SYSTEMS-ORIENTED INTERVENTION IN GRIEF AND MOURNING: A SOCIAL WORK PRACTICUM WITH BEREAVED FAMILIES

BY

MAUREEN KITCHUR HARRISON

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

Winnipeg, Manitoba

August, 1984

SYSTEMS-ORIENTED INTERVENTION IN GRIEF AND MOURNING: A SOCIAL WORK PRACTICUM WITH BEREAVED FAMILIES

BY

MAUREEN KITCHUR HARRISON

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

TABLE OF CONTENTS

Abstract

Current literature reflects an increasing emphasis on the need to focus on the family system when intervening therapeutically in bereavement. This practicum entailed the provision of short-term systems-oriented therapy to high-risk survivors of loss. It also provided an opportunity to investigate the role of social work in bereavement and to develop further skills in social work and family intervention. Seven families with widely varying demographic characteristics received in-person counseling, and a caseload of approximately thirty additional families received bereavement follow-up by telephone. Intervention was based on grief theory, and incorporated communication, structural, problem-solving and network approaches. Results of a Family Concern Form administered pre- and post-intervention, and of an evaluation questionnaire, indicate increased satisfaction with family functioning following the in-person intervention. The systems approach to grief and mourning was found to facilitate assessment and intervention, and the widely varying characteristics and situations of clients provided excellent opportunity for skill development.

Acknowledgements

The learning opportunities in this practicum were realized in large part because of the support, interest, encouragement and very practical assistance of my committee. My advisor, Dr. Kathryn Saulnier, was an invaluable resource throughout every stage of the practicum. Her wealth of practical ideas, the generosity with which she offered her time and attention, and her very supportive style of supervision created an ideal climate for learning. In addition, her own energy and enthusiasm set an example which encouraged me to make the most of opportunities. I am very grateful to her.

I was also very fortunate to have the continuing support and assistance of Mr. Fred Nelson of the Palliative Care ward at the St. Boniface Hospital throughout the planning and implementation of the practicum. Fred acted as my advocate and liason within the Hospital, he served as a resource throughout the practicum, and he kindly devoted many hours to reading and criticizing the draft of this report. His efforts and interest have truly been appreciated.

Professor Ranjan Roy provided very valuable feedback on my written work at every stage of the practicum. His critical eye was responsible for improving the quality of my scholarship at many points, and this rare gift has been much appreciated.

A special word of thanks is due to the St. Boniface Hospital Department of Social Work for allowing me to complete my practicum at the Hospital, and for allowing me such freedom to make use of hospital resources.

Finally, I want to acknowledge the very special support and encouragement provided by my husband Patrick, in whose footsteps I have followed

by completing my M.S.W.

Maureen Kitchur Harrison

August 1984

PREFACE

This practicum came about as a follow-up to a very valuable learning experience I was priveleged to have in my undergraduate social work studies. The opportunity to work briefly with the families of terminally ill patients at the Princess Elizabeth Hospital in Winnipeg led me to feel concern about how families cope after the death of a loved one, when their contact with pastoral and social work supports is usually reduced.

I knew that because bereavement follow-up was not (and still is not) a very well-developed component in the Canadian health care delivery system, families would often be largely dependent upon their own resources after the loss of one of their members.

My concern about bereaved families, and my desire to learn more about the role of social work in bereavement follow-up led me to explore the possibility of an M.S.W. practicum on bereavement at the St. Boniface Hospital. A warm and interested response from the Department of Social Work, especially from Fred Nelson of the Palliative Care ward, gave me the opportunity and support I needed to develop my ideas into the practicum which is reported in the following pages.

INTRODUCTION

A family is more than the sum of its individual members, and a bereaved family is naturally more than a collection of individuals who have sustained loss at a variety of psychosocial stages.

Increasingly, in the literature of a great many disciplines, the family has come to be understood as a system, as "an interactional unit in which all members influence each other" (Worden 1982), and wherein "the successful achievement of one person's task is dependent on and contributory to the successful achievement by others in the family of their appropriate tasks." (Rhodes 1977).

As a human system, the family is seen to possess a set of systemic properties - structure, boundaries, communication patterns, roles, tasks and functions - by which it seeks to maintain equilibrium and engage to some degree in goal-directed activity. In addition, the family system is often described in terms of its rules and values, and in terms of the temporal context in which it exists. (Anderson and Carter 1978).

The development of a systemic view of the family has had great implications for the helping professions - increasingly, the family unit is seen as the most appropriate focus of problem assessment and problem-solving activities. The family therapy movement and the development of ecological theory have helped shift attention from the individual alone to the wider familial and social context of which s/he is a part.

Yet while this shift in perspective has occurred, and while helping interventions have become increasingly systems-focused, loss, grief and mourning have largely continued to be seen as individual phenomena. Caroff and Dobrof noted in 1975 that "we have only begun to understand

that the family as a system - with its complex intrafamilial transactions and its transactions with other systems - can affect the bereavement process."

Indeed, as Dennis Reilly noted in 1978, "it is the rare thanatological work which views death and the family in anything approaching a systems or ecological perspective - that focuses upon the reciprocal interaction between the terminal event and the family as a system in homeostatic balance." Reilly has emphasized the need to focus "upon what is going on between-and-among the family members, and between them and their social networks," and laments that "family therapy, which has so much to offer in this respect, has largely avoided...(the) issue." (Reilly 1978).

Reilly's message has not gone unheeded, and recent research and clinical practice have focused on the wider familial and social context in which individual grief and mourning occur. At Harvard Medical School, for example, William Worden has demonstrated that effective intervention with individual mourners often depends upon an ability to understand how a loss has affected the larger family system. (Worden 1982). Conversely, he has pointed out that effective intervention with a bereaved family often depends upon facilitating the mourning work of just one member.

As systems thinking continues to influence bereavement research, the focus of assessment and intervention activities is being re-defined. Specifically, effective bereavement intervention is increasingly seen to depend upon an understanding of the interdependent nature of individual and family mourning, and upon an ability to assess the impact of a loss in its individual, familial and social contexts.

This systems perspective, though relatively new in thanatological

research, has long been central to social work practice. The increasing emphasis on assessing and facilitating mourning in the broadest possible context is consistent with the long-espoused social work dictum that assessment and change strategies must be focused on the person, and on the environment, and on the interaction between them. (Compton and Galaway, 1975).

The practicum reported in the following pages has been guided by this systems outlook which is so central to social work practice and which is increasingly evident in bereavement research. The literature review with which the report begins focuses first on individual grief and mourning processes, and then examines them in their wider family and social contexts. The practicum itself, a social work intervention with bereaved families, likewise focuses on the-individual-within-the-family-within-the-community, the human 'system' with which social work has traditionally been concerned.

SECTION ONE

THE LITERATURE REVIEW

CHAPTER ONE

GRIEF AND MOURNING IN THE INDIVIDUAL LIFE CYCLE

I Brief Overview of Grief and Mourning Theory

The literature on grief and mourning processes throughout the individual life cycle does not, as one might expect, begin with a consideration of loss and grief in infancy and childhood. The first research on grief and mourning, like research on many other kinds of human behavior, was sparked by observations of adult behavior, and early clinical studies throughout the first half of this century concentrated on attempting to elucidate the processes or 'mechanics' of that adult loss behavior. Attempts were made to find linkages between adult grief and other phenomena such as 'melancholia' or depression.

It is only in the last three or four decades that researchers have turned their attention to loss behavior in infants and children, and as they have done so, the psychological processes and behavioral manifestations of adult grief have come to be more fully understood. Indeed, research on childhood and infant loss behavior has suggested that grief reactions throughout the entire life cycle have as their antecedent the 'separation anxiety' experienced by the infant.

Notwithstanding the importance of this later research, however, a review of the literature on grief and mourning in the individual life cycle may best begin with an examination of the early clinical observations and studies which formed a knowledge base on which later research would rest.

Among the earliest research into individual adult grief was that conducted by Freud, who delineated an intrapsychic mourning process common to many of the patients he saw in private practice. His description of that process, though phrased in psychoanalytic language and using theoretical constructs such as the libido, nevertheless bears repetition today because it evokes such a clear image of the psychological pain and struggle involved in mourning:

> Now in what consists the work which mourning performs?... The testing of reality, having shown that the loved object no longer exists, requires forthwith that all the libido shall be withdrawn from its attachments to this object. Against this demand a struggle of course arises - it may be universally observed that man never willingly abandons a libido-position, not even when a substitute is already beckoning to him. This struggle can be so intense that a turning away from reality ensues... The normal outcome is that deference for reality gains the day. Nevertheless, its behest can not be at once obeyed. The task is now carried through bit by bit, under great expense of time and cathectic energy, while all the time the existence of the lost object is continued in the mind. Each single one of the memories and hopes that bound the libido to the object is brought up and hyper-cathected, and the detachment of the libido from it accomplished...When the work of mourning is completed the ego becomes free and uninhibited again.
>
> Sigmund Freud, "Mourning and Melancholia" (1917)

In later research by Erich Lindemann (1944), the intrapsychic mourning process described by Freud was found to have a clearly observable physical and affective counterpart. Lindemann, who was Chief of Psychiatry at the Massachusetts General Hospital in the 1940's, undertook a study of 101 surviving family members of the victims of the famous Coconut Grove nightclub fire in Boston. His description of the major elements common to their grief responses is now classic. He observed the following:

1) somatic distress, including sighing and shortness of breath, lack of strength and energy, and weeping;
2) preoccupation with the image of the deceased, including hallucinations in which the deceased is present;

3) guilt feelings, coupled with a need to review the circumstances of the death;

4) hostile reactions, frequently directed at friends and relatives; and

5) disturbance of normal behavior patterns and inability to initiate or maintain organized activity.

Lindemann reports that these affective and behavioral symptoms persisted, in varying degrees, until the mourner completed his or her grief work - namely, emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships.

In some of the mourners studied by Lindemann, 'morbid' or pathological grief reactions were evident. The most frequent type of morbid reaction was a delay or postponement of mourning, wherein a shock or denial response allowed the survivor to protect him or herself from the pain of confronting the reality of the loss. Lindemann discovered that such reactions can last many years, as evidenced by those survivors who, at the time of the study, began to mourn for the first time a loss experienced many years earlier.

A number of distorted grief reactions were observed, including overactivity patterned on the activities formerly carried out by the deceased; the acquisition of symptoms belonging to the last illness of the deceased; grief- and stress-related diseases such as ulcerative colitis, rheumatoid arthritis and asthma; progressive social isolation; furious hostility directed at a specific person deemed "responsible" for the death; mild schizophrenia; prolonged insomnia and hopelessness; self-punitive behavior including giving away all one's money and possessions; and finally, agitated depression, in which feelings of worthlessness and guilt led to suicidal behavior.

Although Lindemann's observations tended to be stated in terms of the individual, he did suggest at one point that bereavement could be as devastating for the family system as for the individual survivor. "Not infrequently," he noted, "the person who passed away represented a key person in a social system, his death being followed by disintegration of this social system and by a profound alteration of the living and social conditions for the bereaved. In such cases readjustment presents a severe task quite apart from the reaction to the loss incurred." (Lindemann 1944).

Lindemann's work has become the starting-point or clinical foundation for most of the studies of grief and mourning conducted in the last forty years. His observations and conclusions have been confirmed repeatedly in such large-scale research projects as Peter Marris' London Widows Study (Marris 1958), the London Widows Study conducted by Colin Parkes (Parkes 1970), Paula Clayton's Bereavement Study in St. Louis (Clayton 1973), the Harvard Bereavement Study of Young Boston Widows and Widowers (Glick, Weiss and Parkes 1974), and Alfred Wiener's study of the aged bereaved at New York's Montefiore Hospital (Wiener, Gerber, Battin and Arkin 1975).

Alongside a growing body of clinical data on the physical and psychological effects of bereavement on adults, some important attempts have been made to 'update' Freud's theoretical explanation of grief and mourning and to consider adult mourning in relation to childhood loss behavior. John Bowlby, the British psychiatrist, has been the chief contributor to a unified theory of attachment, loss, separation and grief behavior, a theory which has application at all stages of the life cycle.

Bowlby's schema of individual separation and mourning behavior is based upon the clinical work of Lindemann and Marris, and upon clinical

studies of infant separation behavior such as those undertaken by Robertson (Robertson 1953, 1958). Bowlby's explanation of childhood loss behavior begins with the premise that the infant has a number of instinctual response systems which are a part of the inherited behavior repertoire of humans; when those responses are activated and the mother figure (or what we would now call the care-giver or parent figure) is available, attachment behavior results. From the age of about six months on, when the responses mediating attachment behavior are activated and the parent figure is temporarily unavailable, separation anxiety and protest behavior such as crying and restlessness can be seen to follow. Bowlby describes the infant's affective behavior as being geared towards regaining the lost object, the nurturant parent figure. (Bowlby 1960).

This separation or loss behavior has three distinct phases. First, says Bowlby, after the initial protest and crying or demand for mother's return (which often lasts many days), the child generally becomes quieter. S/he is still highly oriented toward the lost love object and persistent longing may become suffused with intense generalized hostility. The targets of this hostility may be varied, or may clearly be the lost object. Offers of help and comfort are frequently rejected, or where they are accepted, they are also met with contradictory, rejecting behavior. In time, generally over several weeks, this first phase of mourning ends - the child having given vent to its feelings of frustration, anger and sadness, and having exhausted its efforts at regaining the lost parent.

A period of confusion or disorientation often follows, in which the child gradually comes to accept more attention from a substitute care-giver, while still awaiting the possible return of the lost parent (but with less expectation).

Finally, as the child's awareness grows that his/her loss is real and irrevocable, s/he gradually enters a third phase in which s/he begins to relate to a new primary care-giver. In psychodynamic terms, 'decathexis' has occurred, and the tasks of mourning have been completed (ie., the expressive tasks in phase one, the withdrawal tasks in phase two, and the refocusing and reinvestment tasks of phase three). Reality-testing has shown that the loved object no longer exists, and has demanded that the libido be withdrawn from its attachment to the lost object, as painful as that process must be. Withdrawal of the libido has been followed by displacement onto a new object.

Bowlby has argued that the mourning process which is so clearly observable in infant separation behavior is in fact the prototype for mourning reactions in later life. Though the time-frame for adult mourning is considerably longer than that observable in infant separation, Bowlby maintains that the three phases of childhood mourning, each with its particular expressive and intrapsychic tasks, are the same phases found in adult grief. Bowlby has also advanced a thesis regarding the link between childhood loss and pathological outcome in later life, arguing that where the development of a child's trust in a primary care-giver is hindered by excessive pain, delay of satisfaction or parental abandonment, the child may grow to be self-centered and prone to transient, shallow relationships (ie, decathexis may not be sufficiently accomplished and libidinal reinvestment is not possible). In later life, says Bowlby, the child who has not learned to trust may also be prone to depressive illness. (Bowlby 1960)

Bowlby's theory of mourning has had considerable impact upon the study of grief and loss. When it was first published, it was remarkable for its departures from traditional psychoanalytic theory, including Freud's sugg-

estions that ambivalence and oral symptoms such as anorexia are evidence of pathology and regression in mourning (Freud 1915, 1917), Melanie Klein's argument that anger in mourning is always related to the survivor's own death instinct (Klein 1940), and Edith Jacobson's view that aggression in mourning is pathological (Jacobson 1957).

It was departures of this type which resulted in Bowlby's theory becoming so widely valued. In particular, there are at least four major ways in which Bowlby revolutionized mourning theory. First, Bowlby integrated the clinical observations of Frued, Lindemann and Marris with the biological theory of Darwin, allowing speculation about the ways in which grief behavior is both instinctive and adaptive. Second, Bowlby suggested clear links between specific intrapsychic grief tasks and particular behavioral and affective symptoms. Third, he unified existing evidence about childhood loss behavior and adult mourning, forging a new perspective that could shed light on grief and mourning in other stages of the life cycle.

Finally, Bowlby's theory helped to normalize mourning. The publication of his thoery in 1960 and 1961, and his later discussion of pathological mourning published in 1963 helped place the anger, aggression, disorientation and physical illness attendant on mourning in a new perspective. He clarified the role such behaviors play in the restoration of healthy functioning after a loss has been incurred, and indeed, he suggested that the absence of such behaviors may be the first indication of a mourning response gone awry - a conclusion reaffirmed in later studies by Parkes (1972) and by Glick, Weiss and Parkes (1974).

II Grief and Mourning in Childhood

With some understanding of the elements and processes commonly believed to be present in grief reactions, one can begin to look more closely at their manifestation in the different stages of development in the individual life cycle. Evidence suggests that the instincts and processes of the infant separation reaction are present throughout the life cycle, but that they are mediated by the level of cognitive awareness attained at each life stage, and by the particular psychosocial tasks and processes present in each life stage. Consequently each developmental period is characterized by unique perceptions of death and unique reactions to loss.

In childhood, three specific stages have been delineated as a result of the landmark 1940's study by Hungarian psychologist Maria Nagy (Nagy 1948). Nagy conducted her study in Budapest, with 378 children from different religions, schools and social levels. The children were of different levels of intelligence, but most fell within the normal range. They were asked to write compositions and produce drawings on the subject of death, and to later discuss and interpret their work. Nagy found their views of death to correlate with their particular stage of development. Clear differences existed between the death perceptions of children under five years of age, those aged five to nine, and those nine years and older.

Nagy's study has recently been criticized by Myra Bluebond-Langner, whose own study of terminally-ill American children yielded considerably different results (Bluebond-Langner 1977). While Bluebond-Langner's research suggests that children's perceptions of death may well vary according to culture, the passage of time and the psychological state of

the child, there is some question as to how widely the results of her study may be generalized. While Bluebond-Langner's study suggests that further research is needed to determine the extent of changes in children's conceptions of death, Nagy's observations are still widely accepted as a framework for understanding the child's view of death.

The perceptions of death in each of Nagy's three age groupings, when viewed in relation to the developmental needs of children in those age groups, help to explain some of the very specific types of response to loss found at different stages of childhood. For example, Nagy found that in children aged approximately three to five years, death is perceived as a departure, wherein the deceased is still living, but under changed circumstances. Death is thought by young children to be temporary, and is not seen as bringing about a lifeless state in the departed. In developmental terms, we know that the child aged three to five is strongly dependent on his/her parents and insistent on routine (Bloom 1980, p. 8), and that the death of a parent or sibling is significant insofar as it interrupts the security and consistency of the child's environment. Response to loss of a primary care-giving parent is thus likely to be met with confusion and hostility to substitute care-givers. On the other hand, where a more peripheral parental figure has died, the child is likely to be curious about the 'departure'. Phyllis Silverman reports the reaction of one such three year old. To the statement that Daddy was in heaven with God, this child asked "if his father would have his fun clothes on when he stayed with God." (Silverman and Englander, 1975).

The adjustment task facing the child who has lost a primary care-giving parent is to refocus on and reinvest in a new care-giver, fre-

quently the surviving parent. Where the child has sustained a previous loss in infancy, this reinvestment may be shallow and tentative - the child has learned that it can be dangerous to trust. For the child facing a first loss of a primary care figure, the transition may be somewhat easier, provided that a secure, stable environment is quickly re-established to meet the child's need for order, routine and loving care.

The surviving parent's role is crucial here. If the parent was previously peripheral to the child's daily existence, it will be harder to provide a sense of continuity. If the surviving parent is the child's major nurturing figure and is able to provide on-going care in the midst of his or her own grief, the child's transition will be more readily accomplished.

Nagy's study found that as children move into and through the ages five to nine, they perceive death as a person, an invisible 'bogey-man' one avoids. Developing awareness of the inevitability of death reflects a movement towards realism in this age group, but at the same time, their aversion to death indicates a corresponding denial. (Nagy 1948).

Developmentally, the child entering middle childhood has begun to engage in the tasks of developing initiative and a conscience (Erikson 1968). This is of particular significance where death and loss are concerned, for while the child sees death as the 'bogey-man' carrying off a loved one, he or she frequently sees the bogey-man's action as a direct response to his or her own misbehavior. A sense of responsibility and guilt for death of a sibling or parent can become operative (Nagy 1948).

Alternatively, the child may not make as firm a connection between his or her own misbehavior and the parent's death, but carries an awareness of the importance that his or her good behavior holds for the de-

ceased parent. Silverman tells of one nine year old who prays to her father every night, asking if he is proud of her behavior. (Silverman and Englander, 1975).

As well, the child frequently experiences a confusing mix of anger and sadness toward the lost loved one and generally needs "permission" to vent these feelings (Furman 1974). S/he needs reassurance that such ambivalent feelings are acceptable, and that s/he is not "bad" for feeling angry at mommy or daddy for going away.

Children in this age group may tend to integrate a parent's death into their own understanding by playing out the details of the death. Silverman reports that one six year old boy whose father was killed in an automobile crash played "crash" over and over again with his toy cars for several months (Silverman and Englander 1975). Finally, the child in this age group may experience transitory sleeplessness, eneuresis and/or nightmares about losing their surviving parent as a normal part of their reaction to death.

In Nagy's study, by the time the child reaches nine to ten years of age, s/he has grasped both the inevitability of death and the dissolution of bodily life. The child's view of death in this age group reflects the same realism that is beginning to shape his or her view of the world in general. (Nagy 1948).

In developmental terms, the nine to ten year old is increasingly confronted with the need to develop competence and mastery in a variety of settings, and as such s/he continues to rely a great deal on the help and instruction of adults, and particularly on the support of parents (Erikson 1968). It is a time when the child is vulnerable to feelings of inferiority, and needs the reassurance and validation of parents as s/he struggles

to become competent at school, with peers, in sports, etc. Loss of the primary parental figure in this period presents a developmental crisis, for the child's emotional development requires the existence of a nurturant figure (Nagera 1970).

Bereaved children of all ages, and particularly in this age group, have a "short sadness span" (Wolfenstein 1966; Nagera 1970). They cannot tolerate intense distress for long and generally tend to deal with serious losses through massive denial (including denial of affect) and frequently, reversal of affect. While the nine or ten year old can briefly demonstrate real empathy for the grief of others in the family, they tend to impatiently await the family's 'return to normal' and frequently seek solace or diversion in normal activities for their age group in the company of their peers.

It is apparent that healthy outcome for the child is, to a great extent, dependent upon how the family understands and responds to his or her developmental needs and normal reactions to loss and death. There is some evidence to suggest that where the child's needs remain unmet, and where his or her normal 'instinctive' grief or loss behavior is stifled or otherwise interfered with, mourning can take an unhealthy course and result in pathology, the effects of which may last a lifetime (Nagera 1970, Furman 1974).

It has been widely argued that pathological mourning responses are best understood in this context of a normal mourning response gone awry. Bowlby (1961) and Klein (1940) share the view that differences between healthy and pathological mourning are matters of degree rather than of kind. In this sense, grief and mourning reactions may be seen as spanning a spectrum or continuum, with pathological responses being an intensifi-

cation or variation of normal responses. The pathological response in the child (or later in his/her adult years) is most frequently the result of unmet developmental needs and interrupted, inhibited or otherwise incomplete mourning, while healthy responses and outcome result when developmental and mourning work are able to proceed.

Pathological grief and mourning in children takes many forms, and no brief discussion can do justice to the complexity of childhood grief pathology. However, a discussion of some typical pathological responses to developmental and mourning interruption is suggestive of the dysfunction with which intervention may have to be concerned.

For the child in the early toddler stage (ie., one to three years), death in the family may interfere with ego development and object constancy (A. Freud 1952, Nagera 1970, Furman 1974). This may be complicated by the fact that the surviving parent(s) are unaware of, or unable to attend to the child's needs. Regression (ie., loss of recently acquired functions such as walking or talking) may occur (Furman 1974), or the child may develop a symptom, such as the inability to have normal bowel movements (Barnes 1978). Therapy with one particular three and a half year old, who developed such a symptom while his mother was in deep mourning and unable to attend to his emotional needs, centered primarily on helping his mother to soothe his anxieties about death by providing realistic explanations and answers to his questions, and on helping her ease his anxieties about the anger he felt towards his father for leaving. When the child learned that the anger he felt was not bad and would not result in death taking someone else away from him, happy memories of his father were able to gradually emerge, and his bowel functions returned to normal. (Barnes 1978).

A developmental process that death of a family member can interrupt in any stage of childhood is that of the child differentiating him/herself from a parent. The effects of this interruption can be most severe where the child receives well-meaning but inaccurate or distorted information about what has happened to the parent. (eg., "God took Daddy because he loved him so much", or "Mommy is just having a long sleep"). In very young children, where differentiation is not well along, the child may feel that his/her fate is bound up in that of the deceased parent(s). Barnes cites the reaction of a three year old boy who was afraid to fall asleep at night because he was afraid that he, too, might die as his father had. (Barnes 1978). Some children become terrified of illness, feeling that they are bound to experience the fate of their parent who died from an illness. (Furman 1974).

Completing differentiation from the dead parent may be difficult where the child is encouraged to imitate the deceased parent's good qualities. The child's individuality is stifled, s/he may feel that his/her own qualities are not valued and that it is impossible to be as good as the deceased parent, and may respond by withdrawing. (Silverman and Englander 1975).

Alternatively, the child's process of differentiation from the surviving parent may be impeded. S/he may fear that any separation from the surviving parent will bring about the death of <u>that</u> parent, and may act out in ways designed to prevent separation (eg., completely refusing to go to school or playing sick in order to stay home). (Barnes 1978, Silverman and Englander 1975, Furman 1974).

Death of a parent may also interrupt the child's developing sex-role identification, and may prevent or hinder the resolution of oedipal con-

flicts. A wide variety of adverse reactions may ensue, most of which revolve around the child's natural resistance to withdrawing cathexis from the lost parent. Some children withdraw from most normal activities, some keep the deceased parent alive in their fantasies, some invest inappropriate people in their environment with the roles or characteristics of their dead parent, and some children direct intense hostility at the surviving parent (Furman 1974, Nagera 1970, Silverman and Englander 1975). The child's hostility may be based on anger toward the deceased parent and/or toward the surviving parent for not being able to fulfill the role of the deceased parent.

The loss of a parent entails a certain irony or paradox for the child as he or she attempts to deal with that loss, for as Nagera has pointed out, the child's healthy coping and adjustment is to a large extent dependent on that suddenly absent person. (Nagera 1970). The child's normally constituted family no longer exists and s/he must find a place in the surviving family as it reorganizes after the loss.

Coping with loss in the context of family changes may be more difficult for the child where those changes include the eventual introduction of a new parent. The presence of a new parent frequently represents an interruption in both developmental and mourning processes. The reaction of the child can be as severe as regression, or it may be that s/he remains arrested at the level of maturity s/he had reached at the time of the parent's death. (Furman 1974).

A special type of pathological response is that which, on the surface, appears to indicate that the child is coping particularly well. Indeed, it is most frequently found where the child is acting as protector and counselor to the surviving parent. The child may become super-responsible, assuming new household and family duties and ministering to his/her

parent(s)' grief, or may simply function in a relatively normal fashion, marked by slightly more controlled behavior and subdued affective response. (Furman 1974). The child will avoid discussing his/her own feelings about the deceased parent, or will even avoid mentioning anything connected with the deceased parent, so as not to upset the surviving parent. The consequences of this response may be incomplete or delayed mourning work.

Any such incomplete or delayed mourning work can lead in the short term to phobias, fears, amnesia, truancy, stealing and/or self-injury and in the long term to inability to cope with subsequent losses, and to somatic and/or psychiatric illnesses.

A variety of other symptoms and behavior problems may characterize a child's response to loss including: hyperactivity; difficulties in relationships with adults and peers; difficulties in learning, frustration-tolerance and self-control. Pathological symptoms and behavior may surface at any time after the death of a parent or sibling. (Furman 1974). The child's ability to continue a healthy emotional life in which pathological symptoms are no longer necessary depends upon the extent to which s/he can be helped to master the developmental and mourning tasks as yet unmastered.

III Grief and Mourning in Adolescence

Many of the normal and pathological responses to loss found in the child are found in the adolescent as well. But the adolescent has special developmental characteristics and needs, and adolescent grief and mourning need to be seen in the context of those.

Perhaps the most important task or process of the adolescent years is that of the search for identity. (Alexander and Adlerstein 1958, Deutsch 1967, Erikson 1968). Between the ages of about twelve and eighteen, and frequently beyond, the adolescent lives in a transitional world, vacillating between the roles of a dependent child and an independent adult, in an in-between state that is marked by changes in virtually every aspect of functioning. (Kastenbaum 1959). There is little consistency in what the culture expects of the adolescent. Biologically, s/he is an adult, but has no social status to match. The changing and often conflicting demands made on the adolescent provide the occasion and necessity for reorganization of the self-concept. (Alexander and Adlerstein 1958).

The adolescent, while working towards a further differentiation from his or her parents (as part of an evolving self-concept), is still dependent upon the continuity and stability that parents can provide. Parents, siblings and family life form an important background and support for the adolescent's integration of an identity and long-term values.

The adolescent's half-child, half-adult state of development is reflected in his or her understanding of and reaction to death. Cognitively, the adolescent can understand the full implications and finality of death. His or her reality testing is firmly established; an awareness of reality and capacity to adapt to it are sufficiently developed. All the factors

generally considered to be necessary preconditions for adult mourning are well established in the adolescent. (Nagera 1970).

Yet adolescents shy away from the type of mourning engaged in by adults. While they are greatly affected by loss, and react in strong and specific ways, their responses are significantly different from that of the adult mourner. (Nagera 1970, Webb 1979). For example, the adolescent's ability to cope with loss of a parent is different from a child's or adult's. Because of greater ego maturity than a child has attained, the adolescent does not depend as completely on parental figures for development, and is generally more able to find new love objects because of his or her life in the wider community. (Furman 1974, Barnes 1978). Yet on the other hand, because the adolescent's self-picture is often less stable than that of most healthy adults, s/he may find it much more difficult than an adult to integrate a loss. (Alexander and Adlerstein 1958).

The response of the individual adolescent can be seen as partly reflective of the balance of these two factors in his or her own development - a healthy or unhealthy reaction will be shaped to a great degree by the extent to which the adolescent has accomplished differentiation from a lost parent and by the extent to which the conflicts inherent in differentiation were resolved with the lost parent. Typically the adolescent tends to recathect the image of the lost parent when experiencing certain needs or developmental pressures. Fantasies of the parent's return are common, but these are tempered by the natural ambivalence felt towards any parental figure. (Wolfenstein 1966, Nagera 1970).

The normal mood-swings and emotional unpredictability of adolescents are generally evident in their mourning behavior. It is quite common for

the adolescent to remain affectless, and at the same time, to be disturbed by his or her own lack of affect. (Wolfenstein 1966). At other times, the adolescent may exhibit elation or despair, but the general tendency is to isolate those feelings from thoughts of the parent's death and to resist making connections between those feelings and the loss they have experienced. (Laufer 1966, Nagera 1970).

The bereaved adolescent may behave in ways that are baffling to a surviving parent. Lucinda Webb reports that only a few days after the death of her own husband, her 15 year old duaghter and 13½ year old son confronted her belligerently and demanded to know how she felt about them smoking pot or having sex. The seeming irrelevance of their questions in fact constituted a testing of their mother - would widowhood change the mother they had known, would their mother respond differently to them from now on because of the changes that had been wrought in her own life? (Webb 1979).

The adolescent's affiliation with a peer group may be an important factor in his or her adjustment to loss. The peer group is frequently a place where the adolescent can escape from the adult mourning taking place in their household; it is a place where they can choose either to 'talk it out' or 'block it out'. (Webb 1979).

The adolescent's identification with a peer group is likely to be intensified during bereavement - the loss of a parent can stimulate a need for connectedness. The adolescent may identify with the healthy, more mature members of his or her peer group, or may temporarily over-identify with pathology. (Barnes 1978). Important factors in determining that process are the nature of the relationship the adolescent had with the deceased parent (how conflict-ridden it was) and the state

of his or her relationship with the surviving parent. There will be less need to identify with pathology where the adolescent does not feel a need to punish him/herself, the deceased parent or the surviving parent for past hurts inflicted, and where the adolescent sees his or her home as a safe place where emotional support and understanding are available.

In the absence of adequate support, understanding and opportunity to verbalize feelings about a loss, the adolescent may be handicapped in completing the process of development and differentiation. Incomplete mourning may lead to a variety of symptomatic behaviors, including many of those mentioned in connection with children. Among the more common pathological behaviors following loss of a parent are theft, promiscuity and attempts at suicide.

Shoor and Speed (1963) report the case of a bereaved adolescent who began to commit burglaries shortly after the loss of his mother. He had initially remained affectless after her death (a common adolescent response), but his father had not understood the reaction and had responded to it in an angry fashion. The boy, feeling misunderstood, and not able to explain his reaction, reacted by running away from home and engaging in burglaries. In therapy, efforts were made to improve the understanding between father and son, and to help the boy put into words his grief and sense of loss. Delinquent behavior subsequently subsided, and the boy was eventually able to relate warmly to a new step-mother when his father later remarried.

Promiscuity as a pathological response was evidenced by a 15 year old girl in Shoor and Speed's study. Though their description of the case is from a strongly psychoanalytic perspective, it is an example of

how adolescent acting-out can be a symptom of a dysfunctional, closed family communication system. In the situation they recount, an adolescent girl was shielded from discussions of her father's death, and the family rules made expression of her grief very difficult. Her frustration, her need for closeness, and her increasing desire to be treated as an adult, led her into inappropriate sexual encounters in her peer group. In therapy, the mother was urged to openly discuss the cause of her husband's death, and the daughter was assisted to deal with the feelings engendered by the discussion. The daughter was also helped to understand how her sexual acting out was linked to her unfinished mourning work.

Suicide or attempted suicide is a complex, but not uncommon, pathological response to death of an important figure. Adolescence is a time of renewed interest in (or preoccupation with) immortality. The normal interest in immortality can sometimes be employed defensively to deny the horror of death, avoid sadness and/or perpetuate the fantasy of a reunion in the physical sense. (Barnes 1978).

The adolescent who longs intensely for a lost parent, sibling or friend, and/or who wishes to punish him or herself, the dead person or another survivor may struggle with these anxieties and with thoughts of immortality by entertaining suicidal notions. The bereaved adolescent who makes uncharacteristic statements about suicide or immortality needs to be encouraged to express his or her views so that misconceptions about death can be clarified (Barnes 1978), and so that anxieties about death that might otherwise be 'tested out' can be talked out.

IV Grief and Mourning in Adulthood

Although adulthood comprises more than one stage of psychosocial development (Erikson 1968), the psychological processes underlying response to loss are essentially the same in young adulthood, middle age and old age. It is generally agreed in the literature that normal adult mourning comprises several stages, each with its own tasks and symptomatic affects and behaviors. Bowlby's three-stage schema of mourning is still considered to be the best description of that process, though as Bowlby intended, the schema is often found to be most useful when it is flexibly applied (eg. Worden's 'four-task' model - Worden 1982).

The affects and behaviors common to each stage of normal mourning were suggested by Bowlby to have a particular function, and later clinical observations by Parkes (1972), Glick, Weiss and Parkes (1974) and Worden (1982) have confirmed the role of those affects and behaviors in normal mourning. For example, in the first phase of mourning, that of the urge to recover the lost object, weeping and anger are likely to be in evidence. These are behaviors organized to achieve reunion. (Bowlby 1961). Anger may take the form of aggressive expressions towards the self, towards care-givers, or towards the lost object; such expressions were seen by Bowlby as part of the need to "find the culprit, right the wrong, reinstate what has been lost, and ensure that it will never be repeated." (Bowlby 1961, p. 334). The mourner does not want comfort in loss, but assistance towards reunion. Denial and preoccupation with the image of the deceased serve as protection while the urge to recover the lost object goes unsatisfied.

In the second phase of mourning, disorganized behavior fulfills an important function as the mourner begins to adjust to the environment

in which the deceased is missing. Since the patterns of behavior which have grown up in interaction with the lost object have ceased to be appropriate, were they to persist they would be maladaptive; only if they are broken down is it possible for new ones, adapted to new objects, to be built up. (Bowlby 1961).

In the final phase of mourning, that of reorganization and reinvestment, identification behaviors fulfill a particular function. The mourner gradually begins to discriminate between patterns that are clearly no longer appropriate and those that can reasonably be retained, and gradually attempts to put the memory of the deceased in proper perspective. Bowlby, Parkes and Worden have all observed that some mourners find it helpful to adopt particular values and goals of the deceased, or to carry on the work of a lost loved one, as a way of preserving their memory, both internally and externally.

Although there can be considerable individual variation in the timespan over which adult grief and mourning work occurs, the Harvard Bereavement Study found that for a majority of young Boston widows and widowers, one to two years was the norm. (Glick, Weiss and Parkes, 1974). The period of deep and continued grief seemed to last only a few weeks or at most a few months. Further recovery seemed to progress more slowly, and was not yet fully achieved by the end of the first year of bereavement. Most widows and widowers felt in control of their lives and themselves by the end of the first year, although most reported considerable loneliness. Some widows were dating by the end of the first year, and many remarried within four years. Widowers generally moved more quickly toward reestablishing a stable social life based on remarriage. Widows or widowers who failed to begin to move toward recovery during the first year

generally experienced difficulty thereafter.

For adults, as for children and adolescents, it is the completion of mourning work that is so essential to maintaining mental and physical health after bereavement. Incomplete mourning may manifest itself in a truly staggering array of psychological and physical symptoms. (Lindemann 1944, Jackson 1957, Parkes 1972, Lipson 1973, Glick et al 1974). While there is no possibility of exploring the exceedingly complex nature of pathological adult mourning in the confines of this literature review, it is possible to highlight some of the variants of pathological response, including underlying psychological processes and behavioral manifestations.

That pathological responses are a variation or distortion of normal mourning processes may be seen most clearly in John Bowlby's approach to the subject. (Bowlby 1963). Bowlby has identified five major components of normal mourning, each of which, when unresolved, can result in specific symptoms and behaviors. An adverse reaction in an individual may be reflective of one or more of the normal processes of mourning being unresolved.

Bowlby begins by considering the normal yearning to recover the lost object, and observes that open expression of protest and of demand for the object's return is a necessary condition for a healthy outcome. Protest may be made through anger and reproach, and yearning may be expressed in sadness and crying. Both these components of ambivalence need to be addressed in the mourning response. Where both are not addressed, reality testing is more likely to fail, and unconscious yearning for the lost object can persist. Whether the bereaved uses denial, repression, delay or avoidance to resist expression of ambivalent feelings, s/he is prone to experience symptoms of either anxiety and depression (including in-

hibition, indecision, nausea and sickness) or hostility and aggression.

Another component of normal mourning which may persist and give rise to pathology is that of anger and reproach. Healthy outcome is dependent not only upon the expression of anger about loss, but is dependent upon the expression of anger at the real object of that anger. Direction of reproaches towards inappropriate targets (ie., doctors, family, etc.), while often a necessary part of reaction to loss, is not sufficient ventilation of anger. Where the bereaved imagines or accurately perceives sanctions against "speaking ill of the dead", anger may continue to be felt or expressed at inappropriate third parties and/or the self. The resulting clinical picture is often either paranoia in the former instance, and depression, guilt and/or self-injury in the latter instance.

A third common characteristic of normal mourning is the tendency of the bereaved to become absorbed in caring for someone else, particularly in the case of a bereaved spouse who has dependent children, or in the case of bereaved parents who have other surviving dependent children and/or aging parents. This tendency may limit expression of the bereaved person's own grief, whereby grief becomes repressed, or it may serve as a mechanism of projective identification, wherein the bereaved projects his/her own awareness of loss and affects of grief and helplessness on to a vicarious figure. (This may be destructive for the vicarious figure, particularly where yearning for the lost object and/or anger at the lost object are also projected on to the 'substitute'.)

A fourth component of normal mourning which may persist and result in pathology is the denial that the object is permanently lost. This may occur where the bereaved has intensely ambivalent feelings towards the

deceased, or where death has been sudden, or in situations where the fact of death has been hidden from the survivor for some length of time. Denial that the object is lost is a defense mechanism, which when combined with other defense mechanisms, can lead to a variety of clinical conditions including depression, anxiety, hysterical outbursts, psychopathic behavior and schizophrenia or 'splitting of the ego'. (S. Freud 1938, Lindemann 1944, Volkan 1975).

The bereaved individual who denies his or her loss is unlikely ever to have visited the cemetery, and may actively keep the deceased alive through a fantasy life and/or through maintaining habits and behavior patterns oriented towards the deceased (eg., setting a place at the table for the deceased). S/he may develop an object fixation or fetish (ie., investing inanimate objects, particularly possessions of the deceased, with special properties). (See also Volkan 1975).

The last component of normal mourning which Bowlby identifies as one which may become distorted and lead to pathology is that of identification with the lost object. When differentiation between the self and object is blurred or absent, an unhealthy unconscious identification with the deceased may persist after his or her death. Volkan has described how, in such pathology, the deceased may be 'internalized' so that the mourner can have "internal conversations" with the deceased. (Volkan 1972). Alternatively, the mourner may develop the physical symptoms of which the deceased died. (Lindemann 1944, Parkes 1972).

Finally, unhealthy mourning in its most literal sense may result from something other than a delay, prolongment or intensification of the normal psychological elements of mourning - that is, it may take the form of a physical reaction to the stress of bereavement. Biochemical research has

shown that the acute stress imposed by grief starts a biochemical process in the mourner which can result in decreased immunity. (Frederick 1981). The intervening social worker needs to be aware that physical symptoms observed in the mourner may therefore not be indicative of psychological pathology. Such symptoms, however, are added justification for intervening to facilitate resolution of grief, since resolution of grief would, according to Frederick, be expected to restore the immunologic health of the person.

Whether an adult's grief and mourning responses will be generally healthy or unhealthy is determined in part by the age of the survivor, the timeliness of death for the deceased and his/her family, the survivor's experience of previous losses and the extent of the survivor's social support. (Parkes 1972). In each stage of adult life, these factors will be different, and will combine to shape a unique experience of loss.

Erikson has identified young adulthood (roughly between the ages of 19 and 40) as a period in which the individual generally strives to further define an identity in relation to love and work. It is a period in which the development of intimacy (generally in marriage and family) forms a foundation for the tasks and growth of later life. (Erikson 1968).

The interruption of that intimacy through the death of a close family member, particularly that of a spouse, can be catastrophic. Untimely death (that which occurs in a relatively young person or leaves young survivors) is not uncommonly met with pathological reactions (Lehrman 1973). Indeed, in several studies of pathological grief reactions, the majority of patients have been found to be under 45 years of age. (Parkes 1972).

Studies of young bereaved spouses have found that their manifested grief is more intense than that of older spouses, especially the first

18 months after their loss. Young bereaved spouses tend to experience greater shock, confusion, personal death anxiety, guilt, ambivalence and loneliness. (Ferguson 1979, Carey 1979, Sanders 1980).

Ferguson found that young widows face a complex set of problems, only some of which occur for older widows. Many are left with dependent children, and face not only the prospect of raising them alone, but of having to provide financial support at the same time. (See also Lopata 1979). For the woman who gave up a career or put off getting further education in order to stay home with her children, it can be exceedingly difficult to suddenly have to compete in the job market, and frequently, when employment is found, the pay is often too little on which to support a family.

Related to those problems, the young widow frequently cannot afford to remain in the family home and faces the prospect of relocation. Moving presents particular hazards to the grieving individual, as it can represent a dissociation or severance from the past for which the individual and family may not be ready.

Frequently, a deceased husband will not have made a will in early adulthood. This makes settlement of the estate and short-term support of the family extremely difficult, and presents an added stress to an already stressful situation.

Eventually, most young widows were faced with the necessity of re-organizing their social life without a partner. Many felt that they had been "dropped" by their husband's friends, and many felt that they had both lost status and become a fifth wheel. (See also Lopata 1979).

Fortunately, however, a majority of widows and widowers in young adulthood tend to have adequate social support, so that while the early

course of their grief is particularly volatile and rocky, they tend to move more quickly than older widow(er)s to a healthy level of functioning and establishment of a 'new life'. (Sanders 1980). Sanders notes a factor in restored functioning is that they tend to be more motivated by hope than older spouses. One might also observe that they are frequently motivated by necessity.

It is difficult to make generalizations about the experience of bereavement in middle age (approximately 41 to 60 years of age). In this period of life, an individual may still be addressing many of the psychological tasks of young adulthood and/or may be moving towards the "maturity" and "generativity" which Erikson identifies as being preparatory to the stage of old age.

Studies of adult loss reactions tend to separate data into 'older' and 'younger' categories, and the middle-aged individual may be counted as either older or younger depending upon the study. It is therefore difficult to separate out data from the literature which gives a clear picture of a unique middle-age loss experience.

It would appear that a middle-aged individual may react similarly to a younger or older population depending partly upon their age, but mostly upon the major psychosocial tasks they were addressing at the time of the loss.

One theorist has suggested that bereaved women in middle age are hit with a 'double whammy' - they face widowhood at a time when they are already vulnerable to identity crisis. Not only do they face a role transition in relation to their offspring, who are generally becoming independent at this time of their lives, but they lose identity as a wife and as one half of a twosome. (Markham 1979).

The loss of emotional nourishment produces enormous stress and a state of anxiety. This is compounded by changes in friends' attitudes and behavior towards a new widow; many widows feel bitterness and confusion as they come to feel that they cannot even count on old friends.

Widows and widowers in middle-age may feel especially angry about the loss of their spouse, particularly if children have just left the home and the couple had begun to re-adjust to a more intimate relationship. They may be acutely aware that they have been cheated out of a period of respite they and their spouse had 'earned' and hoped to enjoy before a loss of health and mobility in old age.

Adjustment can be just as difficult where the marriage was not particularly happy and where intimacy had been lacking. A study of widowers with teen-aged children found that the more passive and withdrawn a husband may have been with his deceased wife, the greater the likelihood that his troubled feelings (especially guilt) will adversely affect his attempts to raise his children alone. (Wargotz 1969).

The middle-aged individual may respond to loss in many of the ways common to elderly individuals. In Erikson's scheme, the task facing us in old age is that of 'reviewing life' and completing 'integration'. Where an individual can look back over the past with satisfaction, and in the present can offer and be valued for his/her wisdom and experience by the younger generations who will follow him/her, integration will be an easier task and the eventual relinquishment of life will be more peaceful.

The lack or loss of this accrued integration is often signalled by the need to find alternate roads to integrity, ie., by "doctoring" one's memories, and it is often signalled by the fear of death. (Erikson 1968).

Reactions to loss in old age are in part, then, a reflection of where the survivor is in this integration process - the loss of loved ones will stimulate less personal death anxiety and guilt where integration is somewhat accomplished.

Notwithstanding the factors of individual 'readiness' for loss and death, however, studies have found certain trends in the bereavement responses of elderly people. Stern, Williams and Prados (1951) observed a dearth of overt mental manifestations of grief or of conscious guilt feelings. Sanders (1980) reports that for elderly spouses, denial frequently acts as a suppressor variable in grief responses. Bereaved spouses frequently maintain a 'determined optimism' or 'compulsive self-reliance'. They will change habits of long-standing to avoid the daily misery of doing things they did with their former spouse.

In the short-term, bereaved elderly spouses in Sanders' study demonstrated 'remarkable courage' in the face of much loneliness, deprivation and lack of social support. However, over the long-term, older spouses showed exacerbated grief reactions. Despite courage and faith, it became increasingly difficult to maintain an optimistic outlook for the future when time was seen as running out, physical healthy was becoming tenuous, and being alone meant deprivation and also fear for one's personal safety.

Loneliness, anxiety and hopelessness were often accompanied by the tendency to gain comfort in the thought that bereavement would have been more difficult for the deceased spouse. Older spouses mentally reviewed the experience of the spouse's death as a way to prepare for their own death.

Sanders found that in time, the bereavement experience takes a physical toll on the elderly survivor. Stern et al (1951) suggest that somatic

illness may actually be a manifestation of the grief which is suppressed so early in bereavement. It may also be in some individuals a tendency toward self-punishment, an expression of the death wish and/or identification with the deceased.

Pathological reactions in elderly mourners are, as in other age groups, an intensification or variation of normal mourning responses. Stern et al report that the image of the deceased, which commonly undergoes peculiar changes in the consciousness of the mourner, may be idealized to bizarre degrees. This may be accompanied by a trend toward self-isolation and an irrational hostility to persons in the mourner's immediate environment. Idealization of the deceased is commonly a defense against confronting ambivalent feelings towards the deceased, and hostility is often, likewise, a projection of angry feelings that would otherwise be directed at the deceased. Both tendencies may be seen as consistnet with the process of 'life review' and the importance of happy memories to maintain a sense of integrity.

Treatment in the Stern study focused partly on facilitating the mourner's insight into his/her own hostility, self-isolation and/or distortion of the image of the deceased. In addition, a large part of therapy consisted of manipulating the environment. The mechanisms of hostility and self-isolation were interpreted to the mourner's relatives, so that the mourner might, to a degree, be allowed the defenses so necessary to his or her integrity at this late stage in life.

V Implications for Intervention

Grief and mourning throughout the stages of an individual's life are affected by a myriad of factors, only some of which have been touched on here. Many factors, such as previous experiences of loss, can be better understood in the context of the family life cycle.

However, the literature reviewed here allows at least some important conclusions to be drawn, especially regarding intervention. First, there is evidence that the expression of grief and the completion of mourning are pre-requisites to individual mental health at all stages of the life cycle.

Second, an individual's ability to complete grief work may be impeded in a variety of ways, and often such impediments may be overcome with outside assistance. Engel (1961) has likened grief to a disease, in which the natural healing process often, by itself, leads to the restoration of healthy functioning. But when, like a disease, grief takes a course which will result in impaired functioning, the natural healing process can often be facilitated by 'treatment' such as grief counseling or therapy.

Parkes (1980), in reviewing grief intervention services such as a program providing support to high-risk widows in Sydney, Australia (Raphael 1977) and a crisis-intervention service for elderly bereaved spouses in New York (Gerber 1975), concludes that "professional services and professionally supported voluntary and self-help services are capable of reducing the risk of psychiatric and psychosomatic disorders resulting from bereavement." (Parkes 1980, p. 6). Worden (1982) concurs, pointing out that while Freud (1917) saw grieving as a natural process which should not be tampered with, intervention is often indicated when the traditional

supports of that natural process are nowhere in evidence. Intervention does not have to be an intrusion, but rather may be geared to mobilize church, family and other social supports so that individual grief may indeed complete its natural course.

Finally, the literature suggests several clear guidelines or imperatives for effective intervention in individual grief:

1) The facilitation of individual mourning and grief must be carefully attuned to the individual's stage of psychosocial development and be prepared to promote grief work at an appropriate level. The therapist must be prepared to exercise a range of intervention techniques appropriate for a variety of ages. (eg. for young children, play approaches such as Gardner's mutual story-telling technique (Gardner 1971) can be an effective way of dealing with the loss of a parent. See Chapter Three for techniques appropriate to other age groups).

2) Intervention must be based on an ability to make connections between pathological symptoms and unfinished grief or developmental tasks.

3) It is important to recognize that while the completion of each individual's mourning work is in many ways a prerequisite to the family's ability to reorganize and adjust to a death, the mourning of a child or adolescent is an on-going process that may take many years (as each developmental stage is negotiated without the lost parent) and healthy outcome is itself dependent upon the family's readjustment. In this sense, there is no clear separation between the mourning and adjustment process of a child and that of his or her family. Consistent with that, while individual or peer-group

counseling approaches may be used with a child or adolescent, intervention must also be geared to enter into and facilitate the interdependent mourning of child and family. (Shoor and Speed 1963, Jensen and Wallace 1967, Greenberg 1975, Barnes 1978, Kliman 1979, Black 1981).

4) It is equally apparent that the outcome of adult mourning is also, to a great extent, shaped in the family context. While individual counseling approaches are valuable, especially in the early stages of mourning, and while group or network counseling approaches have proven their effectiveness at various stages of the bereavement process, "it is not sufficient to treat each individual in relationship to the deceased and to deal with his or her grief without relating it to the total family network." (Worden 1982, p. 97).

A closer examination of bereavement in the family system will reveal more fully the interdependence of individual and family mourning, and will point to the importance of bereavement intervention which is family-oriented.

CHAPTER TWO

GRIEF AND MOURNING IN THE FAMILY SYSTEM

I Brief Introduction to the Literature and to the Characteristics of the Family System Which Affect Bereavement Adjustment

A review of the literature reveals a few early attempts to consider bereavement in a family or interactional context, although as noted in the Introduction, a systems perspective on bereavement has been slow in developing. One of the first attempts to consider the effects of loss on the family system was made by Willard Waller in his 1951 textbook, The Family. Waller observed that in the bereaved family,

> The sociological structure of the group has been altered; although the original pattern may seem to continue to exist for a time, the fundamental pattern of the dyad or triad later establishes itself; it is at first an all-but-one configuration, and later the absent member is out of the picture entirely. For the group which is left the loss of a member may none the less be an asset; it happens sometimes that parents are woven more closely together by the loss of a child, or the whole family is given a rallying point by the loss of a central member. As we have seen, the life of the departed is always idealized; we may say that the family loses a member but gains a collective representation.
>
> (Waller 1951, pp. 491-492)

A few years later, Thomas Eliot (1955) noted that the interpersonal aspects of bereavement are of as much importance as the personal or individual reactions of family members. Echoing Waller, Eliot pointed out that bereavement can trigger a change in the configuration of interactions and roles in the family group, and that loss can change the role of the family as a whole in the community.

In a 1957 article considering the relationship between bereavement and mental health, Volkart and Michael observed that "familial systems, by their influence on the development of the self, can enhance or reduce the initial vulnerability of persons in bereavement." (p. 293). They argued that insofar as the study of bereavement is concerned, "the family and kinship systems are of the greatest importance." (p. 289).

In recent years, a small number of theorists and practitioners have begun to approach bereavement from the broader perspective foreshadowed in these early writings. Family therapists such as Murray Bowen have have begun to work with bereaved families from the systems base advocated by Reilly. (Bowen 1978). William Worden, in practice and research at both Harvard Medical School and the Massachusetts General Hospital, emphasizes the importance of assessing grief from a family systems viewpoint, and stresses that the probability of grief counseling being effective is greater where the family system is the focus of intervention. (Worden 1982).

Research and practice with bereaved families have suggested a number of dimensions of the family system which are most important in adjustment to bereavement. The openness/'closedness' of the family, its patterns of communication, its distribution of roles and tasks, its intergenerational patterns of dealing with loss, and its stage in the life cycle are dimensions which determine the way the family responds to bereavement, and which often in turn are themselves shaped and changed by the loss event. Although all these dimensions are linked or overlapping in the actual family, each will be considered separately for purposes of discussion and assessment.

A) Openness/'Closedness' of the Family System and Internal Patterns of Communication

The open or closed characteristics of the family system may be seen at two levels - within the family itself, and in relation to the community or society in which it exists. In a four year study applying crisis intervention techniques to fifty families who had experienced a recent sudden death, Rita Vollman and her colleagues at the Fort Logan Mental Health Center in Denver observed that the interactive or open qualities of the family at both the intra- and extra-familial levels have profound significance for the bereaved family's eventual adjustment and reorganization. (Vollman, Ganzert, Picher and Williams, 1971).

In terms of interactiveness with the larger community and society, Vollman and her co-researchers have identified three major types of families. First among these is the atomized nuclear family who tend to lack a closely knit kin network, but who have direct links to community and society through 'social churchgoing', club memberships, schools and the media. This type of family often are well-insured and thus financially prepared for death, but because they tend to incorporate societal values (such as placing a premium on youth and beauty, and avoiding contact with death), they are often profoundly unprepared for the emotional impact of death. Their vulnerability, however, is often offset by the fact that they are accustomed to the idea of seeking/accepting the advice and support of professionals and experts. Left on their own, these families often make faulty long-term emotional and psychological adjustment to loss, but with support can adapt and reorganize in a healthy fashion.

A second type of family is that belonging to a cohesive cultural subgroup. Such families are often closed to mass society, but are highly inter-active with a kin and community network. They function according to norms which allow them to support and be supported in times of crisis, to express grief and anger, and to face the reality of death. These families are less frequently in need of professional help, but as Vollman discovered, when they are in need of help, it can be difficult to intervene effectively in a traditional manner. One can surmise that cross-cultural factors might play an important part in explaining the difficulty of such interventions - unless the worker is a member of, or has experience with, the family's ethnic or cultural group, he or she may be at a significant disadvantage in attempting to join with the family system. In such situations, some variation of a 'network intervention' may be particularly appropriate (eg., Phyllis Silverman's "widow-to-widow" program, Silverman 1968).

Finally, Vollman and her colleagues have identified a type of atomized, nuclear family who are at particular risk in bereavement. These families do not have a large kin or social system, and have few or no links to their community through churches, clubs, neighbours, etc. They are tied up in their family exclusively, and loss of a member is a crisis which often precipitates physical and mental breakdown in the survivors. Even where breakdown is avoided and some type of adjustment is made by the family, the long-term consequences of the loss can be disastrous for the family system. This type of family is often characterized by a resistance to outside help which is as great as their need for it.

The Denver study also identified certain characteristics and

consequences of openness at the intrafamilial level. Families with open internal communication systems were found to be more resistant to societal taboos concerning death, and thus were more likely to make realistic plans for the death of their members. Families who in the past had responded to stress by acknowledging rather than denying the reality and implications of the stressor were more able to cope with the crisis of death. Finally, families in which it was permissible to express feelings of sadness, loss, anger, guilt and relief were found to have greater success in readjustment. (See later supportive findings from this study in Williams, Polak and Vollman 1972).

These findings about openness at the intrafamilial level have been corroborated by a number of other researchers and practitioners. In a 1977 Cincinnati study by Pauline Cohen and her colleagues, forty-two families who had received family counseling prior to the death by cancer of one of their members were followed up during bereavement. The study found a significant positive correlation between the free flow of information within a family and their utilization of internal support systems during bereavement. (Cohen, Dizenhuz and Winget, 1977). The more family members were able to communicate with one another, to share information, and to share in decision making, the greater was the likelihood of an effective adjustment during the post-death period. It is important to note, however, that openness of communication in a family was frequently found to depend upon the mother. In families where the mother has died, the intervening professional must be able to help the family system realign in a way that openness of communication is still ensured, and preferably so that the respon-

sibility is equally distributed rather than resting with one member who acts as the 'family switchboard'.

Murray Bowen has noted the difference that an open or closed relationship system in a family makes in that family's reaction to death. (Bowen 1978). Bowen describes an open relationship system as one "in which the individual is free to communicate a high percentage of inner thoughts, feelings and fantasies to another who can reciprocate." He sees the closed system as one by which members seek to protect each other and themselves from the sensitive subjects and stresses that are a part of living together. Closed communication is an automatic emotional reflex designed to protect the self from anxiety in the other person, but Bowen has observed that instead it heightens anxiety in the family system. He pinpoints the closed communication system between family members as an appropriate entry point for the intervening professional, and stresses the importance of using direct words such as death, die and bury, so as not to reinforce a family's denial and indirect communication.

Fredda Herz (1980) echoes Bowen's definition of an open family system, stressing that openness not only means sharing of thoughts and feelings, but that each family member is able to stay nonreactive to the emotional intensity in the system, and that members can express thoughts and feelings without expecting others to act on them. In her practice with families dealing with death, Herz has found a greater likelihood of emotional and/or physical symptom development when family members are unable to deal openly with one another about the death. In addition, she notes that the isolation and stress of a bereavement experience can close even the most open and well-

differentiated family.

Herz argues that of all the factors affecting family reaction and adjustment to death, the one which can most quickly be assessed and therefore most easily used as a therapeutic starting-point, is the openness of the family system. Most family interventions, she suggests, should be initially directed toward opening up the family emotional system, since it is on that foundation that much of the family's later reorganizing and restructuring work depends.

B) Distribution of Roles and Tasks

Related to the family's degree of openness and quality of communication is its role system. The way in which roles are assigned, instrumental tasks accomplished and socio-emotional functions served, as well as the specific roles, tasks and functions fulfilled by the deceased, have been found to have great significance for the family's reaction and adjustment to death.

Frequently bereaved families are faced with the necessity of filling the role(s) vacated by the deceased. At the intrafamilial level, the family may have to alter its relationships in order to redistribute instrumental and socio-emotional responsibilities and functions. At the extra-familial level, the family may have to drop out of certain activities or they may have to select a new family representative through whom they can relate to a community agency, group or activity.

The way in which the family handles these realignment tasks will depend in part upon how healthy their role system was prior to bereavement. In the Denver study by Vollman and her colleagues (1971),

it was found that

> The resumption of adaptive functioning, following a death, is facilitated in a family where vital roles and functions have been apportioned among members in a just and equitable manner for optimal comfort and staisfaction in their performance. This type of apportionment occurs when roles are assumed according to individual need, ability and potential. In such a case, role assumption is usually explicit and well understood by all family members. When a member of this type of family dies, the critical period of reorganization is not likely to be experienced as a crisis because the family already has a built-in process which allows it to reallocate the role functions of the decedent with minimal difficulty.
>
> (Vollman et al 1971, p. 104)

Even in the healthiest family, however, certain instrumental roles can be difficult to fill. For example, the role of the breadwinner can be troublesome and time-consuming to reallocate if the skills necessary to fill that role are not available among the surviving family members. The family facing this type of difficulty may be at particular risk, since the necessity of resolving such an immediate and pressing problem can detract from or interfere with the completion of mourning tasks.

The socio-emotional role or function of the deceased is also an indicator of the extent to which the bereaved family is at risk. Bowen (1978) and Herz (1980) note that the more emotionally significant the deceased was to the family, the greater the disruption of the family's equilibrium. For instance, in families characterized by marital fusion or dependence, loss of the spouse represents an emotional loss of self to the surviving spouse, which has consequences for the rest of the family.

In families where there is great emotional dependence on a child (ie., whose function it was to camouflage or resolve a conflict), death of the child would severely tax the family's already inadequate

resources to deal with stress, provoking further disorganization and maladaptive behavior. (Vollman et al 1971).

The deceased member may have been deviant in some way (eg., alcoholic, suicidal, etc.) and may have functioned as a scapegoat, thereby becoming a focus for the tension within the family system and effectively maintaining the family structure. Death of such a family member frequently necessitates the appointment of a new scapegoat, or the emergence of a new symptomatic member, failing which the system may collapse. (Vollman et al 1971).

Alternatively, the deceased member who manifested deviant behavior may have been a cause of open conflict in the family, and may not have served a function in the family emotional system, except to act as a drain upon it. The death of this member may herald a period of peace and solidarity for surviving family members. (Vollman et al 1971).

C) Intergenerational Patterns of Dealing with Loss

Although some realignment of the family's emotional roles begins very shortly after a death, many effects of bereavement on the family emotional system are not always immediately apparent. Indeed, mourning has come to be seen by many researchers and practitioners as an intergenerational phenomenon.

Among the first to draw attention to the intergenerational effects of loss were Paul and Grosser (1965), who undertook a clinical study of 50 families with schizophrenic members and 25 families with 'psychoneurotic' members. These families were characterized by a 'fixed family equilibrium', by inability to change and adapt as they moved through the family life cycle, and by inability to cope with loss except through affective denial. These families were discovered to

have sustained an important loss generally before the birth of the symptomatic family member, and had been unable to accept and adapt to the loss. Affects and attitudes towards the lost person remained unchanged and recent losses evoked similar reaction patterns. Paul and Grosser observed that the current style of family life appeared permeated with varying degrees of denial or "warding off" of losses and disappointments. Changes in homeostasis, such as those which would bring about a separation from, or independence of a member, were often resisted.

Paul and Grosser developed a family therapy technique called "operational mourning", wherein the family was enabled to come to terms with its loss, and wherein the symptomatic member could be relieved of the burden of acting out the family's anxiety and denial.

The observations and hypotheses advanced by Paul and Grosser about the intergenerational effects of unresolved loss have been widely corroborated. Framo (1972) has identified ineffective mourning as a key factor in family pathology, while Boszormenyi-Nagy and Spark (1973) and Pincus (1974) have observed that postponed mourning related to one's family of origin impedes the ability to experience emotional loss and separation within the current family.

Norman Paul's case studies (1967 and 1982) illustrate the role of long-denied grief in marital disorders, while studies by Dennis Reilly (1975) suggest that the parents of youthful drug abusers have never fully mourned or resolved their ambivalent ties to their own parents. Reilly speculates that such parents project their unresolved mourning and separation onto their present-day families, and that their collusive behavior vis-a-vis the drug abuser forestalls

separation, while their scapegoating of the abuser functions as an outlet for displaced anger.

Orfanidis (1977) and Walsh (1978) found that the birth of the identified patient in schizophrenic families correlated with a death in the third (ie. oldest) generation of the family.

Murray Bowen (1978) observed the intergenerational effects of loss in his family therapy practice as early as the 1950's, and has described these effects as an "emotional shock wave" which frequently follows the death of a significant family member. He describes the shock wave as a network of underground aftershocks, which can occur anywhere in the extended family system in the months or years following the event. The crucial factor in triggering this shock wave after a death, says Bowen, is the family's denial of emotional dependence on the deceased and on one another.

Aftershocks can include a wide variety of physical, emotional and social dysfunctions, which, unless viewed in the context of the multi-generational family system, tend to be treated as isolated, unrelated events. Bowen argues that if the therapist is aware of the type of family that is usually at risk in bereavement, steps can be taken towards prevention of an emotional shock wave. Bowen uses a 'genogram' to chart the generations of a family, and to become alert to connections between births or deaths and the onset of family problems or symptoms. Paul and Paul (1982) and Bradt (1980) have also advocated the use of a 'family tree' or family 'map' for this purpose.

D) The Family Life Cycle

Whether an unhealthy mourning pattern develops and is, in Lieberman's words, "perpetuated through transgenerational passage," (Lieberman 1979, p. 59), is dependent not only upon the family's openness, communication, instrumental-emotional role system and intergenerational patterns of dealing with loss, but also upon their place in the family life cycle at the time of their loss.

Haley has observed that "symptoms appear when there is a dislocation or interruption in the unfolding life cycle of a family... The symptom is a signal that a family has difficulty in getting past a stage in the life cycle." (Haley 1973). A 1974 clinical study conducted by Trevor Hadley and his colleagues at the University of Pittsburgh supports Haley's observation. Hadley and his coworkers studied symptom onset in 90 families and found a strong positive correlation between family developmental crises of loss and symptom onset in one or more members of a family. (Hadley, Jacob, Milliones, Caplan and Spitz, 1974).

Particular dangers are inherent in loss at each stage of the family life cycle, only some of which can be touched on here. For example, Meyer (1980) has suggested that in the earliest stage of a single family life cycle, wherein the unattached young adult is completing individuation from his/her family of origin and forming a relationship that will be the foundation of a new family, the loss of grandparents can be a significant event. For instance, parents of the young adult may find their feelings about his or her departure exacerbated by their feelings of loss relating to their own deceased parent(s). Separation and individuation of the young adult may, as a

result, be thwarted by the parents, or by the young adult's own feelings of guilt/responsibility towards his or her parents.

Meyer notes that the more mature the parents, the less likely will their feelings be allowed to interfere with the individuation of their offspring. One might also add that the healthier the pattern of mourning 'inherited' by the parents, the more likely they can resolve their feelings of loss and separation in relation to both the older and younger generation.

In the next stage of the family life cycle, that of the new couple, McGoldrick (1980) notes that marital adjustment may be particularly difficult if the couple has met or married shortly after a significant loss. Paul and Paul (1982) cite a case of a husband and wife who enjoyed a reasonably good sexual relationship until the death of the wife's mother. In her inability to resolve her feelings about the loss, the wife shut herself off sexually from her husband. The change in their relationship eventually affected the rest of the family system, and the situation lasted several years before therapy uncovered the loss issue.

Froma Walsh (1980) has suggested that when death occurs in the young family, it is an "off-time" event, and therefore most likely to disrupt the family life cycle and trigger maladaptive/dysfunctional coping behaviors. Herz (1980) concurs, citing the 20 year period in which children grow to maturity as the critical period of the family life cycle in which death has its greatest impact. The loss of a young parent can have deleterious effects on the development of the children in the family, and on the integrity of the family unit as a whole. In addition, this period is critical because the way in which

young parents deal with loss of their own parents, of a spouse, or of a child serves as a model for how losses and separations will be dealt with in the future.

Loss of a child can be particularly stressful on the marital relationship, and can have disastrous effects on family life as a whole. Schiff (1977) notes that within months after the death of a child, as many as 90 percent of all bereaved couples are in serious marital difficulty, and that separation and divorce frequently follow. (See also Tietz, McSherry and Britt, 1977).

In some instances, loss of a child in the young family is followed by attempts to have another child - often seen as a "replacement". This situation can impede completion of mourning for the lost child, and places an unrealistic burden on the new child.

The family whose children are in the stage of adolescence is also at considerable risk after the death of a parent. The normal conflicts of adolescence often may not have been fully worked out with the parent before his or her death, and much related and unresolved anger may surface in the relationship with the remaining parent. A 1966 study by Eva Deyken and her colleagues found overt conflict between mothers and their adolescent children to be positively related to the death of the spouse. The women studied by Deyken had all been hospitalized for depression after trying to cope with their loss and with subsequent conflicts with their teenagers. (Deyken et al 1966).

As children in the family move into adulthood, death of a parent is less likely to have the impact of an "off-time" event, par-

ticularly if the young adult children have largely individuated themselves from their parent(s). The older the parent, the more likely his or her death will be experienced by the family system as a natural, inevitable (but sad) developmental event. However, for both adult children and their parents, a new risk arises - that is, that problems relating to one's family of origin may not get worked through before the death of one's parents. Bowen (1978) has observed in his practice that enabling adults to resolve conflicts relating to their family of origin becomes extremely difficult after the death of both parents.

Notwithstanding the difficulty, therapeutic techniques have evolved to enable adult mourners to 'act out' the unfinished business in therapy, in order that they may relinquish their hold on the dead parent(s) and complete the process of reorganization in their individual and family life. These techniques will be reviewed in Chapter Three.

II Implications for Intervention

Some important conclusions regarding the bereaved family may be drawn from the literature, conclusions which have implications for intervention. First, the mourning processes of the individual and family are closely intertwined and mutually dependent at all stages of the life cycle. As such, it would seem that the grief tasks facing the individual and the family, though often treated separately in the literature, in fact must be accomplished in some sort of harmony if the overall family system is to achieve re-equilibration after the loss of one of its members.

Attempts have been made in the literature to link individual and family mourning tasks (Goldberg 1973, Worden 1982), but perhaps the tasks may be restated in a way that suggests both a natural order and an increasing complexity in the grief work facing a family system. The tasks, as they are outlined below, often overlap in reality, and work may proceed on several tasks at the same time. Nonetheless, each step or task is to some degree dependent upon the partial fulfillment of the step or task preceding it:

1) each individual must be able to begin his or her own grief work, including expression of any sadness, hatred, anger, relief, guilt, fear and/or confusion associated with the loss.
2) individual mourning must be allowed to occur in the midst of the family.
3) family members must be able to share their collective sense of loss with one another (ie., how their loss affects their sense of family).
4) the family must relinquish the deceased as a force in family activities, and must begin to realize they are a newly consti -

tuted family unit with an altered set of needs and resources.

5) the family must realign intrafamilial and extrafamilial roles accordingly, so that current instrumental, developmental and socio-emotional needs are met and can continue to be met.

There is growing consensus in the literature that preventive intervention with the family is indicated where the family is at risk of experiencing difficulty in accomplishing any of these expressive or reorganizational tasks (eg., if a family is lacking in social supports, or if death was sudden or unexpected or untimely). (Williams, Polak and Vollman 1972; Caroff and Dobrof 1975; Cameron and Brings 1980).

In addition, there is considerable agreement that intervention with the family is indicated at any time during the bereavement period if evidence of difficulty with expressive or reorganizational tasks appears (eg. intrafamilial conflict, new or reactivated problems such as alcoholism or depression in individual members, or inability of the family to meet its own instrumental needs). (Pincus 1974, Gerber et al 1975, Bowen 1978, Worden 1982).

The literature offers several clear guidelines for the intervening professional:

1) Whether it is clear that the family is having difficulty dealing with a death, or whether they have presented with problems seemingly unrelated to loss, completing a genogram or family tree with the family can help bring loss issues into focus. (Bowen 1980, Bradt 1980, Paul and Paul 1982). Briefly asking about the dates and circumstances of deaths in previous generations of the family can be a non-threatening way to assess their 'comfort level' with the subjects of loss and death.

2) Intervention with the bereaved family must be ordered and focused in relation to where the family is 'stuck' in negotiating its way to the new life stage that bereavement has decreed:

a) Generally acknowledged is the need to begin by assessing the family's ability to share their feelings about the loss. The therapist should ensure that where it has not already occurred, the expressive mourning work of each individual family member is facilitated in a family setting. Feelings of loss, sadness, anger, relief, guilt, fear and confusion may have to be dealt with. Release of these emotions can assist individual decathexis, and can be an important step in opening up a closed family communication system or in preserving the existing openness in a family's communication patterns. In addition, sharing of expressive mourning tasks encourages the interaction and interdependence that is necessary to the healthy functioning of a system.

b) As family members talk (or resist talking) about the deceased and their feelings for him/her, it is possible to begin to identify the family's structure and role system, both in terms of the deceased member's place and function in the original system, and in terms of the family's post-death reorganization. Issues of 'unfinished business' may emerge (such as an unresolved conflict between one family member and the deceased), and some of the reorganizational tasks facing the family may come into focus. (Worden 1982).

c) If the family has been able to address the expressive tasks of mourning (and perhaps begun to deal with any unfinished business), intervention can begin to assist the family to realign and communicate in ways that will allow it to accomplish unmet instrumental, develop-

mental and socio-emotional tasks. (Gerber 1969, Goldberg 1973, Worden 1982).

In two studies by Gerber (1969 and 1975), this phase of intervention has entailed organizing the resources of friends, relatives and doctors, and has involved problem-solving in areas of employment, offspring's school problems, financial problems, household chores and legal affairs. Similarly, the Fort Logan Mental Health team in Denver (Vollman et al 1971, Williams et al 1972) has used what may be characterized as a network approach by mobilizing the family's natural support system (minister, mother-in-law, babysitter, doctor, neighbour, etc.) to help the family reorganize and make decisions.

Within the family, it may be necessary to help alter alliances, role assignments and the division of tasks where they are the source of tension and distress or conflict. (Worden 1982).

d) Finally, it may become apparent at any stage of the intervention that a previous loss experience is interfering with the mourning work of one or more family members, or that the present loss is presenting particular difficulty for one or more family members. Worden (1982) urges that where possible such issues be dealt with in the family setting, even if the difficulty appears to reside with only one family member. He recommends the use of techniques such as Paul and Grosser's "operational mourning" in conjoint family therapy, as a way to open up the family's emotional system and as a way to break the influence of a dysfunctional intergenerational mourning pattern.

A fuller discussion of intervention approaches such as operational mourning, and of grief assessment devices currently in use will be presented in Chapter Three.

CHAPTER THREE

INTERVENTION APPROACHES

I Instruments for Assessing Bereavement Adjustment

Scales, inventories and indexes for assessing family adjustment to loss are in fairly short supply. Since the emphasis in research and practice has been, until very recently, on individual mourning, instruments measuring grief or adjustment to loss have tended to focus on symptoms of individual physical and psychological health, and have paid little attention to the family or social context in which those symptoms occur. Where the use of such individually-oriented instruments has been supplemented by some attempt to gather family information, it has often been for the purpose of establishing a demographic profile of study subjects.

For example, an instrument used in early bereavement research and practice was a symptom inventory designed by Cassidy and associates to evaluate depression. (Cassidy, Flanagan, Spellman and Cohen, 1957). Paula Clayton and her colleagues employed the inventory in their 1963 study of normal bereavement in St. Louis, and determined that depressed mood, sleep disturbance and crying were the most common symptoms of a reactive depression in the 30 bereaved individuals they studied. (Clayton, Desmarais and Winokur, 1968). In an effort to examine possible relationships between these depression symptoms and other factors in the bereavement situation, the symptoms were analyzed in relation to sex, age, length of the deceased's illness and relation to the deceased.

Consistent with the individually-oriented perspective on grief and mourning prevalent at that time, no information was gathered, either through use of the depression measure or through accompanying demographic questions, that would allow any perspective on the possible relationship between bereavement symptoms and the family or social context in which they occured.

As attention began to shift to the interactional or social context of individual functioning, however, thanatological research and practice began to make use of newer measures which would allow a broader understanding of grief and loss reactions. For example, the Heimler Scale of Social Functioning, developed in 1967, has had application in studies of both terminally ill patients (Allison 1980) and survivors of loss (Scruby 1984). The Heimler Scale gathers information from an individual in several categories, including work, finances, friends, family, energy, health, personal influence, moods, habits and outlook on life. Although its questions on friends, social contacts and family are few and limited in scope, use of the scale in bereavement research does reflect the growing awareness of the need to consider the wider social setting in which loss occurs.

Bereavement research and practice have continued to make use of individually-oriented instruments such as the Goldberg General Health Questionnaire (Goldberg 1972), but an increasing emphasis has been placed on gathering supplementary demographic information which will allow results to be understood in relation to family and social factors in the bereavement situation. For example, the Goldberg Questionnaire, a 30-item measure of an individual's psychological state designed to identify non-psychotic psychiatric illness, was used in a recent Toronto study to compare the psychological health of high-risk widows who received peer

support with those who did not. Mary Vachon and her colleagues, the designers of the study, found that of the 162 widows studied, psychological health was greater in those who had received peer support during bereavement than in those who had not. (Vachon, Lyall, Rogers, Freedman and Freeman, 1980).

Other individually-oriented measures such as the self-report Grief Experience Inventory (Sanders, Mauger and Strong, 1980), and Raymond Carey's self-report measure of adjustment-depression (Carey 1979), have been used to examine individual adjustment in relation to family and/or social factors in the bereavement situation. Carey, for example, analyzed the self-reports of 78 widows and 41 widowers in his 1979 study and found that widowed persons who lived alone were better adjusted than those with dependent children, who in turn were better adjusted than those who lived with independent children. (Carey 1979).

In spite of the broader application of individually-oriented measures in recent bereavement research and practice, and in spite of the growing awareness of the interdependence of individual and family mourning, there is currently a lack of tools for assessing intrafamilial and social factors operative in bereavement adjustment. A few attempts have been made to meet the need for this type of measure, such as at the Boulder County Hospice, where a "Support Systems Assessment" form has been devised for use with survivors of loss. (Walker and Lattanzi 1982). However, considerable room remains for the development of family-oriented assessment devices.

For this practicum, an assessment tool appropriate for use with bereaved families was devised by adapting an existing family assessment instrument. (See APPENDIX II). The Morrison Center Family Concern Form

(Morrison Center, 1983), a 24-item self-report measure designed to be completed by all members of a family aged ten or older, was revised to include items specifically pertaining to individual and family reactions to loss. The revised form allows family members to indicate their satisfaction with instrumental and affective communication in the family, allocation of tasks, decision-making and openness to social supports. It also allows them to indicate their own personal sense of well-being and level of coping in relation to their loss.

In spite of a present lack of assessment devices suitable for use with bereaved families, the literature does offer a wide variety of intervention techniques and models appropriate for work with the mourning family. A sample of these will be reviewed the the following section.

II Treatment Techniques and Models

Whether intervention is preventive or remedial, whether it occurs early or late in the bereavement process, virtually all approaches described in the literature are based on Lindemann's principles of grief management. Lindemann sees the essential task facing the therapist to be that of sharing the mourner's grief work, specifically:

> to assist him to review his relationships with the deceased, to become acquainted with the alterations in his own modes of emotional reaction. His fear of insanity, his fear of accepting the surprising changes in his feelings, especially the overflow of hostility, have to be worked through. He will have to express his sorrow and sense of loss. He will have to find an acceptable formulation of his future relationship to the deceased. He will have to verbalize his feelings of guilt, and he will have to find persons around him whom he can use as "primers" for the acquisition of new patterns of conduct.
>
> (Lindemann 1944, p. 147).

Lindemann's guidelines for grief therapy have been adapted for use with children, adolescents and adults, and they form the basis of a variety of individually- and family-oriented interventions, be they crisis-oriented, short-term or long-term. A selection of these are reviewed below.

A) Techniques and Models for Working with Individuals

i) Children

Like adults, children need to be able to review what they know about the death of a person who has been close to them, they need to be able to express their feelings about the loss, and they need to be able to reinvest in new relationships. In addition, they have three very unique and specific needs - namely, they need help in understanding the irreversibility of their loss, they need reassurance that they are not in any way responsible for the loss, and they need help to recognize that resources exist both within themselves and within their environment that will facilitate their survival and continued growth.

One of the most basic and yet perhaps one of the most important approaches to meeting the needs of the bereaved child is to facilitate the mourning work of the adults around the child, and to guide those adults (particularly parent figures) to share their child's mourning process. (Kliman 1979). This is an approach that promotes openness within the family communication system, and as such it is both remedial and preventive - it addresses a child's immediate needs, it strengthens the parent-child relationship, and it facilitates the decathexis that is so important if a child is ever to accept the possibility of a surviving parent's remarriage. Becker and Margolin recommend that parents encourage their children to participate in religious and/or memorial

observations of a death, such as the funeral, the unveiling of a tombstone, or a visit to the cemetery on a deceased parent's birthday or anniversary of death. (Becker and Margolin 1967). Fassler (1978) recommends that parents help their children cope with a loss through the use of age-appropriate storybooks on death-related themes.

Where support and facilitation cannot be rendered by a child's care-givers or close family, or where such support and facilitation have been ineffective in reducing a child's fears, anxieties, sleeplessness, etc., an intervening social worker may draw upon several therapeutic techniques to promote mourning. One example is Gardner's "Mutual Storytelling Technique", a mode of therapeutic communication with children. (Gardner 1971). In this method, the child and therapist play a game in which the child makes up a story and explains the moral or lesson of the story. The therapist responds with a story, using the characters and situation invented by the child, but re-telling the story from a healthy perspective. The new story suggests the strengths of the characters, as well as the behaviors and coping responses they might appropriately employ in the situations invented by the child. Gardner has used this technique to help children cope with death, and though he cautions that it is a difficult technique to learn, he does recommend it as a particularly useful way of working with latency-age children.

Several other techniques appropriate for facilitating childhood mourning are suggested by Lois Greenberg, a psychiatric social worker who has treated bereaved children at the South Hills Child Guidance Center in Pittsburgh. (Greenberg 1975). As one example, Greenberg relates how she has 'modeled' the burial process for an angry child who had not been allowed to attend his father's funeral. Spontaneously fashioning a tiny

coffin out of clay and burying something in it, Greenberg then watched as the boy re-enacted the ceremony several times. The symbolic burial triggered a discussion of death, resurrection, and how children feel when a parent dies.

Greenberg has also used stories, games, drawings and diagrams, pets, puppet play, a sentence completion test, and a trip to the cemetery as part of her approach to bereaved children. Greenberg has encouraged children to review the past in which their deceased parent or sibling played such an important part, and has helped children preserve a part of that past while at the same time encouraging them to be future-oriented. For example, one child's memories of trimming the Christmas tree led the child to begin her own collection of ornaments, a way in which she could preserve a tradition that she associated with her deceased mother and brothers, but which encouraged her to look forward to successive Christmases.

ii) Adults

A staggering array of intervention approaches and techniques have been devised to facilitate adult mourning. Only a sample of these can be reviewed here.

There are a variety of what may be called "generic" approaches, all based on Lindemann's model. Simos (1977), Arkin (1981) and Worden (1982) have outlined straightforward interventions which involve the counseling tasks and the advocacy or coordinating functions specified by Lindemann. (These are the tasks and functions ranging from encouraging expressive mourning work to helping the mourner establish new patterns of conduct). Simos, Arkin and Worden pay attention to the social context of a loss in that they point out that the grief counselor should be prepared to help

the mourner get assistance with medical, child care, legal, financial and housing problems. There are some differences, however, in the extent to which they feel a grief counselor should be concerned about the family of an adult mourner. Other than mentioning child care, Arkin's only other reference to family is that "it is hoped therapeutic influences will filter through to those dependent upon (the adult)." (Arkin 1981, p. 41). Worden, on the other hand, feels it is crucial that a therapist assess and promote the mourning work of an individual in relation to that of the rest of the family.

Although Lindemann suggested that adult mourning can be facilitated in eight to ten sessions over a four to six week period, there is some variation in the time-frame employed by the generic approaches based on his work. Arkin suggests only that the helper should be aware that acute grief lasts from one to two months and generally recedes by six months. Worden likewise suggests that the counselor be flexible in fitting the time-frame of counseling to the needs of the individual(s) involved. Simos, on the other hand, points out that straightforward grief counseling may be finished in fifteen sessions, or if "a simple grief reaction has tentacles to complex underlying problems," (p. 342), intervention may take considerably longer. In such situations, specialized intervention techniques may be needed, including those designed to promote complicated mourning and/or those designed for other psychological and behavioral problems.

One intervention approach which promotes individual mourning through mobilization of network or peer support is the Widow-to-Widow program developed by Phyllis Silverman at Harvard Medical School (Silverman 1968, 1975). In this type of program, the role of the intervening worker is to

put a newly-widowed woman in touch with another widow, in order that she may have friendship and help during the critical period immediately after the death of her husband. This type of intervention is seen as most effective in situations where the bereaved person is not severely stressed and in need of intensive treatment (Walker, MacBride and Vachon 1977), and it may be seen as being particularly appropriate for the widow who lacks family supports. However, where family supports can be mobilized, the peer support approach may be best considered as a backup or supplementary intervention, not as a substitute.

A behavioral model for handling adult grief, one which has been designed to be used by care-givers from all disciplines, is the BASIC model developed by Proulx and Baker (1981). BASIC is an acronym referring to behavior, affect, sensation, imagery and cognition, and Proulx and Baker suggest that exploration of all these components of the mourning experience with the mourner will help her/him to accomplish grief tasks. Specifically, they point out that by quantifying frequency, intensity and duration of specific behaviors, affects, sensations, mental images and cognitions in the mourning process, problems and goals can be specified, treatment techniques can be addressed to particular problems or goals, and ongoing evaluation of the effectiveness of treatment is made possible.

In describing the BASIC approach to grief intervention, Proulx and Baker do not discuss what is perhaps the most important element in the successful application of this or any other model to human grief - the attributes, attitude and interactive qualities of the therapist. It has been emphasized in the literature that the most important element of any grief intervention is empathic communication, and so while grief inter-

vention might be made more focused and specific with the application of a behavioral model such as BASIC, it should be noted that the success of the model is still likely to be very much determined by the warmth and empathy with which it is administered.

Another approach to grief intervention which should perhaps be subject to some of the same considerations is an interactionist model developed by Tamara Ferguson and her colleagues (Ferguson, Schorer, Tourney and Ferguson 1981). Called "Rescaling Therapy", this intervention is designed to evaluate the biopsychosocial effects of the stress of bereavement, and has been used to help widows identify current imbalances in their lives between expectations and performance. Sixteen specific areas of the widow's life are assessed, ranging from food and shelter through health and social life to finance and religion. After imbalances have been identified, the intervening worker assists the widow to find ways to correct them by changing expectations and/or performances. Ferguson and her associates have tested the approach on 100 women and have found it to be useful where bereavement has occurred as recently as four months or as long ago as five years.

Finally, some specialized psychotherapeutic approaches have been designed to facilitate adult mourning which has been delayed, avoided, or which is otherwise incomplete. These approaches may be used by highly skilled practitioners in situations where simple grief counseling, group and/or peer support interventions are ineffective in promoting adjustment to loss.

Psychodrama is one such treatment approach which allows a survivor to confront troubling aspects of his or her loss and play out possible resolutions. Nolte, Smallwood and Weistart (1975) describe the psycho-

dramatic resolution of a loss which was experienced by a young woman whose father had died unexpectedly six months earlier. The young woman, angry at God, and full of guilt about the unfinished business that remained after her father's death, was asked to play the role of God in a psychodrama. Through the experience, she came to realize that God had not engineered her father's death, and that even though her father was gone, she could still take steps to resolve the unfinished business between them. She wrote a letter to her father, apologizing for the ways she had let him down, identifying the things she had learned from him, and stating her new intention to live free of their past conflicts. The chance to 'stand in God's place', followed by the act of putting on paper her pent-up emotions, enabled her to reach a new peace. She was able to relinquish her father, but still cherish happy memories of him, and she began to get on with her own life.

A variety of other psychodramatic techniques have been developed for use in unfinished mourning, all of them geared to enable the mourner to play out and talk out the unfinished business which prevents them from letting go of the deceased. (See Abraham 1972, Weiner 1975).

Two slightly more conventional psychotherapeutic appraoches to unresolved loss are Volkan's 're-grief therapy' (Volkan 1966, 1975), and Switzer's 'intensive crisis therapy' (Switzer 1972). In 're-grief', mourning is induced (or re-induced) as a step toward breaking pathological identification and denial patterns in bereaved adults. The mourner is helped to bring forward his or her memories of the deceased and of the experiences s/he shared with the deceased, to test them against reality (ie., to put them in perspective, especially where the memory of the deceased has been idealized or bastardized), to express affect, to accept

what has happened and to become free from bondage to the dead. Volkan describes re-griefing as a short-term intensive therapy, one which is effective when the mourner can be seen as often as four times per week over a four to six week period.

Switzer's intensive crisis therapy is an approach useful with the survivor who is resistant to mourning. In this approach, the therapist uses confrontation and insistent questioning to force the mourner to review his or her relationship with the deceased. Using this technique, Switzer has been able to break through a mourner's resistance and take them through the review and expressive tasks in six sessions. In addition, he uses the termination process of therapy as an opportunity to model or rehearse the handling of separation and loss. Through termination, the client has opportunity to test out his/her newly acquired separation skills, as a way of consolidating the gains of therapy.

B) Techniques and Models for Working with Families

As with the techniques and models designed for intervention with individuals, those designed for family interventions are virtually all based on Lindemann's guidelines. As well, many are based on Gerald Caplan's principles of crisis management. (Caplan 1964).

Perhaps the best example in the literature of a crisis-oriented family intervention is that devised at the Fort Logan Mental Health Center in Denver (Vollman et al 1971, Williams et al 1972, Polak et al 1975). In this approach, families are contacted within 12 hours after the death of one of their members, and those wishing to receive service are seen for two to six sessions over a period of one to ten weeks. The total family or social system is involved in treatment, with the aim of the intervention being to increase the effectiveness of the family in coping with

feelings, decisions and subsequent adjustment related to the death. The clinician acts less as a professional and more as a natural resource person to the family system. He or she works in the background of the system as much as possible, connecting family members with relatives and other supportive members of their network, facilitating their coping abilities and encouraging their shared mourning and adjustment. Their grief work is promoted, but in a way that allows them to recognize and use their own emotional resources, and in a way that is likely to make them less needy of professional intervention in subsequent life crises.

A somewhat similar intervention designed for the aged bereaved is that outlined by Gerber and his colleagues (Gerber et al 1975). Based on Gerber's earlier family-oriented bereavement service at Montefiore Hospital in New York (Gerber 1969), the Gerber approach involves a therapy component, in which a psychiatric social worker or nurse assists the mourner to accomplish the tasks described by Lindemann. As well, practical aid is rendered in several ways. For example, suitable friends and relatives are organized to provide on-going support to the bereaved, assistance is given in dealing with legal, financial and household matters, and help is provided with planning for the future. This intervention was designed to be accomplished through approximately four interviews spaced over a six month period.

Where mourning has not been accomplished in a way that allows a family to function well, family therapy may be appropriate. Jensen and Wallace (1967) have developed a short-term approach in which a family can be seen on a conjoint basis, or in which individual members of the family can be seen concurrently. Using Lindemann's and Caplan's guidelines, they will hold an initial assessment interview with the whole family,

and, if there is an identified patient or one member of the family whose mourning is problematic, they will hold several subsequent sessions only with that individual. When grief work has been initiated (or re-initiated) with that individual, the family is then seen together so that mourning and/or work on an identified problem may be accomplished with the whole family system. Therapy has generally involved a dozen sessions over a four to six month period.

A technique for use with families in whom mourning has not been accomplished has been developed by Paul and Grosser (1965). Called "operational mourning", this technique is designed to involve the family in a belated mourning experience with extensive grief reactions. Paul and Grosser describe the technique as follows:

> Mourning is induced by a directed inquiry into the reactions of family members to specific losses. The therapist, through repeated review of recollected details surrounding these losses, invites the expression of feelings of the member directly involved. The other family members are then invited to review such feelings as are stimulated through witnessing the grief reaction. This technique is designed to permit children, often for the first time, to observe the expression of these intense feelings by their parents. This can provide a powerful empathic experience. The patient and other members can kaleidoscopically obtain a sense of affective continuity; the therapist can assure them that the revealed feelings are normal...and revelation of previously unknown "family secrets" can be achieved.
>
> (Paul and Grosser 1965, p. 341)

While not a technique for the beginning therapist, operational mourning can be a valuable tool in opening a closed family communication system, and it can be a powerful way to break a dysfunctional intergenerational mourning pattern.

* * *

The literature reviewed in the foregoing three chapters suggests the complexity and variation in human response to loss. It also indicates the range of approaches and techniques which a systems-oriented social worker can draw upon in helping bereaved individuals and families. On the knowledge base provided by that literature, the practicum described in the following section was designed.

SECTION TWO

THE PRACTICUM

CHAPTER FOUR

DESIGN OF THE PRACTICUM

I Introduction and Purpose

Though there is some debate in the literature regarding the degree of physical and psychological risk and vulnerability present in bereavement, several recent studies have demonstrated that the bereaved are a population with a higher susceptibility to morbidity and mortality than the general population. (Rees and Lutkins 1967; Maddison and Viola 1968; Parkes and Brown 1972; Glick, Weiss and Parkes 1974; Frederick 1971, 1981).

Several programs aimed at alleviating morbidity and mortality among the bereaved have appeared to favorably influence bereavement outcome. (Silverman 1968, 1975; Gerber et al 1975; Raphael 1977; Barrett 1978; Vachon et al 1980). In many of these programs, social workers have played key roles as counselors, therapists, coordinators, advocates and resource persons to bring about individual and family coping and adaptation.

At the present time, however, bereavement follow-up, whether by social workers or other mental health professionals, is not a standard or automatic part of service delivery in the Canadian health care system. Bereavement counseling is only offered as an automatic part of health care in a few settings, such as at the Royal Victoria Hospital in Montreal, where it is an extension of a palliative care program. (See Royal Victoria Hospital 1977, and Ajemian and Mount 1980). In many health care settings the importance of bereavement follow-up is recognized, but lack of funding for bereavement programming and staff means that it is left to the

discretion of already over-burdened social work and pastoral care staff.

On the basis of 1) growing evidence of the vulnerability of the bereaved to morbidity and mortality 2) the effectiveness of social work activities in alleviating morbidity and mortality in a number of experimental bereavement follow-up programs 3) the lack of adequate bereavement follow-up in the present health care system and 4) the inter-relationship between individuals and their families as a factor in bereavement adjustment, the following social work practicum was designed to offer counseling to bereaved families who were at risk of an unfavorable outcome. In addition, the practicum was designed as a personal opportunity to develop further skills in family intervention and to explore the role of social work in the bereavement situation.

II The Setting

The St. Boniface General Hospital was chosen as a setting for the practicum for several reasons. First, the St. Boniface is one of the few hospitals in Manitoba to have a well-developed palliative care program for terminally ill patients and their families. In operation since 1974, the service provides total physical care through both an in-hospital and home-care program. In addition, an inter-disciplinary team provides emotional support, counseling and spiritual care to both patients and their families. Social work staff have played a strong role in the provision of this psychosocial care, and have been active in maintaining a post-death connection with families through written and telephone contacts, a social evening and a short-term bereavement group. These factors pointed to both a family orientation in social work practice delivery, and to an awareness of the importance of bereavement follow-up.

At the same time however, the scope and depth of follow-up services provided to bereaved families appeared to be limited by existing resources, and it seemed likely that the Department of Social Work would be supportive of a practicum designed to provide additional service in this area.

In addition to those factors, the fact that the St. Boniface is a general hospital was ultimately of some importance in its selection as a practicum setting. Because the hospital has medical and surgical wards for children and adults in addition to its palliative care service, it was possible to offer service to families who were at different stages of the life cycle and whose loss experience did not necessarily occur in the context of a palliative care ward.

In terms of the hospital as a physical setting for working with bereaved families, a few facts should be noted. For example, it quickly

became apparent that many families were loathe to return to the hospital for any reason after they had lost a family member there. In many cases, home visits were the only condition under which families would accept service. However, for families who were able to return to the hospital for interviews, the building itself proved to be a comfortable and convenient setting in which to meet. The social work lounge on the main floor provided a relaxed and private atmosphere in which interviews could be conducted (which could not always be said of clients' homes), and the hospital's playroom proved to be an invaluable source of toys and props for interviews with children.

III The Clients

A) Selection

Several procedures were involved in obtaining an adequate client population for the practicum. As a first step, it was decided to send a letter offering follow-up service to families who had lost a family member on the palliative care unit within the previous nine months. (See letter in APPENDIX I). These families were ones identified as being 'at-risk' on the basis of the ward's death review notes. (The death review notes detail the family's preparedness for the death, their response at the time of death, and the factors, if any, which may impede their bereavement adjustment). Twenty-four families were selected to receive the letter, which was mailed in January 1984. Of these, two families responded and requested service. The remaining twenty-two received follow-up telephone calls to ensure that they had received the letter, and two additional families who did not receive letters were also called.

These calls were important in several ways. First, to many who received them, they were further evidence of the palliative care ward's support for, and interest in them. Second, the calls offered further opportunity for assessment of a family's adjustment and provided another opening for families who might want help, but be reticent about asking for it, to make their needs known. Third, many people remarked that the calls provided an opportunity for them to talk about their loss to someone outside the family, even though they did not at the present time feel they needed help in dealing with the loss.

The counseling service offered in the practicum was then initiated with the two families who had responded, and with an additional family

who had been referred indirectly by the ward. Further follow-up telephone calls were made to some families who had requested continuing contact when they were originally telephoned in January. When none of these families proved to be in need of service by March, a second round of letters was sent to twelve new families who had been identified as being at risk. Of these, two families requested service when follow-up telephone calls were made.

Counseling began with these families, and, as with the first group of families who had received letters, follow-up telephone contact was maintained with some families in the second group who wished to be followed, but in an 'arms-length' fashion.

By April, when none of these families wanted more extensive service, a request was made to the Department of Social Work for referrals from social workers on other wards in the hospital who were aware of families needing bereavement follow-up. All of the four families referred were contacted, and two of these requested service.

B) Description of the Client Population

The telephone 'caseload' in this practicum consisted of bereaved individuals in a wide variety of circumstances. These individuals ranged from a young mother with a pre-school child, through middle-aged widows, widowers and bereaved adult children, to elderly widowed spouses. All had been bereaved within the previous year, but a few had also suffered earlier losses of other family members. Some of the middle-aged individuals were employed, although many of them and all the elderly survivors were not working. The majority were city dwellers, although a few individuals lived in rural areas. Most had at least one surviving family member or relative, and several had large families and/or one or more long-

time friends.

The seven families who received in-person bereavement counseling had widely varying demographic characteristics. They may be summarized as follows:

1) Ages and Life Stages
   - widowed mid-30's mother with pre-school child
   - widowed mid-30's father with both a widowed mother and an 8 year old child
   - widowed late 30's man with independent step-children
   - mid-30's woman, bereaved of both parents, married and mother of children aged 8 and 11
   - widowed middle-aged father with two teenagers
   - widowed middle-aged woman with grown children
   - elderly woman, bereaved of brother, married with no children.
2) Recency of Bereavement at time of Initial Contact
   - three weeks, six weeks, eight weeks, ten weeks, three months, four months and nine months.
3) Economic Status
   - three families were in comfortable middle-class circumstances
   - one family was on a fixed income (pension)
   - one family had been on welfare, but were attempting to live on death benefits
   - one family was working class, supported by a single wage earner
   - one family was on social assistance.

4) Type of Community Lived In

- one family lived in a rural neighbourhood
- five families lived in Winnipeg suburbs
- one family lived in the core area.

5) Religion

- five families attended a Protestant church, some regularly, some occasionally or rarely
- one family was Muslim
- one family had no formal religion.

6) Ethnicity

- all families were Caucasian, of German, French or Anglo origin, and all family members spoke English.

7) Special Characteristics

- alcoholism was present in two families.

IV The Intervention

A) By Telephone

Intervention with those families who were followed only by telephone was of a supportive nature. These individuals were given an opportunity to talk about the illness and death of their family member, and about the changes that had been wrought in their lives by their loss. They were asked about their physical and emotional reactions and they were given information about the mourning process. They were questioned about their coping methods, and were given suggestions about ways to strengthen these. They were assisted to identify sources of support (relatives, friends, neighbours, church, etc.) and were encouraged to draw upon these. Finally, they were offered further in-person assistance should they feel in need of it.

B) In-Person

The intervention with families who requested in-person counseling was designed to address the successive mourning and reorganization tasks described in the literature. As such, it proceeded through four major phases:

1) problem-definition and contracting
2) assessment and therapy focusing on expressive mourning tasks (based on the guidelines defined by Lindemann and Worden)
3) assessment and therapy focusing on problem(s)/symptom(s) related to reorganization (based on communication, structural and problem-solving approaches of Satir (1983), Minuchin (1974) and Haley (1976), and on the network approach described by Walker, MacBride and Vachon (1977))
4) termination and evaluation.

Though these phases may be considered as discrete for purposes of discussion, in reality they were often overlapping. In addition, though intervention with each family generally proceeded in the order suggested above, it was not uncommon to 'jump ahead' when a crisis arose, or to 'backtrack' when a problem needed to be re-defined (especially after expressive mourning changed a family's perspective on a problem). As well, expressive mourning work itself tended to continue throughout the intervention, regardless of what point the intervention had reached.

Notwithstanding those facts, the general phases of the intervention may be described as follows:

1) Problem-Definition and Contracting

Initial problem-definition began with most families during the first telephone contact. (Generally, where the family included dependent children, the children were initially identified by the parent(s) as the chief concern. In families without children, excessive guilt, sadness or loneliness, as well as economic and instrumental worries were identified as concerns).

An initial interview was arranged to discuss these concerns, to clarify what other problems the family might be experiencing in their adjustment to loss, and to outline the type of assistance that could be offered in relation to the family's needs.

Frequently at the first interview, the simple fact that a sympathetic listener was paying attention to a family member's concerns was enough to trigger expressive mourning. Often there was an urgent need on the part of some mourners to talk about the illness of the deceased, circumstances of the death, and the funeral. This was encouraged whenever it occurred, as it was in and of itself a goal of therapy. In addition,

however, it generally provided an excellent opportunity to begin to assess the family's coping skills and their definition of the problems facing them. (For example, in at least one situation where a child in the family had initially been identified as the chief concern or problem, it became apparent that the adult's own ability to successfully carry on was in fact the major worry facing him).

At an appropriate point in the first interview, or in some cases not until the second interview, some general contracting occurred in relation to the focus and length of the intervention. The following items were generally agreed upon:

- as appropriate, interviews might include both individual and conjoint sessions.
- interviews could be held either in the family's home, or in the hospital, as the family preferred.
- interviews would generally be no less than one hour, but in many cases (especially when the focus was on expressive mourning), could last one-and-a-half or more hours.
- family members might be requested to sign a consent form in order that therapy sessions might be audio- or video-taped.
- the number of family interviews to be held would generally be not less than three and not more than twelve, and might be held weekly, bi-weekly, or as convenient.
- all members of a family aged ten or older would be asked to fill out a revised Morrison Center Family Concern form (see APPENDIX II) at the beginning and at the end of therapy. This would enable the therapist and family to focus on family concerns needing attention, to plan and carry out a course of action designed to alleviate

concerns, and to determine what change had been achieved in family concerns after intervention.

2) Assessment and Therapy focused on Expressive Mourning Tasks

i) It has been argued by many family therapists that assessment is an on-going process, one which cannot truly precede intervention, since it is only as the therapist joins and interacts with the family system over time that the most important information about the family can be gathered. (Minuchin 1974, Haley 1976).

Consistent with that view, assessment and therapy were interwoven in this practicum. From the initial meeting with the family, and throughout therapy, the therapist worked to assess the family from a systems point of view while attempting to join and bring about change in that system. This entailed careful assessment of individual functioning, as well as assessment of family communication, affective involvement, boundaries, alliances, parental function and relation to the environment. As weaknesses or dysfunction were revealed, efforts were made to strengthen or realign functioning. In this early stage of the intervention, such efforts were focused mostly on communication, since affective communication was essential to accomplishing intrafamilial mourning.

ii) Consistent with the literature on intervention with the bereaved family, therapy began with an attempt to focus on the family's loss. In situations where there was a presenting problem such as a child's disruptive behavior at daycare, it was briefly explained that it would be important for the therapist to get to know the family, how they saw themselves, and how they were before their loss, in order to work effectively on the presenting problem. (This of course would vary with the nature and urgency of the presenting problem).

Family members were actively encouraged in the expression of their full range of feelings relating to the loss. They were assisted to recall and review memories of the deceased, and to put into perspective their image of the deceased (ie., neither idealized nor bastardized). They were assisted to talk about how their loss had changed their sense of identity as individuals and as a family, and in what ways it had changed their roles in the family and the community. (as per Lindemann 1944, Flesch 1975 and Worden 1982).

It was found to be useful in this stage of therapy to complete a family diagram (Bradt 1980) or genogram (Bowen 1980) as a means of identifying previous loss experiences and their potential role in the family's present attempts to adjust to bereavement. This was generally an exercise which the family enjoyed, as children were able to print names and ages of their family members on the family diagram, and adults found themselves recalling long-forgotten relatives.

This phase of the intervention required as few as two sessions with some families, and as many as six or seven with other families. As work proceeded on expressive mourning tasks, on-going assessment of the family system continued.

As mentioned earlier, expressive mourning work was never 'finished' at any point in time, but after it had been addressed to some extent, family members were generally able to begin to refocus on presenting problems and symptoms, and to redefine those if necessary. At this point, work was able to proceed on family concerns other than those related to expressive mourning.

3) Assessment and Therapy focused on the Presenting Problem/Symptom, Major area of Family Concern, and/or Reorganizational Tasks

This phase of the intervention was based on communication, structural and problem-solving approaches of Satir (1983), Minuchin (1974) and Haley (1976), and on principles of network intervention (similar to those described by Walker, MacBride and Vachon, 1977). As well, the crisis intervention techniques described by Caplan (1964) and Golan (1978) proved to be very useful.

The length and intensity of this phase of the intervention varied considerably from one family to another. In some families two sessions and some follow-up telephone calls were sufficient to accomplish goals. In others, three or four sessions and considerable crisis intervention by telephone were required. In still others, six or seven sessions (individual and conjoint) and sessions with important people in their network (such as a doctor or daycare worker) were needed.

As in the first phase of the intervention, assessment and therapy were interwoven throughout this stage of the intervention. The specifics of helping activities depended upon the specifics of the presenting problem, but generally involved:

- leading the family (and sometimes significant people in the family's network) to discuss the problem, and 're-framing' the problem so that it could be seen as belonging to the family system, not just to one individual. (eg. focusing on a child's 'behavior problem' as a symptom of the family's loss, rather than as evidence of the child's 'badness' or 'uncooperativeness'.)
- providing positive feedback to reinforce healthy transactions and build self-esteem (and as a way of modeling positive communica-

tion in some families where criticism amd conflict characterized interaction).

- correcting unrealistic expectations, whether relating to issues such as how quickly one could 'get the mourning process over with', how a four year old could be expected to behave in certain circumstances, etc.
- making connections between behaviors/symptoms and the family's as-yet incomplete reorganization, as a way of 'normalizing' and providing new perspective on some of those behaviors/symptoms.
- delineating roles and functions appropriate to each family member's age and abilities; structuring tasks which enabled family members to try out specific roles and functions (eg. strengthening a mother in her parenting role by having her spend time at home with her child).
- strengthening weak subsystems in order to allow the family to carry out its roles and responsibilities and meet its own needs (eg. promoting involvement between a father and son as a way of fulfilling their emotional needs and as a way of lightening the caregiving responsibilities of the other adult in the family).
- strengthening links between the family and its social network, and mobilizing social supports as necessary (eg. connecting widows with the YWCA widows' group, linking an elderly couple with community resources, encouraging a reconciliation between a widow and her estranged family of origin).

At the end of this phase of the intervention, the revised Family Concern form was re-administered.

4) Termination and Evaluation

This phase of the intervention was generally accomplished in one or two sessions. The overall level of change in the family's responses to the Family Concern form (ie. between its first and second administration) was discussed with the family. Areas of improvement (based on the family's own comments, on their responses to the form, and on the therapist's observations) were reinforced. Areas of original concern in which no improvement was reflected, or with which family dissatisfaction increased, were discussed with the family. Where further intervention seemed appropriate and was desired by the family, a referral was made.

There was a strong attempt to keep the focus on the family unit when referral was necessary. For example, in one situation both parent and child were referred for further help. The most appropriate form of treatment involved separate therapy for parent and child, but efforts were made to have them seen concurrently, and to connect them with a social worker who could keep the focus of treatment on the family unit.

The concluding step of the intervention was one designed to evaluate its effectiveness. Each member of a family twelve years of age or older was asked to complete a questionnaire (see APPENDIX IV) regarding the service they had received. To promote openness in their responses, they were instructed to remain anonymous unless they particularly wished to put their name on the questionnaire. Each individual was given an envelope in which to seal their questionnaire, and they were gathered up at the last interview with the family. (See Chapter Six for details of the evaluation).

CHAPTER FIVE

CASE ILLUSTRATIONS

I Introduction

The practicum afforded an opportunity to observe how seven very different families reacted to loss. Of the factors identified in the literature as most influential in family adjustment, four were observed to be particularly important in the families who received service:

1) intrafamilial communication patterns
2) the family role system
3) previous coping and problem-solving methods
4) openness to social supports and ability to use these effectively.

In addition, two factors commonly identified as influential in individual adjustment were found to play an important role in the overall adjustment of the family system:

1) survivors' sense of their own self-worth
2) survivors' relationships with the deceased, including strength and security of attachment, degree of reliance and intensity of ambivalence.

In families where all six of the above factors were generally healthy, the natural mourning process could be facilitated with brief, supportive intervention. Where problems existed in one or more of those areas, however, mourning was more complicated and intervention tended to be more lengthy and complex. The following case examples will illustrate how the factors cited above influenced adjustment in particular families, and how intervention was tailored accordingly.

II Mourning in a Healthy Family System

Case 1 - A "One-Shot" Intervention

A request for an interview was received from Mrs. J., a woman in her mid-thirties who had lost both parents approximately four months earlier. Mrs. J. felt she was handling her own grief fairly well, but was concerned about the eldest of her two sons. Eleven year old Rob was missing his grandparents terribly, had fallen behind in school, and was overeating and gaining weight. An appointment was arranged at which the whole family was asked to be present, although Mrs. J. was somewhat confused by this request, since her husband and younger son were not experiencing any difficulties.

The conjoint interview afforded opportunity to review the illnesses and deaths of the grandparents with the whole family, and to explore the coping methods the family had used during those crises. In addition, it afforded a chance to observe the family's style of communication and to assess their progress as individuals and as a family in dealing with their losses.

The J. Family spoke lovingly of their deceased family members, recalling how 'Grandma' and 'Grandpa' had lived with them for a period of time. They spoke of how glad they were that they had been able to nurse their loved ones through their illnesses. Mrs. J. described how supportive her husband had been through that period, and she mentioned the continuing comfort she received from her extended family, especially cousins. As the family talked, they cried openly, and both Mr. and Mrs. J. remarked that in many ways their sadness had brought them even closer together as a family.

Rob was encouraged to review his own special memories of his grand-

parents, and his younger brother joined in. Rob recalled how he had come home from school each day and talked about his day with his bed-ridden grandmother. That ritual had strengthened their attachment and over time Rob had begun to feel guilty if he 'neglected' his grandmother and went out to play with friends. He reported tearfully that he had recently had difficulty concentrating at school because he often thought about his grandmother, how much he loved her, and how he wished he could have done more for her when she was so sick. Rob was encouraged to let his tears come, and at the same time was helped to review his efforts on his grandmother's behalf and to realize that he could not have done more for than he did. He was reassured that his grandmother had undoubtedly wanted him to play with his friends as boys his age should, and he was helped to recall times that she had urged him to go out and be with his friends. Rob was also helped to focus on his happy memories of his grandmother, in order that his image of her would be less troubling.

Mr. and Mrs. J. were asked about their methods for handling Rob's problems, and they described their attempts to be supportive of Rob and yet at the same time to be firm with him regarding snacking and school work. They outlined the homework guidelines they had set down so that Rob could catch up at school. These were reasonable and appropriate to Rob's circumstances, and when Rob was asked how he felt about having to do schoolwork at home, he appeared very accepting of his parents' loving intent in making him do the extra homework.

Mr. and Mrs. J. wanted to know if there was more they could be doing to help Rob, and aside from some suggestions regarding Rob's snacking and mealtime habits, they were encouraged to continue in the firm but supportive course they had embarked upon with Rob. It was sugges

to them that some changes in Rob's performance at school and his eating habits might be more likely to occur now that he had 'unloaded' his burden of guilt and some of his sadness.

In follow-up telephone calls to the family, Mr. and Mrs. J. spoke of a 'turn-around' in Rob. He was no longer weepy around the house, his schoolwork had improved, and he had started to lose weight. They remarked that they were beginning to feel like a normal family, after the long period of illness, death and mourning they had been through. The changes they had experienced were maintained over several months.

In summary, this family presented because of a concern about one member who had been unable to decathect from his deceased grandparent. The strong, interdependent relationship between Rob and his grandmother made it difficult for him to let go of her. However, once Rob's expressive mourning received some additional encouragement in the presence of his family, and once the family was reinforced in its problem-solving approach, the natural healing process was able to proceed. The family's connectedness with a supportive network, and their healthy affective, communication and role systems were factors which sustained this process and helped result in a healthy outcome.

III Mourning in a Family with a Closed Style of Communication

Case 2 - A Brief Intervention

Mr. L. and his two teenaged children were not a family who could easily request assistance with their adjustment to loss. The emphasis in their family, throughout the illness and death of Mrs. L., had been on coping. Mrs. L. herself had set the tone in the family, refusing to talk about about the seriousness of her illness, and stressing her intention to return home from the hospital at the earliest opportunity in order that she could cook and run the household. During the entire period of Mrs. L.'s illness and death, the two children, Joan and Colin, managed to maintain honors and exemptions at school, and were encouraged to remain active in their many extra-curricular activities.

Because of their excessive emphasis on coping and control, the family were identified as being at risk at the time of Mrs. L.'s death. Initial telephone calls to Mr. L. after the death were met with a bright and upbeat response. He recounted how he and his children had 'pitched in' with the housework, and how they were managing very well. Yet at the same time, he displayed an obvious need to talk about what he had been through. Although he rejected initial offers of a home visit, he responded positively to offers of continuing telephone follow-up.

After a number of phone calls, each one focusing more closely on Mr. L.'s feelings and on his uncertainty about how his children were really handling their mother's loss, the suggestion of a home visit was finally accepted. Mr. L. was initially seen alone, and at this meeting he poured out his frustration and regret that he had not confronted his wife about the seriousness of her illness. He expressed great regret and sadness that his wife had 'gone and died' without either he or she

expressing their deep feelings for one another. He explained that although their family life had always been happy, there had never been much openness and dialogue about feelings. Because of this, he indicated, he did not know how to talk to his children about their mother and he could only hope that they were able to handle their sadness appropriately.

The importance of a family being able to mourn together was explained to Mr. L., and he expressed a great desire to be able to do so. He had grown close to his children through their cooperative efforts at running the household since Mrs. L.'s death, but he realized that unless he could talk openly to them about his wife and about the day-to-day concerns they faced as teenagers, the family unit would not truly be strong or healthy. In addition, he was helped to realize that for his own mental health, he needed to be able to give himself permission to show his own sadness to those closest to him.

The L. family had been able to draw upon the support of a few friends and neighbours, but had no family network on whom they could rely. This factor had perhaps increased their intention to cope on their own, but at the same time this lack of support made them more vulnerable, and increased the importance of the family being able to support each other.

At the first conjoint family interview each member of the family was asked to fill out a family concern form. Each one of them, unbeknownst to the others, expressed dissatisfaction with their ability as a family to talk about the member of their family who had died recently. In addition, each one of them described themselves as less than satisfied with their ability as a family to share feelings like anger, sadness and hurt.

Intervention activities were quickly geared to promote the family's ability to talk together about their loss. Guided by grief intervention theory and by Satir's view of the therapist as both model and teacher of

communication (Satir 1983, pp. 125-130), the family was assisted to review Mrs. L.'s illness and death. The therapist gently used 'reality' words such as 'cancer', 'die', 'death' etc., and assisted family members to do the same as each one talked about his or her loss. Each individual was listened to attentively by the therapist, was encouraged to speak for him/herself, and was encouraged to describe and express his or her feelings as s/he recalled memories of Mrs. L. and of her illness and death. In addition, each was encouraged to listen attentively when other family members spoke.

The family's style of communication was discussed, and each member was asked to talk about some of the specific factors that made it difficult for him or her to talk openly about their loss. Mr. L. took that opportunity to explain to his children that he had held back from discussing their mother's illness because he had wanted to protect them. Likewise, he told them, he had not spoken much about their mother since her death because he had not known how to go about it. Both children responded that they had held back talking about their mother in order to protect him. The family could quite clearly see how their failure to openly check out each other's feelings had contributed to each member's feelings of isolation.

As the need to openly express sadness and to share feelings within the family was discussed, Joan, the elder of the two children, began to make some important connections between family communication and her own behavior. She remarked that her recent attempt to 'trash' her room was probably a way of getting rid of some of her feelings, since she could not talk to anyone in the family about them.

Following from this, the therapist helped the family spell out rules

for more accurate and effective communication (Satir 1983, pp. 129-130), so that frustration, anger and sadness could find a more appropriate outlet. Specifically, they were coached in ways of telling each other that they felt angry, sad or lonely. They were also assisted to think of ways that they could openly share their memories of Mrs. L. in the future, and each member was encouraged to choose and preserve his or her own special memento of Mrs. L.

Once shared mourning had been started in the family, attention could be directed to other areas of family functioning with which dissatisfaction had been expressed. These areas were extremely few in number in this family, and centered mostly around the division of responsibilities. Based on Haley's problem-solving approach, the family was assisted to describe the changes they desired in the division of responsibilities. (Haley 1976, p. 40). Mr. L. tended to identify the youngest child's lack of cooperation as the 'problem' and since Colin generally agreed with this description of the situation, he and his father were asked to brainstorm about ways in which the youngster could be motivated to do his fair share and thus reduce the burden of household responsibility on Joan.

Given Mr. L.'s desire not to have to 'police' the children, and given Colin's desire for some sort of a check-list to help him keep track of his responsibilities, a self-administered check-list was suggested by the therapist as one approach to the situation. Placed in strategic spots throughout the house, the form would remind Colin of his duties, would reduce Mr. L.'s need to 'police' Colin, and would serve as a clear definition of those tasks lying outside Joan's realm of responsibility.

In the family's final concern forms, changes were evident in items relating to both mourning and sharing of responsibility. Specifically,

an increase in satisfaction was expressed by all three family members in items relating to communication and sharing of feelings about their recent loss, and in addition, all three members reported an increase in feeling good about themselves as individuals. As well, as the family sought to redistribute its responsibilities, one member reported an increase in satisfaction in that regard, one member reported a decrease in satisfaction, and one member reported no change in his/her level of satisfaction.

In summary, this family's initial adjustment to loss could be seen to have been impeded by a closed style of communication. Though able to share their feelings with people outside the family, such as friends and neighbours, they had difficulty expressing them to one another. In a time of severe stress, the family pattern of closed communication proved to be inadequate. When intervention assisted in bringing mourning 'out of the closet' and in changing the family's communication style, they were able to recall and draw upon their memories of the positive relationship they had enjoyed with Mrs. L.

With the aid of a problem-solving approach, the family was then able to address their attention to instrumental changes and to proceed in adjusting to their loss. Their efforts were supported by their natural tendency to cope and to problem-solve, the generally appropriate role system they had devised in their newly structured family, and by their effective use of limited but reliable social supports.

IV Mourning in Multi-Problem Families

Case 3 - Mourning Complicated by Alcoholism and Poverty

Mr. K., a core area resident in his early forties, was referred for social work follow-up after the death of his common-law wife. Several factors indicated that he might face a difficult adjustment to his loss. Specifically, Mr. K. was a recovering alcoholic, and had been unemployed and living on social assistance for the last few years. He had no close family of his own for support, and he had what could be characterized as an ambivalent relationship with Mrs. K.'s surviving adult children.

Three weeks after the death, Mr. K. himself phoned to request an appointment. He expressed great sadness on the telephone, and said that although he felt he needed help, he did not want to have to return to the hospital setting. An appointment was arranged at his home.

Mr. K. presented as a truly dejected figure. His sadness, loneliness and hopelessness were evident in his facial expression, his voice and his posture. He described the close interdependent relationship he had had with his wife for fifteen years, and his fear of facing the future without her. He talked about his relationship with her children, indicating that because he lacked the official status of a father, he felt he could not unburden himself to them, especially since they too were grieving. At the same time, though he had a desire to be close to them, he described their difficulties with drugs and with the law, and indicated that he had had conflicts with some of the children in recent years.

His connections to friends and to the community did not appear to be much stronger or more promising. Though he belonged to, and regularly attended an Alcoholics Anonymous group, he felt that the group lacked understanding and sympathy for his new situation. He described their

emphasis on coping and on making the best of things, and recounted their efforts to get him to 'cheer up'. One or two close friends he had made through the group did offer him support and assistance, but his responses to their efforts gradually discouraged them. Mr. K. tended either to rely on them totally for his needs or he tended to reject their assistance, believing that he was unworthy of it.

Mr. K. indicated that his past approach to problem-solving had been to escape by getting drunk, and he stressed that he did not want to repeat that pattern in his present situation. However, having been 'dry' for only four months, he was unsure of how strong he could remain in this resolve.

In addition, Mr. K.'s instrumental worries contributed to his unhappiness. Because of his new 'single' status, City Welfare would soon require him to move from the apartment that had been home to he and Mrs. K.

An intervention was planned to focus on several of Mr. K.'s concerns. Attention would be given to assisting him with his expressive mourning work, to strengthening his family ties, and to helping him negotiate some satisfactory living arrangements with City Welfare. It was hoped that if mourning work could be facilitated and family supports could be mobilized, Mr. K. would be less inclined to rely on his former problem-solving methods.

As mourning work proceeded, the extent of Mr. K.'s former reliance on Mrs. K. was revealed. In many ways, she had 'mothered' him, and his fear of the future was at least partly related to the loss of this protection. It became apparent that Mr. K. had gravitated to the type of relationship he had had with Mrs. K. because of his own previously unhappy homelife when he was growing up. He had been treated, in his words,

"like a dog", and she was the first person who had ever loved him for himself.

Mourning work also revealed Mr. K.'s low self-esteem. He felt unable to draw upon the support of other people because he often did not believe they really wanted to help him and because he believed he was not worth helping. He tested offers of support by relying so totally on the person offering the support that it was eventually withdrawn, thereby 'proving' that it was not really sincere or that he was not really worthy of it.

Mr. K. was encouraged to accept offers of help from friends when they were forthcoming, and was reassured of his worthiness and value as a person. At the same time, he was encouraged to identify strengths within himself that would make it unnecessary for him to behave in a totally dependent fashion on those who did offer help.

As grief work sessions continued, efforts were made to arrange a meeting at which Mr. K.'s step-children could be present. These were unsuccessful, but Mr. K. was encouraged to strengthen his network ties by spending time with those of his step-children who did not have drug or alcohol problems. He was also encouraged to make contact with his family, who lived out of town. In addition, an extension of his apartment lease was negotiated with City Welfare.

These new efforts at alleviating Mr. K.'s situation were not enough to prevent him from returning to his customary methods of problem-solving. As the reality of his loss sunk in, and as he attempted to negotiate his environment without the assistance of Mrs. K., he began to drink again. Intervention during this period was often crisis-oriented, often via telephone, and consisted of 'direct influence' techniques such as advice giving, advocating a particular course of action, warning Mr. K. of consequences and linking him directly with community resources (as per Golan

1978, pp. 99-100). Specifically, Mr. K. was assisted to get medical help when he had been in a fight, he was 'talked down' when he was drunk and self-destructive, he was taken to an alcohol treatment center, and he was encouraged to make contact with his former A.A. sponsor.

Throughout this period, he was further encouraged in the strengthening of his network. Specifically, he was advised to get in touch with his own siblings, of whom he had spoken positively. Eventually, he reached the decision to contact his family, and that communication resulted in a plan to leave Winnipeg. Mr. K. expressed a desire to start afresh, and would do so by visiting his family and by looking for work in the province where they lived. When he left, he expressed hope for his future, saying that he would "get through this somehow".

In summary, Mr. K.'s mourning can be seen to have been complicated by a number of factors. His dependent relationship on the person he lost, his low self-esteem, his lack of social supports, his inability to effectively use those supports he did have, and his unhealthy problem-solving methods all contributed to a difficult adjustment. Intervention aimed at facilitating his mourning and strengthening his self-esteem and his connections to social supports was somewhat effective. Although he reverted to previous problem-solving methods, he eventually saw the futility of these and was able to take some new, healthier steps towards coping with his situation.

Short-term telephone follow-up has indicated that he has maintained sobriety, is attending A.A. meetings and is looking for employment in the province where one of his siblings resides.

Case 4 - Mourning in a Twice-Bereaved, Multi-Problem Family

Mr. B., a mid-30ish laborer, was referred for bereavement follow-up several months after a double tragedy struck his family. In an unexpected turn of events over a two-week period, Mr. B. lost both his father and his wife. The family's attention had been focused on Mrs. B., who was in the final stages of an incurable illness, when Mr. B. Sr. was hospitalized for minor surgery. A post-surgical complication arose, and Mr. B. died suddenly. Two weeks later, Mrs. B. succumbed to the disease she had been fighting for the past year.

Left to mourn with Mr. B. were his mid-60ish mother and his seven year old son. As a family, they were at considerable risk for a number of reasons. The unexpectedness of Mr. B. Sr.'s death, plus the death of Mrs. B. when the family was already in shock would have been enough to throw any family into chaos. In addition, however, there were indications that Mr. B. had a serious drinking problem, that he was unprepared to parent his seven year old son, and that he lacked the emotional resources to deal with the loss of his father (to whom he had been very close) and his wife (with whom he had had a very stormy relationship).

An initial meeting was arranged with Mr. B. In that interview, Mr. B. readily identified many of the problems facing he and his family, and indicated his desire that someone would 'fix things' so that he would not feel so miserable. When asked to complete a family concern form, Mr. B. indicated that he was less than satisfied with 17 of the 25 aspects of family life it covered, including ability to share feelings about loss, communication, decision-making and allocation of tasks. In addition, he indicated that he did not feel good about himself, and that he had doubt about his own ability as an individual to carry on with

living since having lost his father and wife. Suggestions to Mr. B. that these feelings and concerns be explored and dealt with in a family setting (ie. with his mother present) were firmly rejected. Mr. B. appeared to fear the perspective his mother might bring to the discussion, particularly his assertion that he was a "controlled alcoholic". In addition, the family had reorganized its parenting functions so that Mr. B.'s son now lived with Mrs. B. Sr., and while Mr. B. had some negative feelings about the arrangement, he appeared to fear that an open discussion of the situation could result in him having to take greater responsibility for parenting.

It was suggested to Mr. B. that he could be helped to deal with many of his loss-related feelings in individual sessions, but that the family problems of such great concern to him could not be 'fixed' unless the family as a whole (ie. he and his mother) eventually met to discuss them. Several individual sessions were arranged to begin to help Mr. B. deal with his losses, but so threatened was he by the thought that these individual sessions might eventually lead to family-oriented counseling, that he cancelled or 'forgot' every individual appointment that was arranged in the next two months.

Mr. B. grew increasingly unable to handle his feelings about his losses during this time, however. So great was his desire for help, that he eventually identified his son as having a 'problem' and requested an interview to deal with it. The subsequent session attended by he and his son proved to be a turning point, for while it was ostensibly an opportunity to discuss seven year old Peter's recent behavior at school, it quickly became a family grief work session. Mr. B. broke down and released his great despair, his hopelessness and his suicidal thoughts.

In front of his son, whom he had taught to "fight, not cry", he wept and mourned. His son, whom he often called "the little brat", crept into his father's lap to comfort him. This physical affection, usually spurned by Mr. B. as "unmanly", was gratefully received. Father and son were encouraged to let their feelings out and to talk about the family members they so desperately missed.

The father-son interview provided a valuable opportunity for the therapist to model and teach communication as per Satir's guidelines (1983, pp. 125-130). Peter was talked to and listened to in a warm and respectful fashion, his questions were thoughtfully answered by the therapist, and his statements were carefully re-stated or 'checked out' to make sure that his message was understood. Mr. B., who generally appeared awkward and embarrassed when addressing his son, had an opportunity to observe the therapist's interaction with his son, and to see that this type of communication was effective and enjoyable for both participants. As well, Mr. B. and Peter were encouraged to talk directly to each other, and they were assisted to re-phrase statements so that they could be more easily understood by one another. In general, however, they tended to understand each other fairly readily, and therapeutic efforts were able to be directed more towards increasing the affective dimension of their communication (ie. getting Mr. B. to state his message with more warmth and caring, where possible).

Having triggered shared mourning in at least one part of the family system, and having encouraged increased communication and closeness between father and son, intervention would continue to be focused on mourning and on the father-son relationship for the next few months. Several sessions were spent with Mr. B., helping him to review his relationships

with his father and his wife, the circumstances of their deaths, and the meanings their loss would have for his future. Because Mr. B.'s relationship with his father had been close and fairly positive, he needed only minimal assistance to begin to lay that relationship to rest.

Considerably more work was required to put his relationship with his wife into perspective. Their marriage had been stormy, but he had been very dependent upon her. Mr. B. expressed absolute terror and despair at the prospect of managing on his own, "without a woman", and with the responsibility of a young child. His fear of facing the future by himself led him to idealize Mrs. B. in his memory, and he struggled to come to a realistic view of her that would allow him to lay their past to rest and begin to reorganize his life without her.

The process of reviewing and relinquishing his relationship with Mrs. B. involved several steps for Mr. B. Of his own accord, he brought in a picture of her and talked about its meaning for him. He was helped to recall Mrs. B.'s good points and weaknesses, and he was helped to recall both happy and unhappy memories of their past together. This review led Mr. B. to plan a car trip to the places at which they had honeymooned and vacationed together, and eventually, to dispose of their wedding rings at a special place he had shared with her. He began to envision his life without her, and he took steps to learn to deal with household and financial matters which had previously been looked after by Mrs. B.

As this process occurred, several individual sessions were also held with Mr. B.'s son. Through play techniques such as drawing, tape-recording a 'radio show', and the use of dolls, Peter was helped to talk about his losses. Typical for a child his age, he initially expressed many of his feelings about loss in relation to the family dog who had died earlier.

However, as the play sessions proceeded, Peter gradually became able to express the sad feelings he had about losing family members. He revealed that he had had thoughts of killing himself in order to be with his deceased family members. Peter was helped to identify alternative ways of dealing with sadness and loneliness, and he was helped, through the use of children's books, to discover how other children handled sad feelings. He learned that he could turn to his family and friends for comfort, and that he could keep his happy memories of his mother and grandfather alive by making his own special memorial of them (eg. through drawings and a scrapbook).

The scheduling of individual sessions with Peter provided an opportunity to make contact with Mrs. B. Sr., who was willing to participate in any type of interview with her son and/or grandson. She was initially seen with her grandson, since her son still would not consent to attend a meeting at which she would be present. Mrs. B. Sr. was asked to complete a family concern form, and her responses indicated dissatisfaction with several areas of family functioning. Like her son, she was concerned about the family's ability to listen to and understand each other, to communicate good feelings to one another, to make sensible rules and take on responsibility, to make family decisions, to be consistent with discipline, and to feel good about themselves as individuals. She was also concerned about her son's use of liquor. On the other hand, she indicated that she felt able to carry on without her husband, and discussion of her loss confirmed that she was dealing with it in a healthy and appropriate fashion.

Mrs. B. Sr. also appeared to be handling her parental responsibilities in a fairly positive fashion. She indicated that she had been surrogate

parent to her grandson in the past when her son and his wife had been unwilling or unable to fulfill their responsibilities as parents. She had taken over much of the parenting responsibilities during Mrs. B.'s illness, and her present parental role seemed natural and fitting to her, especially in view of her son's shift work and drinking problem.

Mrs. B. Sr.'s position as parent, though perhaps not ideal, appeared to be adaptive and functional in the family's current situation. Intervention with Mrs. B. was thus focused on helping her use her parental abilities to greatest advantage. Specifically, she was encouraged to speak positively of her deceased daughter-in-law to her grandson, even though she had long harbored bitter feelings about her daughter-in-law's abilities as a wife and mother. In addition, she was asked to help promote Peter's mourning work through the use of children's books, and by helping Peter compose a memorial notice on the one year anniversary of his mother's death. She was also directed to promote involvement between her son and grandson, and she willingly complied with all these directives.

In the meantime, as Mr. B. progressed with his mourning work, he grew more able to discuss his role in the family and this allowed some intervention in the family structure. Specifically, efforts were made to help Mr. B. clarify the boundaries around himself as a parental subsystem (as per Minuchin 1974, pp. 143-147), by encouraging him to spend more time with his son on a regular basis. Mr. B. was able to see that this was a way he could begin both to reduce his fears about parenting and address the question of how much parental responsibility he actually wanted. As this occurred, Mr. B. took steps to meet with his mother to discuss Peter's future and to arrange a contingency plan for Peter's care should something happen to either of them.

Mr. B. was also helped to finally discuss his alcoholism openly. He explained that he had been in an alcohol treatment program once, but that he would not consider doing it again, even though his health was in jeopardy. However, towards the end of therapy, Mr. B. met and became involved with a woman, and this relationship began to have a very positive effect on him in several ways. He expressed his feeling that for the first time in a long time he had a reason to look after his health, and he remarked that since his new woman friend was not much interested in social drinking anyway, it had become easier for him to cut down on his own use of liquor.

Mr. B. and his mother were not seen together until the end of therapy, since it was not until then that Mr. B. would consent to attend an interview with his mother. This alone represented an important change in the family system, but in addition, several more changes were evident. Mr. B. and his mother were able to openly discuss Mr. B.'s drinking problem, and they were able to discuss changes in their present parenting roles. Both agreed that Mr. B. needed to reduce his drinking, and both agreed that Peter needed to be raised by his own father. They discussed the type of changes that would be necessary if Mr. B. were to be able to parent effectively, and Mr. B. agreed to consider seeking outside help with parenting (such as a parenting class).

In addition, Mr. B. discussed the relationship he was developing with the woman he had met recently, and he expressed their desire for counseling sessions in which they could be assisted to develop their relationship in a healthy fashion. Arrangements were made so that therapy could continue briefly with Mr. B. and his woman friend.

Although intervention with the B. family had included almost no con-

joint sessions, the family-focused intervention activities which had been carried out with the individuals and dyads in the family system appeared to have promoted considerable change in the family as a whole. In their final family concern forms, both Mr. B. and his mother indicated increased satisfaction with items related to the family's ability to share its feelings about loss, its communication and its rules. In addition, Mr. B. expressed increased satisfaction with his own and with the family's ability to carry on in spite of having lost a family member.

In summary, the B. family's adjustment to loss can be seen to have been complicated by ineffective communication patterns, by Mr. B.'s use of liquor as a coping mechanism, by the ambivalent relationship he had had with his wife, and by the family's inability to share its feelings about the death of two of its members. With the aid of intervention related to those factors, and with the family's ability to adapt its role system in a time of crisis and its connectedness with a limited number of reliable social supports, the B. family was able to proceed in a healthy fashion towards readjustment.

Case 5 - Mourning in a Multi-Problem Family with No Social Supports

Mrs. A., a mid-30ish suburban mother, was referred for social work follow-up two months after the death of her husband. Mrs. A. described her own loneliness and lack of social supports as concerns, but identified the behavior of her pre-school daughter to be the major problem facing the family. Four year old Margaret, who attended daycare full-time, was exhibiting considerable aggression and refusing to nap at daycare, and in addition she was difficult to manage at home.

Through the use of a family concern form, a family tree and a social support map, it was clarified that Mrs. A. was totally lacking in social supports. She had had a very unhappy childhood and had been estranged from her family of origin, all of whom lived overseas, for many years. She did not get along with her in-laws, had no close friends, and had only occasional contact with neighbours and with a few families who attended her church. Mrs. A. reported an inability to be calm or patient with her daughter, she reported difficulty in feeling or demonstrating affection toward her daughter, and she expressed considerable ambivalence about her role as a parent. In addition, she complained that since the death of her husband, she had felt exhausted and unable to function adequately around the house.

An intervention was designed to focus on all Mrs. A.'s concerns, beginning with her daughter's behavior and with the loneliness and exhaustion she was experiencing as part of her loss. Consistent with the literature, initial activities were focused on assessing and promoting individual and shared mourning work for Margaret and Mrs. A. It was hoped that by opening up the family emotional system and ensuring that mourning proceeded, changes might be triggered in Mrs. A.'s emotional and physical health, in the relationship between Mrs. A. and her daughter, and possibly

in Margaret's behavior. Specifically, Mrs. A. was instructed and assisted in the use of children's storybooks about death, as a way to promote dialogue between she and Margaret about their loss, and as a way of promoting involvement between them and strengthening the boundary around them (as per Minuchin 1974, p. 146). Mrs. A's mourning work was promoted in several individual sessions, and she was referred to a widows' group, which would provide her with some desperately-needed social support (as per Walker, MacBride and Vachon 1977).

As work proceeded with Mrs. A., it was gradually revealed that she and her husband had had an ambivalent relationship, and she had expected his death to be a relief. She had not expected to have to mourn his loss to any great extent, and so the sadness, exhaustion and depression she did feel were confusing to her. These factors, along with the fact that she had always considered weeping to be a sign of weakness, made her seek escape in intense activity after her husband's death. Mrs. A. was assisted to understand that even a conflictual relationship needs to be mourned when it is over, and she was encouraged to release her feelings through the tears which she had heretofore forbidden herself.

In addition, Mrs. A. gradually began to open up about her unhappy past. Her troubled relationship with her own mother, and a previously unsuccessful parenting experience which had resulted in her giving up her first child, were slowly revealed. Mrs. A. was helped to see how these factors made it difficult for her in the present - how her lack of an effective parenting model and her unresolved relationship with her mother made it hard for her to feel positive about herself, about her own abilities as a parent, and about her daughter Margaret.

A strategy was devised to address the mother-daughter relationships

in both generations. First, therapeutic efforts began to be focused on altering the inappropriately rigid boundary which Mrs. A had originally established to end the conflict between she and her mother. Using Satir's guidelines (1983), Mrs. A. was instructed in rules for effective non-conflictual communication and she was encouraged to initiate contact with her mother. She was also assisted to express her feelings in a 'therapeutic letter' as a way of preparing for eventual dialogue with her mother, and she was helped to rehearse appropriate ways of expressing and revealing her feelings in telephone calls. She was assisted to find words to convey to her mother her desire for a future connection.

Second, Mrs. A. was assisted to deal with Margaret's problems at daycare and to get specific help with parenting Margaret. With regard to the former, meetings were held with Mrs. A. and the staff of the daycare attended by her daughter, and a modified behavioral approach was devised to handle Margaret's continuing behavior problems. The approach required (and assisted) Mrs. A. to spend more quality time with her daughter, and as such it reinforced her in her parental role and at the same time strengthened the boundary around she and Margaret. With regard to the latter, Mrs. A. was registered in a special parenting class which taught child development and anger management, and she was linked with a teaching homemaker who could both coach her in effective discipline and teach her to enjoy and have fun with Margaret.

A psychological assessment of Margaret was arranged, and through that, Margaret was enrolled in play therapy to help her develop a more positive self-image (which would reduce her need to behave in an aggressive, attention-seeking manner), and to further work on her adjustment to loss.

Other intervention activities designed to assist Mrs. A. with her ambivalent relationships with her deceased husband, her mother, and later, with her in-laws took place over several months. She was gradually able to lay to rest her relationship with her husband, and she began to gain some perspective on the importance of resolving her conflicts with her mother and her in-laws.

Towards the end of therapy, Mrs. A. began to take steps which would enable her to return to work. She began to look forward to "feeling useful", having contact with more adults, and having a paycheque. She had maintained on-going contact with the widows' group, and had begun dating. (Her approach to dating was cautious and well though-out, as she had no desire to become involved in another unsatisfactory relationship, and she acknowledged her need to be selective and careful to avoid hurting her daughter, herself, or a man with whom she might become involved). As her social isolation eased, and as Mrs. A. gained help with parenting, she began to express optimism about her ability to cope more effectively.

In her final family concern form, Mrs. A. indicated increased satisfaction with the family's ability to talk about their loss, and in her abilities to be patient and calm, show care and concern, be positive towards others and make sensible rules. She indicated no change in her ability to be consistent with discipline or to enjoy family activities, but she expressed hope that on-going parenting training would make a difference in these items.

In summary, mourning in the A. family can be seen to have been impeded by virtually every risk factor identified in the literature. Ineffective intrafamilial communication; ineffective coping and problem-solving methods (eg. breaking off relations with family members, handling

anger by yelling and spanking); inability to link with, and use social supports effectively, low self-esteem; and ambivalent ties to the deceased, all contributed to this family's difficulty in adjustment.

With a multi-faceted intervention extending over a period of at least seven months and eighteen sessions, this family was assisted to improve its communication and boundary system, its coping and problem-solving methods, its links with social supports, its members' low self-esteem, and its unresolved ties to the deceased. Upon termination, social and parenting supports were left in place, and arrangements had been made for on-going therapy for both Mrs. A. and Margaret in order that they could maintain and perhaps increase the gains they had made in therapy to date.

CHAPTER SIX

EVALUATION

I Introduction

As stated in Chapter Four, the practicum was designed with three specific objectives in mind:

1) to offer counseling to bereaved families who were at risk of an unfavorable outcome

2) to explore the role of social work in the bereavement situation

3) to develop further skills in social work and family intervention.

The extent to which these objectives have been fulfilled may be evaluated against certain criteria. Each will be considered separately in the following three sections.

II Evaluation of Outcome

Outcome of the intervention with bereaved families can be evaluated in relation to two major criteria:

1) Whether increases occurred in clients' satisfaction with family functioning (on the basis of pre- and post-intervention scores on the Family Concern form).
2) Whether clients reported improvement in their major areas of concern, and whether they reported satisfaction with the social work service they received (as reflected in their responses to the evaluation questionnaire administered upon termination of service. See questionnaire in APPENDIX IV).

Each of these is considered below:

A) Evaluation on the Basis of Pre- and Post-Intervention Scores on the Family Concern Form

Of the seven families who received in-person counseling, five completed both pre- and post-intervention concern forms. Of the remaining two families, one was seen only once and completed neither pre- nor post-intervention forms, while the other family completed a pre-intervention measure but left the city before arrangements could be made to complete the post-intervention form.

Results for the five families who did complete both before and after self-reports indicate increased satisfaction in some areas of family functioning, decreased satisfaction in other areas, but an overall increase in satisfaction for every member of every family. (See APPENDIX III).

More specifically, in Family A, across-the-board increases

(ie. in every member) were reported in relation to item 4 (communication about loss) and item 27 (feeling good about themselves as individuals). No across-the-board decreases in satisfaction were reported in any items. On some items, one person reported increased satisfaction where another reported a decrease or no change.

In Family B, both members reported increased satisfaction in relation to item 6 (listening and understanding). There were no areas in which both members reported a decrease, although each member reported some individual decreases in satisfaction. (For one member these related to recreation, and for another, these related to discipline and use of alcohol). On one item (item 21 - making family decisions), one member reported a decrease while the other reported an increase.

In Family C, both members reported increased satisfaction with item 9 (being positive, saying nice things about others) and item 21 (making family decisions). There were no areas in which they both reported a decrease, although one member reported some individual decreases.

In Family D, the only member reporting indicated increased satisfaction in several areas of functioning, including item 4 (communication about the deceased), item 7 (being patient or calm with others), item 8 (showing care and concern), item 9 (being positive, saying nice things about others), item 11 (dealing with matters concerning sex and companionship), item 12 (making sensible rules), item 15 (use of self-control) and item 17 (deciding upon discipline). Decreases in satisfaction were reported in two areas.

In Family E, the only member reporting indicated increased satis-

faction with item 4 (communication about the deceased), item 6 (listening and understanding) and item 27 (feeling good about him/herself). A decrease was reported from "very satisfied" to "satisfied" in item 2 (sharing feelings about day-to-day matters).

In all families, areas of increased satisfaction included items which were the focus of intervention and items which were not. Likewise, areas of decreased satisfaction included items which were the focus of intervention and items which were not. This was to be expected, and can be explained in terms of the "ripple effect in the family system" (Greenberg 1975) which occurs when changes are made in any one part of the system. In many cases, discussion of individual decreases in satisfaction revealed that these were the result of intervention activities which stimulated awareness of existing weaknesses in the family system (eg. some family members reported decreased satisfaction because it was painful to recognize areas in which some personal changes might have to be made. Others reported decreased satisfaction because of their stated desire to be more realistic about their view of the family. In both these types of situations, decreases were seen as progress).

In addition, some decreases in individual satisfaction resulted when the family was assisted to change a dysfunctional pattern which had served one individual (eg. in Family B, a much-needed reorganization of decision-making processes - item 21 - resulted in the increased satisfaction of one member at the expense of another who had been well-served by the original system).

On the whole, the results of the Family Concern forms were positive. While it could not be said that sweeping changes occurred in

any family, satisfaction with family functioning did generally increase. The case-study design of the intervention (ie. the lack of standardized treatment techniques due to the widely varying presenting complaints of families, and the lack of a control group) do not permit firm conclusions to be drawn regarding the cause(s) of change in family functioning. Several factors may have contributed to the changes reported, including:

1) reactivity of the instrument itself (because as a self-report it is an obtrusive measure)
2) history
3) maturation.

It is fully expected, and indeed could even be said to have been a goal of therapy, that maturation did influence outcome. The intention of the intervention was to facilitate the natural healing process in each individual and family, by making them more open to each other and to the supports available in their environment. It is hoped that increases in satisfaction were a result of the intervention itself and of an enhanced ability to draw support from other sources.

B) Evaluation on the Basis of Clients' Responses to Evaluation Questionnaires

As described in Chapter Four, the fourth and final stage of the intervention included the administration of an evaluation questionnaire to each member of a family twelve years of age or older. (See the full questionnaire in APPENDIX IV). The questionnaire included items which could be answered with a checkmark, and also provided space for clients' comments regarding the changes they had experienced

and the service they had received. In designing the questionnaire, an attempt was made to balance the desire for detailed feedback from families with the need to keep it a reasonable length and relatively easy to respond to. (In general, individuals took fifteen to twenty minutes to complete the form). Eleven individuals received and completed the questionnaire.

Twelve of the eighteen questions in the questionnaire pertained specifically to client satisfaction with the social work intervention offered in this practicum (questions 3 through 13 and question 18).

Responses to these questions may be summarized as follows: (See the summary of the other six questions in APPENDIX IV).

3) Consistent with the demographic data reported in Chapter Four, two clients reported their first contact with the social worker to be approximately 1 month after the death, three reported 2 - 3 months, four reported 4 - 5 months, one reported 6 - 8 months, and one reported one year.

4) Related to this, nine respondents felt that their first post-death contact with the social worker occurred at about the right time, while two respondents would have preferred an earlier contact. Of those two, one had been contacted at 4 - 5 months, the other at 6 - 8 months.

5) Seven respondents indicated that they met with the social worker only in their own home, while four indicated that they met only at the hospital.

6) Of the above seven respondents who were seen only in their homes, three indicated that they would <u>not</u> have accepted service had they had to come to the hospital. One of those added the comment "only

because going to the hospital is too painful."

Two respondents who were seen only in their own homes indicated that they would have come to the hospital had it been absolutely necessary, but that they "preferred to meet at home."

7) Asked to indicate how helpful they found their meetings with the social worker, six checked "very helpful", four checked "a little helpful", and one checked "not sure", adding the comment "Just waiting to see the course life will take."

Of the four who checked "a little helpful", only two offered explanations in the space provided. One indicated, "it got us talking about my Mom just a little bit more than before," while the other commented, "I told her some important things, but alot of things I didn't remember to."

Of the six who checked "very helpful", all offered comments, including:

- "...the meeting helped me understand the feelings of each individual person (in the family)."
- "It helped the entire family to fully understand and cope better with the situation."
- "(It was helpful) by talking about any problems and giving advice."
- "I appreciated the support given my wife."
- "(I) felt more secure having someone to talk to about everything in confidence, someone so understanding."
- "I believe that it is much easier to pour out your feelings to someone other than your family and close friends. Just talking about your loss is so good for a survivor."

8) Ten respondents indicated that they attended a meeting with the social worker at which other members of their family were present.

All ten felt those meetings were helpful. One respondent did not have other family members present at a meeting, and would not have liked to, saying, "As my family have their own lives established, I am the one who must live with changes."

9) The topics which respondents recalled having discussed with the social worker are listed below in descending order of frequency:

- the illness of the deceased family member (10)
- communication with the deceased family member during the time of his or her illness and hospitalization (10)
- past relationships with the deceased family member (10)
- communication between the respondent and other surviving members of the family (10)
- the medical care the deceased family member received before his or her death (8)
- feeling sad (8)
- concerns about the behavior or coping of children in the family (7)
- difficulty with sleeping, eating or health (7)
- loneliness (7)
- anger (6)
- feeling empty (6)
- fear (5)
- feeling guilty (5)
- the funeral of the deceased (4)
- helplessness (3)
- religious beliefs (3)
- decisions relating to financial matters (2)

One respondent pencilled in a topic not on the list:

- "making new connections".

10) Related to the above, nine respondents reported that there were no additional topics they had wanted to discuss with the social worker. One person did not answer, and one person pencilled in "new relationships." Presumably that is the respondent who later asked for continuing counseling for he and his new woman friend. (See case illustration 4 in Chapter Five).

11) Respondents identified a wide variety of "major concerns" which were worked on in the intervention. These included:

- communication with family members (4)
- children (3)
- loneliness (2)
- household affairs (2)
- emotions (1)
- anger (1)
- guilt (1)
- behavior of family members (1)
- relationships (1)
- how to be supportive to another family member (1)

In regards to the change that was experienced in relation to these concerns, three were described as "much the same" after the intervention, eight were described as "somewhat better" and six were described as "much better". One respondent did not check off any answer, explaining that she had not yet started a widows' group, but that she expected it would "prove very gratifying and helpful".

12) All eleven respondents said they would recommend the type of help they had received to other bereaved families.

13) Five respondents said that they felt the help they had received from the social worker would make it easier to deal with future loss. (Two pencilled in "Definitely!") Six respondents indicated "perhaps" to this question.

18) Seven respondents added additional comments in the space provided at the end of the questionnaire. These comments were lengthy and positive. Three of the seven respondents included praise for the service they had received at the hospital while their family member was alive. Perhaps the tone of the comments in this section can be best summed up by one respondent who said, "If you could, you should please carry on the good work, helping others in their dark hours!"

Some general comments and conclusions may be stated in relation to these client responses. First, the responses to questions 3 and 4 suggest that there is considerable range in what survivors see as the appropriate point at which to receive bereavement follow-up. This is undoubtedly due to the fact that differing risk, stress and coping factors cause some survivors to desire assistance earlier than others. Given the difficulty of predicting the point at which survivors may most need assistance, bereavement follow-up may best be offered at several points in the bereavement process, including at the time of death and at several points throughout the first year.

Second, responses to questions 5 and 6 indicate the importance of bereavement follow-up service delivery being flexible (ie. community-based where necessary).

Third, responses to question 8 generally reaffirm the value of having the family unit as the focus of intervention.

Fourth, responses to question 13 suggest the preventive element

which may be present in bereavement follow-up. Once mourners learn effective ways of releasing their feelings and sharing them in a family setting, they may be better equipped to do so without intervention in the future. (This may be an additional sense in which bereavement intervention is cost-effective).

Fifth, while responses to question 18 do suggest that the intervention was felt to be particularly beneficial by some clients, these responses may also, in part, be indicative of the simple gratitude families felt for having received service at all. Most clients recognized that social work counseling programs for the bereaved are not a standard offering in the health care delivery system, and as one woman said, receiving the bereavement care she needed made her feel like a "special case".

Finally, the overall responses to the twelve questions on the intervention suggest that it was valuable to families in several ways. Specifically, the intervention appears to have been timely for most families, and it appears to have met the need for in-home counseling expressed by some families. Counseling sessions were reported to have been helpful to ten out of eleven respondents, with most respondents indicating that the interviews provided opportunity to discuss all the subjects they needed to talk about. Fourteen out of seventeen family concerns were described as better after the intervention while three reflected little or no change. All respondents said they would recommend the service they had received, and approximately half felt it would make future losses easier to deal with. Finally, more than half of the respondents chose to add personal comments expressing their satisfaction and gratitude for the service they received.

* * *

Overall, while the intervention did not appear to bring about dramatic changes in any family, and while there were undoubtedly areas in which better service could have been provided, results of the Family Concern form and evaluation questionnaire are consistent with one another and indicate that the intervention was, on the whole, beneficial to those who received it.

III The Role of Social Work in Bereavement

The practicum was intended to allow exploration of the role of social work in bereavement. The extent to which this objective was fulfilled may be assessed in relation to at least two criteria:

1) What conclusions does the practicum yield regarding social work intervention in bereavement?

2) What recommendations can be offered on the basis of the practicum's findings?

Each of these is considered below:

a) Conclusions Regarding Social Work Intervention in Bereavement

The practicum yields several conclusions regarding bereavement intervention:

1) As suggested in the discussion of clients' responses to the evaluation questionnaire, there is considerable difficulty in attempting to define the point at which survivors may most need assistance with mourning and adjustment. Depending upon individual risk, stress and coping factors, intervention may be welcomed by survivors at a variety of points in the bereavement process.

2) As suggested in the literature, and as discussed in "Implications for Intervention" in Chapters One and Two, a wide range of intervention techniques and activities are necessary to promote mourning and adjustment to loss. Intervention with bereaved families needs to be broad-based and flexible enough to include both individual and conjoint counseling, to employ a variety of age-appropriate treatment techniques (in some cases ranging from puppet play with children to life review with the elderly), to provide practical assistance with

instrumental concerns, and to strengthen network and social supports.

3) Telephone contact plays an important role in bereavement follow-up. In this practicum, this was found to be true in several ways:

a) Telephone follow-up calls to families who had received the letter offering service confirmed one factor which has been cited in the literature as an important mediator of adjustment. Specifically, the vast majority of at-risk families who declined in-person service did so because they could identify one or more reliable social supports whom they felt would adequately see them through their crisis.

b) Telephone contact proved to be an important reinforcement of the letter as a means of offering service. It would appear that a telephone call was felt by families to be more personal, and/or that an offer of service by telephone was believed by families to be more sincerely meant.

c) The telephone is a relatively non-threatening 'no-obligation' medium through which a resistant (but needy) client may discuss his or her loss. Continuing telephone follow-up with one such individual was the only means by which he could eventually be convinced of the safety of more personal service. With another such individual, lengthy telephone discussions allowed her to ventilate some of her anger about multiple losses she had experienced. Although this woman refused more personal service, an important part of her mourning work was accomplished through the use of the telephone.

d) The telephone proved to be an invaluable intervention tool when crises arose in some families. A telephone call was an

effective and relatively quick way of referring families to appropriate community resources, and on one occasion it was a medium for suicide prevention.

e) Telephone contact proved to be a valuable means of post-intervention follow-up.

4) As suggested in the discussion of client responses to the evaluation questionnaire, community-based intervention (ie. that which could be offered in the clients' home) was found to be a valuable and necessary part of service delivery.

5) The family/systems orientation to intervention suggested in the literature proved its value and utility in this practicum. Families themselves expressed considerable satisfaction with the family- and network-focused intervention, both in comments made in interviews and in their responses and comments on the evaluation questionnaire. In addition, the family/systems approach was valuable from the point of view of the intervening worker. Specifically, the broader assessment base it provided often made it easier to locate sources of individual pain, and it generally made it possible to design an intervention which addressed both that individual pain and the family dynamics and social factors contributing to it.

B) Recommendations for Social Work Intervention in Bereavement

On the basis of the foregoing conclusions, the following recommendations may be made:

1) That in-person bereavement counseling be available as a regular part of health care services, and that it be offered at several points in the bereavement process, including at the time of

death and at regular intervals throughout the first year after loss occurs.

2) That such counseling be offered in a flexible manner, so that those providing the service have both the time and the means to provide service in clients' homes.

3) That bereavement follow-up have as its focus, wherever possible, the-individual-within-the-family-within-the-community, and that as part of that focus, intervention be able to:

    a) offer (or link clients with) individual and family counseling

    b) mobilize social supports within the clients' networks

    c) link clients with peer supports in the community (such as widows' groups).

4) That improved death education be offered in both schools and the community, so that children and adolescents learn at an early age that death can be talked about, and that feelings of sadness, anger, guilt, relief, confusion, etc. are a normal response to loss and need to be shared. This type of education and dialogue would be an important step toward lessening the fear of death, removing social taboos, preparing individuals for the loss events which are inevitable in their lives, and ultimately reducing morbidity and mortality rates in bereavement.

IV Skill Development Afforded by the Practicum

The practicum was intended to be an opportunity for the development of further skills in social work and family intervention, and indeed, it presented several challenges and opportunities in that regard.

The heterogeneous nature of the client population was perhaps the factor which most demanded that my skills be broadened and developed. Because of clients' widely varying demographic characteristics, including ages and stages of family life, socio-economic status and family member lost; and because of the wide variety of risk factors, presenting complaints, coping mechanisms and styles of interaction present in these families, I found it necessary to expand my repertoire of intervention techniques and skills, and to become more proficient at employing those techniques and skills I already possessed.

Specifically, I learned new ways of working and communicating with children, and I experienced some of the personal pleasure and clinical results that are possible when a child is reached through make-believe.

I learned new ways of helping clients finish unfinished business with family members who were deceased, or from whom they were estranged. What I have labelled "the therapeutic letter" proved to be a powerful medium by which clients could express long-inhibited feelings of anger, guilt, remorse and forgiveness.

I learned to deal more effectively with alcoholics, to work within the reality of a client's drinking problem and to be more dispassionate when a drinking bout "interrupted the flow of therapy".

Crisis intervention skills which I already possessed were tested and refined, and I learned to be more skilled at handling family dynamics in the interview setting. In particular, I became more comfortable with

family conflict, more appreciative of it as an assessment opportunity and better able to use it as a point of therapeutic entry.

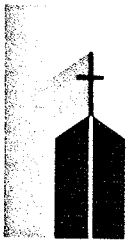
The practicum demanded that I become more creative with the use of practice aids such as books, toys, tape-recorders, and that I become more spontaneous and creative with my use of self in the interview setting. The practicum also demanded that I become more familiar with the network of social services existing in Winnipeg.

Finally, the evaluation component of the practicum presented opportunity to become more familiar with the use of assessment and outcome measures. The Family Concern form was found to be a valuable assessment instrument, and its use assisted considerably in focusing intervention activities. The evaluation questionnaire likewise provided focused and specific feedback on the intervention itself. The use of both these instruments reinforced my intention to utilize assessment and outcome measures as a regular part of future practice.

Overall, the practicum presented excellent opportunities to develop and refine practice skills with individuals and families. It offered a challenge to become more flexible, more self-aware and more adaptive, and as such, it proved to be not only professionally rewarding, but personally rewarding as well.

APPENDIX I

LETTER OFFERING SERVICE TO BEREAVED FAMILIES



Hôpital Général - St. Boniface - General Hospital
409 Tache Avenue,
WINNIPEG, MANITOBA R2H 2A6
(204) 943-0311

Please allow me to introduce myself. My name is Maureen Kitchur Harrison and I am a Master of Social Work student at the University of Manitoba. I am writing to you because I want to tell you about a counselling program I will be offerring over the next few months to families who have been associated with the St. Boniface Hospital's Palliative Care program on wards E2 and E3.

For many families like your own who have lost a member through a recent death, readjustment can be very difficult. Grief, loneliness, economic worries and new responsibilities can be hard for family members to cope with. Sometimes children's behavior patterns change and can be difficult for a parent to deal with. It is common for the bereaved family to feel isolated and without resources.

If your family is facing any of these difficulties and would like help dealing with them, you may be interested in the counselling program I referred to. Beginning in February, I will be able to provide counselling to a limited number of families on a confidential, individual basis. There will be no cost.

If you are interested in knowing more, or if you wish to make an appointment for your family, please telephone me at 453-2366, or leave a message for me at 237-2449 before February .

Yours sincerely,

Maureen Kitchur Harrison, B.A., B.S.W.

APPENDIX II

THE REVISED MORRISON CENTER FAMILY CONCERN FORM

And

INFORMATION RELATING TO ITS RELIABILITY AND VALIDITY

THE REVISED MORRISON CENTER FORM

To be completed by all family members aged ten or older

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing now in each area. Put a check (✓) in the box that shows your feeling about each area.

	Very dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc. about day-to-day matters					
3. Sharing problems with the family					
4. Being able to talk about the member of our family who recently died					
5. Sharing feelings like anger, sadness, hurt, etc, about losing someone in our family					
6. Listening and understanding					
7. Being patient or calm with others					
8. Showing care and concern					
9. Being positive, saying nice things about others					
10. Knowing what behavior to expect at different ages					
11. Dealing with matters concerning sex					
12. Making sensible rules					
13. Being able to discuss what is right and wrong					
14. Taking on responsibilities					
15. Use of self-control					
16. Proper use of alcohol, drugs					
17. Deciding, agreeing upon discipline					
18. Being consistent with discipline					
19. Participation in family fun and recreation					
20. Making individual decisions					
21. Making family decisions					
22. Seeking help for family problems from friends, relatives,church, etc.					
23. Participating in activities outside the family (ie., community, church, school, with friends, etc.)					
24. Feeling that our family can manage and carry on even though we've lost a close family member					
25. Feeling good about our family					
Make the last ratings for yourself:					
26. Feeling that I can carry on with living even though I've lost a close family member					
27. Feeling good about myself					

Background on the Original form and on its Revision

Because of the lack of appropriate family assessment devices for use with bereaved families (see discussion in Chapter Three), it was decided to adapt a family assessment instrument in current use.

The original Morrison Center Family Concern form has been in use for over five years at the Morrison Center For Youth and Family Service in Portland, Oregon. It has been found to be an effective instrument for measuring clients' satisfaction with aspects of their family's functioning and interaction, although no figures on its reliability are currently available. The original form is brief, easily understood by family members over the age of ten, and is simple to administer.

Because of the form's assets, few changes were required to make it appropriate for use with bereaved families. The items numbered 4, 5, 24 and 26 on the revised form were ones added for the purposes of this practicum. In addition, items 2 and 23 were re-worded to make them more appropriate to bereaved families.

Sensitivity to Change

The original and revised forms permit a relatively large range of change. Categories of response at either end of the scale permit both very low and very high indications of satisfaction. Five categories of response allow a client to indicate a change in feelings about his or her family without presenting a bewildering number of possible response categories.

The number of items on the form make it possible to observe changes in some areas even while no change occurs in other areas. The number of items thus prevents the danger of inferring general satisfaction or dissatisfaction on the basis of limited information.

Reliability

No figures are available on the reliability of the revised form, since the present intervention constitutes its first use. This is a disadvantage to be weighed against the form's merits and utility. The lack of an appropriate measure to supplement the therapeutic interview necessitates the use of this untried original self-report measure, but as Bloom and Fischer have pointed out, "there is little evidence that self-reports are any more or less reliable or valid than many other forms of measurement." (Bloom and Fischer 1982, p. 169).

Face and Content Validity

The revised form appears to have face validity, when considered in the context of the literature on normal and bereaved family functioning. Its content taps the elements of functioning cited in the literature as important indicators of non-bereaved and bereaved family functioning including problem-solving, communication, roles, affective expression and involvement, behavior control, and response to loss. (Vollman et al 1971; Goldberg 1973; Epstein, Bishop and Levin 1978; Epstein, Baldwin and Bishop 1983; Walsh 1982).

Criterion-Related Validity

The revised form cannot be fully validated by comparison to other instruments, since none tap exactly the same elements. (Had there been such an instrument, it would have been the measure of choice for this practicum). However, the validity of the original Morrison Center Family Concern form allows some validity to be assumed in the revised instrument, and the comparison of the results obtained by the revised instrument with the observations made by the therapist in interviews with clients indicates an acceptable level of validity.

Weaknesses/Limitations

a) the aforementioned lack of data on reliability

b) because the self-report is an obtrusive measure, it may be subject to reactivity

c) although the revised Family Concern form is a direct measure of client satisfaction with family functioning, it is an indirect measure of the actual family functioning itself. The therapist may only make inferences about family functioning based on the satisfaction ratings. (This is offset to some degree by the opportunity to observe client interaction and functioning in the therapeutic interview).

APPENDIX III

DIFFERENCES BETWEEN PRE- AND POST-INTERVENTION SCORES

ON THE FAMILY CONCERN FORM

FOR THE FIVE FAMILIES TO WHOM IT WAS ADMINISTERED

AN EXPLANATORY NOTE ON THE REPORTING OF CHANGES IN PRE- AND POST-INTERVENTION SCORES ON THE FAMILY CONCERN FORM

In the following tables, an increase or decrease in satisfaction is represented by a plus (+) or minus (-) sign in front of the number of response categories the item changed over the course of the intervention. Given that there were five possible categories of response on the Family Concern form, the maximum change that was possible on any given item was plus or minus 4 (ie. from very dissatisfied to very satisfied).

The notation "nc" indicates that no change occurred, while the notation "--" indicates that the item was not applicable to the respondent or that data is missing.

DIFFERENCES BETWEEN PRE- AND POST-INTERVENTION SCORES
ON THE FAMILY CONCERN FORM

FAMILY A

	Member 1	Member 2	Member 3
1. Showing good feelings (joy, happiness, pleasure, etc.)	+1	nc	nc
2. Sharing feelings like anger, sadness, hurt, etc. about day-to-day matters	nc	nc	nc
3. Sharing problems with the family	nc	nc	nc
4. Being able to talk about the member of our family who recently died	+1	+1	+1
5. Sharing feelings like anger, sadness, hurt, etc. about losing someone in our family	+1	nc	+1
6. Listening and understanding	+1	nc	--
7. Being patient or calm with others	-1	nc	+1
8. Showing care and concern	nc	nc	nc
9. Being positive, saying nice things about others	nc	+1	-1
10. Knowing what behavior to expect at different ages	nc	+1	-1
11. Dealing with matters concerning sex	nc	+2	nc
12. Making sensible rules	nc	nc	nc
13. Being able to discuss what is right and wrong	nc	nc	nc
14. Taking on responsibilities	-1	+1	nc
15. Use of self-control	nc	+2	-1
16. Proper use of alcohol, drugs	nc	nc	+2
17. Deciding, agreeing upon discipline	+1	+1	nc
18. Being consistent with discipline	nc	nc	+1
19. Participation in family fun and recreation	nc	nc	nc
20. Making individual decisions	nc	nc	nc
21. Making family decisions	nc	-1	nc
22. Seeking help for family problems from friends, relatives, church, etc.	nc	-1	nc
23. Participating in activities outside the family (ie., community, church, school, with friends, etc.)	nc	nc	-1
24. Feeling that our family can manage and carry on even though we've lost a close family member	nc	nc	+1
25. Feeling good about our family	nc	nc	nc
26. Feeling that I can carry on with living even though I've lost a close family member	nc	+1	nc
27. Feeling good about myself	+1	+2	+1

DIFFERENCES BETWEEN PRE- AND POST-INTERVENTION SCORES
ON THE FAMILY CONCERN FORM

FAMILY B

	Member 1	Member 2	
1. Showing good feelings (joy, happiness, pleasure, etc.)	--	+2	
2. Sharing feelings like anger, sadness, hurt, etc. about day-to-day matters	nc	nc	
3. Sharing problems with the family	nc	--	
4. Being able to talk about the member of our family who recently died	nc	+1	
5. Sharing feelings like anger, sadness, hurt, etc. about losing someone in our family	nc	+2	
6. Listening and understanding	+1	+2	
7. Being patient or calm with others	+2	nc	
8. Showing care and concern	nc	nc	
9. Being positive, saying nice things about others	--	+1	
10. Knowing what behavior to expect at different ages	--	+1	
11. Dealing with matters concerning sex	nc	nc	
12. Making sensible rules	--	+1	
13. Being able to discuss what is right and wrong	--	-1	
14. Taking on responsibilities	+1	nc	
15. Use of self-control	--	-2	
16. Proper use of alcohol, drugs	nc	-2	
17. Deciding, agreeing upon discipline	--	-3	
18. Being consistent with discipline	--	-1	
19. Participation in family fun and recreation	-1	nc	
20. Making individual decisions	nc	-1	
21. Making family decisions	+1	-1	
22. Seeking help for family problems from friends, relatives, church, etc.	nc	nc	
23. Participating in activities outside the family (ie., community, church, school, with friends, etc.)	-1	nc	
24. Feeling that our family can manage and carry on even though we've lost a close family member	nc	+1	
25. Feeling good about our family	nc	nc	
26. Feeling that I can carry on with living even though I've lost a close family member	nc	+1	
27. Feeling good about myself	nc	nc	

DIFFERENCES BETWEEN PRE- AND POST-INTERVENTION SCORES
ON THE FAMILY CONCERN FORM

FAMILY C

	Member 1	Member 2	
1. Showing good feelings (joy, happiness, pleasure, etc.)	-1	nc	
2. Sharing feelings like anger, sadness, hurt, etc. about day-to-day matters	nc	+1	
3. Sharing problems with the family	-1	nc	
4. Being able to talk about the member of our family who recently died	nc	+1	
5. Sharing feelings like anger, sadness, hurt, etc. about losing someone in our family	nc	nc	
6. Listening and understanding	nc	nc	
7. Being patient or calm with others	nc	nc	
8. Showing care and concern	--	nc	
9. Being positive, saying nice things about others	+1	+1	
10. Knowing what behavior to expect at different ages	+1	nc	
11. Dealing with matters concerning sex	-3	nc	
12. Making sensible rules	+1	--	
13. Being able to discuss what is right and wrong	-1	+1	
14. Taking on responsibilities	nc	+1	
15. Use of self-control	nc	+1	
16. Proper use of alcohol, drugs	+1	nc	
17. Deciding, agreeing upon discipline	--	--	
18. Being consistent with discipline	--	+1	
19. Participation in family fun and recreation	nc	nc	
20. Making individual decisions	nc	--	
21. Making family decisions	+2	+1	
22. Seeking help for family problems from friends, relatives, church, etc.	nc	+1	
23. Participating in activities outside the family (ie., community, church, school, with friends, etc.)	nc	+1	
24. Feeling that our family can manage and carry on even though we've lost a close family member	-1	nc	
25. Feeling good about our family	nc	--	
26. Feeling that I can carry on with living even though I've lost a close family member	+1	nc	
27. Feeling good about myself	+1	nc	

DIFFERENCES BETWEEN PRE- AND POST-INTERVENTION SCORES
ON THE FAMILY CONCERN FORM

FAMILY D

	Member 1		
1. Showing good feelings (joy, happiness, pleasure, etc.)	nc		
2. Sharing feelings like anger, sadness, hurt, etc. about day-to-day matters	nc		
3. Sharing problems with the family	nc		
4. Being able to talk about the member of our family who recently died	+1		
5. Sharing feelings like anger, sadness, hurt, etc. about losing someone in our family	nc		
6. Listening and understanding	nc		
7. Being patient or calm with others	+1		
8. Showing care and concern	+1		
9. Being positive, saying nice things about others	+2		
10. Knowing what behavior to expect at different ages	nc		
11. Dealing with matters concerning sex (and companionship)*	+2		
12. Making sensible rules	+2		
13. Being able to discuss what is right and wrong	nc		
14. Taking on responsibilities	—		
15. Use of self-control	+1		
16. Proper use of alcohol, drugs	—		
17. Deciding, agreeing upon discipline	+1		
18. Being consistent with discipline	nc		
19. Participation in family fun and recreation	-1		
20. Making individual decisions	nc		
21. Making family decisions	nc		
22. Seeking help for family problems from friends, relatives, church, etc.	nc		
23. Participating in activities outside the family (ie., community, church, school, with friends, etc.)	nc		
24. Feeling that our family can manage and carry on even though we've lost a close family member	nc		
25. Feeling good about our family	nc		
26. Feeling that I can carry on with living even though I've lost a close family member	-1		
27. Feeling good about myself	nc		

* the respondent added this item on both the pre- and post-intervention forms.

DIFFERENCES BETWEEN PRE- AND POST-INTERVENTION SCORES
ON THE FAMILY CONCERN FORM

FAMILY E

	Member 1		
1. Showing good feelings (joy, happiness, pleasure, etc.)	nc		
2. Sharing feelings like anger, sadness, hurt, etc. about day-to-day matters	-1		
3. Sharing problems with the family	nc		
4. Being able to talk about the member of our family who recently died	+1		
5. Sharing feelings like anger, sadness, hurt, etc. about losing someone in our family	nc		
6. Listening and understanding	+1		
7. Being patient or calm with others	nc		
8. Showing care and concern	nc		
9. Being positive, saying nice things about others	nc		
10. Knowing what behavior to expect at different ages	--		
11. Dealing with matters concerning sex	--		
12. Making sensible rules	nc		
13. Being able to discuss what is right and wrong	--		
14. Taking on responsibilities	nc		
15. Use of self-control	--		
16. Proper use of alcohol, drugs	--		
17. Deciding, agreeing upon discipline	--		
18. Being consistent with discipline	--		
19. Participation in family fun and recreation	--		
20. Making individual decisions	nc		
21. Making family decisions	nc		
22. Seeking help for family problems from friends, relatives, church, etc.	--		
23. Participating in activities outside the family (ie., community, church, school, with friends, etc.)	nc		
24. Feeling that our family can manage and carry on even though we've lost a close family member	nc		
25. Feeling good about our family	nc		
26. Feeling that I can carry on with living even though I've lost a close family member	nc		
27. Feeling good about myself	+1		

APPENDIX IV

THE EVALUATION QUESTIONNAIRE

and

SUMMARY OF RESULTS
OF QUESTIONS NOT RELATED TO THE SERVICE COMPONENT OF THE PRACTICUM

(QUESTIONS 1, 2, 14, 15, 16 and 17)

Your answers to the following questionnaire will help improve social work service to bereaved families. Please check off the response which you think best answers each question below. A space for comments is provided in selected questions and at the end of the questionnaire. Thank you for your assistance.

1) How did you and your social worker come into contact?

_____ The social worker sent me a letter, and I responded by telephoning him/her.

_____ I telephoned the social worker after being given her/his name and phone number by another social worker.

_____ The social worker telephoned me or someone in my family.

2) Do you feel that a social worker should contact every family at least once after the death of one of their members?

_____ Yes _____ No

3) How soon after the death of your family member was your first contact with the social worker?

_____ one month

_____ 2 - 3 months

_____ 4 - 5 months

_____ 6 - 8 months

_____ 9 - 11 months

_____ one year

4) My first contact with the social worker after the death of my family member was

_____ too soon

_____ later than I would have preferred

_____ at about the right time

5) I met with my social worker

_____ only at my home

_____ only at the hospital

_____ at my home and at the hospital

6) Would you have been willing to meet with the social worker if she could meet with you only at the hospital?

_____ Yes _____ No

7) How helpful were your meetings with the social worker?

_____ Very helpful

_____ Helpful

_____ A little helpful

_____ Not sure

_____ Not at all helpful

Please explain: _____

_____

_____

8) Did you attend meetings with your social worker at which other members of your family were present?

_____ Yes (If yes, go to question 8 a) below)

_____ No (If no, go to question 8 b) below)

a) If you answered yes to the above question, were those meetings helpful for you?

_____ Yes _____ No

b) If you answered no to question 8, would you have liked a meeting at which your family could have been present?

_____ Yes _____ No

9) Please examine the list below and place a check beside the topics that you discussed with your social worker:

_____ loneliness

_____ helplessness

_____ anger

_____ religious beliefs

_____ the illness of your deceased family member

_____ the medical care your family member received before his or her death

_____ communication with your deceased family member during the time of his or her illness and hospitalization

_____ your past relationship with your deceased family member

_____ the funeral of your family member

_____ fear

_____ feeling guilty

_____ feeling empty

_____ feeling sad

_____ communication between you and other surviving members of your family

_____ concerns about the behavior or coping of children in your family

_____ decisions relating to financial matters

_____ difficulty with sleeping, eating or your health

10) Is there any subject not listed above which you would have liked to discuss with your social worker?

_____ Yes _____ No

If yes, please list: _____

_____

11) Please list two main concerns or problems that you worked on with your social worker:

a) _____

b) _____

How much change have you experienced in relation to item a) ?

_____ It is much better

_____ It is somewhat better

_____ It is much the same

_____ It has become worse

Please explain in what way it is better, worse or the same: _____

_____

_____

How much change have you experienced in relation to item b) ?

_____ It is much better

_____ It is somewhat better

_____ It is much the same

_____ It has become worse

Please explain in what way it is better, worse or the same: _____

_____

_____

12) Would you recommend the type of help you received to other bereaved families?

_____ Yes _____ Perhaps _____ No

13) Do you feel that the help you received from your social worker will make it easier to deal with future losses?

_____ Yes _____ Perhaps _____ No

14) Have you (or do you hope to) participate(d) in any kind of group for bereaved individuals?

_____ Yes _____ No

If yes, at what point do you think attending such a group can be most helpful?

_____ about one week after the funeral

_____ about one month after

_____ about three months after

_____ about six months after

_____ a year or more after

15) Were you invited to attend a social evening for bereaved families at the St. Boniface Hospital?

_____ Yes _____ No

16) If you attended the social evening, did you find it helpful?

_____ Yes _____ No

If yes, what did you find most helpful about it? _____

_____

If no, was there a particular reason it was not helpful? _____

_____

17) If you turned down an invitation to attend the social evening, please check any of the reasons below that apply to you:

_____ you didn't want to return to the hospital

_____ you felt it was too soon to attend a social evening

_____ you felt it wouldn't be any help

_____ you thought it might make you feel worse

other: _____

18) Any other comments you have regarding the social work service you received, or on social work services for bereaved families in general, would be most welcome: _____

_____

_____

_____

_____

THANK YOU!

SUMMARY OF RESULTS OF EVALUATION QUESTIONS NOT RELATED TO THE SERVICE COMPONENT OF THE PRACTICUM

Six questions not relating to the service component of the practicum were included in the questionnaire:

1) Question 1 was designed to provide a context in which a respondent's answers could be understood. Ten respondents reported that the social worker had contacted them or someone in their family. One reported having contacted the social worker on his/her own. The mode of initial contact did not appear to make a significant difference in respondents' replies to other questions.

2) Question 2 was designed to gather client opinion on the importance of bereavement follow-up in general. Eleven respondents felt that a social worker should contact every family at least once after the death of one of their members. One of those respondents qualified their answer with the clause "unless parents were in their eighties".

Questions 14, 15, 16 and 17 were designed to gauge client feelings about two other types of bereavement follow-up.

14) Five respondents had (or hoped to) participate(d) in a group for bereaved individuals. Three of these thought such a group would be most helpful about one month after the death, one thought about six months after would be most helpful, and one thought a year or more would be most helpful. Six respondents had not (and did not hope to) participate in a group for bereaved individuals.

15) All of the respondents had been invited to a social evening for bereaved families at the St. Boniface Hospital.

16) Of the five who attended the social evening, two did not find it helpful, explaining that they "knew nobody except the doctor". Three found the social evening helpful because of the opportunity to talk to pastoral and social work staff and meet other 'survivors'.

17) Of the six respondents who turned down an invitation to the social evening, their reasons were as follows:

- thought it would make them feel worse (2)
- did not want to return to the hospital (2)
- felt it was too soon to attend a social evening (2). (Both these respondents had been invited approximately three months after the death of a spouse).

BIBLIOGRAPHY

Abraham, Ada (1972). Death and Psychodrama. Group Psychotherapy and Psychodrama, 25 (3), 84-92.

Ajemian, Ina & Mount, Balfour. (Eds.). (1980). The Royal Victoria Hospital Manual on Palliative/Hospice Care: A Resource Book. New York: Arno Press.

Alexander, Irving E. & Adlerstein, Arthur M. (1958). Affective Responses to the Concept of Death in a Population of Children and Early Adolescents. The Journal of Genetic Psychology, 93, 167-177.

Allison, Helen (1980). An Evaluation of Social Work Practice with the Terminally Ill: A Single Subject Design. Master of Social Work Practicum. Calgary: University of Calgary, Faculty of Social Welfare.

Anderson, Ralph E. & Carter, Irl (1978). Human Behavior in the Social Environment: a social systems approach (2nd ed.). Hawthorne, NY: Aldine Publishing Company.

Arkin, Arthur M. (1981). Emotional Care of the Bereaved. In Otto S. Margolis et al (Eds.), Acute Grief: Counseling the Bereaved (pp. 40-44). New York: Columbia University Press.

Barnes, Marion J. (1978). The reactions of children and adolescents to the death of a parent or sibling. In Olle Jane Z. Sahler (Ed.), The Child and Death (pp. 185-201). Saint Louis: The C. V. Mosby Company.

Barrett, C. J. (1978). Effectiveness of Widows' Groups in Facilitating Change. Journal of Consulting and Clinical Psychology, 46 (1), 20-31.

Becker, D. & Margolin, F. (1967). How Surviving Parents Handled Their Young Children's Adaptation to the Crisis of Loss. American Journal of Orthopsychiatry, 37, 753-757.

Black, Dora (1981). Mourning and the Family. In Sue Walrond-Skinner (Ed.), Developments in Family Therapy (pp. 189-201). London: Routledge & Kegan Paul.

Bloom, Martin (Ed.). (1980). Life Span Development: Bases for Preventive and Interventive Helping. New York: Macmillan Publishing Co., Inc.

Bloom, Martin & Fischer, Joel (1982). Evaluating Practice: Guidelines for the Accountable Professional. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Bluebond-Langner, Myra (1977). Meanings of Death to Children. In Herman Feifel (Ed.), New Meanings of Death (pp. 47-66). New York: McGraw-Hill, Inc.

Boszormenyi-Nagy, I. & Spark, G. M. (1973). Invisible Loyalties: Reciprocity in Intergenerational Family Therapy. New York: Harper and Row.

Bowen, Murray (1978). Family Reaction to Death. Family Therapy in Clinical Practice (pp. 321-335). New York: Jason Aronson, Inc.

Bowen, Murray (1980). Key to the Use of the Genogram (Family Diagram). In E. Carter & M. McGoldrick (Eds.), The Family Life Cycle: A Framework for Family Therapy (p. 6). New York: Gardner Press, Inc.

Bowlby, John (1960). Grief and Mourning in Infancy and early Childhood. The Psychoanalytic Study of the Child, 15, 9-52.

Bowlby, John (1961). Processes of Mourning. International Journal of Psychoanalysis, 42, 317-340.

Bowlby, John (1963). Pathological Mourning and Childhood Mourning. Journal of American Psychoanalytic Association, 11, 500-541.

Bradt, Jack O. (1980). The Family Diagram: Method, Technique and Use in Family Therapy. Washinton,DC: Groome Center.

Cameron, Jean & Brings, Barbara (1979). Bereavement Outcome Following Preventive Intervention: A Controlled Study. In I. Ajemian & B. Mount (Eds.), The Royal Victoria Hospital Manual on Palliative/ Hospice Care. New York: Arno Press.

Caplan, Gerald (1964). Principles of Preventive Psychiatry. New York: Basic Books.

Carey, Raymond G. (1979). Weathering Widowhood: Problems and Adjustment of the Widowed During the First Year. Omega, 10 (2), 163-173.

Caroff, Phyllis & Dobrof, Rose (1975). The Helping Process with Bereaved Families. In B. Schoenberg, I. Gerber, A. Wiener, A. H. Kutscher, D. Peretz, A. C. Carr (Eds.), Bereavement: Its Psychosocial Aspects (pp. 232-242). New York: Columbia University Press.

Carter, E. & McGoldrick, M. (Eds.). (1980). The Family Life Cycle: A Framework for Family Therapy. New York: Gardner Press, Inc.

Cassidy, W. L., Flanagan, N. B., Spellman, M., & Cohen, M. E. (1957). Clinical observations in manic-depressive disease. Journal of the American Medical Association, 164, 1535-1546.

Clayton, P. J. (1973). The clinical morbidity of the first year of bereavement. Comprehensive Psychiatry, 14, 151-157.

Clayton, P., Desmarais, L., Winokur, G. (1968). A Study of Normal Bereavement. American Journal of Psychiatry, 125, 64-74.

Cohen, P., Dizenhuz, I. M., & Winget, C. (1977). Family adaptation to terminal illness and death of a parent. Social Casework, April issue, 223-228.

Compton, B. R. & Galaway, B. (Eds.). (1975). The Focus of Social Work Intervention. Social Work Processes. Homewood, Illinois: The Dorsey Press.

Deutsch, Helene (1937). Absence of Grief. Psychoanalytic Quarterly, 6, 12-22.

Deutsch, Helene (1967). Selected problems of Adolescence (Monograph Serial on the Psychoanalytic Study of the Child, No. 3). New York: International University Press.

Deyken, Eva et al (1966). The empty nest: psychosocial aspects of conflict between depressed women and their grown children. American Journal of Psychiatry, 122.

Eliot, Thomas D. (1955). Bereavement: Inevitable but Not Insurmountable. In H.Becker & R.Hill (Eds.), Family, Marriage and Parenthood (pp. 641-668). Boston: Heath Publishers.

Engel, G. (1961). Is Grief a disease? Psychosomatic Medicine, 23, 18-22.

Epstein, N. B., Bishop, D. S., & Levin, S. (1978). The McMaster Model of Family Functioning. Journal of Marriage and Family Counseling, October issue, 19-31.

Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster Family Assessment Device. Journal of Marital and Family Therapy, 9 (2), 171-180.

Erikson, Erik (1968). Life Cycle. In D. L. Sills (Ed.), The International Encyclopedia of the Social Sciences, 9, 286-292.

Fassler, Joan (1978). Helping Children Cope: Mastering Stress Through Books and Stories. New York: The Free Press.

Ferguson, Tamara (1979). How Young Widows Have Coped with their Problems. In I. Gerber, A. Wiener, A. H. Kutscher, D. Battin, A. Arkin, & I. K. Goldberg (Eds.), Perspectives on Bereavement (pp. 33-46). New York: Arno Press.

Ferguson, T., Schorer, C. E., Tourney, G., Ferguson, J. (1981). Bereavement, Stress and Rescaling Therapy. In O. S. Margolis, H. C. Raether, A. H. Kutscher, J. B. Powers, I. B. Seeland, R. DeBellis, & D. J. Cherico (Eds.), Acute Grief: Counseling the Bereaved (pp. 158-166). New York: Columbia University Press.

Flesch, Regina (1975). A Guide to Interviewing the Bereaved. Journal of Thanatology, 3, 39-103 & 143-159.

Framo. J. L. (1972). Symptoms from a Family Transactional Viewpoint. In C. J. Sager & H. S. Kaplan (Eds.), Progress in Group and Family Therapy. New York: Brunner/Mazel.

Fredrick, Jerome F. (1971). A preliminary study on the physiologic effects of grief. Omega, 2, 71-75.

Fredrick, Jerome F. (1981). The Biochemistry of Acute Grief with Regard to Neoplasia. In O. S. Margolis, H. C. Raether, A. H. Kutscher, J. B. Powers, I. B. Seeland, R. DeBellis, & D. J. Cherico (Eds.), Acute Grief: Counseling the Bereaved (pp. 111-117). New York: Columbia University Press.

Freud, Anna (1952). The Mutual Influences in the Development of Ego and Id. Psychoanalytic Study of the Child, 7, 42-50.

Freud, Anna & Burlingham, Dorothy (1944). Infants without Families. New York: International Universities Press.

Freud, Sigmund (1913). Totem and Taboo. Standard edition, 13, 1-161.

Freud, Sigmund (1915). Instincts and their Vicissitudes. Standard edition, 14, 237-258.

Freud, Sigmund (1917). Mourning and Melancholia. Standard edition, 14, 152-170.

Freud, Sigmund (1938). Splitting of the Ego in the defensive process. Collected Papers, 4, 372-375. London: Hogarth Press.

Furman, Erna (1974). A Child's Parent Dies: Studies in Childhood Bereavement. New Haven: Yale University Press.

Gardner, Richard A. (1971). Therapeutic Communication with Children: The Mutual Storytelling Technique. New York: Science House, Inc.

Gerber, Irwin (1969). Bereavement and the Acceptance of Professional Service. Community Mental Health Journal, 5, 487-495.

Gerber, I., Wiener, A., Battin, D., & Arkin, A. (1975). Brief Therapy to the Aged Bereaved. In B. Schoenberg, I. Gerber, A. Wiener, A. H. Kutscher, D. Peretz, A. C. Carr (Eds.), Bereavement: Its Psychosocial Aspects (pp. 310-333). New York: Columbia University Press.

Glick, I. O., Weiss, R. S., Parkes, C. M. (1974). The First Year of Bereavement. New York: John Wiley & Sons.

Golan, Naomi (1978). Treatment in Crisis Situations. New York: The Free Press.

Goldberg, D. P. (1972). The Detection of Psychiatric Illness by Questionnaire. A Technique for the Identification of Non-Psychotic Psychiatric Illness (Maudsley Monographs #21). London: Oxford University Press.

Goldberg, Stanley B. (1973). Family tasks and reactions in the crisis of death. Social Casework, July issue, 398-405.

Greenberg, Lois I. (1975). Therapeutic Grief Work with children. Social Casework, 56, 396-403.

Hadley, T., Jacob T., Milliones J., Caplan, J., & Spitz, D. (1974). The Relationship Between Family Developmental Crises and the Appearance of Symptoms in a Family Member. Family Process, 13 (2).

Haley, Jay (1976). Problem-Solving Therapy. New York: Harper & Row, 1976.

Heimler, Eugene (1967). The Heimler Scale of Social Functioning.

Herz, Fredda (1980). The Impact of Death and Serious Illness on the Family Life Cycle. In E. Carter & M. McGoldrick (Eds.), The Family Life Cycle: A Framework for Family Therapy. New York: Gardner Press, Inc.

Jackson, Edgar N. (1957). Understanding Grief: Its Roots, Dynamics and Treatment. New York: Abingdon Press.

Jacobson, Edith (1957). Normal and Pathological Moods: Their Nature and Functions. The Psychoanalytic Study of the Child, 12, 73-113.

Jensen, Gordon D. & Wallace, John G. (1967). Family Mourning Process. Family Process, 6, 56-66.

Kastenbaum, Robert (1959). Time and Death in Adolescence. In H. Feifel (Ed.), The Meaning of Death (pp. 99-113). New York: McGraw-Hill Book Company, Inc.

Kazdin, A. E. (1980). Research Design in Clinical Psychology. New York: Harper and Row.

Klein, Melanie (1940). Mourning and Its Relation to Manic-Depressive States. International Journal of Psycho-analysis, 21, 125-153.

Kliman, Gilbert (1979). Facilitation of Mourning During Childhood. In I. Gerber, A. Wiener, A. H. Kutscher, D. Battin, A. Arkin & I. K. Goldberg (Eds.), Perspectives on Bereavement (pp. 76-100). New York: Arno Press.

Kubler-Ross, Elisabeth (1969). On Death and Dying. New York: Macmillan Publishing Co., Inc.

Laufer, M. (1966). Object Loss and Mourning during Adolescence. The Psycho-Analytic Study of the Child, 21, 269-293.

Lehrman, Samuel L. (1973). Reactions to Untimely Death. The Psychiatric Quarterly, 30.

Lieberman, Stuart (1979). Transgenerational Family Therapy. London: Croom Helm, Ltd.

Lindemann, Erich (1944). Symptomatology and Management of Acute Grief. American Journal of Psychiatry, 101, 141-148.

Lipson, Channing T. (1973). Denial and Mourning. In H. M. Ruitenbeek (Ed.), The Interpretation of Death (pp. 268-272). New York: Jason Aronson, Inc., Publishers.

Lopata, Helena Z. (1979). Women as Widows: Support Systems. New York: Elsevier North Holland, Inc.

Maddison, D. & Viola, A. (1968). The Health of Widows in the Year Following Bereavement. Journal of Psychosomatic Research, 12, 297ff.

Markham, Sylvia (1979). Widowhood in Middle-Age: A Crisis in Identity. In I. Gerber, A. Wiener, A. H. Kutscher, D. Battin, A. Arkin, & I. K. Goldberg (Eds.), Perspectives on Bereavement (pp. 26-32). New York: Arno Press.

Marris, P. (1958). Widows and their Families. London: Routledge & Kegan Paul.

McGoldrick, Monica (1980). The Joining of Families Through Marriage: The New Couple. In E. Carter & M. McGoldrick (Eds.), The Family Life Cycle: A Framework for Family Therapy. New York: Gardner Press, Inc.

Meyer, Patricia (1980). Between Families: The Unattached Young Adult. In E. Carter & M. McGoldrick (Eds.), The Family Life Cycle: A Framework for Family Therapy. New York: Gardner Press, Inc.

Minuchin, Salvador (1974). Families and Family Therapy. Cambridge: Harvard University Press.

Morrison Center for Youth and Family Service, The (1983). Family Concern Form. Portland, Oregon: The Morrison Center.

Nagera, Humberto (1970). Children's Reactions to the Death of Important Objects: A Developmental Approach. The Psychoanalytic Study of the Child, 25, 360-400.

Nagy, Maria (1948). The Child's View of Death. Journal of Genetic Psychology, 73, 3-27.

Nolte, J., Smallwood, C., & Weistart, J. (1975). Role Reversal with God. Group Psychotherapy and Psychodrama, 28, 70-76.

Orfanidis, M. (1977). Some Data on Death and Cancer in Schizophrenic Families. (Presentation, Georgetown Pre-Symposium Meeting). Washington, DC.

Parkes, Colin Murray (1965). Bereavement and Mental Illness. (Part One, A Clinical Study of the Grief of Bereaved Psychiatric Patients. Part Two, A Classification of Bereavement Reactions). British Journal of Medical Psychology, 38(1).

Parkes, Colin Murray (1970). The First Year of Bereavement: a Longitudinal Study of the Reaction of London Widows to the Death of their Husbands. Psychiatry, 33, 444ff.

Parkes, Colin Murray (1972). Bereavement: Studies of Grief in Adult Life. London: Tavistock Publications.

Parkes, Colin Murray (1975). Determinants of Outcome Following Bereavement. Omega, 6(4), 303-32.

Parkes, Colin Murray (1980). Bereavement Counselling: does it work? British Medical Journal, 5 July, 3-6.

Parkes, Colin M. and Brown, R. J. (1972). Health After Bereavement: A Controlled Study of Young Boston Widows and Widowers. Psychosomatic Medicine, 34, 449-461.

Paul, Norman (1967). The Role of Mourning and Empathy in Conjoint Marital Therapy. In G.H. Zuk & I. Boszormenyi-Nagy (Eds.), Family Therapy and Disturbed Families (pp. 186-205). Palo Alto, Calif.: Science and Behavior Books, Inc.

Paul, Norman & Grosser, George (1965). Operational Mourning and Its Role in Conjoint Family Therapy. Community Mental Health Journal, 1(4), 339-345.

Paul, Norman & Paul, Betty (1982). Death and Changes in Sexual Behavior. In F. Walsh (Ed.), Normal Family Processes (pp. 229-250). New York: Guilford Press.

Pincus, Lily (1974). Death and the Family: The Importance of Mourning. New York: Pantheon Books.

Polak, P. R., Egan, D., Lee, J.H., Vandenberghe, R. H., & Williams W. V. (1975). Prevention in mental health: a controlled study. American Journal of Psychiatry, 132, 146-149.

Proulx, Joseph R. & Baker, Patricia D. (1981). Grief, Grieving and Bereavement: A Look at the BASICS. In O. S. Margolis, H. C. Raether, A. H. Kutscher, J. B. Powers, I. B. Seeland, R. DeBellis, & D. J. Cherico (Eds.), Acute Grief: Counseling the Bereaved (pp. 191-198). New York: Columbia University Press.

Raphael, B. (1977). Preventive Intervention with the Recently Bereaved. Archives of General Psychiatry, 34, 1450-1454.

Rees, W. D. & Lutkins, S. G. (1967). A statistical study of the pathology of bereavement. British Medical Journal, 4, 13ff.

Reilly, Dennis M. (1975). Family Factors in the Etiology and Treatment of Youthful Drug Abuse. Family Therapy, 2, 149-171.

Reilly, Dennis M. (1978). Death Propensity, Dying and Bereavement: A Family Systems Perspective. Family Therapy, 5(1), 35-55.

Rhodes, Sonya (1977). A Developmental Approach to the Life Cycle of the Family. Social Casework, 58(5), 301-311.

Robertson, J. (1953). A Guide to the Film "A Two-Year-Old Goes to Hospital". London: Tavistock Child Development Research Unit.

Robertson, J. (1958). Young Children in Hospital. London: Tavistock Publications.

Robertson, J. (Ed.). (1962). Hospitals and Children. New York: International Universities Press.

Royal Victoria Hospital (1977). Palliative Care Service: Pilot Project - Jan. 1975 to Jan. 1977. Montreal: McGill University.

Sanders, Catherine M. (1980). The Comparison of Younger and Older Spouses in Bereavement Outcome. Omega, 11(3), 217-232.

Sanders, Catherine M., Mauger, P. A., & Strong, Jr., P. N. (1979). The Grief Experience Inventory. University of South Florida: Loss and Bereavement Resource Center.

Satir, Virginia (1983). Conjoint Family Therapy (3rd ed.). Palo Alto, Calif.: Science and Behavior Books, Inc.

Schiff, H. S. (1977). The Bereaved Parent. New York: Crown Publishers.

Scruby, Lynn (1984). Evlauation of the Effectiveness of a Bereavement Intervention Program with Key Persons of Cancer Patients. (Abstract). Winnipeg, Man.: The University of Manitoba School of Nursing.

Shoor, Mervyn & Speed, Mary H. (1963). Death, Delinquency and the Mourning Process. The Psychiatric Quarterly, 37, 540-558.

Silverman, Phyllis (1968). The widow-to-widow programs: An experiment in preventive intervention. Mental Hygiene, 53, 333-339.

Silverman, Phyllis & Englander, Sue (1975). The Widow's View of Her Dependent Children. Omega, 6(1), 3-20.

Simos, Bertha (1977). Grief Therapy to facilitate healthy restitution. Social Casework, June issue, 337-342.

Stern, K., Williams, G. M., & Prados, M. (1951). Grief Reactions in Later Life. American Journal of Psychiatry, 108, 289-294.

Switzer, David K. (1972). Repressed Affect and Memory Reactive to Grief: A Case Fragment. Omega, 3(2), 121-126.

Teitz, W., McSherry, L., & Britt, B. (1977). Family Sequelae After a Child's Death due to Cancer. American Journal of Psychotherapy, 31(3), 417-425.

Vachon, Mary L. S.)1976). Grief and Bereavement Following the Death of a Spouse. Canadian Psychiatric Association Journal, 21, 35-42.

Vachon, M., Lyall, W. A. L., Rogers, J. Freedman, K., Freeman, S. J. G. (1980). A controlled study of self-help intervention for widows. American Journal of Psychiatry, 137(2), 1380-1384.

Volkan, Vamik D. (1966). Normal and Pathological Grief Reactions - A Guide for the Family Physician. Virginia Medical Monthly, 93, 651ff.

Volkan, Vamik D. (1975). 'Re-Grief' Therapy. In B. Schoenberg, I. Gerber, A. Wiener, A. H. Kutscher, D. Peretz, A. C. Carr (Eds.), Bereavement: Its Psychosocial Aspects (pp. 334-350). New York: Columbia University Press.

Volkart, Edmund H. & Michael, Stanley T. (1957). Bereavement and Mental Health. In A. H. Leighton, J. A. Clausen & R. N. Wilson (Eds.), Explorations in Social Psychiatry (pp. 281-307). New York: Basic Books.

Vollman, Rita R., Ganzert, Amy, Picher, Lewis & Williams, W. V. (1971). The Reactions of Family Systems to sudden and Unexpected Death. Omega, 2, 101-106.

Walker, Julie R. & Lattanzi, Marcia (Eds.). (1982). Understanding Loss and Grief. Boulder: Boulder County Hospice, Inc.

Walker, Kenneth, MacBride, Arlene, & Vachon, Mary (1977). Social Support Networks and the Crisis of Bereavement. Social Science and Medicine, 11, 35-41.

Waller, Willard (1951). The Family, revised by Reuben Hill. New York: Dryden Press.

Walsh, F. (1978). Concurrent Grandparent Death and the Birth of a Schizophrenic Offspring: An Intriguing Finding. Family Process,17(4).

Walsh, F. (1980). The Family in Later Life. In E. Carter & M. McGoldrick (Eds.), The Family Life Cycle: A Framework for Family Therapy.

Walsy, F. (Ed.). (1982). Normal Family Processes. New York: Guilford Press.

Wargotz, Helen (1969). Widowers with Teen-Age Children. In A. Kutscher (Ed.), Death and Bereavement (pp. 257-269). Springfield, Illinois: Charles C. Thomas, Publisher.

Webb, Lucinda (1979). Death and the Child in America Today. In I. Gerber, A. Wiener, A. H. Kutscher, D. Battin, A. Arkin & I. K. Goldberg (Eds.), Perspectives on Bereavement. New York: Arno Press.

Weiner, Hannah (1975). Living Experiences with Death - A Journeyman's View Through Psychodrama. Omega, 6(3), 251-274.

Wiener, A., Gerber, I., Battin D., & Arkin, A. (1975). The Process and Phenomenology of Bereavement. In B. Schoenberg, I. Gerber, A. Wiener, A. H. Kutscher, D. Pereta, A. C. Carr (Eds.), Bereavement: Its Psychosocial Aspects (pp. 53-65). New York: Columbia University Press.

Williams, W. V., Polak, Paul, Vollman, Rita. (1972). Crisis Intervention in Acute Grief. Omega, 3, 67-70.

Wolfenstein, M. (1965). Death of a Parent and Death of a President. In M. Wolfenstein & G. Kliman (Eds.), Children and the Death of a President (pp. 62-79). New York: Doubleday.

Worden, J. William. (1982). Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner. New York: Springer Publishing Company.