

Featured Innovation

Fostering Resilience in Families in Which a Parent Has Died:

An Interview with Irwin N. Sandler, PhD, and Tim S. Ayers, PhD

Irwin Sandler, PhD, Tim Ayers, PhD, and Sharlene Wolchik, PhD, of the Prevention Research Center at Arizona State University in Tempe, Arizona have designed and run a randomized experimental trial to evaluate the Family Bereavement Program, an intervention for parentally-bereaved children and the surviving parent. The program is derived from clinical observations and research showing that loss of a parent is a highly stressful event, which can lead to future mental health problems in the child. Specifically, these researchers note that the death of a parent can lead to further family stressors, which may increase mental health problems of the surviving parent and have a negative effect on the parenting received by the child. This education and support program is designed to build coping skills within children themselves and to promote the parent's use of healthy and effective parenting skills. For children, the intervention aims to teach problem solving and emotional regulation skills to help them recognize and deal with their feelings as well as the stressful situations that can follow the death of a parent. For parents, the targeted parenting skills include fostering a warm and responsive relationship with the child, maintaining positive routines, and using effective discipline. To achieve these goals, the researchers designed separate courses for parents, children, and adolescents, which take place over twelve consecutive weeks. These sessions include group "homework" so that all family members are developing and practicing dovetailed skills. Sandler, Ayers, and Wolchik are reporting on their findings from the experimental evaluation of this group intervention elsewhere.¹ Here they focus on the details of what they did, barriers they faced and strategies for overcoming them, as well as how the Family Bereavement Program might be adapted to other non-experimental settings.

*What follows are the edited comments from two interviews with Irwin N. Sandler, PhD, and Tim S. Ayers, PhD, conducted by Anna L. Romer, EdD. [Citation: Sandler IN, Ayers TS, Romer AL. Fostering resilience in families in which a parent has died: An interview with Irwin N. Sandler and Tim S. Ayers. *Innovations in End-of-Life Care*. 2001;3(6),www.edc.org/lastacts]*

Background

What led to the development of the Family Bereavement Program? What prompted this intervention?

Irwin Sandler (IS): The Family Bereavement Program is a program at the Prevention Research Center at Arizona State University, a research center funded by the National Institute of Mental Health. The Center was first funded in 1984 and has been operating continuously since then. Our mission is to develop programs to promote resilient outcomes for children and families facing highly stressful situations. We saw two large gaps in the literature that we wanted to address. The first was that programs to help bereaved children were not using the findings from the literature about factors that seemed to lead to better adaptation for bereaved children. We thought it would be important to develop a program specifically focused on improving factors that research had found to predict better mental health outcomes for these children.

The second rationale for the program and our study of it was that there were few scientifically valid studies evaluating the effects of programs for bereaved children. We thought it important to conduct as careful a scientific evaluation as possible in order to assess whether, in fact, our program led to better outcomes. We had done a previous evaluation of a program that showed some small positive effects, and we wanted to take what we had learned to build and test a program that would have stronger effects.²

What are the key goals of the intervention—for parents and for children?

IS: The goals of the program are very simple, to build strengths in children and parents to promote resilient outcomes and prevent mental health problems for bereaved children.

For children and adolescents, we hope to improve their ability to cope with stress, to increase their ability to deal with their grief-related feelings, and to help them communicate with their families. For parents, we hope to improve their ability to build a stable and positive family environment in the face of a devastating loss. The program also aims to help them use effective discipline, to help them deal with their own grief and depression, and to help them shield their children from stressors that inevitably follow the death of the spouse/parent.

Program Design: Supporting Healthy Functioning in the Face of Loss

IS: One of the ways our program differs from more traditional bereavement support is that the sessions are designed to build and practice concrete skills to support healthy family functioning. The program is not designed as a crisis intervention, but rather aims to build long-term adjustment by helping children and families adapt to life following the death of the parent/spouse. We also aim to create a safe place to talk and process feelings and receive support. In these elements the program mirrors a more typical bereavement support group.

Specifically, we were seeking to modify the following mediators of positive mental health outcomes for children who have suffered a major loss, such as divorce or death of a parent: positive parent-child relationships, stable positive routines, and effective discipline. The intervention is designed to protect against parent demoralization and life event stressors associated with the loss of a parent. We hope to influence children's beliefs about their ability to control events in their lives, threats to self-esteem and negative appraisals of self-esteem, as well as their capacity to recognize and express their feelings. Because these beliefs and skills evolve in the soup of family interactions, we chose to intervene with parents and children, teaching similar and complementary skills to surviving parents and children separately. We divided the children by age, since developmental differences affect how they process loss and grief. When we implemented the program there were separate groups for adolescents and children. The actual curriculum for children and adolescents was similar, but the facilitators taught the concepts in developmentally appropriate ways. Each part of the family is learning with peers who are also bereaved, and then going back into the family armed with new communication skills and understandings about the grief process. The following chart shows how the program components map onto the mediators we were targeting. [*See [Mediators Targeted in Child/Adolescent and Caregiver Programs](#).*]

The implementation of the Family Bereavement Program was part of an experimental study. How many children and parents participated in experimental and control groups? How did you recruit the families who participated?

IS: The study involved random assignment of 90 families (135 children and adolescents along with their caregivers) to the Family Bereavement Program (FBP), and 66 families (109 children and

adolescents with their caregivers) to a self-study control group. The study was run over a three year period, between spring of 1996 and fall of 1998, with the intervention or self-study program being delivered to six successive cohorts of families ranging from 21 to 36 families participating in each cohort. We recruited families for the program from a wide variety of community referral sources, including schools, clinics, hospitals, hospice, churches, victim witness programs, and others. The largest referring agency was the schools, which referred about 60 percent of the families. Schools are one of the first agencies that become aware of the needs of bereaved children. Indeed many schools and school-based health clinics are already running programs for bereaved children.

Criteria for inclusion were that the families had a child between ages 8 and 16, and had experienced the death of a parent or parent figure in the past 3 to 30 months. The average time passed since the death was ten months. We screened out families in which the caregiver was experiencing clinical levels of depression or the child was experiencing clinical levels of conduct problems and referred them directly for mental health services. One of the strengths of our sample was that the families who participated in the intervention represented a diverse cross-section of the population of the Phoenix metropolitan area, with approximately two thirds being white (not Hispanic) and the remaining third being ethnic minorities. Cause of death was also heterogeneous, including sudden unexpected deaths from accidents, violence, suicide, drug overdose, to anticipated death from terminal illness.

Tim Ayers (TA): The reason we set a lower age range limit for the children is that we were teaching kids other ways to look at problems. One of the skills we were encouraging the children to use was more positive reframing of problems or challenges they confronted in other areas of their lives. From the literature that we've reviewed, we know that this skill typically tends to emerge between the ages of 8 to 10. Children at this age have the ability to think about their thinking. That is, in part, why children had to be at least 8 years old to participate in the program.

Why did you choose 30 months or two and a half years as the cut off? Was there a theoretical reason for that?

IS: The choice of 30 months was not based on any specific theory, but reflected the fact that we wanted the program to be for families experiencing a relatively recent bereavement. The program is not crisis-oriented, so we did not want to begin earlier than three months after the parent's death, but we also wanted to work with families that were still restructuring their way of functioning and would be more amenable to change.

The program screened out families who were experiencing clinical levels of mental disorder. Does this mean that none of the families in the program were receiving any other kind of clinical intervention to support their bereavement or transition to having no spouse, or just one parent?

TA: From the program evaluation perspective, obviously we wanted to evaluate the effects of our intervention as compared to no intervention, but we didn't tell families that they couldn't seek out other treatment. I'm sure some families did so during the course, or after they finished the program. Some families reported that they actually had done some grief work prior to their involvement in our program.

According to your inclusion protocol, how did you measure an acceptable level of depression for participation, in the context of the death of a family member?

TA: We screened participants in two areas, and this came from our experience with the two pilots

that we ran prior to starting the intervention trial. First of all, we screened participants for any evidence of serious suicidal ideation either from the parent or the child. We automatically referred people with evidence of serious suicidal ideation because we felt that we were not set up as a program to respond to that kind of need. We helped connect people who fell in this group to more intensive services in the community and paid for a thorough assessment to get them to the most appropriate services.

Second, we had a two-stage screening process to screen out parents suffering from such severe depression that we felt it unethical to offer our prevention program. In one of our first pilots we had a parent that was so depressed that she cried much of the each of the sessions and it was clear that such parents would not be able to take part in the exercises and use the program, and would not benefit from the intervention. The Beck Depression Inventory (BDI)³ was used as the first stage screen, and we used a high score as our first screening threshold to invite the parent in for a second stage diagnostic interview. We then administered a structured clinical interview, and conducted the diagnostic interview to assess the presence of affective disorders. If the bereaved parent met the criterion for major depression at that point in time we encouraged him or her to get other services. And again, the program paid for their assessment and provided quite a bit of information to these families about other treatment options.

TA: We also screened children prior to their participation and again used a two-stage screen. The concern here was that children who would not work well in a group and who needed more intensive services should be referred to such services. As part of the initial screen, each child had a teacher complete the Achenbach's Teacher Report Form (TRF).⁴ We used a very high cut-point again ($T \geq 70$) on three subscales of the TRF, which were: delinquency, aggressiveness, and attention problems. We then invited those children who scored high on this measure to come back in for a second stage screening. We conducted a diagnostic interview with the parent and the child called the Diagnostic Interview Schedule for Children, the DISC, with these families.⁵ We excluded those children who met diagnosable criterion on attention deficit disorder with hyperactivity, conduct disorder, or aggressiveness. With the exception that we kept children in the intervention trial who had an attention deficit disorder if the disorder was being well-managed through medication.

In the area of conduct problems or aggressive behavior, if a child was at a diagnostic level on oppositional-defined disorder or conduct disorder, we felt again it was important that the family get more intensive treatment than that could be offered in this group.

Why did you offer children in the control group books on bereavement?

IS: Children, adolescents and caregivers in the control group each received three books about dealing with grief. Different, age appropriate books were selected for children and adolescents, while the caregivers received books for adults. Books were chosen for the control group because they are readily available to the public and would most closely represent a "treatment as usual" condition. We chose what we thought were good and helpful books, and provided a curriculum guide for reading them – so we felt that the control group was also receiving a beneficial service from the study.

Separate Courses for Parents, Children, and Adolescents

TA: Each group (parent, child and adolescent) participated in 14 sessions (12 group sessions and 2 individual family sessions) offered over the course of twelve weeks. The sessions include active learning, emotional support and skill-building activities. Counselors with master's degree level training served as the group facilitators. Each group was made up of 6 to 10 participants.

The Child/Adolescent Program

Goal Setting

TA: At the outset of the course, children select their own specific goals for what they want to accomplish in the program. Thus they individualize the program towards accomplishing what is important to them. This process involves a discussion about how they would like things to be different, identifying reasonable goals, and how to set them. The goals are usually decided upon in the second week's group session. The program builds motivation around one's own goals. Some examples of the goals set were: "Feel less sad." "Do better in school." "Get along with my mom or my sister." "Feel better about myself." Working toward their goals involves taking concrete steps outside of the course and monitoring how effective their actions are in helping move them toward accomplishing these goals.

Children can then use the goal-setting and other skills taught in the course to deal with other stressors in their lives. These skills include problem solving, communication, positive reframing of problems, distinguishing controllable from uncontrollable events, learning to express their feelings, and decreasing negative "doom and gloom" thinking. They apply these skills over the course of the program and discuss how they are applying the skills in their groups during weekly check-ins as well as during the two individual sessions. The goal is not only to have them learn the skills but to have them learn a sense of efficacy in dealing with the stressors in their lives, their feelings, and their roles as contributors to their families' strengths. A summary of the topics of the 12 group sessions gives a concrete sense of what the facilitators are teaching and how we hope children move through the course. Each group session lasts two hours. Some parts of some sessions are offered conjointly in the caregiver groups.

Summary of Children's Curriculum: Session and Topic

Session	Topic
1	Introduction to the Program
2	Family Time
3	The Event-Thought-Feeling Link
3a	First Individual Session
4	Distinguishing Between Types of Hurtful and Hopeful Thoughts
5	Replacing Hurtful Thoughts with Hopeful Thoughts
6	Good Communication Sharing Your Feelings
7	Teaching Appropriate Responsibility for Problems and Avoiding Negative Appraisals about Excess Responsibility
8	Problem Solving

9	I-Message for Problem Solving
9a	Second Individual Session
10	Integration of Program Skills
11	Skill Review and Relapse Prevention
12	Review and Closure

[See [Child Program Content and Process Objectives](#) for details about each session.]

IS: To reiterate what Tim has said, these new skills are often used to help children accomplish both their own and the program's goals. For example a child may use communication skills to get along better with his or her surviving parent or to share feelings with a supportive other. Children may use problem-solving skills to plan how to do better in school. The skills we are teaching the children often work in conjunction with those we are teaching the adults, who are learning new skills and practicing at home by approaching the children differently. It creates a synergy, through which all members of the family are working together to change behavior and put into practice the new skills they are learning.

Weekly Grief Discussions

TA: In every session, there is a grief discussion and a targeted activity in which the individuals talk about a selected issue common to bereaved children. This part of the program usually takes between 20-30 minutes out of each two-hour session. Each grief discussion focuses on one feeling or experience that is common among bereaved children or adolescents. The discussion topic is different each session, ranging from feelings of sadness, anger, guilt, and fear to those unusual experiences that sometimes happen to bereaved children, which others may not know about. Each session has a group activity, and an opportunity for each child to share his or her own experiences. The group leaders are trained to elicit discussion on these topics. [See [Child/Adolescent Grief Discussions: Prompts by Topic](#)] For example, in the second session with the children's group, the discussion is about hiding feelings. In the exercise, each child writes down a feeling he or she has had, or that a kid *like* them may have had, after experiencing the death of a parent. Those pieces of paper with the feelings on them are then placed under a black sheet or a blanket in the middle of the group, and effectively hidden. Then, the kids discuss what the feelings might be and why kids might hide that feeling. That way, each child has the opportunity to see what everyone in the group has been experiencing, and compare it to their own experience. Afterward, there is a discussion about it not being necessary to hide feelings and some of the problems that arise from hiding feelings. These discussions draw on the children's own experience and offer an opportunity for kids to brainstorm and problem solve ways in which they can be more open about their feelings.

Building Family Skills

IS: A third key component of the program is to build individual child and family relationship skills to promote resilience. Children learn new skills in the program and actively practice them at home as well as engaging in activities that promote parental warmth and stability. One of the ongoing, weekly assignments is called Family Time. Many newly bereaved families find it difficult to engage in enjoyable activities together as a family. These activities are given as homework for each family in

the group. [See [About Family Time](#) and [Family Time Information Sheet](#) for details about this activity.]

Teaching Children to Express Feelings and Solve Problems, Parents to Listen and Coach

TA: We have several exercises to help children communicate more effectively with their parents, both in terms of expressing how they are feeling as well as asking effectively for what they need.

The "I-Message for Feeling" evolved out of a very common technique: the "I-statement." For example, an "I-Message for Feeling" might be: "I feel angry that my dad got in trouble with drugs." When we started the program we wanted to teach the children the "I-Message for Feeling" saying, essentially, "I'm feeling a certain way" and asking their parents to listen to them as they talk about that feeling. Often "I-statements" combine the expression of feelings with a call to action. We decided to break that up a little bit to be more congruent with what we're trying to teach in the program from the parent or the guardian's perspective.

We constructed a variant of the I-statement that we call an "I-Message for Problem Solving." The form of this message is: "I feel X, and I would like your help in solving the problem." We wanted the children's skills to work together with the *guided* problem solving skills that we were teaching in the caregivers' program. So, we set the kids up to initiate support from their parents. At the same time, we are teaching the parents communication and listening skills, so that they are attuned to hearing when their children come to them with either an "I-Message for Feeling" or an "I-Message for Problem Solving."

If the child does come to the parent or caregiver with an "I-Message for Problem Solving," our goal is for the parents to engage the kids in guided problem solving. This process entails the parent or caregiver teaching the children how to think about problems and guiding the children to consider specific questions. For example, the child might brainstorm a range of possible actions by asking him or herself: "Well, what are all the things that I might do to deal with these feelings?" Then, parents encourage children to consider the set of all possible responses in terms of consequences and choices: "What do I think is the best thing to do?" "What may be some of the consequences if I were to do that?" Ideally, this process leads children to making a more thoughtful choice before taking action.

As you can see from the session topics, we teach the "I-Message for Feeling" early on in the program, to encourage children to speak to their parents about the ways they are feeling. Later on in the program we teach the children the "I-Message for Problem Solving." Just prior to that, in terms of the caregiver program, we teach the parents or caregivers, the skills to guide their children in the same problem-solving process that we are teaching in the child and adolescent groups.

Gaps Between Design and Implementation

TA: We initially taught the "I-Message for Problem-Solving" in some of our pilot studies, as "I feel X when this happens, and I would like to do Y, to make the problem better." We quickly learned that from the caregiver's perspective this message was fairly demanding. The way many parents or caregiver's heard the message was: "This is the way this problem is going to be solved." So, we backed up and during our second pilot to encouraged a more collaborative approach. We didn't think that we had taught the children to deliver an ultimatum to their parents or caregivers when we taught the "I-message for Problem Solving," but from the parents' perspective, and the way in which it got conveyed by the children, that's what happened. This is an example of how important it is to observe how participants assimilate the concepts you are trying to teach, and to modify what the facilitators do, depending on how the curriculum is translating in practice.

Teaching and Supporting Good Parenting Skills: The Parent Group

IS: For parents, the process is similar. They learn family skills to build resilient families; communication, creating positive routines, one-on-one time, quality time, effective discipline, positive reframing of stressors, skills to help them deal with their own grief and to shield their children from overwhelming stressors. The following summary of topics for each session will help flesh out just what we mean:

Summary of Parent Curriculum by Session and Topic

Session	Topic
1	Introduction to the Program
2	Family Time
3	Communication Part 1: Catch'Em Being Good and Listening
3a	First Individual Session
4	Communication Parts 2 & 3: One-on-One Time and Listening
5	Communication Part 4: Feeling Responses and Saying No
6	Guided Problem Solving and Using Listening Skills to Hear your Children Talk about Grief
7	Parent Demoralization
8	Discipline Part 1: Steps 1 and 2: Adopting Clear and Realistic Expectations and Sizing Up the Problem
9	Discipline Part 2: Step 3: Developing a Change Plan
9a	Second Individual Session
10	Discipline Part 3: Step 4: Using the Change Plan, Evaluating and Reevaluating it if Necessary
11	Helping Your Kid Deal with Tough Times
12	Review, Maintenance of Strategies and Closure

[See [Caregiver Program Content and Process Objectives](#) for details about each session.]

IS: As this outline demonstrates, the focus in the parent group is on enhancing existing parenting skills and building and developing new parenting practices, which they might not have previously

used. The deceased parent may have been the disciplinarian, or may have initiated enjoyable family activities. Now the surviving parent has to learn to take on these roles for the well-being and stability of the family. The program focuses on building on or developing the relationships between the surviving caregiver and each of the children. This was done in a variety of ways that all include enhancing listening skills so communication is effective and children feel listened to and understood, ensuring that the surviving caregivers spend quality time with their children, and instituting stable positive routines within the family.

In the parenting group, several early sessions focus on teaching listening skills in modeled conversation. Then, parents are encouraged to go home and try these skills out with their own children. In progressive weeks they discuss successes and failures. One benefit of the group setting is parents have the opportunity to learn from one another's experiences. They can see their peers as models for future behavior and problem solving, rather than only receiving instruction from the facilitator.

The focus on discipline centers on the consistency of discipline practices. This includes giving clear rules, setting clear contingencies, and following through with the plan. From consulting with other bereavement experts, we learned that during times of grief many bereaved parents find it challenging to provide consistent follow-through in their disciplinary practices with their kids. As with any children, bereaved children need consistency in their parents' discipline practices. They continue to need to know what is expected of them and that their misbehavior will have consequences.

Guided problem solving involves combining the listening skills the parents are learning in the group with a model of how to guide the child through a problem the child may be experiencing at home or in school. This process mirrors the model of problem solving that is taught to the children and adolescents in their groups. Teaching these skills in tandem to all the groups allows the child to know that the parent is aware of the skills he or she is learning in his or her group. This approach encourages parents to sit with their children and listen, puzzle out the problem together, and help the child generate solutions, without the parent stepping in and solving the problem for the child. These problems can range from trouble with homework, to difficulties with peers at school, to no longer being able to afford certain things due to the loss of income after the death of the parent. This skill set serves to place the surviving parent in the role of coach and helper to the child, while at the same time, reinforcing the skills the children are learning in their groups.

One of the goals was for parents to shield children from negative events associated with the death. What kinds of things were you hoping the parents would shield the children from?

IS: We developed a measure of the stressors that are unique to bereaved children. For example, other people saying bad things about the deceased parent; high expectations for the child to "be the man of the house" or other changes in roles in the family. We particularly noted that observing the surviving parent's distress is distressing to children.

TA: Toward the end of the program we really engage the parents in a discussion about these stressors. We identified three areas, based on children's report and our other research, that are very troubling to a child. These were:

- Conflict both within the family and conflict about the death of the parent. For example, relatives say bad things about the deceased parent.
- The surviving parent's own distress, depression, anxiety or difficulties coping with the death.

- Anniversaries and major events.

TA: The eleventh session in the caregiver program targets these areas. The caregiver groups talked about ways in which parents or caregivers could reduce their children's exposure to some of these kinds of events. For example, we encourage parents to try to limit children's exposure to conflict between relatives and the parent about the death.

The area that got really tricky was figuring out how to deal with the parents' own distress. We certainly didn't want to tell parents, "You need to hide your feelings." Instead, we advocated a model of positive coping when distressed, to give the child a sense of reassurance, that coexists with the grief and sadness. We offer a statement such as the following as a way both to acknowledge the reality of the distress, without letting it overwhelm the family: "You're right, Johnny, I'm really upset right now, I'm really missing your daddy. And sometimes I cry and I'm really upset, BUT I'm here for you, and we're going to make it..."

IS: The idea here is to convey a message that is louder than the immediate sense of helplessness and distress. That message is: "We're going to make it. I'm sad now, and you're right, and sometimes you'll see me cry, but, we're going to make it. I'm going to be all right, and you're going to be all right." So we actually developed a scale to measure this kind of message. We call it "Talk with Reassurance." It's not denying that these things are happening, but rather doing two things: one is to talk about the sad feelings but in a calming and reassuring way. The second thing that we did tell parents was not to dump their problems on their kids. We gave rather direct instructions: Do not to burden the child with money problems, for example. If money is limited the parent faces that problem, and it's ok for the child to be aware of it. However, the child should not become a confidante to whom the parent expresses their fears and sense of the hopelessness of dealing with the problem. Rather, the child should be reassured that the parent will find a way to deal with it, which may involve everyone doing things a bit differently than before.

How do the individual sessions mesh with the group sessions?

TA: Two individual sessions are scheduled during the twelve weeks, during which each facilitator meets one-on-one for an hour and a half, with either the child or the parent to discuss how things are going. Participants talk about problems in using the skills and their progress in accomplishing their individual and family goals. These sessions are rather labor intensive for the group facilitators. During the second individual meeting both facilitators get together and coach each child and parent or caregiver pair in the guided problem-solving process.

What kind of training and ongoing supervision do you do with the facilitators?

IS: Training for child and parent facilitators is similar. It involves learning the specific content of the sessions so they can do them well and naturally without relying on the manual. It involves role playing to practice implementing the program. It involves trouble shooting possible problems in doing the program. Finally and most importantly, training uses the same group techniques we use with families to get the group leaders actively involved in processing and "owning" the program; to make it their own so that they have a sense of efficacy in doing the program.

Impact of the Program

What were the most important findings of the experimental study?

IS: We interviewed children and parents before they entered the program, immediately after completion of the intervention and 11 months later. The interviews were quite extensive and

included the reports of caregivers, children and adolescents and teachers. In addition we obtained behavioral observation based measures of caregiver-child relations. All the measures were selected to be reliable and valid as measures of the constructs we were trying to change in the program. The results, based on this wide array of psychological measures showed that we did successfully improve the skills we had targeted: positive parenting, coping, reduced stressful events, improved feeling expression, and improved mental health of the surviving parent or caregiver.

Eleven months following the program, children who participated in the course showed a decrease in symptoms of anxiety and depression and showed fewer instances of externalizing problems, i.e., acting out. However, the positive effects of the program were not uniform across all children. Children who had more problems before they entered the program experienced greater improvement, particularly on internalizing symptoms such as anxiety and depression. Also, girls showed more benefit from participating than did boys. This effect was not anticipated but it may be due to the fact that most of the group leaders were women or that most of the surviving parents were female. This result may also be due to the different roles played by boys and girls in families following bereavement.

We used a whole range of standardized self-report measures to assess these effects individually with parents and the children or adolescents. We also administered a parent-child interaction task that was taped and which we rated on dimensions of positive affect, the presence of open-ended questions, validation, etc. In addition, we asked parents and children to complete a self-report scale on the dimensions we were hoping to change as a result of the intervention.

We also have done additional analyses that show the mechanisms by which the program improved children's mental health problems. The major ways the program is working are to improve positive parenting, to reduce stressful events to which the children are exposed and to decrease children's need to inhibit their expression of feelings. Change in these areas is most clearly related to improvement in children's mental health.

Barriers

What kinds of problems did you encounter when you implemented this program?

IS: We found that some families needed logistical support, such as transportation. People have very hectic and busy lives. We provided dinner prior to the program sessions to accommodate their schedules. The program is long and intensive so we needed to watch our time so we could cover the program material in each session. Some families are very disorganized and needed a great deal of support in carrying out the program. Some parents were experiencing very high levels of distress and grief, and needed extra support. The families bring their own unique dynamics and it is important to understand each one's situation and use clinical judgement in helping them use the program to meet their needs. It is important not to pathologize the families nor try to change long-ingrained patterns of family dynamics, but to keep focused on immediate goals, which they select and that can realistically be accomplished.

What barriers did parents encounter in trying to learn the skills?

TA: The parents express very high levels of satisfaction with the Family Bereavement Program. Some activities are almost universally loved and appreciated, such as Family Time, quality time, and one-on-one time. Other activities may meet some family needs more than others. Parental hectic schedules, competing demands, and their own distress sometimes make the program more difficult to do. Early on we needed to learn to guard against instilling guilt in the parents. Parents should use

the program to meet their needs, but not get stuck feeling guilty about not being perfect.

What other kinds of problems did you discover in running the program?

TA: Group leaders reported that they needed more time. The sessions are jam packed with activities and it is sometimes difficult to cover everything. We dealt with this issue by having the group leaders use their skill and ingenuity. They were generally a very resourceful and talented group. However, we did keep a focus on completing the sessions as described in the program manuals. The easiest sessions involved positive family time and quality time. The most difficult sessions in the child program involved teaching problem solving skills. There is a great deal of material here that we are trying to get across in a limited amount of time.

You report a low dropout rate—what was it? To what do you attribute that? What did you learn from parents about what motivated them to keep with the program?

IS: There was a very low dropout rate, more than 90 percent of the families completed at least half of the program, and two thirds of the families attended all of the sessions or completed a makeup session for the sessions they missed. Families were not compensated for attending the sessions. We attribute the low dropout rate to families seeing the benefits of the program in their own lives, and receiving group support from other members of the group. It is also important that we minimized logistical barriers to their attendance such as by providing dinner, and transportation if needed. The program makes demands on them and requires their active involvement. Investing so much of themselves may keep them involved.

Did you learn anything about what you might recommend as "ideal" timing for such an intervention?

IS: As mentioned, the program is not a crisis program. We do not want families involved prior to three months following the death because they are dealing with more immediate issues of grief and are less likely to be ready for the skill building in developing their new family structure. Other than that, the program seems appropriate at any time families are ready to deal with their family and grief issues.

Participant Feedback

TA: Regular opportunities to "check in" and talk about how the program was going and to report on efforts to practice the skills outside of the sessions were built into the curriculum. In addition, in session #11, we asked each child to teach a lesson on the skill that he or she had learned and found to be most valuable. They generally made posters to teach their lessons although some children used other creative approaches such as writing a poem or song or developing and acting out the skill in a play. They selected a wide range of skills as the most helpful. Some of the most popular activities were family time, communication of "I-Message for Sharing," and "I-Message for Problem Solving." Teaching a lesson to their peers was a very powerful aspect of the program in the sense of building a sense of efficacy in the children.

What makes this program innovative?

IS: The program is innovative because it specifically targets the factors, which are most consistently related to resilient outcomes for bereaved children according to research.⁷ A second distinction is that our research shows that the intervention is generally successful in strengthening these factors. Last, the program is unique in its very strong emphasis on building healthy family functioning. The family is the most important resource for the children and the children's long-term well-being will

come from changes in how the family functions outside the sessions more than anything that is said or done *in* the session.

Next Steps

IS: We are now engaged in re-interviewing the families six years after they participated in the program. We will assess their continued use of program skills for healthy family relations, and coping as well as mental health problems, healthy functioning in school, work and social relations and their use of services.

One critical step is to learn more about how the program works and how long the effects last. For example, we need to learn about why the program is effective. Are some aspects of the program more effective than others? We test this by seeing which aspects of resilience seem to account for improvement in children's well-being, and thinking about what elements of the program are building those aspects of resilience. Research that is in progress offers some clues. For example we are learning that our efforts to teach parenting skills are paying off! Improvements in parenting are directly related to improvements in children's mental health problems.

Adaptation to Community Settings

What needs to happen for health care professionals working in community settings to adapt your program successfully?

IS: We are in the midst of learning how to translate this experimental program into community agencies where it can be delivered as a community service. In some ways we have prepared well for this step, but there are important considerations to attend to, in order to translate this program successfully into community services. On the positive side, we have detailed manuals that describe everything that goes on in the program and a great deal of experience with 135 children and adolescents from a wide range of ethnicities, and bereavement situations. A wide range of organizations might successfully use the program including independent community agencies that specialize in bereavement issues, hospices, schools, and churches.

We are eager to consult with people working in community organizations about how to translate these tools to their settings. However, there are areas that are as yet unknown. We invested a great deal of time in training and supervising the group leaders. How self-explanatory are the manuals? How much training or consultation would be necessary to deliver the program effectively? We debriefed with group leaders after each session, but this level of supervision and coaching is probably not practical. Can leaders who have less intensive coaching conduct the sessions in a natural way so that the ideas come across and families feel that the course is tailored to their needs? Can community agencies adapt the curriculum to make it their own, yet maintain the integrity of the program as it was designed so that it still meets the needs of the families and "works" i.e., buffers children against risks of developing mental health problems?

The most important resource a community organization needs is the human resource, i.e., professionals who really want to learn about and use the program effectively. Organizations need to have a commitment to provide the training and the time to learn to implement the program. They also need adequate logistical support such as space, materials, or dinners for families, if necessary. There are a lot of practical issues that need to be considered in mounting any new program and every agency knows the issues that pertain to them.

We will need to address these considerations in collaboration with community agencies as they

partner with us to translate these exciting research findings into effective services that can be delivered in communities. We also believe that agencies will want to consult with us on the use of the program and receive training on the program model and how to make it fit their agency.

What are the implications of your work for teachers, and other community members dealing with children who have lost parents, or families who have lost family members due to events of Sept. 11 and its aftermath?

IS: We believe that our work has important implications for community members dealing with children who have lost parents due to events of Sept. 11 or its aftermath. The most important lesson of our work, and that of other researchers in the field, is that children and families have great strengths that enable them to be resilient against even such a tragic experience. A second lesson is that programs such as ours can be effective to help families marshal their strengths and resources to help their children. They can provide a safe place for children to talk about, validate, and make sense of their experiences with others who understand. They offer the opportunity for families to be together in a nurturing and positive way, to provide structure and consistent discipline for children and for parents to hear and understand their children's experience. Most important we have learned to be optimistic that children's power of recovery should not be underestimated, particularly when they are provided with a supportive and stable environment in which to recover and grow.

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