



## Taking the Private into the Public

Annette Wilson

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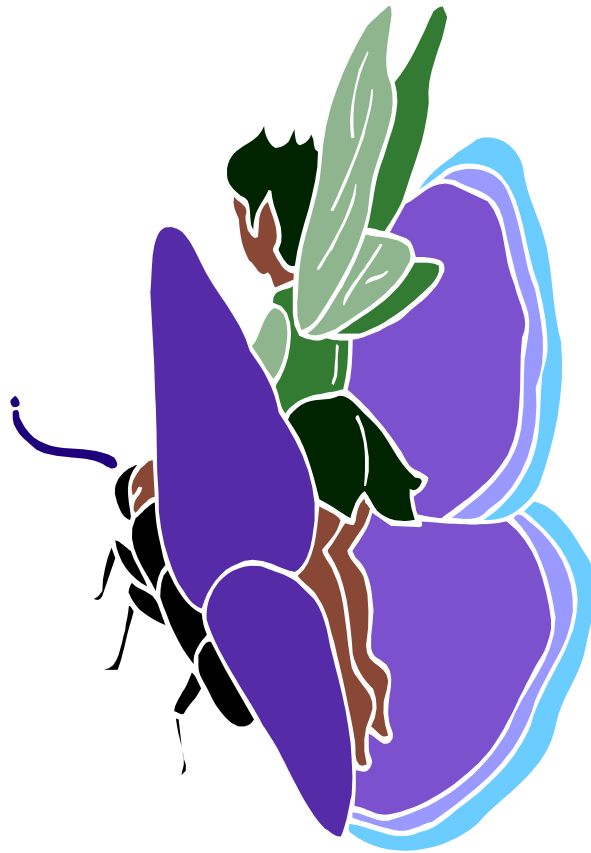
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# TAKING THE PRIVATE INTO THE PUBLIC

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ANNETTE WILSON

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PROFESSIONAL DOCTORATE IN SYSTEMIC PRACTICE

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2012

UNIVERSITY OF BEDFORDSHIRE

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## ABSTRACT.

This document is an invite to join me on a journey that follows the path of bereaved children, adolescents and their families who attended seven bereavement groups within a mental health setting. This thesis sets out to illustrate how families hold and maintain grief within the family system and how effective a bereavement group is as a form of therapeutic intervention.

The bereavement group is a platform where families bring their private stories into a public domain and talk about the concerns that they have seen in their families since the bereavement. As an insider/outsider researcher I am of the opinion that by talking, listening and sharing their stories with other families with similar experiences within the groups, families can begin to think about what could be done differently if they want something to change within their family system. By sharing, families learn how to go with their grief without their loved ones and begin to create new narratives about the next part of their journey.

The group can provide an opportunity for families to hear the 'Untold' stories and begin to create new narratives within their family system. The bereavement group also acts as a lens that allows me to look into my practice as a family therapist within a social constructionist framework and make new meaning of the stories that families bring within the bereavement groups. A tapestry is created from the complex diverse stories of grief that are interwoven with each family that attends the bereavement group. Each family brings their own pattern of bereavement and creates new patterns as their experience is shared with other families.

Data is taken from the conversations at the assessment, treatment and follow up stages to highlight what difficulties the families have when there is bereavement. This is to ascertain what factors may be contributing to holding and maintaining the grief in the family and whether a bereavement group is effective in bringing the issues out for all family members to discuss. Different methods are used to deconstruct the different themes and unpick the 'Told' stories.

At the end of this journey my hope is that there is more awareness about the effect of bereavement and how it shows itself in children's mental health and how the family system can be affected.

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# PART 1

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## **INTRODUCTION/the context**

This introduction will provide a brief background as to how the journey of curiosity started, how I became interested in bereavement as a research topic and what aspects of bereavement I am trying to find out about. It will also explain the structure and the content of the different chapters that come together to make up my research project and the aims and objectives of the thesis.

This research project explores an area that engages me as an emergent family & systemic practitioner in a community based mental health team in London for children and adolescents up to the age of 18 years called Children and Adolescents Mental Health Service (CAMHS). CAMHS is a National Health Service (NHS) provision that supports children and young people with emotional, behavioural and psychological mental health problems within a multi-disciplinary setting. The children and adolescents referred to this service are reflective of the diverse communities in London –‘multiethnic, multicultural and multilingual’. My responsibilities include doing generic assessments and offering family and systemic therapeutic intervention as a sole clinician and within a family therapy forum working with the two way mirror and a reflective team.

A death is a punctuation in a family’s life cycle, so when a bereaved child or an adolescent is referred to CAMHS, it is a privilege to join a family on their journey and be able to map what has happened. To be able to trace who the family members are within the family, to be able to find out what the conversations were at the time of the death and to talk about what happened at different junctures of the bereavement experience helps in understanding what changes have occurred in the families since the death and how they have coped as a family. What I found was that there was an amazing resilience that families demonstrated after experiencing sudden, traumatic and complex bereavement. With most of the families there was also a difficulty in talking about the death and the changes that had occurred as a result of the individual dying. Usually there was limited or no awareness that what was happening within one system would inform another, parents/carers were not always aware that what they were doing or saying, or in some cases, not doing or saying was creating and contributing to a change in the child’s or adolescent’s behaviour. I also recognized that the ideas that I was using and the theories that I had based my professional practice on were evolving with time and were changing the more I worked with bereaved children, adolescents and their families. I am now able to reflect on whether the approach that I have used is always compatible with the bereaved families that I was working with; for example the length of death, person who died, the grieving stage or the religious and cultural beliefs.

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From working with so many bereaved children and their families, I now have further understanding and a more empathic approach when thinking about the difficulties that some families experience when someone dies in the family and how that may manifest itself in a child or adolescent's emotional, social and mental wellbeing than when I first began this research journey. With bereavement, there are so many beliefs about what holds the grief in place, thus preventing it from moving along and changing as time passes. I hope that the research will stress the importance of families' cultural and religious bereavement stories joining those of the professionals' stories and moreover demonstrate that there is no right or wrong way to grieve and that there is no dominant view that should be privileged when working with children, adolescents and their families. The aim of this research is to create opportunities for there to be more thoughts and further understanding about what conversations are taking place and what happens in a family when someone dies. It aims also to demonstrate that there is a relationship between child mental health and complex bereavement.

The bereavement group is co-facilitated by another family therapist and I discussed the co-workers' relationship on p.143, however this thesis is my own research and I have worked on it independently

It is guaranteed that death will come to all of us, each and every one of us will experience bereavement at some stage in our lives but when it is unexpected, traumatic or follows an illness it can introduce so many different factors within the family. I am curious about what interactions take place in a family when there's a death and what factors contribute to the difficulties that arise within the family system and result in a child or an adolescent showing psychological, emotional pain and a deterioration in their behaviour. I am curious about what will enable a family in knowing how to go on/carry on in life having experienced bereavement, and the effectiveness of a therapeutic intervention bereavement group in these situations. I wanted to gain further understanding about the issues within families at the time of and after a death and how families cope and talk when difficulties emerge. I wanted to reflect on how difficulties were discussed within seven bereavement groups over a period of two years. My objective was to bring forth the multiple views and concepts that families have about talking or not talking and to illustrate how children and adolescents make sense of their bereavement experience within a group setting.

Starting out I believed that talking within a group setting would help some families to come together and share their personal experience of bereavement within their families, whether it was the death of a child, adolescent, father, mother or a grandparent. I also believed in communicating with bereaved

children, adolescents and their families about all aspects of their bereavement as part of my practice in order to get a fuller picture of what has taken place in the family and to see where the tension is. By listening to each other, families could begin to understand what had gone wrong in their family and what was causing the change in their child's/adolescent's behaviour and begins to change their pattern of interaction in their family system. Morris (1974) maintains that if we study how people react to change in general, this will give us some indication of how they will react to what must be the most disruptive of all changes (the death of a loved one).

I was intrigued by the relational dynamics in the families. It is an 'amazing' time when families are expected to forget their differences and to come together to bury the person who has died. By amazing I am referring to the unpredictability, the difficulty, the sadness, the regrets, the secrets and the untold stories that rise to the surface for many people. So many things get forgotten in that moment when a person dies and then re-emerge following the death. Some families need therapeutic intervention in making sense of and consolidating the untold and the told stories within their system.

I was interested in the narratives of the children, adolescents and their family members as to what events had led to the young person's referral to a mental health service and the perceptions of the families, whether talking within a group had reduced the concern of the parent/professional, the risk factors surrounding the young person and contributed to improving the relationship between the child, adolescent and the adults within the family system. I wondered about how the interaction between therapist and client within the group would inform the extent to which the untold, unheard stories would be told within this forum and how new narratives could be co-created in order to create the change that would assist the family in adjusting to their bereavement and knowing how to continue life without the person who has died. I would argue that it is fair to say that if grief is prevented, halted or affected in any way by and within the family system, it will show itself in the child or adolescent's behaviour. Thus I hoped that the research would generate new meanings, greater knowledge and further explanations as to why some bereavements are more difficult to cope with than others and whether communicating with other families within a therapeutic group would assist in deconstructing the complexity that enshrined some of the private stories that many families hold as their reality. I hoped the research would inform issues of approach, method and techniques (Burnham, 1992) in my practice and that I would learn what was not experienced as helpful.

The research project is framed around a six week bereavement group that runs every term for children, adolescents and their families, developed over six years ago by myself and another family & systemic psychotherapist.

I have focused here on seven bereavement groups where over 37 families and a total of one hundred and thirty six family members came together over a two year period and talked about the difficulties that they were having in relation to a significant loss in their lives and shared how they were coping with the death in their family, and together in collaboration with the other families and therapists/facilitators in the room began to create new stories of how they go on following their bereavement. One of my research questions queries why grief is held and maintained in a family system and the further along I went into the research, the more I observed the relationship with the unresolved issues within the family system and the child/adolescent's mental health. The objective of the research project is to reveal the way in which death has such an impact on family functioning and if complicated can pose a risk for immediate and long term mental health problems in children and adolescents. The other research question explores whether a group is an effective therapeutic intervention for bereaved children and their families.

### **“Is the group effective when a family has experienced bereavement?”**

**And**

### **“What holds and maintains the grief within the family system?”**

In this research I adopted a systemic social constructionist stance, placing importance on the participatory and the co-creational nature of the outcome of the research by all parties. The use of relationship questions, rather than statements or suggestions, is central to the systemic method (Tomm, 1988). All the participants are known to me within the client/therapist context and I have responsibility for their cases. It was necessary to pay attention to how such 'dual relationships' (Tomm 1991) are conducted as I have the position as insider researcher, facilitator and therapist. Along with the families/participants and as therapist and researcher we are both architects of the research and an audience to it. I aim to be mindful of my ethical responsibilities to them. Both the children, adolescents and their families were engaged in therapy. The term 'therapy' was used to describe the use of conversation to perturb the system of the clients, opening up space and differences to enable the

emergence of change (Bateson in Keeney 1983). The responsibility of the therapist was to 'open up space for the not yet said' (Rober 1999). I strove to employ the concept of 'systemic self reflexivity' (Pearce and Waters 1996) to consider my influence in what was constructed in the groups and what emerged from the data. I wanted to use the narrative, whether it was from the notes, videotapes of sessions, stories that the children had written or from pictures that they had drawn. I also wanted to convey that change can take place when families come together and help each other within a group setting (Yalom et al, 2005), by sharing their personal experience of bereavement within their families.

I take the position that, as Gergen (1991) suggests it is not always possible to separate the subject from the object or the knower from the known, as I was a part of all of the seven groups. It was sometimes difficult to describe what was happening within the bereavement group at the time, because of the different emotions that I may have been experiencing. I was trying to have an inner talk with myself, trying to process and manage what I was hearing and to protect myself from the pain that I was hearing (Fredman, 1997) whilst having an outer talk with the families in the room at the time. I feel that I am now in a better position to describe and reflect about what strategies were in place for the families' narratives to emerge and become more explicit within the seven groups. There was a period of adjustment of allowing the researcher to come from within and help me to identify where the moments of change were and to mark the occasion when a family realised that the manner in which they were grieving was affecting the child/adolescent and their family system. By assuming the researcher role, I was also able to detect and indicate what practice was contributing in bringing forth those moments.

I used a form of Thematic Analysis ( Braun & Clarke, 2006) to identify the themes that emerged within the narratives given by the children, adolescents and their families within all the groups and analyzed using aspects of Co-ordinated Management of Meaning ("CMM") (Pearce 1976; Cronen, 1999), within a social constructionist frame (Gergen, 1999). "CMM" has been used as the frame to construct and study the main stories within the data and ultimately it will illustrate the way the participants attending the group think about themselves and reveal who they are and the way that they are living (their realities). It will show how they have made sense of events, objects of their social worlds-selves, relationships, organisations, culture and episodes (Oliver, 1992) in relation to their bereavement. All of which is essential in constructing what has happened prior to them being referred to CAMHS and then onto the bereavement group that they attend. In most of the referrals it was not because someone had died within their family but because they were having difficulty processing the grief and some 'issue' or

factor was preventing that process from taking place and thus was having a detrimental effect on an individual and on the family system.

The **social constructionist** assumes that we actively and purposely construct and interpret our own realities from the meanings that are available to us. This approach is concerned with the way in which individuals are constituted by the social world; the way in which the world of language and symbols are accessible to us; the way in which we use them to construct our sense of self and our sense of our world around us (Pearce, 2001). This approach seems to fit the data that has been collated from the participants who had attended the bereavement groups. By attending a bereavement group, families were entering a public arena where their private narratives of their experience would become public and take on a new form by being a part of a group where they would be interacting with other individuals.

The **thematic analysis** is a method for identifying themes, analysing discourse and reporting patterns (themes) within qualitative data (Braun & Clarke, 2006), and involves searching across a data set. It will assist in exploring the different themes, concepts that are embedded throughout the data and will illustrate the moments where change emerges and emphasise the patterns/themes which are of interest and relate to the research question. The patterns/themes will also report the experiences, meanings and reality of the participants who attend the bereavement groups and the meaning that they have made of their bereavement as a family unit. Thus thematic analysis is also a method that works both to reflect reality and to unpick or unravel the surface of 'reality' (Strauss & Corbin, 1990).

My aim is to make a connection with my audience. When I write about bereavement, I am talking about all of our families, whether it is within the nuclear or extended family or the family and friends' network that we have. These are personal stories that have become public. The children and adolescents are informing us by their behaviour that these stories cannot be left untold as they are affecting them and they need to talk about their feelings publicly so that they can realise that they are not the only child, adolescent or family who is feeling like this. It is a certainty that within all of the seven groups, there is always more than one family who insists that they do not want to talk about how they feel because it makes them sad. It is with the same certainty that I can say that they are usually the families who have the most to contribute and often feel much better as the weeks go by. They are often the families who end up not having to come back to CAMHS. I would like this research project to help people believe that change can happen; that there is something instrumental about unpicking a difficulty in the family

or sharing an untold story which will unlock the grief and allow for something new to be created within this new family system that has to adjust to the loss of a loved one but knowing that they are ready to go on with their lives without the person who has died. I would also like this research to be a celebration of the way some families have worked together to take that first step following a death in their family towards making a difference in their families and ultimately reducing the chance of their child/adolescent developing long term mental ill health.

By listening to the children, adolescents and their families before, during and after each of the bereavement groups, I noticed that when families told their stories there was so much contention entangled in their bereavement experience. I wanted to explore the content of these arguments that were causing the difficulty because I believed that they were the underlying reasons for many of the families' distress and children's mental health.

## **Structure**

Thus I wanted to use five lenses to capture the research project. The research is divided into five parts: the first part introduces what my aims and objections are and briefly provides the background to the families (participants), the groups (therapeutic intervention), the therapist/researcher and the changes that were expected to occur from attending the groups

Part two represents the second lens that highlights the literature that accompanies some of the theories and different therapeutic interventions for bereaved children, adolescents and their families and introduces issues that arise from the review.

Part three is the third lens that looks at the methodology and the way in which the data is interrogated and introduces some of the stories that emerge from the families who attended the seven bereavement groups.

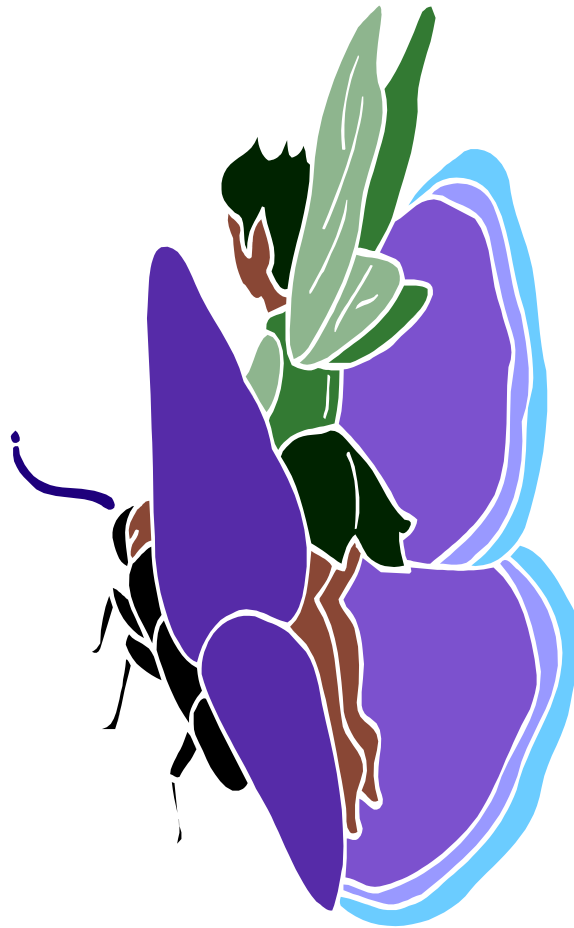
The fourth part is the intervention in the section on 'families' I explore what is meant by the concept 'family' and the affordances and constraints that arise between how a professional perceives a family and how a family sees themselves. There is discussion on some of the components that bind a 'family' together and how these interpretations fit with the 37 families that took part in the research project. By highlighting the different family structures, life cycles and family scripts I illustrate what factors influence or inform how some of the families function and the resources that they have within their unit to combat



any difficulties that arise. Then I introduce the structure and aspects of the bereavement groups as a form of therapeutic intervention which will offer some historical content to the concept of this way of working and will explain the frame of the family therapy bereavement group. This is also the forum where the children, adolescents and their families discuss the difficulties that they are experiencing in relation to a significant loss in their lives. This behaviour may take the form of extreme anxiety/sadness, poor attendance at school, depression, disruptive or erratic behaviour that puts them at risk like self harm, suicidal ideation, psychosis and eating disorder at home and within school. The majority of the referrals that are received by the Family Therapy Bereavement Group are very complex because of the unresolved circumstances around the death. For example, maybe the parents were separated and have formed new relationships, the relationship might have been abusive and there was domestic violence. For some the death was sudden, unexpected; for others the person who has died had been ill for some time. Whatever the circumstances, the child/adolescent is having difficulty in coping and the difficulty is usually within the family system that they reside in. The role of the therapist and the researcher is discussed in some detail to demonstrate the dual role and having insider and outsider perspectives and how that operates within the therapy room, within a group, identifying some of the advantages and constraints of having a both/and position of therapist and researcher. I will introduce the concept of change, and the way in which I intend to refer to it in relation to the children and adolescents within the research. I will also explore what changes have occurred in the families since their bereavement, how we understand change within the therapeutic intervention/process and within the family therapy bereavement group.

Part five focuses on the findings that have come from the data and the different themes that have arisen. These are discussed in order to see if there is evidence for whether or not a group is an effective therapeutic intervention for bereaved children and their families. Moreover what are the factors that contribute to holding and maintaining grief within a family system?

# **PART TWO**



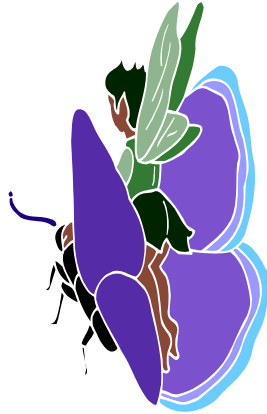
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# SYSTEMATIC LITERATURE REVIEW

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Until the 1980's, the notion of children's grief was an evolving one in the field of death/bereavement studies. Children were thought to lack the capacity to mourn (Sharma, 1996). It has only been in the last two to three decades that children have emerged as the subject of a growing body of thanatological inquiry (Barnard, Morland & Nagy, 1999). This may be partly influenced by the UK policy shift in relation to children as illustrated by the various legislation and policies that emerged during the last two decades. There has been some debate in the UK and USA about the long term impact of bereavement on children (Harrington & Harrison, 1999). There has been significant increase in the services being provided to meet the needs of bereaved children and adolescents since the late 1980's (Rolls & Payne, 2003; Akerman & Statham, 2011) and a burgeoning bereavement literature, where children and adolescents are increasingly represented in studies (Noppe 1997; Christ, 2000). However, as a result of the overwhelming growth in the past twenty years of the publication of research reports, reviews and studies, this literature review will serve as a map on a journey of information within a timeframe that is critical to the understanding of the development in bereavement and grief work with children and adolescents. It will also identify the current themes and approaches to the study of grief, as well as some of the unanswered questions and gaps in the field.

Bereavement is one of a range of difficult life events that children and young people may face. Nearly 4% of American children experience the death of a parent before the age of 18 (Social Security Administration, 2000). Over 24,000 children and young people are bereaved of a parent in Britain, approximately two children and young people under 16 are bereaved of a parent every hour of every day in the UK (Winston's Wish, 2011). That is around 53,000 children and young people every day. Many more children will experience the death of a grandparent, and, more rarely, a sibling, classmate,

or teacher during their school years. 4% of 5-16 year olds have experienced the death of a parent or sibling, this amounts to 358,300 young people every year. Around 6% of 5-16 year olds have experienced the death of a close friend of the family; this equates to 537,450 children in the UK and 13% of 5-16 year olds who have experienced the death of a grandparent, which is 1,105,000 children in the UK (Winston's Wish, 2011).

Recent studies have found that bereaved children and adolescents are more at risk of developing a wide range of mental health problems during their childhood and adulthood (Lutske et al, 1997; Melham et al 2008) and if the grief is left unresolved, such problems will develop and become more complicated and traumatic (Fauth et al.2009). Several studies have investigated the efficacy of the various intervention programmes and the extent to which they have contributed in reducing the mental health problems of parentally bereaved children (Currier, Holland & Neimeyer, 2007). Having a position of therapist/researcher within a group for bereaved children, adolescents and their families has prompted the journey to search for studies that focus particularly on intervention programmes for multiple bereaved families. The journey began with initially ascertaining what programmes were available for multiple families and how effective they were at reducing the difficulties that the families presented with. The research question has developed from a place of curiosity about what holds and maintains grief within a family system and how effective a group is in unlocking that grief. My research question: Is a group an effective therapeutic intervention for families who have experienced bereavement?

## **Background**

The search covers the development in the bereavement domain in the last ten years, the period from 2000-2010. This time frame was chosen because there were a number of policies that emerged that were paramount to the wellbeing of children and adolescents and it covers the period that I started to work in the children's mental health field. During this time there was the National Service Framework for children, a government initiative which was launched by 'Every Child Matters 2003' (HM Treasury, 2003). The aim of this policy was to commission services to promote children and young people's emotional wellbeing in Britain. There was a stipulation that all agencies and professionals work together around the physical, mental and emotional health of all children. This was followed by the Children Act 2004 that has been described by the Department of Children, Schools and Families as the legislative spine for developing more effective and accessible services focused around the needs of the child,

young person and their families. In 2009 the Social Work Task Force was set up by the government to undertake a comprehensive review of frontline social work practice and to make recommendations for improvement and reform of the whole profession across adult and children services. The Munro review of child protection was commissioned in June 2010 as part of a national drive to improve the quality of child protection, focusing on the child's journey from needing help to receiving it (www.education.gov.uk). The final report published in May 2011 made over 15 recommendations and encourages that *the Government and local authorities should operate in an open culture, continually learn from what has happened in the past, trust professionals and give them the best possible training.*

## **Objective**

The aim of this systematic literature review is to locate previous studies in my subject area and to ascertain if (and if so how well) my research topic has been covered previously. The review is an attempt to summarise some of the existing evidence concerning bereavement and different therapeutic intervention to get an idea of the benefits and limitation of a specific method (Mulrow, 1994). The systematic literature review is also an attempt to look at the body of work on the topic of bereavement and to be able to assess the treatment and intervention groups that were designed to reduce the psychological distress of children, adolescents and their families who were experiencing difficulty, following bereavement in the family system. The aim is also to undertake a thorough survey of the short term multi-family treatment and therapeutic intervention groups. *The systematic literature review will also show the process I had gone through to achieve a better understanding of myself and the research that I intend to find out more about (Hemingway, 2001).* The intention is also to see how the literature review will inform my practice and enable me to interrogate my data and *to ask myself during this process* to what degree do these groups appear during the literature review for bereaved children, adolescents and their families, and if so, how effective were they? What were the themes that were emerging from the studies and what were the explanations given for the children and adolescents having difficulty in coping with their bereavement?

*It is important to note that although my research question predated the systematic literature review it did help me to understand the findings.*

There are several reasons that have been identified by Wallace et al (2004) for undertaking a systematic review:

- To make sense of an information explosion by bringing together and exploring gaps and weaknesses in the knowledge base
- To influence decision making or legitimate action, which could include educational practice
- To generate new insights and understanding, for example by confirming or modifying theory.

A systematic review should also include 'any knowledge that exists in answer to a particular question' (Coren & Fisher, 2006); i.e. a research question. The purpose of a review is also to look in detail at a specific area and then the researcher can evaluate their own data against it. One way of conducting an effective systematic literature review is to be transparent about the process that is involved so that the reader is aware of how the review was conducted and the rationale for the decisions made. Another method is systematic mapping, a process developed to 'map out the existing literature on a particular topic' (Coren & Fisher, 2006). This process is based on a clear search question, inclusion and exclusion criteria and extensive searching, all of which will be attended to within the next section. There are differences between systematic review and maps in terms of differences in goals (Kitchenham & Charters, 2007); a systematic review aims at establishing the state of evidence, focusing on identifying best practices based on empirical evidence. Whereas systematic mapping does not study articles in detail; instead the main focus is on classification, conducting thematic analysis and identifying publication fora. Both study types share the aim of identifying research gaps. Systematic reviews show where particular evidence is missing or is insufficiently reported in existing studies. This is not possible with systematic maps. There is also a difference in process, breadth and depth. A common view is that systematic mapping is often conducted based on only the abstracts. However the abstracts can sometimes be misleading and lack important information. With a systematic review, a more detailed study and analysis of the papers is conducted, the more papers one considers the more effort is required and the validity of the results increases. A systematic map is commonly used for mapping studies which can complement a systematic review. Therefore a systematic map can be used as a first step, to get an overview of the topic area. Then the state of evidence in specific areas can be investigated using a systematic review. However, the focus on depth, empirical results and the validity that the systematic review uncovers was of high importance for me as a practitioner.

A systematic literature review was chosen for this research project for the purpose of building theories, and obtaining an understanding of my practice. It was also used to provide an unbiased, objective and systematic approach to answering a research question by finding all of the relevant research outcomes from 'primary' empirical studies, and secondary studies. Historically family therapy had a weak record of using empirical data to support the development of models and methods that have changed recently and there has been an increase in evidence base systemic family therapy practice (Carr, 2009a).



## METHOD

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The aim of searching in a systematic review is to find as many potentially relevant items as possible (Coren & Fisher, 2006). This section describes searching over 16 electronic databases from the University of Bedfordshire and NHS Athens search engines on several occasions and over a number of weeks (Table 1). Databases specific to the topic were considered, as some of them are aimed at young people, and interventions that catered for their needs. The internet was searched for websites that focused on children, bereavement, multi-family therapy and resources like Cruse and Child Bereavement Network. Some of the journals were hand searched like Group-work, Human Systems and Family Therapy that were not available electronically, but would expand the scope of material identified (Braye & Preston-Shoot, 2005). It is recommended that researchers aim for a balance between specificity (“very specific searching that may limit retrieval”) and sensitivity (“broader searching that may lead to a very extensive retrieval which will likely include a higher proportion of irrelevant information”) (Coren & Fisher, 2006).

Assia	Medline	BEI	ERIC
Psycho Info	CINAHL	Cochrane	C2SPECTR
SocIndex	HMIC	IBSS	Ebsco
E Journals	SIGLE	SSCI	Athens

Table 1: Databases searched

A range of different search terms were derived from and which would capture the research question. These included some of the main themes that had emerged to date and were mentioned in the introduction. It was important to explore as many strings of terms (i.e. multi-family group work AND bereavement, multi-family group AND loss) as possible so that search was thorough (Table 2).

## **Search Strategies (Applying key wording)**

The searching process of all the data was initially started by applying key words like multi-family group work and loss and found that there were over 8,000 results. Then, when it was narrowed down to a specific period 1995-2010, it was reduced to 4,854. Changing the search term slightly to incorporate multi-family group and bereavement gave me 803 hits, then 581 results during the period of 1995-2010 and then a lower result of 355 when the timeframe was adjusted to the last decade, 2000-2010. It also seemed appropriate to include the family therapy aspect in the search, as the bereavement group is set within a family therapy context and facilitated by two family therapists. Hence, when I searched multi-family, group work, bereavement and family therapy this produced 52 results, and then when I introduced the time frame of 1995-2010, it produced 26. In order to see if there would be a significant difference in the results, the search term was adjusted to include children's group, bereavement and empirical studies, the outcome for which was 5 results. Continuing with the theme of children, bereavement and groups, adolescent was added to the search as they are also the referred client group that attends the bereavement group, when the results increased to 19. Surprisingly, there were 304 results when the search was redefined to children under the age of 18 years and the term bereavement was used, which was primarily because bereavement and children are such large subject areas.

One of the limitations of the search was a short timeframe but it allowed me to position my research in a decade where there was a particular focus on children and adolescents and as a way of containing the search. Popay & Roen (2003) indicate that this factor can result in providing 'a thin description of identified work and a partial picture of evidence .....'. The review also restricted its search to English language material, which was not unusual but would reinforce the bias in the geographic location of journals, with primarily US and UK sources being included (Braye & Preston-Shoot, 2005).

Database	Period covered	Search Term	Results
SocioIndex/ PsychInfo/Medline, CINAHL, ERIC, BNI E. Journals, HMIC, AMED, BEI		Multi-family group work and loss	8169
	1995-2010	Multi-family group work and loss	4854
	1995-2010	Multi-family group work and loss	7,171
	2000-2010	Multi-family group work and loss	4,188
		Multi-family group work and bereavement	803
	1995-2010	Multi-family group work and bereavement	581
		Multi-family group work and bereavement	413
		Multi-family group work And bereavement And family therapy	52
	1995-2010	Multi-family group work And bereavement And family therapy	26
PsycInfo/ SocIndex	2000-2010	Multi-family group work and bereavement	2221
	2000-2010	Multi-family group work and bereavement	355
		Children's group AND bereavement AND Empirical studies	5
	2000-2010	Children and adolescents AND bereavement AND group	19
	2000-2010	Children and adolescents AND bereavement group AND Effective	4
ASSIA	2000-2010	Multi-family group work and bereavement	556

Table 2 example of searching strategy

By this stage I had accumulated a large quantity of material and felt that this would be a good juncture

to stop searching and just browse through the abstracts to ensure that they were of relevance, thus checking that keywords like bereavement or grief, death, children, adolescents, adults, family-based-intervention and treatment studies were part of the text. I would later go on to refine this selection process, but at this stage browsing the abstracts gave me an idea of the body of work that was available on bereavement and provided a foreground in which I could then contextualise my research even if at the end of the process I would not be using all that I had discovered. Popay & Roen (2003) ascertain that a systematic approach to searching for literature usually reveals that a particular body of work is more extensive than originally thought. I finally decided to use the results (355) from the multi-family group work and bereavement review from 2000-2010 as this search not only produced a breadth of materials but captured the research question and themes and produced an overall map of what the search had uncovered. Then I was able to investigate one part of the map in detail, namely the outcome of the intervention. At this stage of the process, I was not thinking about the quality of the studies that I had retrieved, that would happen later. The quantity also made the search manageable.

A similar process was used with ASSIA (Applied Social Sciences Index and Abstract), focusing on the last decade using the same search term: multi-family group work and bereavement. These produced 556 results, which were vast (see Table 2). Over 500 results were not relevant as many of the papers covered issues pertaining to death, dying and other aspects of bereavement like palliative care and focused on different types of terminal illnesses, thus only 21 articles were retained as they were relevant to the type of intervention that I was interested in and offered different and additional articles to those which I already had. Moreover, there was a vast number (51) of duplication between all the databases, with some articles appearing up to five times.

The NHS Athens database was used and seemed appropriate as I work for the NHS, to ensure that the relevant databases from different fields were covered, which was paramount. Most of the knowledge base would be addressed within the mental and physical health domains but again maybe from a palliative, treatment context, rather than intervention. Moreover, researchers and practitioners come from the various fields within the NHS and would offer different contributions to bereavement. The search term was refined to include group, families and bereavement studies, and equated to 235 results. When the term studies was removed, it increased dramatically to 5412, once again because terms like group, families and studies are large concepts and subject areas by themselves (see table

3). I was disappointed by the quality and content of the search, especially as I am an insider researcher working within the NHS and providing a service like the bereavement group. So much of what is being done on a clinical level within the NHS is not captured or represented on the NHS Athens. Braye & Preston-Shoot (2005) state ‘.....a search of the knowledge base might not uncover (all studies/literature) because it is not codified in traditional academic forms’.

At this stage I decided to browse the 5412 results in order to determine the relevance of the abstracts that had emerged during the search and to further familiarise myself with the literature that had been written on the subject area. It was not until I had begun the systematic literature review that I became aware of the body of work that existed on bereavement. Until that point I had been unaware that it was such an extensive area, but felt that this accumulated peripheral knowledge could only inform my research and widen the frame in which I wanted to place my research. At the end of this process, I decided to add the 235 results from this search to the 355 results that I had already.

Database	Period covered	Search term	Results
NHS Athens	2000-2010	Group, families and bereavement studies	235
	2000-2010	Group, families and bereavement	5412

Table 3 NHS Athens database

## **Saturation**

I continued redefining the search, using single keywords or terms and even using the phraseology that some of the articles had employed to categorise their subject area, with all the databases until the results became repetitive, producing the same articles on each occasion and any different article that did emerge did not add anything to the knowledge base as they related to other areas of bereavement like palliative care, hospices, couple therapy, parents who were bereaved of a child, which included

articles on parents who were bereaved by suicide. I knew at this point that I could stop searching and was ready to go onto the next stage because I was also becoming familiar with the data. Glaser & Strauss (1967) refer to this stage as saturation, meaning when the collection of further data does not shed any new light on the issue under investigation. This is further supported by Strauss & Corbin (1998 [1990]) who state that saturation should be more concerned with reaching the point where it becomes "counter-productive" and that "the new" that is discovered does not necessarily add anything to the overall story, model, theory or framework (p.136). At the end of searching all 16 databases, I eventually came away with 611 (235, 21 and 355) results. Further refining was necessary so the material was separated out using inclusion and exclusion categories (Table 4).

<b>Selection criteria</b>	<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
Population	Bereaved Children and adolescents up to 18 years and their families	Older adults
Intervention	Studies on various bereavement interventions and treatments.  Concepts about the impact of different types of deaths on the family and different diagnoses of grief with children	Palliative care, hospices  Trauma Grief  Large scale traumas
Outcome	How effective were group interventions?  What were the themes that were emerging from the studies?  What were the explanations given for the children and adolescents having difficulty in coping with their bereavement?	
Study design/type of paper	Empirical papers  Conceptual papers	Papers not in English
Time frame	All relevant papers since 2000	

Table 4: Inclusion and exclusion criteria

## **Inclusion /exclusion criteria**

The decision to determine what literature to include and exclude from the review was based on clear criteria. The strongest evidence comes from empirical studies (which are scientific studies with findings based on observations made about events and experiences that have occurred and been reported) that focus on different types of bereavement treatment and/or intervention that have been tried and assessed to have worked successfully with children, adolescents and their families as a group. The studies had to include children up to the age of 18 and to have taken in a range of different settings like schools, community and other institutional settings. Studies ideally would have been conducted by professionals within either clinical and/or academic departments. I was also interested in studies that had focused on the child/adolescent's grief and other theories about the long term effect of bereavement and why some families had difficulty coping and adjusting years after the bereavement had occurred, because I wanted to compare findings with my own data to see the similarities or to expand on the analysis given. I was searching for studies which focused on children and adolescents who had experienced bereavement and were showing psychological, emotional, pain and loss in their behaviour. I was also interested in how that was expressed within the family unit to build on my own observation and experience as an insider/outsider researcher (Preston-Shoot, 2009). I was also looking for studies that evaluated the effectiveness of groups and other similar therapeutic interventions that had a bereavement focus.

Moreover, there was also the aim of extracting themes that were similar to and different from the ones that I had identified within the body of my data. I also decided to include materials that were about bereaved adults, couples and parents as part of the criteria relating to participants, as very little has been written on treatment or intervention for bereaved families as a system, so I was hoping that some of the findings from these studies would recommend treatment or intervention methods for the whole family as part of their data analysis. These criteria would form my inclusion articles that were to be the material that I would later include as further reference to do my analysis.

## **Screening of Studies**

The abstracts were carefully scrutinised and categorised by attaching different coloured labels and marking them with an assortment of highlighters. Abstracts were divided into empirical, conceptual and narrative and the focus would be on assessment, interventions, treatment, theories and models of bereavement. That made it easier to know at a glance what I was going to retain and what I was going to disregard. Many of the abstracts were not always explicit and there was often an overlap with some of the categories. The labelling process was very time consuming and took over a week to complete, but it all seems paramount to the overall literature review. After the initial screening the material would be divided into three categories: an inclusion, exclusion and a maybe category using the criteria that focus particularly on intervention programmes with multiple bereaved families and the extent to which they reduced the mental health problems of the children and adolescents. It was essential to the process to be very specific about what it was I was looking for and what was to be included as it was very easy to become immersed in the literature and think that all the material was of relevance because they were on the subject area of bereavement rather than the context that was of relevance to the review. Yet at the same time, I did not want to be too rash to disregard material in case it was to be of relevance at a later date. Hence, why it seemed useful to separate the material and create three categories (table 5).

The inclusion category was a wide range of 80 predominantly empirical studies on various bereavement's interventions and complicated grief with children and adolescents. I would later need to retrieve the full papers in order to assess the quality of the research and seek evidence for the outcomes of the intervention. The Maybe category was 48 articles, mainly narratives about different experiences of bereavement and finally the 432 items which were to be excluded from the literature review pertained to various models and theories of bereavement, resources and some studies that were about older people and that were on large scale traumas that may have occurred during the last decade, for example the World Trade Centre attacks of September 11 2001. The decision to exclude any empirical studies about traumatic grief was imperative to the research project as the bereavement group did not accept those types of traumas as a part of their referral criteria (table 4). Child traumatic grief is conceptualised as occurring when children/young people's love ones die in circumstances that are subjectively traumatic, and they develop trauma symptoms which impinge on these children/young people's abilities to engage in the typical tasks of grieving (Cohen et al, 2004). These types of trauma



typically are referred to specific research teams and agencies that often emerge following a trauma of this magnitude.

However, there will be a section on child traumatic grief that is specifically linked to these children and adolescents who experience these events because CTG is also referred to within some of the studies to categorise the various symptoms that children present after experiencing a bereavement and in order to differentiate between the types of grief that some of the studies refer to as part of their findings. Moreover, some of the children and adolescents who have attended the bereavement group have seen a parent die or found a relative when they had died, and witnessed neighbours dying, or had relatives murdered, commit suicide and die other horrific deaths where they had had to identify the body of the dead relative. Therefore to some extent this area is dependant on the referral at the time and whether short term intervention is the most appropriate form of treatment for a child/adolescent that has experienced this type of trauma. Traumatic grief is a concept that is emerging in the field of bereavement, as it is only recently acknowledged that a child or adolescent may be struggling with the joint manifestation of both grief and trauma. Trauma is defined as any event that is outside of the usual realm of human experience that is markedly distressing (Mitchell & Everly 2001). In response to a grief response the traumatised person is preoccupied with the scene of the trauma and the violent encounter of death (or an experience that could have resulted in death). Traumatic grief is where a person suffers from grief as a result of a death and also from traumatic distress (Jacobs, 1999). As a service we do not define what traumatic is.

Number of included studies (Yes Pile)	Studies that may be referred to at a later date (Maybe Pile)	Number of excluded studies (No Pile)
80	48	432 (excl. duplicates)

Table 5 Exclusion and Inclusion category

## **Quality Appraisal of Included Studies**

I re-read the papers that I had retrieved and placed in the inclusion category rather than the maybe and exclude category, I was mindful that I was a single researcher and that most systematic reviews are conducted by a team. There is the potential for both human error and bias when only one reviewer screens the data at any stage of the project (Coren & Fisher 2006). At the initial stage I was unfamiliar with a lot of the literature and had not scaled down my research topic and as a result my lens was a wide one, but as I traveled along the research journey and began to understand what I was looking for and started to make the inquiry into my data with the help of my supervisor I became more reflective and aware of my biases.

Some of the studies (Brown & Goodman, 2008) were not always explicit in their design or with their findings (Ellis & Granger, 2002) and on a number of occasions I contacted the author/s (Ellis, 2002; Faber, 2007) for further clarification and to have a dialogue about what their current position was regarding the outcome of their research. I was interested to see if they thought their findings would still be applicable in today's economic and social climate, bearing in mind that some of the papers had been written in the earlier part of the decade.

Assessing the quality of the material was very challenging primarily because there is more importance placed on empirical work than any other form of evidence (Braye & Preston-Shoot, 2005) and it was not uncommon to ask myself what research was. Unfortunately like so many subject areas, there is a shortage of empirical research in bereavement which also demonstrates the gap between the research and the practice. It has been acknowledged that different fields acquire different ideas about what constitutes best evidence (Wallace et al., 2004). Bereavement is one of those fields because of the sensitive nature of the subject. In order to participate in a study, each participant has to have experienced a death. Therefore, there are numerous ethical issues to consider when conducting research within bereavement (Beck & Konnert, 2007). Due regard has to be given to the vulnerability of the participants, the usefulness and worth of the research, the risk and benefits to the participants in bereavement research, their competency to consent, and the appropriate time and method of recruitment for bereavement studies. There are very few studies that explore these ethical issues or refer to them within the body of their research. In the UK, I had to present to two ethics committee and obtain approval before I could commence the research. One of the NHS ethics committee's concerns

was whether the children and adolescents were going to be re-traumatized again as a result of my research.

Thus it is a challenge to assess the quality of research that was not a randomized controlled trial, as in most cases randomized controlled trials tended to subscribe to a standard research design, whilst other research might use a less standardized design. This was illustrated in how some of the studies were written up and what is attended to within the body of the text. There was a lack of participants' contribution and feedback and I would have liked to have seen more information about the participants and their difficulties and hypothesising about why participants were still having difficulty some years after their bereavement. The majority of the materials are from the US, with a few from the UK/Europe, Canada and Ireland (Table 6). Some of the traumatic events reported are country specific (World Trade Centre attacks of September 11 2001) but studies are arguably transferable to the UK context because death is part of everyone's life cycle. There was material from the Caribbean and Africa that was in the Maybe pile that I have retained for reference with regard to culture, rituals and different support systems that are omitted from the main material.

Country of Origin	Empirical papers	Conceptual Papers
USA	40	15
UK	12	8
Caribbean		1
Finland	1	
Canada	1	1
Ireland	1	

Table 6: Retrieved literature sources

On the first reading of the literature, I was disappointed and surprised that there were no apparent studies or evidence about multi-family bereavement groups for children, adolescents and their families, which made me even more curious about reading further to ascertain what interventions were available and what areas of bereavement the studies had focused on in the last decade. However, this systematic literature was still an opportunity to compare, consolidate and expand on some of the

themes that had emerged from the bereavement group data that I had gathered for the purpose of this research project. Moreover, it was important to be familiar with the frame in which the research project would be located and where it would fit according to the research that has been conducted within the bereavement field.

	<b>Types of Intervention Researched</b>	<b>References</b>
	Family Bereavement programmes	Goodkin et al 2001 Ayers et al.,2003 Sandler et al., 2010
Buddy	Bereavement camp for children	Faber & Sabatino, 2007
Grief counsellors	Grief groups for children	Cohen et al, 2002 Brown & Goodman, 2004 Brown et al, 2008
	Support group (adults)	Pietila, 2002 dejong-Berg, 2009 Twohey-Jacobs 2004
School based counsellors	Grief counselling	Rowling & Holland, 2000 Samide & Stockton, 2002
	Bereavement groups for children	Rolls & Payne, 2003 Christ, 2010
	Sibling groups	Moss & Raz.,2001
	Groups for bereaved parents	Twohey- Jacobs, 2004
	Therapeutic Camping	Webb, 2002 Barrett, 2004
	Family focused grief therapy	Tonkins, 1991
	Internet support groups	Wagner, 2006
	Play & Expressive Therapies	Webb, 2003, Drewes & Schaefer., 2010
	Parental guidance programmes	Ellis & Granger, 2002

Table 7: Types of intervention researched

Most of the literature referred to a wide age range of children or did not identify children's ages: where findings referred to a specific age range this was more commonly 'young people', 'adolescents', or 'teenagers' rather than say children under the age of 11 etc. There appeared to be far less literature on the impact of childhood bereavement on children's educational outcomes than their emotional and psychological wellbeing, and in particular a lack of longitudinal research considering whether there was a long term impact on educational qualifications when children reach adulthood. Generally, research on the impact of childhood bereavement or the effectiveness of interventions to support bereaved children/adolescents tended to have small sample sizes, lacked comparison groups and rarely considered how effects change or develop over time.

## A REVIEW OF THE THEMES

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Grounded theory was used as a method of analysis for the data. It is not a qualitative only theory as a code is the link between data and theory. Grounded theory begins with a research interest, the task of the researcher is to understand what is happening there and how the players manage their roles. One of the goals of grounded theory is to formulate a hypothesis based on conceptual ideas, thus generating some theories regarding the social phenomena that you are interested in observing. In this case: the multiple interactions within the bereavement groups and the families' bereavement experience. Another goal is to discover the participants' main concerns and how they continually try to resolve them. What differentiates grounded theory from much other research is that it is explicitly emergent (Glaser, 1992). It does not test a hypothesis. It sets out to find out what meaning accounts for the research situation as it is. The aim is to discover the meaning implicit in the data. As the data is collated from the group, questions were asked, what is going on here? What is the situation? How is the family managing? And as a result categories are formed (Glaser & Holton, 2004). The category then becomes a theme or a variable which makes sense of what the participant is saying.

The 80 papers that were included in the review were read repeatedly to see how each study answered the research question, then the literature was organised into first categories and then themes. As the research question has two parts to it, the initial category included the various types of therapeutic intervention (family bereavement programme FBP) that were available for bereaved children and their families and the provisions that were provided in schools and other facilities where the children would have access to support. The second category was based on the second aspect of the research question which focused on what held and maintained the grief within the family system. Thus literature in this category focused on different types of grief, the new emerging theories, the effects of bereavement and any contributory factors that prolonged the grief.

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## **THE OUTCOMES, ISSUES AND THE QUESTIONS, THAT CAME FROM THE SYSTEMATIC LITERATURE REVIEW.**

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Following the review of the studies, I would like to discuss outcomes of the different methods of intervention (table 7) and attend to some of the issues that have arisen within the literature and that are current within the field of bereavement, and are relevant to the thematic analysis of my data. I would also like to find answers to my research question and to see what has not been answered and where the gaps are.

While there was a consensus within the literature that most children, adolescents and adults do not require therapeutic intervention when they have experienced a bereavement, and go on to cope well even after sudden death (Akerman & Statham, 2011), there is an overwhelming recognition that children's responses to coping with the death of a significant person may, when unsupported and when the grief is left unresolved, become complicated and traumatic (Brown & Goodman, 2005). This grief can develop into a wide range of mental health problems as mentioned earlier. Some research has indicated that parentally bereaved children have an increased rate of psychiatric problems in the first two years after the death (Brown et al., 2008, Ellis et al., 2002). This will be discussed in further detail later in the review.



## ALTERNATIVE SUPPORT SYSTEMS

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One of the themes that emerged within the literature was that of alternative support systems. For example, in one of the studies on African American adults who were parentally bereaved when they were adolescents (Ellis & Granger, 2002), there was an indication that one of the advantages of the African American family system was the extended family relationship, that was often highly supportive during the period of bereavement and during other tragic events (Longres, 1995). Boyd-Franklin (1989) has documented that the roles of the family members are flexible, in that the family functioned as a network of 'mutual emotional and economic supports for its members and therefore in the event of a parent dying, family members would support each other significantly and adjust their roles accordingly during the grieving process. Thus it was found that African American families were more inclined to rely on informal help like their family, religious institutions and their friends for support and, in general, underutilised psychotherapeutic services. They were also less willing to visit mental health clinics which were seen as foreign and hostile places (Neighbors et al., 1998). African American families often do not want the stigma that is attached to attending a mental health clinic, which is also a common theme amongst other communities within the UK (Burnet et al., 1999; Sathyamoorthy et al 2001). Ten years on, Ellis (2010) maintains that this pattern of receiving support from within the family and the church still applies to the African American community when there is a death in the family system. I am somewhat sceptical of this view and know from practitioners and from my own clinical work in the field that African American families and the Black and ethnic minority communities within the UK do engage with services, if slightly reluctantly, and that could be said about many families at the beginning, but it is for the clinician to ensure that the term mental health is understood within the context that the child or adolescent is receiving intervention. Moreover, Ellis & Granger's (2002) study sample size was small and the participants were adults who had been bereaved when they were adolescents, which probably accounted for the perception of professional agencies and therapeutic intervention at the time.

There was a similar theme in some of the English speaking Caribbean islands like Jamaica, Trinidad, Barbados and Grenada whereby family and friends offered social support before and after the burial or cremation. Traditionally in some of these Caribbean islands, families of various religious and cultural groups come from broad geographical regions to gather together, to observe a period of mourning prior to and after the disposal of the body of the deceased (Marshall & Sutherland, 2008). These traditional

practices and customs that are linked with death and bereavement were attributed to the historical, socio-cultural and religious influence of the various cultural groups that had been a part of those societies and still reside on those islands today. Other studies have investigated the strength of social support as an important coping resource for the bereaved person and there has been some indication that it has assisted favourably in the resolution of grief symptoms (Engler and Lasker, 2000) and been associated with better bereavement outcomes in the first year of bereavement (Stylianios and Vachon, 1993). These studies are very important in the bereavement field because religion and culture has a significant role in bereavement and has to be acknowledged when working with all families, not just families from various communities. Cultural factors have to be taken into consideration. For example in some cultures, extended family members play a very significant role in a child/adolescent's life, and the death of a relative who is not a first- degree relative can still have a profound effect (Salloum, 2008).

Alternative support systems was an important aspect of the research as when a family loses a loved ones, other family members or close friends often support the bereaved child and their family system. Many of the families who attend the bereavement groups how evidence of this and some families receive support from the community, within their church and their mosques.

## CHILDREN & GRIEF

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However, despite these alternative support systems, there are studies that have found that one in five children is likely to require a referral to a specialist service (Dowdney, 2000). These children and adolescents are the ones that are the participants that we are concerned about and as a result many of studies during the last two decades have either focused on investigating or referred to complicated grief responses in children and adolescents and identifying the multiple dimensions of grief responses in children. I have made the distinction between normal, complicated and traumatic grief: complicated grief is linked to children and adolescents finding it painful to recall memories of the deceased and a preoccupation with the deceased (Melhem et al., 2004). This type of grief was associated with functional impairment, suicidal ideation, and increased depressive and post traumatic stress disorder symptoms. Since 9/11, much has been written about grief complications arising from the survivors from the loss. This type of traumatic grief was found amongst the children of parents who were killed in the World Trade Centre (Brown & Goodman, 2004) and related to depressive, post-traumatic stress disorder, anxiety symptoms and poorer coping mechanisms. In the bereavement literature much has been written about the children suffering from post traumatic stress symptoms (PTSD) and other stresses arising from violent death (McClatchey & Vonk, 2005). These are not necessarily the studies that I am focusing on, but they provide a background and context to the topic that has been focused on within the bereavement domain. However this is not to say that the children who attend the bereavement groups have not found their experience traumatic and generally as a service if a child has witnessed someone dying, or someone in the family was murdered or committed suicide it is deemed as a traumatic episode in their lives.

### **Brief background to Complicated Grief in Adults**

The concept of complicated grief linked to bereavement was originally introduced in the 90's. Since this period there have been many studies varying in sample size, types of bereavement, age, and the type of kinship with the deceased, which have demonstrated that complicated grief is different from depression and anxious forms of bereavement, and predicts mental and emotional impairment

(Prigerson & Maciejewski, 2005). In the past decades, studies (Prigerson & Jacobs, 2001) have highlighted that a syndrome of complicated grief encapsulates the protracted and debilitating grief reactions that are experienced by a significant minority. 10-15% of bereaved adults are said to have this condition. The symptoms are very severe and include chronic and disruptive yearning, pining and longing for the deceased, trouble accepting the death, excessive bitterness towards the death, uneasiness to move on, numbness and detachment, feeling that life is empty, cognitions about a bleak future and being agitated. There would also have been significant impairments in functioning for at least six months (Jacobs, Mazure, & Prigerson, 2000).

### **Child Bereavement Literature**

Dialogue is still ongoing in the child bereavement literature about defining features of complicated or traumatic grief and how to assess it (Brown et al; 2005). One of the thoughts to have emerged from research on adult complicated grief is that the same condition that exists in adults exists in children. Unfortunately, there has not been as much empirical work in complicated grief in children in contrast to the burgeoning literature on complicated grief in adults. However, the few studies that do exist have referred to children showing separation distress and yearning (i.e., typical adult Complicated Grief (CG) symptoms) as the central features of the condition. Studies relevant to this construct included a cohort of adolescent survivors of suicide (Melham et al., 2004) and another published study of a group of 7–18 year olds whose parents died from suicide, accidents, and sudden medical conditions (Melham et al., 2007). The tools that have been used to test complicated grief in children had to be modified to accommodate children and adolescents rather than adults. What was important with this study was that the mean age was adjusted from 18.3 years (Melham et al., 2004) to 13.3 years (Melham et al., 2007), the criteria for Complicated Grief also shifted to include a stronger emphasis on avoidance symptoms and to exclude searching for the deceased, as the latter would be a common feature amongst younger children who are bereaved.

### **Child Traumatic Grief**

Another category of grief that was dominant in the literature was that of childhood traumatic grief (CTG), which arose from early child development and child trauma treatment research. CTG is conceptualized as occurring when children, whose loved ones die in circumstances that are subjectively traumatic,

develop trauma symptoms, which impinge on these children's abilities to engage in the typical tasks of grieving (Cohen et al; 2002). This type of grief typically is linked to a traumatic event as the concept of the CTG has been explored by several independent research teams using a variety of cohorts, including adolescents exposed to war in Bosnia (Layne et al; 2001), and children and adolescents experiencing deaths due to a variety of causes like murder, suicide and road traffic accident and sudden death like heart attack. (Cohen et al; 2004; Cohen et al 2006; Salloum & Vincent, 1999). Studies also included preschoolers experiencing the death of parents due to family violence (Lieberman et al; 2003), and also children whose parents died in the line of duty on September 11th, 2001 (Brown & Goodman, 2005). A number of children and adolescents who attended the bereavement groups would have experienced traumatic events like murder, suicide and road traffic accidents so would fall under the category of CTG.

Therefore, childhood traumatic grief is a condition that some children develop after the death of a close friend or family member. Children with childhood traumatic grief experience the cause of that death as horrifying or terrifying, whether the death was sudden and unexpected (due to murder, suicide, motor vehicle accident, natural disaster, war, terrorism, or other causes) or due to natural causes (such as cancer or a heart attack). Even if to the adult, the manner of death does not seem to be sudden, shocking, or frightening, the child may perceive the death in this way and can be at risk of developing childhood traumatic grief. When a child is struggling with childhood traumatic grief, the child's trauma reactions interfere with his or her ability to go through a normal bereavement process. Because of the interaction of traumatic and grief reactions, any thoughts, even happy ones, of the deceased person can lead to frightening memories of how the person died. Because these thoughts can be so upsetting, the child often may try to avoid all reminders of the loss so as not to stir up upsetting thoughts or feelings. A younger child may be afraid to sleep alone at night because of nightmares about an incident that they may have witnessed, while an older child may avoid playing football because their father used to play football with them or used to accompany them to football matches. This might bring up painful thoughts about how his father died in a terrible car accident. In this way, the child can get "stuck" on the traumatic aspects of the death and cannot proceed through the normal bereavement process. It is also noted that not all children who experience a traumatic death will go on to develop child traumatic grief. Some children will be able to grieve without complications. It is still only a small number of grieving

children who can develop some symptoms that can become difficult and perhaps interfere with their daily functioning. Brown et al (2008) have identified some of the contributory factors like PTSD, anger and depression, children with previous trauma and bereavement histories, the more traumatic the death i.e. murder, witnessing the actual moment of death and the parent/carer's emotional distress can all influence a child's grieving process.

From the literature, it would appear that the groups which are researching complicated grief and child trauma grief continue to gather data using different assessment tools. There are more similarities than differences between the two concepts and both are still relatively new fields and in their infancy. Therefore, although empirical literature on CTG is emerging, our understanding of the epidemiology, aetiology, and clinical characteristics of CTG is limited (Brown et al., 2008). However, there has been an interest in the risk factors associated with developing CTG and an acknowledgement that a number of factors may increase the likelihood of children developing CTG following a death. Risk factors for CTG may be conceptualised temporally, namely before, during, or after the death (Brown et al, 2008). Risk factors could be significant in explaining why families have difficulty processing their grief and experience not being able to cope when there is a death. Before discussing some of the risk factors that might be of significance to the development of bereavement research, it is important to discuss what 'normal' childhood grief reactions are.

### **Normal Childhood Grief**

There is limited research about the range of "normal" childhood grief reactions and at what point these reactions enter into a range that could be considered severe enough to warrant clinical intervention. The literature (Worden, 1991) informs us that normal grief is associated with missing the deceased. There has also been an acknowledgement that not every child who experiences a death will develop childhood traumatic grief. Many children will experience an appropriate grieving response and in time, with adequate support, adjust to the loss of the loved one. Children experiencing normal grief usually want to talk about the person who died, do things to remember the person, and perhaps find comfort in thinking about the person. Over time they also are able to complete the following "tasks" of normal bereavement: accept the reality and permanence of the death; experience and cope with the range of feelings about the person who died, such as sadness, anger, guilt, and appreciation; adjust to changes in their lives and identity that result from the death; develop new relationships or deepen existing

relationships with friends and family; invest in new relationships and life-affirming activities; maintain a continuing, appropriate attachment to the person who died through such activities as reminiscing, remembering, and memorialisation; make some meaning of the death that can include coming to an understanding of why the person died; importantly, continue through the normal developmental stages of childhood and adolescence (Goodman, Cohen et al 2004). In some cases however, children may have enduring difficulties that interfere with their ability to function and remember the person who died in positive ways. These are the children who are referred to CAMHS, those who are experiencing normal grief but need support to work on the difficulty that is interfering with their functioning.

For children experiencing childhood traumatic grief, thinking or talking about the person who died often leads to thoughts of the traumatic manner of death. Thus it is for this reason these children try to avoid thinking or talking about the person who has died and avoid having frightening feelings associated with these reminders and as a result they are prevented from completing the grieving process without the input of therapeutic intervention.

### **Similarities between 'Normal' Grief and Child Traumatic Grief**

In both normal grief (also called *uncomplicated bereavement*) and childhood traumatic grief, children often feel very sad and may have sleep problems, a loss of appetite, and a decreased interest in family and friends. They may also develop increased complaints of physical discomfort (such as headaches or stomach aches), or they may regress and return to behaviours they had previously outgrown (such as bed wetting, thumb sucking, or clinging to parents). They may also be irritable, do risky things, be withdrawn, have trouble concentrating, and think often about death. It is when it interferes with the daily functioning that, as mentioned earlier, therapeutic intervention is warranted. Other evidence has also suggested that unresolved childhood grief is implicated in adult depression, marital breakdown and psychiatric problems (Rolls & Payne, 2003).

Risk factors for traumatic bereavement include a previous loss or multiple losses, sudden death, violent death and the child's perception that his or her own life was threatened (Brown et al., 2008). Few studies have addressed this population. Children with this condition also may have traumatic grief reactions with greater emphasis on the loss of the person, rather than on the details surrounding the

loss. Some of the children and adolescents who had experienced quite traumatic deaths (suicide, murder) demonstrated symptoms of this type of grief.



## THERAPEUTIC INTERVENTION

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Thus, it is clear from all the literature that children do grieve and some will require support and validation to mourn and move on (Wilson, 1994). Where there has been a parental death, it is often beneficial for the child and adolescents to receive some of this support outside of the family unit because family members are often too preoccupied with their own grief to provide it (Healy-Romanello, 1993). There was a wealth of studies (Table 7) on the different types of intervention and treatment for bereaved children and adolescents and parents and adults in a range of settings (Goodkin et al., 2001; Sandler et al 2003; Rolls & Payne, 2003). Within the literature, the main role and focal thrust of many of the therapeutic supports in treatment, or in the provision of services geared toward the amelioration of children's grief, was to help them engage and tolerate the experience of grieving in developmentally appropriate ways, reduce emotional or physical discomfort associated with the stress contained in this process, and make sense of the death event (Faber & Sabatino, 2007). Examples were given of interventions like grief groups for children and adolescents (Cohen et al., 2002; Brown & Goodman, 2005) within schools (Rowling & Holland 2003), hospices and community mental health settings that are able to offer counsellors and groups (Twohey-Jacobs, 2004) at the beginning of the grieving process and found to be very valuable in helping children and adolescents deal with the loss in a support group setting (Tonkins, 1991). It has helped children and adolescents to know that other children had similar feelings and reduced their negative feelings by talking in a group. By attending support groups within schools children build their own coping strategies and naturally start to support one another, feel less isolated through meeting others in similar circumstances, normalising their experience. The children also have an opportunity to express emotions in a safe place, are easier to manage in class and are less likely to become a school refuser. Some families appreciate an alternative to one to one counselling which for some children is not appropriate and for some children it is easier to talk to an adult who is not emotionally involved and is outside the family unit (Child Bereavement Charity). The children do not have to miss any lessons or come out of school to attend because some bereavement support groups are run through PSHE (Personal, Social and Health Education or via SEAL (Social & Emotional Aspects of Learning) within schools. Most of these provisions are time limited and structured and the trained facilitators are not always counsellors or therapists (Rainbowsgb.org). Thus, many of these children will not need any further therapeutic intervention after the initial support; indeed some researchers have questioned the

effect of grief counselling and have indicated that counselling may not be helpful for many children especially if they are experiencing 'normal' grief and may even have negative effects as a result (Gamino, 2002; Jordan & Neimeyer, 2003).

## **Managing Grief in Schools**

From the literature, school is a place where the majority of young people spend a large part of their lives and what they learn from staff and indeed other students may have far reaching effects (Coggan et al., 1997; Holland, 1993). Children of primary and secondary school age (5-18 years) spend a large part of their day with individual teachers, such that school has been referred to as a "secure second family" (Holland, 1993). Schools are also one of the agencies that refer children to different services when there are concerns or provide services as part of the curriculum. In the United States, school has been interpreted not just as a place of education, but as the hallmark of vital socialisation, hope for the future and providing a sense of community (Speaker & Petersen, 2000); this quality applies equally to most European schools. Rowling & Holland (2000) asserted that society has expectations of schools beyond those of academic achievement. Currently, school counsellors provide children with most bereavement support in the United States (Wass et al., 1990) and Australia (Rowling & Holland, 2000). In the United Kingdom, however, children do not usually have such a ready access to school-based counsellors although more secondary schools that are academies are buying in different support agencies ([newacademyguide.com](http://newacademyguide.com)). Studies in the United Kingdom stress the role of schools in providing support to bereaved children for "routine" deaths, as opposed to those occurring through disaster or trauma (Samide & Stockton, 2002). The ways in which schools support children going through significant loss have been described as 'reactive', such as providing counsellors in response to an event which has already happened; or 'proactive', for example providing training in loss awareness, an example being the Lost for Words project developed in the Humberside area (Holland, 2008). The UK resilience programme would be an example of a proactive response to childhood bereavement, aiming to make all children better able to deal with difficult and stressful situations; while the Targeted Mental Health in Schools (TaMHS) is an example of a reactive response (Akerman & Statham, 2011). Research has found that teachers are often assumed by others to perform a supportive role in bereavement (Rowling, 1995) and the family separation and reorganisation (Tripp & Cockett, 1998) that may follow a death. Indeed, some researchers advise that certainly many teachers may be rightly

perceived as an important contact in the student's bereavement experience (Reid & Dixon, 1999) at a time when parents may be under considerable emotional pressure. Although it is agreed that children's behaviour may be very different following bereavement and that many factors would impact on children's responses (Lowton & Higginson, 2002). There are fewer empirical studies about how teachers in Britain manage bereaved children, and as a result British teachers' experience of managing bereaved children within their classes goes largely unreported. However, there needs to be recognition that teachers are paramount in identifying and monitoring symptoms of grief and have supported bereaved children either by providing the resource/intervention on site or making a referral to an external agency.

Some of the literature has mapped in depth the UK childhood bereavement services that are available and have emerged in the last ten years (Rolls & Payne 2003, 2004, 2007; Akerman & Statham, 2011). The studies outlined the experience of children's and parents' bereavement, the experience and review of the use of UK childhood bereavement services. They found that although some had difficulties in attending group interventions, bereaved parents expressed their need for support and advice to help them provide appropriate care for their bereaved child. Those children and parents who participated in service interventions were able to describe the significant ways in which they found the experience helpful, and the ways in which this had an impact on both their internal (emotional) and external (social) worlds (Rolls & Payne, 2004). Parents in this study identified, *'services act as parenting support services by shouldering some of the responsibility for meeting their bereaved child's needs at a time when they are themselves significantly disabled'* (p.299). Services also educate parents about "normal" bereavement, and offer age appropriate advice and guidance on how to manage many of the difficulties that may arise (Rolls & Payne, 2004). Studies about the impact of grief on children and the benefits of the bereavement services support for them are limited. The bereavement services have been criticised (Harrington & Harrington, 1999; Wilkinson, 2001) about the assumptions that they have made about childhood bereavement with very little evidence to substantiate their findings. Rolls (2007) found that *'there is a paucity of evaluation literature on UK childhood bereavement services. Services have little evidence upon which to draw, or in which to situate their own service'* (p.4). Interestingly, UK childhood bereavement services appear to be extensively evaluated in terms of the quantity of evaluation. The majority of these evaluations were post-intervention user satisfaction surveys in the form of self-completed questionnaires (Rolls, 2007). The survey would have been more effective if it provided

outline of referral criteria, types of interventions and location of service. Most of the bereavement services were located outside of London. The majority of local authorities and primary care trusts in England did not appear to have specific services or plans to support bereaved children (Akerman & Statham, 2011). This does not correlate with what is happening with the wide range of interventions in the schools or services that receive and accept referrals about bereaved children but do not identify as a bereavement service. The Childhood Bereavement Network undertook a survey of all local authorities and primary care trusts in 2009, but was unable to obtain a clear picture of the support available (Penny, 2010). The low response rate to this survey despite reminders and discrepancies in survey responses, suggested that bereaved children's needs may not be recognised as the particular responsibility of any department or aspect of children's services (Akerman & Stratham, 2011). Voluntary and smaller independent organisations were not part of this survey.

Children's functioning in school is one of the many areas affected when a child experiences a death and often it is the school that will notice the change in the child/adolescent's behaviour, and as indicated above in a position to either provide or identify what support is needed for grieving children (Samide & Stockton, 2002). School is one of the agencies responsible for making a referral to a specialist agency if they feel that the child needs further intervention or if they are unable to provide the appropriate support. Research has also shown that children and adolescents are unlikely to receive constructive support from friends and teachers because of a number of factors: children are often stigmatised by their peers following the death of a parent because of their lack of knowledge about what to say or because of the discomfort regarding their own feelings (Lohnes & Kalter, 2004). Children may also have less contact with their peers following a death due to family and time constraints (Christ et al., 1993). The literature has also highlighted that even those who are in a position to help a child grieve are not always equipped to do so (Healy-Romanello, 1993; Vastola et al., 1994) and mental health professionals often fail to identify parental death as a contributory factor to a child's clinical symptoms, that may be causing distress and having an impact on their functioning (Vastola et al., 1994). Although more and more teachers are receiving training and developing awareness about what can contribute to a child's behaviour, most teachers would still require assistance from professionals when working with a child or adolescent who had experienced a death (Reid & Dixon, 1999). Therefore, having school counsellors provide grief counselling and/or making referrals to bereavement groups for children has proven to be productive. There have been various studies to find out how effective they

were (Huss & Ritchie, 1999). Some studies included adolescents who had experienced a death of a parent whilst they had been at school, but were looking back at how they had been affected at the time of the event (Abdelnoor & Hollins., 2004). Children were often reported to be feeling less negative and having a reduction in their grief symptoms (social withdrawal, depression, and anger) after they had participated in a grief group (Tonkins, 1991). Feedback from the parents and children indicated that they had benefitted from the groups. Groups were found to provide a realistic understanding of death and support at a time when maybe their friends were withdrawing. Moreover, groups also encourage increased discussions between the children and their families, which is an essential aspect for those affected by the loss (Samide & Stockton, 2002). There is also an increase of school counsellors with the introduction of the various government programmes such as Targeted Mental Health in Schools (TaMHS) and CAMHS, schools in the UK are now able to buy in a counsellor if they feel that it is a necessary resource.

### **Family Bereavement Programme**

The literature also produced various randomised experimental trials of the effects of various Family Bereavement Programs that studied adolescents who had been parentally bereaved prior and after the intervention. Family Bereavement Programmes was one of the few specific interventions for childhood bereavement that has been subjected to rigorous evaluation. The programme is designed to prevent potential mental health complications and conduct disorder (Akerman & Statham, 2011). Studies varied in the length of time that the children and adolescents engaged in the treatment. Overall, the outcome was positive in regards to reducing mental health problems and problematic grief (Sandler et al., 2010); there was also variation with the sample size and the perspective of some of the studies whereby the focus was almost exclusively on grief rather than mental health problems. However, the design of the FBP studies was misleading as I was unclear as to what constituted a family bereavement programme. The programme seemed to be targeted at the entire family, and was designed to help members about grief. In most of the studies, a typical family bereavement programme was 14 weeks, consisting of 12 groups and 2 individual sessions and participants were divided into separate groups for parents/carers, children and adolescents; rather than families being seen as a unit as I had originally thought. The programme was also meant to create a support network for families by connecting them with others who have experienced the same event, and facilitates adaptive coping through the use of a trained family advisor who has also experienced significant bereavement. (Sandler et al 2010). These

programmes were specifically for children/adolescents suffering from problematic grief (Akerman & Statham, 2011), as within the literature these groups are referred for those with 'complicated', 'problematic' or 'traumatic' grief; a small proportion of all bereaved children and adolescents.

With a researcher/therapist lens, I am interested in similar studies like the bereavement group that would support or provide me with answers to the questions that I have with regard to my own data. At this point I am aware of my bias as one of my hypotheses is because death takes place within the family context it makes sense that family therapy and other family intervention designed for parents can help bereaved children and parents communicate more openly and support one another (Moore & Carr, 2000; Kazak & Noll, 2004). FBP was successful for some families because it helped parents deal with their emotional issues so that they could provide the warm and supportive parenting that is so critical in facilitating their children's recovery. Outcomes illustrated that the FBP helped the children to cope and helped the surviving parent to manage stress and maintain close parent-child relationships and effective discipline at home (Silverman, 2000; Schmiege et al 2006; Sandler et al., 2003). Also in comparison with those who did not enter the programme, the improvements were still evident for those who attended the FBP at follow up, six years later (Sandler et al., 2010). The FBP studies were limited in highlighting the context of the groups in terms of their focus and what was attended to as part of the programmes. There was also a tendency to focus on the organisational aspect of the groups. The tools for gathering data were ones used for measuring problematic grief, therefore it is anticipated that participants would score highly as grief was the single focus. Therefore the outcome from these studies cannot be extended to all bereaved children and adolescents as they would not all present with the same symptoms or meet the criteria for problematic grief and would be dependent on factors like the specific meaning of the death, the child's characteristics of resilience and vulnerability, the child's stage of development and the social, cultural, and historical context in which the death takes place.

Interestingly, one of the stipulations of one of the studies (Sandler et al., 2010) was that the mental health of the parent/carer and the relationship between caregiver and child had to be 'positive'. This stipulation would inform the types of families who would be referred to this study. There were also studies that assessed psychological aspects to see whether the intervention was a contributory factor in reducing children and adolescents and their families' mental health problems (Goodkin et al., 2001;

Ayers et al., 2003). These studies suggested that there was some improvement in reducing the anxiety and depression following bereavement. Results also indicated the differences in the way that girls and boys grieve and how they expressed their distress. There was some evidence in the literature about groups of children who might be more vulnerable than others following bereavement. These include boys who lose fathers and girls who lose mothers (Abdelnoor and Hollins, 2004a). Boys in general were found in Dowdney's (2000) review to exhibit higher levels of emotional and behavioural difficulties, and Haine et al.'s (2008) review characterises boys as displaying higher level of externalising behaviours problems, while girls display more internalising problems. In a number of the studies there were indications that girls reported more persistent grief that continued over a period of time and was expressed visibly at a higher level than prolonged grief in boys where boys seem to take longer to recover from bereavement. (Silverman et al., 2000, Schmiege et al., 2006; Sandler et al 2010).

### **Bereavement Groups within the Community**

There were some studies on other groups that were available for the family like sibling groups for children (Moss & Raz., 2001) and for groups of adolescents who were imprisoned and had experienced the violent death of a friend or family member (Rynearson, 2002) and have to come to terms with the traumatic acceptance of the dying as well as the death itself and are at risk of non recovery. Many groups were for parents who were bereaved (Twohey- Jacobs, 2004), other groups were investigating the different feelings that parents and other family members may have about the way that a person may have died. For example, suicide and the effectiveness of support groups, focusing on the way in which people talk about their participation in groups after the family member commits suicide (Pietila, 2002). In the groups where children are bereaved by parental suicide, Ratnarajah and Schofield's (2007) review found that children's adjustment was influenced by several mediating factors: the child's age, personal attributes, level of family support, social environment, and economic and environmental factors, as well as how the child understood and made sense of the death. Some interventions included the use of a manual that would provide the practitioners with clinical examples of how to interact with children who have suffered the suicide of a parent or sibling (Pfeffer et al., 2002). These interventions would then provide the format of the research that would later investigate the impact of suicide on children and adolescents and the remaining family members. Harrison and Harrington (2001) found that

the impact of loss depended to an important extent on the child/adolescent's perception of how the loss had changed their lives. These studies were more descriptive in their outcome including narrative as data with parents and children talking about how they felt before and after attending various interventions and how the death of their loved one had impacted on their lives. There was a wealth of literature about parents who were bereaved and how they coped having lost a child (deJong-Berg, 2009) and the implications for professionals. Some of the studies found that the coping disposition of bereaved parents may significantly influence their overall health. Having a social support network of concerned individuals who will allow bereaved parents to discuss the experience of losing their child has been associated with improved bereavement outcomes (Wortman & Silver, 1992, 2001). Social support from friends and community sources is uniquely important in parental grief because the quantity and quality of support available from within the family may be compromised due to other family member's' grief. The opportunity to share the experience of losing a child with someone whose child also died may lessen parents' sense of shock and injustice and so lessen complicated grief symptoms (Riley et al., 2007). It was important to have a range of studies on parentally bereaved children and on parents whose child had died and to have a collection of studies on some of the more traumatic ways of dying like suicide or murder.

### **The Advantages/Disadvantages of Groupwork**

Yalom (2005, p1-19) identifies some of the benefits of group work as a form of intervention, he states that seeing other group members who are coping or at different stage (of grief) gives hope to those at the beginning of the process and who may not be managing. He also adds that there is an universality aspect whereby being part of a group of people who have the same or similar experience helps people to see that what they are going through is universal and that they are not alone. Yalom (2005, p.8-15) also stresses that group members are able to help each other by sharing information and that there can be a sense of 'Altruism' where group members are able to share their strengths and help others in the group which can increase self esteem and confidence. Yalom (2005) highlights that the group serves as a space for catharsis because by sharing feelings and experiences with a group of people can help relieve pain, guilt or stress. Other benefits include the group cohesiveness and a forum where members can develop their socialization techniques and interpersonal learning p.16-19. Group work can be a source of strength whereby receiving compliments and praise from other group members especially when coming from those who are sharing the same struggle can contribute to a member's wellbeing.



One of the most common disadvantages of group work is that therapy can be generalised and not specific to the needs of the individual. Also members tend not to receive any more attention than any other, so it is often unfocused and impersonal and for some there is the difficulty of talking in a group rather than one to one with the therapist. There is also a greater possibility of personality clashes within a larger group than with a one to one interaction between therapist and patient.

## **Therapeutic Camps**

It is extremely important to identify the studies that use groups as a form of intervention, whether the groups are based inside or outside a clinic setting. Therapeutic camping has also been viewed as a helpful (adjunct) to treatment (Webb, 2003; Barrett, 2004) and had favourable outcomes whereby children had access to open-ended therapeutic outlets to work through the wide range of emotions associated with bereavement and were able to build their confidence and express how they felt, breaking the emotional isolation that often accompanies a death. It has been recommended for normalising the child's situation and support to families. Thus, besides strengthening children's age-appropriate social skills and fostering overall positive self and social development, a major element of any therapeutic camp curriculum is to address children's perceptions and beliefs about the death in view of their cognitive capacities, while using the therapeutic camp activities to enhance their individual social competencies and developmentally appropriate autonomy to redress trauma-related distress (Faber & Sabatino, 2007). This US practice model is based on the premise that children have to engage and complete their bereavement tasks in order to reconcile, let – go - of, and adjust to their loss. There is recognition that many children attend the camp with different levels of grief. One of the studies had a 'buddy system' (Faber & Sabatino, 2007), whereby the child would be assigned an adult who would support that child or adolescent over the duration of the camp. It was the role of the clinician to guide, support, and nurture children to participate in the camp activities that would educate them about grief and invite their self expression in play while providing comfort and safety. This study used four structured group-based activities to explore children's grief. The goal of these activities was to facilitate the beginning of normative grieving and equip the children with information and basic coping skills for management of stress-related emotions. Children were invited to attend the camp without their parent/carer. Other camps had volunteers who supported each child/adolescent through the weekend. Other studies have pointed to the benefits associated with residential camps for parentally bereaved children, including reduced symptoms of traumatic grief and post-traumatic stress (Searles McClatchey

et al., 2009). Although I think it is important to have a range of services for children and adolescents, I felt that some of the camp design models were too structured and restricted as they used a manualised curriculum of different grief models (Ward-Wimmer et al 2002) as their guide and perhaps the children should have been given more space and encouragement to talk freely rather than be assigned topics and be instructed about what feelings to discuss. Although there were positive outcome results which illustrated that the camp had a positive effect on the children's functioning and the parents reported an improvement in their child's behaviour and emotional well being. Again I am aware of my bias as a systemically trained psychotherapist; however with the researcher lens I recognise that some structured programmes creates outcome measures which provide evidence for clinical research. However, it is not sufficient to say it works; there needs to be evidence to support the practice which then validates this type of intervention and demonstrates that there is a need for this type of service in all boroughs. One study illustrated that attending a residential bereavement group was associated with children's reports of feeling happier and parents' reports of feeling better able to cope (Braiden et al., 2009). There were camps where the children were encouraged to engage in activities like riding, music, art therapy, outdoor activities, swimming, dancing and storytelling, a reminder that not all children engage in talking therapy and have used different mediums to express themselves.

### **Other Therapeutic Intervention**

The literature also highlighted the emergence of internet sources whereby Cognitive Behavioural Therapies (CBT) based intervention for complicated grief was available online (Wagner, 2006). It has also become increasingly popular to have support groups on the internet. Many bereavement services have a website which children, adolescents and adults can access and join groups and chat online without the face to face contact, like Cruse, Winston's Wish, Daisy House, SOBS, Child Bereavement Charity (UK base services) which also offer those services as well as resources for bereaved children. It has to be acknowledged that talking therapy is not for everyone. More of the bereavement services provide a website for children and adolescents to access and speak to other bereaved young people. Feigalman et al., 2008 identified a number of successful support groups for suicide survivors who were gaining assistance from this type of intervention.

Play and expressive therapies were also available for children and other family members as a form of group therapy which predominantly used non verbal methods like art, creative writing and music (Webb, 2003; Drewes & Schaefer., 2010). A meta-analysis of 27 studies (Rosnera et al., 2007) found that promising treatment models were music therapy and trauma/grief focused school based brief psychotherapy. Art therapy was used frequently and there were positive outcomes, but there was very little empirical evidence as to how effective it was (Finn, 2003). Other intervention like parental guidance programs were comparing the loss of a parent by working with children before and after a parent died of cancer, focusing on risk and protective factors that mediated the coping of bereaved children, intervention during the terminal illness and the developmental grouping of children to enhance specificity and accuracy of findings and interventions (Christ & Christ, 2006). The study suggested ways to prepare families and health care professionals to facilitate children's mastery of adaptive tasks during the terminal phase of the parent's illness, at the death, and during its immediate aftermath.

There were more long term interventions that made comparisons to see the impact of the death on the children (Webb, 2001). Some interventions had been running for over 7 years, supporting children whose parents (fire-fighters) had died in the World Trade Centre disaster on September 11 2001. In some of these studies the foundation for understanding the unique family and community stressors of 9/11 that impacted the children have been well developed because of the length of the interventions and, as a result, effective stress reduction exercises suitable for use with traumatised children in bereavement groups have been presented with specific drawing and written activities to encourage the processing of feelings. The USA government has invested on every level in all of the interventions for the children and adolescents and their families whose relatives died on September 11.

## UNANSWERED QUESTIONS

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Many of the studies on children and bereavement are focused on the heightened presence of mental health problems (Cerel et al., 2006) within children and adolescents that if left unresolved can develop into complicated grief. However, there was limited discussion as to what the mental health symptoms were within children and adolescents. It was not always explicit that the symptoms that described complicated grief were similar to the ones that belonged to the mental health category, or that complicated or traumatic grief were forms of mental health. For example, Ellis & Granger (2002) identified bereaved adolescents as demonstrating loss of concentration, anxiety, thoughts and attempts of suicide, low self esteem, academic problems, identity problems, and having difficulty in family and peer relationships. These symptoms can also manifest themselves in substance abuse, gang & criminal activity (Beckmann, 1990), where it is not always apparent that bereavement is the underlying cause behind the behaviour. However, although the symptoms were described briefly, there was no immediate mention of any intervention being utilised by the adolescents or that the adolescents were exhibiting signs of mental ill health. There was an acknowledgement that these 'troubled signs' could become long term behaviour or hinder the adolescents from performing their everyday activities and may warrant therapeutic intervention, rather than informal support from family, the church and friends. Another of the gaps identified within the literature is the minimal information available regarding the frequency of black and minority ethnic children, adolescents and adults receiving or accessing therapeutic intervention (Ellis & Granger 2002).

There is a noticeable gap between research and practice in the area of bereavement (Sandler, 2005); this was visible in the material that was available during the literature search. The relationship between practitioners and researchers is not always a productive one, with clinicians ignoring research and researchers dismissing clinical knowledge and skills (Anderson, 2003). It is important to note that there have been many attempts to explain the interaction and various suggestions about how to close the gap or make it smaller. The bridge between researchers and clinicians needs to be a bi-directional one, so that information is able to flow both ways in order to improve research and practice. There was only one empirical study that had both community based clinicians and university based researchers who collaborated on a two year theory driven base evaluation of a therapeutic camp for grieving children (Farber & Sabatino, 2007). The process began with the researchers learning about the theoretical

frameworks that underpin the camp practice model and curriculum as well as researching existing literature on the specific theoretical components of the model and camps in general. The researchers also taught the clinicians about nuances of research design, instrumentation, and statistical analysis for requisite empirical camp evaluation and the clinicians teaching the researchers the nuances of the therapeutic activities in view of specific therapeutic goals. Both clinicians and researchers strove to better understand and articulate the theoretically driven practice model used for camp. Therefore, I suspect if there was a closer collaboration between researchers and clinicians, the studies would feel more connected and not so repetitive at times. This is where I feel that I am at an advantage to observe studies as I have the position of both researcher and therapist, which enables me to draw resources from both perspectives, which is paramount because of the sensitive nature of bereavement. Rarely did any of the studies discuss the longevity of the positive outcomes which was reflected in the general lack of follow ups or when studies expressed their difficulty in contacting some of the participants after the research was conducted. The studies were also weak on identifying whether the children needed further therapeutic intervention following their input. I had reservations about some of the follow up (Sandler et al., 2010) studies and the possibility of re-traumatising participants some years after the initial trial. In this case there was a 6 years gap and or, I would have appreciated a more in depth follow up and identifying how the children had managed their grief during that 6 years period and whether or not they had needed any intervention in that time or suffered a relapse. It is not uncommon for follow up to be weaker than the original study because of the participants who drop out, move out of the location with no forwarding address. Maybe a shorter time period would be more effective from the first study to the follow up. With the families who attend the bereavement groups the follow up aim to be within a 2-3 months period. I was reminded of the NHS ethical committee and their concern about re-traumatising children. Due regard should be given to service users and participants within empirical research and their experience of being a part of a study should be included at some stage within all studies.

Much of the literature does not provide sufficient explanations about why some families have difficulty processing their grief and are not able to cope when there is a death. This area is crucial in making sense of why a child or adolescent's grief can remain unresolved, and explaining that it is not always linked to the person who has died but to other significant factors within the family system. Exploring risk factors is significant in providing possible explanations as to why there is a dramatic change in a child and adolescent's behaviour, that is different from the description of complicated grief, but is visible in

the way that they express their emotions in the form of extreme anxiety/sadness, poor attendance at school, self harm, depression, eating disorder, disruptive, erratic, unusual or inappropriate behaviour at home and within school. All of which requires professional intervention of some form.

Some researchers have suggested that there are a number of risk factors that contribute to certain children and adolescents being more at risk of developing difficulty: if they have experienced a past trauma, this can make children at greater risk of developing PTSD symptoms following a current trauma (Pine & Cohen, 2002). Similarly, exposure to multiple deaths of significant others may be a risk factor for later mental health problems (Worden, 1996; Ribbens–McCarthy & Jessop, 2005). The characteristics of the death itself may provoke vulnerability factors for child traumatic grief. Among children, more violent causes of death also made the grieving process qualitatively more difficult and prolonged. Closer relationships with the deceased are associated with higher rates of suicide ideation, PTSD, substance abuse, agoraphobia, and other severe mental health symptoms among bereaved children (Brent et al., 1995; Salloum & Vincent, 1999; Thompson et al., 1998). Life threats with interpersonal violence are often associated with children' internalising and externalising symptoms, (Brown & Kolko, 1999). Studies have shown that children and adolescents find it difficult to talk about how they feel. Children who witness physical distress in their dying parents tend to have greater mental health difficulties than children who do not observe such distress (Saldinger et al., 2003).

The way in which the parent/carer coped after experiencing a death often has an impact on the rest of the family members. Parental emotional support has been found to predict children's adjustment following diverse traumatic events (Pine & Cohen, 2002). Nevertheless, following violent deaths, parents/carers tend to be less able to provide emotional support to children (Clements & Burgess, 2002). Lin et al (2004) found that children's resilience following a parent/carer's death was positively predicted by the surviving parent/carer's provision of warmth and discipline, and negatively influenced by a parent/carer's mental health. There was also an assortment of instruments that were used in studies to screen for different aspects of bereavement amongst adults like a grief evaluation measure (GEM) to assess the risk factors such as a mourner's loss, medical history, coping resources before and after the death, and circumstances surrounding the death (Jordan et al., 2005).

The role of parental and other emotional support both at the time of the death and subsequently may be crucial to children's responses. For many children, death represents the ultimate uncertainty, loss of safety and threat, and as children mature they become more, rather than less, able to understand the permanency of death, and thus more able to recognise the threat (Lieberman et al., 2003). Parents can provide a protective shield for children at this vulnerable time if they are able to contain their own emotional reactions. However, for many bereaved children, this is not the case and the children and adolescents often need more than the support that they receive within the family system.

As mentioned in the introduction, the majority of the literature has come from the US and one of the core differences between the literature from the US and the UK, and the other countries that I have mentioned, is the reference to race. The studies in the US pay attention to the ethnicity of the participants and state what percentage of children and adolescents were from different cultural groups. Obviously some of the studies were more diverse than others, but where the participants were mainly African American (Ellis & Grange, 2002) or predominantly White (Sandler et al., 2010) that information was included, although there would not necessarily be any explanation as to how the participants were chosen. This was a recurring weakness on the part of all the studies. I am aware that within the US, geographical areas are quite divided in terms of the different communities that reside there but, having said that, the same can be said about the UK. In one of the camping studies (Faber & Sabatino, 2007), the children were all African American children from the Washington DC area, but the professionals and the buddies were not all African American. Therefore, with the remaining studies if the ethnicity of the participants is omitted, then that leaves unanswered questions about the children. This section is of relevance to my research project, as the bereavement group caters to so many different cultural groups who have different religious beliefs about death, dying and bereavement. Therefore I was very attentive to the findings of the literature on the make up of groups and the context of themes that researchers/clinicians noticed in the studies.

Gender differences in grief responses have also been examined in the literature (Thomas, 1996). Girls tended to experience more emotional problems, especially depression, in response to loss. Other researchers (Stinson & Lasker, 1992) highlighted that boys tended to experience more anger and were more likely to aggressively act out. Other findings indicated that girls experienced greater mental health

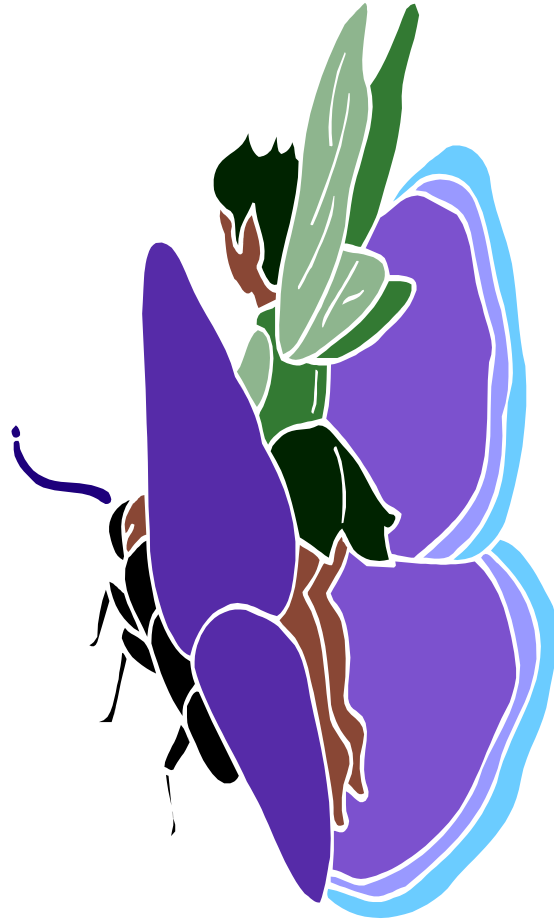
problems after parental death than boys (Silverman et al., 1999) and reported higher levels of problematic grief than boys (Ayers & Wolchik, 2006).

Socio-economic status was raised as one of the risk factors by a number of the studies (Ellis & Granger, 2002; Fauth et al., 2009) and also a factor as to why some communities did not access therapeutic intervention when they were bereaved. In previous studies, there has been an indication that within the general population, there is a consistent relationship between low economic status and low level of education/skills to mental and physical health problems (Morgan & Chinn, 1983). Socio-economic status has been identified as being a contributory factor interacting with the mourning process of children, creating a synergistic risk effect for children (Schilling & Koh, 1992).

Obviously in the countries where you have to pay for services or contend with the long waiting list of other non fee paying services, this might explain the under-utilisation of professional mental health services by many communities. This is definitely the case in the United Kingdom, where there is an overwhelming pressure on the therapeutic services and shortage of resources for low income families. Only one of the studies with African American families cited financial accessibility to be the only significant perceived reason why they did not access professional help (Healy, 1998). It was also stated that African American adolescents of low socio-economic status were expected to be less likely to have received professional help during their grieving process. No additional information was provided by the researcher about her own recommendations based on her research or what the families would have found useful.



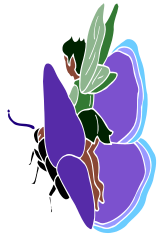
# PART 3



## The Stories behind the Data (methodology chapter)

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## MAKING SENSE OF THE DATA

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The aim was for the research project to be a camera capturing different moments of each family's bereavement experience so that I could begin to understand the events that had led to the child/adolescent's referral to the groups. In this chapter I intend to discuss how I set about making sense of my data and introduce the methods that were used to interrogate the data as part of that process. This section will also focus on how the data was collated and begin to introduce the families' stories.

Data was gathered from **five main areas** within my practice: the therapeutic conversations (storying), the therapeutic intervention (the bereavement group), the narratives/conversations (magical moments), the position of therapist/researcher and the outcome of the bereavement group (changes). By attending to these five areas the research project highlights through the conversations what some of the complex issues were for the children, adolescents and their families, who often were unable to identify what the issues were or to discuss the difficulty that surrounded the grief. I will be using examples to illustrate how the data was analysed from the research project, whether a group is an effective therapeutic intervention for bereaved children, adolescents and their families, and what factors seem to maintain grief within a family system.

I wanted to demonstrate the importance of 'the family' within the grieving process and show that some of the difficulties that they experienced were of a general rather than specific nature. These problems are not always easily spoken about either by the families or by professionals, so the difficulties can become even more complex, and develop into secrets that can bind the grief in place. Theories tend to focus on the stages of emotions like sadness, guilt, blame, denial and acceptance (Kubler Ross, 1970) rather than the relational aspects. The data will show that for the families who attended the seven groups, bereavement is not just about feeling sad because a loved one has died, it is about a range of different factors like displacement, fear, separation that will emerge from the data collated from the five

areas mentioned. The methodology will create further understanding about what these factors are and how they inform how a family interacts and talks with each other when there's a death. This chapter will concentrate on the meaning behind the tension, bringing to the surface some of the secrets, untold and unheard stories that are thought about and acted upon but never spoken about openly within the family. One of my initial hypotheses was that by having therapy within a group, families would be able to talk more effectively and encouraged to think differently about the issues that they are confronted with following the death in their family.

From a therapeutic perspective the group is a space that is aimed at providing opportunities for the families to bring some of their private (home) issues into the public (group) domain so that the conversations can begin to reveal the patterns that have been interwoven into the family scripts and beliefs. Part of the intervention was enabling the child/adolescent to air their concerns about what had happened in the family, what they remembered and what they would like to happen or see change within their family. Every effort was made so that no one was marginalised. Within the group setting, all family members were given an opportunity to talk and to tell their story, so that different stories could emerge through the stories that each family member had about each other and, in conversations with each other, new stories could be co-created (McAdam, 1995). This was an integral part of the group process which illustrated the many ways in which bereaved children and adolescents express these difficulties in their behaviour, showing that they are affected emotionally, socially and mentally (Harrington 1996; Melvin & Lukeman, 2000).

The research questions: IS THE GROUP EFFECTIVE WHEN A FAMILY HAS EXPERIENCED BEREAVEMENT? (IS A BEREAVEMENT GROUP EFFECTIVE?)  
AND  
WHAT NURTURES GRIEF WITHIN THE FAMILY?

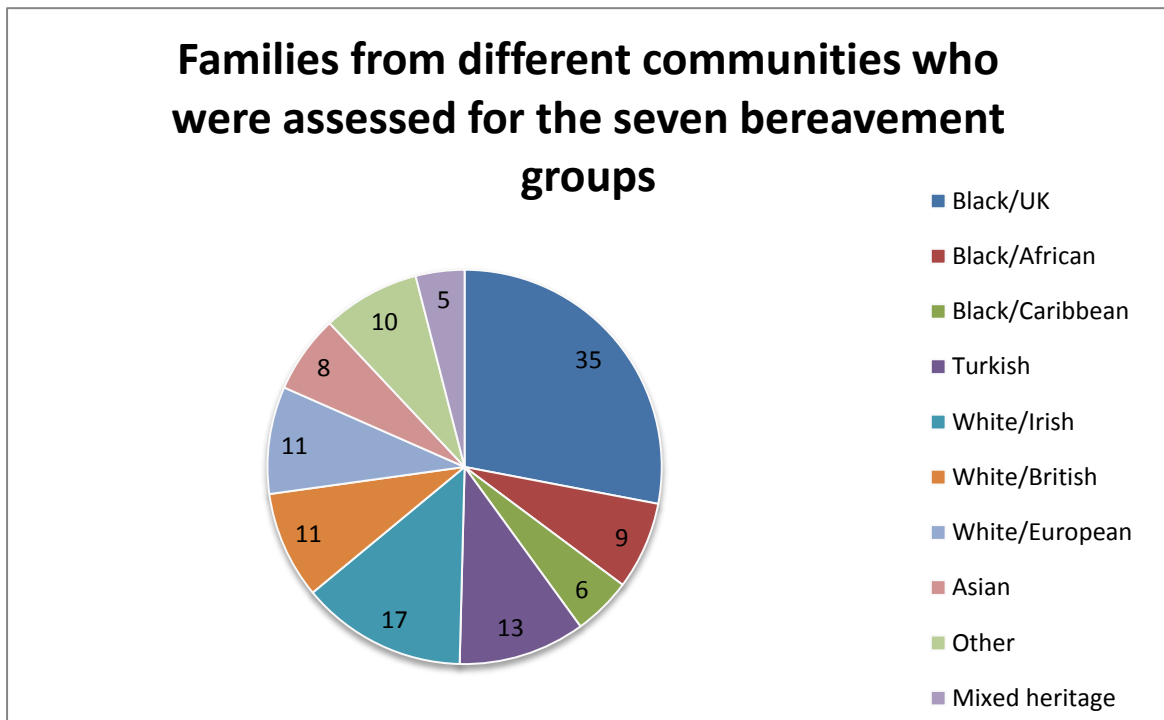
HAVE led to other questions which have arisen during the doctoral journey. From talking to the families I began to reflect about the many facets of death, what bereavement allows a person to do

differently and in what position? What are the new storylines that are brought into the family without discussion? Does a death bring out another aspect to the person who is grieving? Can an individual get so consumed in their grief that they are unable to think outside of their grief and are unable to attend to everyday responsibilities? Taking a different position in the family can create a change in the dynamics in the interactions and result in other family members feeling resentful, angry and frustrated about the un-negotiated change in positions. In the quest to uncover multiple findings and realities I recognise that there is no singular, objective truth out there but was overwhelmed at the prospect of unravelling multiple truths and realities as experienced by the children, adolescents and the families who attended the bereavement groups during the two year period. It was a unique opportunity to bear witness to so many personal accounts of what had happened before, during and after their bereavement. These are not stories that are generally told or spoken about. When a person dies it is generally thought that family members go through a grieving process and move on (Worden, 1991). However there are so many factors that can intervene and change the mood of the bereavement and create a new mood in the family, a mood that can hold the family in the same position for months or years.

## **Participants**

Starting in September 2008, 37 families, approximately one hundred and thirty six family members including the referred child or adolescent, were written to about the research project and given a month time scale to respond and a SAE. An information sheet about the research project and consent form was included. Individuals were also invited to contact me if they had any questions about the research. The NHS had a standard format that can be adapted for one's own research but it also served to ensure that a certain protocol was followed. If the families chose not to take part, then their experience would not be included in the text of the research document. Permission had to be obtained from the families so that references could be made to some of their experiences and outcomes after attending the bereavement groups at CAMHS. All of the 37 families gave their consent to taking part in the research project and to attending the bereavement groups and were assessed accordingly using the clinical rooms at CAMHS. Five families out of the 37 did not attend any of the 7 bereavement groups

which were run in the course of this research.



### **Ethics Approval**

Ethics approval was obtained from both National Health Service (NHS) and Kensington Consultation Centre foundation (KCCF) /University of Bedfordshire ethics committees. Written approval was obtained from the NHS ethics committee whereby an application form had to be completed, and I had to be interviewed by the ethics committee. I also had to inform the ethics and research department of the Trust that I worked for and follow a separate procedure. The NHS ethics committee wanted reassurance that the children and adolescents would not be re-traumatised by the research and that their wishes and feelings were considered at all times. Data would be retrieved from the children and adolescents who attended the groups and if the children became upset by the assessment or/and the treatment then they would be treated as in therapy sessions, no family would be contacted for further information. Once ethics approval was granted by both the NHS and KCC/University of Bedfordshire, participants were contacted. It was essential that families did not have to re-tell their stories again for the purpose of the research. For many of the families once they had completed their therapy they did not want to be reminded of what had taken place and the difficulties that they had experienced.

Families are very vulnerable when they come to therapy, so as a therapist you have to be mindful of the balance of power and make the relationship as collaborative as possible. Families should not feel that something is being done to them, but rather that something has been created together in therapy.

[Letters were written to the participants asking their permission to partake in the research.](#)

## **Ethics**

The issue of ethical consideration is raised as being an essential part of the process from the beginning and ethical approval was sought and given by different committees. However, it is interesting to think about the fact that group work is usually offered to people who are in some sense vulnerable i.e. unwell, disabled, managing their lives with difficulty, engaging in problematic behaviour (criminal activities or substance abuse) (McDermott, 2005). The children, adolescents and their families are very vulnerable when they attend the bereavement group and it is the responsibility of the therapist/researcher to ensure that the participants are not re-traumatised unnecessarily and that the research therapy does not harm the participants emotionally. All family members had the choice of participating or not. Their participation has to be voluntary. However, because it is the child/adolescent who is referred and there may be a concern about risk, then therapeutic treatment from CAMHS may be a recommendation from social services, but CAMHS is not statutory. The same assessment process is conducted with all families regardless of their referrer and there is also an attempt to try and work in partnership with all agencies. Most families who are referred by social services welcome this intervention as usually the cases are not with the safeguarding team so their attendance within the bereavement group is voluntary. Receiving treatment is not dependant on them participating in the research project. Any approach was non-intrusive and not requiring participants to do more than they are comfortable with or more than is required to answer the research question (McDermott, 2005). The literature stresses the ethical issue of a person's right to service and that no person should be coerced into participating in research. Ethical considerations are prominent in participant observation, especially concerning whether consent is informed, openly given or withdrawn during the process. Special care is needed when the participant observation is in a group, in case group pressure had led some reluctant member to acquiesce (Doel & Orchard, 2007).

## **Therapeutic conversations (storying)**

Within the bereavement groups, there are multiple opportunities to create possibilities to explore some of the unspoken stories in relation to the bereavement and to discuss some of the difficulties that are reflected in the children and adolescents who are referred to the groups. The **therapeutic conversations (storying)** is the families' experience of their bereavement. Conversations highlight what sense each family member has made of that episode. Episodes can be defined as a category of events and objects in our social world (Pearce, 1994). Thus episodes are given meaning through the weaving together of strands of stories from different contexts within the groups. Sarbin (1986) argued that human beings impose a structure on their experiences and that this structure is presented both in the accounts of themselves and the experiences that they give to others, and in how they make sense of those experiences to themselves. This is a narrative structure whereby individuals organise their experience in terms of stories (Burr, 2003). In no way is this to suggest that people are living in a fantasy world or that the stories that people produce are in any way whimsical. The narrative metaphor proposes that individuals live their lives by stories, that these stories are shaping of lives, that they are real not imagined and that these stories provide the structure of life (White, 1991). The stories about and around these contexts are different for each individual and will be affected by stories from other experiences, family stories, cultural stories, stories about time and development, societal stories and life script stories (Lang & McAdam, 1995). 'Stories' provide a frame that facilitates the interpretation of the experience. It is through the stories and narratives that individuals have about their lives and the lives of others that they make sense of their experience (Bateson, 1972; White, 1991). The narrative is an organising principle whereby it is present in all manner of facets of daily life; it is present in the remembering and recalling of events and in the accounts that are told to others (Burr, 1995). The hope of the group is that all family members will be able to talk freely and that each conversation will bring forth and weave together layers of expressed hidden voices of those who are not there because they have either died, or are part of the family unit but are not necessarily attending the group. The conversations will also give some indication of what may have taken place in the family, prior to them attending the bereavement groups. The stories of concern about the children and adolescents attending the bereavement groups are often recounted from one context to another. For example, the teachers will often talk to parents/carers about how sad or disruptive the child/adolescent is in class. This is then relayed within the referral form and then told again within the initial assessment interview



with client and therapist. As part of the assessment the children are asked to describe how they feel and why they think they have come to CAMHS. I do not just depend on the professionals' construction of how a child is feeling and the reasons why they think the child's behaviour has changed. A part of the group is the 'going to and fro' in conversations so that they can share the experience of some of the events that they have had as a family and what has led to the referral to CAMHS in the first place. Shotter & Katz (1999) explain this 'to and fro, back and forth, relationally responsive movement' as a dance where something occurs in the interaction between two or more living beings. It is important to have all family members attending as a unit because, in the telling of stories, individuals are very selective about what is included and what is left out. The more family members that attend the group, the more versions of the stories will be told and it is at this juncture that the data is extracted and stored for later analysis. These relational conversations become the context in which new stories arise and become stories that can be lived or enacted (McAdam, 1995).

The late Michael White (2007, p.80) expanded on Bruner's (1986) proposal that stories were composed of dual landscapes – "a landscape of action" and a "landscape of consciousness". The landscape of action consisted of (a) events that were linked together in (b) particular sequences through the (c) temporal dimension – through past, present and future – and according to (d) specific events. In a story, the landscape of action would provide the individual with an outlook on the unfolding of events across time. The landscape of consciousness is significantly constituted by the interpretations of the characters in the story, and features the meanings derived by the individuals through "reflections" on the events and stories as they unfold through the landscape of action. Perception, thoughts, speculation, realisations and conclusions dominate this landscape and manifest themselves through an individual's (a) determination of desires and preferences of the characters, (b) personal and relationship characteristics and qualities, (c) their motives and their purposes and, (d) the substantiation of the beliefs of these characters (White, 1991). These desires, qualities, intentional states and beliefs become elaborated through conversations and come together and develop into 'commitments' that determine lifestyles. It is the 'private' lifestyles that need to become public in the bereavement group. The narratives that individuals construct about themselves are not private matters. As individuals we are heavily dependent upon others in the construction of the story (Gergen & Gergen, 1984). This concept is particularly important within the bereavement groups as each family member is asked to tell their story in front of other family members and to some extent the stories need to be compatible with

those of the other people who feature in the account. However, this is not always the case as sometimes, because of the event (the death), family members will have different stories, especially if they were not aware or cannot remember what other family members were doing at the time of the death or at the funeral. The stories will not be told in the same way and each family member will tell their story differently. The therapist within the group is interested in the 'difference' in the stories, as often it is those stories that contribute to the difficulty in the family. Thus it is the 'difference which makes the difference' (Bateson, 1976, p.99), and allows for an alternative to be explored and change in the interaction to begin to take place. At the end of the six weeks some families begin to change their stories in the way that they are told as the grief has been allowed to take a smaller space in their minds and other parts of their stories can be told, the stories that have been hovering underneath the surface.

### **Therapeutic intervention (The Family Therapy Bereavement Group)**

Another area where data is retrieved is within the context of the **therapeutic intervention**: 'The Family Therapy Bereavement Group', where the context and cause of the difficulties emerge and become explicit within the families within a group setting. There is a process whereby the group contributes to these conversations taking place. One of the questions to emerge is what is it about each of the groups that enables these conversations? The core of the research are the narratives/conversations (stories and different experiences) from the families that have attended the groups during the two year period and have received therapeutic intervention from a systemic approach. Samper & Garcandia (2003) describe this *'therapeutic practice as a conversational process that must bring forth and express the multiple contextual meanings that lie in the background of our clients' lives in order to understand their stories and experiences'* (p.22)

The groups provided a forum for children and adolescents to talk about what was preventing them from grieving and what is contributing to the change in their behaviour (Anderson, 2007). Some of the children talked about their feelings outside of the groups but essences of what they discussed come back into the groups. Children/adolescents are holders of lots of information. They have views and ideas; they are active participants in family life and have a lot to contribute to therapy sessions, both through what they say and what they do. The meaning that we give to a child's communication will depend on the contexts that we use to make sense of communication; personal beliefs about family,

culture and gender and professional beliefs about death and the child's developmental level (Fredman, 1997 p.22). Often they get blamed or are perceived as the ones with the 'problem' (McAdam, 1995) and the ones that are brought to see the specialist. Children are extremely observant of what is happening within a family. They are keen observers of their parents and older siblings and are aware of who does what and when. Part of the therapeutic intervention is to work with them so that they can make sense of what is happening to them and also make sense of the behaviour that has been presented in the context in which they show it and make sense of their bereavement episodes.

The way that stories are unfolded within the bereavement group will nearly always be different because of the different families who make up each group. Although as a group they come together, individually they tell their stories. Shotter's (1993) 'idea of taking into account what must be already there' in the background is an essential contributory factor to the shape that each group takes. The background refers to what each family brings into the group which includes stories about their bereavement and the way in which their family has been affected. Therefore the 'background' also shapes the context of the groups, creates the connection between the families and makes it possible for the families attending the bereavement group to 'go on' with each other, to follow 'each other' without being misled, becoming disoriented or confused', because of their shared experience. Shotter (2004) also says that this connection gives 'a voice to the ethnic characteristics that are 'already there' and hidden in each client's personal and family history. The connection will be based on their bereavement, their difficulties and the concern about their child/adolescent. This coming together gives meanings to each family's experience, particularly those untold and unheard stories (White and Epston, 1990). Each family attended the groups at different stages of their grief, thus some of the families were ready to engage and share their feelings while others were more reluctant to attend and talk about their bereavement episodes. Despite these differences each family is encouraged to begin telling their story at the same point about who has died and how they died. I was also curious to see if each family that attended the family therapy bereavement group weaved their own design, and to what extent each family's design differed from the others and if listening would influence what is then being told.

Part of the therapeutic intervention is joining the client's grammar (Wittgenstein, 1953) whether they are a child, an adolescent or an adult. This means trying to see the world as they see it, at their developmental level and using their language. Children learn in a particular way, moving from concrete operational thinking to abstract thinking (Piaget, 1954). We were aware of how each child/adolescent

was feeling and responded and questioned appropriately. The bereavement groups catered for families which can mean that babies and small toddlers attend the group. Therefore there is a need to enter their grammar by asking questions that will assist us in understanding where they are coming from and the sense that they have made of the death within their family. Children communicate in their own special unique ways (McAdam, 1995) and the space is created for them to find their voices and not have their voices silenced by a parent who may want to talk on their behalf or who is of the opinion that the child/adolescent is not aware of the family's situation or secret. By having all the family members present, listening to conversations and observing interactions, the therapist is able to detect whose voice is being heard within the family and whose is being silenced, and what meaning is given to the silence and what action is taken based on that interpretation. Nothing is taken for granted within the group and as part of the therapeutic intervention everything is questioned in order to enter the child's grammar and to listen to the voices of those members of the family who have not attended the groups, but whose presence is brought into the groups because they are a member of the family and related to the person who has died. Cecchin; (1987) maintained that as a way of understanding and working with complexity of interactions, neutrality is a necessity for curiosity. The families who attend the bereavement groups always tell stories about the members of the family who have not attended the groups. For example there may be 19 members, there can also be an additional 6 voices being brought into the group. Each group, and each family or individual who attends the bereavement group, has their own history, ways of relating and as mentioned earlier their own collection of stories. It is the collection of the stories that needs to emerge as well as the stories that have not been told and are unheard.

### **Creating New Stories**

Lang & McAdam (1995) referred to systemic story creation as a way of giving attention to the unique details of any particular group, family or individual, and connecting with the unique coherence of that group of people. Through the process of systemic story creation, curiosity (Cecchin, 1987) is raised: a sense of awe, wonder and respect for the family system and an interest in the details of each family and their unique connections of stories (Lang & McAdam, 1995). It is with this approach that the therapist, as part of the therapeutic intervention, will join the grammar of the client's world, and from within that world try to create a different story with the client – a story or stories that will enable there to

be a shift within the family and to move away from blame or guilt or whatever story or emotion that has been privileged and is causing the problem within the system. This process of joining the client's grammar and meeting the client at the place where they are is very important because families are at a very vulnerable stage and there needs to be a balance between holding onto the client's story and introducing the therapist's input as a way of creating a systemic story. The data will map some of these conversations that highlight what was happening within each family system which will assist in the process of trying to make sense of the difficulties via the stories that they tell. Boscolo & Bertrando (1996, p.46) emphasised the importance of individuals having the motivation to change things and who want to emerge from the distress, as it can be difficult (not impossible) to create a therapeutic context without it. Not all the families that attended the groups were able to imagine anything changing within their current situation. Hence, that is why it is necessary for the client to develop a trusting relationship with the therapist and the therapy where possible, so that there is the basis for the therapist to introduce new stories or different interpretations of the families' circumstances.

de Shazer (1988) also talked about the importance of distinguishing between 'customers' and 'window-shoppers' and maintained that it was not possible to conduct therapy with 'window-shoppers'. It is part of the group's stipulation that families commit to the six week treatment programme. It is very frustrating to have families who attend on an ad hoc basis or who do not prioritise it. This rarely happened but on a few occasions it occurred; families wanting to leave earlier than the finishing time. At a later stage there were discussions about the effect on the group and on the children/adolescents who had to be taken out of the group prematurely just at the point of sharing how they were feeling with the other children and adolescents. It would be fair to say that even families who are window shoppers become customers after the first week. Some of the families would say that they were only coming for the first week and would attend all six weeks despite saying how difficult it was and that they were not coming the following week. There have been some reflections as to why some families do not engage and there is really no single explanation. For some families the group is not the appropriate therapeutic intervention for them, they would prefer a one to one session, or it is too soon to talk about their bereavement and they find it too difficult to talk about how they feel. With these families, therapy may not be for them and you have to try to engage them on a different level that may involve doing home visits or being more flexible and not so rigid in approach. The level of frustration that was felt with families who did not engage (at the early stage of the bereavement group) has been replaced with a

more thoughtful approach and more considerations has been given and a tailored approach has been adopted over recent years to meet the needs of the families who are bereaved. The more that I have gained confidence in my skills and ability to work therapeutically with bereaved children and their families, the more I am able to work at their pace and meet them where they are at with their grief and not try to drag them to where I think that they should be. For example, families now have a longer assessment and when they are ready then they attend the bereavement group. There is recognition that there are families who will never attend the bereavement group and may benefit from family therapy sessions where the adults and children are seen separately and together as part of their intervention. The outcome is families feel more secure and empowered and engaged better as a result. Out of the 37 families assessed, 5 (24 family members) did not attend the bereavement group. This figure does not include the three families that attended but did not complete the six weeks.

## **Moments of Change**

The **conversations extracted from the bereavement groups** will encapsulate the themes that will later form the data. This part of the research will ultimately concentrate on what has been created within the context of the groups that contributes to the children and adolescents and their families being able to go on and how that is being talked about in the families. It will celebrate the magical moments when change takes place, the change that enables the families to go on. These moments are also commonly referred to as the 'aha' moments, described as an instant at which the solution to the problem becomes clear, a sudden understanding, recognition or resolution. A research team in North-Western University (2004) has described the physiological response as experiencing a burst of electrical brain activity, like a big light bulb going off in your brain a split second before having an 'aha' moment. Interestingly in another study (2006) the same North-Western university research team found that 'aha' moments tend to occur in the prepared mind; in other words, if we are open to change and maybe looking for some kind of change, then 'aha' moments are more likely to happen. This connects with Boscolo & Bertranda's (1996) idea of individuals being motivated to want change in their lives and move away from the problem. Wittgenstein (1953) talked about how we only know something when we know how to go on, how to act with that knowledge. McAdam (1995) supports this view as she believes that when people come for therapy the change has already happened but they do not know how to live it in

practice. It is the therapist's responsibility to pick up on the changes that have happened within the family and develop them as part of the therapeutic process.

These moments of change, McAdam (1995, p.185) says, can be done as a lived experience within the therapy session. She refers to these moments as '*catching butterflies*'. The butterflies represent the changes that have emerged from the '*chrysalises of stories*' lived but not yet told. It is part of the therapeutic intervention to be aware of these '*butterflies*', '*seeing them and enjoying them and exploring their beauty*' (p.185). McAdam (1995) advises us as therapists to be mindful, as often these '*emergences have been lived in the past but have never been languaged. By languaging them they then become part of someone's history as well as their future*' (p.185). The act of articulation is paramount for these butterflies to emerge.

These moments have also been referred to as '*momento bomba*', a description that illustrates the significant moments that occur in dialogical interactions with families and which Samper & Garciandia (2003) referred to as '*a moment where new meanings burst forth from within the conversations, and where the explosion of new understandings that follows allows the family to move on*'. These moments are also known as '*transformative microevents*' (Samper & Garciandia, 2000) that can change the course of therapy and inform the way that the families interact with each other around the bereavement. It symbolises the beginning of a family's understanding and transformation that helps them to reorganise their experience in a new way. Interestingly, the metaphor '*momento bomba*' is what removes the stuckness, enabling the families to become unstuck.

When using the term 'moving on' I am not suggesting that there is a time frame or that families have to forget their past and move on. The bereavement group offers opportunities for families to come and talk about the person who has died and to celebrate moments with us as part of the therapy. Wingard (2001 p.2) maintains that dealing with the grief is not about moving on and forgetting. It's about remembering the person who has died, and bringing them with us wherever we go. She claims that '*there are those who say, 'We've got to forget about the past and move on'. That's fine to a point, but I think we have to acknowledge the events that happened in the past that had an impact on our grandparents, our parents, and, whether we acknowledge it or not, on ourselves. When people say, 'Forget the past', they're asking us to leave a lot behind. They're asking us to desert our old folks. We cannot move on and leave them behind - we must bring them with us wherever we go*' (p.2). Although Wingard (2001) is referring to the aboriginals in Australia who have suffered genocide and are experiencing social and

economic problems, this view is one that is echoed in all of the bereavement groups, family members saying that they can't move on, or they do not want to forget and we tell them that is not what we are asking them to do. Wingard (2001, p.2) recommends that '*We simply have to find ways of grieving together because it's far too hard to do it on our own*'. Families have told us over the years that it has felt better sharing their grief in a group with people who have experienced a bereavement like themselves and who have been referred to CAMHS.

### **My position as therapist and researcher**

Working within constructionist framework, knowledge is constructed within the social world; it is constructed out of our interactions with others (Penman, 1994). Communication creates the social world for the therapist, researcher and the families who are a part of the process. Within this research project, I have positioned myself as the therapist and the researcher. Penman (1994 p.4) states that it is '*in the very act of participation that we are influencing what we set out to know.....with our conversations we are always changing our understandings*' (p.4). Hence, as the therapist and researcher I am a part of the change because I am a part of that interaction and a part of the group.

However, as a therapist I am mindful of what I bring into the sessions. McAdam (1995) says that it is difficult to bring nothing, as no individual can be completely neutral; hence the importance of working within a team, working as a therapist with other therapists observing behind the two way mirror and receiving regular supervision. Each question that is asked has a hypothesis or a prejudice behind it. In the position of therapist and researcher we have to be aware of and reflective about what we bring forth and what we are contributing to the co-creation of the client's reality and that of the children and adolescents in particular. The questions are informed by our professional and personal stories, even when striving to have a 'not-knowing' position (Anderson & Goolishian, 1992) in relation to the families. An awareness of the inequality of power should always be at the forefront of the therapist/researcher's mind, as potentially power can be used to create a monologue, telling people how to live their lives. Working collaboratively is very user friendly where dialogue is created where children and their families can tell us about their lives (McAdam, 1995). The 'professional self' cannot be separated from the 'personal self'. As a therapist, as well as listening attentively to the client, you are also listening to your own 'voices', and you cannot ignore your past experiences (Boscolo & Bertrando, 1996). Thus the



questions and comments raised by the therapist should be informed by what the client is saying. Having inner talk is part of being a therapist, always asking oneself 'what exactly is the client telling or implicitly asking me at this moment? How does this relate to the previous session and what do the client's words and expressions indicate about what they are thinking and feeling?'. As the therapist in the group, a listening stance is adopted towards what the families are saying, connections are continually being formed all the time. In the bereavement groups there was always a public acknowledgement when there was a shift in a family; comments are made when there was a change, sometimes by the therapist and sometimes by other group members.

Neutrality has been identified as being central to the development of a moral position (Hedges & Lang, 1993). It is important that the therapist within the group does not impose upon nor 'colonise' the families with their ideas and ways of thinking about bereavement. It is useful for the therapist to reflect and be aware of the influence that they can have on a family within a session (Selvini et al., 1980) and families should never be able to identify the therapist as having sided more with any family member than with another. Here Cecchin (1987 p.405) asserted that it is 'the creation of a state of curiosity in the mind of the therapist' which facilitates the development of 'multiplicity and polyphony' of explanations, punctuations and descriptions. The therapist is not interacting with the family or learning their grammar. Instead the focus is on each family member's language because there is a recognition that for every situation there will be many interpretations and therefore not just one voice but many diverse voices telling that story, a multi-verse. Each version is significant and is regarded as the true representation as there is no one version of the truth, which is why curiosity is core to the interaction with the participants in the group. This is what you are aiming for within the group setting, with so many different individuals who are at different stages with their grief. Each version represents a piece of the puzzle of the problem in the family, thus the environment needs to be created so that the pieces of the puzzle can emerge.

Depending on what position is being privileged, different lenses are worn. For example, as therapist I am continually exploring meanings given by families and the de-construction of the 'how' and 'when' of events, difficulties and referred problems. There is also a focus on the 'memory of the past' (Boscolo & Bertrando, 1996) which will inevitably relate to the person who has died in order to look for connections to and continuity with the client's future and present situation. John Burnham (2004) states that naming

one person in the relationship as ‘therapist’ doesn’t automatically make it a ‘therapeutic relationship’ and he stresses the importance of developing self-reflexivity as a process whereby the therapist *‘makes, takes or grasps an opportunity to ...observe...listen to ...question the effects of their practice, then to use their responses to their observation/listening to decide ‘how to go on’ in the particular episode or session’* (p.3). The practice of self-reflexivity ‘tends to emphasise the internal activity’ of the therapist, as they search their own resources’, which includes as mentioned earlier the ‘inner talk’.

This reflexive process is also referred to as ‘checking out’ or ‘talking about talk’ (Dallos & Stedman, 2009). This has been a significant part of the role of therapist within the bereavement groups, especially as the group was formed by us and piloted by myself and my colleague. Our development and growth as therapists within a group setting with clients who have been bereaved has been continuous on many levels over the six years and with each group. Lang & McAdam (1995) talk about having a series of basic premises arising out of a) cultural beliefs and practices, b) our personal prejudices, c) our professional training, d) our moral positions in relation to certain strongly held views about life, e) our assumptions about what is mentally healthy and unhealthy, f) our beliefs about the way families or other professionals should behave, and g) emotions that are or should be felt as appropriate to particular situations. All of these can inform who we are as therapists inside the therapy room. It is important that as therapists we do not become fixed about what we think is the truth. Potentially there can be ethical issues when you have the position of therapist/ researcher’, and an insider/outsider perspective and consideration needs to be given to how decisions are made, and what sacrifices are made, and whose needs are prioritised- the therapist/researcher’s, the participants’ or the agency’s? For a number of reasons both I and my co-worker received external supervision for the work that was carried out within the bereavement groups, someone who was not connected to CAMHS in any way. At the time there was an acknowledgement that the work was specialist and skills that were needed could be obtained from outside of CAMHS, no one in CAMHS could provide bereavement supervision at the time. Both I and my co-worker thought of a family therapist who specialised in bereavement work and then made the necessary contact. It was essential that we looked after ourselves and took time to talk about our practice and how we were coping with the referrals that we were getting. It also helped to have a supervisor who did not work in mental health to offer different perspectives and have an outside lens. As a result of the insider position it was difficult to see from outside of the groups.

The position of Insider/Outsider (Preston-Shoot, 2009) posed many challenges. For example, there was more of a commitment in running the group every term because of the research element as more opportunities would be presented to gather more data and more outcomes. Prior to that the timing of the groups was not always so rigorously planned due to the other work commitments and because planning, assessing and facilitating the groups over six weeks was very tiring and demanding and everything to do with the group became our sole responsibility.

Therefore, 'any act of participation in communication brings about change in understanding (Penman, 1994). Thus change is inevitable for me (the researcher/ therapist) and the families who have attended the bereavement groups. In orienting to the practice, my focus as a researcher and therapist is on the construction of formative activities in the space between people (Shotter, in press); and what happens in the "elusive moments of human communicatings" (Dervin, 1993, p.53). *In looking at the elusive constructed moments, as both participants of the group, and as therapist and researcher, we can choose to look forward or backward* (Penman, 1994, p.4). Both have affordances and constraints; to look backwards will lose the moment and Penman (1994) says that the 'momentum of conversation is forward'. In looking forward, we are presented with the unfolding of options. As therapist and researcher, there is a moral responsibility to create opportunities for the possibilities of change to take place and if change is to come it should be for the good of the participants in the process. I am as involved as the participants (families) in the construction of a mutual social reality. Thus, it is only in the positioning as therapist and researcher that I am able to be reflective of the process we are engaging in, which means that I am researching and creating the practice that I am a part of. By participating we are influencing what we set out to know. McDermott (2005) maintains that '*everyone in the group becomes both participant and observer, power shifts as meanings are constructed, negotiated, challenged or allowed to prevail*' (p.36). McDermott also talks about the location of the researcher, either being a 'researcher - only' and 'outsider' or a 'practitioner- researcher' and 'insider'. With this research I have adopted the position of 'researcher practitioner', and doing 'insider research' having a view from inside. These locations can '*obscure an element of what is happening as well as enrich our perspective*' (p.44). From this perspective the researcher may focus on the group and work from the perspective of the group-as-a-whole, as a unit, in order to observe the relationship between the participants in the group that may account for the changes that have occurred as a result of the intervention. McDermott (2005) advises the practitioner/researcher to be mindful of the limits and the

advantages of such a location and emphasises the need to be reflective and be able to step back from their practice and to be careful of remaining within a theoretical frame. Having regular supervision and working with a co-worker and implementing recording and monitoring ensured that an objective location is maintained within this dual position.

### **Recruitment for the Bereavement Groups**

All of the children and adolescents who attended the bereavement group and were participants in the research project would have gone through the standard referral process at CAMHS. The child/adolescent would have been referred by a professional from their school, doctor from a general practice (GP) or a paediatrician from an A & E department within a hospital, Youth Offending Team (YOT), social services or a health visitor. All of the referrals to the bereavement groups would receive screening within a multi-disciplinary meeting and a decision would be made as to whether it was a suitable referral for CAMHS or another agency. At this stage, various factors such as the immediate risk and the urgency of the case were taken into consideration. If the risk is too high it may be that another therapeutic intervention is introduced at that stage and the bereavement group offered at a later stage. If the decision was for the child/adolescent to be referred to the bereavement group, then the case was allocated to me as therapist or to an assessment (multi-disciplinary) group where further information was gathered. This task could also be carried out by myself or involved co-working with another clinician or conducted separately by another clinician. There could be some delay before a child/adolescent attended the bereavement group. Either way the child/adolescent or their family would be assessed by me or my co-therapist who was facilitating the bereavement group as well. Assessment for the bereavement group consisted of one or multiple sessions depending on the family at the clinic. Some families find it particularly hard to engage and need more support and intervention prior to attending the group. This can take the form of multiple visits to the family home, school and individual sessions with the adolescents and their parent/carer. Support workers were allocated to some of the families to assist them in attending appointments/ sessions.

## **Process**

The participants who were assessed came from different communities consisting of Black/UK (35), Black/African (9), Black/Caribbean (6), Turkish (23), White/Irish (17), White/UK (11), White/European (11), Asian (8), mixed heritage (5), and Other (10), (see table 1). This was reflective of the diverse cultural area of the London borough. In total there were 37 families and one hundred and thirty-five family members who were assessed to attend the 7 bereavement groups during the two year period and were a part of the research project. At the initial stage of assessment there were 50 adults consisting of 13 Males and 37 Females, there were 46 children up to 12 years of age, of whom 36 were boys and 37 adolescents aged 13-18 of whom 22 were boys (see table 2). After the families have been referred to CAMHS and have gone through the assessment stage, families then have to go through the therapeutic intervention stage (bereavement group) where they receive treatment for the difficulties that they have been experiencing. Of the 37 families that were assessed, 5 families did not attend the bereavement group. Due to the 5 families that did not attend, there was a slight reduction in the number of male and female participants. However there was still the same distinctive pattern whereby the largest groups to attend were the under 12 boys and adolescent boys in the children group and the females in the adult groups. This is reflective of the high number of boys aged 5-12 who are referred to CAMHS with emotional and behavioural difficulties. However, I was expecting a higher percentage of adolescent girls to have attended the group, as some of the literature has suggested that girls are more inclined to experience more emotional problems especially depression in response to loss. They also experience higher mental health problems following parental death (Silverman et al., 1999). The figure for the female' participants almost treble the figure of that of the men participants within the psychological services. Although men and women experience problems at roughly the same rate, women are more likely to access services when they face light or moderate mental health issues than men. It can be attributed to culture-related factors and the values and expectations associated with the specific gender roles which are endorsed by men and women. Men are viewed as not talking about their feelings and hiding their pain. The data also illustrated that it was mainly the men who died within the family and predominantly from cancer.

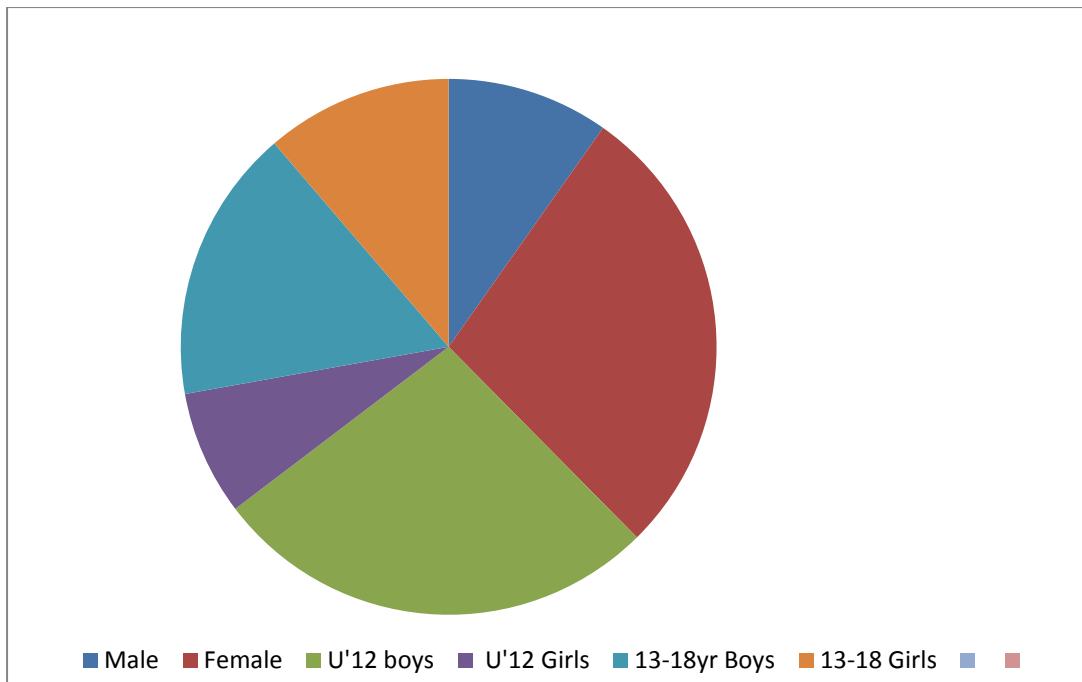


Table 2

The participants attended for six sessions on a Thursday from 3.30-5.30pm, following their initial assessment which usually consisted of one session but over time has taken longer periods so that families feel more prepared to attend a group. Every effort is made to ensure that the families do not have to wait long before attending the bereavement group. The bereavement group took place every term for six weeks. Data was also retrieved from referral forms, case notes and videotaped sessions for that period.

### Data

Data have been collated from within the context of the seven bereavement groups over a two year period. Participants contributed their narratives and experiences during the bereavement groups that they attended. The data will consist of initial referral details, notes of sessions and information from other agencies that are contained within the case files, drawings and written materials by the children and adolescents and videotaped sessions of all the groups to date. The data was obtained at three stages: **the referral stage**, where the families were referred to CAMHS, assessed by a clinician and

referred on for treatment to the bereavement group the **therapeutic stage** (six weeks short term intervention/family therapy bereavement group), where transcripts were taken from seven groups in the first and last week (the 6<sup>th</sup> week) of each of the groups, and therapeutic notes after each session; and from the **follow up stage**, where families were offered an appointment to find out how they had managed since attending the group and to discuss the next stage which was either to offer further therapeutic intervention if necessary or discuss closing the case. Before closing the case, schools would be contacted to see if there was an improvement in the child or adolescent's behavior, a recording of this telephone conversation and the school report would also be noted and placed within the case file. Owing to different therapeutic needs of the families, the follow up sessions have taken place at different intervals.

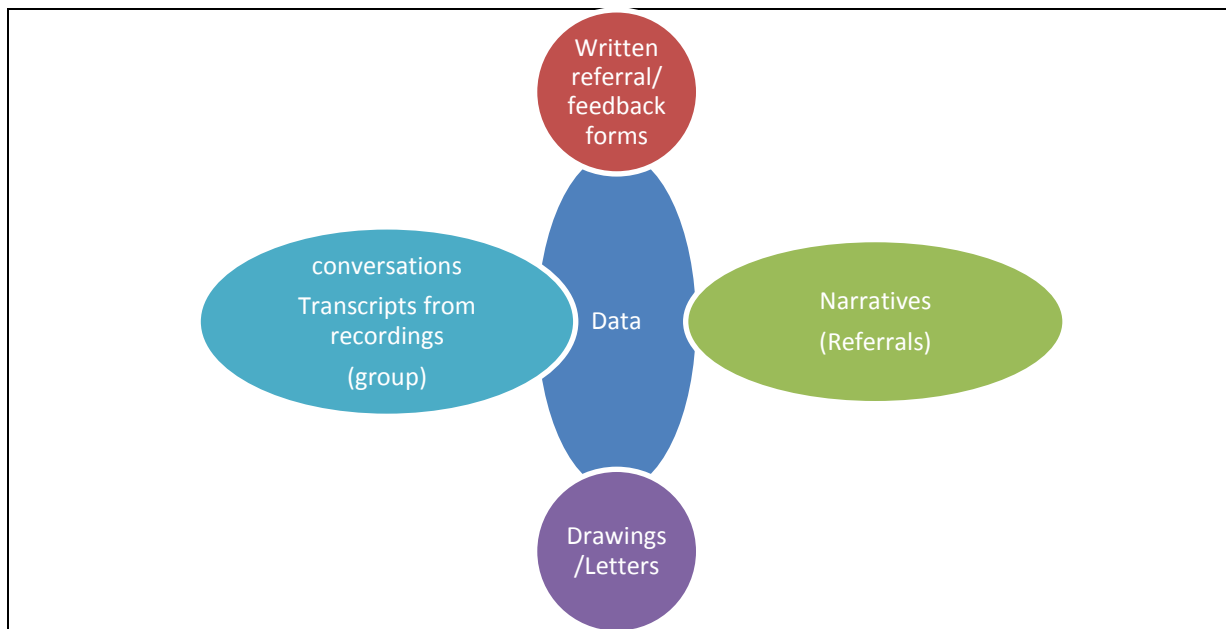


Diagram 1: The form of the data

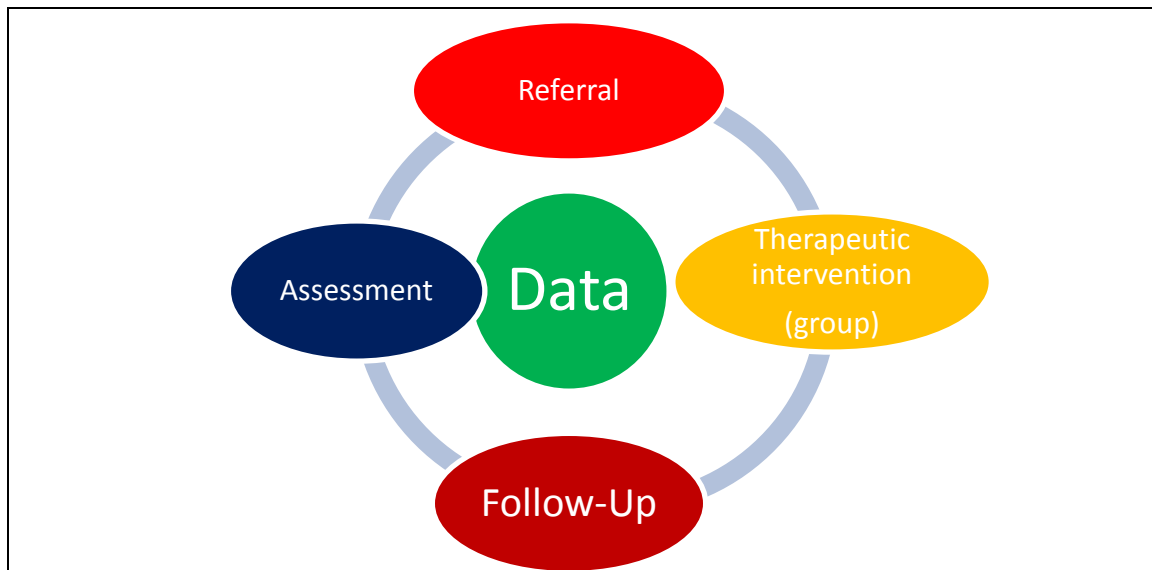


Diagram 2 different stages where data were collated.

The data were taken from the referral, assessment, treatment and follow up stages of the research project (diagram 2) and extracts read and re-read in order to identify what the potential themes were and to check for emerging patterns, for variability and consistency. Transcripts were then coded manually and collated accumulating a long list of the different codes that were used across the data set. The different codes were identified and sorted into potential themes and then finally grouped together under different themes (Taylor & Ussher, 2001). This process involved me reading the transcripts several times, each time thinking of what is being said by the families, how it's being said and who is saying it and what they might mean by what they say. This process was necessary in order to extract the necessary themes.

### **Method of Enquiry**

This is a qualitative research study (Penman, 1994; Chen & Pearce, 1995). Qualitative research involves any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification (Strauss & Corbin, 1990). It can refer to research about peoples' lives, stories, and behaviours, also about organisational functioning, social movements or interactional relationships. In thinking about how I would like to research my subject area, I have been informed by Penman's concept of psychotherapy being primary research. She describes primary research as *'involving direct participation in the conversation, in the communication process, whereby secondary*



(empirical) involves a more removed position' (p.3). Hence with primary research the researcher is participating in the very same process that he/she is researching. For example, within the bereavement group one is participating directly in conversations with others (families) and it is this conversation that is the source for understanding. Secondary research involves the collation or summary of existing research and comes from either an internal or external source, not a research subject.

My research has assumed the identity of action research (Whitehead & McNiff, 2006). Carr (2006, p.428) refers to action research as practical philosophy as it takes 'ethically informed human practice as its unique object domain'. It is also 'a form of reflective enquiry undertaken by practitioners in order to improve their own practices, their understanding of these practices and the situation in which these practices are carried out' (Kemmis, 1998, p.42). Action research refers to the practice and checking that my practice was progressing in the way that I wanted it to. It involved me thinking about and reflecting about the way that I was working within all of the groups (McNiff, 2002). This doctorate has included enquiring into my practice as a family therapist which is an integral part of this research as I have the role of researcher and practitioner. This form of self reflection enables me to change aspects of my work practice and explore some of the meanings behind my actions and words. The process created the space for me to ask myself why I was doing the things that I did and why I had taken certain positions in the bereavement groups and with different families (Lomax & Whitehead, 1996). As the research developed, as a practitioner I was continually following through some of the ideas that I had regarding families who had lost loved ones and thinking about what therapeutic intervention would be most helpful. The objective is that what I am learning about myself as a practitioner informs my existing practice and creates new effective ways of interacting with the client group that I work with. The Grounded Theory was ideal for exploring the social relationships and behavior of the group that had been affected by a common factor (Crooks, 2001). With grounded theory I was focusing on the interaction between myself the researcher and the participants, the researcher perspective being part of that process. By immersing myself in the data my aim was to understand what the participants viewed as being significant and important as part of their bereavement experience. (Glaser, 1978).

There might be a change in how a group is organised depending on what is learnt from the previous group. Patterson & Higgs (2005) also claim that hermeneutics is the most appropriate research approach for studying 'judgement artistry in professional practice, as it is best viewed through an interpretive lens rather than an empirical' (p.4). Hermeneutics has been described as 'the theory and

*practice of interpretation*'. I am interested in adapting the 'hermeneutic circle' in order to '*understand the whole through grasping its parts, and comprehending the meaning of the parts divining the whole*' (Crotty, 1998, p.92). The hermeneutic circle of reflective dialogue will allow me to deconstruct how the whole contextualises each of the parts. This involves repeatedly returning to the data/ research question again and again, each time with an increasing understanding and a more complete interpretative account of what has happened in the family since the bereavement and how different events may have contributed to the family's conflict. Collating all the conversations and fitting them with the research question in order to make meaning of the data is part of that process. Moreover, by focusing on the conversations and all different forms of interactions at the pre-group, beginning and end of group there will be further opportunities for more 'momentos boamba' to take place within the family therapy bereavement group.

### **Methods of Analysis**

The collated data will be analysed using a mixed methodology consisting of Thematic Analysis and Co-ordinated Management of Meaning ("CMM"), (Pearce 1976) within a social constructionist frame (Gergen, 1999). The decision to use these different methods was determined by the research question, the data and the meanings which might emerge from the findings. The aim for this section is for the (transcripts) extracts to be embedded within an analytic narrative that will illustrate the story/stories that I want to tell about my data and to make a compelling argument in relation to my research question.

The **social constructionist** assumes that we actively and purposely construct and interpret our own realities from the meanings that are available to us. This approach is concerned with the way in which individuals are constituted by the social world; the way in which the world of language and symbols are accessible to us; the way in which we use them to construct our sense of self and our sense of our world around us (Pearce, 2001). This approach seems to fit the data that has been collated from the participants who had attended the bereavement group. By attending the bereavement group, families were entering a public arena where their private narratives of their experience would become public and take on a new form by being a part of a group where they would be interacting with other individuals.

The **thematic analysis** is a method for identifying themes, analysing discourse and reporting patterns (themes) within qualitative data (Braun & Clarke, 2006) and involves searching across a data set. It will assist in exploring the different themes, concepts that are embedded throughout the data and will illustrate the 'momento bomba' (magical moments) that emerge and emphasise the patterns/themes which are of interest and relate to the research question. The patterns/themes will also report the experiences, meanings and reality of the participants who attend the bereavement group and the meaning that they have made of their bereavement as a family unit. Thus thematic analysis is also a method that works both to reflect reality and to unpick or unravel the surface of 'reality' (Strauss & Corbin, 1990).

"**CMM**" is a means of understanding the role of language and communication in the co-construction of reality; listening to the language the participants use, paying attention to what is socially constructed by them. It has been used as the frame to construct and study the main stories within the data and ultimately it will illustrate the way the participants attending the group think about themselves and reveal who they are and the way that they are living (their realities). It will show how they have made sense of events, objects of their social worlds-selves, relationships, organisations, culture and episodes (Oliver, 1992). CMM is intended to make the invisible visible. All of which is essential in constructing what has happened prior to them being referred to CAMHS and then onto the bereavement group. In most of the referrals it was not because someone had died within their family but because they were having difficulty processing the grief and some 'issue' or factor was preventing that process from taking place and thus was having a detrimental effect on the individual and on the family system. **CMM provides the frame within the context of my research for exploring what stories the participants are using to make sense of their bereavement experience (Cronen, 2001). Some of the focus of the research is observing if the change in the stories occur during or as a consequence of their co-ordinated actions with other participants in the group over the six weeks. CMM theory focuses specifically on the flow of communication between people. By telling their stories each family member notion of who they are is created within their stories and acts as explanations for the actions that follow after the death of their loved ones. It is the telling and the re-telling of these stories that the 'self' can develop in to what picture the individual wants to present to the world (Holmgren, 2004, p.45). The concept of Co-ordination has to do with the fact that our actions do not stand alone in regards to communication. Words and actions come together to produce the patterns in the 'Stories lived' (Pearce Associates 1999, p.12) and as**

practitioner you are mindful of the other side of the story. This is why it is important for everyone to tell their story.

An aspect of this co-ordination is the establishment of rules which are essentially rules of meaning used by the participants engaged in the communication to interpret or understand a particular event (Death). CMM is a valuable theory as it seeks to provide a way to clarify communication (Moore, 2001, p.4-8) and the process encourages the researcher to understand and explain particular viewpoints that the families may have.

## **Themes**

A theme captures something important about the data, in relation to the research question, and represents some level of patterned response or meaning within the data set. There were different levels of themes. Some of the codes went on to form main themes: such as, 'What has changed within the family system?' and others formed sub themes which related to emotional feelings and various concepts like guilt, blame, denial and anger. Some of the codes did not seem to belong or have any significant data. Braun & Clarke (2006) maintain that it is acceptable to create a 'theme' called miscellaneous to house the codes temporarily and advise that it is unwise to abandon anything at this stage of this process. It is important that the data within the themes should cohere together meaningfully whilst maintaining a clear and identifiable distinction between themes (Strauss & Corbin, 1990). Reading the extracts and checking whether the themes form a coherent pattern is an important part of thematic analysis. Primarily, there were two data sets representing two different stages which created different findings, which was reflective of a before and after process taken from the participants in all seven groups. Although there were two data sets, all participants went through the same process and the same type of coding was applied to the data.

The first data set produced findings about the families' experience of their bereavement (see set 1 for some examples of what participants had expressed at the referral and assessment stage prior to them attending the group). By re-reading the extracts I then grouped them under the themes which as mentioned earlier in this chapter are derived from the data and the research questions.

The intention is to give examples of what family members said, extract themes and try to make meaning from their words. The second set revolved around the bereavement group - (see set 2). In the last 6<sup>th</sup> session of all the seven groups, each participant is asked to give feedback about their experience and the group. As each person talks, the rest of the group listen, no questions are asked during this time. The only request that was made to influence the feedback is that participants try not to use one word like good or great to describe their experience. Each participant is encouraged to speak freely and take their time and use their own words.

## **Data Set 1**

I was interested in families' initial reaction when thinking about attending a bereavement group. Listening to what was said prior to the group

### **Extracts**

*I will not be coming to the group only\_ as I don't need the group.*

*I don't want to talk around people in a group.*

*I just don't want to go and it isn't going to help.*

The **theme of hopelessness** emerged, thinking that nothing or no-one could help them in their time of grief. Families are saddened by the fact that nothing will be the same without the person who has died and they were often afraid that they would have to create a new/different life from the one that they were familiar with. The enormity of death has been underestimated. There is also a fear of a group setting and telling their story.

I went on to explore what their initial reaction was when the person died, trying to identify the different emotions when they realized the person had died.

### **Extracts**

*I remember being in the house and someone screaming that he had been knocked down.....And when I got there he was just lying on the pavement.*

*I went in to wake my dad and when he didn't say anything I shook him and he was cold.*

*Yeah, but when he went to the mosque, he was expecting to see his dad as we had told him that was where his dad was and he ran around crying, looking for him*

I wanted to know why the parents/carers felt that the children/adolescents needed to see a professional/ specialist. Theme of concern and anxiety emerged within this section.

### **Extracts**

*He was alright at first, then recently his behaviour at school has changed, lashing out at school, fighting he had a three day suspension; the teachers referred him as they were worried.*

*My daughter might want to come because she was close to her dad.*

*She has already lost her mother who was murdered when she was a baby.....they never found her killer.....*

I wanted to know about their life with the person who had died.

### **Extract**

*Yes...very sick for a long time and towards the end, had to sleep downstairs as he couldn't really climb the stairs nor do anything he was in a lot of pain*

There were themes that came from some of the narratives that were shared within the groups:

### **Theme: Living with illness**

Stories of families with a terminally ill individual and how caring for an ill parent or child often meant going to the hospital as part of family routine, sharing a room with a parent or/and grandparent who was in pain. Seeing the person change physically as the illness affected their physical form.

I wanted to assess the current situation and any difficulty the family might be having

### **Extract**

*Her dad goes to the cemetery every day...he can't be around the house...Blaming each other for not taking her to the doctors sooner.*

*Now he is always touching me at night to see if I am okay, not sleeping and he doesn't want to talk about it.*

### **Theme: Blame**

Feelings of blame that some parents have when a child dies within the family and expressing different ways of coping with the grief can bring create within the couple's relationship and there's a further loss

when the father leaves the family home. Children/adolescents can also fear that the existing parent/carer may become ill and die and become anxious when the parent goes to sleep or work. I wanted to get stories about the person before they died, including stories of illness.

### **Extract**

*My wife died and I don't know what to do as she used to do everything*

**Theme: Feelings of helplessness**, not knowing what to do when the main parent/care has died and feeling overwhelmed by all the responsibility of parenting and running a house as the existing parent/carer. The existing parent has to often adjust to a shift in position from sharing the parenting to being the sole parent. .

### **Examples of data set 2**

Data set 2 provided an insight into how some of the families experienced the bereavement groups and how they felt the groups had helped with their grief if at all

I wanted to explore what the families had found difficult to bring to the group/ what were some of the difficulties in coming to the group?

### **Extracts**

It has been quite painful coming here, especially the first week,

I wish that I had come with my mum to other weeks as coming today I know that I would have enjoyed it

It's been hard coming here.

It was hard to talk at first, but it got better as I got to know people.

It has raised things that I would prefer to forget, but I am glad that I came.

**Theme of beginnings**, the difficulties that families expressed about starting a group with new people to talk about their personal stories of bereavement, the anxieties of talking publicly and being with people that they do not know can bring feelings of uncertainty and vulnerability and fear about 'breaking down' in front of strangers. These are challenges that may appear overwhelming for some of the families and

present prior to them attending the groups. For some families it is the challenge of forming new relationships with other families who have experienced a similar journey of bereavement and then having to look at the relationships that they have with the people in their family. I am aware that being in a public arena can be challenging for many of the families who attended the bereavement groups and for some it was the first time that they had ever attended a group. Initially with the first few groups there was shortsightedness on our part and an expectation that once in the group, participants would adapt to being with other bereaved families and would relax within their surroundings. We underestimated [in the pilot group](#) how stressful being in a group could be, especially for families who have experienced bereavement. [This was illustrated by the low attendance in the first week of the first group and then from then onwards attempts were made to provide more support to the families.](#)

It was also very important to find out the ways in which the group had not helped (the families felt that nothing had changed). This provided us with feedback and enabled us to change aspects of the group.

### **Extracts**

*I don't think it's helped me, if anything it has brought back more memories, it hasn't brought back my daughter (crying)*

*I feel like the group wasn't really for me but for the children.*

*I feel like I need something else this hasn't been enough. It isn't long enough. I still need to talk to someone about how I feel*

Many of the families raised the issue of the length of the group (six weeks) being too short for them and expressed that it was not sufficient time for them to experience any change in how they felt from when they had first been referred to the service. At the time of the pilot group I had conducted brief research by contacting various bereavement organisations across England and talking to therapists who worked with bereaved children and their families. They all stressed the importance of short term intervention. Short-term or brief psychotherapy has emerged as the most favoured and practised form of psychological intervention (Garfield, 1989). deShazer (1985) commented on the focus being on the client's attributes, strengths and predilections. There has been discussion around the ethics and whether brief therapy works effectively to resolve client issues. It was found that the outcomes were nearly equivalent to longer term therapies and there was a respect for the clients' autonomy and that



most treatment was collaborative. Based on some of the feedback from families who attended the group and an awareness of my practice, there is now a longer assessment period and more flexibility in when and where the appointments take place and to some extent recognising that families may need a longer period to engage with the therapist before attending the bereavement group and a relationship needs to be formed before hand before they feel comfortable to attend. Meeting each family where they are at is essential for the therapeutic intervention to be effective, which means considering their individual needs.

I was interested in how the families had experienced sharing their bereavement/ grief in the groups

### **Extracts**

*To be honest, I didn't know what to expect, as I had never been in a group like this before. Before I came I thought I was by myself,*

*To listen to other people speak and to know that they may have the same problems, not coping*

*It has helped me to come to know that other children feel like me and to be able to talk about how I feel with people of the same age.*

*It has been so good for me to hear other people talk; I thought that it was just me feeling this way.*

**Relationships** is a major **theme** that appears in the data, the way in which different types emerge through the narrative, and how connections are made in the family and in the group. These connections informed the shape of the group too. I suspect that emotion was a dominant factor that brought some of the families together, listening to another individual voice similar feelings and talk about their experience can create a bond and empathy amongst the participants.

*I also wanted to know what the bereavement groups had helped with*

### **Extracts**

*To know that other people has had the same experience that I am not alone*

*I understand more now*

*It was good to hear my sister talk as I would never know how she felt, and I am glad that the group helped us as a family*

*I have more of an understanding of the children than I did before coming to the group.*

Listening to other families talk about their feelings gave some families further understanding about their own grief, and hearing how another family was coping or what they had experienced and how they had made sense of that experience was fundamental to the relationships that were formed and reformed within the group during the six weeks period.

As part of the research I wanted to know what the families thought about the length of the therapeutic intervention which is considered short term in the therapy domain

### **Extracts**

*The group needs to be longer, more weeks because I am just getting comfortable, ready to talk and trust and then now it's finished.*

*The group isn't long enough and I am worried about what happens now*

*I am scared of being by myself, for six weeks I had had people to talk to.*

The element of time and duration of the group, families needed to be reassured that they would all receive further intervention if necessary and a follow up appointment. For some of the families they had never spoken about their bereavement since their loved one had died. The families needed to know that they were not going to be abandoned once they had spoken about what was happening within their family system and how they were or were not coping with their difficulties.

*I wanted to know if the families were satisfied with the group setting*

### **Extracts**

*I am glad that the children were able to meet without the adults being around, that was good. We were able to talk.*

*It has been great coming here every week, it is going to be strange not coming here anymore.*

*It's been fun.*

*And I was interested in if the families thought that there was a change in the family system*

### **Extracts**

*I can see the difference in my family, we are talking more.*

*Things are better now; me and my mum are getting on better*

*I feel like our family has come together. I know how everyone feels; now we have other problems.*

It was not unusual to get feedback from the parent that they felt that nothing had changed. Sometimes it was enough that things had not got any worse. In situations like these the questions would be asked how would they know if change had happened, what would it look like? And what would need to happen to prevent things getting worse? Some families said that although they felt that the bereavement group had helped them as a family it had not help them with their loss or help to bring back the person who had died.

### **CMM**

Reading both sets of the data there was an overwhelming sense of participants wanting to tell their story, which led me to think of the bereavement groups as forums for 'storytelling'. It would be within the telling of the stories that tension would be noted and difficulty observed and by listening to the stories, and making sense of the episode that had caused the conflict, new stories could be created that would enable the families to move on ( Pearce & Cronen, 1988; Hannah, 1994). In much the same way as we interpret oral speech as comprising complete thoughts that grammarians call "sentences," so we interpret the flow of actions into complete units into episodes (Cronen, 1992; Pearce, 2001). Episodes are bounded sequences of messages that have a narrative structure and are perceived as a unit (Pearce, 1994). The vocabulary of names for episodes is often used for answering the question, "what are they doing?" One way of unpacking the meaning of a message is to look at the temporal context. The meaning of a message is defined, in part, by its placement within a sequence of events. What came before and after the message? Therefore, in the telling of their story, episodes are described and the process of unpacking what came before an event took place is explored by the therapist within the bereavement groups, which is an integral part of the therapeutic interaction between client and therapist in the group (Bateson, 1972). This process is done with all the clients and participants who

attended the bereavement groups. Anderson & Goolishian' (1988, p.381) describe the 'not yet said' moments that are within any relationship or conversations. The 'not yet said' creates the possibility of a new story that might resolve the concern that the children and adolescents have.

Within the frame of CMM, attention would be given to the **Coordination** of the stories told within the bereavement groups and the process by which participants attempt to call into being 'conjoint enactment of their stories' about what is good, desirable, and/or acceptable and to prevent the conjoint enactments of their stories of what is bad, painful, and obstructive (Pearce, 1989). The latter is the stories that need to be told by the participants. Coordination is the way we "fit" our actions into those of other people to produce patterns. It is the way a family might assume a pattern of grieving without any consultation or discussion with each other about what has happened. It does not necessarily entail understanding or agreement with each other, or that they like, want or recognise the patterns that they have produced. Often they do not like the pattern that has been co-created because they are stuck into always reacting in the same way with each other and therefore nothing changes and it also does not 'fit' all family members, which is what causes some of the unrest within the family. The adult way of coping does not always fit the child and as a result creates tension which is manifested within the child's behaviour. Children frequently refuse the emotions that parents/carers construct for them and often grimace and wince in response to the descriptions (Fredman, 1997, p.50). An example of this is where the adult and child/adolescent have a different relationship with the person who died; this can inhibit the child/adolescent from openly expressing their grief if they are of the opinion that the remaining parent doesn't feel the same about the person who has died. Below are two extracts from parents who had been separated from the person who had died.

*'She wasn't my wife when she died, we were divorced. The only reason that I came to this country was to look after the children. I do not need to come to any group... ..I didn't love her'. (Group 3, family 14, ex wife died of cancer)*

*'No, we had separated when he was little and I wasn't aware that he had gone back to taking drugs, the whole family is cursed, one brother is in prison for murder, one has drugs problems and the other has a drink problem. He also had a daughter the same age as \_'*  
*(Group 4, family 20, ex-partner /dad died of overdose)*

Many families are unaware of the patterns that have developed after the person has died, as often they are created in the aftermath of a death occurring in the family. One of the aims of CMM and family

therapy is to enable people, individually and collectively, to be able to produce "better" patterns of communication within the therapy room (hence the bereavement groups) to then go on to introduce them into the family home. The Management of Meaning or Coherence is: the process by which we tell ourselves (and others) stories in order to interpret the world around us and our place in it. Coherence is achieved by telling stories about ourselves, individually and collectively, and about the world around us. Pearce (1976) notes that people are simultaneously meaning-makers (in a world where the substance of which is stories) and actors (in a world where the substance of which is events). These cannot be separated but neither are they the same thing. Pearce (1999) also maintains that 'We' always live in the tension between the stories we "tell" ourselves and others and the stories we "live" with others. Hence this tension is the source of much of the joy and pain of human interaction which is manifested in countless dramas that are transported into the therapy room, hence the bereavement groups. I would like to propose that it is because of the stories lived and told after the person has died that conflict is created within the family system. Depending on the relationship that the person who died had with individuals in the family, they would have different stories to tell which is where the tension is created, which is the dominant story that is told and who is the author of the story. There are also public and private stories about the person who died which can be further complicated if the media is involved. If you are the surviving partner and there were issues of infidelity and domestic violence or you were separated and have gone into another relationship, the story can be embroiled in bitterness, scorn, anger and fantasy to some extent. "*The stories we tell are subject only to the limits of our imaginations; however, the stories we live are performed in concert with other people...*" (Pearce, 2001). The same story is not told by all the family members, only some, some stories are untold and unheard.

### **Using the LUUUTT Model**

LUUUTT is an acronym for 1) stories Lived; 2) Unknown stories, 3) Untold Stories, 4) Unheard stories, 5) stories Told, and 6) storyTelling. By using the LUUUTT model, a feature of "CMM" (Pearce, 1976), it will be possible to further re-define the themes that have emerged from coding the data and make the necessary connections to the different stories that are told or not told by the families who attended the bereavement groups. Moreover it will provide an opportunity to analyse and 'unpack' the data in more detail and provide explanations about why grief is held and maintained within the family system and whether the bereavement group is an effective therapeutic intervention. Unpacking,; the meaning of conversations is a typical CMM activity. The first aspect of this process is that of seeing conversations

as "packed" with more meaning than might at first be apparent. Thus, it will be in the unpacking that further stories will be told and space created for the untold stories to be heard within the group. It was my role as therapist and researcher to do the 'unpacking' and to be involved in many conversations at any given time with the participants who attended the bereavement groups. Pearce (1999) maintains that 'we' are always in more than one conversation. Everything we say has multiple meanings in the various conversations of which we are a part. Each participant belongs to a group but the referred child or adolescent is also the individual client, and as a therapist I was clinically responsible for managing the therapeutic intervention that they received whilst they were allocated to me. The concept of the tension between stories lived and stories told are familiar to many systemic practitioners. Stories lived are the co-constructed patterns of joint-actions that are the basis of the interaction between client and therapist; stories told are the explanatory narratives that people use to make sense of stories lived (Pearce, 1999). When this was applied in the bereavement groups it was often the story told by the adult that created the 'problem' for the child. Although most people feel the need to align stories lived and stories told, they cannot be identical, and the tension between them provides the dynamic for much of our everyday lives. Rarely has there been any family where each family member had the same story about what happened when the person died. It was also true to say that people told stories in such a way as to make the events of their lives coherent. However, the tension between stories lived and told was not sufficient to guide us to the potential richness of any given communication pattern. In addition, there are unknown stories which the participants are not (currently) capable of telling (see case study 1).

### Case Study 1

*An example of this is where an older brother had lit the match that had set the house fire which his baby brother had died in. For years his mother would maintain that it was not his fault. By doing this she was preventing him from talking about the event, further increasing the guilt that he was feeling. In talking to other children about what had happened he was able to tell his unknown story, say that he was responsible as he had lit the match, let his mother and siblings hear that and his mother was able to listen. The mother was unaware of the effect she was having on her son. There was a marked improvement in his behaviour once he spoke about his memory of the night. It had taken this family seven years to engage with any service. (Group 7, family 35, baby brother died in house fire)*

These are the (difficult) stories that need to be told and unpacked within the group. There are also the untold stories which the participants are perfectly capable of telling but have chosen not to (at least, not to some of the others in the situation); and unheard stories which, although they have been told, have not been heard by some important participants in the situation (Pearce, 1976). The unheard stories are the stories that as family members sit side by side and begin to talk about their experience, other members often are hearing this for the first time. On a number of occasions it has been amazing to observe the children's faces when they are hearing something new about the person who has died and are intrigued by events that unfold. It could be that they were a baby at the time that their parent died.

## Case Study 2

In this family of three boys and dad, mother had died when the youngest was six weeks old. Of the three brothers the youngest one had the most behavioural difficulties, his knowledge of his mother was gathered from his father and other people who knew her, but rarely shared anything as they found it painful to talk about her. His brothers had also been very small when she died and didn't remember much about their mother. Therefore the family was encouraged to write down the questions that they wanted to know about their mother, their father was expected to provide the answers. Some of the questions were: when was her birthday, what was her favourite food, how had the parents met?  
(Group 5, family 25, mother died)

It is the unheard stories that were encouraged to be told by each and every family member within the bereavement groups. Unheard stories become untold stories, and untold stories become, after a while, unknown stories. The central feature of the LUUUTT model is storytelling. Unlike the other CMM models, it deals with "how" the stories are told rather than their content, narrative features, or place in the conversational interchanges. I am interested in all aspects.

Immanuel Kant; (1724-1803); created the concept that human perceptions are structured by the structure of the human mind. However Kant thought in terms of static experience and the newer idea is that human beings' experience occurs in stories. Narrative structures, plots, roles, comprise the templates in which we live our lives. That is, whatever worlds we know will have the fundamental structure of stories because that's the way we perceive, think, and live (Pearce & Pearce, 1998).

This is known as storytelling, nothing passes but the mind grabs it and looks for a way to fit it into a variety of possible scripts. That is how we explain how things happen, how we make sense of what has taken place. The telling of the story of how the person died within each of the families is paramount to the opening of the group. It demonstrates how each family member has made sense of the death and identifies the origin of the story.

The children found different ways of expressing themselves other than through narratives, and used other media like drawing and writing about how they felt. When they wrote something or drew a picture, that would be taken as part of a conversation and would be responded to by the therapist. The excerpts below are representative of some of those conversations. *Many of the children writings were noted and discussed amongst myself and my co-worker. The writings were viewed with equal importance as if the children were talking. I have chosen to add copies of written excerpts from some of the drawings and letters rather than the original products as the children often took their drawings home with them when given the option to take them or leave them behind. The excerpts illustrate some of the children's feelings and thoughts about the person who had died and about their ambivalence regarding their bereavement.*

One of the children, expressing why he did not want to talk about his dad.

***Extract***

*Why I don't talk about my dad? It will stop me being happy.....because I don't want to be angry.....or to cry.....I don't want to upset myself.*

An older brother talking about some of the difficulties that he was experiencing with his younger brothers who he felt responsible for since their father died of cancer.

***Extract***

*Why I'm not talking to my brother about dad?  
He doesn't listen  
He doesn't understand  
He doesn't know what will happen if he carries on like this  
He doesn't feel that I am a grown up, a big brother.*



The **theme of parentification** occurs when the oldest adopts the dead parent's role and takes on what he or she perceives as their responsibility. In the case above the oldest son feels that he has to parent his younger siblings. This can happen when the existing parent is having difficulty coping and has distanced themselves from the children and is showing that they are unable to cope without the person who has died and needs support.

An adolescent expressing some of his frustrations that he felt

**Extract**

*If we are going to talk, what will we talk about?  
What we have to do now after our dad past away  
What we not suppose to do  
Take the situation serious and get on with life.  
Be together, hang on to each other, not break each other's heart and help each other  
(Group 2, family 7, age 15)*

**A poem written by a boy about his father.**

*Dad  
Caring  
Loving  
Argued a lot  
Selfish  
Good provider  
Funny  
Hard worker  
Good person  
Alcoholic*

**The same boy talking about how he felt.**

**Extract**

*I felt sad when dad went to hospital and I was worried. I was angry at him for putting himself in the hospital (Group 2, family 8, dad died, age 11).*

The above child was clearly feeling that his father was at fault and that his death could have been avoided if he had not drunk. The boy was angry because of the way the death had affected both his and his mother's lives. The mother had to seek employment and take on the role of the breadwinner within the family when her partner died.

**A family talking about the strategies that they used to manage their feelings.**

**Extract**

*Laughter*

*Instead of being angry*

*To stop yourself crying*

*Camouflage feelings*

*To distance you/someone from feelings*

*To show joy/pleasure*

*For comfort*

*(Group 2, family 5, family exercise)*

**An adolescent talking about how he felt that he had changed.**

**Extract**

*Don't smash things anymore*

*(Group 5, family 26, age 14)*

***What an adolescent thought needed to change and talking about what had changed in her family.***

**Extract**

*We need*

*More bonding (socialisation)*

*Go to family events*

*Sometimes my brother takes his anger out on me (beats me up)*

*We stay in our room; we don't stay in the living room like most families*

*(Group 5, family 22 14yrs girl)*

Some of the themes were interwoven within some of the data and represented some of the emotional feelings that families have when someone died and to some extent are normal symptoms of grief. It does not matter how old you are when someone important in your life dies, it is difficult to sort out the different feelings that you have as a child or adult ([www.childbereavement charity](http://www.childbereavementcharity.org)). Feelings like anger, guilt, blame, shame, worry, confusion, disbelief; loneliness will manifest themselves in many forms within the family. There are so many reasons why a family might feel these emotions and each family unit's circumstances may influence the way that a child/adolescent sorts through their feelings. Anger was experienced by many of the children/adolescents who attended the group and was often very

difficult to deal with because people reacted by getting cross with the child/adolescent's behaviour. It was often the emotion that brought the child/adolescent to the attention of their teacher as an underlying problem behind their behaviour. It was not uncommon for family members to have different feelings about the person who has died. Numbness was common amongst the adults when they appeared as if they felt nothing and wanted to get on with their lives (denial) that was because it was hard to take in that being dead was permanent and that you would be living your life without the person who has died. For some families guilt was expressed when they had not been there when the person had died, because they had wanted to go out on that day or not wanted to visit the hospital. These emotions can be tangled up for years rather than months or weeks, and come and go, rather than as stages that an individual might go through ([www.griefencounter.org.uk](http://www.griefencounter.org.uk)). Many of the families had been bereaved for a number of years before attending the group. Hence, by attending the group families are encouraged by other families and given permission to grieve. It is important to stress that these emotions are not insular. They are often woven into the difficulties that some families are experiencing.

### **Outcome of the bereavement groups**

The context in which a group outcome is measured is highly significant. For example, the bereavement groups were based within a community based mental health clinic. There are affordances and constraints as a result of the setting. For example, there is reluctance on the part of some of the adolescents who attend a mental health establishment. McDermott (2005) maintains that different contexts make different kinds of evaluations possible, limiting some aspects and facilitating others. Different measures were put in place at various time points (pre-group, beginning, end and at post group) to ascertain the difference the group made to individuals and their families. Outcome was based on a number of factors. Information was initially gathered about the reason for referral at the assessment stage, where the concern and the risk is noted and put on the database. Then every week, therapeutic progress notes were written up about each referred child/adolescent. This recording monitors any change that the therapist/s within the bereavement group would have observed within the child/adolescent's behaviour over the six weeks period. This change would be further validated by the child, adolescent, parent, carer, family member or school reporting their own observations of changes in behaviour or feelings. With every family that attended the bereavement group there would have been

some shift within the family system, which was counted as an outcome. Although it is important to stress that within the bereavement groups outcome meant many things. Being able to talk, listen and share feelings as individuals and as a family and bearing witness to other families' experience can help to reduce feelings of isolation and despair and create the slightest shift, which for many was a new experience. There were a number of examples where change had been observed.

There was a family where the dad had died of a drug overdose, leaving behind a partner and three teenagers who had not been told how their father had died. The son stopped attending school, refused to leave his bed and was unable to talk about how he felt. On the initial meeting he interacted from his bedroom with his head under the duvet cover, his face was covered. In the first bereavement group session he sat outside the group circle with a hoodie over his head. The following week he came into the group circle, the week after, the hoodie came off and he was able to interact fully. By the fifth week he was able to sit around the table with his siblings and ask his mother the questions that he wanted answers to about his father. By the sixth week he was back at school. With this case the outcome was clear.

With another case the outcome for younger child at the end of the six weeks, could be realising that his dad has died and was not coming back, whereas prior to attending the group he had not understood that his father was dead.

Sometimes an outcome does not include all the family members; it may only be the child/adolescent where there has been a change.

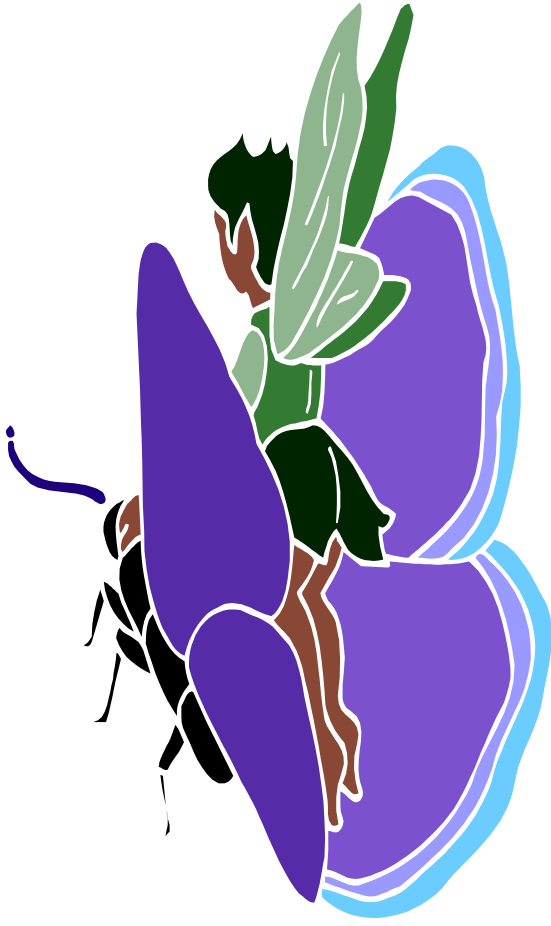
A classic example was where a family was referred because the grandmother who had been a significant figure had died, everyone in the family was affected, the son had stopped attending school and was getting into trouble with the police, one of the daughters was self harming and expressing suicidal ideation and the other daughter had stopped attending college. The mother who had been the youngest sibling and only daughter was alright for the first six months after her mother died and then was unable to go to work because of her grief. During the group the mother and one of the daughters were able to talk and express how they felt about the grandmother dying, the daughter was able to communicate that she wanted her mother to take responsibility for them and stop acting like one of them and be their parent. In this instance the mother was sharing the daughter's bedroom, using her toiletries and wearing her clothes. As

part of the therapeutic process both mother and daughter were able to write down what they each needed to do, for things to get better. At the end of the group the suicidal ideation had stopped and the mother had returned to work. Unfortunately, the other children never engaged.

Often it was the parents/carers or the referred child/adolescent who would express that there had been an improvement in the family's functioning and say that they went home and talked after attending the group. Or a parent/carer will report that they have witnessed a change in their child/adolescent's behaviour, this could be an improvement in mood, less arguing, attending school and communicating more amicably with everyone in the family. Following the group, the child/adolescent's school is contacted to see if they had observed any change in the child's behaviour and to find out if they were still concerned, especially if they had made the referral. As part of the follow up, the family is invited in to ascertain if further intervention is needed and change is noted there. This session is also for the therapist to see for herself if there is a change in the child/adolescent's presentation. This was something that was closely monitored throughout the six weeks. Outcome is measured by the formal measures like the strength & difficulties questionnaire (SDQ) which is a brief screening questionnaire for 3-16 year olds (Goodman, 1997); unfortunately not all the children/adolescents in these groups were given them, unlike in the other groups that followed. Although it was protocol for all parents/carers to be sent them with their first appointment letter, this was not always returned or followed up with the early bereavement groups.

**This chapter has described the way in which I have set about getting data in order to answer the research questions and how I interrogated and made sense of the data as part of that process. By focusing on five main areas within my clinical practice within the bereavement groups, opportunities were created for exploring how the data emerged from therapeutic conversations (storying), the therapeutic intervention (the bereavement group), the narratives/conversations (magical moments), the position of therapist/researcher and the outcome of the bereavement group. Using a social constructionist framework, thematic analysis and CMM as tools to analyse the data, a context was created for the bereavement groups to act as forums for storytelling for the families' private untold and unheard stories to be told publicly. These stories provided some explanations about why the grief was held and maintained within the family system and whether the bereavement group was an effective therapeutic intervention. Moreover, these explanations will be a source which will be explored further in the findings chapter.**

# PART 4



## THE INTERVENTION

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## FAMILIES

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The participants in the research project are children, adolescents and their families. The term 'Family' is used throughout the study and there needs to be some consideration as to what is meant when the term family is used within the body of the text. 'Family' is a word which continues to be used by all of us as if it has a unitary meaning, despite the fact that we are all aware or should be aware as professionals (Jones, 1992) that a significantly large number of people do not live in traditionally structured families at all. Many of the families who attend the service do not represent the traditional connotation of 'family' of an intact family with two parents, heterosexual with not too many and not too few children, where the woman is meant to be the 'homemaker' and the man the 'breadwinner' (Stratton, 2011). Families in the post-industrial western countries, and indeed the families who were referred to CAMHS and were a part of the research project, consist of single parents with children, remarried or reconstituted families, families where some of the parents had children with multiple partners and extended families where there were more than two children and grandparents had a dominant role. In other families both parents were employed and therefore the roles of 'homemaker' and 'breadwinner' merge into one and there is an expectation that as both parents work, the childcare and household chores are shared by both parties or mother is working part time or both parents are unemployed. It was difficult for some parents to have jobs because of frequent school and professional meetings around their child's behaviour that they were expected to attend. In some of the families, the parents would also have a mental health problem which is an important issue in the family that is likely to be affected by a significant death and influence how the children in that family respond to the death (Worden, 1996). These parents were also likely to be on medication for their condition and accessing psychological services.

There are other thoughts about what constitutes a 'family'. Carter & McGoldrick's (1989) view is that a family can comprise of 'an entire emotional system' of at least three or four generations. Family is not restricted to the members of a particular household or to a given nuclear family branch of the system, different family stories were co-created with the forming of the family unit. There are also families that are non-biological and the children have been fostered or adopted or where the children/adolescents are raised by other family members/carers and not by their parents for an assortment of reasons. This



was the case for a number of children/adolescents who were displaced following the death of their parent/carer.

Early theory and research on family functioning in the social sciences and psychiatry sought to define “the normal family” in terms of a universal set of traits or a singular family form, in the model of the intact nuclear family with traditional gender roles (Parsons & Bales, 1955) that stems back to observations of typical middle class, white suburban families in the 1950’s, which became the standard deemed as the ‘norm’. There has been a reluctance to move away from that yardstick and accept that families have become more diverse, varied and complex as a result of contemporary life (Walsh, 1996). Typically families are still evaluated in comparison to one standard (Walsh, 1995) when they access services and are frowned upon when their family does not resemble the ‘norm’. Families are shaped by people who share a history and a future and are living systems.

The definition of “family” differs greatly within the different communities with some defining an intact nuclear family, others favouring a wider network of family like aunts, uncles, cousins, and grandparents who are all involved in family decision making, who share holidays and life cycle transition points together and who tend to live in close proximity, if not in the same house (Rotunno & McGoldrick, 1982). There are those families who go even further and include three or four generations. There are also families where ‘family’ includes the community and extends to close long time friends who are considered family members (Hines & Boyd, 1982), and for others the definition of ‘family’ includes all their ancestors and all their descendents (McGoldrick, 1982). Thus the bereavement group accepts all types of families as it is not the responsibility of the therapist to define who makes up an individual’s family and there is not one set course or normative sequence by which families develop over time.

All of the above descriptions of ‘family’ have at some stage attended the bereavement group during the research project. For example, there have been families where a close friend has parental responsibility because no one in the family unit has put themselves forward when the mother has died, or where the aunts have taken on the responsibility for their nephew when their sister has died or the family where grandmother has taken on the care of her granddaughter when her daughter in law was murdered and her son was dependant on drugs. As part of the assessment process each child/adolescent and the responsible adult are always asked who else is in their family and as a result a genogram is drawn to represent their ‘family’ and an invite is extended out to all ‘family’ members. A genogram is a useful tool that provides a three generational picture of a family and its motion through family life (Carter &

McGoldrick, 1989). Within the bereavement group all cultures and ethnicities are embraced and families from a range of different communities have accessed the group. Despite the differences in structure, families have attended the group because they have experienced bereavement and either their child or adolescent (or a sibling group) is having difficulty at school or at home and a referral has been made to CAMHS on their behalf. It is useful to explore some of the components that organise a family when trying to bring forth the mechanism that holds and maintains the grief within the family, thus preventing them from moving on. By exploring the various family life cycles and family scripts where they exist, I will be illustrating what informs how a family confronts and manages a disruptive experience, buffers stress, effectively reorganises, and the way in which the decisions that they make about moving forward with life can influence immediate and long term adaptation for all family members and for the family unit.

### **Family Life cycle.**

Many of the families who attend the bereavement groups had gone through so many different stages in their lives and their life cycle did not always follow the predicted pattern as suggested by various theorists. Michael Solomon (1973) was one of the first therapists to discuss a family life cycle perspective; he outlined tasks for a five stage family cycle (marriage, the birth of a first child and subsequent childrearing, individuation of family members, departure of children and integration of loss) and suggested using the framework as a diagnostic base for treatment. Others have divided the family life cycle into different numbers of stages. Duvall (1977) broke the family life cycle into eight stages, all of them addressing the events related to the comings and goings of family members: marriage, the birth and raising of children, departure of children from the household, retirement and death. Not all families go through each cycle smoothly and for some families they take issues from one stage into another because of events that might occur and remained unresolved, and there is an overlap in some stages. Some of the families who were assessed for the bereavement groups did not fit either Solomon or Duvall's theories as they did not go from one stage to another. For example they were often not married and some parents were still living in their parents' home. Hill (1970) stressed the three generational aspects of the family life cycle, describing parents of married children as forming a 'lineage bridge' between the older and younger generations of the family; he claimed that at each stage of the life cycle

there is a distinctive complex role for each family member with each other. Combrinck- Graham (1985) emphasises the “oscillations between the centripetal and the centrifugal” periods in family development, like life experiences such as birth or illness, that require a pulling together and primacy of relationships, and other experiences such as starting school or a new job that demand focus on individuality (Carter & McGoldrick, 1989). There is a mutual interdependence as the generations move through life (Duvall, 1977). The way in which a family is organised has a fundamental influence on how they cope with transitions and life experiences like illness and death. Carter & McGoldrick (1989) talk about the family process existing within a linear timeframe and the impact of one generation on another. They use the example of the three or four generation families who must adapt to life transitions simultaneously and describe the complexity of one generation moving towards older age, whilst the next is adjusting to children leaving home, the third with young adulthood, forming careers and intimate relationships and having children, and the fourth being inducted into the system. Thus it is very arduous for the family to cope with painful experiences such as illness and death which are particularly difficult for families to integrate. Changes within family life cycle patterns have escalated dramatically due to lower birth rate, longer life expectancy, the changing role of women, and the increasing divorce and remarriage rate. Fredman (1997, p.5) maintained that people often sought help not because they were unable to manage their grief but because those around them could not cope or because they were concerned about the effects that they were having on other people. Effective therapeutic intervention can assist family members to proceed through the different stages successfully and make the adjustment where necessary. Family life cycle offers a useful framework for studying the predictable stages through which a family passes. It offers a more positive view of the family’s capacity to retain its stability and continuity at the same time that it evolves and changes its structure as new relational processes occur.

The meaning of family is changing drastically, since it no longer just organises around the rearing of children and has moved away from the family life cycle. Families have to continually be adjusting and changing their structures to accommodate all the different patterns and changes all the time. In my view services have not always acknowledged these changes or struggles and insist on assessing families using outdated approaches which are not always conducive and hinder knowledge rather than develop awareness about the families the children and adolescents are raised in. The approach is often based on parents living together and raising the children as a unit. Many of the families that access CAMHS are not representative of that model, parents are often separated or divorced, and the children are

predominantly raised by one parent, usually the mother. Each family that attended the bereavement groups underwent a family therapy assessment that would include collating information about their family's personal situation and circumstances, patterns and beliefs in order to get a realistic perspective of the family as they are really living and with them as authors of their stories.

## **Family Scripts**

At the start of the research I was surprised by the number of families who were influenced to some degree by family scripts. Family scripts can be defined as the 'family's shared expectations of how family roles are to be performed within various contexts' (Byng-Hall, 1995). Expectations were used to imply anticipation of what is to be said and done within family relationships, as well as family pressures to perform the roles as expected. If one member fails to perform in the prescribed way another member of the family may be recruited to take up that role instead. Often family members see things differently and vary in their wishes to change the patterns, either now or in the next generation. Byng-Hall (1995) suggests that family scripts are revealed when patterns of family interaction are either observed or repeated. For example, when an episode is acknowledged by the family as being typical of what happens in that particular situation, it can be seen as a scenario that represents the family script for that particular context. Families also have myths which consist of shared family images and legends that portray those images which help give the family its sense of identity (Byng- Hall, 1973; Bagarozzi & Anderson, 1989). To the family their myths represent truth. Myths may consist of attributions of particular roles to certain members of the family, for example, "the mad one", the "naughty one", "the quiet one". Stories that are told by the families often support these myths. Therefore the family myth becomes the family consensus about which home truth can-not be spoken in public and it becomes a closed belief system. However, there can be tension between the life cycle and script, whereby the script has to be re-written by family members because of the events in the life cycle. Whether it is a natural catastrophe or a personal tragedy or an unpleasant unexpected crisis, this tension prompts the reorganisation of the family's life story and not all family members are ready to change their script or acknowledge and adjust to their life cycle. Conflict and change are as much a part of family life as tradition and continuity.

All families have the potential for resilience, and their level of resilience will determine how they cope with life's different transitions. Walsh (2003) has described resilience as 'the ability to withstand and rebound from disruptive life challenges', more of a developmental process unique to each family that enables families to create adaptive responses to stress and in some cases to strive and grow despite all the adversities. It has become an important concept in mental health theory and research over the past few decades. How a family organizes itself, how it retains its cohesion, how open it communicates and problem solves together to cope with the challenges, will forecast its ability to recover from trauma and manage stress. The support of a network whether it's friends, neighbours, the church, colleagues or via therapeutic intervention can often contribute to family recovery (Goldenberg & Goldenberg, 2000). It is not so much that a competent family passes through a particular stage stress free or without resisting the change, but rather that it has the resilience to use its potential strengths, resources and effective interpersonal processes to manage the necessary disruptions. Thus, changing the family script and expanding or adjusting the family life cycle along the way/over the years to reflect their unique journey. A family might have a script or a belief about resilience or how they have coped in the past with crisis and that may inform how they deal with the current bereavement. A therapist might expand on or shift a family's script or belief.

One of the focuses of the research project is how the family manages each of the many unfolding challenges and how they have made sense of their loss. All families have problems but it is what they do with them that distinguishes them. Having to explain death to children challenges the adult to have to bring to the open ideas and beliefs that she or he may never have had to articulate before (Fredman, 1997, p.xxi). Of all human experiences death poses the most profound challenge for families (Walsh, 1996); this is despite the fact that death is a normal, significant life event and transition in the family life cycle (McGoldrick & Walsh, 1991; Fauth et al., 2009). Hence there are many families who experience bereavement and are able to make the necessary adjustment without support from external agencies (Ribbens McCarthy & Jessop, 2005). The children and adolescents who attend the bereavement group need specialist support because their reactions have persisted and become severe, following a death. Many families and therapists believe that the professional view is to be privileged above their own cultural and religious stories (Fredman, 1997. P.67), There is a concern around the mental health of the child/adolescent when there is a prolonged lack of interest in activities they used to be involved in, prolonged refusal to attend school or poor academic performance, continuing problems with sleeping,

persistent low self-esteem, shame or guilt, persistent aggression, anxiety, physical complaints or eating disturbances, prolonged fear of being alone, and signs of chronic depression (Hands on Scotland, 2007). The child/adolescent might need immediate treatment for risk-taking behaviour, for example; drug or alcohol abuse, sexual experimentation, and fighting. Some of the issues included having repeated desires to join the dead person, copying symptoms/behaviour of the deceased or repeatedly dreaming of their own death. Sometimes they were convinced they had caused harm/death. Maybe the death of their parent or sibling was by suicide and they were told that the person had died in another way and then they have found out the truth afterwards. If they were directly or indirectly responsible for the death, this can have quite an impact. The majority of these symptoms and articulations of grief have been addressed within the bereavement group during the research project and will be incorporated within the findings.

Within the research, there was a need to illustrate the ways in which the children's behaviour had changed with time. For many of the children and adolescents they experience different feelings at different stages of life and it was not unusual that as the children got older, they wanted to go over the details of the death again (Fauth et al., 2009). A number of the participants struggled with adapting to the death several years after the event and something had triggered the emotions, bringing everything to the surface and they were having difficulty articulating what they were feeling. This was the case for some of the children/adolescents where the feelings had manifested themselves in their behaviour; it was more a presentation rather than a verbalisation.

On reflection I think that families may simply not be aware that there is a problem for the child/adolescent at the time of the death and it may be an apparently unconnected event at a later date that highlights a child's need to reconnect with the deceased. This can manifest itself in many ways. The children may begin to create stories based on their imaginations, they begin to see similarities between themselves and the person who died that may or may not exist and become curious about the person who has died, which may result in them asking lots of questions. This may take place some time after the person has died. Listening to the families it was not long before I realised that there were so many factors associated with the bereavement. The relationship between the parents is a significant factor, whether they are living together or apart at the time of the death can have an enormous impact on the grieving process. For many of the children and adolescents attending the seven groups they had experienced an extended period of disrupted relationships with family and friends. A significant number

of parents/carers were unable to meet the child/adolescent's needs because of their own grief. Hence why the parent/carer or school might feel that the child/adolescent needs specialist help because they themselves are emotionally unavailable and the child may feel more at ease talking to a relative, family friend or to a counsellor; although the child/adolescent may also be frightened of causing upset within the family, especially if they are angry with the main caregiver.

Within the research the children/adolescents were sometimes encouraged to talk to each other without the adults in the room, some of the parents/carers expressed their discontentment when their child/adolescent did not want to talk to them. This was evident throughout the research whereby the children/adolescents just wanted space away from their parents to talk about how they felt, especially when they were trying to make sense of their feelings. It seemed to help them normalise their feelings, hearing other children expressing similar feelings. Honesty was a major issue within the research whereby the children/adolescents expressed the importance of their parent/carer providing clear information about the bereavement. The tension was created when parents/carers tried to hide things from the children/adolescents. McGoldrick & Walsh (2004) say that "*because family structure can break down with the loss of a parent/carer, extended family members and friends need to help the surviving parent reorganise their daily routines and provide appropriate care and protection for children through the disruption*". Some of the children who attended the bereavement group were living with a family's friends and extended families because their main caregiver had died. Few of the children/adolescents had difficulties adjusting to their new 'family' beliefs and scripts. Attending the bereavement group they realised that other children/adolescents had similar experiences. For some children/adolescents the loss of a parent/carer meant that they were no longer living in their family home.

### **Systemic Family Therapy and Circular Questions**

Family therapy can take place in a family home, because families are sometimes emotionally unable to leave their home after the bereavement, or in an inpatient unit depending on the agency and client group. Sometimes there is one therapist present and sometimes more than one. In some circumstances, there may also be a team of people, sitting behind a one-way mirror, in another room, who are watching what is going on, and helping the therapist conduct the session. The sessions may also be recorded. Family therapy can take many different forms including the systemic approach, pre

and post Milan (Asen, 2002). Systemic Family Therapy is an approach which uses the idea that the problem lays within the family as a whole, and not just within a single person( Boscolo et al,1987). All of the bereavement groups were facilitated by two family and systemic psychotherapists, using a therapeutic intervention that involves working with the whole or part of a family. The groups took place in the clinic. In regards to bereavement it was practice to explore issues such as how everyone sees everyone else, what the expectations about the problem (the bereavement) are in the family, and the function the problem (the bereavement) has for the family. Within the seven bereavement groups this approach was adopted throughout all of them. By having most or all of the remaining family members in the session it was thought possible to identify the problems and relationships, ideas and attitudes of all the family to get a sense about what is going on for the whole family. Once these areas were clear the aim of the session would be to shift the problem, attitudes, and relationships, to a position that was more beneficial, less damaging, or simply more realistic. This can be done in a number of ways, which may include education, homework tasks, experimentation (i.e. suggesting that the family try behaving or relating in a different way), or attempting to provide some insight to the family members about what was really going on. The emphasis is on the whole family, and not blaming one or more individuals for the problem that has emerged since the bereavement.

Family Therapists have adopted the idea of a family as an open system that is '*...a system in exchange of matter with its environment, presenting import and export, building up and breaking down of its material components* (Von Bertalanffy, 1968 p.149). A system can then be described as a group of 'elements' in interaction with one another over time, such that their recursive patterns of interaction form a stable context for individual and mutual functioning (Jones,1993). In Family Therapy, human beings (family members) are the 'elements' within the systems which mutually influence one another when living together, growing together and changing with time, with the changes that will occur as part of the biological and life stage changes, which in turn alter relationships, for example when children start school, or become adolescents. The family system is thus an open rather than a closed unit because it interacts with other individuals, groups and contexts, such as for example extended family, friends and colleagues as well as with larger systems such as the community and with outside events, such as economic and war events (Jones, 1993). Bateson (1979) developed this way of thinking when he described human systems in terms of "*information/communication*", he talked about sequences which resembled stimulus and response and human systems showing circular interaction i.e. action a



might lead to action b, which might lead to action c, which might in turn give rise to action a (Jones, 1993). Thus individuals are seen as responding to feedback and eliciting it in relation to those significant others with whom they interact. Family therapists observe the interactions of families in an attempt to distinguish those patterns.

The concept of circularity was introduced by the Milan team as a technique of circular questioning in an attempt to translate the implication of Bateson's (1972) idea of cybernetic circularity into the day to day work of therapy with human beings and their families. Bateson had the view that the family system was constantly evolving. The family was always changing its members, who remain connected with each other, influencing one another continuously over time. This view was also shared by myself and my colleague within the groups, we also believed that patterns of interactions are passed on through generations, therefore the history of family is important so that the ideas, beliefs, perceptions and hopes that are held can be addressed, along with the behaviour. Bateson (1972) observed that the knowledge that we have of external events is always apprehended by mechanisms that scan for differences. His example is the movement known as Micronystagmus, vital to sight, by which the eye shifts quickly back and forth picking up differences of shape, colour and brightness (Boscolo et al., 1987). Thus the Milan group used circular questioning as an interviewing technique that would also scan for differences. By circularity therapists would conduct their investigation on the basis of feedback from the family in response to the information they gather about the relationships and therefore about difference and change (Selvini-Palazzoli et al., 1980). This was explained by Tomm (1985) who stated that to understand a system is to understand the coherence in its circular organization. Thus it is the circular connectedness of ideas, feelings, actions, persons, relationships, groups, events and traditions that are of interest to the systemic therapists. Therefore the aim of the therapists would be to see family members as elements in a circuit of interaction, and explore the family's circularity by bringing out the differences: differences in behaviour, relationships or feelings and beliefs at different points in time (Preston-Shoot & Agass, 1990).

Circular questions would fall into several categories: differences in the perception of relationships in the family ("Who was closer to their father, your daughter or your son?"); questions about differences of degree ("On a scale of ten how bad do you think things have been since your mother died?"); Now/then differences ("Did she start cutting before or after your husband died?"); and hypothetical and future differences. ("If your dad had not died how different do you think your family would be?") (Boscolo et al.,

1987). Further structure of the circular questions and circularity was expanded on with Peggy Penn (1985) who described a technique “feed forward” that encouraged families to imagine the patterns of their relationships at some future point in time. Penn (1985, p.299) states that *since the maps of the future are not yet set, the families are free to construct or imagine a different set of alternatives to their dilemma/current circumstances*, which is useful when working with bereaved children, adolescents and their families who are having difficulty adjusting to the loss in their family system.

Bereavement will affect the family system in many ways. The death of a family member means that the system is ‘irrevocably changed’. Raphael, (1994) maintains that the interlocking roles, relationships, interactions, communications, and psychopathology and needs can no longer be fulfilled in the same way as before the death. The family unit changes and a new family system need to be constructed. The family view of itself, the family myth is challenged and impossible to maintain.

Using some of these ideas enabled us to take our time to consider what was happening and how it was happening in the families. We listened and observed how families had managed previous crises and how they connected and disconnected as a result of the bereavement that they had faced. It was important that families acknowledged that they were not only grieving for the person who had died but that they were also mourning for the loss of the old family system that was lost with the person who had died. Some of the families were able to recognise that changes had taken place within their family’ system and were informing the scripts, beliefs and different myths in various forms. It was difficult for many families to acknowledge that a different family system had developed as a result of the bereavement. It was important as a therapist to recognise that all families have their own way of grieving and could not be judged by the length of time that a person had died and coming to terms with a loss of a loved one is a very painful process that cannot be rushed. Therefore we were not prescriptive in our approach, flexibility and empathy was essential in the interaction with the families.

## CHANGE

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In this chapter I discuss how and why I intend to refer to the process of change in relation to the families who attended the family therapy bereavement groups. A death in the family can mean multiple losses: There is a loss of the person, a loss of roles and relationships, loss of the intact family unit, and the loss of hopes and dreams for all that might have been (Walsh & McGoldrick, 2004). A death also requires the family to make immediate and long term family reorganisation and changes in the family's identity. Families have to reassess who they are and how they are going to be without the person who has died. The terms acceptance and adaptation in relation to families 'moving on' when they have experienced a death do not mean resolution in the sense of "getting over it". Nor does resilience in terms of loss mean just "bouncing back" by putting it behind you, cutting off from the emotional experience, and moving on. In this context it means active coping, struggling well, and forging strengths to meet the many challenges (Walsh, 2003). Coming to terms with a death can mean finding ways to make sense of the bereavement, putting it into perspective, and including it as part of life experience. At least that is the aim of the therapeutic intervention. When the latter does not happen, the families will find it difficult to adapt to some of the challenges that may come up, which will increase the tension and heighten the stress within the family system.

Many of the children who were referred to the bereavement group had a range of different reactions to death, depending on their stage of cognitive and emotional development, on the way the adults communicated with them around the death, and on the caretaking that they have lost. I believe that if there is a lack of openness in the family system, and mourning and communicating about the death is prevented or hindered in any way, then this may manifest itself in symptomatic behaviour (stomach ache, headache, pains and illnesses that can not be medically identified) in the child and young person. One of the aims of the family therapy bereavement group is to shift the level of openness within the family system so that changes can occur in one part of the system, which will ultimately have an impact on the rest of the system. Hence, allowing for the opportunities for multiple narratives to be constructed within the domain of the group and for families to begin to think and to talk about their difficulties differently and their bereavement experience within a group where other participants have a similar experience.

## **Background behind the Research Question**

Initially when I began this journey I was curious about the way in which children, adolescents and their families held and maintained their grief and whether the bereavement group was an effective therapeutic intervention in unlocking the grief and helping families adjust to their bereavement and take the necessary steps in coping with their loss. I was also thinking about what this change in the family would look like, who else would recognise that change had taken place, and how I could capture and account for this change and where the evidence was for this change. One of my thoughts, was the idea that the changes that had occurred within the children and adolescents were somehow linked to them attending the bereavement groups. Thus there was a connection between what we were doing in the bereavement groups and the changes that had occurred within the families. This change was identified as positive because often it meant that after attending the group, the majority of the children and adolescents were no longer exhibiting behaviour that was causing concern and no longer required a service from CAMHS. Usually, if further therapeutic intervention was needed after the group, it was for other issues that had arisen during the six weeks which needed more exploration. Hence, the research project was an excellent opportunity to document some of the narratives about these changes over the six years span that the group had been running, looking at the first seven groups.

However, at this moment in time I am curious and fascinated about the journey of change within families where there has been bereavement. This shift in my focus is a result of thinking about what holds the grief in place. Every school term children, adolescents and their families from different communities and cultural groups attend the bereavement group and share narratives about what happened in their family when someone died and how the death has affected each member within the family. The families also share some of their cultural and religious beliefs and those of the wider community of which they are a part. This includes scripts about how death is perceived and how they receive death as a community. Each family brings something different to the group, whether it is secrets, guilt, blame, laughter, tears and mystery to name a few of the variables. The narratives are interwoven with stories about the person who has died. Over the years I have noticed with increasing awareness that some families, despite their many differences, are similar in the way that they are unable to talk about the deceased without experiencing intense and fresh grief as if it had happened yesterday. As mentioned earlier, the primary reason why the children, adolescents and their families

attend the family therapy bereavement group is because they are having difficulty processing the death and are not able to cope or manage because of so many different factors that may be blocking the grieving process. It then becomes more complicated than a child or adolescent feeling sad because they have experienced bereavement. In order to deconstruct and make sense of what is causing the difficulties, it is a necessary part of my role as a therapist to take the mapping of some of these changes from within the private domain which symbolises the house/home of the families into the public domain which is the family therapy bereavement group in this context. Most family intervention before, at the time of, or after the death is directed toward opening up family emotional systems.

Change will also be viewed in terms of a change in the referred child or adolescent's behaviour, or where the behaviour is not getting any worse. There is a recognition that change in one aspect of a person's life will have an effect on and be affected by other aspects within a family system. The change that is being measured is viewed in the context of an improvement in behaviour and symptoms and not deterioration, and will be monitored by whether the child /adolescent may or may not require any further therapeutic intervention following the bereavement group and the child/adolescent is not re-referred to CAMHS.

Having outlined what some of the presentations are within the referrals to CAMHS, it is necessary to also discuss what aspect of bereavement I am referring to so as to emphasise the level of complexity of the issues that the child and adolescents are experiencing.

## **Bereavement /Grief**

Bereavement is the reaction to the loss of a close relationship. Sometimes grief is used to describe this reaction; however I am using grief to describe the emotional response to loss, the complex amalgamation of painful effects, which may include sadness, anger, helplessness, guilt and despair (Raphael, 1994). Over time there have been many theories, concepts and books that emphasise the necessity of the bereaved family to talk about the person who has died. Links have also been made between the bereaved individual's 'failures to talk' with 'a poor prognosis' for resolution of the grieving process (Fredman, 1997 p.1). Healthy grief has been described as feeling abnormal and relentless, as

if it is never going to end (Worden, 1991). As the bereaved person comes to live and adjust to their loss, the intensity of the pain slowly begins to diminish and with time, life comes back into their hearts and lives. The 'letting go' of the grief and thereby being able to 'move on' (Worden, 1991). To some extent my practice and professional belief was based on this concept, the working through the loss which in therapy terms is talking about the bereavement, but the talking is not just because talking will help with the grief but it allows for stories to be told and for episodes of death to be shared and events surrounding the death to become general rather than specific to that family. However, for some they are overwhelmed by the intensity of the pain, get 'stuck' in it and resort to maladaptive behaviours which bring no solution but multiple concerns about the bereaved child, adolescent and adult in the family. There is no single factor that leads to complicated grief which is discussed fully within the systematic literature review chapter. There have been several explanations as to why some people fail to grieve or get stuck in the grieving process. The reactions of a child or adolescent to a parental death are varied, and professionals have offered various theories. Kubler-Ross (1970) describes stages of mourning; both Parkes (1972) and Bowlby (1989) proposed that the individual must go through different series or phases before mourning is resolved. The psychological model assumes that the degree to which a child makes sense of a death is influenced mainly by the child's age, level of emotional and cognitive development, and emotional closeness to the dead/dying parent and to the surviving parent (Bowen, 1976; Schiff, 1977; Kubler-Ross, 1976). Another study (Elizur & Kaffman, 1983) suggests that it may be the surviving parent's withholding of emotional expression, over restraint, and an inability to share the child's grief that has the greatest impact on the child's adjustment. Later in the mourning stage it is the parent's anxiety, and inconsistency – that is, the inability to move past his or her own initial grief into structuring the child's world - that seems to have the most effect on the child's adjustment. Thus it is not so much the parent's grief reaction, but the inability to express it in the system and thus letting it come between the child and the parent.

Families do not generally seek treatment for issues relating to a recent or past death. Treatment is often sought for a problem or dysfunction in a family member or relationship. Although the symptoms are part of the emotional shockwave following death, the family does not view the death as the important issue in the current problem and so will not mention it (McGoldrick, 2004). It was surprising the number of parents who would ask their doctors to make a referral for their child to CAMHS because they were concerned but who did not mention the death in the family or the nature of the bereavement.

What does change look like in a family that has experienced bereavement and is having difficulty processing the changes that the bereavement has brought about in the family system? The change can be represented in many ways. It can be visual in a family member's change of behaviour and in their interaction with each other. Or it can be hidden, unspoken about, almost as if the death has not taken place. What is it that is creating the change in the family? Who else has noticed these changes? The adult in the family and teachers and other professionals have noticed the change in the child/adolescent and are concerned. Is the change a direct result of someone dying within the family system or is the change related to the bereavement? The change in the family has been brought to the surface via the bereavement in the family and the family is unable to talk or unwilling to adjust to see what this change means and what needs to be explored as a family system.

The change that I want to pay attention to is the one that brings the child/adolescent to the attention of external agencies, the change that is manifested in the child/adolescent's behaviour and is a cause of concern. What does this change look like? So to begin to answer this question I can use the examples with which I am familiar within the context of my work, starting with when the child is referred to the service.

The aim is to map the journey of the change; starting with how the family was functioning and interacting with each other prior to the bereavement, and then during the bereavement and after the bereavement. The therapeutic intervention has a number of different stages that can include working with the children, adolescent and a parent/carer during the period when the parent/carer is terminally ill and dying and after when the parent/carer has died. Families only attend the bereavement group when the relative has died. The majority of the intervention has been offered to children and adolescents after the family member has died.

This part of the research will ultimately concentrate on what is being created within the context of the family therapy bereavement groups that contributes to the children, adolescents and their families being able to go on. It will celebrate the magical moments when change takes place, the contributory factors that enable the families to go on. It will highlight the practice that unfolds during some of the interaction between the families and the therapist in the group. Moreover it will also demonstrate how I as a researcher and therapist am able to identify what change if any has taken place, and whether this is via the practice in the room. Also an acknowledgment that the focus of the research is not only about

families changing and moving on from their grief but an attempt at describing how they begin to confront some of the issues that are presented and that emerge within the bereavement group.

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## **GROUP WORK/ MULTIPLE FAMILY THERAPY**

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In describing bereavement groups I am aware that at times different terms have been used. Reference has been made to the Multi-Family Group (Laqueur et al, 1964; McFarlane, 1982; Asen et al, 1982 & Anderson, 1983). The Group work (Papell & Rothman, 1962; Klein, 1972, and Pernell, 1986) frame that has been historically and widely used by the social work profession from the 1900s (Maloney, 1963) has also been used to describe characteristics of the bereavement group. Both Multi-family group (MFG) and Group work capture core features but neither model was used explicitly as a basis to develop the bereavement group, but rather the professional education and practice and imagination of two therapists excited about working with lots of families informed the shape of the bereavement group. Having 'a moment' of what they wanted the group to be like.

The bereavement group is a core part of the research project and will be referred to throughout the doctoral journey. Therefore I would like to take this opportunity to talk about aspects of 'the group' as a frame from which the data has emerged. The group was created as a form of family therapy intervention for children, adolescents and their families. Historically in CAMHS, group work has been used for short term intervention, such as the Webster Stratton parenting groups (12 weeks), and anxiety groups that are based within secondary schools. These groups are usually organised in partnership with other agencies. Many decades ago, at the National Conference of Social Work in 1942, Gertrude Wilson emphasised the use of group work in effecting changes in the values of individuals and society as a whole. She believed that group work was a process through which group life was influenced by a worker who directed the process toward the accomplishment of a social goal conceived in a democratic philosophy. She defined group work as [1] developmental, as it provided for normal social growth; [2] protective or corrective, in that it could be offered to people without groups; and [3] instrumental in achieving of socially desirable ends. By understanding the personality of each member, the worker influenced the process within the group, and participation in the process helped members use the group for their own growth and development (Reid, 1981).

Some of the literature historically has focused on the group as a whole as a unit of intervention (Hartford, 1971; Klein, 1972) and placed less emphasis on work with individuals in the group. Others place their emphasis on changing individual group members within the group context (Rose, 1998;

Sundel et al, 1985). Toseland & Rivas (2001) maintain that when leading any group, the facilitator should direct their attention to individuals, the group as a whole, and the community in which the group functions. The facilitator focuses on the individual members to help them accomplish their goals. The facilitator intervenes with the group as a whole to achieve an optimal level of group functioning and to ensure that the group accomplishes its purpose. The facilitator will also assess the group's environment and decide whether to help the group adapt to it or change it. The bereavement group is also a therapy group and this term will be used at times to describe the nature of the group. During the 1940s and 1950s group workers began to use groups more frequently to provide therapy in mental health settings. Therapy groups are often associated with the professionalisation of group work as a method of practice. Thus the bereavement group is a psychotherapy group for bereaved children, adolescents and their families at a community mental health clinic within this context. Therapy groups are 'insight oriented relying less on program activities and more on treatment of an individual's problems' (Trecker, 1956) sometimes influenced by Freudian psychoanalysis and ego psychology. Fritz Redl (1944) and Gisela Konopka (1949; 1954) helped make group services an integral part of child guidance clinics. Konopka (1947) wrote that the use of group work in a child guidance setting would provide an opportunity for a child to test out reality in a safe environment.

The structure of the family therapy bereavement group has evolved from various discussions with the other co-creator and facilitator (family and systemic psychotherapist) of the group in the setting up stage over six years ago. At the time we had ideas of what we wanted the group to look like, based on our imagination rather than on anything that we had ever seen or read and from working with a wide range of families over the years. The idea of having more than one family in the room was primarily based on the belief that as family therapists we are one of the few professionals who are trained to work with as many family members in the room at any given time. It was also the way that we were working within our therapeutic work practice as family and systemic psychotherapists with children, adolescents and their families within a mental health setting. Ironically, it was not until four years later that I became aware of the multiple family therapy group work approach and all the various group work projects through which I realised that the family therapy bereavement group was functioning in a similar format. By introducing Laqueur's (1964), Asen et al's (1982) and Cooklin et al's (1983) models, I am able to make the necessary connection and to provide the audience with a portrayal of the structure of the family therapy bereavement group.

## **Multiple Family Work**

The concept of Multiple Family Work was historically introduced by Peter Laqueur and his colleagues in the sixties (1964). They used multi-family group therapy (MFGT) in a hospital setting with schizophrenic patients and their families. The presence of a number of families altered the context of the work and different roles, relationships and behaviours were able to emerge. By working with four or five families at the same time within a therapeutic context, Laqueur and his colleagues were able to observe 'improved' communications and 'better' understanding in these families as they learned from each other. Initially, Laqueur focused on inter and intra-family communication, in the hope that family members would understand some of the patient's (their family member) behaviour and also the symptomatic members of other families. This would encourage them to reflect on their own lives and the possible ways that they might contribute to the patient's behaviour. Laqueur (1976) asserted that the MFGT was distinct from other forms of therapy as it allowed the community to enter into therapy via other families. The community in this sense was represented by groups of people (families) with similar difficulties being brought together to have a shared experience of helping each other and being supported within that group. In the beginning, multiple family therapies were a combination of group therapy, family therapy, psychodynamic practice and attachment theory. Laqueur has continued to refine and define this type of intervention. This way of working was seen as being effective by many, primarily because it enabled a person to explore his or her own family dynamics in front of other families without being overwhelmed by his or her own family context (Boylin et al., 1997). This initiative has led to the setting up of more formal groups that have focused on a whole range of different presentations. It has been further expanded by Cooklin (1983) and Asen et al (1982) who went on to form the Marlborough Family Day Centre in London (as it was known at the time), providing a more intensive multiple family programme for families who were involved with various professionals and agencies like social services, police, probation and psychiatric services and also where more than one member in the family presented with a chronic problem. A further unit was introduced in the seventies whereby families would attend for over seven hours a day and for five days a week for a period of many months. This model of working has been in practice at the Marlborough Family Service for over three decades.

## **The Intervention (The Family Therapy Bereavement Group)**

The idea of the Family Therapy Bereavement Group (FTBG) came about primarily because there were no bereavement services or facilities for bereaved children and their families in the London borough where I work as a family & systemic psychotherapist within Children and Adolescent Mental Health Service (CAMHS). Thus the children and adolescents were being referred to the FTBG via CAMHS because they had been socially, mentally and emotionally affected by a death in their family. The shape of the FTBG has evolved over the years through many discussions between myself and my co-worker before, during and after each group and changes have been made, for example from open to a closed group, whereby no new family can join after the second week. This does not apply to family members who may join at any time during the six weeks that each group runs for. Both I and my co-worker wanted to see what was being created by the families within the room and as a result the group has been influenced by the families that have attended over the last six years. The bereavement group is facilitated by two family and systemic psychotherapists (I and another colleague who works in the adolescent outreach part of CAMHS).

In the beginning it was very much about working with what each family brought into the group. As therapists in the room, we were guided by the various needs, conversations and stories of the children, adolescents and their family members and then the group as a whole. Over the last six years, the structure of the group has remained the same; for example the group usually takes place on a Thursday afternoon and lasts for two hours. The FTBG runs during a school term and for a six week period. There is a process prior to the children, adolescents and their families attending the group. Families attending the group have to be assessed to see if they meet the criteria of the bereavement group and to introduce them to the idea of having therapy within a group setting. In order to meet the criteria for the group, children and adolescents have to have a death within the immediate family/carer (extended) system that is significantly impacting on them and their functioning life. These children and adolescents would have already met the criteria for CAMHS and their referral would have been accepted. The aim of the group is to provide a forum for children, adolescents and their families to explore their bereavement and its impact on their lives. Letters are provided for schools/ colleges and for employers requesting that the children, adolescents and their family members are given time to

attend the group. A leaflet explaining about the FTBG is also given to the family. The same consideration is given to families attending the FTBG as when working with one family. For example, if a signer or an interpreter is needed then that provision is put in place. The same consideration that is given to children and adolescents receiving therapy within generic CAMHS is given to each family member's therapeutic needs in the group, paying attention to what each individual says or in some cases does not say, always thinking about the dynamics, trying to make sense of what is being said and simultaneously trying to construct new meanings to enable the family to think differently about their experience. Throughout the group the therapeutic intervention has to be focusing on the child or adolescent who has been referred to CAMHS because there is a concern about their emotional, physical or mental wellbeing which has manifested itself in the change in behaviour and thinking about strategies to treat the presented behaviour.

### **The First Bereavement Group**

The first group was a pilot to find out if a bereavement group was necessary and it helped us as therapists/facilitators to highlight what changes needed to be put in place, what was effective and worked well with the families and what was ineffective, what was not working. So for example in the pilot, there was more structure but this had to be abandoned because the families were unable to work at the pace that we set. The families were unable to focus on so many activities in the first group. It was also important to find out if children, adolescents and their families would attend and engage in group therapy. We wanted to see if families would come together and talk in a group setting about their bereavement. One of the challenges included getting the families to attend a bereavement group within a mental health setting. This often meant arranging support for families to attend, so having family support workers to bring the families to the group. Making telephone conversations to reassure and explain to the families about what they could expect as part of the service and to find out what some of the difficulties were within the family system. This could result in making referrals to other agencies to work on the issues that are outside of CAMHS' remit (education and developmental needs). Some families required home visits and a number of sessions prior to attending the group.

We were aware of the stigma attached to mental health and the negative relationship that many people from ethnic minority communities have with the mental health services. Therefore we acknowledged that it would be difficult for families to attend on many levels, such as the nature of the group and as mentioned where the group was located. Many of the families raised the issue of attending a mental health clinic during their first appointment. A number of the adolescents voiced their fear of being seen as mad or having an illness and did not want to be seen attending CAMHS, as it was close to where they lived and where they attended school. There was also a general lack of awareness about what mental health services like CAMHS offer, so it was important to explain the structure and how CAMHS worked in terms of confidentiality in the first appointment. Many of the young people highlighted their concerns about friends, families and the wider communities finding out about their difficulties and the fact that they were attending a mental health service (Young Mind 2005 p.26). Over the years, there have also been concerns highlighted in research studies (Sue & Sue, 1990; McPherson 1999; Sashidharan & Francis, 1999; DOH, 2001) about the over representation of black men and women in psychiatric inpatient units. This has contributed to some communities viewing the mental health sector with a fear of misdiagnosis, holding a lack of trust in services and professionals and constructing possible reasons for not engaging (Street et al, 2005).

Many families have expressed how difficult it has been to take that first step of entering the bereavement group in the first week, but they do take that first step and stay with the group for the six weeks. As a result of the high number of families referred to the FTBG for treatment over the years, the group has become a valuable resource and part of a service on offer to the children, adolescents and their families who have been referred to CAMHS within the borough.

### **The Aim of the Family Therapy Bereavement Group**

There are a number of variables which can influence the outcome such as facilitator, group size, group participants' characteristics, the severity of problems which bring people to the bereavement group, the motivation of participants and the social support that is available to them and in some cases enables them to attend the group (McDermott, 2005). The group focuses on the difficulties that families are having within the family system. The aim of the group is to create multiple opportunities and possibilities

to highlight and explore some of the unspoken stories and difficulties that are reflected in the children and adolescents who are referred to the groups. It is the hope that within the FTBG the context and cause of the difficulties will emerge and become more explicit within the families. Thus the group will provide a forum for children, adolescents and their families to talk about what is preventing them from grieving and what is contributing to the change in their behaviour. (Anderson, 2007). The FTBG has a systemic approach to bereavement focusing on the impact of death and loss on the family as a functional unit, taking into consideration 'the chain of influences that reverberates throughout the family network of relationships, including partners, children, siblings and extended kin' (McGoldrick, 2004). The group is co-created by the therapists and families who attend each group. Hence the frame of the group remains the same but the context of the group changes according to what themes, issues and conversations are raised within each of the groups. Therefore the mood of the group is constantly being redefined by the families who attend. In some aspects the Family Therapy Bereavement Group shares many similarities with Laqueur, Cooklin's and Aisen's therapy groups, in that families come together and have been referred by a professional/agency. The families primarily attend the FTBG because they have all had a bereavement or in some families multiple bereavements, so immediately they meet on common ground and secondly because the children and adolescents are expressing difficulties in their behaviour. By bringing the families together in this context, the hope is that we as therapists can unpick some of the stories, family scripts, beliefs and feelings and try to make the connection with what is being presented in the group. Each group is defined by the different children, adolescents and their families and the different issues that arise and are presented within each group.

### **The Size of the Group**

The group has been a valuable resource because of its capacity to engage people at different levels of their grief (Mullender, 1996) so families who are recently bereaved can attend as there is no stipulation as to how long a family has to wait before they can attend the bereavement group. On an organisational level the bereavement group is another treatment option that is available and contributes to assessing and offering treatment to children and adolescents who are referred to CAMHS. It has been very cost effective over the years as the group can accommodate up to 6 families, normally two

families can be seen during that period by each therapist (if the families turn up). In the bereavement group there has been a minimum of 9 participants and up to a maximum of 28 participants in the groups during the two year research project, with families turning up every week, being seen in a two hour session slot, by two therapists. Therefore it increases the number of children and adolescents who can be seen in that period without any extra cost to the organisation. There are generally advantages and disadvantages regarding small and large groups. Some members feel more able to express their feelings in a small group and might hide in a larger group and not get involved in group tasks (Preston-Shoot, 2007). The large size of the bereavement group is uncommon within therapeutic group work, as the average size of any group work is 8, as *this facilitates task orientation, expression of disagreement and social interaction (and) the smaller the group the greater the likelihood that the one to one interaction between members or with the group workers will develop rather than interaction as a group* (Preston-Shoot, 2007 p.76). Some members may feel comfortable in a larger group. The bereavement group is not a traditional nor a self-directed group and it is recognised by both therapists/facilitators that opportunities are created to ensure that the group achieves its purposes and that each member is made to feel comfortable and secure within the group regardless of the size. The only stipulation about size is that it accommodates up to 6 families in any given group. The bereavement group has been a success because of the attendance of the families which is partially due to the way the participants influence each other. Listening to each other's stories makes them feel that they are not alone. To know that other families have experienced bereavement and have a child/adolescent who is presenting with difficulties, provides the common ground upon which the families connect.

***"It was good to talk to other adults and to listen to other families; you don't feel so bad because everyone is here for the same reason". (Group 6, mother died of cancer)***

***"It has been so good for me to hear other people talk; I thought that I was by myself" (Group1, family 1, baby died)***

***"It has been good to talk and to listen to other people". (Group 2, Family 5, Father died)***

Members of treatment groups tend to be bonded by their common needs and common situation. Groups have the broad potential to provide useful information, coping strategies and social skills for families in crisis (Walsh, 1996). Resilience is gained through contact with other families dealing with



similar challenges and through learning from each other. The group can influence and shape participants' behaviour (Home, 1996) and 'produce good individual and group outcomes', whilst 'interaction allows spontaneous sharing of experiences...'. Home (1996) maintains that both influence and interaction can result in some members' contributions being heard and valued more than others and that the final outcome may not be representative of the entire group's experience. This may be the case for some groups but with the bereavement group, strategies were put in place to enable all the participants to talk. It is the facilitator's responsibility to encourage all participants to tell their stories, a mascot was held to indicate whenever someone wanted to talk and simultaneously questions were being asked all the time by the therapist in the room, to not only get a fuller description of what has happened but also hear to the quieter members.

### **The Rhythm of the Group**

There would be a circular approach of going around the room ensuring that everyone had contributed to the telling of their family story and their individual story. The quieter members are encouraged to speak, even if it is to say '**I don't want to talk**'. The more talkative members are managed in a way so that they do not overpower and silence the other members. Therapy is taking place within the group therefore the moment that the group begins; Boscolo & Bertrando (1996) argued that the therapist acquires the right to decide what to speak about and, therefore, the themes of the conversation, and to decide when to pass from one theme to another, or when to interrupt the speaker (child, adolescent or family member and interpreter if need be), to suspend or conclude the session and so forth. To some extent within the bereavement group, it is the therapist/facilitator who opens the group and introduces the reasons why the group has taken place, because it is a voluntary group even when the referrals are made by social services. There has also to be a level of curiosity and neutrality on the part of the facilitator so the members decide what they want to talk, about which may in turn evoke questions from the therapists and the other members within the group. Neutrality at one level seems to be a way of translating into human terms Bateson's (1972) idea that all parts of a given system must, if the system is seen systemically, be given equal weight (Boscolo et al., 1987). The therapist will be multi-positional; using circular questioning allows the therapist/facilitator to move in an equivalent way from member to

member. The bereavement group is managed by the therapists similarly to the way a therapy session with a single family is co-ordinated. It is not conducive for either therapist to be too directive or authoritarian as it is important that the members feel safe, respected and welcomed and that no one will feel that the therapist/facilitator has taken a family member's side. "*Neutrality becomes synonymous with the effort to avoid induction by the family system and to move freely in therapy*" (Boscolo et al., 1987).

Although the groups are run in a collaborative and social constructionist frame, things are considered rather than imposed; it is still important to acknowledge the power of the therapist/researcher. A collaborative approach takes the position that there is no such thing as an objective problem. Problems are a form of co-evolved meaning that exists in ongoing communication among others and self. Problems are considered part of everyday living; they are not considered the product of individuals or families. From a collaborative perspective each observation, problem description, and understanding is unique to the people involved and their context. "Each problem is conceived as a unique set of events or experiences that has meaning only in the context of the social exchange in which it happened" (Anderson, 1997a, p.74). The problem is not fixed, can be collaboratively explored and defined through conversations with all the family. The vast majority of families who attend the bereavement group readily accept this way of working with therapists and in a group, and are comfortable with the idea of bringing their private conversations into the public domain. There are many explanations for this. Some families may be keen to get on and discuss what brings them into the group, for others the concern around their child/adolescent is so stressful and involvement with agencies new and strange that the additional strangeness of being in the bereavement group with other families and two therapists/facilitators makes no difference. Some of the families may not feel able to object but are willing to give anything a try. Most of the families that are referred to CAMHS have gone to their GPs and made the referral themselves so are asking for the therapeutic intervention and want to attend therapy as a family. However, it is important for the therapist/facilitator to consider any apprehension the families might be feeling and to be prepared to facilitate the families' questioning of the group as a form of therapeutic intervention. Not every family likes talking and looking back at the early groups I viewed 'not talking' as a problem within the group or as the family struggling with their bereavement and being in denial. Over time my thinking has changed to generate room for more perspectives as brought

to me by the families I have worked with over the years.

The concepts and themes that emerge will often guide and focus the therapist in probing and prompting questions until an understanding is reached in the room between participant and therapist. Probing questions rather than directing encourages participants to share their experience and their feelings (Abu-Samah, 1996). In treatment groups like the bereavement group, members are expected to disclose their own concerns and problems (Toseland & Rivas, 2001) and therefore the proceedings of the group are confidential and participants are informed about the confidentiality policy at the outset. This is extremely important because in the majority of the groups some of the children/adolescents attend the same school, and are sensitive about their peers knowing that they come to a mental health agency. When answering questions, the family members will reflect on their experience and will reason the action that was taken at the time. It is those feelings that the therapist wants to unlock and to understand the meaning (within a context that reflects what has been described). The same approach is used within a family therapy session where all family members are in the room and everyone is invited to say what has happened or is happening within the family, all voices are to be heard, not just the dominant voices, which in a family are often the parents. Attention is given to the details of each child, adolescent and their family member and their position within the group and to the stories that we hear or have before us when we meet each family. Individuals' constraints can normally enhance or restrain group behaviour and achievement (Douglas, 2000); however with bereavement because everyone is at a different stage with their grief, it is unlikely that in that first week individuals will have such an influence on each other because the first week is the telling of each member's private experience of their bereavement, which is usually an exhausting process. For example, there is no stipulation in the group about the timing of the bereavement, there have been families where the death have been as recent as six weeks and as long ago as six years, some families have a single death, others multiple deaths, however the focus of the group is on the impact of the death on the family, not on the timing.

Each group has its similarities and differences and may vary in fundamental things like showing emotions. There might be a group where all the participants of the group cry when telling their story and when they are listening to other families telling their story, whereas with another group there would be either very little or no tears over the duration of the group. Each group will make up their written ground

rules at the beginning of the first week, which are then placed on the walls of the therapy room for the weeks ahead. Each group takes careful planning and time invested in ensuring that issues are addressed prior to, during and after the group has ended; (on a weekly basis and at the end of the six weeks) between myself and my co-worker. There are many tasks involved: referrals have to be assessed prior to the group and letters written to the family and referrer with the details and stipulations of the group such as the time of the group and committing to a six week treatment programme. Monitoring the size of the group, finding out who will be in attendance, booking the room in advance, allowing ample time for the pre and post session conversations with the co-worker, these are an integral part of ensuring that the group runs effectively.

All interpreters are booked in advance and for the duration of the group. However if there is dissatisfaction with the quality or conduct of the interpreter, then this is reviewed and immediate steps are taken to ensure that a suitable interpreter is booked in time for the next session. On many occasions more than one interpreting agency has been contacted for a particular language and some interpreters do not want to come back after the first week, because they have found it quite difficult to interpret the other families' bereavement stories. Some interpreters find this process quite upsetting. All interpreters are spoken to before the group begins and informed about whom the group is for and what is expected from them. It is very difficult to prepare them for what they are actually going to hear because it will be the first time that the therapist/facilitator in the room will be hearing the story in that context and by all members in the family. There is always a de-briefing after each session for the support services. Interpreting for a family member in a therapy session is different from interpreting for a family member in a group where it is paramount that all that is heard and said is interpreted precisely. Group members are advised to pause in the telling of their story, so that all of what they say is received and then passed on by the interpreter in the room. It is not uncommon to have more than one interpreter in the bereavement group.

A solid framework has to be provided from the onset, one that can be developed and refined (Harry et al, 1997). There has to be the commitment on behalf of the facilitators to develop a group work package that is available for the organisation to have as part of their service plan. The facilitator of the group has to have the responsibility for running the group. This is done in partnership with the administration staff who play an essential role ensuring that the leaflet is produced and referrals are monitored when they

arrive at CAMHS, so that no child or adolescent is kept waiting unnecessarily for treatment. Levine (1979) suggests that “group therapy can help with anything that individual therapy can, providing an appropriate group is available and the individual will accept the group as a mode of treatment”.

Home (1996) has raised the issue of participants not feeling comfortable discussing sensitive or controversial subjects in a group of strangers. However, in the bereavement group it was felt that the experience of being bereaved is what would help them relate to each other. Everyone starts off on an equal footing because of the death in the family, but owing to the circumstances surrounding the death and the family relationship with the person who has died, it may be uncomfortable sharing controversial issues like suicide, murder, or if the person was having an affair or involved in drugs etc. During the six weeks, the adults and children/adolescents are separated into two groups as part of the programme for the third and fourth week so that there is ‘adult talk’ and ‘children talk’ and that each group can talk freely with their peers. This is always appreciated by both the adults and the children/adolescents. If either group wants to bring what they have discussed into the larger group then they can, but it is voluntary. ‘Family talk’ is usually in the 5<sup>th</sup> week. Abu-Samah (1996) focuses on the empowerment of the group and states that individuals empower themselves when they realise that they have the capacity to act and decide for themselves. To some extent the group is shaped by the participants but the decisions are made by the facilitators as to the structure of the group and the order of what takes place every week, not the content. That is decided by the members and the therapist; the therapists are always appreciative and overwhelmed by what the members share within the public domain. Obviously what is shared is determined by the participants but it is the responsibility and skills of the therapist to encourage the participants to feel comfortable enough to talk about their experience, recognising how difficult the members might initially find it to talk within the group. It helps families to see the same therapist who assessed them prior to the group beginning, a familiar face when they walk into the group as they would have met the families prior to attending the group. It is also a conscious effort so that families do not feel that they are telling and re-telling their story to different professionals.

The interaction in the group is dialogical (Shotter, 2001) which involves a two way process of interaction between the children, adolescents and their families and the therapist, whereby to listen and encourage another person to talk about their feelings and experience is part of the group process. Dialogical also means the joint nature of human activity which is another term for collaborative and social construction.

Shotter describes it as “when a second living human being responds to the activities of a first, then what the second does cannot be accounted as wholly their own activity - for the second acts in a way that is partly 'shaped' by the first (and the first's acts were responsive also)... this is where all the strangeness of the dialogical begins ("joint action" - Shotter, 1984; 1993a and b). It is also “what is produced in such dialogical exchanges is a very complex mixture of not wholly reconcilable influences - as Bakhtin (1981) remarks, both 'centripetal' tendencies inward toward order and unity are at work, as well as 'centrifugal' ones outward toward diversity and difference. Shotter (1999) also explains that “it is a result of our socialization into such dialogical activity-flows, we develop background, practical, relational- responsive forms of understanding of how to 'go on' within them - such forms of understanding are constitutive of what counts for us as the significant, stable and repeatable forms within that flow”.

The systemic therapist takes an interest in the internal and external dialogue of each participant and thus in their ideas, words, and emotions about themselves, the systems they belong to, and the therapeutic system (Boscolo & Bertrado, 1996). Within the group timing is paramount, for example when in a dialogue consideration is given to when would be the right time to introduce, accept or abandon themes. A premature introduction of a given content may create resistance, yet overlooking a topic that may be significant to the participant can diminish their interest or create tension in the conversation/dialogue. As a therapist within the group we have to decide whether what we consider to be interesting at any given moment is also interesting for the client. To dwell too long on specific content could emphasise its importance and overshadow in some way other significant aspects. This is so important within the group, that as a therapist you do not get fixated on a point. With curiosity comes mindfulness. There is a certain level of autonomy where everyone has the opportunity of expressing how they feel and to describe the sense that they have made of their world and their reality, which can be different from the person sitting next to them who is often a family member. By reflecting on the experiences that they have undergone, they are actually making sense of their past and linking it to their current situation with the aid of the group members and the therapist in the room. McDermott (2005) claims that everyone in a group becomes both a participant and observer, especially as the ‘power shifts as meanings are constructed, negotiated and challenged or allowed to prevail’. Abu-Samah (1996) talks about the dialogue taking place in a non-authoritarian context where the position of

therapist/researcher and the participant is a subject – to –subject relationship, ... with mutual trust, respect and reciprocity, the information, as knowledge, is shared together. I would expand on this and say that within the context of the group the participants are expecting the therapist to assist them in making sense of their grief, they want to feel better and they want their children's behaviour to improve. The therapist is expecting the participants to tell their story and a level of transparency is expected from the client. Therefore what the client says must be the truth as they know it.

Although at the same time the therapist is interested in the "Not yet said". Anderson & Goolishian (1988) describe this "Not Yet Said" as creating possibilities of new perspectives or constructions that may resolve the concern. In bringing forth the "Not Yet Said", the therapist widens the repertoire of distinctions of who we are and redefines the meaning that the participant has attributed to their experience. Usually the therapist is encouraged by a family's response and willingness to engage to know when to ask the "Not yet Said" and this has to be the client's choice but prompted by the therapist's curiosity and knowing when there is an element of safe uncertainty (Mason, 1993). This means establishing a safe environment for the members to take risks within the public group. Burnham (1988) talks about a safe team as a place where absolute realities can be suspended for a time, so that the unsayable can be said, and again this can be applied to the co-workers creating that environment and what the group offers to members, where members can risk expressing partial or unreasonable views or feelings about the person who has died in the knowledge that these will not be acted on/ 'jumped on' or be suspended around the family member's neck for the duration of the six weeks like a *'label of identity'*. In bringing the complexities of the grief, families need a safe place in order to think fully and differently about what has taken place in their families.

Minuchin (1974) used the very apt metaphor of the "dance" to represent the therapeutic relationship. The greater the flexibility in the rhythms and movement between the two dancing partners, the more likely it is that they are temporarily coordinated and that the therapy will have a positive evolution (Boscolo & Bertrando, 1996). Therefore within the group the therapist is dancing with each participant, with each family and with the group as a whole and the co-worker. Each dance has to co-ordinate with the different partners and each sequence differing from the others. The dance has to be very fluid with the co-worker, no stepping on toes or dancing to different tune. Bateson (1994) expands on this and states that 'we are called to join in a dance whose steps must be learnt along the way. Even in

uncertainty we are responsible for our steps'. In order to dance with the client, the therapist's rhythm has to be modulated to suit, within certain limits, those of the client. At the heart of systemic therapy lies the assumption that human beings in their interaction with one another (Burnham 1988) extend invitations to join with one another. The therapist does not stand outside this interaction, she extends and accepts invitation.

## **Co-Working**

The advantage of having two lenses inside the bereavement group has always been a valuable asset of co-working. The bereavement group has always had two therapists/facilitators and the same co-workers for the seven groups and the many others that have followed in subsequent years. Two therapists working as a team regularly over time constitute a different entity from two therapists as individuals (Burnham, 1988). The bereavement group captures so many different moments of what is happening or has happened in the family by the conversations that they have with each other and the way that they relate as a family unit. It is by deconstructing the conversations and their interactions that as therapists/facilitators we are able to make sense of the conflict and difficulty within the family. Two therapists in the bereavement group act as two lenses within a group, focusing on the participants from different angles. Although there is co-working in the group, outside of the group we do not co-work with any of the families.

When family therapy was first practised it was common to use co-therapy, that is two therapists working together in the same room with the clients. This became less frequent with the introduction of the one way mirror or screen (Burnham, 1988). Bateson (1978a) talked about the advantages of having a one way mirror as a 'double description'. I think that the same could be said about co-working, obtaining more than one view of an event, which would enable us to achieve the cognitive or emotional equivalent of a binocular vision, thus gaining, in a metaphorical sense, perspective on our observations and experiences. Co-working can offer two perspectives with which to analyse situations (Blacklock, 2003).

Co-working has been said to model effective interactions, offering a cooperative and creative relationship based on collaborations, trust, and clear communication, constructive use of difference and the expression and resolution of disagreements (Groves and Schondel, 1997/98; Blacklock, 2003). The responsibility of the bereavement group is shared. As co-workers we accept total responsibility for



monitoring the families within the groups and the progress of the group is discussed before and after each group. Whitaker (2001) has identified the importance of co-workers sharing similar views about their approach to the group, what they hope the group can accomplish and how they will function in it. There is a general discussion about the aim of the group in the initial assessment and in the first week of the group. Preston-Shoot (2007) stresses the necessity of having compatible attitudes when dealing with the variety of problems and situations that may arise in the group. There is a lot of discussion at the onset of the group about the techniques, aims, idea about what the group is about and who the group is for, the structure and expectation of the group is always reviewed after each group has taken place.

There is a level of confidence in the co-working relationship that has increased over the years and with the group but was strengthened by the initial planning and preparation of the early groups when everything was all new and there were lots of meetings regarding aspects of the group before it took place. As co-workers a dance (Minuchin, 1974) has developed over the years and within the groups that allows for new steps to be taken and new rhythms to be created. Twosomes has been described as being closed (Burnham, 1988) As co-workers, we are peers within the bereavement group with levels of experience as family therapists and have worked together within the family therapy forum as part of the family therapy team. We are also a very stable team; it would seem that teams of two only are likely to stay together longer (Hoffman in Boscolo et al., 1987). Families will have the same therapists/facilitators for the six weeks, the duration of their treatment.

As part of the research project I interviewed my co-worker and it was very interesting to reflect back on the seven groups and the way that we felt at the time. (R) represents the researcher asking the questions and (C) the co-worker reflecting and answering some of the questions.

® ***“What do you remember about the first group?”***

© *“Very interesting..... Because there was really a lot of desire, enthusiasm, keenness to do this type of work.”*

® ***“Groupwork or bereavement?”***

© *Both, it was really recognising at the time that often young people were referred and somewhere in their history was bereavement; there was nothing at the time for this in the borough. I wonder who was doing the work, who did what at the time?*

*It was really difficult to find a venue.*

® ***A town hall.***

© *Yes, massive room, actually the biggest room that we've ever had since.*

® ***We could do with it now, the room, because the size of the group has increased.***

© *It's interesting to reflect on the thinking, the planning, needing support workers so that if someone got...*

® ***Stressed? Having support workers to deal with that, but now we deal with it, now it's a part of the group.***

® ***I wonder why we thought about dealing with the upset separately?***

© *Challenges, we had a child with disabilities.....It was a big building, a public place it was an issue of safety, strangers. Children had to go to the bathroom and we had to keep them safe.*

Interestingly when discussing the co-working relationship, Minuchin's (1974) and Burnham's (1988) analogy of the dance is referred to by my co-worker when reflecting about the working relationship that was created within the bereavement group.

®) ***When did it take its form? How did we get there?***

© *"A dance before and throughout the group, it's always been continued, our own dance?!"*

® ***"How did we get to the place, where we have established our own dance?"***

***"I am still wondering about how we get to the place of being, where we had our established dance?"***

© *"I don't know if it's because from the beginning we've come from a training establishment where creativity, different steps have been very much a part of .....where training is about the joining, the grammar, the listening, hearing, being aware, noticing .....that has enabled us to do that step".*

© *"The group is the way it is because of who runs it and who comes into it. Having the ability to be creative, to connect, to respond and join with different people. People have to join in with the dance whether it's one step or multiple steps".*

© **"When we are all dancing together?"**

© *"Yes, knowing your co-worker, confident in co-worker /facilitator who you know will be there noticing the same things, different things but noticing..... even though we might come from different positions in how we work with the families collaboratively. We take time to connect, share, to be in motion pre, post session, in the group. We take care of the families inside and outside the group".*

Thinking about the factors that have made the group effective and successful:

© *"Sharing the big responsibility, our caring, passion, commitment and believing that the group is and does work....space to talk transparently with other children, adults within a structure that is created just for that".*

© **"What do we take into the next group?"**

© *"New dance steps, ways of dancing build on, develop a catalogue of different memories, different voice to take forward and which can be helpful at some point, the experience which is growing each time ."*

It was interesting to reflect after so many years on the first seven groups some years on, I was intrigued by the emotion that the memories provoked and amazed at the passion that we both still shared and expressed. Looking at the dialogue afterwards I was struck by the way that we would finish each other's sentences and the way in which we had developed as group workers and in confidence in working with bereaved children and their families.

## THE ROLE OF THERAPIST AND THE RESEARCHER

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Within the context of this research I have two roles: one as a therapist within the family therapy bereavement group and one as a researcher who is enquiring into the practice that is being created within the group. Thus, I have positioned myself as the therapist and the researcher within the group. As the therapist, my role is to create a space (family therapy bereavement group), where family members could talk and be listened to..... which allows them to transform their theories, their understandings and ways of being individually and together (Anderson, 2007).

Thus within the group, I have two roles but in this position I am one person trying to look at different factors using more than one lens at any given time, trying to think about what is being created and working with the families to construct new meanings to some of the experiences that have been expressed within the group. My co-worker would have the position of therapist and facilitator. One of the ways in which we work is to bring to the foreground what has taken place in the past, linking to what is happening in the present. It is an integral aspect of our practice to explore and investigate the relationships between the different systems that are brought into the therapy room by the families. As a therapist and a researcher, I am curious about what is happening in the various systems that is causing the effect. In this instance, the effect is visible in the child or adolescent and is being manifested either in an emotional, social or physical way.

### **The Insider/Outsider Perspective**

As a therapist I am an insider, but as a researcher I am an outsider looking in at the practice that is emerging within the therapy room. Am I able to be both an insider and outsider or do I stop being a therapist when I assume the role of researcher? Having an insider position as a researcher is different from having an outsider position; there are many strengths and challenges of conducting qualitative research from each membership status. Am I able to operate as a researcher and a therapist simultaneously and how does one influence the other? Maykut & Morehouse (1994) wrote "*The qualitative researcher's perspective is perhaps a paradoxical one: it is to be acutely tuned-in to the experiences and meaning systems of others—to indwell—and at the same time to be aware of how*

*one's own biases and preconceptions may be influencing what one is trying to understand".* In order to answer some of these questions, I had to think about how and when I adopted each role. As therapist/facilitator within the bereavement group, I have assumed an insider position but that has not given me the same status as the other members (families) in the group. Corbin Dwyer & Buckle (2009) state that *"the issue of researcher membership in the group or area being studied is relevant to all approaches of qualitative methodology as the researcher plays such a direct and intimate role in both data collection and analysis"*. They also maintain that *"whether the researcher is an insider, sharing the characteristic, role, or experience under study with the participants, or an outsider to the commonality shared by participants, the personhood of the researcher, including her or his membership status in relation to those participating in the research, is an essential and ever-present aspect of the investigation"*. An adolescent in one of the groups asked my co-worker and me whether we had experienced bereavement ourselves and was curious about why we chose to run a bereavement group. At the time it felt uncomfortable to answer what felt like a personal question and I focused on her reasons for asking the question in that moment. As a member of the group she wanted to highlight that we were not sharing our experience of bereavement like the other members in the group. In my role as an insider researcher I will and have developed knowledge that not only will enhance my understanding of the families' experience but also has and will assist me within my work practice when working with other families and colleagues. However I do belong to the group (community) in which I hope to conduct the study as it is important for qualitative researchers to situate themselves in the research (Ely et al., 1991).

Corbin Dwyer & Buckle (2009) suggest that one of the benefits to being a member of the group one is studying is acceptance. One's membership within the group automatically provides a level of trust and openness in the (families) participants that would likely not have been present otherwise. Being an insider might raise issues of undue influence of the researcher's perspective, but being an outsider does not create immunity to the influence of personal perspective. I have not restricted myself to only having an insider or an outsider position. Corbin Dwyer & Buckle (2009) introduce the concept of the space between that allows researchers to occupy the position of both insider and outsider rather than insider or outsider as it limits one to an either/or, or one or the other position rather than the both/and stance. They talk about a dialectical approach that allows the preservation of the complexity of

similarities and differences, by suggesting that *“not being a member of a group does not denote complete difference. It seems paradoxical, then, that we would endorse binary alternatives that unduly narrow the range of understanding and experience”*. Fay (1996) believed that to be considered the same or different requires reference to another person or group. Fay (1996) noted that each requires the other: *“There is no self-understanding without other-understanding”* (p. 241). Accepting this notion requires that noting the ways in which we are different from others requires that we also note the ways in which we are similar. This is the origin of the space between. It is this foundation that allows the position of both insider and outsider (Corbin Dwyer & Buckle, 2009). Holding these various positions has allowed me as a researcher/facilitator and therapist within the bereavement group to have multiple lenses in which to gather my data and to analyse from different perspectives.

The group was started before I began my research journey; therefore I was functioning as a therapist in the group for a number of years before I began my research. The role of an insider researcher was adopted once I became clearer about what the focus of my research was and knowing what I wanted to pay attention to. Initially it was like having a camera lens and not knowing what to capture. Everything was and could have been of relevance. The bereavement group was the background and I had to decide what images would be projected on the lens. I am always aware that whatever comes out of the background (bereavement group) goes back into it. This allowed me as therapist to make the necessary adjustments, in order for the group to become more accessible to all families. Over the years, I have been in many bereavement groups with my therapist and researcher hats on, which has meant that a lot of inner talk has taken place whilst I have been positioned in the group. At times I have found myself making the different connections and reflecting on my practice and pushing myself to ask a question that challenges the feelings in the room. On reflection, I would say assuming the researcher role, in addition to having the therapist role, has provided me with the ‘courage’ to introduce something new but of relevance in the room. The term ‘courage’ is used loosely to refer to a boldness that is felt prior to asking the question and not be intimidated by the difficult and uncomfortable responses from the families. Introducing something new is similar to taking the next step in moving the family onto another level, to a place where we will all be dancing to the same tune but taking different steps. The decision to move to another level has been made within a therapeutic framework but with a researcher’s curiosity. As the therapist, I ask the question within a therapeutic context to see if I will get

a desired outcome within a researcher's framework, as I am experimenting with the hypothesis that I have about the family system. Rose 1985 (p.77) asserts that "There is no neutrality. There is only greater or less awareness of one's biases. And if you do not appreciate the force of what you're leaving out, you are not fully in command of what you're doing". For example, if my focus is 'magical moments' that represent the change or shift in the family. The 'moments' where the 'missing something' has been discovered, or the new connection has been created and then brought back into the system, which will hopefully be explored to enable the families to move on to create a new family script. In this example, the researcher will be noticing the process of how that moment came together. In this role I am asking what I did to make that happen, what was created between the therapist and the client. What has come out of that collaboration; magical moments cannot be created in isolation? However, does this mean that I have become more curious about the relationship between my practice and the changes that were perceived in the families who had attended the bereavement group? I think not. I have always been curious about each family that I have worked with even when I am wearing different lenses and different hats (therapist or researcher). Being an insider does not make me a better or worse researcher; it just makes me a different type of researcher.

This journey provided the space to research into my practice. Until that point there was neither the time nor the space within my work schedule to explore at a more in depth level. A lot of the thinking and preparation for the group was done outside of my normal work schedule. Whilst preparing for the first seven groups I felt that everything to do with the group was my responsibility, doing everything, feeling totally responsible because the success of the group was a result of the planning and time that went into it at the beginning. As therapist and facilitator there has always been a sense of ownership for the existence of the group. Despite the bereavement group taking place every term, there was never enough time to evaluate or absorb and make sense of some of the things that were said and done by the children, adolescents and their families. Therefore, it has been imperative to the development of the bereavement group to have the space to be able to describe the 'something that is happening in practice' through a vehicle like a research project. External supervision was provided for this purpose, which we both attended.

Facilitating the group and attending to all the administration, there was little time to think about what service had been developed within CAMHS for the children and adolescents and their families living in

the borough. On this research journey there have been opportunities to look at the experiences of the families that attended the first seven bereavement groups. I had just always been working within my practice and not able to see outside of it. Most of the time it felt like I was working from within the middle of the practice, always in the middle of complexity, never having time to reflect. Becoming a researcher has allowed me to assume an outsider's position as well as an insider's. Being reflective was an integral part of my systemic training and current work practice. Working within a reflective team is also a weekly feature within my work as a family therapist. The reflective team (the team behind the screen) consists of other family/systemic psychotherapists and clinicians from the multi-disciplinary team (psychiatrists, psychologists, child and adolescent psychotherapists, and speech and language therapists) and on occasion professionals from other agencies like social workers who may join us in the therapy room with a family. Thus there is always an 'outsider' element present within the frame of family therapy. It has been an interesting process to reflect on my practice and acknowledge areas where I asked a question on impulse or with caution. Having both roles has empowered me to think differently about the same situation and to think about the changes that have taken place for me professionally as a practitioner and as a researcher.

Having the position of a researcher can influence what I focus on and pay attention to as a therapist within the group. As a researcher, I am also able to initiate moves that can make a change to the situation. One of the advantages of being a researcher is that I can expand domains of questions that may have been overlooked or not been asked as a therapist. This is done in my quest to understand and to be coherent about my practice and the extent to which my practice contributes to any of the changes that may be occurring within the family system. The researcher's role was different, in that it was not a clinical one but similar in that there was equal curiosity in both roles. However, on more than one occasion, I have been curious as to whether I had asked the family a question as a therapist or as a researcher. The researcher role is a relatively new one, therefore I am still adjusting to the role but I recognise that having the position of a researcher has provided me with more awareness that enables me to map when something has shifted in the family in the group, it creates a punctuation that can be explored.

As a researcher, I have moved out of my comfort zones, areas that I am familiar with and deliberately put myself in the discomfort zone, so as to ask the question that might trigger or provide the realisation within the family that something needs to change within the family system, in order for there to be an



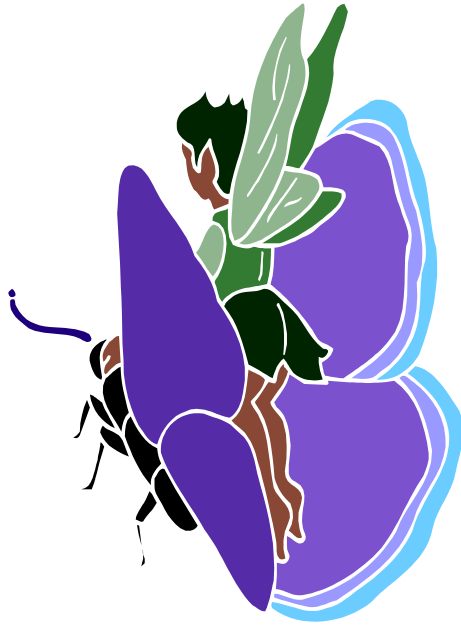
improvement in the child's or adolescent's behaviour. The enquiry is not always comfortable because the question that I have dared to ask is not always received favourably by the family member at the time. Often it is the enquiry into the response that provides the meaning and enables the family to make that change. The purpose of the enquiry is to assist in enabling 'something to come into visibility'. In a researcher's mode I am being carried away to somewhere where I am not always familiar with the environment, as it can be outside of the normal comfort zone of therapist and client. It is also a practice based enquiry, based on what is being created and emerges within the room at that moment. Thus who makes the decision as to what step is taken, the researcher or the therapist? Who is more curious as to what creates the next step, what informs the practice for the next step, and who will benefit more from the answer, the researcher or the therapist within me? The therapist within me will ultimately decide on the question to ask, as the therapist role is one that is more comfortable, then I can ask myself the same question with the researcher's hat on and see to what extent the question would be framed differently. Earlier I mentioned being in the middle of the practice and reflecting on various processes. I have now realised that I need both the roles of therapist and of researcher in order to do this effectively. How can I show myself to my audience what it is that I am doing? Or have done, if I am researcher? This can only be done within the body of this doctorate where I am explicit about the methods that I used to arrive at my findings and to be transparent about the fogginess that became clearer on the way. There has not always been transparency with this role because as I mentioned it took some adjusting to the position of researcher.

Whereas as a therapist a significant amount of training was had before I began working as a family & systemic psychotherapist. Some of the questions that I have asked over the last three years have been in reflection back to the previous and current bereavement groups and the lens that I was looking through at that given time. I am not able to go back and change how previous groups have gone, or change the questions that I have asked or the outcomes. However, I am now able to think about the groups, about interactions and situations that I am curious about and instigate to some extent the space to explore what I am focusing on as a researcher. For example, at the time of writing this I am exploring what holds the grief in place within the families. What beliefs are holding the stories in place and thus preventing any change from taking place within the family system? Or at least allow a shift that will enable the child or adolescent to grieve appropriately? Therefore I have to focus on asking questions that will assist me in deconstructing various beliefs and scripts that the family may have and going back

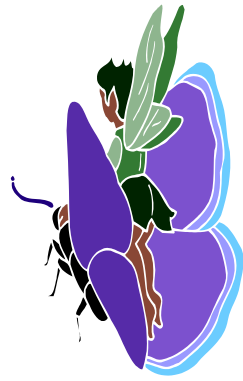
to my data and immersing myself so that I extract new information that I may not have had the skills at the time or known exactly what /where I needed to look. My lenses have multiplied over the years in the position of therapist and researcher and I can now wear two lenses comfortably rather wanting to look through one.

I would like to think that the role of therapist and researcher enables me to create a place for something different to happen and looking for something different within the bereavement group. Hopefully, I too have changed over the period of time and as the research developed. I can track the difference in my work practice, although I do wonder who else has noticed. I have noticed going back into my work after spending time on my doctorate, I feel more energised and excited about the area that I am working in and the children, adolescents and their families that I am working with. I am able to verbalise what happens within the bereavement group and how families can benefit from attending. Moreover, I have more awareness of the difficulty that families have communicating with professionals after they have experienced a death in their family and think of other ways of assessing them, i.e. at their homes, having longer assessment periods before treatment (the bereavement group). I am also slowly becoming aware of the importance of how to present the inside systemic world to the outside world, thinking about terms, jargon and thinking about the different audiences that need to be reached. The next stage will be how to find a research method that will allow me to capture and construct those passing moments into events when change happened in the families within the domain of the bereavement group.

# PART 5



# FINDINGS



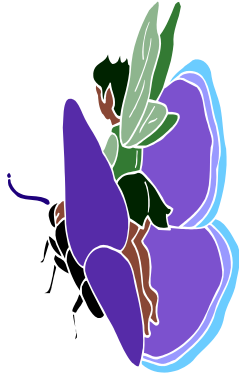
## FINDINGS

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Throughout this doctoral journey there have been many routes that have been taken in order to find out whether a group is an effective therapeutic intervention for bereaved children, adolescents and their families, and to discover what factors contribute to holding and maintaining grief within a family system. On these trips the map of the children, adolescents and their families' bereavement journey from the beginning to the follow up stage were considered at all times. Some routes have already led to discussing the data that was collated at three junctures (1) referral stage, where the children and adolescents are referred to CAMHS, (2) the therapeutic stage (six weeks short term intervention/family therapy bereavement group) and (3) the follow up stage. However, a further trip has been necessary in order to explore the seven bereavement groups in some detail, to ensure that different variables are considered, to see in what way they have contributed to shaping the group process and creating the different types of outcomes and influencing the level of grief within each family system.

Therefore it is with this intention that the lens of the research questions will be used to read the data from the perspective of different variables in order to highlight the similarities and differences between the seven bereavement groups and to identify the ways in which the different variables may be a significant factor in maintaining or working through the grief within a family. I will also use the five main areas from my practice: the therapeutic conversations (storying), the therapeutic intervention (the bereavement group), the narratives/conversations (magical moments), the position of therapist/researcher and the outcome of the bereavement group in which to organise and thread the data through.

At the end of this journey evidence will have been scrutinised based on the data that will illustrate why a group is an effective method of intervention for bereaved children, adolescents and their families and what contributes to holding and maintaining the grief within a family system.



## IS A GROUP AN EFFECTIVE THERAPEUTIC INTERVENTION WHEN A FAMILY IS BEREAVED AND WHAT IS HOLDING AND MAINTAINING THE GRIEF WITHIN A FAMILY SYSTEM?

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### **The Seven Bereavement Groups**

In previous chapters there has been some discussion about what constitutes a group, and the form that the bereavement group has taken to provide therapeutic intervention for the children and adolescents who were referred to CAMHS because of the difficulty they were having following a death in their family. In this section, there will be an introductory discussion about each of the seven groups, tracing the themes that are interwoven in the stories, then focusing on the similarities and differences between the groups and exploring the variables that may have contributed to forming the characteristics of the seven bereavement groups.

**Group one** was a pilot; it was the first group to run following the planning stage which included the research that was conducted and the proposal that was presented to the main agency (CAMHS), outlining what services would be offered and the benefits that the group would provide for the children and adolescents referred to the agency. In the beginning, the bereavement group was a joint initiative between CAMHS and a project that was a branch of the Youth Offending Team (YOT), with both agencies providing the resources (family therapists, support workers and refreshment) to facilitate the group. The first group had 11 members, three families by three mothers, two of whom had lost small children under the age of 4 to a road traffic accident and to complications following a bout of pneumonia. The third female had lost her ex partner, the father of her three children, two of whom had been referred to the service. The women were more or less in the same age range, mid 30s-40s. It was predominantly a female group; with only 4 male members, of the 8 children/adolescents 4 were male. It

was the first group that my co-worker and I had ever facilitated together. We had previously worked together in the family therapy forum with families that had been referred via the family therapy team. This group was structurally different from the six other groups that are a part of the research project. This group had two male support workers because it was felt at the planning stage that some of the families might need support with smaller children and if members got upset and wanted to leave the group.

The first week, none of the families turned up despite the high level of preparatory sessions and home visits that had taken place with two of the families. Therefore it was decided to use that time as space for the facilitators and the support workers to discuss their own personal and professional experience of bereavement. On reflection, the timing of the group was problematic as it was exam period for some of the adolescents aged 14-16 who were attending the bereavement group. This had been an oversight on the facilitators' part and to date May–June is a time of the year that is avoided. However, this is not always possible in the scheduling of the group. With the first group, everything was a new experience except for the therapeutic aspect. Some of the families had major external issues with their housing that had to be addressed throughout the six weeks that the group ran. It also became apparent in the second week that there were too many professionals in the group. In addition to having the two family therapists and two support workers there was also an interpreter resulting in a ratio of five professionals to three families that had three adults. This problem created an inequality and an intrusive atmosphere in the group and at times it felt very uncomfortable having so many workers looking and listening to the families telling very personal stories about their bereavement. It was also very difficult for the support workers to focus on the designated tasks that they were appointed for, despite the pre-meetings that had taken place to explain everyone's role prior to the group commencing. The members' attendance was very erratic and they were emotionally very vulnerable and needed a lot of support prior to the group. During the six weeks, contact was made with the families in between meetings. This was also a very tearful emotional group who spoke through their tears. There was also a very angry sibling group whose father had not told them that he had been terminally sick.

Of the seven groups, this was the most unpredictable group, never knowing if the families were going to attend from one week to another. The two families who had lost small children became very close and were able to support each other, they were able to relate around their common experience, as the mothers had also separated from their partners following the death of their child. At the end of the

group they exchanged mobile numbers promising to keep in contact. One of the mothers was further along in her grief as she had another child following the death of her youngest child. This was also the family that seemed to be managing their bereavement and no longer required or needed further intervention at the end of the group. All of the families' bereavement was under 2 years, so the death was still quite recent. Themes of guilt and blame were an integral part of the group with one couple blaming each other for not taking their child to the doctors when she was sick, and then feeling guilty because the child had died. There was a split in another family where the dad had died and the mother had been aware that the father had had a terminal illness. This group took place in temporary accommodation because of the lack of space in the main building. For the second group there was a move of the staff team, and the bereavement group moved with the family therapy team. For the following six groups the bereavement group had access to a large group room with an extra room attached where the family therapy equipment was held and refreshments could be made.

**Group two** took place three months later and of the six families that were assessed, five attended the bereavement group. 16 members in the group, slightly more adults (7) than the first group which had only three adults, one family had two adult children and a family member who attended the group. There were 9 children and adolescents who were similar in age and used the tea break to communicate; this was also a more cohesive group that was probably a reflection of the growing experience of the facilitators, who had changed aspects of the group as a result of the pilot group. In the first group we had planned the sessions; as to what was going to take place. In this session the structure was less rigid and more time was given to the families taking their time to talk, rather than trying to get them to do planned activities. By talking families were able to share what had happened and how it had affected them as individuals and changed the dynamics in the family. There were no support workers as we felt that we could manage any issues or difficulties that could arise in the group and we were less anxious about families not attending. The group took place in a bigger room with a separate room for refreshments and it was also in the building where I worked, so a more relaxed atmosphere. It felt like receiving guests rather than we were all visitors visiting a new building. The majority of the families attended, again all the carers were female (5) because in the five families all the deaths were male members of the family (3 fathers, 1 brother and 1 grandfather). However, there were also 7 males in this group, two of the families had multiple deaths and relatives that had been murdered. This group was a very happy, engaging and committed group that listened to each other



attentively, asking questions, supporting and encouraging each other to speak if they witnessed any discomfort. A request was put for family pets to be allowed to attend the first session prior to the group commencing. Thus pet cats joined the group in the first week. All families were notified in advance. A loose programme was maintained unlike the first group whereby a structured week by week itinerary had been planned but not implemented. The second group laughed together in contrast to the first group who cried together as a way of communicating. An interpreter was needed as it was also a very diverse group, with families from different communities. However, attendance by the family that needed the interpreter was the most erratic. This family also came extremely late and left early on another occasion, this was very disruptive and was a learning process for the facilitators whereby ground rules had to be stipulated about contacting the group if they were not attending and arriving on time so that families did not have to keep repeating their stories or get interrupted whilst speaking because of late arrivals. Interestingly, this family went on to receive further therapeutic intervention for some time following the bereavement group. The administrative staffs were also asked not to interrupt and that the group would contact them if anything was needed, as a knock on the door or the phone ringing was most disruptive and affected the mood in the room. Basically the same rules about not being disturbed that were applied within a therapeutic session were applied within the bereavement groups. This became a fundamental rule that was adhered to at all times in all the following groups.

**Group three** followed four months later, had five families and 19 members in total. Two male and three female parents attended the group. All the children/adolescents had been parentally bereaved, each having either a mother or a father who had died. An interpreter and a British sign language interpreter (BSL) were needed for this group. This group emphasised the wide range of needs that could exist in a group, where every family was so different. A very complex group with issues of separation, there were situations whereby the parent who attended the bereavement group had separated from their partner prior to them dying and in some cases had gone on to form a new relationship. With one family the man had to leave his home country to come to the UK to care for his children who had been living with his ex partner. There were lots of conflicts between existing parents and the adolescents in three of the families. Some of the adolescents and adults were angry about attending as they felt that it would not help them feel any better about their loss, but they ended up contributing the most. This was a very expressive group but was unlike the first two groups as there were hardly any tears like the first group or lots of laughter like the second group. This was a very verbal group, where members wanted to tell

their stories. There were also children/adults with special needs so consideration had to be given to how members spoke, all of them had to explain certain terms that were used and talk at a slower pace for the signer and interpreter to be able to interpret what they were saying to the families that they were with. Time was given to allow children/adolescents with speech impediments to express themselves at their pace. There were also younger children who wanted to know where their father had gone. None of the families really related to each other except in the larger group, as their focus seems to have been on their own issues and what was happening within their family.

**In group 4**, only 4 of the 6 families who were assessed attended. 10 members in total attended this bereavement group. Many of the families had external factors and other commitments (court appearances and hospital appointments) which affected them engaging fully. Some of the families expressed their difficulties in attending the bereavement group, either because their loss was months rather than years old or because they felt that they were not coping and they were hoping that the group would provide the confidence for them to parent their children/adolescents without the main carer/parent who had died. Interestingly the parents who had lost their youngest child did not attend despite saying that they would. Some of the families that did not attend had already received treatment from other disciplines, who had then referred them to the bereavement group, therefore when they did not attend the group they would be asked if they still required further intervention, and if they did they would be referred back to the referrer and if they did not the case would then be closed. This group was a diverse group like the other three groups, an interpreter was also provided for one of the families. There was also a balance of male and female parents attending the group. Of the 4 families, 3 families consisted of parentally bereaved children. Again the families were unable to support each other and did not work together as they were immersed in their own grief and needed a lot of individual support within the large group. This group was also scheduled during the May-July period that was traditionally the exams and SATS period which influenced the attendance of the adolescents on some weeks.

**Group 5** was the largest group, with 6 families and 27 members attending the bereavement group every week between September and November. Of the 27 members there were 10 adults (2 male parents and 4 female parent/carers, there were relatives and family friends). 8 adolescents and 9 children aged between 4-12 years attended. There were large families, some extended, some reconstituted and some of the members were family friends caring for an adolescent who was bereaved. A very diverse group but no interpreter was needed for this group as all the members spoke

fluent English. All of the children/adolescents in this group were parentally bereaved. Two of the adolescents were living with family members and one was living with a family friend. The adolescents got on extremely well, were more or less around the same age, very caring and encouraging towards the younger members of the group. A very talkative dominant group that was eager to split into the adult and children/adolescents groups easily. This allowed for everyone to be given enough space to talk. Only one adult was reluctant to attend the group and needed extra work in between sessions. This was an amazing group that worked extremely well together in spite of some of the tragic ways that some of the parents had died (murdered and in a fire).

**Group 6** consisted of five families with 14 members attending the bereavement group. In the group there were 6 adults, consisting of two male and four female parents/carers. A diverse group like all the other five groups. A Russian interpreter was needed for one of the families. This was a group that had secrets, some of the younger children had not been informed that their parent had died and another child was not made aware of the true nature of the death. One of the parents had found it difficult to attend and sent his son by himself. By the time this was realised it was too late to send the child home. Most of the families found it difficult to attend for a range of different reasons, so needed extra sessions in between weeks to encourage them to continue for the duration of their treatment. External factors had to be addressed in between the weeks. This group was not particularly close and members were more concerned with dealing with conflict within the family outside of the group. This was a group where members of the family were visibly at different stages of their grief and were in some cases reluctant to allow other members to progress within the group because moving on felt as if the family members were forgetting the person who had died.

In **Group 7**, 4 of the six families assessed attended the bereavement group. Of the 16 members, 10 were male children/adolescents, 6 adults with one male parent/carers. Everyone who died was male including two children and grandparents who had been father figures within the family systems. The two families that did not attend the group also lost male relatives (fathers). This was a very confident group of children and adolescents who were determined to get answers about the person who had died and were determined that their parents listened to what they were saying. For example, in one family where an older brother had died, the surviving son was reluctant to talk initially because he expressed that every time his brother's name was mentioned his parents would become distressed. However, by

stressing his feelings his parents became aware of how he had felt overlooked and ignored since his brother had died. Again a diverse group that was reflective of the borough where CAMHS was based. An interpreter was needed for one of the families. This group also had very committed members who generally attended every week. Members were similar ages and a good rapport developed over the weeks. The children and adolescents continued their communication outside the group and the older ones encouraged the younger children to join different groups that were available. Disclosures were made outside the group between the children/adolescents and came back into the group the following week. These disclosures enabled one of the families to discuss an incident that had remained unspoken about for almost eight years.

### **The Facilitators**

Before running the first group, there was a lot of preparation and planning on the part of the facilitators for each of the groups. Preston-Shoot (2007) stresses the importance of preparation for effective groupwork and the necessity of preparing every time a practitioner engages in groupwork because *“every new experience will involve familiar and uncharted challenges and trigger expected or unanticipated preoccupations and concerns”* (p.109). Background reading was completed around bereavement which emphasised the potential difficulties that a child/adolescent can develop if they are not recognised as being bereaved, i.e. difficulty at school, or attendance problems, and which may manifest themselves in psychosomatic symptoms, or the children’s roles in the family may change, for example becoming a young carer, or even taking on parentification. Helping a child talk about their bereavement, share their concerns, worries, fears and even their misunderstandings is a vital part of helping a child get in touch with their own natural resilience. Doing/running groups for multiple families helps children, adolescents and their families to see that they are not alone in their grief which is also really important in the bereavement process. It was also important to recognise that their parents would need support too, so that the family would move through the grieving together. The research also identified the different therapeutic models that were available and had been used by various bereavement agencies. The short term model fitted the type of service that was to be delivered to the children and adolescents who were referred to CAMHS. There were benefits of short term work as it was felt that it was less intrusive, more focused and the approach was more of collaboration between therapist and client. As facilitators we had to be mindful about not undermining the parent as being the person who could help the child through the bereavement, but perhaps the child could get extra space

and support which they could discuss with the parents. However thought had to be given to the parents and their ability to cope with their children/adolescents during their bereavement. Consideration was given to the down side of brief work as it may be too little intervention for the child and family and there needs to be the capacity for recognising when a child needs more intervention and who would be able to provide this service if CAMHS did not have the resource to do this. Engaging hard to reach families may also be difficult for an approach that was focused on brief interventions. How hard can the service work in getting to these hard to reach families? The latter has always been a challenge and an integral part of running the group.

There are a number of factors that have to be addressed prior to the groups commencing. This included assessing potential families for the groups. So finding out who were the referred children and adolescents that needed the bereavement groups, which often meant announcing in the team meeting when the next bereavement group would be running. Attending to the leaflet that accompanies the paperwork of every group that has taken place, the work on the leaflet is done in partnership with the administration manager who designed the leaflet, and the facilitators have to decide on the colour of the leaflet for each group. Letters are drafted and sent out inviting families for an appointment, assessments are then carried out and the letters are sent out to the family, referrer, school, college and work notifying them of time and duration of group. Shopping (refreshments) is brought for the group on a weekly basis by one of the facilitators. Practical functions include arranging the chairs. In one of the buildings chairs were taken from other offices because there were never enough chairs in the group room. The group and family therapy room and interpreters need to be booked in advance on the system and from the interpretation agency. The room booking needs to include sufficient time either side of the group for pre and post group discussion, preparation and tidying away at the end.

The facilitators have grown alongside and inside each group, where learning is continuous and starting from the very first group where no one turned up on the first day, to facilitating a group with over 27 members attending. Each group has prepared us for the next group to come, because as we enter into a group as facilitators we take the knowledge from the previous group and bring it into the next group that follows, thus positioning ourselves to work with whatever emerges each time with more knowledge than we had before. As facilitators we share the feeling of not knowing with group members what each

family will introduce in that first group session, at the same time knowing that whatever emerges will be developed as part of that particular group.

The bereavement group is the responsibility of the facilitators. Starting off with a pilot group and establishing a group that became a part of a service that is available to children and adolescents who are referred to CAMHS, is an enormous responsibility. There have been differences and similarities within each of the groups, each family is unique when talking about their own personal bereavement, bringing something different. The learning has been tremendous and continuous on both a personal and professional level. My knowledge about families and their experience of bereavement has increased with each family that has attended the groups and with each group that has taken place. Now I am more aware of the many strategies that families implement when coping with a difficult bereavement, either not wanting to talk about the death as it made them too emotional and made them remember how difficult things had felt at the time of death, identifying the problem of the family system within one child/adolescent therefore taking the focus away from the relationship between child and parent. Or continuing with their lives like the death never took place thus not allowing for the grief to be expressed by themselves or their children. Some families have a coping mechanism that allows them to get through the day to day pressure that allows them to function at a basic level of just eating, sleeping, working and trying not to think or talk about the death in case it aroused fresh memories. I am more confident about theorising why there is a difficulty in the family system from witnessing and partaking in so many bereavement groups. This orientation has come from identifying what has informed my practice and the systemic approach that I use as a family therapist/facilitator of a group. By listening to the families' difficulties has made me reflect about the way in which I communicate and interact with so many children, adolescents and their families. I have learnt that there are so many different factors that may be a part of a family's bereavement experience and can to some extent influence their grieving process. Understanding the way families have coped with some of the traumas and difficult deaths has been paramount in increasing my empathy and has helped me to assist families to acknowledge their feelings of sadness, grief, loss, even if at times they are tinted with feelings of negativity and rejection provoking behaviour. It has also lessened my impatience with those families who struggle with grief and are unable to adjust to the loss of a loved one. From witnessing so many families grieve has helped me to develop a capacity to process and manage my own emotion when listening to each individual telling their story. Preston-Shoot (2007) states that practitioners need to

anticipate what a group may arouse in them and he suggests that this process involves “*considering their fears, feelings and expectations of the group and whether they can make a contribution from the knowledge and skills they possess*”. He also insists that “*they will also need to have the ability to control and contain personal needs and problems if they are to engage successfully with members*”.p.110

With each group new situations have arisen that have needed to be dealt with immediately and in the moment. For example children on the edge of exclusion, so attending professional meetings and having extra sessions with the family and young person to find out what the pertinent issues are. Some children need to have support within the classroom, so having to initiate a Children Assessment Framework (CAF) referral so that a family support worker or an educational psychologist can work with the family. One family had an infestation and had to be removed from the property so that the house could be treated as they were attending the group with bites and sores from where they had been bitten. Other families have needed assistance with benefits and a referral is made to another agency to support them. The idea is that once these pressing matters are dealt with and families receive the appropriate support, families can attend the group and be able to think clearly about how they feel about their bereavement. With so many families attending the seven bereavement groups during the research project, this has meant that each family member who attends the group becomes a client and receives an individual assessment and a care plan. Being part of a group whether as member or facilitators means that everyone becomes aware of each other very quickly. As facilitators nothing can prepare you for what you are going to bear witness to, as there is always an excited feeling of not knowing what you are going to hear but having safe uncertainty (Mason, 1993). This means establishing a safe enough environment (group) for families to take risks, it is imperative that families feel safe enough to bring their private stories into the public forum. Creating a feeling of ‘safe uncertainty’ means establishing ground rules cited by members of each group and ensuring that the confidentiality rule was included at the start of every group. Each family has to feel that whatever was said in the group could be discussed by families at home but would not be repeated to people who did not attend the group. It was important that this rule was adhered to because so many of the children/adolescents went to the same schools. Families were encouraged to speak without feeling that other members would judge them by their action. As facilitators it was our role to manage the group effectively, to ensure that everyone felt safe and that no family member felt bullied, intimidated or unable to speak and that everyone was treated with a level of respect and that what they were saying was appreciated and

valued by the other members. Therefore everything that was said by members in the group was acknowledged by the facilitator in the room or by another group member. Coming into the first session symbolises that the family has taken the first step by talking about their bereavement within a group. It was important that they stayed for the next 5 weeks in order to complete their treatment plan.

The sense of responsibility for the bereavement group has developed over the years and can be overwhelming on occasions. Some of the anxiety that was experienced in the first two years of running the group was incredible, no annual leave was taken whilst the groups were running and no attention was given to any illness or tiredness that we were feeling as we were adamant that the group would run each school term. This I now recognise as commitment and belief in group work as a method of intervention for bereaved children, adolescents and their families. During the 6 weeks period, my co-worker and I would commit to doing all the tasks that were involved in running the bereavement groups in addition to our normal workload. On reflection it is apparent that this way of working contributed to the pressure that we felt. This was alleviated somewhat by having discussions with each other about what we were doing and what was emerging from the groups. The stress more or less became a part of us until the group ended in the sixth week, which was why the supervision was necessary. There we were able to raise our anxieties and talk about our practice. In the wider team there were uncertainties in the initial stage about this way of working so there was some reluctance on the part of the clinicians to refer children/adolescents to the bereavement group. So we ran a few workshops for the wider team and other agencies about the bereavement group to give them an idea of what was happening within the groups. This is no longer an issue as the referrals to the bereavement group are now a single point of entry and I do the majority of the assessments. This resilience is a characteristic of how the family therapy team functions with so few resources, just getting on and managing the difficulty amongst ourselves. On reflection there have been advantages and disadvantages to this way of working, managing independently and by default showing that there was no need for additional resources because we were providing a service with minimum complaint to the wider team and management. Nonetheless, this hectic pace continued until the 5/6 group where we gave ourselves permission to relax a little and not re-create structures like the format of the weeks, the break, the beginning and ending of each session and of each group that were established in previous groups and that had become a stable fixture of the bereavement group.



The vast experience of being a part of so many complex groups has meant that specific skills and abilities as a groupworker have developed over the years. I have learnt how to understand and guide interactions within a group setting and to look for patterns of interactions within a group, family members or a system. Toseland & Rivas (2001) say that group leadership skills are behaviours or activities that help the group achieve its tasks and members achieve their personal goals. (p.109). For example where there is conflict between adolescent and parent, thought is given to how the conflict can be unpicked and resolved which often starts by each family member telling their story. This approach has not always felt comfortable and the situation can become tense but often it has been conducive to bring the issue that is causing the spilt in the relationship to the surface so that it can be explored from different angles and all versions of the events are told. Ephross (2005) states that being still and listening is a major skill of the group worker so that members can be free to talk and reflect (without being judged) (p. 31). Over time I have felt more confident about my skills to respond and communicate effectively with the children and their families, and feel passionate about going into the discomfort zone and allowing the families to vent their anger and unhappiness at me when I have asked a challenging question. This is only done when members have begun to perceive the group as a safe place in which their thoughts and feelings will be accepted. Toseland & Rivas (2001) claims that advice, suggestions, and instructions should be timed appropriately, so that group members are ready to accept them. Members should be encouraged to share information, life experiences, resources as well as their opinions and views. This confidence has come from working with so much complexity, being a part of the tension and staying in the midst of it in the room until the tension lessens. Transparency is very important here so that families are aware of what you are doing so a question would be asked to them to see if they have understood why you have asked the question. Or until either the child or the parent has listened to how the other is feeling and there is a shift in their relationship. The facilitator needs to be honest with the members regarding the group's purpose and ensure that there are no hidden agendas (Kurland & Salmon, 1999). Some of this knowledge has included knowing when and how to intervene, by using communication as a form of mediation, when attempting to explore difficulties between family members. I have also learnt how to use language as a way of getting families to think about their own behavioural patterns. Cronen & Lang (1994) describe communication as a process by which we co-create what we ask and together with conversations (which are the primary focus for understanding how people live together) are core tools for understanding how problems arise and also how we are able to create ways forward beyond problems and difficulties. It is important how language

is used as certain words in English might not translate appropriately or with the same meaning in another language. Over the years I have developed skills from working with individual families to working within a whole group where communication has been circular and everyone participates in exchange. This can only be attributed to the intensity and nature of the bereavements that the families bring and being able to join them on their many journeys. Experience has guided me to know what works with a family, to acknowledge when an approach or an intervention is too soon and when a family needs more time. It has also allowed me to explore my own awareness. Listening to one person talk, then to how they interact and how they talk as a family allows me to make sense of what has happened and to reflect on what the interaction is evoking in me and the many interpretations that have been given to a single episode. The questions are aimed at individual family members, families and the group. The group feels like a big family that has many layers and many different family members who may not be familiar with each other but are coming together to provide the background for the picture. Instead of using one lens I have multiple lenses capturing different interactions at different times and using CMM to make meaning of the different episodes and various interactions between family members and allowing for the multiple interpretation of what has taken place at any given time, which reinforces that there is no single meaning given to any one episode. The bereavement group is a group that has smaller groups within it and where groups are constantly forming. As facilitator you create the context in which the participants come together to form a group. Now I am able to demonstrate more understanding and acceptance in valuing a family member's experience before asking a direct question whereas before my approach was perhaps more tentative and clumsy but as my confidence has grown so have my skills and abilities as a groupworker. There are many explanations for the shift in my approach, I have learnt how to listen differently, I have had time to stand back and think, to reflect and talk in supervision and to various audiences and most importantly I am still developing my practice. Taking more time to develop more of an understanding of a family in the assessment stage and not rushing them into treatment has meant that families are more likely to engage and will discuss any anxieties that they may have about therapy, whether it is in a group or in their home. Having an understanding of each family enables me to be aware of a family's strength and fragility and what areas they need and would be able to work on without re-traumatising them. Taking time away from the group has enabled me to develop a meta-position so that I can see what has been created over the years and how the different families who have attended the groups have fared. Moreover, I have developed skills in creating and maintaining the group's framework, aims and boundaries which Preston-Shoot (2007)

states is essential when doing groupwork with children. Looking back from then to now there is an ease in which the families' scripts and stories are challenged, there was more tentativeness in the beginning, more inner talk than outer talk was going on inside me as a therapist/facilitator . I have also thought about the meaning of a word, a phrase, a sentence, a paragraph and how to use and respond to them within a particular context. Cronen & Lang (1994) agree that to work from a systemic position is to recognise that the meaning of an utterance depends on the context in which that utterance takes place.

## SIMILARITIES/DIFFERENCES IN AND BETWEEN THE SEVEN GROUPS.

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All of the seven groups have families that have experienced bereavement and had a child or adolescent referred to CAMHS because of concerns about their emotional, psychological and social development. These concerns have either manifested themselves in a change in their behaviour or were interfering with their normal functioning, whether it was at home or at school, or both. It is difficult to identify any one factor that contributed to the characteristics of the groups. The only factors that have remained constant are the two facilitators and that it is a bereavement group for children, adolescents and their families.

Walking through my data again with different lenses I was struck by the homogeneity (similarities) and heterogeneity (differences) that were in and across the seven bereavement groups. Here is the beginning of the heterogeneity (which is the nature of opposition, or difference between qualities, hence the constituents are of a different kind. The parts (or constituents) are connected, and viewed in respect to the parts of which it is made up), and homogeneity (where all the constituents are of the same nature; consisting of similar parts, or of elements of like nature), thus, the balance of difference and commonality in between and across the seven groups (Preston-Shoot, 2007). Thus in order to assess what factors have contributed to making the bereavement group an effective therapeutic intervention it is important to explore all the variables that are interwoven in some or all of the groups.

## **The Relationship between Therapist and Family**

There are so many variables that could be a major factor in creating a cohesive thus effective group and one of those variables is the therapeutic alliance that the children, adolescents and their families have with the therapist. In that initial session the concept of the bereavement group is introduced as a form of therapeutic intervention and the family is informed about the way in which their therapist will be working with them during that time and they are welcomed to the service and told what they can expect and in what timeframe. The relationship between the therapist and the family is imperative to the outcome of any intervention. The bereavement group has had a wide range of parents/carers who fall into different categories such as the parents/carers who are willing, and have the ability to create change within their family system, and then there are other parents/carers who appear unable and unwilling to change and put up barriers all the time. Many of the parents who attended the seven bereavement groups were willing to work with the therapist, and they were the ones who went to their doctors because they were concerned about their child/adolescent and they wanted their doctor to make a referral on their behalf. There are parent/carers who feel that their children need to attend the bereavement group because of the concerns that they have. It may be because they do not know what to tell the children. With one particular family the father had died in a car accident, children never got to say goodbye. The therapeutic alliance defined as the collaborative bond between therapist and the client is widely considered to be an essential factor in the effectiveness of psychotherapy (Martin et al., 2000). Some researchers have even gone as far as suggesting that alliance is more important than the type of treatment (Safran & Muran., 2000). Clinical supervisors believe that therapists relationship skills, rather than techniques or theoretical orientations, are the most important aspects of effective treatment (Blow & Sprenkle, 2001). Green (2004) has criticised most branches of family therapy as being too limited and too focused on specific change orientation interventions, rather than the vicissitudes of the therapeutic alliance. He maintains that treatments do not succeed or fail based on the particular orientation of the therapist, but rather on the therapist's ability to develop and maintain an emotionally positive alliance with all members of the system in treatment.

***“I thought everything was alright but I think the children especially have lots of questions and worries so the group will be a good place. We don't have any family so since my husband died we have been by ourselves and I don't always know what to tell the children. He died in a car accident” (Group 3, family 10, father died in road traffic accident)***

Or they recognise that there is a change in the child's behaviour. With one little boy his dad used to make him tea in the mornings, and he couldn't understand where his father had gone.

*“Yes... since his dad has died he is much quieter and does not talk as much. I know he misses his dad as they used to do a lot of things together”. (Group 3, family 13, father died of heart attack)*

*“She's not listening to me and is arguing all the time” (Group 1, family 1, baby daughter died)*

*“..... He was kicking and biting himself, having problems sleeping and was disruptive in school” (Group 2, family 8, father died of liver failure)*

In one family the father's death coincided with the son starting school

*“Yes, he hasn't settled, keeps running around the school and is having difficulty in relating to peers and is very sad. It is hard work at home”. (Group 6, family 30, father died of heart attack)*

These parents welcome the referral to CAMHS and will work with the therapist in the bereavement group to make the necessary adjustments that would make the difference in their family dynamics. This was the case for many of the families who attended the bereavement groups. For example, one of the families in the first group, where the youngest child had been knocked down outside the family home, engaged well with the therapist from the initial assessment and were willing to think about how the family had changed since the accident and what they needed to work on as a family.

*“I remember being upstairs and hearing my mother scream and when I came downstairs and went outside, my brother was lying on the pavement not moving”.*

*(Group 1, family 2, toddler died)*

Working in collaboration the family was able to move from the home where the accident had happened and talk openly about how they felt about the mother having another child to replace the one that had

died. A second family had engaged well and had been excited about attending the group, they actually found the process of attending the group very difficult and expressed that talking about the baby that had died was just bringing up memories that they found painful.

***“We don’t know what to do anymore as we used to all take care of her, we don’t have anything to replace it with.....We don’t know what to do,.....”***

***(Group 1, Family 1, baby died)***

There were problems with the couple’s relationship following the toddler’s death and issues had been left unresolved and themes of blame and guilt had further complicated the grieving process.

***“She had a cold, but we thought that it would go away. Each, waiting for the other person to take her to the doctor. We just never thought that she would die, she has always got better. This time it just got worse and she never recovered”.*** (Group 1, family 1, baby died)

Both of these families needed no further intervention at the end of the group and their cases were closed to CAMHS. Others parents have been referred by the child/adolescent’s school and were committed to attending all the appointments/sessions until things had got better and no further intervention was necessary. This was true for another family in the second group where all the family members wanted to work with the therapist so that the referred adolescent would begin to talk about how he felt following his father’s death. In this family the mother had gone to work in the morning, not knowing her husband had died of a heart attack and only found out that he was dead when she rang later on in the morning and asked her son to wake his father up.

***“Then when I got to work, I rang the house and asked \_ to wake his dad as it was getting late. (Crying) and he came back and told me that he couldn’t wake his dad up and that his dad was cold”.*** (Group 2, Family 5, father died of a heart attack)

There were three other families in group 2 who were all prepared to work with the therapist. In one of these families, the mother was very enthusiastic about attending the group because both she and her son had experienced multiple deaths within a very short space of time. In one of the sessions she describes finding her mother dead in the kitchen and trying to hide it from her son.

*“I found my mother on the floor. \_ was in the house at the time because she always picked him up from school. I had to cover her so that \_ didn’t see her lying on the kitchen floor”.  
(Group 2, family 8, dad died of liver failure)*

This child had experienced the death of his grandparents with whom he had a very close relationship and was living at the time of their death. When he attended the bereavement group his father had only been dead six weeks so he needed further intervention months after the bereavement group had ended, to work on the issue of loss. He was also finding it very difficult to separate from his mother and blamed his dad for dying and leaving them to cope. Two of the families from group 2 fell into the category whereby the parents/carers attended the group because they wanted their child/adolescent’s behaviour to improve but did not think that they were part of the therapeutic process. Their alliance with the therapist was solely based on the therapist ‘fixing’ their child/adolescent or ‘fixing’ what they saw as their problem, which is not uncommon. In this group, there was a family where the older brother had died mysteriously, (the word murder was never mentioned), and in her grief the mother would talk affectionately about her dead son and negatively about her teenage daughter, who was often sitting next to her in the group. The mother became very angry when any of the group members reminded her that her daughter was still alive and perceived this as a hostile attack from the other group members. The group was not as effective for this family as we would have liked and the daughter had to continue to have individual therapy. Probably a more intensive assessment would have highlighted that the mother was still grieving and the daughter had accepted her brother’s death and was feeling angry towards her mother and did not want to have family therapy with her mother.

For the other members the support of the other group members encouraged them as parents/carers to think about their parenting style and different ways of expressing grief and they were very sad when the group ended and as part of their feedback requested that the group have more sessions. Brief therapy is usually between 6 and 8 sessions. deShazer et al (1986, p. 207) maintained that there was a distinction between (a) brief therapy defined by time constraints and (b) brief therapy as a way of solving human problems. He also held the view that when considering a client’s behaviour and ideas it was not necessary to have a concrete understanding of the client’s family dynamics, personal history or experiences of the client and that the focus should be on the presence of something (the conflict/ the

grief) rather than the absence of something (the person who has died). By focusing on the presence means that one is no longer focusing on the problem. The bereavement group will not bring back the person who has died so the focus is what is happening now within the family. The assessment will attend to the personal history, experiences etc and what therapeutic intervention will benefit the family. The question of how many sessions can not be looked at in isolation, the timing of the death, whether the child/adolescent received intervention before attending the group and whether there are other mental health issues are all significant factors that need to be considered. Moreover, in the initial stage families were not offered either group or individual sessions, their care plan usually consisted of the bereavement group as therapeutic intervention, whereas some years on the bereavement group has developed into a service and other therapeutic intervention is offered alongside, instead of and before attending the group. The families who required further intervention were provided with more psychological therapy either by the family therapy team or another discipline but the majority of the families just needed a follow-up session before ending.

### **Families who Struggle and are Reluctant to Attend the Group**

There were also those parents in all of the seven groups who did not want to attend, and when they did, they did so reluctantly, so the engagement was a slow process as they were resisting any move that would create a change in their family system. This was demonstrated by families who were either constantly late or who would find an excuse to leave the group early. It is frustrating as a therapist when you are aware that the children want to engage but the parent/carer finds it hard to see outside of their own grief and either unconsciously or consciously creates barriers that interfere with the therapeutic intervention. The sibling group in this family was fighting amongst themselves as the oldest son had adopted the role of father in the family after his father had died. The mother was constantly going to the doctors with various complaints about her health.

*(Brother 1) My brother doesn't listen to me. He doesn't understand that I am in charge now.*

*(Brother 2) Things are very different, my brother thinks that he is my dad, always telling me what to do and he's not?*

*(Mother) My health has suffered; I go to the doctors all the time. I was never sick before.*

*(Group 2, family 7, father died of cancer)*



They continued to have family therapy for some time after the group had finished and the oldest sibling was referred for individual psychotherapy but I suspect if the boys had been able to attend the groups properly some of their feelings and frustrations would have been normalised by listening to the other children and adolescents who attended the group. This model of short term intensive group therapy would have challenged some of their private beliefs and family scripts and allowed them to think about changing their views or listening to each other's feelings about the bereavement. Outside of the group therapeutic intervention was more long term, disjointed and erratic as appointments were also missed, therefore there were longer periods between each therapy sessions.

In group three one of the families similarly would just complain about attending the group and one of the mothers felt that there was no point in discussing her husband's death and wanted to use the group to discuss her son's behaviour, as he was deemed as having the problem.

***“Okay, maybe he’ll talk to you as he doesn’t talk to me. And I am fed up of talking. I just need a break from them all. Maybe after the group people will believe me when I say that he has something wrong with him!” (Group 3, family 12, father died of a heart attack)***

This mother went as far as she wanted to diagnose her son herself and genuinely believed that the loss of his father was not influencing her son's behaviour. It was felt by the therapist at the time that it was more her unwillingness to discuss the boy's father that was having an impact on their behaviour and as they were unable to remember their father, the boys had to rely on their mother who was still angry with her husband. With families who are more challenging there is a need to adopt a position of curiosity (enquiry and challenge) and neutrality (refusal to take sides). (Stratton et al., 1990). The aim was for a positive, supportive relationship between mother and child/adolescent and asked each what they were proposing to do about their current relationship and what they thought needed to change in their interaction and how.

***“No, and as the years have gone by it’s hard to remember. I don’t think that his brother even remembers his dad because he was quite young when his dad died. I am just tired of him always getting into trouble at school and now smoking and lying to me. I can’t trust him. His father’s death is no longer an issue”. (Group 3, family 12, father died of a heart attack)***

This mother wanted to pretend that the death did not happen and focused on everything but their bereavement. Another example of this is a mother who was unable to grieve or come to terms with how her husband died (found dead in another woman's house) and focused instead on past issues with her son, leaving no space for mourning. This was an example of a parent who wanted the therapist to 'fix' her child/adolescent. As therapist/facilitator there is a need to recognise that some difficulties are too complex and multi-dimensional to change within a six weeks short term bereavement group, although it would be fair to say that it also depends on the family's willingness to work with the therapist. More sessions are now offered (if needed) before and after the group so that the families feel that they have sufficient time, and not only the group to talk about their bereavement experience. There would still be a focus in those follow up sessions on whether further intervention was needed and if there had been significant change in behaviour and less of a concern. However there has only been a small percentage that raised the issue of the sessions not being long enough, and that was in the initial stage. Since the seventh group it has not been mentioned and there have been 14 groups to date and an overwhelming positive feedback for this type of intervention. This may be because we have developed as practitioners over the years and are more informed about the area that we are working in and a more client led assessment is carried out and careful consideration is given to whether the group is the appropriate intervention for that particular family. Currently the majority of the bereaved children who are referred to CAMHS are offered an assessment which is 2-4 60mins appointments, then 6 weeks short term therapeutic intervention (2hrs per week) and 1-2 follow up sessions and further intervention if necessary.

***“I am fed up with his education! School's just a nightmare ... Trying to get his school not to kick him out. He's also been smoking and we are not just talking cigarettes either! Appointments all the time with his YOT worker, nothing seems to be working.....” (Group 3, family 12, father died of heart attack)***

These families required additional therapy, in some cases the bereavement group had come after a long period of other interventions and the hostility between child and parent is chronic, their progress was limited so the structure of the group changed slightly to focus on these tensions. As therapists/facilitators we have emphasised the importance of assessing the child/adolescent when they

are first referred and in the cases where bereavement is highlighted at a later date we have asked to join the therapist in the room to assess the family's suitability for the bereavement group. As part of my professional development it has been an integral part of my growth to acknowledge with time that not all families that are referred are suited for group work. During their assessments some families have shown that it is too soon after the death and they are not ready to talk about what happened with other people. This is usually linked to the nature of the death (murder, suicide or drugs related deaths) or where there has been a lengthy court case attached and they are weary of talking but still want therapy. However there have been families who have experienced all of the above and have attended the bereavement group and have said that they have found it useful. There is no one rule that stipulates that all families get offered the same treatment, it is dependent on their individual needs. Initially the bereavement resources were limited to a group but it now has alternative interventions. Generally the majority of bereaved children and adolescents who are referred attend the bereavement group.

The assessment stage has changed and can go slower if need be and not follow the normal generic process of 2-3 appointments and as mentioned there is more of a nurturing element to build up the trust in the therapeutic relationship between client and therapist. This reflection has enabled me to think about and offer other therapeutic intervention to families who are not able to attend the group for whatever reasons, whereas before I may not have had the confidence and creativity to think of and offer alternative treatment outside of the bereavement group. Burnham (2002) says that 'No worker ever reaches a stage of perfection. Therapists increase their repertoire as the complexity of their work increases' (p.164). There will always be families who are referred by school or their GPs who do not engage or stop attending after one session, they find the whole therapeutic intervention upsetting and have commented that it brings up feelings that they would prefer to keep buried. Burnham (2002) states 'resistance and lack of motivation are often pejorative terms applied to those families who apparently defy a therapist's best efforts to change them'. However, he advises that to overcome resistance the therapist needs to explore 'to what and to whom is the family resistant?' With these families you try to engage on different levels and then inform the network so that everyone is aware of the difficulty that the family is having engaging. These families can be of concern, because the child/adolescent is often exhibiting signs that they are not coping at school and at home, but it is not ethical to force families to attend if they really do not want to. The reality is, not all children and adolescents who are referred will want a service for a multitude of reasons, for example it could be because it is a mental health service,

or they do not want to talk about their bereavement or they have not got the time or energy to commit to treatment or it is too soon and they want to grieve privately rather than publicly. Or some family members want to come and others do not. If an adolescent requests individual therapy, they are referred to another agency.

Across the seven groups there have been parents/carers who attend the group but are comfortable in their place of grief and unwilling or unable to reflect on how their action was having an adverse affect on their child/adolescent. This could be said of the family above. In group 5, one of the families where the mother had died when the youngest child was a baby, the father had to reflect on his parenting style as he tended to give the children everything they wanted to compensate for the loss of their mother and his poor parenting skills. Interestingly the children were prolific shoplifters. Up until his wife's death he had not shared or taken part in any of the child care responsibility and after his wife's death he became the main carer. This parent struggled every week to come to the group and would think of different excuses for not attending although he wanted the children to attend. This was not unusual across the groups; many of the parents/carers expressed how difficult it was for them to attend the bereavement group. However, this parent was willing to work with the therapist and attended the bereavement group. As a family they were able to talk about their feelings about their grief and loss so that any further work would focus on the other issues that had arisen within the family. For this family the bereavement group was a success because their problem was reduced and the 'stuckness' shifted to allow new behaviour to come forth. It also helped the parent to focus and think about what needed to be attended to within the family system. Success can take different forms. It can mean that the child/adolescent has stopped cutting, is talking, is attending school, is eating, is sleeping and is interacting with friends and family as they were before the bereavement. When family, school and therapist are all satisfied with the outcomes and things have improved/changed even a little, it may be that the intervention is stopped or something like a family support worker is needed to get the parent back into a routine with the children or be less chaotic. It can be so difficult to get back into a routine (back to school or work) when a family has lost a loved one. We can not underestimate the scale of the loss and how overwhelming it can feel at times. A time frame can not be suggested for how long a family grieves.

However, prior to commencing the bereavement group the families were not aware of the benefits of the group and there were often mixed emotions whereby some families did not want to attend the group

themselves but wanted their children to attend. With these families there was more emphasis on the benefits in the family attending the group as a unit. Often examples would be provided about other families who had benefitted from attending the group, in some cases more support and encouragement were given to these families to help them in attending the bereavement group. These were often the families who were very appreciative of the group and would request that the group be longer than six weeks.

***‘I will not be coming to the group only\_ as I don’t need the group.’ (Group 2, family 9, mother murdered & grandfather heart attack)***

Interestingly although this grandmother did not attend the bereavement group she was willing to attend some individual sessions on a regular basis at a later date, and she ensured that her daughter and granddaughter attended every week. This worked out very well for the family to be able to talk openly without the grandmother who was quite a dominant matriarch in the family system and who up to a point decided what could be discussed inside and outside of the family. The therapist got to know the family on different levels and was able to explore the various contextual levels with this family where so many family dynamics were played out in a group, on an individual level and in the therapy room. With this family there were so many contextual levels such as: the existing parent was a drug addict and constantly in rehab, the child’s other parent had been murdered, the child had moved from the maternal grandparents who were the initial carers to her paternal grandparents. Moreover, the child also lived with the paternal aunt and her family and the aunt and grandmother had not always agreed on boundaries etc. However, the grandmother even went as far as welcoming the reflective team in a number of later individual and family therapy sessions.

Some families felt that a group would not help them. Again a position of curiosity and neutrality had to be maintained and awareness that not everyone felt comfortable within a group or receiving therapeutic intervention. Therefore it would be the role of the therapist/facilitator to ensure that these families were included in all discussions about their treatment plan and again consideration was given to families’ past experience of different agencies and the service that they might have received. One of the roles of the therapist would be to ensure that the experience was more collaborative rather than directive.

*'I just don't want to come and it isn't going to help.'* (Group 4, family 15, mother died of cancer)

*'And it isn't going to bring my mum back.'* (Group 2, family 4, mother died of cancer)

As mentioned earlier some parents/carers were prepared for their children and another adult to attend, but were reluctant about attending themselves.

*"Well, although I don't need to come I will bring the children, well my son and my daughter hopefully."* (Group 3, family 10, father died in road traffic accident)

*'I don't have anything to say.'* (Group 3, family 14, mother died of cancer)

Some of this reluctance was transported into and across the seven groups although the child, adolescent and family member might talk. It was always the ones who said that they did not want to talk who talked and who would look for every excuse why they were unable to attend. Suddenly appointments that were not mentioned before were scheduled in the bereavement group slot, or the child wanted to attend an after school activity that they had previously not been interested in. This issue would be addressed within the whole group and the importance of attending all sessions and commitment to the group was stipulated. Moreover, the effect that irregular attendance had on the other group members was also stressed. Members were reminded that their child/adolescent was referred to the service because someone was concerned about them and the difficulty that some families may have in attending the bereavement group was acknowledged. This only needed to be done on a few occasions in the early stage. Several studies have suggested that successful therapy is highly related to increases in resistance. When confronted with a client's resistance, an attempt is made to understand where the resistance is coming from and what it represents psychologically. Bischoff & Tracey (1995) define resistance as 'any behaviour that indicates covert or overt opposition to the therapist, the therapeutic process or the therapist's agenda'. The perception of resistance is often when we feel that the family is 'not going anywhere' or that we feel stuck. There is a need to ask ourselves where we want the client to go, to work collaboratively means to establish a mutually agreed upon objective which does not have to be lengthy, it may be that a family eats dinner together twice a week. There needs to be a level of reflection on the part of the therapist where empathy is shown and not

bombarding the client with lots of questions with no thought as to how they may feel about what has happened and what is being discussed in the therapeutic domain. With the families who attended the first few groups, I wanted to help them forget their pain too soon and move on with their lives, I am now aware that I offered explanations before the families were ready to accept them and pushed the family too soon because of my own discomfort with their emotion and the way that I was affected by their bereavement stories. It could have been the pushing that caused the family to resist. Over time I have slowed down the pace and taken smaller therapeutic steps and there has been less resistance and a better engagement. [In the bereavement groups that have followed, there has been more of a commitment from the families demonstrated in the high attendance rate and little or none DNAs \(families that do not attend\) over the six week period. .](#)

Part of the group process is encouraging them to come and telling them how well they have done, if that is the case. The first week of the group is paramount in the cementing of the group. It is important to show empathy and acknowledge the families taking the first step by attending the group. It cannot be emphasised enough how difficult that first week is and how incredible the families are in telling or listening to stories within the group. It is not always easy for families to see change or the progress that has been made since the assessment appointment, or throughout the duration of the group. Therefore it is the therapist's role to talk about what changes have been made, whether they are physical (appearance) or mental (mood) or within the family system or an improvement in the child or adolescent's behaviour.

Every attempt was made on the part of the therapist to meet the parents/ carers at the place that they are at in their grief. However, ultimately the focus is on whether the referred child/adolescent is ready to make the change and create strategies as part of that alliance that will enable them to cope with their own grief and that of their parent/carer. Generally, in all the bereavement groups there are always families where one member is reluctant to consider different options or reflect on their pattern of behaviour and the impact that they have on the family. So decisions are made that try to accommodate different stages of grief and ways of mourning and recognise that not all members will have changed or will feel better at the end of the six weeks treatment. I recognise that when a family resisted it could have been because they found it hard to accept the death of a loved one, it could be too threatening or inconceivable to them to fully accept the loss. So taking things slower and trying to work with the

resistance is very important as it does not push the client to a place that they are not ready to go yet. Burnham (2002) talks about the reluctance to change might reflect a basic split in the family, or between the family and professionals, about the cause of the problem. Common disagreements revolve around such issues as: is the problem organic or social? Is the problem school–or family based? p.169) Working collaboratively, the client can come up with ways in which they may want to honour and remember their loved ones and in time the absence will become easier to manage and then when the resistance gets smaller, emotions related to loss, closure, guilt and blame etc. can begin to be addressed. Resistance may be an indication that the family, is dealing with a very important issue that has multiple conflicts and layers.

***“I feel like I need something else, this hasn’t been enough. It isn’t long enough. I still need to talk to someone about how I feel.” (Group 6, family 27, daughter died of cancer)***

***“It hasn’t helped me coming, things aren’t any better. If anything it is worse”. (Group 3, family 12, husband died suddenly)***

They may need further intervention whether it is from CAMHS or another agency or for the therapist to acknowledge that no amount of therapeutic intervention at this time is going to be effective or beneficial to that parent/carer or on a rare occasion a child/adolescent is not willing to engage with the therapist. As mentioned the assessment stage includes more sessions and there are more follow up sessions after the group. Or an alternative therapy is offered that may prepare them for the group or longer intervention if the death is of a traumatic nature.

It was only by going through the data several times that I became struck at how many parents/carers across the groups had similar views. By attending the group, some parents became more aware of how their behaviour was having an affect on their child’s emotional well-being, others were unable to accept and were more inclined to focus on their child’s behaviour and the affect it was having on them, the adult/parent. With these parents/carers there was no consideration that the child/adolescent’s behaviour was an expression of the difficulty that the family was having adjusting to the bereavement.



***“He tends to stay at his girlfriend’s house quite a bit. It’s much better when he doesn’t come home. He is always in trouble with the police. I just don’t understand what has happened.”(Group 4, family 20, father died of drug overdose)***

The adolescent is also avoiding any contact with his mother, not able to talk to her about his father.

The groups (2, 3, and 5) which had the most children, adolescents and young adults and whose voices were the most dominant in the three groups were similar in character. Reflecting back it appeared that the young people were able to be productive and think about their bereavement and were interested in exploring the patterns of behaviour in their family systems. This was evident from the way in which they were able to express themselves and used the group to talk freely about issues (Asen, 2002, p.22-23) In 15 of the 16 families the children/adolescents had all been parentally bereaved, 10 of the families had been bereaved within 1 year of them attending the group, and 6 of the families had been bereaved from 2 to 8 years. Thus the majority of the families were under 2 years. I suspect, in addition to having experiences in common like having the same person die in the family, and sharing the experience about the time and nature of their death, it was also having the space to ask questions, to talk about what they really felt and to share with other children/adolescents of their own age who had a similar bereavement experience. The strength in talking and sharing cannot be overestimated for unlocking something that has been locked. In the case of many families it can just be feeling that your existing parent has finally heard what you said and is ready to do something to change some of the patterns that have developed since the other parent has died. The systems then become unstuck and new narratives can be developed as change slowly emerges. Change varies from one family to another. For one of the families it may be that by asking questions about the mother that they barely remember or never knew enables them to feel closer to the parent that died. Or it can be that for many of the children/adolescents the behaviour has not got worse, in other cases there is an improvement and the risk has stopped (cutting/suicidal ideations). By the end of the bereavement group, 12 of the 16 families who attended these three groups were beginning to take steps to make some of the necessary adjustment that was needed to move on without the person who had died and were able to identify the way in which the bereavement group helped their families. See table 1 for what some of the families have said about the way in which the bereavement group has helped them.

<b>Who died in family</b>	<b>Extract</b>	<b>Group/Position of family member</b>
Father died in road traffic accident	It has made me understand things better, I feel like we communicate more now	Group 3, mother
Mother died of cancer	We talk more now	Group 3, adolescent 18yr
Father died, liver abscess	I wish that all my children had come, they would have really benefitted from coming. I can see the difference it has made to _ & _ when they have come that I wish that I had made them come.	Group 3, mother
Mother died of cancer	I think it has brought our family closer together	Group 3, daughter 18 referred YP
Mother died from alcohol related illness	I am glad that we came as a family it has really brought us close together	Group 5, aunty to referred adolescent
(same as above)	I would not have known what _ felt if we hadn't all come together and listened.	Group 5, aunty
Same as above	I realised that we have not been listening to him.  This group has really been good for my family thank you for getting us to come. I wasn't sure at first but I am glad that I am here	Group 5, aunties
Mother died of cancer	It was good to talk to other adults and to listen to other families; you don't feel so bad because everyone is here for the same reason.	Group 6, father
Mother died of cancer	I feel closer to my family now	Group 5, family 25 sister
Father murdered	The group was enough for us as a family, we were able to be honest and say how we really feel rather than what we think adults want us to say.	Group 5, family 22 niece
Sister died of cancer	It has made me think about my other children not just about _ (the daughter who died)	Group 6, family 27 mother
Father died of heart attack	It was good to come as a big family, and to be able to talk.	Group 2, family 5 son
Brother died in fire	I can't believe the change in my children, it has helped us to talk about what happened my son died and to think about how we felt and to be more open. It has also helped my son to see other boys of his age	Group 7, family 35 mother

	here so that he was able to talk about his feelings.	
Brother died of cancer	This was the right time to come to the group as it would have been too soon before.....	Group 7, family 32
Mother died of cancer	Yeah we talk more at home now	Group 3, family 11, daughter

Table 1: What some of the families thought had changed within the family system and how the group had helped them.

### **Death & Secrets**

For some of the children across the groups, once they found out how their parent died, they were able to process how they felt and make the necessary adjustment to the loss. There were a number of parents in some of the groups who had not spoken to their children about the way the other parent had died. There was often mystery around the death and on occasion misplaced guilt as some children felt that they had contributed to the parent's death in some way. In other families the parents/carers were almost too explicit and insensitive when referring to the person who had died. Writing a letter or designing a memory box helped some of the primary age children to say goodbye to the parent who had died and to ask them the questions they were curious about in a letter or a drawing. In one of the children's letters he asked his father if he was happy living in heaven and happy living with god. There are so many cases where the children felt happier once they were able to really say how they had been feeling and to identify what they were not happy with. The majority of children spoke about the change in the parent who was living. It was difficult for some children to see their parents upset and most are uncomfortable with the parent crying all the time.

*“My dad isn't so sad now, he doesn't cry as much as he did before’.” (Group 4, family 16, mother died of cancer)*

*“I didn't want to come to this place but I am glad that I did because my mum and dad are better. They do not cry as much.” (Group 7, family 32, older brother died of cancer)*

This can make children feel more vulnerable and scared that something might happen to the existing parent. See some of the comments below:

*'It was good for\_ to be amongst other children.'* (Group 2, age 13 family 5, father died of heart attack)

*'It helped me to talk with other children.'* (Group 2, age 13, family 9, mother murdered/grandfather died)

*'Okay, I have enjoyed talking to other young people like me.'* (Group 5, age 15, family 23, mother died in fire)

*'I am glad that the children were able to meet without the adults being around, that was good. We were able to talk.'* (Group 5, age 14, family 22, uncle murdered)

*'It has helped me to come to know that other children feel like me and to be able to talk about how I feel with people of the same age.'* (Group 5, age 14, family 26, mother died from alcohol related illness)

*'I know that my dad is dead now.'* (Group 3, age 6, family 13, father died of heart attack)

*'I wish that I had come with my mum to other weeks as coming today I know that I would have enjoyed it.'* (Group 3, age 18, family 13, father died of heart attack)

*'It's been fun.'* (Group 2, age 13, family 5, father died of heart attack)

*'I enjoyed the biscuits.'* (Laughter) (Group 2, age 11, father died of liver failure)

By being in the same room and having a therapist facilitate that type of conversation can contribute to the change in attitude and shift the emphasis and tension in the relationship between family members. In all of the groups, many of the parents expressed that they were hearing their child/adolescent talk about their feelings for the first time. A common complaint was that their children/adolescents never spoke to them about how they felt. The bereavement groups helped families to begin to talk in the public domain (group) with the view that the talk will continue back into the private domain (the home). Midway through all of the groups the members have relaxed and stopped resisting and at that stage were looking forward to coming on a weekly basis and were beginning to worry about the group ending.

*'But now I don't know what I am going to do when I don't have the group to come to on a Thursday.'* (group 2, family 11, husband died of liver failure)

*'I am scared of being by myself, for six weeks I had had people to talk to.'* (Group 3, family 10, husband died in a road traffic accident)

*'The group needs to be longer, more weeks because I am just getting comfortable, ready to talk and trust and then now it's finished'.* (Group 7, family 34, father died)

*'The group isn't long enough and I am worried about what happens now.'* (Group 4, family 16, wife died of cancer)

*'I wish the group was longer than 6 weeks.'* (Group 3, family 13, husband died of heart attack)

*'Yeah six weeks wasn't enough.'* (Group 3, family 14, mother died of cancer)

Brief or short term intervention was deemed as being the most appropriate therapeutic intervention because it focused on the present (the presenting difficulties and the stresses of clients), the grief. One of the advantages is that the connections between the clients' past and their present difficulties are made in order to discover how changes could be facilitated and reduce the presenting problem. The request for longer intervention can be viewed as fear and parents thinking that they would be alone with their feelings once the group finished. None of the children requested longer intervention, more consideration would have been given if CAMHS were an adult service but it is for children and adolescents where risks needed to be attended to immediately. The group does that. For some of the above families the group acted as an introduction to therapy and follow up and further intervention focused on other issues within the families. None of the families who attended the seven groups required additional bereavement intervention, if further intervention was needed the focus was always on other problems within the family. The bereavement group is a form of brief therapy, but not structured by goals or outcomes. There is a wide variation between what practitioners call brief therapy. Brief should not be synonymous with hurrying or short changing clients nor is it doing less of the same (de Shazer 1988). There is little difference between the outcome of brief interventions and those of time-unlimited therapies. Literature has shown that offering long term therapy does not necessarily produce greater outcomes for the clients (Barkham and Rowan 1993; Steenbarger, 1992). The main disadvantage is that families may not be afforded the opportunity to do the work that they need on the presenting problem, hence why brief therapy is not for chronic disorders. However the families do not just attend the bereavement group they are offered a full care plan that includes assessment, treatment, follow up and further intervention if necessary. Interestingly after the first seven groups, there

has not been a request for the bereavement group to be longer, so it may be that we are doing something differently and families did not feel that they only had the group, as they may be anxious about not having enough time. Therefore brief therapy is suitable for the majority of the bereavement children and adolescents who are referred to CAMHS because it is a very intensive intervention, although it must be stressed that the assessments for the bereavement groups that followed the initial seven groups can often take longer than 2-4 sessions depending on the nature of the death.

Bringing the group to an end has not always been easy but it has always been clear from the onset of each group that the bereavement group is for six weeks and there has always been an evaluation process where each family member expresses how they have found attending the group and the therapist has always been explicit about the progress that the families have made and what they will take away from the group experience in terms of learning and achievement (Preston-Shoot, 2007, p.139). Each family has a follow up too. It is at this stage that there is a discussion about the changes that have been observed and that a follow up session will take place to see if the changes have been sustained or if there is a need for further intervention and that if they have any further concerns in the future then they are to have their doctor make a new referral. The majority of the families provided positive feedback about the way in which the group has helped them and their grief/bereavement (see Table 2) below

<u>WHO DIED</u>	<u>EXTRACT</u>	<u>GROUP &amp; FAMILY</u>
Baby brother	... so it's been really good listening to other people's experience or I should say it has helped.	Group 1, family 2
Baby sister	To know that other people have had the same experience that I am not alone	Group 1, family 1
Father died	I understand more now	Group 1, family 3
Father died	It has been good to talk to others and hear other people' experience	Group 2, family 5
Father died	Coming here has given me more confident, I feel better about myself.	Group 3, family 13
Mother died	It was easier to talk in front of everyone than I thought. And everyone listened.	Group 3, family 11
Mother died	I feel so different than when I first came to the group I don't feel so sad or angry anymore, not as much	Group 4, family 10
Dad died	I am glad that we came and I wish that my mum was able to come.	Group 5, family 16
Mother died	It has made me understand what has happened, and I thank you for that	Group 5, family 20
Mother died	Yeah thank you, it really helped us to communicate better.	Group 5, family 20
Grandfather died	I am glad that we came; it helped me to talk about how I feel and listen to how other people are coping.	Group 7, family 36

Table 2: How some of the families felt that the group has helped them and their grief/bereavement

## Talking in the Group

This section explores and provides some examples of some of the difficulties that families find difficult to talk about across the seven groups and that were linked to the theme of secrets within the various family system. There were family members who had similar characteristics across the groups whereby they wanted to dominate the group and would try and talk generally about themselves all the time. In those situations the facilitators have to manage the situation so as not to silence the talkative member but to introduce the other members who may feel intimidated by the amount of talking that the person is doing. Preston-Shoot 2007 states that “A degree of firmness may be necessary sometimes to redirect the discussion, or to involve others and to tactfully curtail a dominant member’s contributions”. On reflection those members found it difficult to talk about their bereavement and had multiple stories about how the person in their family had died. They would often embellish the dead person’s personality, giving them ‘saint like’ qualities which would visibly irritate other family members, who would have different perspectives. In two of the cases the person had been murdered. Hence it would be difficult to talk about the nature of the death; if, for example, the child/adolescent was not aware of the true circumstances surrounding the death of their dad or brother. The excessive talking could be interpreted as a shield which was used to prevent questions from being asked. With some of the members they were fearful that the true events would emerge so were only willing to tell their story once and did not want to encourage questions or any curiosity. Therapists are confronted with unpicking the meaning of the secret for the family and where the shame bound origins come from, their own values in regards to secrecy and the family secret in particular. Imber-Black (1998) suggests that a child intuitively knows that secrets are being kept from them, they may not know the content but they know of the secret’s existence. Family secrets function in part to create intimacy and distance among family members. Secrets also create boundaries and alliances depending upon who does and does not know the secrets. For some families it is the first time that they were having contact with CAMHS or a therapist. During the initial assessment they provided information about who had died within the family, what happened around the death, any circumstances around the death which they thought were relevant, what were the current concerns regarding the child/adolescent and what was happening within the family system. Any major disclosure is made at this stage, usually at the end of the session the parents/carers will ask to speak to the therapist away from the child/adolescent.



A disclosure might include the real way the person died rather than the version that has been told to the child. Preston-Shoot (2007) suggests that knowing how and where to intervene is a skill and the intervention may include **“holding onto sensitive issues or difficult topics and not retreating into a safer arenas, or holding on to tension and differences until these can be resolved or integrated into the group’s understanding”** p.148-149. The therapist has to balance what she knows and what the child/adolescent knows and what the parent/carer wants the child/adolescent to know.

**“.....That he was attacked by some people which he was. I just haven’t told her in details that he was murdered ....or that he was mixed up in drugs.....the trial is still ongoing. She seems to be okay, I have tried to keep the same routine I don’t really think that she’s been affected as she lives with me and she has not really seen him for some time. I have always been responsible for everyone in my family”. (Group 5, family 22, father murdered)**

The funeral was also delayed because of the autopsy and circumstances of death.

In these cases the focus would be on how the family was coping. These situations would be difficult because the hope is that the real stories are revealed within the group, so that the guilt that the child/adolescent was feeling would lessen. One of the families had told the child that their uncle had died in a car accident whereas he had died from a drug overdose; this child was blaming himself as he was meant to have been with the uncle that evening but changed his mind at the last moment. He thought that it was his actions that caused his uncle’s death. The hope is that the untold stories become told so that new meaning can be made about the death. In the cases of the families where there were secrets about the nature of the death, the children/adolescents had some suspicion that their parent/carer was not telling them everything and were angry and frustrated that they were not being told the truth. This came out in the assessment appointment when the child/adolescent was seen by themselves. Another family wanted the group to assist in telling the child that their father was dead and would not be returning. This particular mother had waited a year before telling her young child, the child had thought that his father had gone on holiday.

**“Yes, he hasn’t settled, keeps running around the school and is having difficulty in relating to peers and is very sad. It is hard work at home”. (Group 6, family 30, father died heart attack)**

The groups which had bereaved mothers had similar dynamics; members in these groups found it difficult to create new narratives and were reluctant for anything to change within the family systems. Some of these parents wanted everything to remain the same because then they would be able to hold on to the memories that they had of the child that had died. By accepting that some things had to change meant that some of the parents in these groups needed to make the necessary adjustments within the family system and create space for those changes to take place.

***‘I don’t think nothing has changed. It was good for me to come here and share my grief as I was by myself, talking to each other but the group doesn’t bring back the person who has died. So nothing has been gained. I know what I need to do now that my wife has gone.’(Group 4, family 16, mother died of cancer)***

Often the same parents would show resistance when family members expressed wanting things to change in the family, they would be chastised for wanting to forget the child who had died. The main role of the therapist/facilitator would be enabling the children/adolescents within that family to tell their unheard stories so that the parent/carer could listen to how they felt (the other children in the family were often forgotten) and they were empowered to talk about what they would like. In one of the groups the sibling group did not want to have any more therapeutic intervention, since their sister had died they had been receiving weekly intervention at the request of the mother.

***“I don’t think it’s helped me, if anything it has brought back more memories, it hasn’t brought back my daughter (crying).”(Group 6, family 27 daughter/sister died of cancer )***

In another family the child requested that his parents did not go to the brother’s grave on a daily basis, as he felt that it made them sad and unable to talk to him when he came home from school. This family was appreciative that their son was talking to them as they had not really heard him talk since his brother had died. The family was able to listen to him differently after he shared his feelings.

***“They still go the cemetery but not as much and they don’t always get upset. So now I go with them.” (Group7, family 32, older brother died of cancer)***

Every group has been different because of the different members and their own personal religious or cultural experience of their bereavement. Diversity has been mentioned throughout this research and the various communities from different cultures have introduced different ways of grieving and preparing their dead, whether it was religious or culturally specific. Interwoven with family scripts and beliefs the group has been a learning forum for families and the facilitators. Listening to a family from another culture describe their way of mourning can sometimes stop the flow of tears and make a member curious about how another family mourned their dead or coped with their relative dying at the hospital or with their family members at home. As therapist the cultural and religious stories have to take their place alongside the professional stories as it is how some families make sense of their loss. The differences have predominantly been in the atmosphere that was created in each group by the people who attended; despite some of the similarities within the groups every family brought something different into the group, whether it was laughter, crying, anger, secrets, resistance or/and blame just to name a few. The groups where the children/adolescents were parentally bereaved were very different from the groups where parent/carers (mothers) had lost a child. These groups were more sensitive than where the children/adolescents were parentally bereaved and a lot of thought had to be given to encouraging all voices so that the parent/carers, who found it difficult to talk about their child's dying would not feel that their feelings and stories were not welcomed. There had to be recognition in the groups that family members could be at different stages, levels and phases with their grief and that for parents who lost a child their grief ranged from feeling almost back to normal and the next moment they felt deep levels of anguish and pain. These swings in emotions could last for months or years in many cases. With bereaved parents they often spoke about their feelings as if there were no reason to go on, since there was no one for whom they would be strong or feel responsible for. It can be very difficult for bereaved parents to hear stories of surviving children, even from other bereaved parents. Their loss was not only of present relationships but also of future hopes and dreams (Coulson, 2009).

## VARIABLES

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There are a number of variables that need to be considered when discussing what contributes to the effectiveness of a group and what holds and maintains grief within a family system. Some of the variables have been mentioned briefly like who died within the family, the period since the death and the type of death, and the ways in which these variables may manifest themselves in a member's behaviour or narrative. There are also themes that can be traced through most of the groups and which suggest why some groups were more cohesive than others.

### **Displacement/Loss of Place**

The theme of displacement/loss of place is a very strong issue in the groups. Some of the children and adolescents had to move from their place of residence to live with different guardians after their mother died. One of the adolescents had to move from living with her maternal grandmother to moving to another location to reside with her paternal aunt and her family

*“And then she went to live with her maternal grandmother who was an alcoholic who allowed her to do what she wanted. So she is not used to having boundaries, she is used to coming and going?”*

*(Group 5, family 23, father murdered)*

These living arrangements do not always work out, like this one that broke down very soon afterwards and then the adolescent had to go and live with her paternal grandmother within months of her mother dying. This young person and her reconstituted family received further therapeutic intervention after the bereavement group finished. Another child lived with her paternal aunt when her dad was murdered and her mother was not available to look after her. The child's aunt explained the situation to the therapist/facilitator during the assessment.

*“\_is now living with me permanently, she has always been with me since she was little when her parents couldn't really look after her. She knows about her dad but not really about the way that he died..... It is going through court at the moment. It has also been in the papers..... Her mother hasn't been in contact yet”. (Group 5, family 22, father murdered)*

This theme was present in three of the seven groups; in group 5 two of the adolescents were living with either a family relative or a family friend. Some of the children/adolescents had to relocate immediately after their parent/carer died, increasing their sense of grief with the loss of home/place in the family. In addition to coping with their grief, they were displaced by having to move from their family home and then having to join another family and finding their place within a new family. Bereavement can bring so many changes, one adolescent had to move away from her friends, leave her place of residence and school, miss her exams and move to a new area and live with a friend of her mother (who already had her own adolescents). Unfortunately neither her father nor her maternal grandparents offered her a place to live when her mother died. This was a very tragic referral and this young person showed tremendous resilience when she had to identify her mother's burnt body and listen to her mother's scream for help as she died in a fire. This was a very traumatic case which was investigated by the police and the adolescent was constantly being called upon to provide information about her mother.

The information above was provided in the assessment appointment but not in the bereavement group. Along with her carer at the time they decided what they were going to share with the group about the circumstances of her mother's death. The group helped this adolescent to grieve and talk about her feelings with other adolescents in the group and to feel supported within an environment where she could talk about her mother's death. The individual follow up sessions focused on her feelings of loss, displacement, and other issues pertaining to her living conditions at the time.

***“Yes, and she wasn't able to get out of the building in time. I had to go and identify her body”. (Group 5, family 23, mother murdered)***

***“Yeah they found my number as she tried to ring me and I have to go and listen to the tape” (Group 5, family 23, mother murdered)***

***“My mother left a message and they wanted me to hear her last message and to hear what she was saying. The police are not sure about the nature of the fire.....” (Group 5, family 23, mother murdered)***

The feeling of displacement and loss of place has contributed to the adolescents in this group presenting as very independent, less dependent on the adults around them and more ready to accept the loss of a parent, especially in the majority of the cases where their parents had been separated or divorced so they had already experienced a loss which has enabled them to make sense of their current loss. This is one of the hypotheses that I have about why group 5 was so successful despite it been the largest of the seven bereavement group with 26 members. It was mainly the adults in this group who needed further support.

One of the advantages of the bereavement group being a therapeutic intervention is that the children, adolescents and their families were monitored over the 6 weeks, so as a therapist/facilitator you were very aware and in a position to note when changes were taking place or if there was a change in a child or adolescent's behaviour. In one of the groups one of the adolescents spoke about being parentally bereaved and presented as being very lively, engaging well with the other adolescents, she was also articulate about her feelings, then as the group was coming to an end, the therapist/facilitators noticed that her mood was changing and she became quieter and quieter in the last two weeks. At the time we wondered if she was experiencing delayed shock as a result of her mother's death or/and whether she was realising that she was alone except for her relatively new friend's mother who knew her mother briefly, and that the group would end after six weeks which could have been regarded as another loss. This adolescent and her carer were offered further interventions to discuss the new placement and for the young person to make sense of everything that had happened. Fortunately she engaged well with the therapist, collaborated extremely well in those sessions and worked well with other agencies that were supporting her, especially later when there was conflict with her new carer and she had to be moved once again. It was imperative that the children/adolescents who were displaced were supported within their new homes and that they were monitored very closely until it was felt by the therapist that they needed no further intervention, and their schools were not concerned about them and were satisfied that they had settled down and there were no further symptoms after their bereavement. For a number of the children/adolescents, going to a new school following their bereavement was just another difficult adjustment that they had to make within a short space of time, leaving their old school that they had been at for years and leaving friends that they had made.

## **Parents who are Separated or/and Divorced**

As a therapist and one of the facilitators in the groups I was always amazed about the level of complexity of some of the cases and what adjustment the families had to make following their bereavement, especially if at the time of death the parents had separated, divorced or were no longer residing together. 13 of the parents/carers from the seven groups were in that position. In some of the families this made the grieving very difficult, especially when the parents/carers had developed new relationships or had a destructive relationship with the person who had died and there had been domestic violence in their relationship prior to the separation. Often they were in a different place from their children/adolescents and in some families the children/adolescents felt unable to grieve or talk about the parent/carer who had died. In group 1, all the parents/carers were separated, one before the bereavement and the other two parents had separated after their child had died. In group 2, one family had separated before the mother had died but the father did not take on the responsibility of the adolescent, who went to live with a family friend. In group 3, the parents had divorced and the mother had moved to the UK with the children and when she died the father had to leave his country and come to the UK to care for his children. This father was very vocal about how he felt about his ex wife.

*“I have had to give up work to look after them, we don’t have any family or support in this country.*

*I don’t need to be here because I didn’t love her.....” (Group 3, family14, mother died of cancer)*

There was conflict in the relationship that he had with his children because the children were very unhappy about the way that their father referred to their dead mother. It was very difficult to shift the father’s frame of mind and it became important for the children to be supported and be given space to explore how they felt and to be able to put their father’s feelings into the context of what had taken place prior to the mother dying. With this family the children responded well in the group and the father was there out of duty but was able to hear what his children were feeling. In one family in group 4, the parents had separated when the adolescent had been a baby, and both mother and son found it very difficult to communicate following the death of his father. The adolescent began to stay away from the family home and the mother was happier when he was not at home as there were fewer arguments. It

was difficult to discuss the father as he had died from a drug overdose, the son had not known about his father's drug use prior to his (father's) death. The group was unable to change the pattern of interaction between this mother and her son; the mother felt rejected and was not able at the time of the group to consider any other narrative. Moreover, her son was not prepared to attend the group with his mother.

***“We used to be really close but since his dad has died we can’t even talk to each other.”  
(Group 4, family 20, father died of drug overdose)***

In group 5, in four of the six families the parents had separated prior to the parent dying, one parent had separated by the time that the father died in a fire and the mother had a new partner whom the children had developed a positive relationship with. Separation is a crisis experience, evoking grief, anger and anxiety (Preston-Shoot & Agass, 1990). This parent was very sensitive about how she spoke about her ex partner which helped the children to feel that they were able to talk about their dad. In group 6, three of the parents had separated, two before their partners had died. In one of the families the mother did not tell her little boy that his father was dead until nearly a year later. There had been a history of domestic violence so she had not been feeling positive about him. In another family, the father had died in another country and the children had not been able to go to the funeral. In the group the mother expressed that the father had not been interested in the children before he died, so she had not felt that it was necessary for the children to attend his funeral nor did she have the funds to pay airfares and she had moved on and had already formed another relationship. There was conflict in the relationship between the mother and the oldest son and between the oldest son and his step father because he felt unable to talk about his father with his mother who showed no interest and did not encourage her sons to talk about their father's death. The group positioned the mother into sharing things about the boys' father that they had not known before and the group enabled the boys to ask the questions that they had not felt comfortable asking prior to coming to the group. This mother brought her sons every week despite the struggle and conflict she expressed and the therapist/facilitator was able to explain to the mother why her sons, especially the older one, might feel resentment and be experiencing different types of loss: his father's rejection and sudden death and his mother's new relationship which had contributed to the distance in the relationship between her and her son. In group 7 two parents were separated prior to the bereavement, the latter family were attending the group



because the grandfather had died and he had taken on the father figure within the family when the father stopped having contact with the children. The group enabled the family to celebrate and talk appreciatively about their grandfather's contribution to the family and the loss that they felt. In most cases the separation and divorce added a vulnerability to the surviving parent and the child/adolescent who in some of the families was not aware why their parents had separated/divorced. So there is anger already in the relationship between child and living parent, child and the parent who had died and between the living parent and parent who had died. This anger needed to be addressed with the grief that formed part of the multi-dimensional complex relationships that members brought into the bereavement group.

## BLAME AND FAMILY

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Another major variable across all except one of the groups was the theme of blame where the parent /carer held another person responsible for the death of their child. It is important for the therapist/facilitator to not **let the tone of blame inform and dominate the narrative in the therapy room/group so that alternative narratives and other themes can come out in the talk**. So trying to focus on what behavior is contributing to the blame rather than the blame itself allows there to be space for more narratives to be introduced (Parkes, 2001). Where the adult or child died in a traffic accident then the driver was held responsible. In the case where the boy blamed his dad for dying and leaving his mother and him 'behind', he was angry with his dad's dependency on alcohol. This young person felt that his father would still be alive if he had stopped drinking. In group 4, there was a family whereby one of the sons was thought to have been playing with the matches (when he was a toddler) that started the fire his baby sister died in; this was an unspoken blame, one that was never spoken aloud in the family system so the introduction of a new approach had to be suggested sensitively in the bereavement group. Within the LUUUTT model, these are Untold stories, ones that are not shared, at least not with others in that event. There may be a number of reasons why an individual may choose not to tell this story. This family needed additional sessions alongside the group sessions as the adolescent was putting himself at risk. There was a similar scenario with another family in group 7, where one of the adolescents had also lit the match as a young child which set the fire that killed his younger brother. However, in this family the mother was insistent that the son was not to blame, refusing to allow him to talk about his memories of that night or how he was feeling about the incident, that was quite traumatic for any child/adolescent to have to make sense of or accept their part in the event. The mother thought that she was helping him by saying he was not to blame. Then one evening something magical happened when the adolescent was walking out of the building with some of the older adolescents from the group. In conversation he mentioned that he was to blame for setting the fire and needed to talk about the night it happened. His mother overheard the conversation and when they got home the talk continued. The family continued the conversation in the bereavement group the following week and for the first time since the fire the mother said that she recognised that by saying that he wasn't to blame she was preventing him from talking and taking responsibility for the fire that killed his baby brother. The family had been stuck for eight years in the same position. By allowing her son to tell his story and accept responsibility, he was able to release the guilt that he had been feeling and carrying for those

eight years. By bringing forth the 'private' talk into a 'public' domain the 'untold' stories and 'unheard' stories were given permission to become 'told' stories. This process unlocks the constraints that were holding the grief in place and families were able to adjust to the bereavement and the changes in their family. The 'untold' and 'unheard' stories were unraveled during the weeks; sometimes the family is asked a question that they have never been asked before. These questions are not planned but arise out of curiosity about the family script and family life cycle and in connection with the story that is emerging. A question might unlock a door to other memories or another episode that is significant. The 'untold' stories and 'unheard' stories are often enmeshed and a contributory factor to the difficulties in the families. With the LUUUTT model, there are the Unknown stories that often surround the person who has died or the ones family members do not know exist or are not capable of telling. It is how the stories are told rather than their content. The 'spiraling evolutionary process works, so that the unheard stories become untold stories, and untold stories become, after a while, unknown stories, and vice versa' (Pearce & Pearce, 1998).

## **Blame**

The majority of the families where the issue of blame was a contributory factor (Worden, 2009) held the medical profession responsible for either their spouse's or child's death. By focusing on what the medical professional's action or lack of action were when the person died allows families to have some distraction away from what they were really feeling or how they were coping with their bereavement. This was especially the case when the person died suddenly and the doctor had either not detected the illness earlier or forewarned the family about the gravity of the illness. This was certainly the case for two of the families where the mothers died suddenly and the fathers blamed the doctors who had been caring for their partners. For one of the fathers whose partner died of cancer, he sent the children away to be cared for by different relatives. When he felt more able to cope he brought his children back home to live with him. He was able to grieve openly by crying and talking in the group about how he felt about the changes brought about by the bereavement. By the end of the group the tears had lessened which was an indicator that he was feeling better; hence he was able to focus on more things in his environment rather than on how he was feeling emotionally and begin to think about adjusting to life without his partner. However, with the other family the father's focus was on the medical profession

whom he blamed for his partner's death and his priority was his children that he now had sole responsibility for. This father found it difficult to talk about his own feelings. Instead he built a shrine in his house in honour of his partner and had a big picture of the deceased on one of the walls in the house. This family needed further intervention to manage the issues that had become problematic within the system.

In another group there were two different types of blame: one where a child blamed himself for his uncle's death, he felt in some way that he had caused the road traffic accident to happen even though he was not present when his uncle died. With the other family the mother had been ill for a long time before dying and then the father remarried again and had more children. This father decided not to attend the group despite agreeing at the assessment appointment and sent the child instead, which was of concern especially as the child found it difficult to engage and talk about his own feelings of loss and would replicate his father, echoing his fathers' speech patterns and mannerisms. He was more comfortable talking about what he thought were his father's concerns. It is important to be mindful that the children and adolescents who are referred to the bereavement group are there not solely because they have experienced bereavement but because they are having difficulty with their grief (Raphael, 1994) and something within the family system is holding and maintaining that stuck position. Preston-Shoot & Agass (1990) maintain that 'systems are continually evolving and occasionally stuck rather than homeostatically organised to change (p.49) and they suggest that "the stuckness derives from the system's continued efforts to apply outdated and erroneously internalised maps and meanings to new situations which require different solutions". This concept is based on Cecchin (1987) and Byng-Hall (1988) who had stated that a stuck family had a script which was too tightly written (p.50). Therefore some of the variables provide a foundation upon which the therapist/facilitator can begin to ask questions and which will enable the therapist to get to the strands of the variables that are interwoven with the grief. The quote below was indicative of the way some families attribute blame to professionals.

***“Yes I am never going back to him, he could have told me that she was very sick; they never told us that she had cancer.” (Group 4, family 16, mother died of cancer)***

## GUILT

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Guilt was another feeling that some of the families had across the groups; the guilt would manifest itself in the child/adolescent's behaviour, as the anger would turn inwards towards themselves (Parkes, 2001). Often guilt would accompany blame so those parents and children who experienced blame would be feeling guilty about their own conduct because they were convinced that they were at fault due to something that they did or said or something they did not do (Worden, 2009). With one of the groups, one of the adolescents was feeling guilty because he had argued with his father the night before he died and he never got the opportunity to say he was sorry for some of the things that he had said. In another group, the siblings felt guilty when they forgot to think or talk about their deceased sister. Some of these feelings are not usual amongst bereaved children, adolescents and their families; therefore it is imperative that they were reassured that they were in no way to blame for the death of someone close and they were encouraged to talk about how they feel. With guilt the therapist has to be careful that the child/adolescent does not think that they are attributing blame to them so transparency is needed when exploring guilt and blame.

## FEAR

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Fear is an important factor that often complicates the grieving process within a family system, (Raphael, 1994). It is an emotion which accompanies secrets and the untold stories that families try to hide from other family members, especially children and adolescents (Parkes, 2001). There is a fear that the secrets and stories that are hidden will be discovered by the children and adolescents in the family, the fear can be further fuelled by what they think might be the repercussions of the children finding out the truth. This may take the form of the adults in the family hiding the real circumstances surrounding an individual's death, another version would be constructed for the children/adolescents within the families. The group may encourage the family member to talk openly and share the true events but this has been after the child/adolescent has been informed of the truth. For some families this has proven too difficult and they stopped attending midway through the group. Four families did not want to complete the six weeks treatment. This is often done in order to protect the children/adolescents from finding out if an individual committed suicide or was murdered, like in the cases of some of the families who attended the bereavement groups. As mentioned earlier some of the children/adolescents in the bereavement groups were aware that not all of the full facts were being told to them which further aggravated whatever emotion they were feeling. Hence, there is another type of fear that immobilises families when someone dies. This fear allows the families to hold onto their grief for safety, by holding on and immersing themselves in the grief, the family does not have to confront the changes that are taking place in the family nor make the necessary adjustment to continuing life without the person who has died. Fear can be described as a safety net, something that holds you in place. It is understandable when a parent dies, the other spouse is left with all the responsibility, having to take on tasks that they may have never done before or in addition to the ones that they had before. This can be very frightening and the parent may feel isolated. Having to adjust to a death of a close one and adjusting to new responsibilities can be very stressful for the surviving parent/carer. Death can provoke feelings of anxiety and fear about one's own health and mortality. Fear can act as a shield to the grief and can be disguised as a defence mechanism to stop the therapist from asking questions or being curious.

## MAGICAL MOMENTS

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There were magical moments when change happened and families were able to move on to accepting that the person had died and they would have to adjust to life without them. Smaller moments are used to describe significant changes in a family, which could be moments which contribute to a shift in the family system whereby the child/adolescent in the family may stop cutting, start going to school again or begin to talk about what was worrying them. Thus magical moments symbolise different things for different families. In one of the families, where the mother had died when the boys were very small and had no memory of their mother, they had an opportunity to write down questions that they wanted their dad to answer. It was amazing to see the change in their faces and body postures as their dad provided the answers to their individual questions. It made an enormous difference to those boys to know what their mother's favourite food was, what her favourite colour was and when her birthday was. Having this information made them feel closer to her as it made them feel that they knew things about her. It was difficult for the dad to talk about his dead wife at the beginning but once he saw the boys' determination, he respected the fact that his sons were asking, which meant that they wanted to know. That was a magical moment which was illustrated in an improvement in the two youngest boys' behaviour at school and it seemed to lessen the burden of the oldest one who had been feeling responsible for his dad and his brothers. The father had become depressed when the mother had died. After completing the bereavement group, the father was referred onto the adult mental health team for support. The other magical moment in the group was in a family where an adolescent was cared for by his aunts following his mother's death. In the latter weeks of the group the adolescent was feeling very pressurised by his aunts, began to sob uncontrollably which influenced the dynamics in the family system because it was the first time that they had seen him cry since his mother died and also it made them stop talking and listen to how he was feeling. This created the shift for the aunts to begin to consider that he was not coping with his mother's death and he felt very isolated despite there being such a large extended family. This episode helped the aunts to move away from the anger that they were feeling towards their sister's death.

Across the seven groups there have been moments where a shift in the family has meant that the family has been able to change a pattern or behaviour within the system which has been the necessary ingredient for them to make the adjustment in managing their grief or coping with their bereavement.

These moments are magical because something new was created and it was wondrous to witness. In each group there has been a magical moment when change has happened. I will be using the ABC model (McLeod, 2009) to describe each event. This model is a slight derivation of the cognitive behavioural theory ABC approach. Within this context **A** represents the antecedent: what was going on before in the family or the group to enable the magical moment to happen and **B** is the behaviour that represents the interaction that symbolises the shift in the family, and **C** is for consequences, the outcome of the magical moment for each family member. I will provide examples of random magical moments from across the seven bereavement groups.

In group 1, the changes in the families were a slow process and happened over the weeks, for example: family 2 spoke about how each family member felt on the day when the youngest child in the family got knocked down, when the group began to ask questions it became clear that things could have been handled differently by the health authority. Up to that point the mother had not realised that the children had witnessed the accident and she had not thought to ask them about what they had seen. Also at the time of the child's death the mother was not kept informed about what was happening because the doctors did not speak her language and she did not speak sufficient English at the time to comprehend what they were doing or saying. Since the death of her youngest child, the mother had gone on to have another child (a boy), the couple had separated after their bereavement and the father had left the family home. There were concerns about the youngest daughter's emotional wellbeing and the teachers were unsure if her low mood and change of behaviour was related to her brother's death. By listening to the children's encounter with the accident the mother realised that she was not alone in her grief and that the children were also affected by their brother's death. This realisation brought the family closer together. The family was able to think about what was needed to move on so they began to focus on moving from their accommodation (the child had died directly in front of the building) and making a new home in another location.

In group two, family 5 (the father had been found dead by his son whilst the mother was at work) had been seen by another discipline and had not really made any progress and their attendance had become erratic towards the end. In the bereavement group it was noted by the therapists that when other family members were talking and laughing, the referred adolescent was the quietest, absorbing all



that was said, observing everything and only answering when asked a question but not really volunteering any information. In one of the weeks, during a discussion about different feelings, the adolescent told us that he would have preferred not to have found his dad dead in the house and things would have been better if his dad had died at the hospital or if someone else had found him. When asked for whom would it have been better, it took him a while before he could say that things could be better for himself. It was important that his feelings were normalised by the therapists in the room and the positive actions were highlighted. The shift in his thinking created an amazing transformation and literally in front of the group he became more talkative, volunteering information and offering his perspectives at different moments from then on. Family members were able to step back a bit as they had been feeling very protective and guilty that he rather than them had found his father dead. The adolescent continued talking from within the group (public) into his home (private) domain. In the follow up he was able to express how he had been feeling and what he had been thinking about. No further therapeutic intervention was necessary.

In group 3, there were three different magical moments with families who attended the bereavement group. In one of the families the referred adolescent's sister was deaf and her mother who had died had been the only person in the family who could communicate with her using sign language. Therefore when the mother died she was unable to talk to anyone in the family. With the help of a BSL signer she was able to tell her family how isolated she had been feeling since the bereavement and the reasons why she always wanted to go out rather than stay at home with them. The relative was able to give examples of how her world had changed when her mother died. The family was able to hear what she was saying and together they were able to negotiate new ways of communicating. It was amazing how a new dialogue had been created between them. Up to that point the rest of the family were not aware of how difficult it had been for her to be in a house where her family spoke a different language from her. Interestingly this group member was not the referred adolescent and yet she was able to use the group as a forum to express the difficulties that had arisen for her since her mother's death. The family was able to move on together and did not require any further therapeutic intervention.

There was another family where the referred child did not understand where his dad had gone. Initially the child's father's body had been placed in the mosque. On a visit to the mosque the little boy had run

around looking for his dad as he had believed that his dad was in the mosque. Over the weeks in the group he would sit and just observe what was going on around him, speaking slowly and opening up when the children came together as a group. On this particularly week he announced to the group that he had something to say, when he had everyone's attention he told the story of how every morning his dad would make him tea and they would sit and talk before his dad went to work. Now that his father was not around he did not have that routine. His mother's role had changed since the death of her husband and at times she felt stressed looking after her family as a single parent and making the necessary adjustments in her new role. The referred child was the youngest in the family.

***“He is the youngest of five children and I am only worried about him and his sister as I have had enough of his brothers who pretend to be going college but I know that they aren't but they are not talking to me and when they do we just argue. They were never like this when their dad was alive.” (Group 3, family 13, father died of a liver abscess)***

***“I just feel that everything is down to me now. I have to take care of everything. I am so tired I have tried to go back to college to get more education so that I have a qualification, plus pressure from my course and then looking after the children by myself!” (Group 3, family 13, father died of a liver abscess)***

In the final week of the group the little boy announced to the group that he now knew that his father was dead and that he was not coming back. That was magical. As part of his follow up session he wanted to make a memory box for his father and over the weeks that was what was worked on. At the end of the sessions when he felt satisfied with what he had produced, it was decided that no further intervention was needed.

As mentioned earlier, magical moments mean different things to different families. It was important that families felt that they had achieved something by attending the group and trying to work together to create change within the family system. For many of the families this was the first time that they had ever spoken about their bereavement outside the family network. For another family in group 4, it was magical to watch a father develop confidence in looking after his children. When his wife had died, the children had been sent to various relatives, and at the end of the group he was talking about what he had to improve in his family as he acknowledged that since his wife's death he had more or less

allowed the children to do what they wanted so he felt that he had to establish firmer boundaries and tighten the rules around the house (i.e. bedtime). This was an incredible change to how he had initially presented at the start of the group, whereby he had been very distressed and submerged in his grief, mourning the loss of his wife and feeling that he was unable to cope without her. Parenting the children was a new responsibility for him and he had felt daunted by the prospect as his wife had mainly taken care of the childcare up to this stage.

*“My wife died and I don’t know what to do as she use to do everything...” (Group 4, family 16, wife died of cancer)*

*“I could not cope and the children were living in different places, my son was with me and my daughter was with her aunty...” (Group 4, family 16, wife died of cancer)*

*“Yes (crying) and we don’t know what to do as she took care of everything”. (Group 4, family 16, wife died of cancer)*

*“I am glad that we have come it has really helped me to understand my nephew and how he feels. Maybe understand my sister and why she was the way that she was”. (Group 5, family 26, mother/sister died of alcohol related illness)*

*“Coming here has made me realise that I miss my sister and I am so sad that she’s not here anymore. I am glad that I came. I am going to miss not coming anymore. ” (Group 5, family 26, mother/sister died of alcohol related illness)*

*“It has made me understand what has happened, and I thank you for that.” (Group 5, family 26, mother/sister died of alcohol related illness)*

In some groups the families had a wide range of different reactions which at times were unpredictable so some of the magical moments were unexpected. In the same group another father attended with his daughter who was referred because she was self harming and had attention seeking behaviour at

home and school. This girl had been receiving treatment from another discipline and although the behaviour had lessened there were still concerns and it wasn't until the father and daughter were in the room together talking about what they remembered about the mother's death some years ago, that the opportunity for change was created when it was revealed that the father had not heard his daughter's story. The girl had been five when her mother had collapsed into a diabetic coma, never regained consciousness and subsequently died later in hospital. Her father who had not been in the house at the time had not realised that his daughter had lain in the bed next to her mother and had tried to close her eyelids. He had been very surprised when she had told him that she remembered trying to close her mother's eyes because they were open. This moment was magical on so many different levels, for the daughter to be able to tell her story and for her father to hear her story of what she remembered happening on the day her mother died, for the first time in five years. The father stopped avoiding the episode he had not wanted to listen before and had assumed that he knew how his daughter felt but never asked her.

In some bereavement groups, the magical moments took place at different times in different families over the six weeks. In group 6, a magical moment occurred when a mother had lost her oldest daughter to cancer after a prolonged illness and was having difficulty coping with the three other children. The children were in conflict about saying how they felt and telling the mother what she wanted to hear. It was imperative that the children spoke about how they really felt as the mother wanted them to mourn their dead sister everyday and felt they had to talk about her and if they didn't, it meant that they had forgotten her existence. Towards the end of the group, the children were asked if they felt that they wanted any more therapeutic intervention as a family. This family had received extensive support from a number of agencies prior to and after the daughter had died. This was asked to stop temporarily once the family began to attend the bereavement group to avoid having too much intervention at the same time. The children said they felt that they had had enough and that they were only having them at the moment because that was their mother's wishes and they were only repeating themselves every day with the workers who came to their house. Two of the older children said that they felt that their mother had favoured their older sister and was not interested in them. The mother had even gone as far as having another child because that was her dead daughter's wishes when she was alive. The girls told their mother that she would probably still benefit from speaking to a counsellor but they no longer

required any intervention. The referred adolescent said that she felt that if she tried to be like her dead sister then her mother would love her more. Although it was very difficult for the mother to hear what her children felt, especially as it was apparent that they had been feeling like this for some time and had not said anything, it moved her to really listen to them for the first time since their sister had died. In the same group in another family, a mother had not told her 4 year old son that his father had died until just before attending the group. The father had died over a year ago, the mother had found it difficult to explain to her son what had happened to his father, but sensed that the absence of his father was influencing the change in his behaviour. The couple had not been living together at the time of his death. By the end of the group he was able to articulate that his father was dead, the moment that he understood that his father was dead was magical for creating a path for there to be change within the family system. The mother was able to release the guilt that she had been carrying and to mourn without fear of being discovered by her son. This family was referred to other agencies for speech and language input, the mother was also keen to attend parenting classes.

### **Follow Up Appointments**

Every child/adolescent who attended the bereavement group is offered a follow up appointment to see whether the progress made within the group has been maintained within the family systems and there are no further concerns. Or to see if further intervention is needed to look at other issues within the family. The timing of the follow up appointment varies according to child/adolescent, urgency and the need to give the family some place to be independent from the bereavement group. Some families have needed further intervention to contain what was raised within the bereavement group and appointments are offered almost immediately after the group has finished. Some families attend and are never referred back to CAMHS. Of the 37 families that were referred and assessed five did not attend the bereavement group and have also not been re-referred to CAMHS. Of the 32 that attended the seven bereavement groups, 21 have not been referred in a three - five year period since attending CAMHS. During the follow up appointments they have mentioned that the bereavement group was what they needed to address issues within their families and they have been able to maintain the change of behaviour and had continued to allow new narratives to be developed as part of their family script. Neither the parent/carer nor the school was concerned about the child/adolescent's behaviour.

A school report is obtained and the child's teacher is spoken to before the case is closed. The child/adolescent is seen by themselves so that they can talk openly about how they are feeling and have been coping since the group. Many of the families in this category looked visibly happier and more radiant and were able to say that if they needed further support they would contact their GP, to date none of them have. 11 families required further intervention; this has varied from offering a few appointments to make a memory box, or to ensure that the adolescent was coping with their new placement/carer and that they were making the necessary adjustment. Others had to be referred to parenting groups for support on parenting style. Other families have needed longer intervention where they had not completed or attended the bereavement group for the six weeks. A number of families fall into this category. In this group, 7 families were referred to family therapy team and the work has continued with the same therapist who was in the bereavement group as a form of continuity. The other four child/adolescents have been referred to another discipline for individual treatment or psychiatry assessment.

## **Conclusion (Reflections along my journey)**

Yet again I have arrived at punctuation during this exciting but exhausting journey. I have developed as a therapist and as a researcher, and I now have a closer relationship with my research project because I have a better understanding of bereaved children and their families from when I initially ran the first seven groups and when I began the research. Attention has been given to the voices of the children, adolescents and families that have attended the bereavement groups over a two year period and I have made an attempt to bring some of their experience in to a public arena so that maybe other children and their families will realise that they are not the only ones experiencing some of the feelings that can be a complex part of bereavement process.

The intention of the opening chapters was to begin dialogues that would become the core of my research project but as I wrote I realised that they are such massive areas and I only wanted to refer to them in locating that what I was trying to explain. I wanted to write about what I felt was missing and what I wanted to draw attention to, I wanted to share what was shared with me so that it could be shared with others. As mentioned, I would like to contribute, to shape how bereavement is perceived by professionals, if only to stress the way that one system can affect another, and to bring in the cultural and religious stories of the families and to normalise the way mental health is perceived in relation to children, so that children and adolescents can voice how powerless they feel when the main caregiver is unable to help them make sense of their feelings when someone has died within the family. The bereavement group bears witness to what has been created within a family therapy bereavement group with multiple families and hundreds of children and adolescents.

There is significant evidence to support the view that a bereavement group for children, adolescents and their families is a very effective additional therapeutic intervention, based on the outcome. It could be argued about whether the moments are magical for the therapists, researcher or for the families attending the bereavement group. It is a six week therapeutic intervention that aims to focus on complex and multi-dimensional bereavement, to be able to identify within that period what the underlying issue is for the child, adolescent and their family, and to shift or adjust a belief and create in collaboration new patterns of behaviour and family scripts within the family system which would assist in understanding what is informing the child or adolescent's behaviour and help in improving, stopping or changing the worrying behaviour. For the families magical moments mean a new direction, a resolution to something, either a change in behaviour or an incident that has been difficult to

understand or make sense of, it symbolises fewer concerns about the child/adolescent, less stress, less disruptions within the relationship between adult and child, and means more understanding about what has happened within the family system since the bereavement occurred. For the researcher it means being able to understand how the magical moments were created, what happened before and what will happen after and how everyone has contributed to that moment by being a part of a group. This research has explored what factors can and have contributed to creating and maintaining grief in a family system, it has also highlighted how families have struggled with the difficulties that they experience after the death of a loved one and how they have worked to unlock and talk about some of the emotions and feelings that have arisen during their bereavement.

This research project has focused on the similarities and differences within and across the seven bereavement groups, identifying the factors and the different variables that have contributed to ensuring that the group has overall been an effective therapeutic intervention for bereaved children and adolescents and their families, and what has created and contributed to maintaining grief within a family system. The follow up has shown that many of the families have not needed any further therapeutic intervention after attending the bereavement group and have not been re-referred throughout the doctoral project.

The research presents the first seven bereavement groups and since then there has been many other bereavement groups that have taken place since and have introduced different factors that have made me conclude that not all families can grieve openly in a group setting, and the more traumatised the death the more intervention is needed before they can access the bereavement group. Many of the bereaved children and their families who had the latter bereavement groups have received therapeutic treatment outside of the clinic setting and in their homes and within the community. The assessment periods have taken longer and alternative ways of working are considered. Reflecting, I wonder if I had taken time to do longer assessments if the families who did not attend the some of the initial seven groups would have come. The bereaved children and their families are still being held within the family therapy team but the systemic work takes place within the clients' home. During the course of the research project I have worked with many bereaved families and I no longer think about short term intervention or the bereavement group as the only options but working at the client's pace and considering some of their religious and cultural stories that come out with my professional stories, and



together a treatment plan can be tailored to meet the needs of the more traumatised families who have had difficult deaths within their families.

The research project has strengthened my practice in so many ways that I am able to work with families more confidently inside and outside of the groups, I can offer advice and consultations to other professionals based on my experience which is developing all the time. With each family I learn something new. Working in this way has also led me to think about how I protect myself from some of the horrors and suffering that I hear and how to remove the images that the families have passed onto me when sharing their bereavement stories. It has made me think about PTSD and introducing different outcome measures to capture signs and symptoms of the diagnosis and the way in which his multi-family group approach can apply to different traumas. Bereavement can bring so many different things and should be approached from different angles.

The research project was the foundation for other bereavement groups that have followed and continues to be an essential part of the CAMHS service where I work and which caters for many of the communities within that borough. Ideally it should be a therapeutic intervention that is available in all CAMHS within every trust. There still needs to be a recognition that like all major transitions and changes in children's lives they may need some support in making sense of what is happening in their families and why they are feeling the way that they do. The group has the potential to cater for a range of bereavement for example we have run groups for bereaved fathers, bereaved women and families where there has been death by murder. Over the years I have wondered if the group can be facilitated by other professionals such as psychologists or other psychotherapists from other disciplines and how different would the outcomes be from the group being facilitated by family therapists.

I am encouraged by the number of research projects that are focusing on bereaved children; however I would like to see more comparative studies and further research within the family therapy domain and ultimately more bereavement groups available for bereaved children, adolescents and their families within different establishments and provided by different agencies.

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