapy will include all family members in the treatment process, paying specific attention to needs of siblings or other members not involved previously. Therapy will focus on supporting and enhancing the group treatment process through improved communication skills, role clarity, problem-solving skills, and appropriate affective expression and response.

Treatment services will be delivered through the Community Services Program of The Manitoba Adolescent Treatment Centre at 228 Maryland Street. Sessions will be held on Tuesdays beginning February 4, 1997 6:30 - 8:00 P.M. Group sessions will continue to March 25, 1997 with Family Therapy Follow-up sessions to be arranged with families on an individual basis.

Referrals can be directed to Ms. Tozeland or Ms. Croll at 958-9634.

APPENDIX C

Practicum Consent Form

I understand:

That the services being offered are part of a Master's of Social Work practicum at the University of Manitoba. The services will be provided by a graduate student working under supervision.

That the intervention could bring to awareness other issues as a result of the process.

That any information obtained during interviews, group sessions and/or questionnaires may be used as part of a written report of this practicum.

That the information gathered, as part of this practicum, can only be reported in a manner which does not reveal my identity or that of any one in my care.

That treatment will be video-taped and/or audio-taped for the purposes of supervision and that they may be reviewed by the supervisor and the therapist. I am aware that these tapes will be erased after the practicum is complete.

That all information reported will stored be in a locked cabinet, with access only by the therapist and supervisor.

That I do not have to answer any questions I do not wish to, and that I can withdraw at any time from this project. Withdrawal will not affect my eligibility for receiving service from this agency.

Signature of client(s) or parent/guardian

Date:

Signature of clinician or other witness

Date:

APPENDIX D

ADMINISTRATIVE OFFICES

☐ 120 Tecumseh Street
Winnipeg, Manitoba
R3E 2A9
Phone: 477-6391 Fax: 783-6948

☐ 228 Maryland Street
Winnipeg, Manitoba
R3G 1L6
Phone: 958-9600 Fax: 958-9618

PROGRAMS

☐ Intensive Long Term Treatment Program
120 Tecumseh Street
Winnipeg, Manitoba
R3E 2A9
Phone: 477-6391 Fax: 783-6948

☐ Assessment/Outpatient Services Program
120 Tecumseh Street
Winnipeg, Manitoba
R3E 2A9
Phone: 477-6391 Fax: 783-6948

☐ Community Services Program

☐Acute Treatment & Consultation Team
228 Maryland Street
Winnipeg, Manitoba
R3G 1L6
Phone: 958-9624 Fax: 958-9618

☐Community Child & Adolescent
Treatment Services
228 Maryland Street
Winnipeg, Manitoba
R3G 1L6
Phone: 958-9624 Fax: 958-9618

☐Educational Psychiatric Services
700 Elgin Avenue
Winnipeg, Manitoba
R3E 1B2
Phone: 786-7841 Fax: 783-6063

☐Children's Forensic Services
[illegible] Sherbrook Street
Winnipeg, Manitoba
R3N 1X9
Phones: 945-8160 Fax: 945-2112

COMMUNITY SERVICES PROGRAM

CONSENT FOR ASSESSMENT/TREATMENT

RE: NAME: _____ D.O.B.: _____

ADDRESS: _____

MHSC #: 6 Digit _____ 9 Digit _____

As the legal guardian of _____ I hereby give my permission for the Community Services Program to effect therapeutic assessments, treatments or interventions according to commonly accepted professional standards, deemed to assist in the health care of the above named.

This may include:

ASSESSMENTS		TREATMENT
- Community Assessments		- individual
- individual	- pharmacological	- family
- couple	- psychological	- group
- family	- social	- medical & psychiatric
- group	- occupational therapy	- medical
- educational	- social	- psychological
		- emergency interventions

SUPERVISION & STAFF EDUCATION
- audio taping
- video taping
- direct observation
- I agree for this to be used for professional education purposes only

Signed: Name: _____

Address: _____

Date: _____ Signature: _____

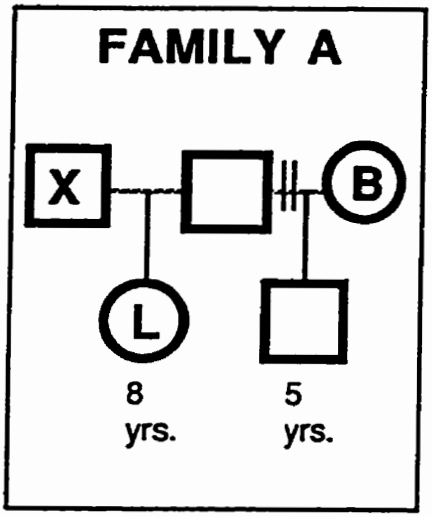
Witness: Name: _____

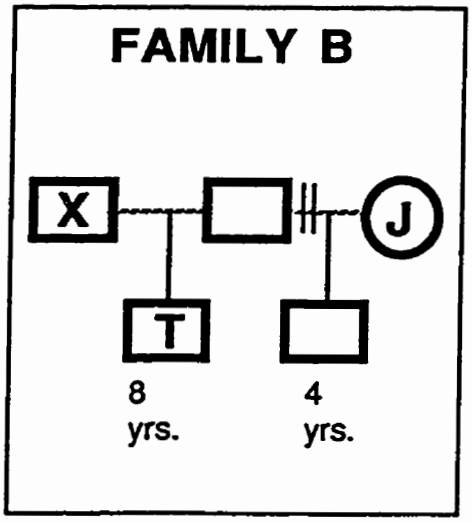
Address: _____

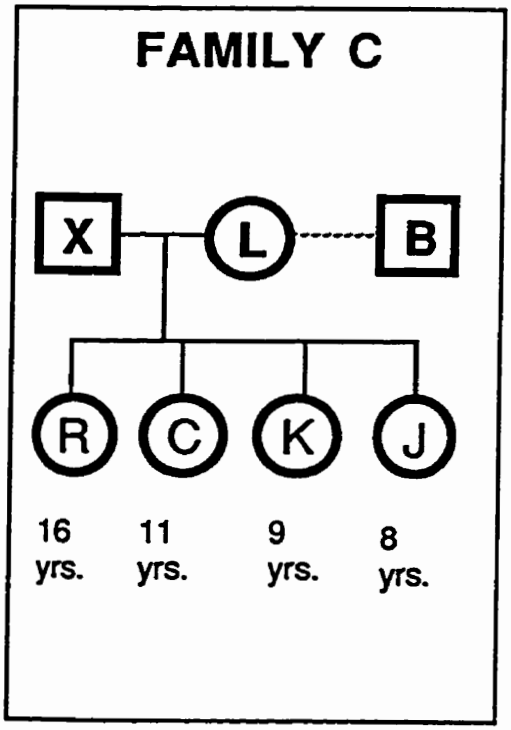
Date: _____ Signature: _____

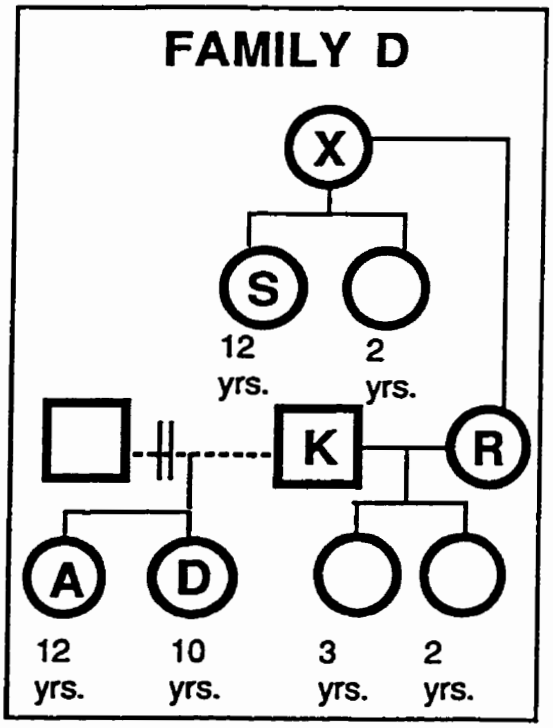
APPENDIX E

GENOGRAMS









APPENDIX F

SESSION AGENDAS

Session One

Objective: to begin the engagement process for the group

Multiple Family Group Time

I. Welcome and Introductions
   a. Welcome participants to the group
   b. Re-state the purpose of the this group
   c. Parents/caregivers introduce themselves (first names) and also introduce their children (first names)

   Parents invited to indicate who died and how the deceased was connected to them and the child they are accompanying. Concept of 'the talking stone' may be used during introductions.

II. Housekeeping
   a. Times, dates, location information
   b. Absence can be indicated prior to 4:30 p.m. to therapists
   c. Review of weekly group format

III. Group Rules
   a. Confidentiality
   b. Voluntary participation
   c. Respectful participation

Children's Play Group Time (refer to Ms. Judy Tozeland's report)

Parents' Psychoeducational Support Group Time

IV. Needs Assessment
   a. What do you need to help your child cope with their loss? (List on flipchart)
   b. Develop a weekly focus from the assessment

Coffee break

Multiple Family Group Time

V. Debrief small group work
   a. Discussion

b. Story time: I Wish I Could Hold Your Hand

VI. Wind-up

Session Two

Objective: develop group cohesion

Multiple Family Group Time

I. Welcome Back
   a. Comments or questions from last session
   b. Brief overview of this session

II. Group Activity
   a. "Question Bag"
   Introduce this activity as a 'ritual' for beginning each group session that will provide children with opportunities to anonymously share their questions about death, and give parents opportunities to respond.
   b. Therapists will assist with this activity and discussion

Children's Play Group Time

Parent Psychoeducational Support Group Time

III. Session Focus
   a. Children's Grieving Processes
   b. Discussion

Coffee Break

Multiple Family Group Time

IV. Coming Together
   a. Debrief small group work
   b. Story time: When Uncle Bob Died
   c. Discussion

V. Wind-up

Session Three

Objective: increase understanding of children's needs related to loss

Multiple Family Group Time

I. Welcome Back
   a. Comments or questions from last session
   b. Brief overview of this session

II. Group Activity
   a. "Question Bag"
   b. Discussion

Children's Play Group Time

Parent Psychoeducational Support Group Time

III. Session Focus
   a. Assisting children in the grieving process
   b. Discussion

Coffee Break

Multiple Family Group Time

IV. Coming Together
   a. Debrief small group work
   b. Story time: Sunflower Mountain
   c. Discussion

V. Wind-up

Session Four

Objective: increasing understanding of parents needs in familial loss

Multiple Family Group Time

I. Welcome Back
   a. Comments or questions from last session
   b. Brief overview of this session

II. Group Activity
   a. "Question Bag"
   b. Discussion

Children's Play Group Time

Parent Psychoeducational Support Group Time
III. Session Focus
   a. Review common myths related to grief and loss
   b. Consider needs of parents in supporting their own grief issues
   c. Discussion

Coffee Break

Multiple Family Group Time
IV. Coming Together
   a. Debrief small group work
   b. Story time: Badgers Parting Gift
   c. Discussion

V. Wind-up

Session Five

Objective: increase awareness and understanding of grieving tasks

Multiple Family Group Time

I. Welcome Back
   a. Comments or questions from last session
   b. Brief overview of this session

II. Group Activity
   a. "Question Bag"
   b. Discussion

Children's Play Group Time

Parent Psychoeducational Support Group Time
III. Session Focus

a. Review tasks of grieving for children, couples and families
b. Consider commemoration rituals to assist grieving
c. Discussion

Coffee Break

Multiple Family Group Time

IV. Coming Together
a. Debrief small group work
b. Story time: Hurt - Annie's Story
c. Discussion

V. Wind-up

Session Six

Objective: increase awareness and understanding developmental influences in grieving processes

Multiple Family Group Time

I. Welcome Back
a. Comments or questions from last session
b. Brief overview of this session

II. Group Activity
a. "Question Bag"
b. Discussion

Children's Play Group Time

Parent Psychoeducational Support Group Time

III. Session Focus
a. Review normal tasks of developmental stages for children and families
b. Discussion

Coffee Break

Multiple Family Group Time

IV. Coming Together
   a. Debrief small group work
   b. Story time: Hurt - Billy's Story
   c. Discussion

V. Wind-up

Session Seven

Objective: increase awareness of symptomatology related to grieving and formally begin process of termination

Multiple Family Group Time

I. Welcome Back
   a. Comments or questions from last session
   b. Brief overview of this session

II. Group Activity
   a. "Question Bag"
   b. Discussion

Children's Play Group Time

Parent Psychoeducational Support Group Time

III. Session Focus
   a. Review physiological and emotional symptoms of grieving
   b. Discussion

Coffee Break

Multiple Family Group Time

IV. Coming Together
   a. Debrief small group work
   b. Discussion and planning for termination
   c. Group Activity: begin 'the flower and the tear'
   d. Story time: Hug Me

V. Wind-up

Session Eight

Objective: termination process
Multiple Family Group Time

I. Welcome Back
   a. Comments or questions from last session
   b. Brief overview of this session

II. Group Activity
   a. Complete 'the flower and the tear'
      each participant used coloured paper, scissors and markers to design their own collage of a flower and a tear.
   b. Debrief the activity in the large family group with each member sharing their feelings related to their loss (the tear) and the ending of the group. Each member then shared their feelings and thoughts related to the positive memories of their loved one that had died, and their positive feelings and memories of the group (the flower).
   c. Celebration time with cake and refreshments

III. Wind-up
   a. Saying goodbye
   b. Reminder of family follow-up sessions

APPENDIX G

GROUP CLIENT SATISFACTION SURVEY

Parent's Grief and Loss Group Date:

Please circle your answer:

1. How would you rate the quality of service that you received?

4	3	2	1
excellent	good	fair	poor

2. Did you receive the kind of service that you wanted?

1	2	3	4
No definitely not	Not really	Yes generally	Yes definitely

3. If a friend were in similar need, would you recommend this service?

4	3	2	1
Yes definitely	Yes probably	Not really	No definitely not

4. Has this service helped you in understanding your child?

4	3	2	1
Yes,a great deal	Somewhat	Not really	Made things worse

5. Was the setting appropriate for this service?

1	2	3	4
No definitely not	Not really	Yes generally	Yes definitely

6. The most helpful part of this service was .....

   The least helpful part of this service was .....

   I would suggest changing .....

   Additional comments:

APPENDIX H

THANK YOU LETTER

Dear

Ms. Judy Tozeland and myself would like to thank you for your participation in our practicum program. We appreciated the opportunity to get to know you and to share in the process of healing from your loss. We wish you all the best in your future together. Please find enclosed certificates of appreciation for your participation.

I will be contacting you within the next few days to arrange follow-up visits and discuss the family therapy component of this program. I will also pick up the completed post-test measures at this time.

I look forward to seeing you again soon.

Yours truly,

Linda Croll,
B.S.W., R.S.W.

Judy Tozeland,
B.S.W., R.S.W.

APPENDIX I

We hereby recognize that

NAME

has successfully completed the
Parents's Group for Grief & Loss
and has demonstrated a high level of commitment to their personal growth.
Judy Tozeland and Linda Croll, hereby present this

Certificate of Completion

with all the rights and privileges ensuing therefrom.
In witness thereof, the following have affixed their signatures, March 25, 1997.

Judy Tozeland PWC
Person Who Counts

Linda Croll PWC
Person Who Counts

APPENDIX J

FAMILY THERAPY CLIENT SATISFACTION SURVEY

Family Therapy Follow-Up Date:

Please circle your answer:

1. How would you rate the quality of service that you received?

4	3	2	1
excellent	good	fair	poor

2. Did you receive the kind of service that you wanted?

1	2	3	4
No definitely not	Not really	Yes generally	Yes definitely

3. If a friend were in similar need, would you recommend this service?

4	3	2	1
Yes definitely	Yes probably	Not really	No definitely not

4. Has this service helped you in understanding your child?

4	3	2	1
Yes,a great deal	Somewhat	Not really	Made things worse

5. Was the setting appropriate for this service?

1	2	3	4
No definitely not	Not really	Yes generally	Yes definitely

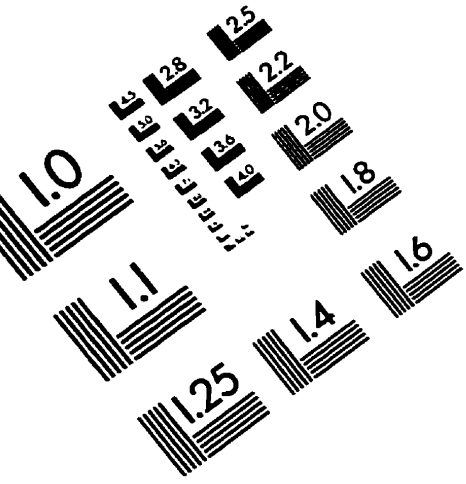
6. The most helpful part of this service was .....

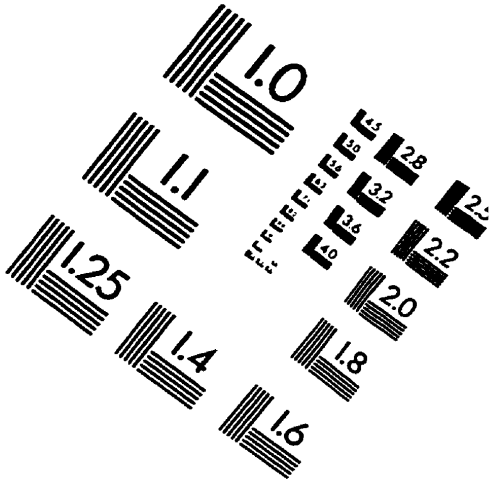
   The least helpful part of this service was .....

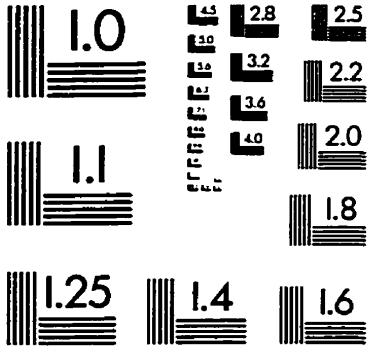
   I would suggest changing .....

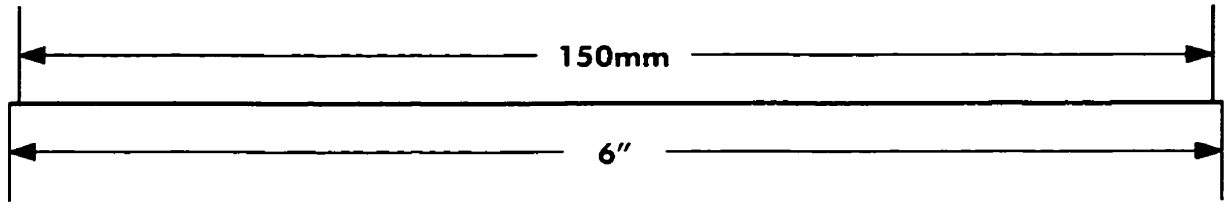
   Additional comments:

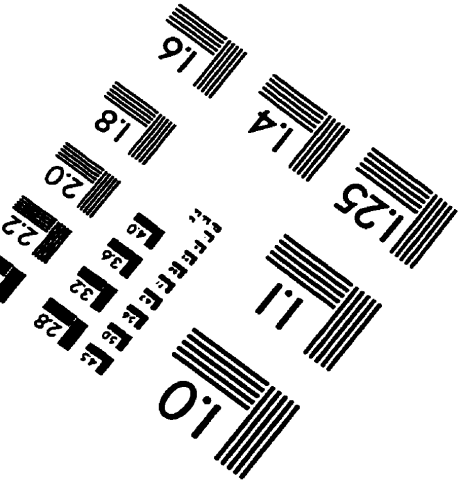
IMAGE EVALUATION
TEST TARGET (QA-3)

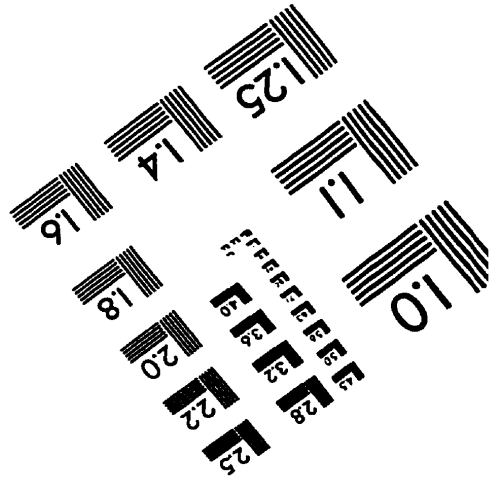












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