WORKING THROUGH GRIEF AND LOSS WITH CHILDREN AND THEIR FAMILIES: GROUP AND INDIVIDUAL APPROACHES

BY

JUDITH C. TOZELAND

A PRACTICUM REPORT

Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

WORKING THROUGH GRIEF AND LOSS WITH CHILDREN AND THEIR FAMILIES: GROUP AND INDIVIDUAL APPROACHES

BY

JUDITH C. TOZELAND

A Thesis/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

ACKNOWLEDGEMENTS

A project like this involves more than just one person and requires the support of one's community. I would like to take this opportunity to thank the members of my community for their understanding, patience, and encouragement. Thank you first to my husband John, for his unquestioning confidence in me, his consistent moral support, his ability to listen (and listen, and listen) which provided an objective sounding board, and of course for his amazing computer skills and knowledge. Next I need to thank both my daughters and my son-in-law for their enthusiastic encouragement and patience in also listening and listening. It was great to have my own personal cheering section.

Next I would like to thank my family, John's family and friends for their interest, encouragement, and support while I worked on this project. This is another group that was very good at listening and listening. I managed to keep all these people up to date at exactly what stage I was at any point in the process! A special thanks to Janette Stephenson who patiently read and edited the first draft.

I would like to make a special notation in remembrance of my father who passed away during the work on this degree. This brings home the need to celebrate our accomplishments with people we care about.

I would like to thank all my colleagues at the Child Guidance Clinic for their suggestions, encouragement, and interest. I know how fortunate I am to have this kind of support and I am most appreciative of these listeners as well.

A special thanks goes to Linda Croll, my co-therapist, whose wisdom, enthusiasm, experience, humour, and support, made this project much more enjoyable and enriching. I am very fortunate to have such amazing people in my life.

I would like to thank the members of my committee, Dr. Diane Hiebert-Murphy, Dr. Laura Mills, and Kim Clare M.S. W. for their time and commitment to this project. A special thanks goes to Diane as she has been my advisor over the past four years. She has seen me through a few crisis and tears, as life has proceeded on through academia, work, and home. I truly appreciate her understanding, patience, and skills as a social worker and I have learned much from her example.

I would like to say a special thanks to the people I worked with who shared their experiences and allowed me to be a part of their lives for a time. I appreciate their courage, honesty, and willingness to grow.

Table of Contents

Table of Contents

Table of Contents

Table of Contents

page

Table of Contents

page

Table of Contents

page

LIST OF TABLES

ABSTRACT

This practicum focused on assisting children and their families in coping with grief from the loss of a parent or significant adult. The theoretical approach taken was a systemic, developmental perspective which considered the child's and the family's development. The intervention methods were individual play therapy and group work. The children in this practicum were between the ages of 5 and 12 and had lost a parent within the last two years. The practicum included two interventions: a) eight children and their guardians were seen in group therapy, and b) three children were seen in individual therapy and their caregivers received counselling. Themes that emerged from the intervention focused on the ability of the family to allow, support and accept the feelings their children were experiencing, the open or closed communication system of the family in tolerating the expression of grief, the function the deceased served in the family, the developmental level of the child at the time of the death, and how emotionally close the child was to the parent who died. The primary focus in this work involved providing an opportunity for children to express their grief and for parents to understand and support the grieving process their children were experiencing.

CHAPTER ONE

Introduction

Losses occur in people's lives as an inevitable part of living. In my work as a social worker I have worked with people who have experienced a vast and wide-ranging number of losses in their lives. Unresolved grief has a profound impact on how people function and cope with all manner of stresses (Shapiro, 1995). Early writers such as Kubler-Ross (1969) have highlighted the need to become more open with the dying by acknowledging the fear and loneliness of people affected by death. Her ground breaking work on the stages of death has stimulated a vast plethora of research and thought on this subject. Other writers such as Stephen Levine (1995) discuss the spiritual and more philosophical aspects of death and how this impacts on our everyday living. Self help literature for parents (e.g., Dillon, 1995; Fitzgerald,1992; and Grollman, 1995), have been available for parents to use and become more informed and confident in talking to their children about death. These resources have been useful in providing a framework and context for understanding the subject and planning ways of intervening.

How children grieve, what is normal, what is abnormal, how can a helper assist in allowing a safe environment for children to express and resolve their grief, were all questions which came to mind in considering the topic for this practicum. The loss of a parent through death has a profound impact on how children understand and make sense of the world, as well as how they cope in day to day living (Shapiro, 1995). This specific type of loss was chosen for study with the realization and hope that many of the principles and the knowledge could be applied to all other situations where loss has occurred.

Play is a natural medium for children by which they learn, gain experience, test new ideas and thoughts, become socialized, and recreate their world as they see it (Doka, 1995; James, 1994; Krall, 1989; Lubimiv, 1994). As play is such a natural process, using play in therapy was chosen as

a primary form of intervention with children in both the individual and group format.

Children's play changes and matures as does the child. An understanding of child development and the relationship of the child within his or her family were also major areas for study and learning. This knowledge is very useful in working with any family and can be easily generalized to many situations. Learning how this applies specifically in situations of loss deepens the understanding of how the family and the child react in the loss situation and can allow the social worker to intervene in the family in a more sensitive, effective and knowledgeable way.

The use of the group as an intervention method for children and their families was chosen, but with a somewhat different format than has been used in the past. Often children are seen in a group on their own (Baker & Sedney, 1996) and the parents meet separately for support counseling. Of interest to this practicum was to integrate the child's and the adult's emotional experiences of the loss, as they attended the group at the same time.

It was in the individual time with the children, during the group intervention, that play techniques were utilized. Many learning opportunities were provided by using play within the context of the group and in individual counseling. The goal of this practicum report is to talk about the learning that took place and the implications for future practice.

Aims of the Practicum

The aims of this practicum were twofold. The first was to assist children who had experienced a significant loss from the death of a parent or significant person in their lives. This was explored through the use of both a group intervention and individual work with children.

The second aim was to provide an opportunity for learning skills in intervening with children and families who have experienced a loss through death. Learning took place through developing and running a group with a

co-therapist and through individual play therapy with three children and their caregivers.

Both a group intervention and an individual intervention were chosen to provide a wide range of skill development. A group offers a range of dynamics requiring different skills and intervention techniques than those required in individual work with children. The three children chosen for the individual portion of the practicum were young children who would benefit from play therapy and allow me an opportunity to further develop my play therapy skills.

The expected educational benefits for the therapist, in the group intervention, included:

1. Enhancing group work skills for working with both children and adult group members.
2. Developing skill in the use of the parent/child relationship to promote emotional healing and long term well being for the child.
3. Exploring grief and loss issues with children and caregivers in a group setting and understanding which parental issues are relevant in assisting children to grieve in a healthy and effective way.
4. Incorporating caregivers into the therapy with their children and learning about the effectiveness of this process. Of interest was not only how each person expresses and resolves her or his grief, but how the relationship between the caregiver and child affects the resolution of these emotions.
5. Studying the group intervention process and learning how that dynamic adds to the resolution of grief.
6. Developing co-therapy skills in facilitating groups.

Learning goals in the individual intervention included:

1. Developing skills in play therapy with individual children.
2. Developing therapeutic skills in assisting the child in resolving grief and loss issues.

3. Developing skills and understanding in comparing the group and individual interventions and determining when to choose either intervention given the circumstances of each family.
4. Developing skills when working with parents of the grieving child to assist them in supporting their children.
5. Increasing theoretical knowledge in relation to play therapy and grief work.

CHAPTER TWO

Literature Review

Introduction

The experience of grief and loss affects families and their children in very individual and unique ways. There are also many commonalities which assist in exploring a framework for understanding this experience and assisting both adults and children in coping effectively with the loss of a loved one. This practicum report explores general themes and notions from a developmental perspective concerning the grieving process, specifically with children who have lost a parent, and interventions strategies that assist in coping with loss.

There are several models and frameworks that describe the grieving and mourning process (Baker, Sedney, & Gross, 1992; Doka, 1995; Kubler-Ross, 1969; Morgan, 1987; Parks, 1972; Schaefer & Lyons, 1986). General characteristics include the emotional impact, for example, experiencing emotions of anger, fear, and sorrow (Grollman, 1995; Jewett, 1982). There is then a process of acceptance and finally making sense of the loss by some form of commemoration and conclusion. The theories put forth in the subsequent literature review illustrate a variety of these concepts and the complexity of the grieving process, specifically with children.

As children grow through different developmental stages, their experience and reconciliation of the loss has distinctive qualities from those of adults (Baker et al., 1992; Crenshaw, 1990; Fitzgerald, 1992; Shapiro: 1994; Webb, 1993; Worden, 1996). These distinctions are explored in order to have a better understanding of how children resolve their grieving emotions. Tied to normal reactions to grief and loss is a question of when an individual requires professional intervention.

To gain a better understanding of the grieving process for children, family systems theory, group work theory and using play in therapy with children will be explored as they provide an added dimension in

understanding and intervening with bereaved children.

The premise of the practicum is that grieving the loss of a parent involves grief work for both the child or children in the family and the remaining parent. Mourning and grief work can be enhanced and expedited by direct intervention with a therapist. The family needs to be looked at as a system whether the intervention is a group format or individual therapy with the child. The child's stage of development affects how effectively and in what form the child is able to resolve his or her grief at a particular moment in time and this can change and evolve as the child grows (Shapiro, 1994). The literature also supports that children do grieve (Bowen, 1978; Furman, 1974; Shapiro, 1994; Webb, 1993; Worden, 1980), and experience longing, sorrow and pain at the loss of a parent, although this view has changed from a prior, psychoanalytical belief that the child had to be at least in adolescence to fully comprehend and experience mourning (Wolfenstein, 1966).

Grief and Loss

Developmental Issues

Overview

This discussion is focused on how children normally resolve issues of loss and grief. For any child the loss of a parent is a profound change in their lives. Depending on how the parent died, the age of the child at the time of the death, and personality factors, the reaction to the death can be extremely varied (Shapiro, 1994). Children expect parents to live forever and take this as a given in their lives. When this reality is shattered a basic trust is also violated (Shapiro, 1994). Children will process a loss of this magnitude for their entire childhood because the loss takes on new meaning with each developmental stage through which the child progresses (Baker & Sedney, 1996; Shapiro, 1994).

There are clear distinctions between adults' grief and children's grief (Baker & Sedney, 1996; Crenshaw, 1990; Doka, 1995; Jewett, 1982; Webb,

1993). Firstly, as children grow and develop cognitively and emotionally they understand and make sense of the death in a progressive manner. Their insights and understanding are very different at age four than at age fourteen or twenty four. Their reactions may seem less intense closer to the actual death but they continue over a longer duration of time as the death is being processed through the different developmental stages (Baker & Sedney, 1996). Secondly, children cannot sustain prolonged emotional intensity so they shift to another thought or activity moving in and out of the pain (Doka, 1995; Webb, 1993). This activity is usually play as it is a natural medium for children and allows a diffusion of the intensity of the emotion they are experiencing. Thirdly, children have limited ability to verbalize their feelings as opposed to adults who are much more able to articulate and analyze their experience (Webb, 1993). This varies as they grow and mature gaining more sophisticated levels of thinking and reasoning. Fourthly, children need a reliable adult figure they trust to assist them in dealing with their loss (Furman, 1974). Finally, children differ quite distinctly from adults in that they choose to remain connected to the parent figure by emulating their characteristics whereas adults will detach themselves from the deceased as a way of providing emotional distance (Shapiro, 1994).

Attachment is also a significant factor in children's grief (Bowlby, 1980, 1982; Caplan, 1990; James, 1994; Shapiro, 1994; Webb, 1993). The loss of the attachment figure can lead to children experiencing a prolonged period of distress and disability. Baker, Sedney, and Gross (1996) state that "When a child's parent has died, the child's grief reaction will be affected by his or her strong developmental need to identify with the parent who has died" (p. 112). This is a key thread in intervention and treatment as children need to have a meaningful and significant attachment in order to feel safe, protected and loved as well as an identity figure from which to model themselves. This enables them to move on both cognitively, socially, emotionally and developmentally (Bowlby, 1980, 1982; Caplan, 1990; James,

1994; Shapiro, 1994; Webb, 1993).

Children's Understanding of Death

This next section is a general overview of how all children from infancy to late adolescence, understand and make sense of the grief experience. This practicum report focuses on children from the ages of five to twelve. A review of the development spectrum assists in putting this age group in the perspective of the developmental continuum. Of particular interest is the thought and language processing abilities as the child moves through a progressive development in understanding and emotional growth. An aspect of this development is the cultural and family context in which the child is raised. The move from magical thinking, to cause and effect thinking (which leads to feelings of self blame and responsibility), to seeing death as an inevitable and unchangeable fact of life, is an important factor in working with and assisting grieving children.

Infancy

According to Shapiro (1994) infants have no ability to cognitively comprehend death and can only experience the physical separation. The sensorimotor cognitive developmental stage involves the infant experiencing the world through the five senses. Infants' experience of the world comes through their physical care and nurturing by their caregiver, in a consistent and predictable manner. This develops basic trust and a sense of hope in the world. When this trust is broken due to a death the effects experienced are not remembered cognitively but emotionally as basic trust has been violated.

Preschool children

Children from the ages two to six years are still in the magical thinking stage (Grollman, 1995; Schaefer & Lyons, 1988; Webb, 1993). Children at this age can experience the loss directly and long for the absent person. Cognitive development of pre-operational thought processes enables toddlers to use symbolic language and they are beginning to associate words for people and actions (Rogers & Sawyers, 1992). Children of this age are

literal in their thinking and need to have words used that are very direct (e.g., died, not gone away or gone to sleep). They have not yet conceived of the irreversibility of death. To them death is reversible and they think they may cause a death just by wishing it. This cause and effect is typical of the thinking capacity of this age group and is tied in with magical thinking and pretend.

Middle years children

Children ages six to nine think of death as a taker (Baker & Sedney, 1996; Fitzgerald, 1992; Schaefer & Lyon, 1988). They are afraid it is contagious. There are still some aspects of magical thinking and they can overestimate the power of their thoughts and wishes. They are in a transitional stage with confusion over language such as "soul" and "sole of a shoe" for example (Schaefer & Lyon, 1988). They do, though, have increased ability for concrete operational thought (Shapiro, 1994). The cerebral cortex of the brain has developed to the degree that higher functioning is present in language, perspective taking, problem solving, and self control. They are able to use language to express themselves, ask questions, describe events logically and sequentially, and discriminate between relevant and irrelevant information. They are able to understand the difference between behaviour and intent and can be helped to understand that they are not to blame for certain events in their lives. Concrete operational thought is based on what is observable and touchable (Shapiro, 1994). Often this age group is preoccupied with morbid thoughts and are fascinated by the image of death stalking around and are scared of the bogeyman (Baker & Sedney, 1996; Schaefer & Lyon, 1988). As with younger children, play often helps them work out stressful feelings (Doka, 1995).

Preadolescents

Children ages nine to twelve years see death as inevitable, universal, and irreversible (Baker & Sedney, 1996). There are remnants of cause and effect thinking here (Grollman, 1995). They can still believe that if they

think or wish for something to happen that they have the magical power to make it happen. They are interested in the biological details of what happened. They like the ritual of the funeral and are concerned with relationships with others and practical things. He or she probably grasps death intellectually but may have a hard time letting it sink in. Emotional development at this time focuses on the task of industry versus inferiority (Corr & Corr, 1996). Self esteem is dependent on the child's ability to perform and produce. Emotional tensions can still be released through play (Doka, 1995; James, 1994; Webb, 1993). It is not uncommon for children of this age to appear unaffected or non-caring about a death, and continue to retain a close connection to the deceased, including illusions that the deceased is still present (Baker & Sedney, 1996). Children in this age range strive to be the same as others their age and any sign of differences, such as loss of a family member, may result in feelings of shame (Shapiro, 1994). Death may be perceived as punishment for bad behaviour based on cause and effect thinking. The importance of rules makes rituals very necessary at this stage of development. Concrete thinking and general curiosity lead to detailed questions regarding the death and what will happen next for the child (Shapiro, 1994).

Adolescents

Teenagers from thirteen to eighteen philosophize, criticize and day dream. They have similar grief reactions as adults, especially in their later teens (Shapiro, 1994). They need help through the grief in understanding their emotions and they need to be taught how to cope in a crisis (Schaefer & Lyons, 1988). Many teens find death an outrage as its occurrence interferes with their beginning understanding of life and their newly forming values and beliefs (Fox, 1985). This ties in with their state of development as they are struggling with issues of identity, independence and planning for the future. They are in the cognitive development stage of formal operational thought with a new capacity for abstract thinking that includes the primary

concepts related to death: universality, irreversibility and inevitability (Shapiro, 1994). Increased abilities in perspective-taking allows adolescents to think more globally and understand the concept of universality. Adolescents understand that death is irreversible, but are still vulnerable to thinking that a deceased family member may appear. The emotional tasks of identity, independence and separation from family can be further complicated with the loss of a family member as the adolescent struggles with lost attachments resulting from death.

Developmental Issues in Children's Grief

There are a number of developmental issues that arise when working with bereaved children. An understanding of normal development and the impact of a significant loss assists in knowing when and how to intervene with children.

It is a commonly accepted and consistent fact that up to about nine or ten years of age most children cannot conceive of the irreversibility or finality of death as well as the inevitability of death for all living things. Coping strategies are also tied to how well the child has mastered a separate, well individuated sense of self worth (Baker & Sedney, 1996). This is an ongoing developmental process for all children. It is of particular significance for children who have lost a parent through death as the individuation process is greatly affected because the parent is not physically there (Bowen, 1978). It, in effect, forces the child to deal with this issue of individuation regardless of his or her readiness psychologically. Another factor is the child's psychological defensive and coping strategies that are used at different phases of development (Baker & Sedney, 1996). This is summed up by their statement:

> Younger children tend to use more primitive defenses, such as denial and projection, which distort their perceptions of reality to a significant degree. School-age children and adolescents are more likely to use defenses, such as intellectualization and isolation of affect.

> These defenses allow children to split their emotions off from their thoughts and repress the more unpleasant affects. Adolescents may be able to use more mature defenses, such as suppression and sublimation, that are often seen in healthy adults as well (pp. 116).

Depending on the age and specific circumstances of each child these developmental factors influence and affect the grieving process. Understanding the defenses used by the child enables the adults to know that, for example, the intellectualization is a way of coping, not necessarily a denial of reality. Bereavement reactions (Baker & Sedney, 1996) differ also from one developmental stage to the next. For example preschool children up to five years old may have sleep disturbances such as nightmares, regressed toilet training, temper tantrums, and a return to babyish behaviours to mask the anxiety of the feeling that things are out of their control. School-age children from ages six to ten may seem to deny the emotional significance of the death and wish to have things continue as usual without drawing attention to themselves as being different. Feelings of grief tend to be shown only when children feel very safe. Excessive guilt is a concern with children in this age range who are still vulnerable to cause and effect thinking and they may feel they did something to cause the death. They may worry about the remaining parent and that person's well being. They can also become preoccupied with their own health and safety. These factors relate significantly to the age group studied in this report. Adolescents show similar traits as the previous age group and have a strong need to fit in and appear the same as their peers. This can affect the expression of their grief and may lead to depression and other acting out behaviours such as delinquency, running away, excessive drug use, and risk taking behaviour (Shapiro, 1994). These individuals also struggle with philosophical ideas about death and the realities of care-taking at home since one parent has gone.

Definition of Terms

For the purposes of this practicum report grief is defined as emotions experienced following a loss, usually anger, fear and sadness (Bowlby, 1960) and a process expressed by a variety of thoughts, emotions and behaviours (Wolfelt, 1983). Bereavement is defined as the status of the person who has suffered a loss and is experiencing distress (Webb, 1983). Mourning is defined as the mental work following the loss and understanding fully the future implications, meaning the person's loss is irreversible or permanent (Webb, 1993).

Approaches to Understanding Children's Grief

Two major approaches are considered in this discussion. These involve a psychoanalytical approach and a cognitive developmental approach. Aspects of both these approaches are discussed as they dominate the literature and influence the types of intervention strategies that are most appropriate with children.

There has been a strong psychoanalytical influence in looking at the bereavement process in children. Some assumptions made by psychoanalytical therapists have been problematic (Shapiro, 1994). Wolfenstein (1966), for example, did not feel children were capable of grief work before adolescence as they did not have the ego development or maturity to experience longing and sorrow. A grief work approach would therefore not work with children who have experienced loss, other than to be understanding and supportive. Psychoanalysis has a different value system, than that of a developmental perspective, for understanding the child's behaviour as it does not acknowledge the possibility that children can grieve and mourn prior to adolescence.

Further to this Furman (1974) considers the process of mourning as beginning the awareness, comprehension and acknowledgment of the death. This raises questions about whether or not infants and toddlers are able to mourn. Furman's work suggests two year olds are able to grasp the concept

of "dead" if it relates to something that they are able to symbolically identify such as a bird or small animal. The death of a caregiver or significant person is not as easily comprehended because of the intense attachment issues (Furman, 1974). She therefore concludes that children are not mature enough or able to comprehend the death cognitively or emotionally at this stage and therefore cannot mourn or do the grief work.

The psychoanalytical perspective stresses the maturing capacity for coping with overwhelming emotions. This is important in understanding how the child incorporates the experience of grief into his or her ongoing development (Shapiro, 1994). The fact that this perspective does not allow for a grief work while still a child is the point of dissension. This will therefore have an impact on how pyschoanalysts approach and intervene with children who have experienced loss.

From a cognitive developmental perspective, children who have had a significant loss can grieve and mourn, it is simply a different process than adults. The mourning cannot be complete until the child can understand the implications of the loss in the future. The child moves in and out of the grief and cannot tolerate the emotional intensity that an adult can (Grollman, 1995). They still grieve, but it takes a different form. The cognitive developmental perspective challenges the psychoanalytical perspective in this aspect of grief intervention.

Webb's (1993) viewpoint is that in order to fully mourn the loss of the loved one the child must be able to comprehend the finality of the loss in the future. This is the viewpoint this discussion will take. It ties in with the developmental notion that children cannot fully comprehend the irreversibility of death until age nine or ten. The fact that the child needs to be able to developmentally comprehend the finality of the death in the future explains why children need to rework the experience as they grow up. It has different meaning and understanding as they mature.

A child's grief, especially in reference to the loss of a parent, differs

greatly from adults, as has been previously established. Children require a more complex understanding of death and this changes over time as does the child's ability to comprehend, both emotionally and developmentally, the impact of the death (Worden, 1996).

Shapiro (1994) sums this up succinctly when she states:

> A cognitive-developmental perspective stresses the importance of the child's cognitive stage in the symbolic representation of experience: in language development; in development of the capacity for systematic, logical thinking; and in understanding causality. The child who has lost a loved one uses the evolving cognitive tools for making sense of the death and integrating the experience of loss and grief as part of ongoing development (p. 75).

Developmental psychology suggests it is useful to assess whether the child's adaptation to stressful life events interferes with the child's ongoing development (Shapiro, 1994). This allows an individualized view of each child within his or her own context and does not pathologize his or her behaviour which could be quite a normal, healthy reaction to an abnormal situation. Risk and resilience literature integrates ecological or relational approaches to normal development with an understanding of the ways high stress environments can disrupt the ongoing developmental process (Shapiro, 1994).

Johnson (1989) adheres to a psychoanalytical viewpoint that encourages a detachment from the deceased person before more adaptive behaviours can begin to be developed. This is different than a developmental perspective in which the attachment is encouraged and the relationship integrated into the child's experience. There can still be a healthy resolution to the loss with the relationship changing as the child develops emotionally and reintegrates aspects of the new relationship into the next stage of development. This redefinition of "letting go" to the new thinking of accommodation (Klaus, Silverman, & Nickman, 1996) is a shift in thinking

in the area of loss, allowing for the redefinition of the relationship. In considering the current thinking it seems to be an outdated expectation that the child must detach from the deceased person before he or she can successfully resolve his or her grief and complete the mourning.

Recognizing both perspectives have merits, this discussion, for the most part, follows the precepts of the cognitive developmental perspective. The fact that the psychoanalytical approach does not acknowledge the ability of children to experience grief prior to adolescence and the fact that this approach does not allow for a changing and ongoing relationship with the deceased are limitations, in my view, to assisting the child in fully resolving the emotional issues in healthy grieving.

In summary, an understanding of the terms grief and mourning, with grief meaning the emotions experienced and mourning referring to the process of expressing grief over time while understanding its permanence in the future, gives us a clear definition of terms in considering this subject. Of the two major approaches outlined, psychoanalytical and cognitive developmental, the latter approach allows for a broadened discussion and consideration of the grief experience. This approach acknowledges that children can and do grieve and mourn the loss of a parent and are able to resolve these emotions. An understanding of the expectations for each developmental stage assists the therapist in appropriately assisting the child through these emotions.

Psychological Tasks for Bereaved Children

An understanding of developmental stages assists in providing a general guideline of how children think, feel and behave at differing ages. Stages also refer to the phases an individual goes through in the grief process such as denial, anger/guilt, bargaining, depression and acceptance (Kubler-Ross, 1969). This report looks at the tasks of grieving which are connected to the stages and yet independent from them in many ways. Baker et al. (1992) discuss three tasks that children must accomplish in the

grieving process. They describe these as:

> understanding what happened, while employing self-protective mechanisms to guard against the full emotional impact of the loss; accepting and reworking the loss, and bearing the intense psychological pain involved; and the consolidation of the child's identity and resumption of developmental progress in age-appropriate developmental issues (p. 105).

These tasks are affected by the developmental stage and need to be accomplished before the child can go on to the next phase of development and grief.

In the first phase children need to have a clear understanding of how the person died. If they have been shielded or protected from the truth they could remain stuck in this phase and not progress to the second two stages. There could be misunderstanding and possibly a fantasy built around the event which is incongruous with other information the child receives. The child also needs to feel safe and secure in his or her environment in order to ask questions and truly understand what happened. If this is not present he or she could stop asking questions and may learn it is not safe or appropriate to learn the truth. Thus the child could remain stuck in the first task of grief.

To be helpful a therapist might support parents in telling the child the truth, in age appropriate language; assist parents in understanding the child's fears and worries; and encourage parents to provide basic parenting such as child care, limit setting, open communication and nurturing support. The therapist also needs to support the child's connection to the deceased until he or she is ready to redefine a new relationship in terms of attachment to the deceased and a reattachment to other significant people in his or her life.

The second task of grief involves an emotional acceptance of the loss, reevaluating the relationships to the deceased, and bearing the emotional

pain that accompanies the loss. What has been found, opposed to a psychoanalytical perspective of detaching from the loved one, is to rework the relationship within the mourning process. Detachment is not essential or necessary and could in fact be a sign of healthy recovery from the loss (Baker & Sedney, 1996). This affects how therapy proceeds as the therapist has choices in redefining the new relationship in terms of the loss while still maintaining the healthy aspects of the lost relationship. Although children may fantasize about the deceased the therapist can assist the child to maintain a distinction between reality and fantasy. The second part of this task is to bear the emotional pain of the loss. As many children can tolerate only small amounts of emotional pain this phase is often prolonged with children as they go in and out of the grief. This needs to be approached gradually so as not to overwhelm the child's coping abilities.

In the last task, the child needs to reorganize his or her sense of identity in relation to the loss along with his or her ongoing identity as an individual. This experience needs to be incorporated into his or her ongoing personality development and a new relationship with the deceased needs to be defined. The child needs to invest in "new relationships without an excessive fear of loss and without a constant need to compare the new person to the dead person" (Baker & Sedney, 1996, p. 111). The child needs to continue on in his or her own development and age-appropriate activities. Lastly the child needs to be able to bear any painful memories or reminders that occur naturally in his or her life such as anniversary dates, birthdays or special holidays.

Worden (1996) defines four tasks which are similar to Baker et al. (1992), with a slightly different focus in the last point. He feels the tasks are: to accept the reality of the loss; deal with the emotional impact of the loss; adjust to an environment where the deceased is missing; to relocate the dead person within one's life; and to find ways to memorialize the person. Although there are similarities with Baker et al. (1992), Worden adds the

dimension of memorializing the deceased.

In summary the tasks of grieving are related to the child's psychological development. Children need to understand the event while protecting themselves from the emotional pain. They need to accept and rework the loss, then consolidate the loss into their identity and personality. Commemorating the loss is the last function that needs to be incorporated to allow full resolution. These four points are major conceptual building blocks in this practicum report.

Role of the Family

Emotional support and permission to talk about and share feelings is a crucial factor in healthy grief resolution (Bowen, 1978; Shapiro, 1994). The role of significant adults in children's lives is a major factor in supporting the child through the grieving process. A number of issues arise here as to the attachment of the child to the deceased person, the function of the deceased in the family, the caretaking role of the deceased and the nurturing role of the deceased. In relation to the remaining family configuration the openness of the family system to allow expression of feelings, who is now available for nurturing, and who organizes the family so that it continues to function are all key factors in considering how well children are able to resolve grieving issues (Bowen, 1978; Shapiro, 1994).

When a family experiences a profound loss such as that of a parent, a period of mourning, upheaval, and reorganization occurs. During this state of crisis, reorganization and grieving, all family members are affected. The developmental stage of the family has an impact on how these issues are resolved and dealt with. Healthy bereavement requires that family members recognize and respect individual differences in response to their grief and in their ability to cope (Shapiro, 1994). This task involves:

1. Permission to share personal experiences with one another.
2. The ability to understand and feel understood by others.
3. The reestablishment of a coherent sense of past, present and

future.

The ability to freely communicate thoughts and feelings enables the family to respond in a more supportive and caring way to its individual members. Children especially need to be given permission to share what they are experiencing as they are often frequently very aware of how the remaining parent is feeling and do not want to overwhelm or overburden him or her further. Furman (1974) makes a very strong argument that children need a consistent, supportive caregiver during the time of bereavement. It makes it even more difficult for children to progress through the grief process if the parent figure is not able to emotionally support them at this time. This affects the family directly as it is the system in place to provide support and care for the child. For this reason the family or caregiver needs to be involved in the intervention at all phases of the treatment process.

Rosen (1996) believes the family system is one of the most important resources to the child for both healing and readjustment to the loss. This is often overlooked and frequently the child goes into individual therapy and the family is not included as an integral part of the child's therapy. Four tasks he believes the family must accomplish in the grieving process are: to share acknowledgment of the reality of death, to share experience of the pain of grief, to reorganize the family system, and to redirect the family's relationships and goals. The importance of open and honest sharing is stressed. Including children in the death rituals, sharing multi-generational stories, establishing an open system that allows for differing emotions, and the timing of when family members feel able to express themselves are all significant factors in assessing families. The child in the context of the family is a consistent theme when considering the child bereavement literature, although Rosen feels the family has been overlooked as a healing resource for children and should be considered a primary support.

A death in the family creates stress for all family members. Factors

such as where the family is in the family life cycle, who died, how they died, who constitutes the family, cultural factors, discrepancies between child and adult cognitive understanding, distraught emotions, redistribution of family responsibilities or functions, and the added stress of parenting, need to be taken into account when assessing the family's needs, strengths and points for intervention (Shapiro, 1994). Parenting as a distinct responsibility needs to be considered in light of these stressors as parents directly affect how children cope and progress emotionally, physically and psychologically. Children will often sacrifice their own integrity or needs if they feel their parents cannot cope with their feelings or behaviour (Shapiro, 1994). As the remaining parent is essential to their well being, accommodations are often made to ensure the parent can continue in his or her role as caregiver (Sanders, 1995). The family has major adjustments to make as new responsibilities fall to remaining family members. If the system is very rigid it is more difficult for the family to realign to meet new responsibilities (Rosen, 1996).

Once the family has stabilized and has begun adjusting to the loss the family then engages in a developmental process of growth and integrating the loss experience into its family history. Over time the family will continue to integrate a new reality for the system based on the impact of the loss of the deceased. The degree of disruption the family experiences following a death is affected by the type of death, when it occurred, where the family is in the family life cycle, the function of the deceased in the family, and how open or closed the family's communication style (Herz, 1980). Whether the method of intervention and focus of attention are from an inter-generational approach, a strategic approach, a structural approach, or a developmental approach, there is a common thread of considering these factors when assessing a family for bereavement counseling (Shapiro, 1994).

Family Life Cycle

When looking at the family as both a resource and a major factor in

assessing the needs of the situation, an assessment of where the family is in the family life cycle is worthy of consideration. The stages of the family life cycle as defined by Karpel and Strauss (1983) are:

1. Marriage / Coupling
2. Birth of the first child
3. Adolescence
4. Launching of the children
5. Aging and Death of Parents

McGolderick and Carter (1982) have a similar model of development, adding the young adult as a first category. Walsh (1982) also includes parents with young children after the category of birth of the first child. Each of these cycles have certain tasks and responsibilities. If a death or other such trauma occurs during a transitional stage, such as the birth of a child, the consequences may surface as symptoms in later life cycle development such as the transition to adolescents.

There is general consensus that the meaning and consequences of a death of a parent varies depending on the phase of the life cycle the family is negotiating when the death occurs (Bowen 1978; McGolderick & Carter, 1982; Walsh & McGolderick, 1991). There is more disruption in the family when the family is negotiating a transition, such as the birth of a baby or the marriage of a child. The function the deceased person held in the family is also a contributing factor in the degree of the intensity and severity of the emotional reaction to the loss (Bowen, 1978; Herz, 1980). Therefore when it is a parent who dies the emotional reaction and renegotiating of his or her role is much more significant than if a distant grandparent died who did not have a direct caretaking or role modeling responsibility for the child.

Understanding the developmental nature of the family's life cycle and the child's developmental phase, provide a framework for understanding the grieving process and what issues need to be considered when intervening with families experiencing loss. Family life cycle patterns of dysfunction can

often be traced to intergenerational disruption of function, needing resolution (Bowen, 1978). "Life-threatening illness and death disrupt the family's ability to perform the tasks necessary to achieve appropriate shifts in family status (such as launching children, for example) and may have a profound impact on a child's potential for healing" (Rosen, 1990, 1991 cited in Corr & Corr, 1996, p. 234). Formation and maintenance of the family system as a distinct entity entails emotional work and is affected by the flow of developmental issues the family naturally deals with. The family's ability to have open boundaries, its flexibility in accepting change, and the number of changes the family has had to accommodate, are all relevant factors that impact the family's ability to cope with stress. These factors are an important contextual reference point when assessing and planning an intervention after a death has occurred in the family.

Summary

In summary, a developmental perspective takes into account the circumstances of the death, the family's current place in the life cycle, the degree of functioning of the family prior to death, who died, the communication style of the family which is most frequently referred to as open or closed, and acknowledges the delicate boundary between normal and abnormal (Bowen, 1978; Herz, 1980; Walsh & McGolderick, 1991). In assessing these factors in individual families, an opportunity is opened to determine the therapeutic emphasis. This model's strength lies in its overall perspective of the family, putting the family situation into a context that identifies developmental issues, such as life cycle stages. This allows for an opportunity to see the family as a system that is fluid and progressing, as is the child within the system. The model is useful in that it can be flexible, allowing for individual differences both within the system and for individual family members. The family can be looked at from many different perspectives and can be viewed from the very wide continuum of normal. This assists in not pathologizing families, but seeing them within their own

unique context. It is understood that the death of a family member, especially a parent, is a "shattering developmental crisis of both attachment and identity that is precipitated by the loss of an important constituent of the collaborative self "(Shapiro, 1994, p. 139). The goal when intervening is to take these factors into account and restore movement along the developmental continuum to support the family in integrating and establishing the meaning of the death into their lives.

Individual Therapy With Bereaved Children

Early intervention (Fox, 1994), a preventative notion, mandates a prompt response to a psychologically stressful life event. An important question is when to refer for bereavement therapy and whom to refer, the child, or the family or both. Mourning is a process and is not completed in a brief period of time. Referral for bereavement therapy does not usually happen until six months after the death, as it is normal for children and families to have a period of distress and unhappiness involving intense emotions and different behaviours (Worden, 1996).

Based on the Child Bereavement Study, Worden (1996) found that only 33% of children needed direct professional intervention with the majority coping adequately with the grief within the family setting. This raises questions as to the appropriate time to refer for therapy and what the criteria would be for this referral.

Generally in families a death is worked through effectively within the family and social system of the community (Worden, 1996). In one study most children, 67%, did not need specific grief counseling (Worden, 1995). Thus it is important to carefully consider the characteristics of children experiencing distress and requiring this intervention. People have a natural ability to deal with stress and grief. Equally, not all children who require therapy have been traumatized by the loss, although they and their family may need some intervention with the adjustment process. Children still need to have defenses as well as adults do to protect themselves against the

pain of remembering their loss.

Criteria for Treatment Intervention

When to refer for individual therapy and when to refer to family therapy or group therapy requires a careful assessment of the child and his or her family situation. The treatment of choice for children experiencing complicated bereavement resulting in serious behaviour and emotional disturbances is individual therapy, as these children may be less well suited for a group intervention (Worden, 1996). The advantages of an individual intervention is that it provides an environment of emotional safety and stability and a supportive adult relationship (Zambelli & DeRosa, 1992). This does not preclude of course family work as well, as part of the total intervention plan.

Criteria for referral needs to have a framework based first on normal behaviour and grief reactions. Children who have lost a parent to death will be experiencing distress at varying degrees of intensity. The degree of intrusiveness must be evaluated (Webb, 1993). If children show signs of interference with their social, emotional or physical development they may be "stuck" in a grief reaction. Webb (1993) describes vulnerable children as those who show suicidal ideation or who have been directly involved in some way with the death of another person. Vulnerable children are:

> those who themselves have a life threatening disease; children who have already been identified as emotionally disturbed; children who are developmentally disabled and who may have difficulty understanding what has happened; and children who remain "frozen" and in shock long after most grievers have returned to their usual activities (pp. 39-40).

Webb goes on to consider symptoms that would alert adults to distress in children, these being: suicidal hints, psychosomatic problems, difficulties with schoolwork, nightmares or sleep disorders, changes in eating patterns, and temporary regression. Worden (1996) reminds us also that many of

these symptoms can be experienced by children shortly after a loss and are quite a normal reaction. It is the persistence or duration of the symptoms over time that may necessitate a referral for treatment.

Death related factors to be discussed include: the type of death: contact the child had with the deceased; the expression of the "good-bye" to the deceased; the relationship to the deceased, with the closer the relationship the more profound the impact; and grief readiness, whether or not there was anticipatory grief. At times the child may be protected from the truth or it is softened, leaving the child with a sense of uncertainty and confusion about what really happened. The parent is experiencing and dealing with the loss as well and may not be able to fully be available to the child. All these factors need to be taken into consideration when assessing the need for intervention.

Therapy for Bereaved Children

There seems to be little controversy as to whether children can grieve as they clearly experience emotions and behaviours after a loss. "Grief does not focus on one's ability to 'understand' but instead upon one's ability to feel. Therefore any child mature enough to love is mature enough to grieve" (Wolfelt, 1984, p. 20). Although there may be discrepancies about children's ability to mourn there appears to be no question about children's ability to grieve. Understanding that grief is a normal and expected process, an assessment needs to be made as to when this is beyond the normal range of behaviour. The child's behaviour needs to be looked at in light of his or her behaviour at home and in the community. School is often a good reflection or more objective source for viewing the child's range of behaviours. The school is not directly affected by the immediate loss in the same way the family is, and can have a more objective view of the child as they have known the child prior to the death. Teachers will have that before and after perspective without the emotionality of the parent, to assist in determining the degree of disturbance the grief is causing the child.

Johnson (1989) discusses therapeutic intervention for children who have experienced the loss of a parent and how to best assist them in resolving this loss. "Recounting the personal dimensions of the event opens the person to possible disapproval, rejection or humiliation. Trust in the integrity, acceptance and skill of the therapist is essential" (p. 100). Two important points are made in this statement. First the child needs to have his or her story witnessed and accepted. There is a risk to be taken here as his or her story may be misunderstood, denied or not accepted which could lead to a shutting down or repression of emotions related to the events. Secondly, the story may take repeated "telling" either directly or in the themes of play in the safe milieu of a trusted relationship (Allan, 1988; Garvey, 1990; James, 1989). Ideally this expression can occur with the child's caregiver and other trusted adults in his or her life as well. The salient aspect of this point is that there must be a trusting relationship developed before the child can feel safe to take the risk to "tell".

In order for the child to heal, "she or he needs to integrate the trauma experience into his or her life. The event must be understood, its meaning explored, implications and changes caused by the events accepted and acceptance of self accomplished" (Scurfield, 1985, cited in Johnson, 1989, p. 241). In working with bereaved children these factors form a reference point in evaluating the child's progress in therapy.

In looking at a child's grieving process, it is important to link together the developmental stage the child is currently experiencing, the tasks they need to accomplish in the grief process, his or her family's level of functioning such as how resourced and available the parent is to the child, given that they too are in their own grief process, and how his or her play relates to all these issues. In establishing a hypothesis and planning appropriate intervention strategies, all these factors need to be taken into account.

Webb (1993) discusses therapeutic interventions with children and

the need to assess their developmental stage which allows for a better understanding of what they can cope with and tolerate at different points in therapy. She maintains that "Children have limited ability to verbalize their feelings, as well as very limited capacity to tolerate the pain generated by open recognition of their loss" (p. 13). For this reason using play in therapy utilizes a natural way for children to express themselves other than through talking. The ability to express feelings is an abstraction that children at the pre-operational level of thinking are not yet able to perform (Krall, 1989). "Children use their play as an escape from their pain and a way to gain mastery over their complex and confused feelings about the death. Insofar as play is the language of children, children can deal with their feelings through play in a displaced, disguised manner" (Webb, 1993, p. 14). The challenge then becomes recognizing and interpreting the symbols and themes in the child's play that accurately reflect the inner emotions. These connections need to be tentative between the child's play themes and real life experiences as they are dependent on many factors which have already been outlined and they must be seen in the context of the family or living situation (Webb, 1993).

One theme which emerges from the literature is the need for honesty with children, regardless of how painful this information might be (Bowan, 1976; Fitzgerald, 1992; Grollman, 1995). Honesty enhances trust in relationships and in order for children to heal emotional wounds, the healing needs to be done within a context of a trusting relationship. Children need rituals for saying goodbye, either through the formal funeral format of their family or a creative ritual which they can help generate.

Communication is also vitally important. How children are told of the death, how they are listened to, how much freedom they are given to explore their feelings and how this is connected to communication patterns in the family (open or closed), can make a marked difference in the child's recovery. These factors are all interrelated and impact on how well the

family resolves the loss. There is an ongoing thread regarding the developmental stage of the child as well as that of the family, which impacts on this process.

Play

Play is universal to all children (Krall, 1989) and is a preferred and natural medium of expression for children (Schaefer & Congelosi, 1993). Play has a form and a purpose which can be seen quickly and is reflected in the content and symbolism enacted in the play. These factors are reflective of the child's emotional, perceptual, and intellectual experience (Krall, 1989). The use of play in therapy allows the child to express his or her inner life in the medium for which he or she is most comfortable and knowledgeable. The function of play is adaptive, helping a child assimilate experiences and gain mastery over reality and unpleasant experiences (Lubimiv, 1994). The child expresses experiences either symbolically or literally (Freeman, Eptson, & Labovits, 1997) and the therapist can respond to feelings expressed, build an interactive relationship with the child, and gradually help the child understand and restructure the experience in a new more productive way (Johnson, 1989). The relationship is of vital importance in the establishment of rapport and in joining with the child in order to understand his or her symbolic communication (Lubimiv, 1994). This allows for the development of a safe environment to share his or her thoughts and feelings.

For the play to be meaningful to the child, Webb (1993) states, "The therapy must be at the child's pace, using play therapy methods of symbolic communication, in addition to verbal instruction" (p. 45). In order to use play in therapy an understanding of children's developmental processes such as how they think and what is appropriate for different age levels, assists in interpreting the symbolic language of children. A basic belief of play therapy is that the child identifies with and projects his or her own conflicts and concerns onto play materials (Krall, 1989; Schaefer & Congelosi, 1993;

Webb, 1993) and that the play being expressed is reproductive or representative of the reality of the child (Krall, 1989). Krall (1989) states that the interpretation of the play takes into account the age of the child, the intellectual and developmental level of the child and the qualities of the caregiver's relationship as well as the family environment. She feels that play does parallel intellectual development and is tied into the stages children progress through as they mature.

These precepts form the conceptual framework for work with individual children. The therapy must be tuned to the starting place of the child. The therapist needs to acknowledge and understand the process of identification with the symbols that assist the child in recreating their reality. The interpretation of the symbols from the unconscious to the conscious needs to be done carefully and flexibly as much depends on the therapist's judgment, the developmental factors for the child, and the family situation.

The Use of Play in Therapy

Play first began to be used as a therapeutic tool in 1909 by Sigmund Freud with his now famous case of "Little Hans", where the father was used to assist in the case under Freud's direction (Gil, 1994). From here play therapy as a formal therapeutic intervention has been developed and has evolved as a credible intervention of which there are many models. Models that are most commonly known are: Child-centered (non-directive) play therapy, Family play therapy, Fair play therapy, Behaviour play therapy, Structured play therapy and Group play therapy. Theoretical frameworks include psychoanalytical, existential, behavioural, Jungian and developmental (Schaefer & O'Connor, 1982). According to Schaefer and O'Connor (1982), almost every known technique can be subsumed under one of these headings. Fundamentally play therapy utilizes play in conjunction with a theoretical framework that will allow children to resolve emotional difficulties and integrate better coping strategies into their lives.

When considering the death of a parent it is obvious that a profound and likely traumatic event has occurred in a child's life. Using play as an intervention method seems an obvious choice as play is a natural medium for children. Bereaved children in the age group being studied (ages 5 to 12) are still in the developmental stage where play is a natural and comfortable medium for expression. Providing an atmosphere of fun is essential in the use of play in therapy (Schaefer & O'Connor, 1982). As play and fun are both unconscious processes it becomes vital in the therapy situation to provide an atmosphere of trust and safety in order for children to safely bring out their worries and fears (Johnson, 1989; Lubimiv, 1994).

Lubimiv (1994) outlines an approach for both therapist directed and child directed techniques that includes the need to establish a working hypothesis. This allows for connections to be made between the information gathered and the problem being addressed. Questions to look at include a consideration of who is involved in the problem, the child's role in the problem, the function of the problem, and what would happen if the problem wasn't there. Each hypothesis is explored with the child in the session and with the family to determine a working hypothesis that sets the goals for treatment. The first phase involves establishing rapport and a relationship with the child, the next phase of intervention involves exploring the hypotheses and establishing which are most relevant, and the third phase involves addressing the appropriate hypothesis with the child to bring resolution to the difficulties.

For the purposes of this discussion no one particular model of intervention has been used in its pure form. Many different techniques and ideas have been drawn from the play therapy literature, thus the use of play techniques has been utilized and the intervention has been defined as the use of "play in therapy" as opposed to a purist form of play therapy.

Factors to be considered in using play as an intervention, beside those outlined such as hypothesis building, are such things as: how the space is

utilized by the child; whether there is order or disorganization; whether there is clarity or confusion; whether the play is open and fluid or tight; how disconnected or disarranged the figures are, and what boundaries are set up to differentiate the play into an organized story. Inferences can be made regarding controls and defenses depending on the assessment of the home situation (Krall, 1989).

Krall (1989) also looks at the following, all of which are aspects of the assessment: the types of objects chosen for play; the ability to perceive and organize the play objects; the development of fine and gross motor skills in relation to the child's chronological age; the child's ability to develop integrated and sequentially coherent fantasy; and the child's language and language structure. Lastly, how the child relates to the therapist in the session is a factor in assessment. Does the child relate to the therapist as a comforter or someone who frustrates him or her or of whom he or she is wary?

Techniques of Play in Therapy

The range of techniques of play in therapy are voluminous. They can be anything from playing a game to elaborate imaginary structures in the play room. Krall (1989) speaks of choice of toys from a psychodynamic framework where, she believes, the most progress can happen quickly. She categorizes toys into areas that will elicit "the widest array of structural, perceptual, intellectual and symbolic play in the shortest period of time" (p. 32). The belief is that the child will choose the toy or activity that symbolizes the problem and begin expressing his or her emotions connected to the problem. The therapist then intervenes within the child's modality to introduce new, more effective ways of dealing with the problem. This could also include simply witnessing the story and validating it through respectful acceptance of what the child is feeling.

The use of stories and mutual storytelling is also an important tool when working with children (Davies, 1990; Freeman, Epston & Labovits,

1997; Lubimiv, 1994). The goal of using these tools is to enhance and enable the child to express his or her inner feelings and conflicts and to allow an opportunity for them to be expressed in a safe and trusting relationship.The particular tool is not as important as the context of the relationship in which it is being shared.

Conclusion

In conclusion play is an aspect of childhood that is universal and natural to children as a way of self expression. Understanding the play in the context of the child's developmental stage, the tasks of grieving, the degree of distress, and the family situation are all vital aspects of the assessment and intervention. The types of tools used in play with children are varied and plentiful. Developing a working hypothesis enables the intervention to be more focused and effective. Whether the intervention is child directed or therapist directed depends on many factors such as rapport with the child, personality factors, safety of the relationship and timing of the intervention.

Group Work With Children Who Are Bereaved

Levine (1979) suggests that "group therapy can help with most anything that individual therapy can, providing an appropriate group is available and the individual will accept the group as the mode of treatment" (p. 11). Several writers have suggested that group treatment has advantages over individual treatment in certain circumstances (Caplan, 1990; Lieberman & Borman, 1979; Northern, 1982; Shulman, 1992; Toseland & Siporin, 1986; Yalom, 1985). Groups help members realize that they are not alone with their problems and allow members to hear that others have similar concerns (Shulman, 1992; Yalom, 1985). They also give members the opportunity to help each other by being supportive, give feedback, make suggestions and provide information. Liberman and Borman (1979) have noted the therapeutic benefit of the "helper-therapy principle" for members of groups develop a mutual aid basis. As members give and get help, they observe others achieving their goals. This process provides a way of assisting

in developing hope (Yalom, 1985).

Groups have been used to address a variety of concerns experienced by children and adults. The group provides a place for support and helps members ameliorate personal problems through changing their behaviour and expressing their feelings (Toseland & Rivas, 1995). Groups have been used for children who have experienced abuse, need social skills training, have experienced loss and the break up of their families through divorce and separation (Toseland & Rivas, 1995).

There are various types of group interventions. These include therapy groups, support groups, educational groups, growth groups, and socialization groups (Toseland & Rivas, 1995). There are a number of approaches within the group context which include, for example, a psychoanalytical approach, a Jungian approach, a behavioural approach, and a cognitive developmental approach (Schaefer & Connors, 1998).

A developmental group facilitation model was developed by Lohnes and Kalter (1994) to assist children "confront and cope with the difficult feelings and problematic family and peer circumstances that are integral parts of ongoing bereavement" (p. 595). The goals of this group address the issues described earlier in this review concerning the need to take into account developmental issues, to provide a safe environment for children to share their story, to develop coping strategies with their parents who are also experiencing the loss, and to maintain a tie to the deceased person.

The group provides the added dimension of allowing a sharing with others in the same, or similar situations, and assists in normalizing their experience with others who are also experiencing a loss. An added dimension of bereavement groups for children is the social meaning that can be developed from the event (Zambelli & DeRosa, 1991). The group can help to reduce "the impact of risk by altering its meaning" as the group can be a supportive tool to allow the child to express his or her feelings in this context (Zambelli & DeRosa, 1991, p. 485). Children, especially in the age

range of eight to twelve years old, do not like to be different from their peers. There is a commonality in the group. Everyone is in a similar situation, so it addresses the need to be the same as their peers and provides children with an opportunity to share their story in a mutually supportive place. This assists in reducing the stress of dealing with the loss.

The literature is consistent in stating that children need clear, direct and honest language when discussing the death. The group process allows the therapist to address the tasks of grieving in this form of intervention. This direct communication alleviates some of the confusion about what is really being discussed and provides a safe structure to talk about the "unspeakable" in the group. If language is ambiguous there can be confusion and anger causing the child to feel he or she is not permitted to discuss the events honestly or openly.

Group work as a method allows the therapist to deal with the tasks of grieving through the medium of the group. The development of the group and the emotional safety and openness that evolves as part of the group process allows for a sharing of emotions. The group process itself is a vehicle for allowing the range of experiences and feelings to be expressed and normalized.

Group Intervention Techniques

There are a variety of tools and techniques that can be used in working with children in groups. Artwork is one of the more commonly used as it is "a less conventional vehicle of communication than is verbal expression and is therefore less amenable to manipulation by defense mechanisms" (Zambelli & DeRosa, 1991, p. 487). Art provides an opportunity to allow unconscious expression of inner thoughts and feelings and is often less threatening to children than talking about their feelings. Storytelling and mutual storytelling, game playing, bibliotherapy and direct discussion are all techniques that are appropriate in groups with children. The rituals developed in each group are important here because the

structure (Fatout, 1995) of the ritual, providing safety and predictability, allows for expression of emotion (Lubimiv, 1994). Most of these techniques are from the play therapy literature previously reviewed and can be equally applied to a group or individual situation.

In summary the group process itself needs to incorporate the following: open communication within the group; a recognition of the importance of the family and its impact on how children grieve; rituals for the group as well as rituals for grieving; the allowing of an attachment to the deceased to continue; the connecting of the family/caregivers to the process; and a safe, trusting environment to be provided by the group leader(s) (Lohnes & Kalter, 1993; Materson & Reams, 1988; Zambelli & DeRosa, 1991). Along with these factors the group process needs to take into account the tasks of grieving for children, allowing for their developmental progress to continue as each task is completed. Techniques used in the group provide a vehicle for discussion and an opportunity for expression of emotion in a safe environment. Children respond and understand at differing times and each child will be growing in his or her own time frame. The importance of the family/caregiver is vital to the child's progress and is predicated on the support and understanding the child receives at home. The more the caregiver is involved in the process the more the child will be free to express and work through his or her emotional issues.

Therapist Issues

When working with people who have experienced a loss many emotions and reactions become highly visible. A death is an unchangeable event (Warmbrod, 1986), so it is not possible to problem solve or "fix" the problem. The therapist is dealing with a situation from a different vantage point than is found in other counseling situations. This aspect is present in many loss situations, such as divorce or moving to a new town or having a transitional birthday such as 30 or 40 years of age. The person cannot go back and redo the event or make it not happen. Acceptance of change and

new beginnings is an inherent part of loss which all therapists need to consider in their work with children or adults, in either an individual or a group intervention. "The counselor who favours a problem-solving orientation and wishes to have the client learn some new skill or make some life improvement may find grief counseling difficult because it makes such different demands; the death of a loved one is an unchangeable fact" (Warmbrod, 1986, p. 353). A sense of helplessness could be created in the therapist as the realization sinks in that the death cannot be changed. This puts the therapy on a different emotional level for the therapist as well.

A second issue the therapist needs to explore is his or her own attitudes and emotions concerning losses in his or her own life. All people are mortal and must face death, at some point, in terms of a family member not to mention their own death. He or she needs to consider his or her own beliefs and values around the meaning of life and death. Warmbrod reminds us that grief counseling with children differs from most counseling and intensifies the need for self-knowledge and self-exploration. This becomes a personal journey of exploration and learning for the therapist as well as looking at the professional issues. Things such as belief in an afterlife, rituals around funerals, involvement of children in these rituals, the role of the family, symbolic ways of commemorating the death and being able to talk freely about death, are all issues that need to dealt with on both levels. The beliefs will present themselves both consciously and unconsciously so a careful self-examination is vital.

Therapists also need to acknowledge that they may be affected personally by the pain of the bereaved and will need to become sensitive as to when to move forward and when to hold back in their therapy (Schuchter, 1986). Self disclosure can be helpful when showing empathy and understanding and needs to be assessed as to how much and when to share.

As therapists cannot protect children from the pain of their loss, this brings to light a third issue which needs to be considered. A comfort level

for the therapist needs to be formed which can handle witnessing and supporting children's emotions when they face coping with the intense pain of the loss of a parent. "Counselors who have major commitments to be strong and protect children from pain may feel that they have failed and thus find grief counseling personally distressing" (Warmbrod, 1986, p. 353). This is very relevant in the area of grief counseling where a major goal of the therapy is to create safe situations where the child can and will face his or her emotions and pain in the grieving situation.

A fourth issue for the therapist is the decision of when to see children individually, or to recommend family work, or to see them in a group. The criteria and decision making in these areas need to be based on the assessment of the situation, referring to points outlined earlier, such as the degree of distress the child is experiencing, the strengths and availability of the family to support the child, the age of the child, the type of death of the parent (whether it was anticipated, sudden, murder or suicide), the number of previous losses and the developmental stage of the family and the child. All these factors need to be considered by the therapist when planning the appropriate intervention.

A fifth issue, which relates to the group situation, is making a decision about whether the group is for the children only, and when to include the parents in the intervention. Will or should they be involved at certain points or all through the process and what would that look like? The family can be included in some of this process as it is the receiver of the service, but it will depend on the therapist's clinical opinion and experience in making these decisions. In individual work with the child a similar decision needs to be made concerning the degree of involvement of the parent in the child's treatment.

A sixth issue for the therapist to consider is the consent of the child in the process. Frequently the decision for therapy is made by the parent or caregiver in the child's life. This affects how goals are established in the

therapy, the willingness of the child to attend, how engaged he or she is in the process and how ready he or she is to be able to move both developmentally and emotionally in the grief process. Sensitive issues such as raising painful memories or behaviours become important issues for therapy and they need to be dealt with carefully. The balancing of power between the child and therapist is an important related issue here as there is clearly a structural and hierarchical relationship between the adult and the child. It is incumbent on the adult to respect the trust and boundaries of the child in the relationship. Confidentiality for the child is always an issue in working with children and needs to be defined in terms the child can understand. These issues relate equally to both group and individual intervention.

In summary, therapists need to realize that they cannot undo the loss the child has experienced. They need to examine their own beliefs concerning death. They need to be able to accept that they cannot protect the child from experiencing pain concerning the loss. They need to assess the type of intervention most suited to the child. They need to make decisions within the intervention as to when, and to what extent, to include the parent or caregiver. Finally the therapist needs to consider confidentiality with the child client and the imbalance of power between the child and the therapist. These factors are all relevant when planning the most appropriate intervention for the child.

CHAPTER THREE

Practicum Description

The practicum was set up in two distinct phases. The first phase was a group intervention. The group was run jointly with co-therapist, Linda Croll, including both parents and children. The families who participated had experienced a death of a parent within the last two years. The children were between the ages of eight and twelve years old. An exception was made for two children whose aunt had died and their cousin was now living with the family. These two sisters were included as their lives were directly affected by the loss of their cousin's parent. The group met together in a shared time, then a separate time where the children went with one therapist and the adults with the other. The children's group was of a structured, directive format, using techniques of play in therapy, while the parents' group followed a psycho-educational support group format. The group met for eight sessions once a week.

The second phase of the practicum involved working individually with three children, ages five to seven, who had lost a parent within the last two years. The intervention was a combined directive and non-directive therapy format with parental counseling as part of the process. The individual therapy lasted an average of three months or twelve sessions.

Selection of Clients

The target population of the group portion of this practicum was 8 to 12 year olds who suffered the loss of a parent through death, within the last two years. Requests for referrals were made through referring agents such as the Child Guidance Clinic of Winnipeg, St. Boniface Hospital, Health Sciences Center, New Directions for Children and Families, Compassionate Friends and the Manitoba Adolescent Treatment Center, C.S.P. A letter outlining the group format and criteria, along with an explanation of our purpose for doing the group as part of our Master's of Social Work Practica, was sent out to all these agencies. Our outline included the requirement that the parent or

caregiver be willing to participate in the group with their child or children. We accepted both male and female referrals.

To be eligible for the project, families needed to be beyond the immediate crisis of the loss, and ready to begin to process its impact. Clients needed to be developmentally and physically able to participate in group therapy. Participation was voluntary. Families participated in an initial screening interview where the process was explained, written consent forms were signed (see Appendix A), a social history was taken and the children were interviewed. Four families were selected to participate in the group. One family chose to have individual therapy after initially being interviewed for the group intervention. No other families were excluded from the practica. There was a total of six adult caregivers and eight children.

Client referral for individual therapy followed a similar format, although the age range for the children was expanded to include 5 to 7 year olds. The Elizabeth Hill Counselling Center was included on the referral list for agencies in the individual situation. The parent or caregiver of the child also needed to attend the weekly sessions and be a part of the process although the focus of the work was with the individual child. The parent or caregiver was interviewed initially, where all procedures and expectations were discussed and consent forms were signed (see Appendix B). Two families with three children were selected for the individual portion of this practicum.

Setting

The group therapy took place at the The Community Service Program (C.S.P.) of The Manitoba Adolescent Treatment Center at 228 Maryland St. in Winnipeg. The C.S.P. staff are mental health clinicians who provide acute treatment services and long term treatment services to children, adolescents and their families in the city of Winnipeg's catchment area. Services offered include: play therapy, individual psychotherapy, family therapy and group therapy. These services are provided by clinicians with

varied backgrounds in the areas of social work, psychology, psychiatric nursing and occupational therapy. Criteria for service are broad based and are designed to meet the needs of children and adolescents who are unable to receive treatment through other sources. Children and adolescents experiencing disturbances in daily functioning as a result of trauma, abuse or mental health diagnosis are accommodated through this service in a manner that is accessible to the child and the family. The treatment delivery model suggests the least intrusive intervention as a starting point.

The facility at 228 Maryland is equipped with two group rooms that contain two-way mirrors and video-tape equipment. The rooms are designed for supervision and feedback.

The individual therapy took place at the Elizabeth Hill Counselling Center at 321 McDermot Ave. This center is operated by the University of Manitoba and takes referrals from the community with the understanding that therapists are often students in training. They also have full time staff who work with clients as well as faculty members from the university who supervise student placements. The center deals with a number of social and emotional concerns and is a community resource for research, therapy and intervention. This facility also has individual play therapy rooms with video-taping equipment for supervision purposes.

Personnel

Judy Tozeland and Linda Croll were co-therapists in the group intervention portion of the practicum. Ms. Croll works out of the C.S.P. where the group took place. Dr. Laura Mills supervised the group intervention. Dr. Diane Hiebert-Murphy supervised the individual intervention out of the Elizabeth Hill Counselling Center.

Supervision

My committee consists of Diane Hiebert-Murphy, Ph.D. from the University of Manitoba, Faculty of Social Work, Laura Mills, Ph.D. from the Manitoba Adolescent Treatment Center and Kim Clare M.S.W., Director,

Winnipeg Education Center, University of Manitoba. The committee met as a total group to discuss and approve the practicum proposal then again at the end to give feedback at the oral presentation.

Supervision for this project was twofold as there were two distinct interventions. Dr. Diane Hiebert-Murphy, as my primary advisor assisted in the overall planning and structure of the practicum. We had supervision sessions on a biweekly basis, at the Elizabeth Hill Counselling Center to review the video tapes of the individual sessions and discuss case planning and intervention strategies.

Dr. Laura Mills supervised the group portion of the practicum with Ms. Croll and myself jointly. We discussed the group process, themes and varying intervention strategies for the group. Ms. Croll and I previewed the video tapes and discussed themes, gave feedback to each other and took salient points to Dr. Mills for further discussion and clarification.

Procedures

Evaluation Measures

Assessment of families

Pre- and post-test assessments for the group were done through an interview format, with both therapists present.

Assessment of the child

For both the individual and group intervention the Revised Manifest Children's Anxiety Scale (RMCAS; Reynolds & Richmond, 1985) and Achenbach's (1991) Child Behaviour Check List (CBCL) for Ages 4-18 were used. The standardized measures were given at the beginning of the intervention, then again at the end, to each child and parent. An exception was made for the one six year old who was too young to fill out the RMCAS.

According to Reynolds and Richmond (1985), anxiety is a frequent indicator of mental health problems. If the level of anxiety is relieved the individual's level of functioning is greatly enhanced. For this reason the RMCAS measure was chosen as a measurement tool pre- and post-test to see

if anxiety diminished during the therapy process.

The RMCAS, subtitled "What I Think and Feel," is a 37 item, self-report instrument designed to assess the level and nature of anxiety in children and adolescents from 6 to 19 years of age. This instrument may be administered either individually or to groups of respondents (Reynolds & Richmond, 1985). In assessing the results standard deviation norms were taken from a normative parametric sample which were determined by grade level. A lie scale is built into the measure, which measures truthfulness, defensiveness (when the score is high), and social desirability and/or acquiescence in younger children, when accompanied by an extremely high anxiety score. There are 9 questions in the lie scale. These are counted separately and have their own means and standard deviations for scoring (Reynolds & Richmond, 1985).

An internal consistency estimate of .83 was found from its test sample of 329 children. Construct, content, and criterion-related validity have all been established with the RMCAS demonstrating itself as a measure of chronic anxiety in children (Reynolds & Richmond, 1985).

The second measure used was Achenbach's (1991) Child Behavior Checklist (CBCL) for Ages 4 - 18. This is a standardized test which has undergone rigorous testing. The children tested for this measure were disturbed children of normal cognitive ability. The competence items are designed to show behaviour that can successfully be adapted in every day life (Achenbach & Edelbrock, 1981, 1983; Achenbach, 1991). In addition the CBCL has eight categories for measurement. These include the categories of withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behaviour, and aggressive behaviour. There is also a differentiation made between externalizing and internalizing behaviours. These distinctions can assist in understanding how much the child is expressing or acting out their concerns and how much they are holding inside. All categories have T scores which are derived from

parametric testing in large samples (Achenbach, 1991).

In addition to the standardized measures, observations of the children were made during both the group and individual sessions and included discussions with the parent/caregiver. Also, a client satisfaction form was given to all participants at the end of the intervention (see Appendixes C and D).

Duration

The group intervention lasted for eight sessions beginning on February 5, 1997 and ending on March 25, 1997. The sessions began at 7:00 p.m. and ended at 8:30 p.m.

Individual sessions began February 11, 1997 and ended on June 26, 1997. These sessions lasted from one hour to one hour and a half.

Implementation of Procedures

In the group intervention a major feature was working with a co-therapist. We each had a different perspective to bring to the group as we both had quite separate functions. Ms. Croll led the parent's group in a primarily pscho-educational approach, while I led the children's group in a more therapeutic manner where we talked about feelings and did concrete hands-on activities. The preparation for each session was different for both of us as we had quite separate goals for our time alone. Children have shorter attention spans and maturity levels than adults thus creating quite unique approaches in our intervention. We worked together as a team planning the overall objectives for each meeting and discussed our own impressions and gave feedback to each other after each group meeting. We also planned for individual sessions and shared our impressions of themes, group dynamics, and each of our roles during the sessions.

The group sessions followed a general format of a time with all the participants at the beginning of the group lasting about fifteen to twenty minutes. We then split into two separate groups with the adults remaining with Ms. Croll and the children coming with me to a room next door. Ms.

Croll then discussed adult issues with the parents. The children and I spent time on children's issues.

Individual work with the children who attended the Elizabeth Hill Counselling Center followed a more traditional play therapy model, using both directed and non-directed techniques. The children were brought each week by their parent/caregiver. There was fifteen minutes or longer spent with the parent/caregiver discussing how the previous week went and any ongoing concerns, then forty to forty-five minutes in direct play with the child, and a brief closing contact with the parent/guardian. Play was used as an intervention technique but the primary therapy involved assisting the children to express their emotions in a safe environment in the resolution of a grief issue.

CHAPTER FOUR

Practicum Process for the Group Intervention

Group Composition

The response to our request for group membership was limited. We chose the families who fit our criteria the closest. The referrals came primarily through the Child Guidance Clinic or school personnel.

The group consisted of eight children and six parents/caregivers. Three children were sisters whose father had died of cancer in 1995. One sister was too old for the group and did not attend. This family had been an intact unit prior to the father's death with no history of unusual marital discord or separation. Their mother and her new partner (See Appendix G) attended with the girls. This family was chosen for the group as mother stated the girls seemed to be having social and emotional problems such as frequent fighting and arguing which she felt were related to the death of their father. She was requesting additional help for the children and since she was in a new relationship she was concerned as to how the girls would accept this in the context of their mourning for their father. These children were showing signs of distress long after the death of their father.

The second family consisted of a married couple who had six girls in total. The three older girls all attended the group (see Appendix H). The middle child of this group had lost her mother in the fall of 1996. Her mother had been brutally murdered. She had moved into this family along with her infant sister. These three children belonged to a uniquely blended family where nearly all the children had different parental configurations. The oldest daughter was from mother's first relationship. The second daughter from another relationship and the two younger daughters are the offspring of the current union. The baby sister whose mother was murdered is almost the same age as the youngest in the original family. These children were chosen for the group due to the distressing nature of the deceased's death and the impact this was having both personally with S. and and her

adjustment into her new family. She was showing signs of emotional difficulties both at home and at school. She had had no opportunity for anticipatory grief or to say goodbye to her mother. She, in fact, did not see her mother's body after her death which affected her ability to say her goodbyes post mortem. The two cousins were directly affected by the reconstellation of their family and they needed to process their aunt's death as well. The entire family system was in distress due to this change and were requiring therapy to manage their feelings and coping strategies in dealing with the change. It was felt the group process would provide an opportunity for learning and sharing that may help normalize and validate their feelings.

The next family was a single mother who came with her nine year old daughter. The daughter's father had died in the spring of 1996 from untreated diabetes. The parents had been separated at the time although the father had maintained a strong relationship with his daughter and son (see Appendix I). The son was too young for the group. This family was accepted into the group as the child was having serious adjustment problems both at home and at school. She had great difficulty accepting her father's death. He held a crucial function in the family for her as he provided nurturing and material support. This child was showing serious social and emotional problems at school and at home. She had had no chance to say goodbye, nor had there been an opportunity for anticipatory grief.

The last group member was also a single mother who came with her son. His father had died in the spring of 1996, also from untreated diabetes (see Appendix J). This boy had not lived long with his father and had very limited experience or knowledge of him. He has a younger brother who has a different father. He had been seeing the school social worker for social and emotional problems which she felt were related to the death of his father. He had had limited opportunity to say goodbye to his father although he did visit him in the hospital prior to his death. There was very little anticipatory grief as he died quite quickly. He'd had a very marginal relationship with his

father, which may have been causing confusion and anger which was being expressed at school.

There was some diversity in the type of losses each child experienced. Five of the children had lost fathers from illness and natural causes. One child's mother had been murdered. Her two cousins joined her in the therapy. These two girls had lost their aunt and were directly affected when their cousin came to live with them.

Both single mothers were angry and resentful toward the father who had died. Neither of these men had been living with their children prior to their death. There was not the same type of resentment in the other two families. The father of the three girls had been very nurturing and supportive of them. The mother who died had been the sole caregiver of her two children. Regardless of the differences all the parents had a common concern for their children and how they were processing their parent's death. All the parents/caregivers had concerns over the behaviours exhibited by their children.

Some of the presenting behaviours included: aggressiveness toward each other and siblings at home, lying, lack of progress in their schoolwork, daydreaming, stubbornness, and being argumentative. All of the parents/caregivers were feeling frustrated and at a loss at times, in how to respond to their children. There were questions as to how much was related to the death directly and how much was normal childhood behaviour. Each parent was also dealing with his or her own grief or emotions concerning the loss of their spouse, partner, or sister.

Each family brought their own diverse and unique traditions to the group. This included lifestyle differences, cultural differences, spiritual differences and communication styles. We explored the death rituals in particular, focusing on how the children were told of the death, how they were included, their specific family rituals and how their community in general supported them. Three of the families were of Aboriginal background

which included another area of diversity that added to the group's experience. There were also many areas where the group held similar values and experiences. Although there was diversity in spiritual practices the group enjoyed a wide and enlightened discussion on the role of spiritual beliefs and its influence in their lives. This provided a common ground for sharing and mutual support among group members.

Assessment

Assessment began at the point of referral. Each parent was called and an individual meeting time was established where both Ms. Croll and I went to the client's home. We met with them and their child or children to discuss the group, explain the process we were following as students, what their expectations were and how that fit with what we were offering. The evaluation measures were given at this time and a consent form was signed. We were able to observe both the parent and child or children in their home setting. I also had an opportunity to speak with each child individually as we filled out the RMCAS form. Practical things such as child care arrangements for children left at home were also discussed.

The needs of the family were looked at in the context of their family style, how the parent/caregiver was coping with the loss individually, how the child had adapted to the death in relation to the caregiver's reactions, and how well individuated the child was within the family context. The child's defenses and coping strategies were considered in relation to the child's stage of development.

Cultural factors, the family's socio-economic status, religious or spiritual factors, the neighbourhood and the family's life style were taken into consideration. The family's support network within the community and from extended family was also taken into account as part of the total evaluation.

For all the families in the group the death had occurred within the last two years, with most having happened within the last year. As all the

children were between ages 8 and 12 there was at least a beginning realization of the permanence of the death in their lives. Three of the five children had not had a close relationship with the person who died but were affected by the death either through a change in their living situation, as with the two sisters whose cousin came to live with them, or they had lost a parent they barely knew as in the case of our only boy whose father had died. All the other children had lost a parent with whom they lived, although for one child her father had not lived with her for a while.

How well the children had accomplished the three major tasks of grief (Baker et al., 1992) was a major area of assessment. The three tasks assessed included understanding what happened, accepting the loss while bearing the intense emotional pain, and the consolidation of the child's identity and resumption of the developmental progress. One additional task (Fox, 1994; Worden, 1996) was added for the purpose of this discussion and that is the need to commemorate and memorialize the person who died. These four tasks were taken into account when assessing what was reasonable to expect from each child in looking at how effectively they were dealing with their loss. These issues were assessed over the span of the group, beginning with the initial family interview and subsequent observation in the group.

The Group Process

Overview

The general focus in the children's group was to develop a safe environment for the children to ask questions, talk about their experience and express their feelings regarding what was happening to them individually and collectively. The subject of the death was raised from the very beginning and the children were allowed to move in and out of this discussion. We had a sharing time at the beginning of our individual group time. The children were allowed to pass if they did not choose to talk. Any and all questions were answered openly and honestly by the therapist. They

were very curious about the video camera and they all had to experience it by looking though the camera and going behind to the viewing room. The camera that was video-taping our session was set up directly in the room. The video camera for the parents' sessions was in a separate room. Please refer to the previous chapter for the basic group outline. For a detailed description of the group sessions, refer to Appendix E, and to Appendix F for references for bibliotherapy.

Our group ritual followed the format of a general sharing time where a variety of techniques were used such as the talking stone, a temperature check, or naming a colour that could describe your feeling at that moment. This ritual allowed the children an experience of sharing and articulating their feelings. After this formality we did an activity. This progressed from a description or picture of their families, to discussion and artwork describing feelings, to work on a memory collage with a picture of the deceased person in the center of the picture. This project included recall of memories such as favorite hobbies, foods, activities, and things they liked to do, either cut out of magazines or drawn by the children. In the section on feelings, the children filled in colours on how they felt in various parts of their body. They then did a picture of how they would like to feel and when they actually did feel that way now. After the activity each child was asked to share with the group their picture and what it meant to them. Mostly the children shared quite readily, although some needed a little encouragement.

These activities filled the middle phase of the group time. We always joined the parents for the last ten to fifteen minutes where a story was read which the children took turns choosing. As the children became more familiar with each other and me other issues emerged, such as cooperation skills, social or friendship skills, interaction skills, and conflicts between group members and/or their siblings.

General impressions

The girls of the three sibling group were quite shy and reserved about

speaking formally in the group, although they could be quite rowdy informally. Language development and confidence in speaking was limited for all three girls. The oldest of this sibling group is C. (age 11), the next is K. (age 9) and the youngest is J. (age 8). Their mother L. was age 38 and her partner B. was age 45.

The other "sibling" group with the two sisters and cousin were much more verbal and articulate in describing their feelings. The older girl A. (age 12) was very clear and mature in explaining what had happened to her. Both she and her sister D. (age 8) were not as emotionally affected by the loss of their aunt who had not been a caregiver or very close to their family prior to her death. They were both shocked by the type of death she experienced. A. in particular, in fitting with her age, could be quite blunt in her description of her aunt's death and her impatience with her cousin S. (age 10), who wanted to know more of the details. Given the brutality of the murder, the more graphic details had not been shared with S. S. was also a very articulate and bright child who could clearly describe her feelings. She was able to realize the finality of her mother's death and was dealing with processing her loss as well as adjusting to an extremely different family situation. She went from being the oldest of two to the second oldest of six. The parents were R. (age 35) and K. (age 32).

L. (age 8) was preoccupied with her father's death and was clearly stuck in attempting to accept that he had died. She was able to contribute in a very limited fashion to our discussion and sharing of the projects we worked on in the group. Her mother was B. (age 29).

T. (age 8), our only male member, was able to attend only 5 of the 8 sessions due to his hockey schedule and illness. He was somewhat emotionally detached from his father, with whom he had never lived, nor did he have a visiting relationship. As stated his mother, J. (age 26), was very angry and resentful toward his father and had not encouraged their relationship. His father's death, therefore, had not affected his normal every

day routine. He had only seen him a few times since the separation when he was a baby and just prior to his death. He usually showed a great deal of equanimity in the group and was more curious about what his dad had been like than missing his physical presence. A possible hypothesis arose here that he might be confused about his identity as a male as it was clear from his mother's comments in the parent group that she was very angry and bitter toward men in general, his father in particular. This hypothesis arose from discussion with Ms. Croll given his mother's reactions in the parent group. There were no direct behaviours or comments made by T. that indicated confusion or ambivalence that was observed in the group.

Developmental issues

The children in our group crossed the two stages of middle years and pre-adolescence. Many times varying levels of thinking and understanding were present. Six of the children were seven to nine and two were eleven and twelve. For example the three younger children were still interested in imaginary play and enjoyed playing in the play house in the therapy room. They were not able to discuss the loss with the same degree of maturity and sophistication as the older children. They could only tolerate discussion of these experiences for very limited periods of time. This created some misunderstanding and disharmony, as the children were able to withstand different levels of intensity and comprehend with different levels of understanding during our group discussions. When the older children were sharing their feelings or experiences, the younger children would begin some distracting behaviour, such as an argument over a crayon, or tapping their pencil to make a noise, or ask to play with the toys. These behaviours occurred when the emotional intensity was too great for them to feel comfortable (this is consistent with information outlined in the literature review) (Grollman, 1990). The older children were able to reason through more abstract thought. They could distinguish between feelings on both a concrete and emotional level, which the younger children were not yet able

to articulate.

In considering whether to to have a smaller age range I feel the older children provided a good role model for the younger children in how to express their feelings about the loss. The younger children provided an opportunity for playfulness that helped deflect the emotional intensity. There appeared to be a good balance between the developmental stages. Age differences are seen quite naturally in families where children must relate to each other in every day situations. In the safety of the group the different perceptions and understandings could be clarified and discussed.

Family influences

When looking at the family, many factors needed to be considered. First an assessment needed to be made as to whether the family's communication style was open or closed. The more open the system, the more easily the grieving process could proceed (Bowen, 1978). This could be assessed directly in the group where we had a question period and a sharing time. We observed through body language, tonality, and direct communication how open the parents shared themselves and how they supported their children in sharing their thoughts, ideas, and feelings. Other factors considered were: the developmental stage the family was currently experiencing; the stability of the family in terms of the parenting configuration; the financial situation; availability of emotional support; and what function the deceased person served within the family.

We looked at how well the families recognized and respected individual differences in response to their grief and how they coped with their feelings. Communication was a major factor that we looked at in assessing how open or closed the family was in allowing their members to share personal experiences, how they were understood within the family system, and how the system reestablished a coherent sense of past, present and future. In reference to the family life cycle, most of our families were in the phase just prior to adolescence, although one family did have one

daughter who was well into the adolescent phase. There was a clear difference in the emphasis of concern in this family as they were extremely frustrated and concerned about their adolescent daughter. What this did was bring the other group members in touch with their own adolescence and what they would have needed at that time to cope better.

For the most part the families were past the initial phase of shock and disorientation that occurs after a death. Some were farther along in this process than others. The family with the three girls had already reorganized themselves to the point where the mother L. had established a new common-law relationship to which the children were now adjusting. This partner, B., attended many of the sessions and seemed quite open and committed to participating in the process of allowing the girls to fully express and acknowledge their feelings about their deceased father. We attempted to utilize the family as a healing resource for the children by including them in the process and allowing them an opportunity to experience personal/group support and to become more educated in the grieving process of children.

The families attending the group were fairly stable in their current situation and all had made a strong commitment to supporting their children through the process. Both the single parents B. and J. had been single for over a year. They were well established in coping as single mothers and were not in a state of disorganization which may have have been the case if a spouse they had been living with had died. The other two families were in committed relationships. Parent L. and step-parent B. had plans to marry within the next year. Parents K. and R. had been married for the last four years but were still in some upheaval and readjustment as they have had to integrate two more children into an already large family. They moved to a larger home during the group intervention which also created more upheaval as all the girls had to change schools as well as neighbourhoods. This family appeared to be the most stressed given their somewhat unusual

circumstances. They had many additional changes requiring adjustment. The mother who was murdered was parent R.'s sister and they had been very close during their childhood.

The function of the deceased person had the most significance initially for parent L. as she was a single parent for a year after her husband died. She had to parent all four girls alone and run the family business. Her situation was now more settled as she was in a new and apparently healthy relationship with step-parent B. and two years had passed since her husband's death. The initial readjustment period had been very stressful for her and may well have laid the seeds for the current problems she was experiencing with her oldest daughter, on whom she relied heavily for babysitting and support after the death.

The two single moms had not counted on their children's father for either emotional or physical support so their deaths were not as destabilizing as it may be for intact families. The father's functional role in the family was very minimal. In parent B.'s family her daughter L. felt the most disruption as she had felt very close to her Dad and received a great deal of emotional support, material support, and nurturing from him. She was taking his death very hard and was having difficulty accepting that it was real.

For parents K. and R. the direct function of parent R.'s sister in their family was extremely minimal as they had not seen that much of each other prior to her death. The disruption came as these two new children had to be integrated into their family and all the changes that resulted from this. Parents K. and R. are taking a direct caretaking role for these two additional children, as well as working through their own emotional reactions to a senseless and brutal death. For S. individually, the death of her mother was a major change as her mother had been her sole caregiver and she was essentially abandoned by her only parent.

Summary and Conclusion of General Impressions

The group intervention had a clear and predictable ritual. The time at

the beginning of each group meeting with everyone together allowed a time for greeting and an opportunity to share the mood and space of each family. The time when the parents met separately allowed an opportunity for different agendas to be met in each situation. The focus with the children was more child centered and activity based. The time with parents was more didactic with information sharing.

The children needed to have child centered activities to keep their attention and interest. The separate children's group enabled individual attention to be focused on each child, with activities that included talking, doing, and interaction. The activities were chosen to both keep the children's interest and allow different avenues for expression and sharing of feelings. These activities did hold the children's interest, making the group both fun and interesting. The children enjoyed having their parents participating in the program and they were excited to share with their parents the projects they were working on. It was helpful having an understanding of the family dynamics and how the parents participated in the adult group. This enabled us to observe directly the parent/child interactions giving us more direct, concrete feedback. The parent's interpretation of an event can be quite different than actually observing all the participants' interactions in an exchange. This direct observable information is very helpful in the assessment of the family's functioning.

Most of the families presented as quite open in their communication styles, with some individual variation (parent B. presenting as more reserved and anxious about allowing her daughter to express negative feelings). All the families were in similar developmental stages with one having a child in adolescence. There was varying availability of emotional support for the different families. Many had extended family they could talk to for emotional support and rely on for physical support such as babysitting. The function of the deceased within the family had great variability as two of the deceased had not lived with their children prior to their death and two had been

primary caregivers.

Analysis of the Group

An analysis of the group involves looking at group dynamics such as the group's climate, social control factors, group culture, hierarchy in the group, and the process of going from the beginning to middle to ending phases (Toseland & Rivas, 1995). Besides a consideration of group dynamics I will also discuss the four tasks of grieving in relation to the group process and the children individually. The individual family's ability to support the child in the grieving process will be also discussed.

Format

In the individual children's time the style was a round robin where the children would take turns talking. We initially had a "talking stone" which the children passed from one to the other. The person holding the stone was the only one allowed to speak. This added a needed structure to allow all the children to have an opportunity to be heard. Although the group was mainly leader centered, with myself setting the agenda and the activities of the group, there was a great deal of space to allow the children to discuss the things that were important to them. One of the challenges was to stay focused on our task of grief resolution. Working within the parameters of an open communication style within a set agenda, I as leader, would have a planned activity such as drawing a picture of your family, or making a collage of memories of the person who died, or drawing a picture with colours representing their feelings, and allow within that context for the children to discuss things of their choice. After the activity was finished the children could play with the toys in the room or draw a picture of their own choosing, time permitting. This helped form group cohesion. All the children enjoyed coming every week and looked forward to the session. Most requests for things to be brought were remembered by the children such as scissors, pictures of the person who died, a special memento and a picture of themselves as babies.

Social control

The social control factor in the group was supplied mainly by myself as the leader. Being children they still needed clear expectations about what was acceptable and what was not. In the beginning stages of the group the need for social control was fairly lax. As the children became more familiar with the environment and me, the rules had to be more rigidly and consistently applied in order to maintain the same level of compliance. For example, when the children on cookie duty one week wanted to go earlier to get the cookies, they had to be reminded of the routine and it had to be strictly enforced. Any change or variation from the rule opened an opportunity for argument and negotiation.

Culture

The group's culture was focused around their common experience of a death in the family. It is highly unlikely these eight children would naturally bond together in an unstructured situation. Within the setting of the group they had a common experience and common activities that they did together and shared with each other. We developed our own rituals within the group that helped form our own unique culture for the time we met. The children all wrote questions for the question box and enjoyed the ritual of sharing these with their parents. They all took turns choosing the stories for the ending and they all enjoyed passing the talking stone in our sharing time.

The norms that developed in the group included turn taking; having a predictable ritual that everyone participated in, such as the sharing time at the beginning of the group, sharing a snack, telling a story, and participating with their parent; and having the freedom and expectation of sharing and listening to feelings for both children and adults.

Roles and leadership

There was a natural hierarchy that evolved in the group, with A. being the oldest of the group, as well as within her family constellation. This allowed a certain amount of freedom for myself. For instance one child had to

be dealt with individually when she became quite upset and distraught. A. could be trusted to maintain some order in the group while I dealt with the crisis. This happened only once when I had to leave the room briefly with a crying child and A. was able to maintain the continuity of the game the rest of the children were playing. The group members were calm and mature enough that this could happen without having to interrupt the parents in their session and have either one of them or Ms. Croll supervise the group while I was out.

This leadership role assumed by A. could also be a detriment at times as she could be quite bossy, judgmental, and insensitive or impatient with other people's feelings, especially her sisters. This could at times inhibit some of the other children from talking. It was clear the other children looked to her for direction and approval. The oldest of the three sisters could also assume a leadership role at times. It was clear she was in conflict about being the second oldest and showing maturity, and just being a child who could behave more irresponsibly and foolishly. At one point she was trying to instigate an argument to get attention and flung her runner at A. She was doing this deliberately in a calculated way. She was not angry or upset. She flung the shoe to get a reaction. When I spoke to her privately about her role as one of the older children and the example she set for the others, she took this seriously and improved her behaviour quite dramatically. She enjoyed the responsibility and role model expectations of an older child. The other children listened to her to a limited degree although this was in the beginning stages. The leadership abilities displayed by the two older girls demonstrated the process of children striving to have and develop power. They both thrived on the feeling of being empowered and could at times take advantage of their position to control or hurt others. When the power was used constructively it greatly enhanced the group. It also provided a teaching/learning opportunity when it was used negatively.

Group development

In the beginning stages of the group, the children were quiet and watchful. We had a formal time for sharing why they were there and who died in their family. All the children were quite open in talking. One child L., became quite emotionally upset during this time of sharing and cried quite heavily. It appeared evident from this experience that L. was struggling with the first task of grieving. She was having difficulty with both understanding and accepting the loss of her father. All the other children were quite respectful and pensive during this episode. Unfortunately T. was unable to attend this first session as he had a hockey game that night. The group began to coalesce at this point as the children felt the intensity and the solemnity of L.'s pain. The impact of T's missing this meeting appeared to put him at a different level of intensity both as a group member and as individual who was grieving. He always had a superficial and emotionally distant affect when he discussed his father's death.

Initially the children took turns easily and listened quite attentively to each other. They were being very careful and on their best behaviour while they evaluated the safety and parameters of the group. They were all very excited having their parents attend the group and wanted to show off for them. One parent commented that she couldn't believe they were her children, they were behaving so well. In the individual sessions they listened to each other very respectfully and complied readily with the tasks put before them.

In fitting with group development, as cited in the literature review, this initial stage of politeness and emotional distance is consistent with the first stage of group development. The children were testing out the emotional and behavioural parameters of the group to determine safety and limits (Toseland & Rivas, 1995). They were very watchful and pensive until a level of comfort was established in the group and with myself.

We had a question box at the beginning of each session with the total

group. All the children had written down "anonymous" questions which were read each week. It was clear that L. had reiterated a number of times the same question of "Why did my Dad die?" and "Why do people have to die?". This last question was, in fact, posed a number of times by different children in the group. There were also questions raised for Ms. Croll and myself as to the emotional support L. was able to receive from her mother.

In the middle phase of the group the children became more relaxed and demanding. They pushed the limits around the time when they could go and get the cookies, how long they could look in the video camera, how often they could go to the bathroom, how many could go at once, and when they could interrupt their parents. An interruption of the parent group occurred on only one occasion when a child was emotionally upset. We were talking at that time about feelings, remembering the person who had died and sharing what was important to us about that person. It was in the middle phase of therapy that much of the emotional work was experienced through expressing feelings and connecting with memories. The children were the most volatile and pushed limits the farthest during this time. There were also some arguments and disagreements with each other which had to be settled with myself as the arbiter.

In the last phase, the children knew we would be ending and there was a great deal of preparation in getting ready for this last meeting. In the second last session, we had the children make a flower with their parents during our joint time together. They also made a tear in preparation for our last meeting the next week. During this time of a shared activity with their parent, we had a general conversation about endings and saying goodbye. In the last session we did not split into separate groups but had a sharing circle where each person shared their flower, symbolizing the good things that had come from the group and the positive memories they had of the loved one who had died. The tear symbolized the sadness we feel when things end. This was an excellent opportunity for the parents and the children as well as

ourselves to talk about what the experience had meant. We then had cake and a celebration to end the group.

In considering the overall impact of the group intervention, a number of factors need to be taken into consideration. Firstly, we needed to have an understanding of where each of the children was in terms of the the four tasks of grieving as outlined earlier. Secondly, the developmental stage of each child needed to be assessed. This connects with Lohnes and Kalter's (1994) group facilitation model outlined earlier in the literature review. Thirdly, the family as a support network for the child needed to be assessed as the family's ability to support and tolerate the child's emotions is a key factor in healthy grief resolution (Bowen,1978; Shapiro, 1994). Fourthly, the group followed traditional group development with a beginning, middle, and ending phase. Group members did provide support and understanding as the group was a safe place to share common feelings of grief and loss (Shulman, 1992; Yalom, 1985). Lastly, how these children fit into the group, their strengths and limitations such as their social skill level, their ability to verbalize their feelings, and their willingness to cooperate in the group were all factors that influenced the effectiveness of the group experience.

Four Tasks of Grieving

To begin with, all eight children were at somewhat different starting points in the grieving process. There was, therefore, a fairly wide range of experience when looking at how each of the children were processing or had processed the first task of understanding the death and using self-protective mechanisms to guard against the full emotional impact. It was clear, as stated previously, that L. did not fully understood why her father died. Developmentally she is still in the magical thinking phase, to a limited degree, and could have been affected by cause and effect thinking. Judging from her apparent distrust of her mother and the relationship difficulties with her mother, it is suspected she may have been blaming her mother for her father's death. This is likely one of the defense mechanisms she used in

shielding herself emotionally as it was clear from the mother's description of his death that he neglected his diabetes and consequently may have been somewhat responsible for dying when he did. From statements parent B. made it was evident that she was angry and bitter toward the father. She stated that the father had frequently undermined her parental authority and would give into L., making her look like the "bad guy" when she enforced limits. The father had also lavished gifts on L. when he saw her. Parent B. was financially unable to compete with this which further reinforced L.'s feeling that mother did not care or "give" to her. She showed the least connection toward her mother of all the children in the group. Her mother expressed a great deal of frustration in getting L. to cooperate at home and do even simple requests. It was clear from parent B.'s remarks during the intake process that although the situation was exacerbated by her ex-partner's death, she was having similar difficulties with L. before he died.

L. is a child who had clearly not accomplished the first task of grieving. This, therefore, made it difficult for her to move on to many of the group activities as she would perseverate in certain areas. For example when we did the question bag at the beginning of the group she wanted to continue the next week with asking the same question, "Why did my Dad die?". She was reluctant to do subsequent activities as she was clearly taken with this notion and had not finished processing it. She was also the most emotional child in the group, and would cry quite easily if we referred directly to her father's death. We did a brief relaxation exercise in week 6, where the lights were turned off, and the children relaxed quietly with their eyes closed. They were directed to find or create a safe place. She became noticeably disturbed and started crying as she was quite afraid. Other concerning behaviours were her hoarding of cookies, sneaking a juice box into her jacket pocket at home time, having difficulties in transition times from an activity she liked, and her apparent lack of closeness to her mother. She never once asked to go to her mother when she was crying even though

she knew she was right next door. She was selective in the requests she chose to hear and cooperate with.

Three of the children, A., D., and T., had not had a direct caregiving relationship with the deceased person. It was not as difficult for them to understand the death, and the emotional impact was less intense. A. and D. were able to talk openly about what happened to their aunt, although D. showed some reluctance and hesitation or shyness when speaking directly about it. She showed closeness and attachment to her own mother and would go to her for emotional support when upset. This happened on two occasions during the group. A. was intrigued with the circumstances of the death of her aunt, and was processing that information. She showed little emotional affect while she talked about this, as it had not touched her in the personal way that it had touched her cousin. The impact of the death on them was more the change it created in their own family, as they now had to share their parents with two new siblings.

T. had not lived with his Dad as a family since he was a baby so his father's death did not have the same impact as losing the main breadwinner or someone who provided emotional support. He was quite detached from the fact of his father's death and was more intrigued with finding out facts about him. At age 8 he was just bordering on understanding the irreversibility of death.

As for the three sisters they had lived the last year and a half without their father. The two older girls had a good verbal understanding that their father had died of skin cancer and knew many of the details of his illness. The younger child still wished and hoped for his return as reflected in her pictures where he was always included as a member of the family. She "wished" he was still here, but knew he was gone. She, too, understood that he was dead but was not able, as yet, to fully conceptualize the finality of his death. All three of these girls retreated into silence when threatened or when placed in a new situation. They were the most withdrawn in the group

when it came to sharing or talking about their projects. K. was the most talkative, especially in the sharing time. She too, though, was reluctant to openly share her projects.

With regards to the second task of grieving, the five children who lost parents who provided a direct caretaking role were all experiencing pain and sorrow over accepting the loss. The three girls for whom the time since the death had been the longest, were less emotional and did not cry or become upset while talking about it. Their mother did share that, after the first session, all the girls asked many questions about their father and she was quite excited to be able to talk about it as a family. He had been very nurturing toward the girls and did many things with them. In the group the girls referred to him quite easily and openly discussed his illness. They reworked the loss through the group experience by listening to other children. When they were not required to speak formally they would all share memories and experiences of their father. The hands-on activities helped to stimulate informal discussion where these issues would arise.

S. was still struggling emotionally with the pain and loss of her mother. At age 9, she was able to understand that her mother was murdered and she was now living the experience of having a new family, and a new birth order. The circumstances of her mother's death also added to the pain, as her death was senseless. It was clear she had not fully resolved this task as one of the questions in the question bag was "why did F. kill my Mom?". Her two cousins, especially A., referred to the death quite openly and with little sympathy for S. at times. At one point in the group S. was expressing regret that she had not seen her mother before she was cremated. A. was very direct in reminding S. of the unpleasant circumstances of the death and she stated that she wouldn't have wanted to have seen her all bruised and such "a mess". It was clear that A. was still dealing with her own shock at the situation and did not hear her cousin's pain at having been denied the physical reality of seeing and touching her mother for the last time. We were

able to talk, in the group, about the need to have the choice of seeing the deceased if we really needed or wanted to, even though it may be painful. Actually seeing and/or touching the deceased helps to bring the reality into clearer focus and allows the opportunity for acceptance of the death to proceed (Grollman, 1990). The group was a safe place for S. to bring this up and express her anger and frustration. This example also illustrates A.'s stage of development as she was stuck in the "gory details" and was not able to show empathy for her cousin at this time.

L. had not been able as yet to accept her father's death and was still struggling with why and how it could have happened. She was still experiencing the pain of his loss and this pain seemed to always be very near the surface. She cried easily in the group and had the most difficulty progressing to new activities if it did not relate directly to her father. The other children were quite able and willing to do new activities and had to be redirected back to the discussion of the loss as they would frequently talk about other things that were going on in their lives. This is consistent with the work of Lohnes and Kalter (1993) who found that the themes that surfaced were not directly related to the loss itself, but to the ongoing adjustment necessary after the death. The children easily moved from talking about funerals to discussion of why some people had blue eyes and some brown, where babies came from, and who was fighting with whom at school. The group situation allowed an opportunity for their feelings to become normalized. They could easily talk about the loss and about everyday things at school or home that concerned them. This supports Zambelli and DeRosa's (1991) notion that the group gives new social meaning to the loss. In the context of the group no one is different, thus normalizing the discussion.

For the three children who did not lose a caregiving parent the second stage was easier, emotionally, to deal with. T. knew only stories about his father, most of which were bad. We had to work with his mother to

remember good experiences she had with his father so that we could build a memory that would commemorate him in a positive way. A number of gender issues emerged here that were discussed in the adult group regarding the role of men in women's lives. This was especially pertinent for T. His role models, including his mother, were quite negative toward men. The emotional impact of accepting his father's death and processing it, was on a different level of intensity than those children who knew their parent in a more nurturing role. His perspective, that his father had not taken proper care of his diabetes, allowed the group to talk about blame and who is responsible when someone dies. This led at times to a discussion of God and of life after death. Each child shared what their views were of heaven. Some of the children had a very strong Christian perspective but all the children believed there was a heaven and their loved one was there, usually watching over them.

For the two cousins, the acceptance and reworking of the emotional impact of their aunt's death related more to their own living situation and the necessity of dealing with the fact that someone they knew was murdered. These two girls were dealing with having their already large family expanded. They had to change residences and schools as a result. They now had to share their parents with a new baby as well as with S. This adjustment was reflected in the group with barbed remarks directed at S., mostly by A. It was clear from some of her comments that she was impatient with S. and she made a few references to the fact that S. lied about certain things. These comments were not confined to A. as at one point, during the Grieving and Loss game, D. made a comment to S. that their grandparents were different implying she was really not a member of their family. S.'s feelings were quite hurt and it was at this point that I had to leave the group with her while she was crying. This event appeared to be a clear indicator of the stresses these girls were experiencing in incorporating S. into their family. Although A. was not part of the initial event, when she heard about it she was quite surprised

that this would hurt S., as to her it was simply a fact and she could not make the connection that S. would feel hurt by being excluded. This also speaks to her and D.'s stage of development, as they were still thinking in very concrete terms. Emotions were very intense at this time as the death created a transitional crisis for the family.

The children were at different places in addressing the third task relating to the death, that of identity issues. For the most part, all the children, except for L. and S. who were still having difficulty understanding and accepting their parent's death, were progressing developmentally. The three sisters, were all in age appropriate grades and are in regular school programs. Each had some behaviour and learning challenges but they were within normal parameters in that they were not referred to the Special Education Department for academic support. They all have meaningful peer friendships and some extra resource help within the regular school services. A., D., and T. were all in age appropriate grades as well and none were getting extra resource help at school for academics. T. was seeing the school social worker for behaviour and emotional support. All these children had age appropriate and meaningful friendships which they shared to some degree in the group. None of the parents expressed concern about any of these children being developmentally delayed. Much of the discussion in the group revolved around school and friend concerns when we were not directly discussing something in relation to the death. Other than for L. and S., there were no indicators that the children were not progressing normally.

As stated, L. showed some signs of emotional disturbance. It was clear that there may be a relationship difficulty with her mother. Her mother expressed a great deal of frustration and anxiety concerning L.'s non-compliance and angry behaviour. Her lack of ability to participate in group activities, if she was interested in something else, was of concern. My approach with her was very accepting and nurturing, allowing her to do

some of the things she wanted with the understanding she would participate with us in a marked period of time. This won her compliance but there was constantly an issue with limits and expectations which needed to be clearly defined and consistently implemented. For example, because L. would take an unlimited number of cookies, very clear parameters had to be defined as to how many cookies each person could take, whether or not they could take cookies home to siblings, whose turn it was to get the cookies, and how many of the adults' cookies could be taken if there were any left. This preoccupation with the cookies raised questions for us about whether her basic nurturing needs were being met.

S. also showed some signs of deprivation, although less obvious. Near the end of the group any shyness had worn off and tensions between the cousins became obvious with S. feeling left out. She would cry or pout more easily and it was clear when her feelings were hurt. She could also be quite aggressive in getting what she needed and felt free to go to her aunt with demands. In spite of these things she was able to participate fully in group activities and was very involved in the entire process.

The fourth task, that of commemorating and memorializing the deceased was addressed through the collage the children created in the fourth and fifth sessions. Through this process of remembering specific things that the deceased liked to do and either drawing them or cutting them out of magazines allowed an opportunity for informal group discussion about the memories. All of the children participated fully, although the two cousins who did not have a lengthy personal relationship with their aunt, deferred to S. for specific details. Most of the children brought pictures of their parent and those who did not have pictures drew one.

T. had difficulty finding things to put in his collage as he had such a limited experience with his father. This activity encouraged him to ask his mother questions about his father, as to his likes and dislikes. It was an opportunity for him to highlight his father's good points. L. needed to be

reminded to stay with the task as she would perseverate on an activity she liked, such as creating questions for the question box. She did share experiences about her father once she started doing the activity. The three sisters copied from each other and had very similar pictures of their father. A. and D. deferred to S. for details of their aunt's life which gave S. an opportunity to share her memories. Each child shared his or her picture with the group. The three sisters needed some prompting as they did not feel comfortable in a formal presentation format. All three girls gained in confidence with this process over the eight weeks of the group.

The progression in the group activities was leading to this point of memorializing the deceased. We had spent a fair amount of time with feelings, describing them, drawing them, and discussing them. A. was developmentally mature enough to recognize that we can feel with our bodies through touch as well as having feelings internally through thoughts. This is an example where the continuum of ages was helpful in that the younger children did not make this connection and the older children were able to share different examples. The children's completed collages were brought into the joint sharing time with the adults and shared with them in the circle before we closed. All of the children, except for L., took their pictures home that night. L. told Ms. Croll that there was not a safe place at home to keep her picture from being destroyed.

Summary

In summary, the group format was predictable and routine for each session. Social control was provided by myself as leader, with the children developing their own hierarchy of leadership. The group developed through a beginning, middle, and ending phase, whereby the children became more confident in testing limits as they became more familiar with each other. They also tested limits more as the emotional content became more intense. The children were assessed for how well they had resolved the four tasks of grief, how this fit with their stage of development, and how supportive the

structure was in their family to allow the emotional content of their grief to be expressed. It appeared that three of the four families were able to support their children in expressing their grief in a safe and protected way. The fourth family was struggling with many other issues, resulting in the child being unable to fully accomplish the first task of grief and therefore not progressing well through the other three tasks. The tasks of grieving provided a framework in which to assess the children and plan the group interventions.

Evaluation

On the CBCL/4-18 all the T scores were examined including the Total T, the Internalizing T, and the Externalizing T. The Total T represents the overall total of the entire problem behaviours including both the internal and external measures. A score over 70 puts the child in the clinically significant area for problem behaviours compared to peers of the same age. The internalizing score represents behaviours such as withdrawn, somatic complaints, and anxious/depressed behaviours. The externalizing score represents more acting out behaviours such as attentional, delinquent and aggressive behaviours. For this group of children, Table 1 provides the Total T scores, Internalizing T's, and Externalizing T's, for both pre- and post-test measures. Child (L.) was excluded in the average score as no post-test scores were available. Her pre-test scores are in the clinical range of emotional disturbance for all three areas.

In the Total T score one child (S.) showed a drop from a clinically significant score to within the normal range at post-test. One child (A.) showed a slight increase within the normal range. One child (D.) showed a minimal decrease within the high normal range. The remainder of the children in the group showed an improvement in scores within the normal range. The overall average indicates the group showed a decrease in problem behaviours from pre-test to post-test. This measure is taken from the

Table 1

Group Child Behavior Check List Pre- and Post-Test Scores (T Scores) and the RMCAS Pre- and Post-test Scores

	L.	S.	A.	D.	J.	C.	K.	T.	Group X
CBCL Total T									
Pre	87	77	54	65	65	65	64	55	64
Post		67	57	64	56	57	56	48	58
INT T									
Pre	79	77	49	66	59	52	43	53	54
Post		65	55	62	54	55	39	40	53
EXT T									
Pre	81	74	57	58	59	67	74	50	63
Post		65	60	58	50	58	65	47	58
RMCAS									
Pre-	22(>2)+	11(<1)-	5(>2)-	14(>1)-	11(<1)-	10(>1)-	17(>1)+	11(<1)-	
Post-	22(>2)+	16(>1)+	5(>2)-	11(>1)-	27(>2)+	7(<1)-	19(<1)-	16(>1)-	
Lie Scale									
Pre-	3(<1)-	5(<1)-	2(>2)-	1(>2)-	7(>1)+	2(<1)-	3(>1)-	1(<2)-	
Post	2(<1)-	1(>2)+	1(>2)-	1(>2)-	3(<1)-	2(<1)-	2(>2)-	0(>3)-	

Note. Group mean excludes data from the member with no post-test data. For the RMCAS, these are raw scores which show how many Standard Deviations the score is from the mean for the normative group and whether the score is above (+) or below (-) the mean.

parent's perception of the child's behaviour and their perceptions may well be influenced by the stress they are experiencing within their own lives.

On the RMCAS one child (L.) was more than two standard deviations above the norm on the anxiety scale. There was no change from pre- to post-test on this measure, except for the lie scale where she decreased one point. Although there was no post-test measure for the CBCL/4-18 for L. there was a post-test score for the RMCAS. Both the pre- and post-test scores for the lie scale were within the normal range for her children her age. Her anxiety remained at a high level during the entire process. She was also having a great deal of difficulty accepting her father's death as well as having behaviour and discipline problems at home. She was the most clinically at risk, as previously stated, on the CBCL/4-18 checklist. These factors are all consistent and demonstrate the level of disturbance and need for this child. It is unfortunate we did not have the post CBCL/4-18 to compare what, if any, changes her mother may have perceived over the span of the group and whether this would be consistent with her RMCAS scores. One other child, A., remained the same pre- and post-test, although her measure was more than 2 Standard Deviations below the mean for a child her age. The lie scale in this case went down one point, so she was more truthful the second time, but her scores indicate that anxiety is not a major difficulty for this child.

Four children were more anxious in the post-test measure, although all their scores fell within the normal ranges for children their age. In each case the lie scale decreased. This could indicate the scores may not have increased if they had been more truthful the first time. I believe they felt safer and more relaxed at the post-test so they may have been more honest or less afraid of saying the "wrong thing".

Two children had a slight decrease in anxiety scores from pre-test to post-test. In both cases the lie scale stayed the same, indicating a drop in anxiety. Both these measures were within the normal range pre- and post-test.

One child, J, appeared to be significantly more anxious from pre-test to post-test. She was within the normal range pre-test but went more than two standard deviations above the norm on the post-test. The lie scale went from the pre-test of being one standard deviation above the norm to being slightly below the normal range post-test. The initial pre-test was done at home in very crowded conditions. Although an attempt was made for privacy with directions to the other girls not to interfere, they did at times comment on her answers, which she then changed. She was clearly influenced by their feedback which in turn affected her score. In the post-test situation, I was able to do the test in a private place. It is apparent she was very eager to please on the first test and may have been much more anxious than her answers reflected. This could explain the large increase in anxiety which her behaviour did not reflect. Her mother did not perceive her having exceptional problem behaviours as she decreased from her pre- to post-test scores on the CBCL in both the Total T, the Internalizing T and the Externalizing T. If anxiety had increased to that extent it is highly likely there would have been an increase in at least the Internalizing T score.

Overall most of the children (except for two) fell within the normal ranges both pre- and post-test with about half showing an increase in anxiety and two remaining the same. The others showed a slight decrease in anxiety. All the children showed a decrease in the lie scale. Some of these changes seem to be indicative of the children being able to be more honest on the post-test as indicated by the overall decreases in the lie scale.

The subject matter we were discussing was sensitive and emotional which could account for the increase in anxiety. Their trust level and comfort with myself could be a factor in their being able to be more honest at the post-test. Although the anxiety levels did not change dramatically from pre- to post-test, the parents noted an improvement in their behaviour at home.

In the evaluation feedback forms given to the children after the group

all the children reported that they enjoyed coming to the group. They all understood that they were there to talk about feelings. Some of them wanted more time to talk about their individual feelings, some wanted more time to play, and all of them liked the cookies and juice! Many of them would not recommend the group to a friend. This could well be a function of the wording of the question which read "I would recommend this group to a friend" but should have read "I would recommend this group to a friend where someone had died in their family". Being very concrete in their thinking and consistent with being like their peers, most of their friends had not lost a parent to death so would not be interested in a group that was specifically formed for the purpose of talking about a deceased parent.

Emerging Themes

A number of themes and issues concerning individual families arose out of this group experience. All the families were dealing with normal developmental issues such as parenting children in the middle years of development, setting limits, taking children to various activities, arbitrating sibling conflict, relationship issues with other adults, and managing their homes. For two of the families getting to the group on time with all three of their children was a major accomplishment of organization and planning. The family with the mix of siblings had difficulty with child care for their younger three children. Consequently parent K. often had to remain home with them. One family, parent B. and L., had difficulty with transportation and needed assistance a couple of times with cab fare. Besides these very normal, everyday responsibilities they were processing the loss of a significant person to their child or children and to themselves. This added another layer of stress to families who were already busy with living and carrying out normal everyday responsibilities.

As of the children, with two exceptions, fell into the normal range of behaviour and anxiety in both the CBCL/4-18 and RMCAS, the situations can be viewed from a normative perspective. Parenting issues were discussed

openly in the adult group, which Ms. Croll and I debriefed after the sessions. Parent B. needed and received a great deal of support from the other group members concerning her frustration and worry about L. At the same point, during the middle phase of the group, as the children were becoming more relaxed and open, the parents too were sharing quite freely in the adult group. This added a dimension of social support and acceptance to the parents who were struggling with their children's behaviours and emotions. Parent L. was also struggling with parenting at home but it related to her oldest daughter, who was not attending the group. There were adolescent issues of identity and independence with this daughter who was struggling for control and who wanted to be heard. Parent L. expressed little concern for the three younger daughters who were attending the group.

As children can accept and resolve the death in so much as they are supported and listened to at home, it follows that L. whose mother was having the most difficulty with her at home, was the child who was having the most difficulty understanding and accepting the loss of her father. Although there are individual familial differences, the other children were all supported at home in talking about their feelings and freely expressing them. The parent group worked toward enhancing this openness and educating the parents as to what to expect and what were normal reactions.

Generally the themes that began to emerge related to everyday living stresses and processing the loss in addition to normal family development and growth. Each of the families had to cope with other children at home, some with child care responsibilities and some with adolescent issues. There were financial worries for most families in differing degrees of concern. The families had varying levels of social support from extended family members and friends. Each of the families were learning and experiencing new communication patterns, many of which were practiced in the group. These included the opportunity to articulate and share painful feelings, especially those focused around the loss.

Children's Group Time

Eight weeks is a short period of time, for children who only see each other once a week, to form close relationships. We also had two sibling groups who could be a strong support to each other, diminishing the need to socialize with others. There was some concern for the two children who came without a sibling for support, especially as one was the only male. The children did, in fact, get along quite amiably. There were very few confrontations between them, outside of the expected sibling squabbles. As the children became more familiar with the setting and with me, they did test limits and the rules had to be consistently enforced as exceptions led to another and another. The children were expected to treat each other respectfully with no name calling or putdowns. This expectation assisted in setting a safe environment with clear boundaries and rules for the group that allowed the children to feel safe and enabled them to talk more freely about their feelings.

The children did not bond as closely as the adults in their group. They were not yet able to communicate as freely as the adults as they did not have the verbal skills or the maturity to tolerate listening to someone else speak for longer than a few minutes, plus they were in various stages of maturity themselves. Most of our communication during the children's group time was directed through myself as the leader. The children did interact when they played in the doll house, after they had finished their project for that session, but most of the formal group time was leader focused. There was trust in myself as leader, but most of the children did not show a great deal of sensitivity to each other. There was initially a respectful silence when L. was crying during the first meeting, but her hoarding of the cookies quickly lost her the sympathy of the group. This also speaks to children's development and their concrete thinking which does not allow for empathy to any great degree (Shapiro, 1994).

The one thing we all did have in common was the loss of a parent or

someone significant in the family. This allowed for a common thread of experience and enabled the group to talk freely about death and what happens when people die. The children were very curious about different rituals, who should go to the funeral, why we have them, what their purpose is, cremation, and the cycle of life. Some of these issues were dealt with through bibliotherapy as we read a different story each week. The children shared their ideas and thoughts during group sharing time, but the sharing was less self-conscious during the activities, mostly artwork, in the session. Artwork was a very effective avenue for allowing the children to express their feelings nonverbally (James, 1984, 1988; Jewett, 1982; Johnson, 1989). They really enjoyed the activity of putting their feelings into colours on the outline of a body. This activity stimulated a great deal of discussion of feelings and was validating for all the children as we discussed this. I reframed some of their feelings in the context of the loss and normal development.

Themes that emerged from the group involved developmental issues such as the need to set clear, fair rules. The children were not mature enough to impose appropriate social behaviour consistently on themselves. They needed the adult authority to define and enforce the limits. The group was primarily leader led with the children responding to that leadership. The interactions between the children were superficial, with no strong friendships developing between participants. The fact that there were two sets of family siblings may have contributed to the lack of relationship development between group members. These children did not see each other outside of the group and this may have contributed to a lack of interpersonal closeness. Developmentally they were still very dependent on parents and their immediate community for social interactions (i.e., they were not at an age where they could go across town on a bus to be with peers in other parts of the city that an adolescent would have the independence skills to accomplish). The loss experience was the main thing these children had in common and this common loss was a major bonding thread that

enhanced group cohesion.

Play in Therapy

As mentioned, the play techniques that were utilized were primarily artwork, bibliotherapy, making the collage, and metaphor. The children enjoyed the check in portion of passing the "talking stone". We also used the temperature check as a way of assisting the children to think about how they were feeling on a scale of one to five and describing why they chose that number. This allowed them an opportunity to develop verbal skills in articulating their feelings. The artwork provided a structure for them to become involved in the activity and stimulated discussion. Many varied issues came up, some relating to the death, others relating to everyday occurrences. Given the restrictions of the group setting, other forms of play were not possible. With only one leader and several children, the activities had to be structured so that all of the children could participate. Still, many opportunities arose for the unconscious feelings to be expressed and validated. In the last session, besides the flower and the tear (both metaphors for things that come out of a struggle) we also gave the children, and their parent/caregiver, a smooth stone for the good times and a rough stone symbolizing when things would not be easy. The stories read during every session were also metaphors dealing with either a loss situation or how other children handled their feelings.

In terms of the play techniques utilized, the emerging themes related to articulation of feelings in the formal sharing time. Others needed the informal times, such as an art activity, to express their feelings. A consistent theme was the flipping back and forth from the loss issue to normal childhood worries involving school, friends, and parents.

Siblings in the Same Group

We assessed the effects of having siblings in the same group. This dynamic had both positive and negative aspects to it. On the positive side it allowed the siblings (I am including the two sisters and cousin in this area as

they lived together as sisters) to hear and experience the same activities, allowing an open discussion of death and all the characteristics attached to this subject. Discussion of death issues may not have been dealt with openly in the family or the children were more able and ready to discuss it now. Communication was clarified and reframed allowing for a new way to view events. The siblings could also provide moral support to each other during the session.

On the negative side, they sometimes were more critical of each other than they would have been to a stranger, bringing in a tone of dissension and negativity which familiarity and family history can engender. Unresolved feelings of jealousy, resentment, and hostility were introduced into the group which non-siblings would not have experienced. The siblings would argue and could be quite cruel to each other.

Both these aspects were present in the group, bringing another dimension of complexity and challenge to myself as the leader, as the different sibling needs had to be balanced against the needs of the overall group. I needed to maintain the balance, as it could have easily become a therapy session focused on one family, taking away from the purpose of the group and excluding the other children.

Themes for Parents' and Children's Group

There was some interplay between the adult's and children's process. Rituals of the group were important to both. They provided a predictable structure which enhanced the safety and trust in both groups and in our joint time together. Communication skills, as highlighted in the literature review, were modeled by both of us for the parents and the children (Baker et al., 1992; Masterson & Reams, 1988; Zambelli & DeRosa, 1992). In our general discussion after the question was read from the question bag each week, we modeled how to listen and validate the concern, how to explore it more fully and how to deal with it directly and honestly. There was some discussion as to how much to tell the children, when it is overload and when it is

necessary information. This was discussed separately with the parents by Ms. Croll. After the story at the end of the session, we would debrief on what the story meant and how the person in the story might be feeling. This raised emotional issues for the adults as well and their feelings were shared in the group with the children.

We discussed the deaths quite openly in the group and put them into a family context. We talked about differences in people within the family, how some cried, some were quiet, some went for walks, some watched television, some wanted to talk while others wanted to be silent. By discussing these differences we attempted to validate that there was no right or wrong way to grieve and that different people expressed their grief in different ways at different times. We were hoping to open the lines of communication and acceptance of differences for all families. Along with this was the goal of normalizing the grieving process and allowing each person the freedom to express their feelings in whatever way was appropriate for them. As the families themselves were experiencing different degrees of distress over the death in their family, there was some disparity or heterogeneity amongst family characteristics. Even with these differences all the people were able to participate fully, even if it was just listening to other's stories.

We did notice a different tone in the adult group when only the women came. There were two times when both our male participants were away at the same time. The women seemed more open and free to talk when it was just women present. This may have been due to the fact that two of the women had had negative experiences with men in their lives or the fact that people may be more relaxed in speaking with their own gender. This was noticed more so in the parents' group. I noticed little difference in the behaviour or participation of the children. Also when our only male child did not attend there was very little difference in the interactions of the girls in the group. He fit in quite easily with little change in the group whether he attended or not.

The group model used met the needs for these families on a number of levels. The model allowed for the joint time of sharing where the adults could model appropriate mourning and demonstrate to their children how to discuss painful feelings. It showed the children their parents were committed to supporting them and listening to them as they attended each week bringing the children with them. It also gave permission to discuss the loss openly in the family. The model allowed each family to see and hear how other families communicate with each other on this issue.

The model allowed for an individual time with each group which enabled the parents to discuss adult issues which would not be appropriate for children to hear. In this time they learned about children's grieving process from a developmental perspective. They could then discuss this in relation to their own child or children. They could also share adult worries and frustrations as they were managing everyday living challenges plus going through the mourning process themselves. Here they could discuss their concerns without burdening or overwhelming their children with their worries. The parents also had an opportunity to receive support, understanding, and strategies from the group and Ms. Croll as to handling different situations.

In the children's individual time, they were able to share their worries without concern for their parent's feelings. They participated in child focused activities without a great deal of formal lecturing and teaching. The focus of the children's time allowed the flexibility of going in and out of the loss experience. Consistent with the notion raised in the literature review, children cannot tolerate the same degree of emotional intensity as adults. The children liked knowing their parents were next door and easily available when needed. They enjoyed showing their parents their projects and being the focus of attention. Having a time for each group individually met the needs for privacy and dealing with age appropriate concerns for each group.

A disadvantage for the parents was the short duration of the group.

They felt they could have participated in several more sessions, both for the group support and the information. For the children the eight weeks was sufficient as they were ready to move on to other issues. A suggestion could be to have the adults continue after the children's portion is finished.

Working With a Co-therapist

Ms. Croll and I spent time planning the group intervention, deciding who would take a leadership role with the whole group and how we would divide the responsibilities. We spent time before and after each session debriefing what happened in the session and refining how we would approach issues that arose in the next session. Generally we took equal responsibility for the first portion of the group, initially introducing ourselves and discussing our goals for the group and the rationale for our sessions. We consistently shared the opening portion, usually with myself picking a question from the question bag and beginning the meeting with this discussion. We both answered the questions from the question bag equally with the parents who also contributed to the answers. Some of the questions were quite provocative, such as "what is evil?" and stimulated interesting discussion. We each led our own individual portions of the group time and shared the ending time.

Together we discussed and evaluated our impressions of what had happened during the sessions and related it back to our theory of grief resolution and group dynamics. We each took very different responsibilities with our individual sessions as our focus related to our individual goals. We tied these individual goals together in an overall understanding of how the children related to their families and the context of the family situation.

We shared the practical responsibilities of ensuring that there were cookies, juice and coffee for each session. We both set up together and cleaned up afterwards. We shared our impressions in supervision with Dr. Mills and had an opportunity for feedback. This added perspective allowed for an enriched experience with the group.

There are several advantages to working with a co-therapist. We had an opportunity to bring our own individual experience and perspective to the entire process. We interviewed the families together and debriefed after each session. This allowed for an expanded understanding of what we had experienced, noticed, and focused on during the interviews. Once the group began we had time to plan each session, which allowed for an opportunity to look at goals and objectives for each session. After the sessions we debriefed both the joint group and our individual groups. This broadened our perspective and understanding of the families as well as examining the group process. We looked at the group, families and individuals in terms of family process, group process, and the grieving process. This greatly expanded the learning experience.

The disadvantages, although minimal, were present as well. The process was time consuming, adding another layer of meetings and time for discussion. We not only had to find time to meet with each other, but with our group supervisor as well. Differences of opinion or focus had to be worked out and some compromises made. When working individually some of the decisions are more straight forward and therefore time efficient. In all the advantages far outweighed the disadvantages, adding to a full and enriched experience.

Conclusion

Themes that emerged from the group practicum experience included a consideration of the developmental stage of the families in the group and the families's ability and openness to support their children through the grieving process. The need for consistent and fair rules, especially in the children's time, was a consistent theme. The use of play techniques in both the children's time and the sharing with the parents (both as witnesses to the children's efforts and as participants) was a significant thread throughout the experience. Having siblings in the same group proved an interesting factor in group dynamics and interactions. Joint themes which considered

similarities and differences between the parents' and children's groups demonstrated both the emotional effects of the process and the need for open communication in the grieving process. Finally, working with a co-therapist was a consistent theme as we needed to be in regular communication and discussion with other.

My experience with the children in the group and their families supported the findings in the literature. It is clear the openness in communication is a vital factor when looking at children having permission to grieve. They need to be able to ask questions and know their parents can hear these questions without dissembling or closing off from them. The model used allowed for this communication to happen in a supportive environment, both from others in the same situation and from ourselves as group facilitators. In examining the four tasks of grieving that were explored it was clear the children could not move onto subsequent tasks until the one before was resolved. The developmental nature of the process allowed us to look at the families and children from a more normative, growth perspective as opposed to a pathological one. Using a combination of techniques for both the groups, such as art therapy, verbal sharing, direct teaching and group support, gave a number of different options to allow for expression of feelings and an opportunity for each person to be heard and validated.

CHAPTER FIVE

Practicum Process for the Individual Intervention

Overview of the Clients

Referrals for the individual cases came from the school system through a Child Guidance Clinic school social worker and from a therapist at the Elizabeth Hill Counselling Center. The first family was initially referred through our request for group participants, but upon assessment of the family, it was felt the children were not well suited to the group. The children, a girl L. and a boy T., twins age 7, were in the care of their grandmother, parent S. age 50, who is their legal guardian (see Appendix K). The family was seen for twelve sessions at the Elizabeth Hill Counselling Center.

When initially considering the children for the group, it was determined they were also too young for the group criteria of 8 years old. Parent S. also questioned how suitable they were to a group as they were quite active and attention seeking and could possibly sabotage the group process.

The children had not had a chance to say goodbye to their mother (she was killed unexpectedly in a car accident while on holidays) nor was there any opportunity for anticipatory grief. The grieving process was complicated by the suddenness of the mother's death, her role as the primary caregiver, the age of the children at the time of her death, and the stress that was placed on parent S. It was decided individual sessions would be appropriate. They needed the individual adult time and attention, which would not be possible in a group situation.

The symptoms the children were displaying were primarily behavioural and were of great concern to their grandmother. She described them as being very difficult to manage, not listening to her demands, and having difficulty at school (mostly academic). She expressed a great deal of frustration in parenting these two children. She was herself, experiencing a

great deal of emotional pain in resolving her daughter's death and the dramatic change it had wrought in her life. In assessing the need for individual therapy, the family circumstances weighted heavily in the decision to see these children and their grandmother individually.

The second family was referred by the child's school counselor. She was requesting therapy for 5 year old S., who was having difficulty at school. He seemed preoccupied with death rituals which was becoming a concern to his teacher. There had been concerns regarding S.'s aggressive behaviour with other children, his frequent talk of burials, caskets, and funerals. S. lost his father in February 1995 due to a heart attack. He lived with his mother, parent J. age 35, and an older brother C., 10 years old (see appendix L). He had no opportunity for anticipatory grief or a chance to say goodbye. He too had lost a parent who had been a primary caregiver and was showing symptoms long after the death which would indicate a need for individual therapy. He was seen for twelve sessions at the Elizabeth Hill Counselling Center.

Assessment

Parent intervention

The assessment phase was somewhat different for the two families as the first family was initially interviewed for participation in the group. Parent S. was interviewed by both Ms. Croll and myself, with the group intervention in mind. At this interview a great deal of background information was gleaned concerning the extended family situation and the circumstances of the mother's death. Parent S. gave a description of the children's behaviour. It was after this interview and much thought by parent S., that she decided to go with individual therapy instead of the group.

It was apparent from the beginning stages that parent S. was finding the task of parenting these two very active grandchildren a great challenge, both physically and emotionally. She herself was still processing her daughter's death. She had been so busy with the parenting and care of the

twins that she had found it difficult to find time to allow herself to do her own grief work.

The assessment phase considered the parent's strengths and limitations. Community or family supports were assessed as parent S. was frequently stating that she was having difficulty coping with these very active, demanding children. An added complication in this family occurred when another grandchild, age two and half, came to live with them for a three month term. This child's mother was having great difficulty parenting and managing her own life and was unable to provide adequate care for her daughter. Parent S. could not see her granddaughter living in such tenuous circumstances and took her in on a temporary basis, while her daughter made some changes in her life. This arrangement was supervised by Child and Family Services of Winnipeg.

With the second family, parent J., was interviewed briefly over the phone to set up the appointment to meet at the Elizabeth Hill Counselling Center. She was concerned with the school's reports about S.'s behaviour and wanted him to have help before it developed into a larger problem. Her primary concern at home was S.'s temper tantrums and outbursts of anger toward her if he did not get his own way.

The assessment included an evaluation of the J.'s ability to support her child, her areas of strength and those areas that needed intervention. J.'s husband had been of Trinidadian background. His family held a funeral service in Trinidad as they were financially unable to come to Canada for the service here. This aspect of S.'s heritage was explored and discussed with parent J. She appeared to be on open and friendly terms with her inlaws and supported S.'s connection to his father's side of the family. Other community and family supports were also explored in assessing where parent J. could get emotional and practical support in times of stress.

S.'s father died quite suddenly of a heart attack at age 57. He had been to the hospital earlier that day with chest pain, which had been discounted

at the hospital as the flu. Later that evening, while S. was sleeping with him, he had severe chest pain and an ambulance was called as parent J. heard his laboured breathing. He died that night. S. was four years old at this time. It was quite upsetting in the household as the older brother saw Parent J. hit his father on the chest to try and revive him. He blamed his mother for causing his father's death. How much, if any, this atmosphere of anger and distrust affected S., was a factor to be assessed in the intervention.

A primary goal in assessment and intervention with the parents involved understanding where they were in their own grieving process and how open or closed they were in their ability to listen to and hear their child's pain. Their own internal supports (how they viewed the death emotionally), what outside supports were available for them to discuss adult concerns, plus areas of cultural and spiritual diversity were assessed. These became areas of intervention in supporting the adult caregiver.

Assessment of children

Assessment of the twins began at the school when I went out to do the RMCAS form with the children. This was done thinking they would be in the group, so I had already met them before they came for the first therapy session. They both had a superficial understanding that they were seeing me because their mother died, and we were going to talk about feelings. Their mother, although the primary caregiver, had been living with a man who was somewhat in the role of step-father and still sees the children for occasional visits. Although this contact is somewhat ongoing, parent S. states it is of minor support to her and she is distrusting of allowing the children to spend extended periods of time with him.

There was an interview with the school social worker and school personnel as well, where information was shared concerning the children's behaviour at school. The boy T. was also being seen by the school psychologist for an assessment of attention deficit disorder. He was having some difficulties with reading and attending behaviours at school. Parent S.

was very concerned about the children's attitudes toward herself, attitudes toward school and their ability to progress academically.

In the subsequent therapy sessions their behaviour and emotional affect, especially in relation to their accomplishing the four tasks of grieving, their ability to join with the therapist, and their style of play were all factors to be assessed. The time with parent S. in the waiting room and their interactions with her during our conversations before and after each session, also gave feedback as to how their relationship functioned. This assisted in increased understanding of the family dynamics. An ongoing connection was maintained with the school social worker for feedback and case planning.

In the second case of parent J. and S., there are quite different circumstances surrounding the father's death. He, too, had been a primary caregiver to S. and S. was actually with him when he stopped breathing. There had been a great deal of confusion and an air of crisis, with an ambulance being called. He was left with a babysitter while his mother went to the hospital. Given S.'s age at the time of the death, a question arises as to how much distress he experienced during this event. He was away from his mother during all the subsequent commotion. Whether he had achieved the first task of grieving in understanding his father's death and to what extent he had been able to express the painful emotions attached to this experience needed to be assessed. As with the twins, his behaviour was assessed in relation to all four tasks of grieving in the individual therapy sessions. His style of play, ability to join with the therapist and his behaviour with his mother were all factors that were considered in the assessment.

Developmental Issues

Two of the children had been five when their parent died and one child had been four at the time of his parents' death. Both parents died nearly two years previous to their coming for therapy. Four and five year olds are still in the magical thinking phase, with little ability to understand cognitively what exactly this experience means. As Baker et al. (1996)

mention, children of this age cannot appreciate the finality and permanence of death as yet. There remains aspects of cause and effect thinking (Shapiro, 1994) and possibly a feeling of responsibility or guilt (Grollman, 1990) concerning their parent's loss. How much developmental factors affected their current thinking and experience were important questions.

For the twins there were marked differences in the children's cognitive reasoning skills and interests. The girl, L., was very articulate. She loved to talk and ask questions. She was a skillful and accomplished reader and could easily read all the bibliotherapy books herself without help. In contrast, her brother, T., disliked reading and conversation. He had little confidence in himself as a reader and would read only when coaxed. When we did read a story he usually had to stand and made a rocking motion with his feet. He liked to look at the pictures but had difficulty sitting still. His conversation was limited to 'yes/ no' answers and he offered some questions but in a very limited way. He loved imaginative play and consistently set up repetitive dramas. L. on the other hand, loved to do crafts and make things. She liked to use her hands and had good fine motor skills. Her brother liked to do gross motor activities with the more action the better.

S. liked to be read to but preferred imaginative play. He could be sedentary in his play and liked to play in the play house or create a house with bricks. He could not manage games with rules as he did not as yet grasp the concepts of following rules. This is very consistent with his developmental age of 6. He became quite frustrated playing checkers or block busters as he could not as yet conceive of following set rules. It clearly spoiled the fun or his interest in the activity. It was not possible for him to tolerate a discussion, especially one that focused on his father's death for any duration of time. He would quickly answer any questions with a shrug or a brief yes or no and get back to "play". It was in the themes of his play that he was able to express the emotional content of his experience, not only of the death, but of his life.

Four Tasks of Grieving

All three children were still at the first task of understanding their parents' deaths and attempting to express the emotional impact. None of them had conscious memory of their deceased parent. Their memories consisted of pictures and stories told by other family members. There was an added layer of sadness as they did not remember details or even the appearance of their deceased parent. In the case of the twins the grandmother had protected the children from having too much information and excluded them in the rituals. For example, they were not allowed to attend the funeral. In S.'s case he was included in the funeral but due to his age there had been limited verbal explanations of what had happened. There had also been a great deal of strain and anger between the mother and the older brother which may have had an impact on S.'s ability to feel safe and his ability to share his emotions concerning his father's death.

In the actual therapy sessions none of the children offered direct feedback about how their parent died or referred to the event without prompting. The play themes reflected the emotionality of the event. All three children were able to act out through their play some of the unconscious factors at work inside themselves. S. would, for example, have consistent themes of disaster where the police and ambulances are called but the people always died. With T. there would be a constant battle with the "good guys" always being killed, even if they were prepared for the battle. There appeared to be no way to stop the disaster from happening. Protective defenses used appeared to be "forgetting" as in not recalling what their parent looked like or memories about them, distracting behaviour which focused their parent's attention on them instead of their sadness, and being lost in the world of play.

Given none of the children appeared to have successfully completed the first task of grieving, the remaining tasks were areas where seeds were planted for future reference and resolution. At one level, the children had

accepted their parents' deaths as they had no choice. They were irretrievably gone. Enough time had also passed that they knew it was a long, long time and their parents had not as yet returned so they were learning from their own experience about the longevity of death. In resolving the second task of grieving which is accepting and emotionally acknowledging the reality of the loss, looking at and reevaluating their relationship with the deceased and facing and bearing the psychological pain that comes with this, the child must be able to explore the loss and reestablish a new relationship with the deceased (Baker et al., 1991). An issue that emerged was the level of safety the twins had to express their pain and loss, given their current family situation. This will be discussed more fully in the section regarding family systems. In S.'s case, he was developmentally unable at this time to do this type of emotional work. He needed to be in a safe environment that did not overwhelm him emotionally so that he could process the loss along with his developmental progress.

Children move forward developmentally, as this is the nature of childhood. How the loss experience is incorporated into their development is the issue here. In order to achieve the third task of grieving, which is a reorganization of self-identity with significant relationships with others, tasks one and two needed to be completed. Tasks of language development and maturity factor into the child's ability to master this last task. As all three of these children are very young this task will need to be reworked as they grow in maturity, understanding, and are psychologically supported in doing this work.

Efforts were made by the guardians of all three children to address the fourth task of commemorating the parents' deaths. At the anniversary time parent J. had a ritual at home with her sons, where she lit a candle and said a prayer with them to remember their dad. Parent S. had taken the twins to the grave-site to remember their mother and show them where she was buried. We also did a commemoration process at the end of our session

where symbols were given to remember our time together. It was difficult to assess how much they understood other than the actual concrete moment of the ritual.

It appears to me there are two levels of developmental growth happening simultaneously. The children are growing and maturing as children normally do. The tasks of grieving are an added layer of emotional and psychological work they must face as this is the reality of their experience. How these tasks are addressed can be coloured by their developmental progress as cognitively they experience their loss from the different developmental stages.

Family Influences

It was very apparent from conversations with parent S. that she was ambivalent about caring for her two grandchildren. She was resentful of the loss of her own freedom. She felt she had finished with parenting as she had raised five children of her own. She found the constant attention they needed to be very draining and demanding. She felt she had no time herself to process her daughter's death as she had immediately assumed the care of the twins. She was in a relationship with a man, although he did not officially live with her in her home. Her relationship with her other children could be described as strained at best. The two daughters were not speaking to her as they were angry at the way she was handling the care of her two and a half year old granddaughter. The two sons were more supportive, but she did not feel that she could count on them for babysitting the twins or providing any real respite for her. Parent S. also described a previous unhappy marriage which had been extremely abusive and difficult, for both her and the children. Her own life had nearly been lost as a result of her ex-husband and she was still recovering from that relationship. She also had little trust and respect for the twin's father who was now trying to visit with them. He had had nothing to do with them when they were infants and had provided only minimal financial support to their mother. He was now married with a new

baby and wanted to become a father to the twins. There was a court proceeding in progress on this matter. Parent S. was fighting any visitation rights by this man but wanted him to pay child support.

In her direct care of the twins, parent S. presented as being very critical and demanding. She was attempting to teach them manners but was not always respectful of their feelings or wishes. For example, she would demand they wait while she was talking but would interrupt them while they were talking or take a toy away with no explanation or negotiation. She had very high expectations of their behaviour which were not always fitting or appropriate for their age. She expected them to play quietly for hours without interrupting or bothering her for any reason. They had to play neatly and were not allowed to make a mess. In the play room both children were very conscious of making a mess and keeping the play area tidy. They both commented on how neat and orderly things had to be. L. in particular was worried about pleasing her grandmother and stated she never argued or disagreed with her. She was very worried about doing the right thing to keep her grandmother happy. According to parent S., L. was always challenging and arguing with her about most requests. They were in frequent power struggles as parent S. did not find L. to be nearly compliant enough. This apparent inconsistency could be a reflection of parent S's high expectations and L's struggle between pleasing her grandmother and expressing her own wishes and desires.

This family was experiencing a major conflict in the stages of the family life cycle (Walsh & McGolderick, 1991). Due to the crisis of the death of her daughter, parent S. went from having launched her own children, right back to the parenting of young children. This crisis made it very difficult for both her and the children to complete the grieving process, as they were focused on resolving this transitional crisis.

For S. and his mother, the situation was quite different. Parent J. was already in the flow of the life cycle of the family with young children (Walsh,

1982). Her husband's death created a crisis in that she was now a single parent but as the family was not in other transitional phases the grieving process was more straight forward. It also appeared very clear that there was a very strong attachment between mother and son. She was very indulgent and accepting of his moods, differences and personal preferences. She clearly enjoyed this child and was openly affectionate toward him. Her older son, although challenging at times, was just on the cusp of entering adolescence. This was beginning to happen just as the therapy with S. ended and the older brother had begun to see his therapist again for difficulties at school.

There were some concerns over parenting expressed by the school and the older son's counselor, but S. on the whole was a cooperative child who wanted to please adults. This was apparent in the therapy sessions and was supported by feedback from school. Parent J. was being assertive with him, as he had learned to skillfully get his way with her by demanding and cajoling. She was aware of this and was setting firmer, more consistent limits. Although she was still grieving the loss of her husband she was able to provide a warm, nurturing parenting experience for S. Unfortunately her relationship with the older son was not as warm and nurturing, especially as he had initially blamed her for her husband's death. The relationship with the two boys sounded quite different from the mother's description and from the feedback I received at school. S. had been involved in some aberrant behaviour instigated by his older brother. Specifically he had urinated on another child at school, at his brother's instigation. This could be a reflection of his development, his eagerness to please others, and his immature moral judgment about right and wrong behaviour.

Parent J. did have the support of her mother, close friends and other family members, on both sides. Parent J. was also able to allow S. expression of his emotions concerning his father's death. She appeared to be open and supportive.

Therapy Process

All three children enjoyed the individual time and attention in the therapy room. Two rooms were used at the choice of the child, unless one room was previously booked. We met on Fridays where we were usually the only ones at the center, so often the therapy room was their choice. The sessions were primarily child directed at first. The child was allowed to choose the toys and the style of play. Basic rules were adhered to, such as being respectful of each other, not breaking the toys, putting the toys away when we were finished, and having the snack at the end of the session. Parent S. did not allow the twins to have cookies. She brought along carrot sticks and allowed them to have juice on occasion. She preferred they drink water. Overall there was little need for forceful limit setting as all three children enjoyed coming and were very co-operative.

As stated the play was child directed for most of the beginning sessions. The boys played in the sand more often, usually with the armies, vehicles and war machines, especially T. All three children liked to play with the play house, especially S. who consistently used it. We read stories, usually my choice, relating to the theme of loss. We played with puppets; we played some games, although S. was not ready yet for games with rules and they had to be adapted to his ability level; we played dress up; we played "house"; we played with paints and play dough; we played in the sand; and we played "store". L. liked to make things with her hands for which neither of the boys had any interest. This could have been developmental, gender driven, or a personal preference.

After the children were comfortable in the play room and easily interacted with myself, I introduced more directed play techniques such as the stories relating to a theme of loss, the Grief Game, and in the final session we did a process of commemoration where the children were given a stone to remember our time together. This included a discussion about the person whom they had lost. Other than these therapist directed interactions.

the play proceeded at the child's direction. Hypotheses were checked out within the play context while we were interacting with whatever the issue the child raised. If for example, the hypothesis was that the child was worried about how to be safe if a disaster occurred, ideas for handling a disaster were suggested in the play. This was especially relevant for S. who had frequent themes of police and ambulance coming to the rescue for fires and floods. The suggestion in the play was to develop resources that could help solve the problem.

The discussion time with the parent was very important, as feedback and explanations were discussed to assess the parent's/caregiver's understanding and involvement in the process. Both parents/caregivers were reliving their own grief process, but they had different parenting concerns in terms of their children's behaviour in everyday activities and specifically as to how they were understanding the loss experience. Parent J. did not have the same parenting concerns as parent S. regarding compliance, the challenging of authority, and loud behaviour. She was concerned about S.'s anger, which at times would cause him to yell and cry. Other than these instances she found him to be quite compliant and easy to parent. Parent S. on the other hand, had concerns every week about the twin's non-compliance to her requests. She stated that they "never listen" and that they "are getting worse and worse". When this was explored further, it was usually her frustration at looking after her two and a half year granddaughter and the lack of co-operation from her daughter, that was causing her the primary frustration. Any sign of noncompliance from the twins was felt even more intensely, as she was worried about this other situation. These weekly check-ins with the parents assisted in allowing an opportunity for support and parental counseling.

A final aspect of the therapy process was creating a situation for commemorating the death for the child with the parent present. Both families were asked to bring in a photo album so that we could look at the

pictures and discuss memories of the deceased. Unfortunately, parent S. did not have the albums organized and did not bring them in. She was to have looked at the pictures at home instead but she was "too busy" to find the albums there either. It was apparent she was unable herself to do any remembering of her deceased daughter, and therefore was unable to share these with the children. Parent J. did bring in pictures, which we looked at and remembered. Afterward a special stone was given to each child to commemorate our time together and give them a tangible keepsake of this experience. Although the twins did not have pictures to look at we did have some discussion with parent S. and they were given the stone. Both children were quite talkative during the post-test measures, especially L. when we did the client satisfaction form. She had many questions about how her mother died, where she was now, why she had to die, and the funeral. This allowed an opportunity for us to discuss these issues more openly. It was obvious this was not a subject open to discussion with Parent S.

In summary, these families presented very different parenting styles plus different expectations of their children. Parent S. had a very closed parenting style that did not invite expression of emotion or differences. She expected the children to obey immediately without question and did not tolerate any opposition. The children were very polite on the surface and had learned that they had to please parent S. for things to go smoothly for them. They had learned it was not a safe or open subject to discuss their mother and their feelings concerning her. Parent S. was adjusting to a transitional stage of parenting young children and was struggling with this adjustment as well as the emotional impact of her daughter's death. The task for intervention became supporting parent S. in her role as caregiver while validating her ambivalent and resentful feelings toward fate. With the children, the goal became allowing them a safe place to begin expressing their feelings and providing a context that did not invalidate parent S.'s values or expectations. These children had experienced a major loss and had

been abandoned by one significant caregiver. The challenge became balancing support for both the children and the caregiver in this system.

With parent J. and S., the issues were more straightforward. Parent J.'s parenting style was very open and expressive. There appeared to be some issues of complicated bereavement for S. as two years later he now seemed preoccupied with graves, burials, and was displaying some unusual anti-social behaviour, which may or may not be related to the bereavement. Some of these behaviours could be simply developmental as he needed to rework the death at a later stage of development. This needed to be further evaluated in the therapy. The relationship with his mother appeared to be strong and uncomplicated, other than parenting issues that are normal to this age of child. The fact that the mother had unresolved issues around her husband's death may have been more of a factor in S.'s current behaviour. She was not in a transitional crisis and there had not been any other unusual circumstances happening in the family.The goals for intervention included evaluating whether S.'s behaviour was beyond a normal developmental phase and assessing how much parent J.'s concern over her legal action with the hospital was interfering with her ability to support and comfort S. appropriately.

Play in Therapy

The play for all three children was imaginative and joyful. All three were highly motivated to come to therapy and loved the individual attention and time given them. Although none of them were able to really "talk" about their feelings or reactions to their parents' deaths, except for very brief, superficial moments, they all reflected their emotions in their play. The two boys especially, had themes of burying, disaster, emergency vehicles, people dying, but not really dying for long, and misbehaviour, especially with stealing and punishment. For L., the themes revolved more around pleasing adults and doing the "right thing" to please. She was clearly needing to be in control, yet wanting to defer to and please me.

The Case of S.

With S. the development of a hypothesis was more straightforward than with the other two children. His situation at home was very stable with his mother. There was a strong and well established bond which allowed him to freely express his feelings. In his play there were recurring themes of disasters. We played out dramas of fire, earthquakes, floods, more fire, people being buried, then rescued. People were buried in the sand, and buried under toys when the earthquake happened. Always the rescue people would come but it would always be too late, then the people would miraculously come alive after being buried. This is very consistent with his developmental age, where he is still in the stage of magical thinking, and not fully comprehending the permanence of death. The hypothesis developed here is that S. needed to repeat and act out his feelings of helplessness and fear when his father had his heart attack. Even though the rescue vehicles came, Dad was still not saved, yet there is the magical thinking that he will really come back later. As recommended by James (1989), the therapeutic intervention with this was an allowing of the drama to play itself out, with little interference, just to witness and hear the story.

Later in the therapy, through myself taking the role of one of the characters, an expression was made of the fear and helplessness I felt as the character. S. was clearly in the director's role giving him a sense of power and control. As the therapy progressed he created more serious and dramatic disasters, with a gradual development of resources that could come and "fix" the situation. At first he was unable to think of any way the problem could be solved, but was able at the end of our sessions to create a beginning, middle and end to the story.

When asked which character he would be, he chose to be a main character, but quickly change positions if it suited him. He had flexibility and confidence in facing the challenges of being in the limelight and would switch roles easily if he felt it was beyond his capacity to manage in that role.

Another major theme for S. involved issues of justice and stealing. Often "the boy" stole something and had to be caught and punished by the police. The punishments were quite extreme, such as five years in jail. Through the use of puppets and stuffed animals, we had one session where we "taught" the puppet the difference between stealing, borrowing, and pretending and why he had to have consequences for taking things that did not belong to him. We also talked about the impact on the person who had his belongings stolen. The hypothesis here covers two areas. One is that his father was "stolen" from him and never returned, with very little meaning or sense made of this. The other is the developmental issue of understanding the difference between borrowing, stealing, lying, and pretending. Children's cognitive abilities are forming at this age in understanding these abstract concepts (Shapiro, 1994). This also brings in the developmental perspective when working with children and how they make sense of their world in accordance with this development. The themes were intertwined between the developmental stage and the tasks of grieving.

Both hypotheses were worked on in the play sessions. Several opportunities arose to work through both these ideas. After a play activity in which the dead came back to life, I always made a clear distinction that in play this can happen but in real life that is not the case. He would nod in sad agreement and knew the difference. Reality versus fantasy was a constant theme given his age and the profound nature of his loss. He was working through the first task of understanding and moving towards accepting the reality of his father's death. He liked to read stories, he played the Grief Game (although to a limited degree), and he loved the play house and the sand box. He also liked to dress up, usually as a policeman or doctor and played quite creatively in these roles. S. was able to freely express his emotions through the play which we created together. This allowed him to have a safe place to practice and make sense of these experiences, factors important in grief work with children (James, 1989; Krall, 1989).

On the justice theme, we spent time in the session (the "teaching" of the puppet for example) playing out catching the person who stole and consequencing him. He did not really comprehend the motive behind the stealing, just that the police would get you and you would be punished. He was needing to play and replay this theme in his attempt to grasp and integrate the concept of right and wrong. This also applies to developmental issues of fairness and justice which he was grappling with in terms of his age.

In the more directed moments such as the picture session with his mother, we discussed openly and honestly the circumstances of his father's death. There was not an emphasis on the more graphic details but the subject was opened and freedom was given to talk about Dad, to remember Dad, to laugh, and to cry about the memories. The commemorative stone was a building step toward commemoration of his dad and symbolically to remember our therapy time together. This goodbye was ritualized with his mother in order to include her in this memory. This is a direct link to the literature whereby a child needs to have the opportunity in an open manner to express and talk about his or her grief (Fitzgerald, 1992; Grollman, 1990; Jewett, 1982).

The Case of T.

Development of the intervention hypothesis with T. followed two lines of thought. First there was the underlying tension and insecurity in the caregiving role of parent S. She was very verbal and open in her ambivalence and frustration in caring for the twins. This raises a questions of how secure both T. and his sister were in the safety and stability of their home. Coupled with this was the question of whether they had unconditional love and support from their grandmother. Secondly, in the death of his mother, how much he had been able to understand what happened and how safe he was in expressing his feelings or asking questions was questionable.

Themes arose in his play which could be related to both these aspects of his life. He usually chose the sand box as his medium of play. A common

story was the "bad guys against the good guys" with T. being the "good guys" and me being the" bad guys". This is also a developmental issue of good versus bad (Shapiro, 1994). Initially he was not sure why we were on opposite sides and looked at me with a blank face when asked why we were fighting. This could well be a reflection of his confusion at home where there was constant battling for no apparent reason. Parent S. did demand complete and unquestioning obedience whether it made sense or not. An example of this authoritarian attitude staged itself at the center, when parent S. and I were talking before I saw the children. T. came in with a toy he was playing with that was noisy. S. took it away without explanation, options, or a warning to keep the noise down. T. did not argue, pout or complain as if this was something that happened routinely. He clearly had learned to accept this and it was not allowable to argue. There was frequent complaining at home, by parent S., concerning the stress of parenting which, to children, may not make sense at all as they are just doing what children do. Similarly, the death of their mother was a random act that made no sense at all. She went away for a holiday and never returned. The therapeutic question became how to assist this child in making sense of events and building a sense of security for him in the home.

I began to ask what we were fighting about with this lack of motive in mind. He thought about this and created a story with a treasure that the bad guys wanted, and the good guys wanted to protect. Through this dramatic enactment, orchestrated by T., with me following orders, certain consistent themes evolved. A major theme was that of right versus wrong. As this is a developmental issue as well there was confusion that was reflected in the play. At home he was restricted and criticized for making a mess, making noise, arguing, not sitting still, and withdrawing. His play reflected this struggle with what was acceptable behaviour and what was not allowed. In the play there was confusion over who the good guys were and who the bad guys were. The bad guys were in fact trying to get the treasure, protect

themselves while getting it, and being ready to attack when this was required. There was in fact little difference between the good guys and the bad guys. As I was the leader of the bad guys I did not have a clear understanding of what my side was doing that was wrong. He was also very concerned in watching me act out the bad guy responsibilities while he watched. For example he would often say "play your guys" or remind me to remind my guys to do their job. At home, parent S. had reported that he often withdrew when he was troubled or uncertain. Withdrawing appeared to be a coping strategy to make sense of the conflicted messages he was receiving about his behaviour. This leads to the notion that T. was not unconditionally accepted for who he was and he had to be watchful in case he made a mistake. The underlying worry about how secure his placement was with his grandmother exacerbated his confusion and uncertainty about being good enough so that he could stay in his home.

In the beginning phases of the therapy the bad guys were robots who did not have feelings. They did not feel it when they were buried or had bombs dropped on them. They did not care that they were the bad guys and were doing something wrong. As the therapy progressed and he determined that the bad guys were after a treasure that belonged to the good guys, they did develop feelings instead of being robots. In the play I would express many differing emotions that the bad guys could be feeling, such as being scared or worried or frustrated. As I expressed the feelings that the robots could be having he began to allow them to have feelings in the play. Simultaneously, at home, parent S. reported that he was not as withdrawn, would talk more and was more cooperative with her requests.

Another theme that arose with T. was his reluctance to do anything he did not feel would be acceptable. This again relates to the overall theme of experiencing unconditional acceptance by his grandmother. When asked who he was in the play, T. usually picked a minor player who was not in the limelight or in a position to make decisions. This supported the hypothesis

of ambivalence that he was fearful to show his true self or take a risk of being in the wrong. He would choose my character to be the leader and his would be one of the soldiers who would just follow orders. He was not equipped psychologically or emotionally to be in charge and needed to be well protected and defended during the "war". In another instance we were using puppets and the puppet was very cranky and difficult to please. Although he would not take on that role, he directed me in the play by adding more and more things that would aggravate the puppet. He was clearly enjoying hearing the puppet express many of the feelings he did not feel able to express himself. This was an opportunity for myself, as a listener to the puppet, to really hear the puppet's frustration, anger and disappointment. In this indirect way it was less threatening for T. to hear these things as his need for protection overcame his ability to risk rejection or censure if he said what he was truly feeling. As it is believed it was really not safe for him to express these thoughts or feelings at home, it was left as a possibility for future times. He needed to use these defenses for psychological protection, as parent S. was very immersed in her own needs and was unable, at this time, to acknowledge or understand T.'s needs. She did meet basic requirements such as food and clothing, but she had little empathy or understanding of the children's right to be heard, especially if she did not approve of, or like what they were saying. This was in contrast to their right to be who they were without judgment or criticism (a precept of unconditional love) (Nelson, 1987).

A portion of the middle and ending sessions were therapist directed. We read stories about grief and loss, did directed artwork, and played the Grief Game. It was clear he had difficulty in sitting still to do these activities. He would stand and rock while I read and when we played the game. When he did some basic drawings he also stood very impatiently while he did these, as he really wanted to play. He had little actual recall of his mother and was complying to please me. He knew she had died and was not coming

back. He made a comment, after reading one of the stories that he wished 'there was no such thing as death". He was able to begin to express at this point, his anger and sadness at the loss of her mother.

His play reflected the good guys being well defended in a corner of the sandbox, with their back to the wall. It appeared that he, also, was making sure he was well protected psychologically from the pain of his mother's death and the possible anger and rejection of his grandmother. These defenses were used to protect against the intense emotional pain of his loss and his fear of rejection by his grandmother. He had already been abandoned in the most dramatic sense, by his mother. His primary concern at this time was playing it safe. Although he seldom made direct comments about his mother, through the reading of stories and the Grief Game, topics such as blaming oneself for the death was raised. His age is still vulnerable to cause effect thinking (Shapiro, 1994). He did not have any ambivalence about this and knew it was not his fault that she had died. He looked quite surprised when asked the question, as it had never occurred to him that it could be his fault.

T. was usually concerned about cleaning up and not making a mess. This was consistent for both he and his sister and I believe, a reflection of meeting their grandmother's needs for tidiness, pleasing her, and respecting her wishes. Both children were well trained in this area, and it need not be seen critically, except for the fact that their staying with parent S. seemed conditional on their behaviour. This can of course lead to insecurity and doubt for children if they fear they will not be acceptable in and of themselves, that is unconditional love (Nelson, 1987).

In the last session, which we held jointly with his grandmother and his sister, he was very quiet. I filled out the post-test measures with him and he was more open about some of the questions, but not nearly as much as his sister. He seemed quite satisfied with the explanation of his mother's death and was more concerned with finishing the questions so we could go out as

planned. He appreciated the crystal which was given to him to commemorate our time together. Given he is just beginning to understand his mother's death and his somewhat tenuous security at home, he was not able to progress past the beginning understanding of the first task. Some of the emotional issues were raised and played out in therapy, but they were mostly at an unconscious level at this time, as the home situation is not able to fully support and allow him to openly express his feelings. The literature supports the need for the child to be supported at home in order to be allowed the freedom to express his or her grief (Baker et al., 1992; Bowen, 1978; Furman, 1974; Shapiro, 1994).

The Case of L.

L.'s play was quite different from the two male children seen. She initially used imaginative play, but quickly gravitated to making things with glue and sparkles. She was eager to please and did not like to make decisions about what to do. She would defer to me to see if I liked what she had chosen or asked if I would choose for her. This quickly generated a hypothesis that this child was afraid of making mistakes and was very eager to please adults. This raised a question as to how secure she was in her grandmother's love and unconditional acceptance. The need to please grandma was a consistent theme in her play. When she made things, it was always to give to her grandmother. She would draw pictures for her brother as an afterthought.

A second hypothesis that emerged was the desire to be in control which conflicted with the first hypothesis for the need to comply with adults in order to please. Although she would defer to me to choose the toys, or the game, or the activity, it was clear she had definite thoughts about what she would accept. Usually the choice was given to her to decide what we should do, except in the instances where I wanted to play the Grief Game, or read stories on grieving and loss, or do some artwork. She clearly enjoyed directing the play, but would often check with me to see if I was approving

or not. She was given freedom to chose and direct in whatever way she wanted, given we adhered to safety rules in the play room. The intervention here focused on setting up choices for her to make and supporting her in making a choice without judgment or criticism. This eventually led to discussions of conflicts with other children and who decided on the play and how to take turns. We practiced these skills with puppets and she became more confident in asserting herself without threatening the other person's rights. This was at a beginning phase and would need continued practice.

A third hypothesis, in relation to L., was that she was unable to fully or freely express her feelings about most things, including her mother's death. It was hypothesized that she was dealing with feeling safe and secure in her home with her grandmother, and was unable to progress very far in the expression of feelings concerning the loss until this basic need was met. Her play consistently supported this hypothesis. For example she was always looking for approval in the things she chose to do. When she chose to play house, she was concerned the child and the house were neat and tidy. She liked to grocery shop and was very conscious of money and how much things cost. It was clear she was repeating statements she had heard before. She was very watchful in assessing my reaction to her choices in case I did not approve. The intervention strategy here focused on giving her permission to safely express herself through our roles in the play. My character would express feelings of frustration, or anxiety, or fear, or worry which I felt she may be experiencing but did not as yet have either the language or the confidence in expressing.

When asked which character she would choose to be in an imaginative play situation she chose to be the mother figure. She liked to direct the play, or choose the activity, as long as I approved. This could be symbolic of the home situation where she wants and needs her grandmother's approval. This could be conflicting with her own desire to be in charge of her life. She is a bright child who is reading fluently and has very strong academic skills. She

has a great deal of natural intelligence so is able to verbalize and question things that do not make sense to her. Given the home situation where she is expected to be very obedient and acquiescent, she is placed in the conflict of subjugating her own will to meet her grandmother's approval and to receive love. As this happens in many families, it is not all that unusual, except there appears to be an underlying lack of commitment by her grandmother to her, resulting in conditional acceptance and love for her.

It was hypothesized that she felt it was unacceptable to overtly show anger, hostility, or aggression. She was always very sweet and cooperative, being on her best and most compliant behaviour in our sessions. Given parent S. was reporting a great deal of frustration with her non-compliance, arguing and rudeness at home, there was an apparent conflict. I would conclude from this that her ability to repress her aggressiveness was more than she was able to do in a consistent way at home. Parent S. also had very high expectations and some of her concerns may have been exaggerated as a result of her own stresses.

In our sessions some of this anger and hostility was just beginning to be expressed later in the therapy when we played with puppets. For example she drew a large black gun and was using it to shoot people if they were in any way bad. In this scenario I, as the puppet, took the role of being afraid of the gun. She "showed no mercy" as she was quite determined to shoot me for any transgressions. She would shoot anyone who did anything bad. The more I expressed my fears and anger, the more determined she became to shoot me (the puppet). This was the first time she displayed anger or aggression openly. This could be a reflection of the rigid discipline she received at home as well as an expression of her own anger and frustration.

Parent S. shared that over the course of therapy, L. became more difficult to manage. She was more defiant, attention seeking and uncooperative. As she was allowed to own and express her feelings in therapy, the more she began to express negative emotions at home. There

was clearly a conflict over her need to please and her need to express her angry, confused feelings. Parent S. showed some understanding and compassion in realizing this, although it created more of an emotional burden for her at home with L.

Although parent S. and I discussed normal childhood development, such as the need to allow children to express their feelings, the need for them to feel secure and wanted, and the issue of attachment given their mother's death, she seemed to understand this very superficially. Her own needs for validation, her frustration at being the caregiver to all these grandchildren and her perceived lack of support from her own children made it difficult for her to really accept and nurture them. Her commitment appeared very conditional to me and therefore must have been even more so with the children who responded on an intuitive, feeling level to her ambivalence. These hypotheses were supported in the play of both these children, and especially with L., who was very cautious not to offend me as the adult and was constantly looking to her grandmother for approval.

The intervention with L. was directed toward supporting her in making decisions and allowing for verbal expression of her feelings. As with her brother, she was unable to express angry or conflicted feelings herself, but through the puppets and as imaginary play opportunities presented themselves, she was able act these out these emotions anonymously and safely in the play. When the issue of the death of her mother was raised directly she had a pat answer of "I remember her in my heart" without any real understanding of what that meant. She had no memory of her mother and had sensed intuitively it was not a safe topic to raise with her grandmother. Parent S. discussed this herself and knew she had difficulty talking about her daughter with the children. She would get upset and shut down the conversation. When we had our last session, L. had a number of questions about her mother as we were filling out the post-test measures. She had been very open and curious for the first time and I answered all the

questions as honestly as I could.

Parent S. was doing some reading on children's grief, on her own, and had some regrets about not allowing the children to attend the funeral. She had blocked all suggestions I had made to have our own ritual for the twins. She was finding it difficult emotionally to reflect on her daughter's death, especially as she had so many child care commitments with her grandchildren that demanded all of her time and energy. The intervention here was to validate and sooth parent S. as she had done the best she could in the circumstances at the time.

As with her brother, L. was not able to fully understand and question her mother's death, as parent S. was not yet able to completely support her in this. Developmentally she was only able to integrate limited amounts of information. Children go in and out of the emotional intensity of the grief and as L. was so young when her mother died, the grieving process has been affected by her immaturity as well as her somewhat uncertain family status (Doka, 1995; Grollman, 1990; James, 1989; Jewett, 1982; Krall, 1989). I believe she has had limited permission to move in and out of the grieving and has been encouraged to stay "out". As stated previously, the family is in crisis in a transitional stage where the grandmother is again parenting young children after she had launched her own children. The death initially created this crisis and it has been exacerbated by having to care for her third grandchild who is still a toddler and very demanding. An added complication is that there is not enough space in the house for this extra child and she sleeps with parent S. in her room. This compounds the stressors on this woman who now does not even have her own personal space in her home as she needs to share this with a toddler. Given these extenuating family circumstances it is not surprising that L. is unable at this time to be supported in expressing her grief as well as other normal, everyday, childhood emotions. The second two tasks of grieving have had seeds planted as well. In the therapy, interventions were directed toward allowing

and acknowledging feelings, whatever they were. L. is progressing developmentally in many areas as she is doing very well in school. Parent S. states she is having trouble with friends because she is so bossy, but this is also normal developmentally. Children practice these issues of leading and following with their play mates as they struggle with balance in relationships (Shapiro, 1994). The commemoration process also planted seeds for the future as L. will have some experience for remembering and memorializing her mother.

Emerging Themes

Four Tasks of Grieving

None of the children had fully understood what had happened to their deceased parent. They knew they were gone and had not come back for a really long time. The twins verbalized that their mother would always be remembered in their hearts but it was clearly a statement they had been taught. Their lives had also been somewhat unstable prior to their mother's death and the degree of attachment and security in that relationship is questionable. According to parent S., their mother had a drug problem and may have been using drugs and alcohol while she was pregnant. She also had had a number of different partners who had come and gone. Parent S. had been concerned about the physical and emotional care of the twins prior to their mother's death. Their father had been very uninvolved although he had been paying child support prior to their mother's death. A primary concern for these children was the stability and safety of their home and a reliable caregiver. As Shapiro (1994) discusses, children will sacrifice their own integrity or needs if they feel their parent cannot cope with their feelings or behaviour. This was happening consistently with L. as will be outlined in more detail later in this report. She made frequent references to parent S's needs and wants, and was very eager to please and appease her. It is of interest that it was L.'s behaviour that parent S. was most displeased with over the course of the therapy. As she began to feel safer in expressing her

feelings, her behaviour became less compliant and pleasing to parent S. At one level parent S. did understand this. She knew that the therapy would bring to the surface emotional issues that had been buried. She was having difficulty, though, accepting the resulting behaviour as it directly impacted on her. This was consistent with T. at times, although not to the same degree in frequency or intensity. Therefore their ability or readiness to fully understand their mother's death may have been of lower priority at this time.

For parent J. and S. there was a great deal more security in the family relationship, especially in S.'s bond with his mother. As stated he had been sleeping with his Dad when Dad had his fatal heart attack. He was removed to another room after the ambulance and police were called. Mother has little memory of what the children were doing other than a friend was looking after them while she went to the hospital. Given the confusion and drama surrounding the death and the subsequent impact on the family, it is difficult to assess how much S. understood or how much trauma he may have experienced. He is too young to express this verbally, and parent J. was quite unaware of either of her children at the time. She was very focused only on her husband's distress.

As the other tasks are predicated on resolution of this first task, seeds were planted psychologically, with all these children which would give them some experience and support in the work yet to be done. As they mature this will have more meaning and significance for them provided the family situation is stable and secure (Bowen, 1978). We did talk about the emotional impact during the readings of the stories, playing of the Grief Game and in our ending sessions with the commemorative stones as a way of planting these ideas for future development when the children are ready.

Role of the family

The role of the family is always significant for children, and this is especially the case for these three youngsters. As stated, with parent S. there were many complicating family dynamics that have impacted on her ability to

support and parent these two children. One of the greatest concerns has been S.'s ambivalence about having the children in her care in the first place. A great deal of the work with her focused on the children's needs for security and attachment to a reliable person, such as herself, who would provide consistent and dependable care. They have already experienced the ultimate abandonment in the loss of their mother. L. especially was feeling the lack of security in her relationship with her grandmother. She continually referred to grandmother as being the most important person and to whom she would always defer and make sure her needs were met first. For example, when asked in the Grief Game what an important memory was of the loved one, meaning her mother, she would recall a memory with grandma. The tone was one of, if I mention my mother, I will be disloyal to grandma and possibly threaten her commitment to me. This was a consistent theme with L. in reference to several situations, whether it was imaginative play, direct questions, or drawing a picture. It was always to please parent S. At the same time this was happening, grandma frequently commented on how difficult L. was at home, how she would not listen and how attention seeking she was. In order for children to fully grieve and have free expression of their emotions, they need to be supported and allowed to express these feelings in the family (Bowen, 1978; Furman, 1974; Shapiro, 1994). Discussion or open expression of the loss was not allowed as it would upset their grandmother, thus repressing an open expression of emotion. These feelings therefore were coming out in indirect ways, through different forms of rebellion and non-compliant behaviour. A covert message had been received by both children that their mom's death was a closed subject and not to be discussed.

T. did not seem as concerned or preoccupied with pleasing his grandmother, although he too was quite watchful of her reactions. This was observed in the waiting room and during my counseling sessions with parent S. The primary concern for parent S. was coping with the rigorous demands

of two young children and dealing with the temporary care of her other granddaughter. This was so all encompassing that the grief work concerning her daughter and supporting the children in their grief, was of secondary concern. As stated, in family life cycle terms she was dealing with a major life transition from having launched her own children to having again become a parent with young children (Bowen, 1978; Walsh, 1982). She had not fully accepted nor resigned herself to this situation. She often spoke of wanting "her life back" and having needs of her own. She was hoping to go to Trinidad with her partner and settle there. This plan did not include the twins. She was also torn between her own loyalty and commitment to the children for whom she was the only reliable source they had for parenting, and leading her own life, independent of the children's needs. In dealing with this crisis, the emotional investment was uppermost in her current life situation and having to revisit the death experience of her daughter was more than she was able to deal with at this time. The work with parent S. focused on supporting her emotionally, negotiating with Child and Family Services for respite time and liasioning with the school to ensure the educational needs of the children were being met. Although our purpose for meeting was to assist in grief resolution, from a broader social work perspective, these major issues had to be addressed first before the family could adequately do the grief work.

With S. and his mother, the situation was quite different. There was no ambivalence about parent J.'s commitment as a parent and she was very loving and accepting of S. She was revisiting her own grief at her husband's loss given the lawsuit against the hospital and S.'s therapy, but she seemed able to deal with this quite adequately without burdening S. with her adult worries. There were still some conflicts with her older son, but given that he was entering adolescence this is a fairly normal developmental phase. She did not express difficulty with these conflicts, but the school had called to have the older son seen again for therapy during the time I was working with

S. The concerns were not obviously related to grief but were more adolescent issues such as making and keeping friends.

Role of the School

The school has been very supportive to all these children in understanding their situation and providing a sympathetic and nurturing atmosphere for all three. S.'s kindergarten teacher was very supportive in redirecting his play or allowing it to be expressed as seemed appropriate at the moment. When he was making caskets and burying toys in it, she took this in her stride and allowed S. to finish his play. She did not draw undue or exaggerated attention to his behaviour. In consultation with her, we discussed normalizing this play and not over reacting to it. This behaviour has now played itself out and S. has moved on to other types of activities. With the twins, they have a school social worker, who is involved with both the grandmother and the children at school. School personnel are very understanding of the children's situation. As there are concerns about T.'s academic skills, he has been seen by the school psychologist for assessment of ADHD, which was found to be very minimal. T. is open to the resource teacher for extra assistance with reading and writing skills. The school has attempted to provide a warm and nurturing environment to support the children there. Both these children have and need continued supports by the school system. There are current academic concerns, specifically for T., which will need to be addressed over time. Parent S. has expressed a number of concerns about both children's education, thus needing the ongoing services that the school social worker and psychologist can provide. These supports are currently in place and will remain after this intervention is complete.

Summary of Themes in the Play

As stated in the discussion on play in therapy, a few common themes arose in the children's play. For the boys there were themes of bad versus good and disasters or fighting. This is consistent with normal development and as well as an expression of their life experience. For L. the primary

theme was how to please adults and control what was happening without apparently choosing it or choosing it only with approval. The boys play reflected the tone of dramatic and urgent changes that had happened to them. They were struggling with how to remedy these fears through secret weapons, bringing in the police and firemen or any authority who could "fix" things. Based on this hypothesis the intervention focused on first hearing the story of the emergency and allowing that story to unfold, then a movement to bringing in resources that could help resolve the difficulty. If the resources were brought in before the story was heard, it was met with resistance such as "that won't work" or "I don't know" or a blank look that said "what are you talking about". They needed time to think and play the story through with suggestions that the story have a purpose. Issues such as why it was happening and what could we do about any problems came at a later time in the therapy. We needed first to develop rapport and tell the story however it made sense to the child.

Other themes that arose related to issues of justice and fairness, which can be connected to the good/bad theme. Tied to this as well is the issue of making mistakes and the fear attached to this. For the twins a primary theme was that of security and unconditional acceptance in their home. This is connected to the good/bad theme as well. How good or bad can you be before your in trouble or possibly moved elsewhere? I believe this was an underlying fear for both these children as there was a constant message at home of how stressful and difficult it was to parent them.

The freedom to ask questions and express emotions was an issue for all three children, but much more intense with the twins. Making sense of what happened in their lives and developing a sense of safety, security and predictability in their current life is consistent for all three children. They all had a profound loss which was random and unplanned. How can they develop a feeling of trust and safety in their life now that the worst has happened? This is compounded for the twins as their caregiver expressed

much ambivalence and angst about her caregiving responsibilities.

This leads to the next point which is the role of the family as an overall theme for all three children. They need their family's support and acceptance in openly expressing their grief and loss. Their understanding of the death will change as they grow and mature and are able to revisit the loss at different stages of development. Open communication is of greater concern with parent S. and the twins, as she is under a great deal of stress and experiencing serious ambivalence about having the children in her care. Without the family support, these children are kept from fully resolving and working through the emotional issues of their mother's death. This ambivalence could also suggest that parent S. may find it too difficult to look after the children and she could find an alternate placement for them. This fear is also reflected in the children's behaviour as previously stated.

For S., his mother is clearly nurturing and supportive of him. She is quite open in talking about the father's death and allows an atmosphere of open communication with her son.

The themes range from specific developmental issues, to security issues, to expression of feeling, to added supports and services in the children's lives. The role of the parent and the environment of safety and acceptance is a major theme. The therapy enabled me to understand the child better and thus work more effectively with the parent in accepting and understanding their child's behaviour. The combination of these factors is, I believe, critical in assisting the families to move forward.

Evaluation

On the CBCL/4-18 (see Table 2) there were varying results for all three children. In the overall Total T score, S. decreased in his total score, of which both totals were in the normal range of behaviour. In both the Externalizing T and Internalizing T he showed decreases in his problem behaviour as well. This is consistent with his mother's reporting of his behaviour, with similar feedback from his school. S. was already within the

Table 2

Individual Child Behaviour Checklist Pre- and Post-Test Scores (T Scores) and RMCAS Pre- and Post- Test Scores

	S.	T.	L.
CBCL Total T			
PRE-	48	76	62
POST-	39	76	67
INT T			
PRE-	50	68	47
POST-	40	68	54
EXT T			
PRE-	46	72	70
POST-	43	72	74
RMCAS			
PRE-		7(>1)-	17(<1)+
POST-		1(>2)-	16(<1)-
LIE SCALE			
PRE-		5(<1)+	6(<1)+
POST-		0(>2)-	1(>2)-

Note. These are raw scores for the RMCAS showing how many Standard Deviations the score is from the mean for the normative group. The + or - indicates whether the score is above or below the mean. There are no RMCAS scores for S. as he was too young to complete this measure.

normal range prior to therapy beginning and showed a reduction in problem behaviours over the period of his therapy. S. did not present as a disturbed child and has many healthy and engaging qualities. These results are a reflection, I believe, of intervention on a specific problem area that shows positive results as so many other things in this child life are positive as well. The RMCAS measure was not used with S. as he was too young.

With the twins the scoring showed a very different picture. There was no change on the Total T score for T. from pre-test to post-test. This total is just above the 98 percentile, moving into the clinically at risk area. Both the Internalizing T and the Externalizing T were the same at pre- and post-test. The Internalizing T was just below the clinically at risk range at 68. Here the area most at risk, was the withdrawn category. Verbally, parent S. indicated the withdrawn behaviour had improved at home, although she did not reflect this on the form. In the Externalizing T his score was just above the at risk range at 72. In this area the section most at risk was the delinquent behaviours such as feeling no guilt, having bad companions, lying, and cheating. Based on the lack of reports from school or specific complaints from home, I would assume these concerns may have been exaggerated by parent S. and are more a function of her fear of these things happening than their actual occurrence.

The family situation became even more stressful over the course of the therapy with parent S. feeling more overwhelmed due to the added responsibilities of caring for her young granddaughter. This could explain her perception that T.'s behaviour had not improved. She did state verbally he was less withdrawn, more talkative, and was less difficult to manage.

In L.'s case all her scores showed an increase in problem behaviours. The Total T score was within the normal range at both pre- and post-test. The internalizing score increased from 47 to 54 but both these scores are within the normal ranges. The externalizing score increased from the 98 percentile into the clinically at risk area. This was consistent with parent S.'s

reports as she felt L. was more challenging of her authority and argumentative. The areas she especially highlighted on the form were argues and fighting.

Again the family as a unit was undergoing a great deal of stress and parent S. was finding the entire situation very difficult to handle. She would state at every session how the children, L. especially, were getting worse. She would then discuss all the other stresses causing difficulty in her life. She was usually able to put the children's behaviour into perspective by the end of the meeting, but it was the same dilemmas again each week. As the CBCL is a measure taken from the parent's perspective, it was clearly indicative of how parent S. was perceiving their behaviour. These results need to be viewed within the context of the overall stress of the family.

On the RMCAS scale T.'s total scores were quite low with a pre-test score of seven and post-test score of one. This is below the average range and went to a very low score in the post-test measure. The lie scale went from five to zero. This post test score was well below the norm for anxiety for children his age and even the pre-test score was below average for children his age. The mean score for this age group is 16.13. This does seem consistent with his behaviour as he withdraws as a way of coping and escapes into imaginary play. He showed a considerable decrease in anxiety from pre-test to post-test and was more honest in his replies in the post-test.

On the RMCAS scale there was very little difference in L.'s total scores with a one point decrease. On the lie scale though she dropped from six points to one. This would indicate she was freer to tell the truth the second time. The lie scale measures such things as social desirability for children her age, which was a therapeutic issue for her. These changes could have been a function of her feeling more confident to as a result of the therapy and, more likely, her increased trust in me. She was more confident in our relationship and it was safe for her to be honest. This could be seen as an indicator of therapeutic growth as she was answering the questions in terms

of her own feelings and not an attempt to please others. Regardless of the change in scores, both her pre- and post-test scores fell into the normal range for children her age.

On the client satisfaction form that the children filled out after the therapy they all indicated that they felt it had been a good experience. They recognized that they were there to talk about their feelings and they felt good about the process. They all stated that they felt nervous before coming and felt much better now at the end of the sessions. They liked playing the best and talking the least.

Summary of the Intervention

Assessment and intervention included evaluating the family and child, or children, in terms of the family's place in the family life cycle and the developmental phase the child was experiencing. The developmental stage of the child at the time of the death was also a factor. The children were assessed in relation to how well they had mastered the four tasks of grieving and how they were supported in these tasks within the family structure. The therapy process was approached from a developmental perspective with an overall goal of supporting the parent as well as the child in the process.

In the direct therapy with the child the style of play was assessed. All the children came to therapy happily, with an attitude of excitement and pleasure. They played freely and were uninhibited. They joined easily and readily with myself as therapist and had no difficulty leaving their parent for our individual time together. The play was child directed, largely imaginative for the boys and more craft focused with L. Later in the therapy the children cooperated willingly when I introduced structured activities related directly to the theme of loss.

The role of the caregiver and the child's behaviour with their caregiver, was a major factor of both assessment and intervention. As the two families were in very different stages, the intervention was quite different. With parent S. and the twins, my role was a support role to parent S. with

referral to other agencies for concrete practical supports. Child and Family Services was contacted for respite time for parent S. The support role included an understanding person to whom parent S. could discuss her frustrations, worries, and fears. Ideas were given for parenting strategies to encourage the children to obey and be more cooperative. Mostly she felt the children needed to change and she was not open to trying different parenting methods herself. She was very frustrated with the school system and links were made with the school social worker within that system. In terms of her own family she was both hurt and angry at the behaviour and attitude of both of her daughters. The care of her two and a half year old granddaughter was of major concern and a forceful impact on the family as she had this child in her care. It greatly complicated the stress within the family and lessened parent S.'s already limited reserves for handling everyday parenting concerns with the twins.

With the children themselves the major focus of the intervention was to create a safe place for them to freely and openly express themselves, without undo censure or criticism. It was clear they felt insecure in many ways in their relationship with their grandmother and there was an underlying fear of abandonment by her as well. This was demonstrated in the themes and hypotheses that were developed in their play as well as the deference with which they treated her in the waiting room. There was ongoing uncertainty about issues of right and wrong, bad and good and how to resolve these without threatening the security in the family. These are normal developmental issues of childhood and have been exacerbated by their family situation. The issue of unconditional love and acceptance was present for both children and was an ongoing point of intervention in the therapy. The challenge became validating their feelings and fears without undermining parent S.'s authority and position. I believe we went as far as we could go in discussion of the mother's death, but there are many ongoing concerns around parenting the twins that remain unresolved and will need

continuing intervention. Parent S. continues to have support through her school social worker and Child and Family Services. Facilitating this support was of major importance in the intervention.

With parent J. and S. parenting suggestions were well received and acted upon by parent J. Her relationship with S. was unconditional and accepting. Her judgment was sometimes of concern as she was quite unsophisticated in understanding children's sensitivities and feelings. For example, when we were looking at the family pictures in the last session, there was a picture of her older son with no bottoms on. He was about ten years old and would have been very embarrassed if he knew other people were looking at this. Parent J. laughed and did not attempt to remove the picture or show any understanding that it was inappropriate to have this picture out for public display.

In her direct relationship with S. parent J. was warm, understanding, caring, and protective. S. was very confident in his mother's love and acceptance. He pushed the limits at times by being pouty or hitting his mother when he did not like something she said. Parent J. was strongly encouraged to set clear, definite limits around this behaviour. She needed assistance in feeling confident in setting limits and that it would not jeopardize S.'s love for her but would in fact strengthen their relationship. My role as support and guide to parent J. was focused more on the parenting issues of setting clear and fair limits. She also needed to discuss the lawsuit she was bringing against the hospital and was clearly set on this plan. I believe she felt this would alleviate her own guilt at her husband's sudden death.

In the direct work with S. he related easily to myself as both a friend and a person in a position of authority. He listened very cooperatively to requests and followed suggestions easily. He was warm and affectionate and treated the toys and the characters in the play with warmth and respect as well. He was experiencing normal developmental issues of right and wrong,

good versus bad and independence and autonomy issues. He was not yet able to play formal games with rules and easily developed his own rules to make it play. He will have to revisit his father's death as he develops and I believe this referral arose out of an instance where he was trying to replay the death experience so he could further understand it. As stated in the literature review children cannot fully mourn until they are able to understand the permanence of the death in the future. S. is still grappling with this concept as are the twins. The relationship with his mother will likely involve challenges to her authority. She may need ongoing support in setting appropriate boundaries and rethinking some judgment decisions concerning her attitude and expectations of what is normal and appropriate for children. This may especially become an issue when her children reach adolescence (as her older son currently is). I believe the therapy went as far as it could for S. at this stage of his development and as stated may need to be revisited as he matures.

Overall Conclusions

The overall themes that arose out of this experience supported the outcomes of the literature review in that children need a supportive, open family system in order to fully express their grief. Issues related to normal developmental concerns as well as issues related to the death were intermingled in the play themes. They progressed through the tasks of grief at their own pace and developmental level, depending on the home support.

Although the focus of the intervention was the direct work with the child, supports to the parent/caregiver were critical in order for the work with the child to be effective and long lasting. Other factors such as cultural issues, the family's socio-economic background, religious views, and community supports were all taken into consideration during the course of the intervention. Although individual intervention is helpful for the child, this needs to be done within the social context of their family and support network.

CHAPTER SIX

Summary and Conclusions

In summary I was fortunate to have a varied experience, by working with both a group, with individual children and with their parents/caregivers. The group experience was a variation on a tried theme, with a co-therapist, which gave me an opportunity to work with a partner. The supervision for this also added variety to the experience as the supervisors were different for the two interventions. I was thus able to have two different perspectives on both interventions and on the subject of grieving and loss. In working with individual children I was able to intervene in a much more personalized way with the children I saw, giving each child my full and undivided attention. There was also an opportunity to work more intensely with each of these parents on their specific issues.

In reviewing the literature on grieving and loss, specifically with children, a wide opportunity availed itself to explore this subject in greater depth than I had been able to in the past. Although my specific aim was to explore this with children in mind, with an emphasis on developmental issues and family supports, it opened the whole subject of death and how our society views death and the dying. I was able to explore, through my reading, the impact on the family who has lost a member as well as looking at the dying themselves. There is a growing body of literature on this subject, covering all aspects from the practical to the spiritual. This has created a philosophical exploration in addition to assessing my intervention techniques with families and children. Having my own father die during the course of this study also brought the whole subject home in a very real and personal way. In exploring the area of death it necessitates an exploration on living and on relationships.

In comparing the group intervention and working individually with children, there were similarities and differences. In the group, many issues could be discussed in a teaching format, for the purpose of discussion, for all

the children to hear. Even if the child did not openly say anything, they were still listening and processing what other children were saying and feeling. This exposed them to a number of reactions and realities. As the group leader, I could utilize one child's situation as a general metaphor for the whole group. With individual children there was not the same opportunity to provide this type of metaphor with other children, although it was done through puppets and the play situations. The focus and intervention was different. There is a certain energy and commonality that is present in a group, that is not present when children are seen individually. On the other side, I did not have the time to really hear each child in the group as much as I would have liked or they would have liked. This came through in the client satisfaction form as well. Some of the children would have liked more time to tell their story and to be really heard by me.

Individual work allowed for total attention to be paid to the child, with no competition from other children. I could focus, not only my attention, but the play was completely personalized to that individual child. The relationship and level of trust was more intense because of this and I had much more time to think through the meaning of the play I was presented. In the group there are often so many things going on at one time that it is very difficult to notice every comment, gesture, or interaction that happened between the children. Both intervention styles have their merits and I am very grateful to have had the experience of doing both. Whether one intervention or the other had more success in resolving the loss would be impossible to comment on as their circumstances were very different.

When reviewing my learning goals I feel I have met my goals and more. In exploring this issue my understanding of developmental issues has been widely enhanced. As well, I have had the opportunity to observe normal family processes and to consider the areas to note in assessing how well families are functioning. This included looking in more depth at open communication patterns, family life cycle phases and supports the family has

in the community. My knowledge in understanding the grieving process, the distinctions in definition around mourning, grieving and bereavement, plus incorporating this knowledge for children, were all very meaningful.

The opportunity to have supervision and feedback for both the group and the individual work was greatly appreciated and assisted in deepening the learning. This feedback helped in both integrating, understanding, and exploring alternate ways of intervening. This direct feedback and consultation was one of the major reasons for pursuing this project and made it even more worthwhile.

Whether a group format or individual intervention is chosen, there needs to be an opportunity to allow the child to express his or her feelings, to be validated and to have a context of support and healing that will help the child to move on. Incorporating play and playfulness into the therapy sessions made the process fun and meaningful for both the child and myself.

References

Achenbach, T. M. (1991) . Integrative guide for the 1991 CBCL/4 - 18, YSR, and TRF profiles. Burlington: VT: University of Vermont Department of Psychiatry.

Allan, J. (1988) . Inscapes of the child's world. Dallas, Tx: Spring Pub. Inc.

Baker, J. E., & Sedney, M. A. (1996) . How bereaved children cope with loss: An overview. In C. A. Corr & D. M. Corr (Eds.) Handbook of childhood death and bereavement (pp. 109 - 129). New York: Springer Pub. Co.

Baker, J. E., Sedney, M. A., & Gross, E. (1992) . Psychological tasks for bereaved children. American Journal of Orthopsychiatry, 62 (1), 105-116.

Bowen, M. (1976) . Family reaction to death. In. P. Geurin (Ed.), Family therapy (pp. 335 - 348). New York: Gardner.

Bowen, M. (1978) . Family therapy in clinical practice. New York: Jason Aronson.

Bowlby, J. (1978) . A secure base: Parent-child attachment and healthy human development. New York: Basic Books, Inc.

Burnell, G. M., & Burnell, A. L. (1989) . Clinical management of bereavement. A handbook for health care professionals. New York: Human Sciences Press Inc.

Caplan, G. (1990) . Loss, stress, and mental health. Community Mental Health Journal, 26 27-47.

Corr, C. A., & Corr, D. M. (Eds.) (1996) . Handbook of childhood death and bereavement. New York: Springer Publishing Co.

Crenshaw, D. C. (1990) . Bereavement: Counseling the grieving throughout the life cycle. New York: The Continuum Publishing Company.

Danbury, H. (1996) . Bereavement counseling effectiveness. Brookfield, USA: Avebury, Ashgate Pub. Ltd.

Davis, N. (1990) . Therapeutic stories for children. Oxon Hill, MD: Psychological Associates of Oxon Hill.

Dillon, I. L. (1994) . Exploring grief with your child. Palo Alto, CA: Enchante Pub.

Doka, K. (Ed.) (1995) . Mourning children, children mourning. Bristol, PA: Hospice Foundation of America.

Fatout, M. F. (1995) . Using limits and structures for empowerment of children in groups. Social Work with Groups, 17 55-69.

Field, T., DeStefano, L., & Kowler, J. H. III (1982) . Fantasy play of toddlers and preschoolers. Developmental Psychology, 18. 503-508.

Fitzgerald, H. (1992) . The grieving child. New York: Fireside, Simon & Schuster.

Fox, S. (1994) . Good grief: Helping groups of children when a friend dies. Boston, Mass: The New England Assoc. for the Education of Young Children.

Freeman, J., Epston, D., & Lobovits, D. (1997) . Playful approaches to serious problems. New York: W. W. Norton & Co.

Furman, E. (1974) . A child's parent dies: Studies in childhood bereavement. New Haven, CT: Yale University Press.

Gil, E. (1994) . Play in family therapy. New York: Guilford Press.

Grollman, E. A. (1990) . Talking about death: A dialogue between parent and child. Boston, Mass: Beacon Press.

Grollman, E. A. (1995) . Grieving Children: Can we answer their questions? In K. Doka (Ed.), Mourning children, children mourning (pp. 17-28). Bristol, PA: Hospice Foundation of America.

Herz, F. (1980) . The impact of serious illness and death in the family life cycle. In E. A. Carter & M. McGolderick (Eds.) The family life cycle: A framework for family therapy (pp. 167 - 195). New York: Gardner Press.

Irwin, E. C. (1988) . The diagnostic and therapeutic use of pretend play. In C. E. Schaefer & K. J. O'Connor (Eds.), Handbook of play therapy

(pp. 148-173). New York: New Market Press.

James, B. (1989) . Treating traumatized children. Lexington Mass: Lexington Books.

James, B. (1994) . Handbook for treatment of attachment-trauma problems in children. New York: Lexington Books.

Jewett, C. L. (1982) . Helping children cope with separation and loss. Harvard, Massachusetts: The Harvard Press.

Klaus, D., Silverman, P. R., & Nickman, S. (1996). Continuing bonds: New understandings of grief. Washington, D. C.: Taylor & Francis Pub.

Krall, V. (1989) . A play therapy primer: Therapeutic approaches to children with emotional problems. New York: Human Sciences Press, Inc.

Kubler-Ross, E. (1969) . On death and dying. New York: MacMillan Publishing Co. Inc.

Lieberman, M., & Boreman, L. (Eds.). (1979) . Self-help groups for coping with crisis. San Francisco: Jossey-Bass.

Levine, S. (1982) . Who dies? New York: Anchor Books, Doubleday.

Lohnes, K. L., & Kalter, N. (1994) . Preventive intervention groups for parentally bereaved children. American Journal of Orthopsychiatry, 64 594-603.

Lubimiv, G. (1994) . Wings for our children. Burnstown, ON. The General Store Publishing House.

Masterson, S. H., & Reams, R . (1988) . Support groups for bereaved preschool and school-aged children. American Journal of Orthopsychiatry, 58, 562-568.

Morgan, J. D. (Ed.) (1987) . Bereavement: Helping the survivors. London, ON: Kings College Ontario.

Nelson, J. (1987) . Positive discipline. New York: Ballantine Books.

Northern, H. (1982) . Clinical social work. New York: Columbia University Press.

Parkes, C. (1972) . Bereavement: Studies of grief in adult life. New

York: International Universities Press.

Rando, T. A. (1986) . Loss and anticipatory grief. D. C. Heath and Co. Lexington, Mass: Lexington Books.

Reynolds, C. R., & Richmond, B. O. (1995) . Revised children's manifest anxiety scale (RMCAS) Los Angelos, CA: Western Psychological Services.

Rosen, E. J. (1996). The family as a healing resource. In C. A. Corr & D. M. Corr (Eds.), Handbook of childhood death and bereavement (pp. 223 - 264). New York: Spring Publishing Co.

Ryan, F., & Gibbon N. (1987) . Loss: A cognitive and affective process. In J.D. Morgan (Ed.), Bereavement: Helping the survivors (pp. 21-26). London, ON: Kings College Ontario.

Sanders, C. M. (1995) . Grief of children and parents. In K. Doka (Ed.). Mourning children, children mourning (pp. 69-83). Bristol, PA: Hospice Foundation of America.

Schaefer, C. E., & Congelosi, D. M. (1993) . Play therapy techniques. Northvale, N. J: Jason Aronson Inc.

Schaefer, C. E., & Connor, K. J. (Eds.) (1988). Handbook of play therapy. New York: John Wiley & Sons.

Schaefer, D., & Lyons, C. (Eds.) (1988) . How do we tell the children: Helping children understand and cope when someone dies. New York: New Market Press.

Schuchter, S. R. (1986) . Dimensions of grief: Adjusting to the death of a spouse. Jossey-Bass, San Fransico.

Segal, R. M. (1984) . Helping children express grief through symbolic communication. Social Casework: The Journal of Contemporary Social Work, 65 590 - 599.

Shapiro, E. R. (1994) . Grief as a family process. New York: The Guilford Press.

Shulman, L. (1992) . The skills of helping individuals and groups (3rd.

ed.) Itasca, IL: F. E. Peacock.

Steele, W. (1995) . Kids on the inside looking out after loss. Charlotte, NC: Kidsright.

Toseland, R. W., & Rivas, R. F. (1995) . An introduction to group work practice. Boston: Allyn and Bacon.

Toseland, R., & Siporin, M. (1986) . When to recommend group treatment: A review of the clinical and research literature. International Journal of Group Psychotherapy, 36 171-201.

Walsh, F. (1982) . Normal family processes. New York: The Guilford Press.

Walsh, F., & M. McGolderick (Eds.) (1991) . Living beyond loss. New York: N.W. Norton & Co.

Warmbrod, M. (1986) . Counseling bereaved children: Stages in the process. Social Casework: The Journal of Contemporary Social Work, 67 351-58.

Webb, N. B. (Ed.) (1993) . Helping bereaved children. New York: The Guilford Press.

Westera, D. (1987) . Assessing spiritual needs in bereavement: Part of the helping process. In J. D. Morgan (Ed.). Bereavement: Helping the survivors (pp. 41-48). London ON: Kings College Ontario.

Wolfelt, A. (1983) . Helping children cope with grief. Muncie, IN: Accelerated Development.

Wolfelt, A. (1993) . The misdiagnosis of ADHD in bereaved children. The Forum Newsletter, 19, 9-10, 18.

Wolfelt, A. (1996) . Healing the bereaved child. Ft. Collins, CO: Compenion.

Wolfenstein, M. (1969) . Loss, rage, and repetition. Psychoanalytic Study of the Child, 24, 432 - 460.

Worden, J. W. (1996) . When a parent dies. New York: The Guilford Press.

Yalom, I. (1985) . The theory and practice of group psychotherapy (3rd. ed.). New York: Basic Books.

Zambelli, G. C., & DeRosa, A. P. (1992) . Bereavement support groups for school-age children: Theory, intervention, and case example. American Journal of Orthopsychiatry, 62 484-493.

Appendix A

Practicum Consent Form

I understand:

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

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

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

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

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

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

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

Signature of client(s) or parent/guardian

Date:

Signature of clinician or other witness Date:

JT/96

Appendix B

ELIZABETH HILL COUNSELLING CENTRE

302-321 McDERMOT AVENUE
WINNIPEG, MANITOBA R3A 0A3

It has been explained to me that the Elizabeth Hill Counselling Centre is also a training and research facility. As a recipient of service at the Centre I understand:

- That the service I, and those who are in my care, will receive is part of a practicum for the Masters of Social Work program at the University of Manitoba.

- That any information obtained from psychological tests, interviews, counselling sessions and questionnaires may be used as part of a published evaluation of this practicum.

- That the information gathered as part of this practicum can only be reported in a manner which does not reveal my identify or that of anyone in my care.

- I have freedom to withdraw at anytime during treatment and that I will be eligible for continued services at this centre or another of my choice (in accordance with the criteria of other referral sources).

- All information reported will be in a locked, confidential cabinet, with access only by the therapist.

- I agree to video taping and/or audio taping of the treatment sessions for the purposes of supervision.

Signature of client(s) or parent/guardian:

Date:

Signature of clinician or other witness:

Date:

JT/96

Appendix C

Evaluation Feedback Form for the Children's Group

DATE_____

Name of Leader(s)_____

1. What I liked about the group_____

_____

2. What I learned in the group_____

_____

3. How I'm feeling now_____

_____

4. My favorite part of the group_____

_____

5. What I would change about the group_____

_____

6. I would recommend this group to a friend Yes No

7. I liked the place we met Yes No

8. Other comments_____

_____

_____

JT/96

Appendix D

Evaluation of Individual Sessions

DATE:_____

Name of Clinician_____

1. When I first came here I felt_____

_____

2. Now I'm feeling_____

_____

3. The things that are different for me are_____

_____

4. My parent(s) or guardian(s) notice this about me now_____

_____

5. What I liked the best about my sessions_____

_____

6. What I would want to be different_____

_____

7. Other comments_____

_____

_____

_____

JT/96

Appendix E

Outline of Group Sessions

Objectives:

1. Welcome and introduce participants.
2. Define the purpose for the group.
3. Provide information regarding group structure and format.
4. Begin to establish rapport between participants and facilitators and among the participants themselves.

Agenda

1. Welcome participants and group introductions.
2. Housekeeping items to promote group structure.
3. Group format and rules.
4. Form sub-groups: children's group and parent's group.

Parent's Group:

a. Needs assessment for parent participants.
b. Negotiate focus for parent group program.
c. Coffee break and discussion time.

Children's Group

a. Ice breaking activity
b. Discussion of who died.
c. Work on folders and questions for the question box

5. Reconvene large group.
6. Storytime.
7. Closure.

Summary:

Parent J. and child T. were unable to attend for the first session. Starting time was delayed due to the late arrival of one large family group. Start-up time was open for negotiation later in this session, but participants chose to have the time remain at 6:30 p.m.

The introductory activity for this session required that parents initiate

involvement by introducing themselves and their children (first names) and stating who had died and the relationship of the deceased to their child. This activity worked well and decreased anxiety for the children in the group. The children were attentive and subdued during this process.

The group format was described to the participants by the facilitators. Group sessions would begin and end with the large group. Each weekly session would begin with a question from the children's "question bag", giving facilitators and parents opportunity to respond to anonymous questions from the children about death. Sessions would end with storytime in the large group. Sub-groups for children and parents would occur each week for approximately 30-40 minutes. The children's snack time and the parents' coffee break would be included in the sub-group sessions.
In the parents' sub-group, parents shared more in depth information regarding the deceased and the impact of the death on themselves and their child(ren). Parents identified the following topic areas in their needs assessment:

a. how to answer their children's questions about death, violent deaths, and fears of illness and death.
b. how to respond to their children's comparisons related to their life before and after the death: also comparing new partner/parents with the deceased.
c. help to increase their understanding of their child's present and future needs related to the loss of the deceased.

Parents were most agreeable to the facilitators' suggestions of incorporating information about how children grieve into the sessions.

In the children's group we began with an ice breaking activity called the "name game". The children were to have a positive adjective that started with the first letter of their name, call themselves by this name, then as we went around the circle each child was to repeat everybody else's name first, then add their own. Two of the children were unable or refused to

participate due primarily to shyness. We then went around the circle and talked about who in their family died and how this happened. L. became quite emotional at t his point and began crying very hard. She accepted comfort quite easily and the other children were quite supportive by remaining quiet and bringing Kleenex. When discussing the different deaths we began to talk about cremation, as nearly all the deceased were buried in this way. We also discussed how the person is not alive nor breathing at the point cremation takes place so there was no further pain or suffering as the person was already dead. (S. was upset that she had not seen her mother's body after her death. Her mother had been strangled to death and was in very rough shape so a decision was made not allow S. to see her).

The group then moved to a physical activity of decorating their folders. This took the remaining time. We also elicited a number of questions that were put into a bag and each week we would draw a question out and discuss with the larger group. These were to be questions the children may not have felt comfortable to ask their parents but were put into the bag anonymously. We then had our snack. Two children were chosen to bring the snack and this became a ritual as each child had a turn. We also had to limit the number of cookies as L. in particular took several cookies which was noticed and commented upon by several other children.

The objectives for this first session were:

1. Develop trust and familiarity with each other.
2. Introduce the fact of the death and that is what we were here to talk about.
3. Establish group rules of safety, respect and confidentiality.

After reconvening in the larger group we explained about the question bag and read a story I Wish I Could Hold Your Hand. This was enjoyed by all and brought closure to our first meeting. The children were also asked to bring a picture of the deceased person for an activity in their group.

Session Two

Objectives for the parent group:

1. Increase cohesiveness and support among members.
2. Increase parents' understanding of children's grieving process.

Objectives for the children's group:

1. Begin to build trust within the group.
2. Create an openness to discuss the loss.

Agenda

1. Reconvene as large group.
2. Check-in with families.
3. "Question bag" activity.
4. Sub-groups:

Parent's Group:

1. Stages of grieving for children.
2. Coffee break and discussion time.

Children's Group:

1. Begin working on memories of the deceased.
2. Snack time - this provided an opportunity to set limits and establish fairness rules.
5. Storytime
6. Closure

Summary:

Start-up time for group was late again this session. Parents with large sibling groups indicated that it will always be difficult for them to attend on time, regardless of the time agreed upon. During check-in time, parent L. volunteered that her children were discussing the deceased openly following last week's session. L. is concerned about her older child that is not included in the group. Parent B. showed similar parenting difficulties to parent L. Parent J. and her child T. joined the group for the first time. Questions from

the "question bag" included: Why do people die? and Why do we have to bury people. These questions generated good discussion about the cycle of life and the different ways that people die. The second question provided an opportunity to discuss different rituals that occur following a death, and that rituals are based on cultural or spiritual beliefs.

In the parent's sub-group, the focus for this session began with integrating parent J. into the group. J. was given an opportunity to add to the list of needs identified by the parents in session one. The focus then moved to phases of grief for children: shock and disbelief, searching and yearning, disorganization and despair, rebuilding and healing. Parent needs as identified in session one were posted on the flip chart paper on the wall as an ongoing focus for discussion. Parents L. and R. initiated discussion related to 'good grieving' and expectations of others for their grief. Parents began to process the differences in grieving for infants, children, adolescents and adults. A discussion tangent included gender issues for surviving parents and their relationship with their child(ren). All parents participated enthusiastically and were supportive of one another. More time would have been appreciated.

The children's group also had to incorporate T. into the group. We again went around the circle and talked about who died and how. T. was able to share somewhat although there was some initial shyness. The children were quite curious about the video camera and all had to take a turn looking into it. They were then instructed to draw a picture of their family for the folder. L. was quite preoccupied with the question bag activity and had difficulty focusing on the task of drawing a picture of her family. During the activity of drawing a picture of their family we discussed feelings. Some of the children were able to recognize that we can have more than one feeling at a time and that some feelings are concrete and some are emotional.

Snack time again became a ritual for who was to get the cookies and how many they were all allowed.

The large group reconvened and the story When Uncle Bob Died was read.

Closure.

Session Three

Objectives of the Parent Sub-group:

1. Continue to increase parents' understanding of how children grieve.
2. Consider the needs identified by parents during information sharing.

Objectives of the Children's Sub-group:

1. Continue to identify memories of the deceased.
2. Continue to build a safe environment for all members.

Agenda:

1. Reconvene large group.
2. Check-in.
3. "Question bag".
4. Sub-groups:

Parents Group:

1. Common myths about loss and grief for children.
2. Coffee break and discussion time.

Children's Group:

1. Create a collage of the different memories and things the deceased liked to do.
2. Share the collage with the entire group and talk about their memories.
3. Snack time.
5. Storytime.
6. Closure.

Summary:

We again started about twenty minutes late. Check-in time included a

high degree of interaction among participants, both children and adults. Children were very comfortable making requests of the therapists and some were initiating approval from therapists through caretaking activities. Parent L. indicated serious concerns with non-attending child and received much support from adult members. Therapists intervened to hold further discussion to parent sub-group and move on with ritual activity of the "question bag".

The question was "What is evil?" This question prompted responses from the children and adult participants as the group struggled to explain this term. Responses were both factual and spiritual with a final decision to defer to a dictionary for further clarification.

The parents' group focus turned to offer support to parent L. regarding the current crisis with her older child. Parent J. was able to identify with the situation and provided L. with reassurance and support. Parent B. was also able to identify with L.'s struggle and shared common concerns in relationship to her future needs with her child.

Information was shared in this session re: common myths, addressed the myth that grief and mourning are the same experience. The group discussed their thoughts with one another. The group worked on finishing their family pictures. The two H. children had to complete their pre-test form. I assisted D. in doing hers. L. had difficulty in drawing her family and in the end only included her Dad in the family picture. The other picture she drew was focused on his death with a picture of a cross and a casket. Questions arose in the group discussion as to who belonged in the family, how we got our eye colour and when was it appropriate to have babies. We also discussed funerals, grave markers and celebrating the anniversary of someone's death as we acknowledge and celebrate birthdays. We reviewed the collage exercise in preparation for next week. Snack time again raised the issue of how many cookies each child should/could have. It was settled at 3 each.

In the large group storytime the children were very high energy and difficult to settle. Parent L.'s children were quite anxious that she left the group briefly to car pool another member. The story was Sunflower Mountain.

Closure.

Session Four

Objectives for Parent Sub-group:

1. Continue to increase parent's understanding of children's grief.
2. Support group cohesion.

Objectives for Children's Sub-group:

1. Continue to reconnect with memories and feelings concerning the deceased.
2. Provide information and openness to discuss death and the rituals attached.

Agenda:

1. Reconvene.
2. Check-in.
3. "Question Bag".

Parent's Group:

a. Common myths continued.
b. Coffee break and discussion time.

Children's Group:

1. Collage activity focused around memories.
2. Informal discussion during this activity and snack.
4. Storytime.
5. Closure.

Summary:

The parent's group consisted only of mothers in this session. Session four was quickly detoured to respond to a crisis for parent B. and her child.

The parents offered B. support, reassurance and hope that the crisis would subside and the relationship could improve. Parent B. responded positively to the support of the group.

Parents acknowledged that they were ready and willing to proceed with the material for this session and the therapist was able to complete the list of common myths about grief and loss for children. The myths were easily tied to the parents' needs identified in session one posted on the wall. In the children's group we worked on the collages. Two of the children had a very limited experience of the deceased as it was their aunt whom they barely knew. This activity allowed an opportunity for their cousin to share her memories of her mother and allow them to know their aunt a little better. All the children worked quite diligently on their collages. Those who had pictures pasted in the middle of their collage. Others drew a picture of the deceased. All the children then talked about their picture and shared their memories in the group. One child J. had difficulty sharing but was able to when prompted with questions about her picture. Child A. was away this day as she was ill. Her sister D. seemed less comfortable in the group and frequently asked to see her mother, complaining that she was also feeling ill. Children who finished their collage early played in the play house while others finished. Each child then shared their picture and talked about the different memories. Everyone participated without difficulty. We then had snack and joined the adults.

Storytime for this session was reading Badger's Parting Gift. During the story reading it was observed the parent B. was able to physically connect with her child and provide her with affection during the storytime. Each child also shared their collage with their parent and most children took it home except L. who was confided to Ms. Croll that there was not a safe place for it at home.

Closure.

Session Five

Objectives for Parent Sub-group:

1. Begin to identify children's needs related to tasks of grieving.
2. Continue to support group cohesion.

Objectives for Children's Sub-group:

1. Connect more directly with feelings.
2. Connecting feelings with memories.

Agenda:

1. Reconvene.
2. Check-in.
3. "Question Bag".
4. Sub-groups:

Parent's group:

a. Tasks of grieving for children.
b. Coffee break and discussion time.

Children's Group

a. Activity relating feelings to colours.
b. Relaxation exercise to create a safe place.
c. Snack.

5. Storytime.
6. Closure.

Summary:

Both male participants were away. The H. family was a half hour late. Due to the lateness of the start we did not do the 'question bag'. Check-in with parent B. indicated that the situation with her child had improved over the past week. Parent B. was given a list of resources last week and is giving consideration to seeking help. Parent L. continues to struggle with the eldest child and finds power struggles an on-going occurrence. Parent R. and family have moved to a larger home and all members are adjusting to the change.

Memories of the old house were discussed and a validation of the need to mourn this loss even though the family was really enjoying and looking forward to the move.

The session focused on the tasks of grieving for children including: developing an understanding of the death and the loss; grieving the loss (phases of grief); commemorating the deceased and learning to go on with life. During the discussion of commemorating, parent L. became emotional when sharing her story about the conflict that the commemoration ceremony has caused between several family members. This provided opportunity for the group to share their thoughts and feelings related to their losses and to offer support to parent L. The parents' role in supporting their children through the tasks of grieving, and the differences for children developmentally, would continue next week.

In the children's group T. was away due to strep throat. This is the second session he missed. A., S., and D. were all a half hour late and we had separated already into the children's time. We had just begun a discussion of feelings. The "talking stone" was passed and each child shared if their feelings were a colour, what colour that would be and why. We then did a relaxation exercise, and turned off the lights to imagine ourselves in a safe place. L. became very upset and crying when the lights were turned off. We then opened the door with the lights off and she was fine. After we all found our safe place, the children drew a picture of what it looked like. C. had great difficulty doing this and began instigating confrontations with other children. We had a little talk and she settled down to do her picture. We then brain stormed feelings, dividing them into good and negative feelings. The children all participated in this activity. We then shared our pictures and had snack.

We joined the adults and a brief debriefing discussion. We then read our ending story.

Story time was Hurt - Annie's Story

Closure.

Session Six

Objectives for Parent's Sub-group:

1. Focus on parental support for the grieving child.
2. Continue mutual aid within group.

Objectives for Children's Sub-group:

1. Continue work on feelings.
2. Continue to develop safety in the group for sharing feelings.

Agenda:

1. Reconvene.
2. Check-in.
3. "Question Bag".
4. Sub-groups:

Parent's Group:

a. Developmental abilities related to tasks of grieving for children.
b. Supportive responses of parents re: above.
c. Coffee break and discussion time.

Children's Group:

a. Children put their feelings in colours on an outline of how they felt about the loss.
b. Children put feelings in colours of how they wish to feel.

5. Story-time.
6. Closure.

Summary:

The developmental differences and abilities of children was well received by group members who are parenting children from toddler age to adolescence. Parent L. found the information related to adolescence of

particular interest given her different situation with her eldest child. Parents R. and K. were keenly interested in development related to toddlers and latency age children. The task of commemorating the deceased provided an opportunity for a highly charged discussion related to the ambivalent feelings of the surviving parent in supporting the child. The impact of legacies, positive and negative, was discussed to increase parents understanding of the importance of the child having some positive feelings toward the deceased. The group began to consider the issue of when to be worried about their child's grieving. This topic would continue next session. A general discussion ensued related to stressors felt by all parents in the group, but particularly the single parents. These parents received recognition and support from the group for the enormity of their task. In the children's group L. was away that day as Mom was ill. S., D., and A all arrived a half our late. We had just begun our session when J., K., and C. arrived as well. We talked again about feelings as T. was away last week and to catch him up. This discussion was expanded upon from previous discussions as the children became more familiar with the process. The children all participated enthusiastically in the activity of putting their feelings through colour on an outline of a person. They worked quite diligently and cooperatively for this activity. They shared their pictures with the group then coloured a picture of how they wanted to feel. C. started to instigate trouble with A. by throwing her shoe at her. C. and I had a talk about her behaviour and she settled down.

Prior to story-time, the children shared their pictures with their parents. The pictures depicted how the child felt when their parent died, and they would like to feel now. The story was Hurt - Billy's Story. Closure.

Session Seven

Objectives for the Parent's Sub-group:

1. Increase parent's information re: When to worry about their child's grieving.

2. Begin termination process.
3. Introduce family follow-up sessions.

Objectives for the Children's Sub-group:

1. Connect memories and feelings as well as facts about death.
2. Begin termination process.

Agenda:

1. Reconvene.
2. Check-in.
3. "Question Bag".
4. Sub-groups:

Parents group:

a. List of concerns.
b. Discuss termination.
c. Coffee break and discussion.

Children's group:

a. Play the "Grief and Loss Game".
b. Begin the termination process with the flower and the tear.

5. Large family activity.
6. Story-time.
7. Closure.

Summary:

We had one family absent today. T. and his mother J. were unable to attend due to illness. The question from the 'question bag' was: "Why did S. kill my mom?" This question sparked a lengthy discussion related to violent deaths and the on-going trauma to the family when a court trial occurs months following the crime. A response from parent R. included information unknown to the child A. who quickly questioned why she was not informed. Sibling issues surfaced as the children regrouped and reevaluated their attachments to parents. This question also sparked a discussion about

'forgiveness' and the spiritual interpretations that many of the children have learned related to this concept.

The parent's group reviewed signs and symptoms of grieving with discussion related to troubled grieving processes. Parent R. shared that her child was worried that the deceased parent has not surfaced in dreams and this provided opportunity to discuss children's feelings of abandonment by the deceased. Further worries, fears and anxieties of the children were shared by the parents. Discussion of group termination was met with joking by saying they will continue in R.'s new home.

In the children's group we played the "Grief and Loss Game" which the children really became involved in. During the discussion about a deceased great grandparent. S. became quite upset as she felt excluded from the test of the family. This incident was dealt with directly between the two children involved and the others continued to play the game while I dealt with this situation. We continued to play the game for one more round. then joined the main group for our termination activity.

The parent-child activity of the flower and the tear was lead by Judy Tozeland. A variety of dynamics between parents and children surfaced as the children proceeded with the activity. J. was called about this activity and she and T. did the same thing at home.

The story for today was Hug Me. The goal here was to connect with warm feelings.

Closure.

Session Eight

Objectives for the entire group.

1. Termination.
2. Follow-up.

Agenda:

1. Reconvene.
2. Check-in.

3. Joint activity with parents and children.
    a. Termination using the flower and the tear and the stones.
    b. Discussion re: follow-up family therapy and post-test measures.
4. Flower and Tear Activity and the Stones.
5. Celebration.
6. Closure.

Summary

The late arrival of one of the large families delayed the start of the group to 7:20 p.m. The waiting time was used by co-therapist Judy T. to assist the children in completing their post test measures. No 'questioning' was done this night as the questions had been exhausted or were repetitive. The children had coloured on the flip chart the week before announcing that this week was our last session. Most of the children added their art work to this. It was displayed at the last meeting.

The flower and tear activity produced emotional responses from some of the parents and thoughtful responses from many of the children. This activity symbolized the loss of the deceased and the end of the group. It was followed by the therapists sharing a smooth stone and a rough stone with each participant to commemorate the group experience. Some of the children also had baby pictures which we looked and discussed how much they had changed since being a baby and that the loss they feel now will change as well. A celebration including a cake followed the termination rituals.

Closure.

In April of 1997 certificates were sent to the children and their families for their participation in the group.

Appendix F

References for Bibliotherapy

Pre-school to age eight

Althea (1982) . When Uncle Bob died. London: Dinosaur Pub.

Brown, M. (1959) . The dead bird. New York: Young Books.

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

Fassler, J. (1971) . My Grandpa died today. New York: Behavioral Pub.

Mellonie, B., & Ingpen, R. (1983) . Lifetimes. New York: Bantam Books.

de Paola, T. (1973) . Nana upstairs and Nana downstairs. New York: G. P. Putnam's Sons.

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

Stein, S. (1974) . About dying. New York: Walker Books.

Stren, P. (1977) . Hug me. Markham ON: Fitzhenry & Whiteside.

Viorst, J. (1971) . The tenth good thing about Barney. New York: Atheneum.

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

Middle years (age 8 - 11)

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

Amos, J. (1991) . Hurt. Austin Tx: Stech-Vaughn Co.

Buscaglia, L. (1982) . The fall of Freddie the leaf. New York: Holt Rinehart & Winston.

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

Coburn, J. (1964) . Anne and the sand dobbies. Greely, Colo: Presco.

Foster-Morgan, K. (1995) . Sunflower Mountain. Toronto: Sunflower Pub.

Holden, D. (1989) . Gran-Gran's best trick. New York: Magination

Press.

Kubler-Ross, E. (1982) . Remember the secret. Berkeley, CA: Celestial Arts.

Linin, E. (1982) . Children are not paper dolls. New York: Corwell.

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

Palmer, P. (1994) . I wish I could hold your hand.... San Luis CA: Impact Pub.

de Paola, T. (1980) . Now one foot, now the other. New York: G. P. Putnam's Sons.

Peterson, K. (1977) . Bridge to Terrabithia. New York: Harper and Row.

Simon, N. (1986) . The saddest time. Morton Grove Ill: Albert Whitman & Co.

Simon, N. (1989) . I am not a crybaby. New York: Puffin Books.

Varley, S. (1984) . Badger's parting gift. New York: Mulberry Paperback Book.

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

Older Children, 12 years and older.

Carven, M. (1973) . I heard the owl call my name. New York: Double Day.

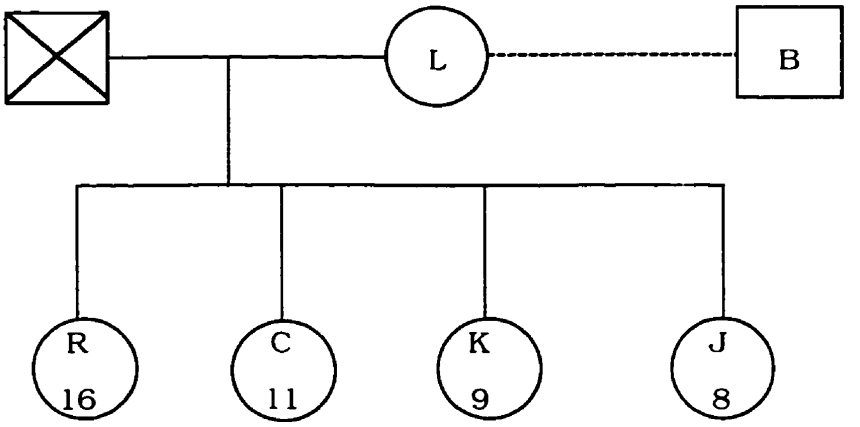
Krementz, J. (1981) . How it feels when a parent dies. New York: Alfred Kropf.

Leshan, E. (1976) . Learning to say goodbye. New York: MacMillian.

Growman, E. (1983) . Straight talk about death for teenagers. Boston: Beacon Press.

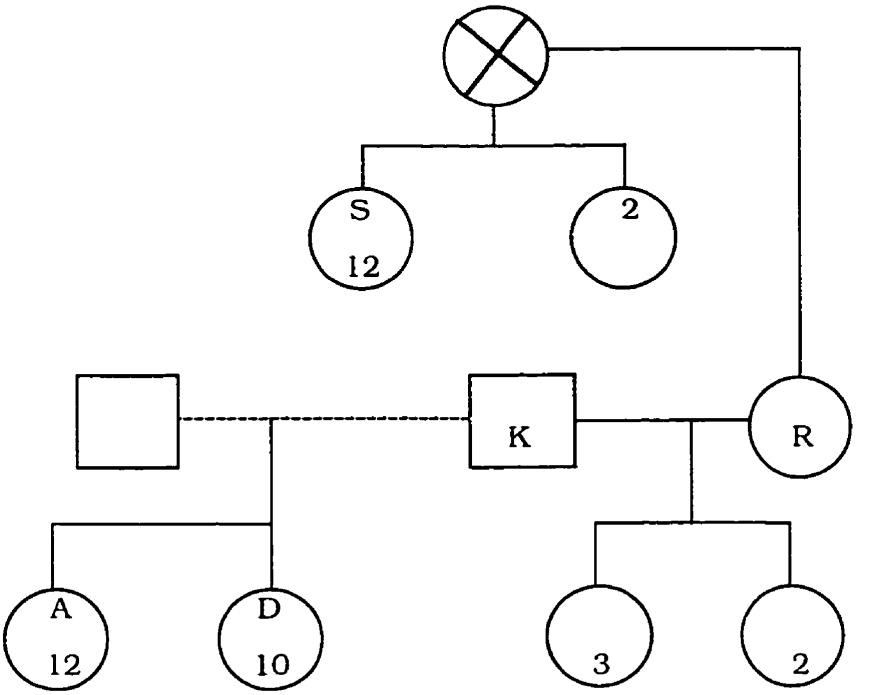
Appendix G

Genogram for Children C., K., & J.



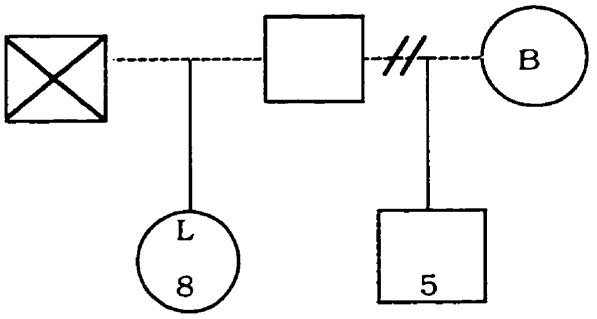
Appendix H

Genogram for Children A., S., & D.



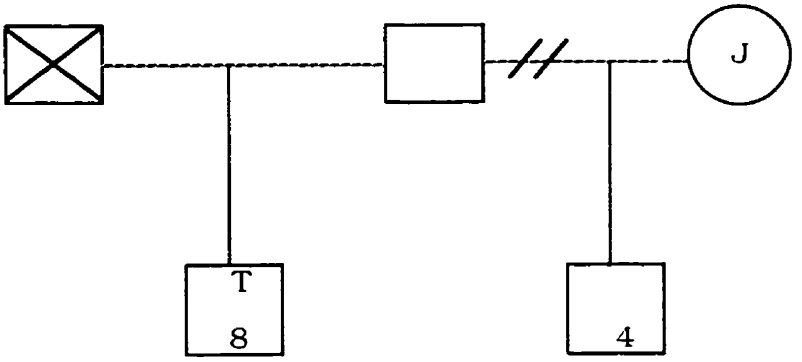
Appendix I

Genogram for Child L.



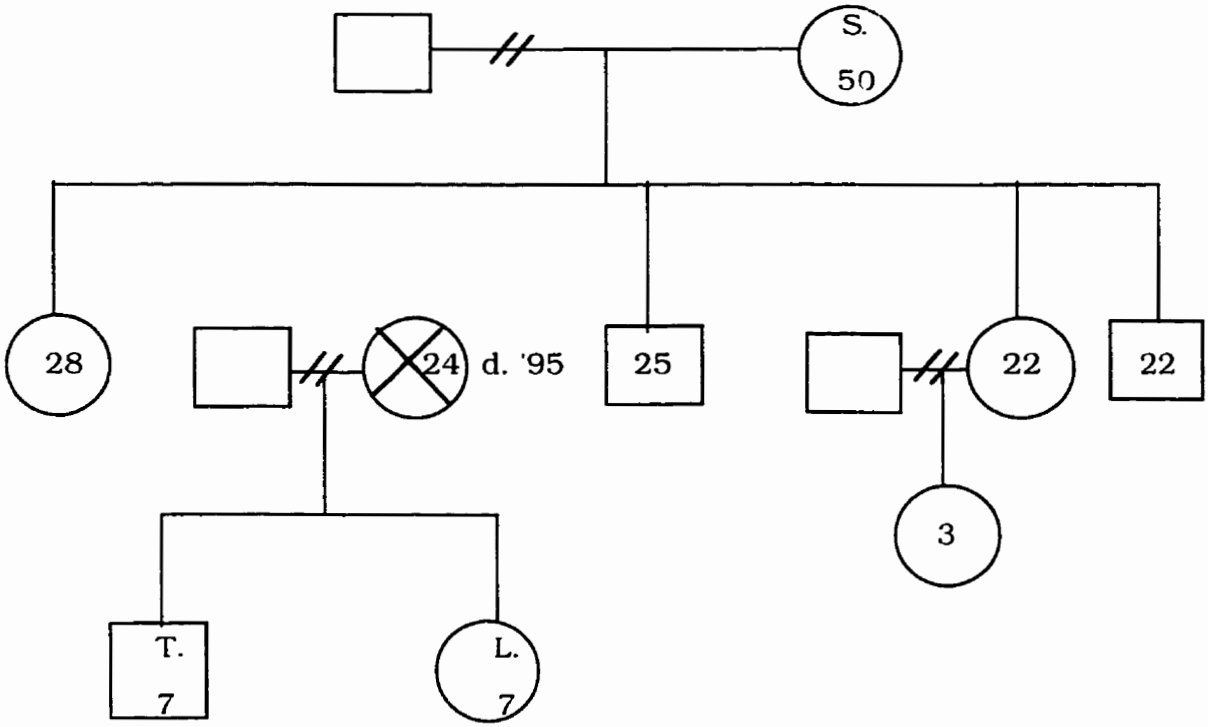
Appendix J

Genogram for Child T.



Appendix K

Genogram for Children T. & L.



Appendix L

Genogram for Child S.

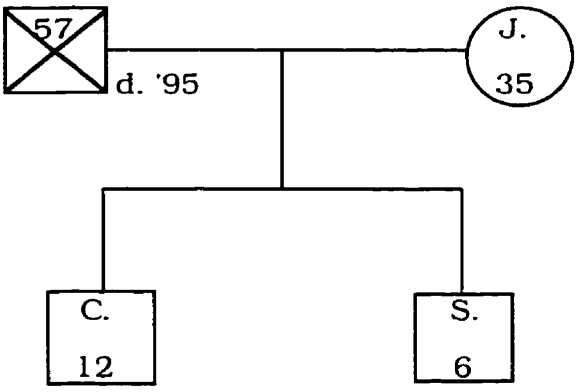
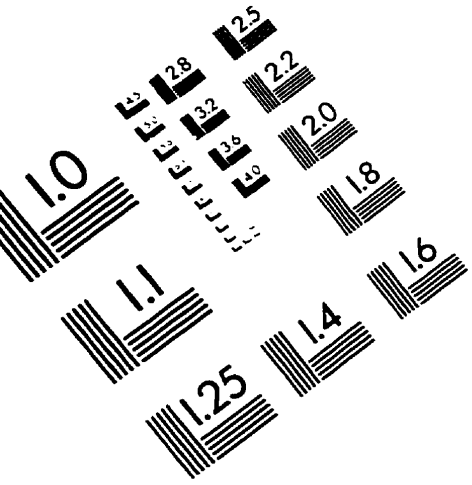
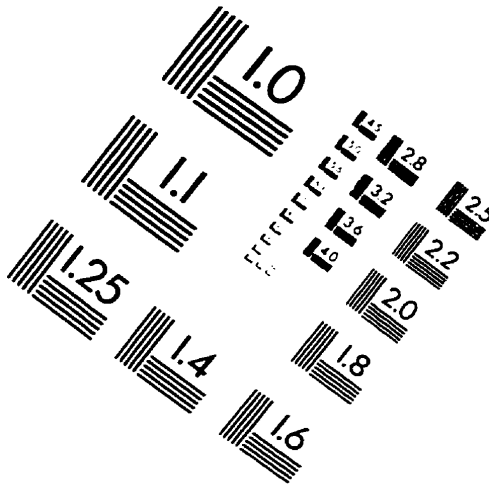
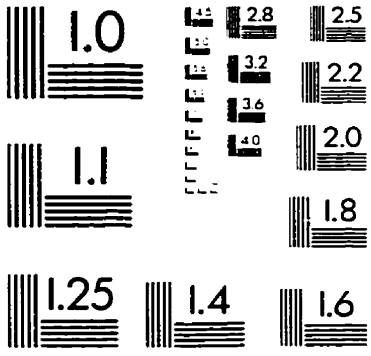
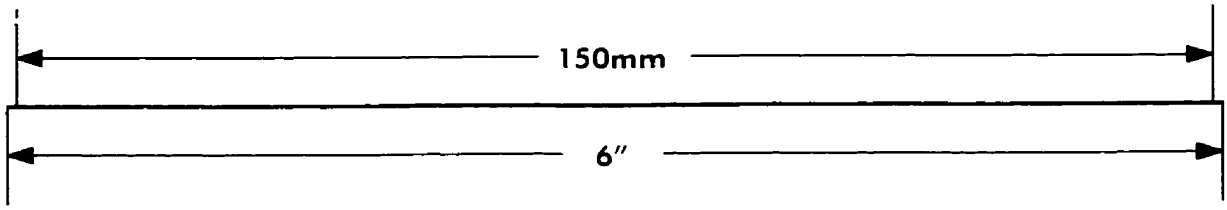


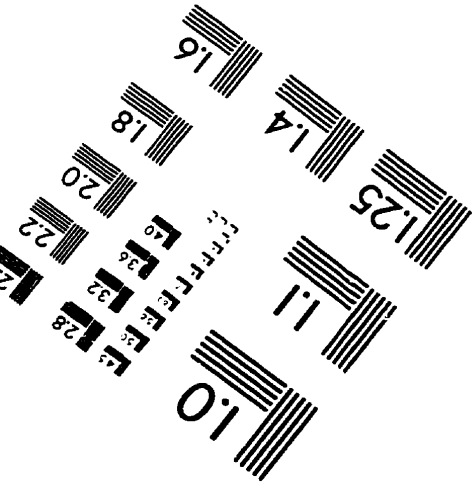
IMAGE EVALUATION
TEST TARGET (QA-3)

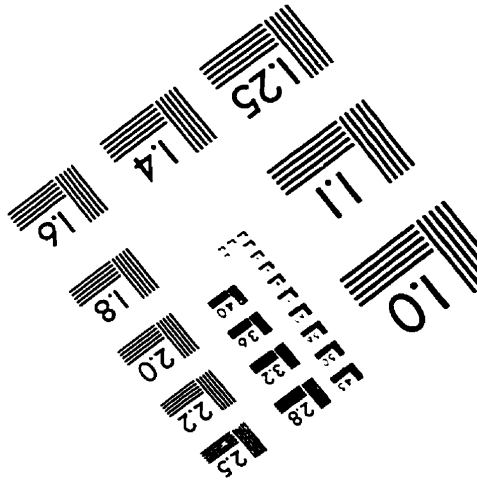












APPLIED IMAGE . Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989