

EXPRESSIVE ARTS THERAPY WITH BEREAVED FAMILIES

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Most current grief programs support the children and/or parents of bereaved families rather than the family as a whole. This exploratory study was a quantitative and qualitative investigation of the use of expressive arts therapy with bereaved families during a weekend camp experience and a series of follow-up sessions. The purpose of the study was to determine the effectiveness of using expressive arts activities in improving the functioning of the bereaved family as a whole as well as individual family members.

Participants included eight families who lost a child to a chronic illness between 2 to 36 months prior to the onset of the study. Children ranged in age from 3 to 15, and parents ranged in age from 26 to 66, for a total of 27 participants. The Child Life Department at Children's Medical Center of Dallas, a division of The University of Texas Southwestern Medical Center in Dallas, Texas recruited the families. Participants received flyers and invitational letters and registered through the mail. Families attended a weekend camp where they experienced a wide variety of expressive arts activities in a combination of group formats: multi-family groups, parents' group, developmental age groups for children, total children's group, individual family group, mothers' group, and fathers' group.

The research design was a pretest/posttest quasi-experimental control group design, but a control group could not be established. Therefore, one-tailed t-tests were used to compare participant functioning between the beginning and end of the study. Instruments used in this study included the Family Environment Scale, the Behavior Assessment System for Children the Beck Anxiety Inventory and the Beck Depression Inventory. In addition, the researcher used qualitative analysis to assess contents of family members' and counseling staff's journals, expressive arts products, and family members' evaluations.

Results of this exploratory study indicated some improvements in children's, parents' and total family functioning. Expressive arts therapy shows promise in effecting constructive change in bereaved families and is deserving of further research.

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CHAPTER I

EXPRESSIVE ARTS THERAPY WITH BEREAVED FAMILIES

Those who will not slip beneath
the still surface on the well of grief
turning downward through its black water
to the place we cannot breathe
will never know the source from which we drink
the secret water, cold and clear,
nor find in the darkness glimmering
the small round coins
thrown by those who wished for something else.

-David Whyte (1990)

“Of all life experiences, death poses the most painful adaptational challenges for the family as a system and for every surviving member, with reverberations for all other relationships” (Walsh & McGoldrick, 1991, p. xv). Indeed, the experience of loss brings with it unimaginably strong emotions, including helplessness, dissociated feelings, and a sense of disbelief (Bowlby, 1980; Osterweis, Solomon, & Green, 1984; Rando, 1984; Worden, 1991). When a family member dies, the family commonly experiences emotional

cutoffs, formation of factions, and other disruptions of the remaining relationships (Bowen, 1976; Parkes & Weiss, 1983).

Elisabeth Kübler-Ross (1995) stated that people in pain, people in shock, people in numbness, people who are overwhelmed with a tragedy that they believe is beyond their comprehension or their ability to cope, use universal symbolic language to communicate. In her work with grieving families, she noticed that often the most powerful, the most beautiful, the most healing, and the most helpful communication was through the spontaneous drawings, paintings, collages, and poetry of those with whom she worked (Kübler-Ross, 1995). Klass, Silverman, and Nickman (1996) described bereaved parents who wrote poetry in attempts to integrate their loss and to clarify the experience of learning to go on with their living children while at the same time maintaining the deceased child as a presence in their lives.

Morgan (2000) ascertained that the most important reality with which human beings must learn to cope is mortality and death. Regardless of the perspective, whether medicine, psychology, religion, philosophy, music, or poetry, death is often described in terms of figurative images or phrases. He noted that, unlike language, the arts have the potential to express diverse themes on many levels simultaneously. By engaging in an experience in the arts, people can be assisted as they mourn, grieve, celebrate life; they can overcome fragmentation and find a sense of meaning in their lives. Because the arts

regenerate the body, mind, emotions, and spirit, persons can be enabled to live more fully while they are dying and grieving (p. 22).

Bailey (2000) observed that some of the greatest art has been born out of experiences of grief; that engaging with the arts in people's lives helps to keep their imaginations alive and to maintain their connection to the earth and the created order of the universe. Thus, the arts and creativity connect people to the energy and breath of life, that is, the spirit. People's wholeness is touched when they engage with an art form. Therefore, the arts enable people to find meaning for their lives, to become reconnected to their spiritual roots that are the source of life, and to overcome the fragmentation of their lives. With this reconnection to the source of their energy, people are able to move forward on their journey of life (p. 128).

Natalie Rogers (1993), the founder and co-director of the Person-Centered Expressive Therapy Institute in Santa Rosa, California, stated that "it is difficult to convey in words the depth and power of the expressive arts process" (p. 5). In her work with people, including those experiencing loss due to death, she offered opportunities to experiment with the arts, advocating the use of stimulating and challenging experiences in hopes of facilitating an engagement with the creative process. Her method, called the "creative connection," is the "process of allowing one art form to influence another directly" (p. 43). She contended that by moving from one art form to another, a person is able to maximize one's creative response by deepening levels of work, thus integrating

the whole of oneself and accessing one's vast inner resources for self understanding and, thereby, changing self concept, attitudes, and self-directed behavior (Rogers, 1993).

Underlying the concept and practice of expressive arts therapy is Carl Rogers' (1961) construct of person-centered therapy that asserted the mainstream of creativity as a human being's tendency to actualize oneself by becoming one's potentialities, a tendency to express all capacities of the self. Expressive arts therapy awakens the healing process when all capacities of the self are encouraged to be expressed and fully integrated (Rogers, 1993). Shaun McNiff (1981) offered how life consists of many modes of expression that flow from one to another making up life as a whole. His view substantiates the expressive arts approach of flowing from one mode of artistic expression to another leading to continued creative self-development long after leaving the therapeutic setting (Knill, 1994; McNiff, 1981; Rogers, 1993). The work of Rogers (1993), McNiff (1981), and Paola Knill (1994) interface together to form the basis for the expressive arts therapy approach to be taken in this study.

Statement of the Problem

Research to date in the use of expressive therapies has illustrated how the combination of art forms as therapeutic tools can serve as a significant "means of assisting individuals to become more completely in touch with themselves, that is, promoting connectedness between their minds and bodies" (Gladding, 1998, p. 6). Mind and body connections serve as part of the

therapeutic process that facilitates increased awareness, insight, and integration. Research in the use of expressive therapies with bereaved families is scarce; therefore, this study will provide pertinent information relevant to the scope of grief and loss therapy and expressive therapies.

Kissane, Bloch, McKenzie, McDowall, and Nitzan (1998) concluded that previous studies have not offered guidelines as to the type of family therapy that might be most helpful to the grieving family. In addition, they stated that inconsistent results of the handful of studies conducted since Paul and Grosser's (1965) study leave mental health professionals with uncertainty about the sorts of grieving families requiring professional help and the most appropriate models of treatment. Family functioning, in their view, has been a neglected aspect of the therapeutic approach to grief work (Kissane et al., 1998, p. 23).

Schneiderman, Winders, Tallett, and Feldman (1996) stated in a letter to the editor of the *Journal of the American Academy of Child and Adolescent Psychiatry* that "despite widespread attention to the experience of families who lose a loved one, many important questions remain unanswered. We know little about which individuals and families will experience poor bereavement outcome or what intervention might shorten their bereavement" (p. 132-133). In fact, Morgan (2000) cited Kastenbaum (1993) as indicating that the social science publications over the past 50 years would leave one to ponder whether anyone ever died or ever grieved, because very little research had addressed these issues (p. 2).

The purpose of this study will be to determine the effectiveness of expressive arts therapy with bereaved families as a method of prevention and intervention for families who have lost a child. Specifically, this study is designed to determine the effectiveness of expressive arts therapy in: a) improving healthy family functioning; b) decreasing social problems and total behavior problems of children as reported by self, parents, and teachers; c) decreasing anxiety levels of family members as reported by self, parents, and teachers; and d) decreasing depression levels of family members as reported by self, parents, and teachers.

Synthesis of Related Literature

The literature relevant to this study includes the history of the use of expressive arts as therapy, the process of expressive arts therapy, an overview of grief and loss, and an overview of family bereavement therapy. Finally, a review of recent research on the use of expressive arts therapy with families, the use of expressive arts therapy with bereaved families, and current trends in grief treatment is presented.

The History of the Use of Expressive Arts as Therapy

“Ritual, drama, dance, and music have been used for healing purposes in the Western world at least as far back as antiquity. Such healing methods all involved the active participation of the person to be benefited” (Weiner, 1999). Weiner (1999) further stated that beginning with Freud’s contribution of “the talking cure” in the late 19th century, psychotherapy experienced a paradigm shift

that, until recently, had the effect of marginalizing action approaches in Western Europe and the United States (p. xi).

Shawn McNiff (1981), professor of Expressive Therapy at Lesley College in Cambridge, Massachusetts, stated that “the ancient predecessor of the expressive arts therapist can be found in every region of the world in the person anthropologists call the shaman” (p. 3). He described the shaman as an early group therapist of sorts who served as an intermediary between people and “forces” that must be engaged in order to influence the course of community life. “Through the use of culturally accepted images, rituals, and other ‘sensible signs’ the group participates in the sacred spheres of life, which are perceived as the origin of wholeness” (McNiff, 1981, p. 4). Thus, with the integration of the arts and therapy, expressive arts counselors are connecting back to the most ancient and time-validated methods of healing (McNiff, 1981). What follows is a brief synopsis of how human beings have used the arts throughout history in the pursuit of health and wholeness.

Almost since the beginning of time, the arts, and particularly music, have been used in connection with physical and mental healing practices (Feder & Feder, 1981; Peters, 1987). Probably one of the early forms of self-expression was that of rhythmic movement, perhaps accompanied by sound and using the body itself as an instrument. Through the use of rhythmic movement, humans related their own beings to the constantly changing world in which they lived: a

world filled with the rhythm of movement, of the days, and of the seasons (Feder & Feder, 1981).

In the earliest tribes of primitive African cultures, shamans used music in connection with magic and religious rituals as a way to drive out disease. The first art images were found in archaeological remains dating back to the Upper Paleolithic era (ca. 35,000 B.C.) (Fleshman & Fryrear, 1981). The Early American Indian tribes encouraged the use of many types of art and combined several art forms in a single ceremony (Fleshman & Fryrear, 1981; Peters, 1987). One such tribe was the Navajo who used combinations of song, dance, and sandpainting in their singing cures (Feder & Feder, 1981). In many parts of the world, though predominantly in North America, Africa, and Asia, drums and rhythm played a very important role in the healing rites of primitive shamans and medicine men. Buddhists of Sri Lanka in their healing rites used an exorcistic ritual involving drumming, chanting, drama, and dancing in attempts to free a person from the persecutions of a demon (Fleshman & Fryrear, 1981). Even now, indigenous cultures continue to use music in their healing practices (Feder & Feder, 1981; Peters, 1987).

As early as 500 B.C., mental patients in Egypt were encouraged to pursue artistic interests and to attend concerts and dances as a way of assisting them in dealing with their mental illnesses (Fleshman & Fryrear, 1981). Ancient Chinese and Hindu civilizations also recognized the healing powers of music in which emotions associated with various modes were used and regulated in musical

drama to promote specific responses in the spectators (Peters, 1987). In ancient India, special music formulae were employed to help achieve oneness with the universe and to promote healthiness of body, mind, and spirit and a purer state of inner awareness (Peters, 1987).

The Greeks found that various types of music and various modes had fairly predictable effects on human conduct and emotions. They began to apply music systematically as both curative and preventative medicine (Peters, 1987). Indeed, the Greeks routinely used the arts in the treatment of mental illness in relation to the therapeutic principle of catharsis; in particular, musical and dramatic performances facilitated a cathartic purge of emotions, considered important to mental health (Fleshman & Fryrear, 1981; Peters, 1987). The Greek approach to preventive medicine could be conceptualized as the interrelationship of mind, body, and soul in balanced harmony (Feder & Feder, 1981), which has recently reemerged in modern Western culture with the holistic body-mind movement.

In the early Middle Ages, music was thought to have either beneficial or detrimental effects on the health and harmony of body and soul (Peters, 1987). The arts were in an ambiguous position. On the one hand, music and visual arts were in the Church and were seen as being in the service of God, yet, on the other hand, profane or secular music and dance were seen as an instrument of Satan (Feder & Feder, 1981). In a sense, the church provided psychological comfort with its music and ritual (Fleshman & Fryrear, 1981).

With the Renaissance came the rebirth and awe of classical civilization that provided impetus for renewed interest in the arts therapies. This renewed interest was seen especially in the medical use of music and its effects on an individual's state of mind whereby the major value lay in music's cathartic and calming influence (Feder & Feder, 1981). During the late 19th and early 20th centuries, interest once again emerged regarding the therapeutic values of the arts (Fleshman & Fryrear, 1981), especially the use of music to treat psychiatric patients (Peters, 1987). In 1908, Psychodrama emerged in Vienna through Jacob Moreno's work in the Theatre of Spontaneity and Psychodrama. His work was among the first innovations in contemporary group therapy (Fleshman & Fryrear, 1981; McNiff, 1981).

Following World War I, occupational therapy was formally introduced as a treatment that included both arts and crafts (Fleshman & Fryrear, 1981). Also, during the inter-war period and World War II, music was used as a general psychological stimulus in the total hospital environment and as an adjunct to psychiatric treatment (Peters, 1987). As a result, institutions began to provide recreational therapy that included dance and dramatics as well as other arts (Fleshman & Fryrear, 1981).

A systemic perspective on the recent development of the holistic health movement focused public attention on the maintenance of health and well-being. Involving both body and mind as interdependent members of a whole system became significant. Thus has evolved a growing interest in the Eastern

philosophy and practice of using music and art to aid in healing, relaxation, meditation, and consciousness expansion (Fleshman & Fryrear, 1981; Peters, 1987).

In his article on multiplicity as a tradition, Paolo Knill (1994) asserted that expressive arts therapy finds its primary focus in the artistic tradition that all the arts have in common. Knill maintained that expressive arts therapy is a discipline unto itself, with its own theoretical framework and focus that evolved from various schools of thought. He theorized that the “artistic tradition that provides a basic foundation for the discipline of expressive therapy is rooted in human imagination and is characterized by an interrelatedness among the arts” (p. 319). In examining the word “imagination,” Knill (1994) noted that humans imagine not only visual images but also sounds, rhythms, movements, acts, spoken messages, moving pictures, and even tastes and tactile sensations. Thus, he asserted that “imagination is the visiting place of soul, where the depth of Psyche is revealed” (p. 321).

Knill advocated for a specialization in the interdisciplinary tradition of the arts. Theories he saw pertinent to expressive therapy include crystallization theory, polyaesthetic theory, inter-modal theory, and theories of integration (Knill, 1994). Crystallization theory attempts to formulate how the therapeutic relationship can provide optimal conditions for emerging images to disclose their meanings through the use of various art disciplines. This theory is built primarily upon the phenomenological premise that meaning in a psychotherapeutic

encounter emerges exclusively from the material that comes forth between counselor and client as they relate with one another. Knill (1994) stated that a variety of sensory and communication modalities exist among all art disciplines.

Within the visual arts, for instance, I know that sensorimotor and tactile senses are engaged when I paint. I know that a painting communicates not only through the visual images, but also through the rhythm of color. Also a painting may evoke a story that depicts an act. (p. 322)

Polyaesthetic theory was premised on the observation of Wolfgang Roshier during the 1950s. He contended that all the art disciplines engage to some extent in all the sensory and communicative modalities. Knill (1994) cited Liao (1989) in viewing therapy as not negating the specificity of the particular art discipline but, rather, as promoting the traditional wisdom that all the arts are members of one harmonic body. Liao also claimed that the human instinct is to be multi-sensory (Knill, 1994).

Inter-modal theory has come about as a result of the use of the arts in psychotherapy. Important research contributed by Decker-Voigt (1975, as cited in Knill, 1994) in Europe helped to resolve the concern regarding the “unskilled mixing” of methods of art, dance, music, and drama therapies. According to Knill (1994), in the early 1970s Shawn McNiff initiated the first inter-modal expressive therapy training group in the United States. The theory for the integrated use of the arts in psychotherapy, which transpired as a result of collaboration with the faculty and affiliated training programs in Europe, distinguished among

intrapersonal, interpersonal, and transpersonal considerations. Intrapersonal considerations refer to the acquired emotional attitude of an individual or a collective toward a particular discipline of art expression. Interpersonal considerations take into account what we understand about group dynamics within the artistic process. Transpersonal considerations evolve from the traditions of the spiritual, religious, and ritualistic use of the arts. Knill (1994) stated that “using the arts in psychotherapy without considering the archetypal powers connected with them—and without fostering our clients’ sensitivity and practice of it—means to forget one of the basic [means of integrating] health and the sacred” (p. 327).

Theories of integration refer to how the individual counselor experiences the integration of the creative arts therapies. Knill (1994) cited Waser (1991) as explaining that “the client and counselor participate as partners in a process of mutual transformation. Both as creator and recipient, each is part and parcel of the powerful energy current that informs the creative process” (p. 3).

Controversy surrounds the use of expressive arts therapies at the present time. Some clinicians advocate the mastery and use of a singular artistic discipline and believe that one could hope to master only a single art form during a lifetime (Knill, 1994). Yet, the foundation for the expressive arts approach lies in the early traditions of minstrels, storytellers, and tribal artists who did not divide their work into specializations according to artistic disciplines (Knill, 1994).

Revisiting the idea of the shaman as the ancient predecessor of the expressive arts counselor, McNiff (1981) stated that

virtually every behavior of today's expressive arts therapist has its counterpart in the practices of shamanism. The shaman is an expert in the process of role playing and created rites of passage to give symbolic significance to key transitions in life. (p. 14)

McNiff (1981) later described expressive arts therapists as artistic alchemists and 20th century shamans "who have discovered that in a time of emotional estrangement the arts offer a very old and predictable hope in sanctifying life through creative enactment" (p. 224), hence having the ability "to relate to the transcendent source of life and the dynamic pulse of creative action" (p. 6). Cousins (1979) cited Albert Schweitzer as stating that

the witch doctor succeeds for the same reason the rest of us succeed. Each patient carries his own doctor inside him. They come to us not knowing that truth. We are at our best when we give the doctor who resides within each patient a chance to go to work. (p. 69)

Perhaps nowhere in the human experience are these experiences needed as in the aftermath of the death of a close family member.

Process in Expressive Arts Therapy

Weiner (1999) explored the question, why isn't talk enough? He stated that:

Primary experience, which exists apart from language, is described by language (a representation, or secondary experience). Language is that secondary experience created by verbalizing primary experiences. Verbal psychotherapy, then, is a procedure for the verbal processing of verbal descriptions of events. (p. xiii)

Action methods, on the other hand, simultaneously engage cognition, affect, and behavior. Weiner cited Van de Kolk's 1996 publication on traumatic stress and the effects of overwhelming experience on mind, body, and society, as providing evidence "that traumatic experiences are stored or encoded differently than nontraumatic ones," suggesting that experiential therapies may have the potential to shift traumatic experience in cases in which verbal ones cannot (p. xiii).

Bayles and Orland (1993) asserted that "making art can feel dangerous and revealing. Making art is dangerous and revealing. Making art precipitates self-doubt, stirring deep waters that lay between what you know you should be, and what you fear you might be" (p. 13). Ward (1999) also described art and fear in her writing about the process of art therapy. She stated that the experience can have its own terror when the emptiness of the waiting page or untouched clay can numb and can dismay one's self. It is like the moment of risk when one stands on the edge of any new experience or relationship. Yet, the actual physical struggle and contact between the medium and the body is so important because it is through the struggle that creative solutions are often found (p. 111).

Ward likened the building of a relationship through a particular art medium as a powerful and sensuous experience, not unlike the power and sensuality of a relationship between humans. An artistic medium, like another person, is an “other,” having its own qualities that respond and react and have to be grappled with if the art or the relationship is to progress (p. 112).

McNiff (1981) cited Moreno (1973) with regard to the creative act and its relationship to psychotherapy.

In the spontaneous-creative enactment, emotion, thoughts, processes, sentences, pauses, gestures, and movements seem first to break formlessly and in anarchistic fashion into an ordered environment and settled consciousness. But in the course of their development it becomes clear that they belong together like the tones of melody: that they are in relation similar to the cells of a new organism. The disorder is only an outer appearance; inwardly there is a consistent driving force, a plastic ability, the urge to assume a definite form: the stratagem of the creative principle which allies itself with the cunning of reason in order to realize an imperative intention. (p. 43)

Knill (1994) wrote about process in his article on expressive arts. He stated that in therapy

the skill serves the emotional process of clarification. An inter-modal transfer supports the focusing process, revealing the ‘quite right’ image,

movement, sound and rhythm or word. The process discloses the 'felt sense', and can allow for insight or a shift in awareness. (p. 324)

Rogers (1993) described the therapeutic expressive arts process, also called the creative connection process, as "moving from art form to art form, [releasing] layers of inhibitions, bringing us to our center—our individual creative force. This center opens us to the universal energy source, bringing us vitality and a sense of oneness" (p. 44). Anthropologist Angeles Arrien, in a conversation with Rogers (1993), stated that the expressive arts therapy model or creative connection process incorporates all of the four intelligences—the mental, the emotional, the physical, and what she considers to be the intuitive intelligence— and that it teaches people how to integrate various aspects of the creative spirit. In effect, expressive arts therapy opens the door to spirituality; creativity takes people into a transcendent space characterized by a sense of timelessness and loss of self-consciousness, where every art piece is an expression of the soul (Rogers, 1993).

Fleshman and Fryrear (1981) described expressive arts therapy process as an opportunity to experience how awareness of self and environment, through texture, color, form, special relationship, sounds, and rhythm, enhances understanding and communication. As a part of the whole therapeutic system, arts therapies basically follow the principles inherent in all therapeutic approaches (Fleshman & Fryrear, 1981). McNiff (1981) maintained that "if art cannot physically eliminate the struggles of our lives, it can give significance and

new meaning and a sense of active participation in the life process” (p. vi). Often, communication can be more effective through the use of the arts than through verbal exchanges alone (McNiff, 1981), because the process of all art involves more aspects of the individual than the verbal therapies can touch (Fleshman & Fryrear, 1981). The arts require the involvement of basic elements found in the connection of mind and body processes that involve breaking down and reforming conceptual structures. Processes such as sublimation, symbolization, identification, and catharsis that are desired outcomes of most therapies, can be contacted and controlled directly through the arts (Fleshman & Fryrear, 1981).

Segal’s (1984) article on helping children express grief through symbolic communication spoke to the use of expressive arts, such as art media, clay, puppets, phototherapy, games, music, and body movement, in therapy. While Segal’s article was not specifically focused on loss due to death or on the bereaved family, many of the ideas presented could be adapted to family bereavement therapy. Segal (1984) did give a physiological description of how expressive arts works that other writers did not:

The expressive arts can be used to draw out unguarded responses because they involve tactile, visual, aural, and kinesthetic senses, most of which are related to the involuntary nervous system. When these senses are aroused, messages are transmitted to the brain and other body organs. The brain responds by tapping into memories and feelings that

have been stored there and releases them into the individual's thought processes, producing an element of surprised excitement. The unplanned response to the images, sounds, and physical tensions evoked by the encounter with art, music, and body movement frees the child to become more in touch with his natural feelings. (p. 593)

Morgan (2000) stated that artistic creations are examples of sublimated energy. He maintained that the creative process is a blend of two elements: the overwhelming awareness of death, and the confrontation of our own possibilities (p. 21). Morgan asserted that grief and creativity are natural partners as both are uniquely human characteristics.

Joining the two ideas together, we draw the conclusion that the awareness of our own death, or the deaths of those who are dear to us, acts as an impetus to make something that will last, to act creatively. Creativity is the ability of the human mind to move from what it perceives to be a lack, to create something that was not there before. (p. 7)

He contended that our anxieties, our confusions, and our weakness are the causes of creativity and that facing death creatively releases energy.

Havelka (1999) succinctly stated that "creativity relates to death" (p. 217). He depicted human culture as attempting to create a vision of reality that transcends death of our mortal existence and projects it into the sphere of immortality. Havelka concluded that from time immemorial, human beings have been searching for something permanent and imperishable; as a result, all

human cultures create works of art in stone, silk, gold, silver, and marble; on paper and leather; in sound, movement, and words that are expected to withstand decay, destruction, and death. Thus, according to Havelka, all people use their creative potentialities to defeat and to mitigate their most pervasive fear: that of passing away, that of impermanence and the loss of personal significance. In endless shapes of artistic forms there emerges the central motive of human existence: to attain both a personal significance beyond the threat of death while one is alive and to claim immortality through others' memories of oneself after one dies (p. 217). Morgan (2000) suggested that

by transforming death into a product of our own creation, we gain some control over it. Hence, the freedom to act as one desires is possible only with control over one's resources and the ability to channel one's energy in the direction one chooses. (pp. 21-22)

Grief and Loss

Morgan (2000) and Sherebrin (1999) traced the words *bereavement* and *grief* back to the French word *ravir* and even further, to its root, the old Frisian word *reva*, which means to steal or to rob. Thus, in experiencing loss, one feels an acute sense of deprivation of a significant person in one's life. Morgan (2000) stated that grief is the price we pay for love; it is the price we pay for security; it is the price we pay for a sense of warmth and for a sense that our lives have meaning (p.1). Simply expressed, "grief is the little kid inside of us protesting.

Grief is that little kid inside of us thinking that if I yell loudly enough, if I scream loudly enough maybe my loved one will come back” (p.1).

Anthropological reports substantiate that the Neanderthals buried their dead with ceremony some 60,000 or more years ago (Pine, 1969). According to Rando (1984), death ritual practices have evolved from the time of the ancient Egyptians, Greeks, and Romans to present-day Western civilization. These rituals reflect each society’s philosophical and religious beliefs and values.

Rando (1984) noted that all societies respond to death with one or more of three general patterns: death-acceptance, death-defiance, or death-denial. The people of technologically primitive [sic] societies were death-accepting, viewing death as an inevitable and natural part of the life cycle, consequently integrating dying and attendant behaviors into everyday life (Rando, 1984). In death-defying societies, such as ancient Egypt, people refused to believe that death would take away possessions. Thus, the people of these societies took action such as building pyramids to hold all of Pharaoh’s money, wives, and possessions for the world after death (Rando, 1984).

The dominant American attitude, Rando contended, is that of death-denial: refusal to confront death. A cultural perspective persists today that death is antithetical to living and that it is not a natural part of human existence (Aries, 1981; Bertman, 1999; Klass, Silverman, & Knickman, 1996; Morgan, 2000; Rando, 1984; Shapiro 1994). Morgan (2000) speculated that contemporary Americans “seem to believe that if we didn’t think about it, if we didn’t talk about

it, it will not happen” (p. 2). He cited Goodman (1981) as characterizing Western culture’s attitude toward death: “We manage to avoid thinking about a highly emotionally charged event that has a 100 percent chance of happening” (p. 2).

Becker (1973) asserted his belief in three possible responses to death. The first response is to deny the reality of death, to act as though it will not happen or is not important. The second response is to become mentally ill, to engage with death in a way that disregards societal and legal boundaries. The third response is to be heroic, to live life fully and to leave a legacy that upholds life and that honors one’s existence (Becker, 1973).

Shapiro (1996) noted that the dominant North American culture gives more credence to scientific explanations of life and death, minimizing the importance of the spiritual components. Sherebrin (1999) contended that the shift from the traditional attitude where the dying person was in charge of his farewells began in the twentieth century with the notion that it would be kinder to conceal the truth and spare the person the anguish of death. The leap from that position to the notion of sparing society the ordeal of death was inevitable. The site of death shifted from the home to the hospital...stripping both the dying person and the family of participation and leaving them as helpless onlookers. (p. 241)

Indeed, the majority of Americans no longer die in their homes. In many cases the dying individual faces death in a lonely, mechanical, and dehumanized

environment away from the comfort of familiar surroundings and from the companionship and sentiment of family and friends (Rando, 1984).

Fewer rituals for coping with death, such as wearing black and staying home for an extended period of time, exist in contemporary Western culture than existed in the past. Phrases like “passed on” and “at rest” are often used instead of “died” and “dead.” Rituals are slowly being replaced with contrivances (Rando, 1984; Shapiro, 1996). In many cases, funeral homes have now taken over the funeral service from the clergy, causing further de-ritualization of the rites (Sherebrin, 1999). Participants in one current social movement consider even funerals to be unnecessary.

The expression of bereavement is notably suppressed as the culture expects families to let go and move on, to reenter the flow of daily life sooner than they may feel psychologically ready (Aries, 1981; Hughes, 1995; Rando, 1987; Shapiro, 1996). “The message is that life goes on and work comes first. Yet mourners frequently cannot comply with society’s expectation of what grief should be” (Hughes, 1995, p. 2).

Denial of death is fostered and perpetuated in children by sending them away because they are “too young to understand” or by telling lies such as “grandpa went to sleep” (Rando, 1984). Interestingly, Lamers (2000) noted that in the earliest versions of fairy tales and children’s literature, death had a natural place in the stories; however, in more recent times, significant transformations

towards diluting, softening, removing, and insulating children from an awareness of mortality has occurred. Yet, Kübler-Ross (1969) upheld,

if a patient is allowed to terminate his [sic] life in the familiar and beloved environment, it requires less adjustment...The fact that children are allowed to stay at home where a fatality has stricken and are included in the talk, discussions, and fears gives them the feelings that they are not alone in the grief and gives them the comfort of shared responsibility and shared mourning. It prepares them gradually and helps them view death as part of life. (pp. 5-6)

Robert Coles (1990), a physician and psychiatrist who studied children's expressions of spirituality, documented that children do think about and experience spiritual matters, particularly in the form of religious beliefs and ideas about God, heaven, the devil, angels, and the spiritual world of ghosts and the supernatural. Kübler-Ross (1983, 1995) expressed that even very young children are able to talk about their dying, that they are aware of impending death, and that they often use drawings to communicate their experiences. She believed strongly that children have an "inner knowing" about death. Wolfelt (1996) stated that in his experience "any child old enough to love is old enough to grieve and mourn" (p. 119).

Rando (1984) expressed that mourners may not anticipate the physical toll the grief process entails, and they usually are not prepared for the intensity of their own emotional reactions and/or do not fully understand the importance of

accepting and expressing them. Family, friends, and others may also be similarly unaware and, thereby, not provide the social or emotional support to sustain the bereaved during their grief work and mourning. In fact, these unrealistic expectations and inappropriate responses to normal grief reactions can make the grief experience for the bereaved much worse than it has to be (Rando, 1984).

Morgan (2000) stated that grief impacts people on many levels: emotionally, biologically, sexually, economically, socially, and spiritually. In essence, all aspects of a bereaved person's life are affected by grief. Grief theory dates back to 1917 when Freud first defined normal reactions to grief in his classic paper "Mourning and Melancholia." He wrote that,

although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition and to refer it to medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (Freud, 1957, pp. 243-244)

Contemporary grief theory begins with Lindemann (1943), one of the earliest researchers to investigate normal grief reactions. Lindemann suggested that acute grief is a normal reaction to an extremely distressing situation rather than an abnormal psychiatric disorder. He further observed common symptoms and effects of normal grief on the physical, emotional, behavioral, and intellectual functioning of the bereaved symptoms and effects that have been widely accepted in grief literature today. Generally, these include somatic symptoms,

preoccupation with the deceased, guilt relating to the deceased, angry reactions, and inability to function normally (Bowlby, 1980; Lindemann, 1944; Parkes, 1972; Rando, 1984; Worden, 1991).

Worden (1991) differentiated grief, a normal reaction to loss, from mourning, the process that the grieving person experiences. He listed four general categories of normal grief behaviors that are inclusive of and expand on Lindemann's work: 1) feelings, including sadness, anger, guilt and self-reproach, anxiety, loneliness, fatigue, helplessness, shock, yearning, emancipation, relief, and numbness; 2) physical sensations, such as hollowness in the stomach, tightness in the chest, tightness in the throat, oversensitivity to noise, a sense of depersonalization, breathlessness, weakness in the muscles, lack of energy, and dry mouth; 3) cognitions, for example, disbelief, confusion, preoccupation, a sense of presence of the deceased, and hallucinations; and 4) behaviors, including sleep disturbances, appetite disturbances, absent-minded behavior, social withdrawal, dreams of the deceased, avoiding reminders of the deceased, searching and calling out, sighing, restless overactivity, crying, visiting places or carrying objects that remind the survivor of the deceased, and treasuring objects that belonged to the deceased (Worden, 1991).

Along with the study of common symptoms and behaviors of grief, researchers have identified phases that comprise the mourning process (Bowlby, 1980; Engel, 1964; Kübler-Ross, 1969; Parkes, 1972; Sanders, 1999). While at first it was thought that people went through these phases in a sequential order,

the general consensus now is that people move in and out of these phases as they need to and that they may even overlap between various phases in the process of mourning (Bowlby, 1980; Hughes, 1995; Parkes, 1972; Worden, 1991).

Engel (1964) described the normal sequence of grief in six phases: being in shock and disbelief, developing awareness, restitution, resolving the loss, idealization, and the outcome. Kübler-Ross (1969) provided the classical model of grief that outlined five stages: shock and denial, bargaining, anger, depression, and acceptance. Bowlby (1980), in his work with infants and young children, and Parkes (1972) endorsed four phases of mourning: numbness, yearning and searching, disorganization and despair, and reorganization. In 1984 Rando presented three broad possible phases that are colored by both the individual characteristics and the pertinent social and psychological factors of each person: avoidance phase, confrontation phase, and reestablishment phase (Rando, 1984). Sander's (1999) phases of grief included shock, awareness, conservation, the turning point, and renewal.

In addition to the identification of phases, some researchers have identified tasks associated with grief and mourning (Lindemann, 1944; Shuchter, 1986; Wolfelt, 1988; & Worden, 1991). Worden (1991) asserted that

phases imply a certain passivity, something that the mourner must pass

through. Tasks, on the other hand, are much more consonant with Freud's concept of grief work and imply that the mourner needs to take action and can do something. (p. 35)

Doing the tasks of mourning, he believed, provides a powerful antidote to the feelings of helplessness that most mourners experience. Tasks offer hope that something can be done and that an end is in sight (Worden, 1991). Worden delineated four tasks of mourning. The first task is to accept the reality of the loss. The second task is to work through the pain of grief, as "it is impossible to lose someone you have been deeply attached to without experiencing some level of pain" (p. 13). Adjusting to an environment in which the deceased is missing is the third task, and the fourth task involves emotionally relocating the deceased and moving on with life (Worden, 1991).

Lindemann (1944) gave the term "grief work" to the tasks of grief that involved freeing oneself from bondage to the deceased, readjusting to one's environment without the deceased, and forming new relationships. Parkes and Weiss (1983) believed that mourners needed to accomplish three tasks: intellectual recognition and explanation of the loss, emotional acceptance of the loss, and assumption of a new identity.

Shuchter's (1986) tasks included living with the pain, continuing a relationship with the deceased, taking care of one's self, developing other relationships, and becoming a healthy, confident person with a balanced view of the world. Wolfelt (1996) outlined six reconciliation needs of children who are

mourning that must be met in order for mourners to heal and grow. These needs include 1) acknowledging the reality of the death; 2) moving toward the pain of the loss while being nurtured physically, emotionally, and spiritually; 3) converting the relationship with the person who has died from one of presence to one of memory; 4) developing a new self-identity based on a life with the person who died; 5) relating the experience of the death to a context of meaning; and 6) experiencing a continued supportive adult presence in future years. Wolfelt's reconciliation needs of mourning possess similarities to the tasks of Lindemann (1944), Shuchter (1986), and Worden (1991), with the exception of the fifth need, the search for a context of meaning.

Complicated or abnormal grief reactions of the bereaved often are linked to serious problems with self-concept and relationships that predispose them to the possibility of mental illness (Worden, 1991). Both Worden (1991) and Wolfelt (1996) differentiated between normal and abnormal grief reactions. In defining the difference, Worden maintained that "pathology is more related to the intensity of a reaction or the duration of a reaction rather than to the simple presence or absence of a specific behavior" (p. 71). He delineated four forms of abnormal grief, or complicated bereavement. These include chronic grief reactions, those that are excessive in duration and reach no satisfactory resolution; delayed grief reactions, those that are seen as inhibited, delayed, or postponed; exaggerated grief reactions, those in which the individual feels overwhelmed and copes using maladaptive behavior; and masked grief reactions, those in which individuals

experience symptoms or behaviors that cause problems that the individual does not recognize as being related to the loss (Worden, 1991).

Wolfelt (1996) described signs of complicated mourning in children. These signs include 1) total denial of the reality of the death; 2) persistent panic, fear; 3) prolonged physical complaints without organic findings; 4) prolonged feelings of guilt or responsibility for the death when the child is not responsible; 5) chronic patterns of apathy and/or depression; 6) chronic hostility, acting-out toward others or self; 7) prolonged change in typical behavior patterns or personality; 8) consistent withdrawal from friends and family members; 9) dramatic, ongoing changes in sleeping and eating patterns; 10) drug or alcohol abuse; and 11) suicidal thoughts or actions.

Klass et al. (1996) revealed a new model of grief based on observations of phenomena not accounted for in contemporary grief models. Rather than loved ones letting go of their relationship with the deceased person and moving on, Klass et al. discovered that the relationship was, in actuality, continued in a transformed and altered state. To illustrate this transformed continuing bond subsequent to death, Klass et al. depicted the relationship between a newborn and its mother. Prior to birth a relationship exists; however, at birth, the relationship changes

into a new set of relationships, with new dimensions and possibilities...the bereaved, like the new mother, have to change their relationship to the

deceased. It does not mean that the relationship ends, though it changes in a decisive way. (Klass et al., 1996, p. xix)

In the grief models that have most recently dominated Western psychological thought, an ongoing attachment or bond with the deceased is seen as a pathological denial of death that delays grief resolution. Taking a virtually opposite view, Klass et al. (1996) considered the ongoing yet altered bond to be at the very heart of healthy grief resolution.

Klass et al. (1996) claimed that only within the past 100 years have continuing bonds with the deceased been denied as a normal part of bereavement. In their proposed model of grief, Silverman and Klass (1996) suggested that interdependence is sustained even in the absence of one of the parties, that the bereaved remain involved and connected to the deceased, and that the bereaved actively construct an inner representation of the deceased that is part of the normal grieving process (p. 16). Their view was supported by a researcher of maternal bereavement (Oliver, 1991) who found that the majority of participants retained a connection with the deceased child through a felt presence or ongoing relationship with the child. All participants expressed the belief that maternal grief is a life-long process with no final resolution or completion (Oliver, 1991).

Rosenblatt (1996) extended the concept of no final resolution or completion. He defined grief as a blended emotional and cognitive reaction to a loss and stated that although grief will not be continuous, many people will never

reach a time when they completely stop grieving. According to Rosenblatt, Freud (1954) described grief work as being done by “fits and starts” and not done all at once. Rosenblatt (1996) also surmised that a major challenge of grief is “to come to terms with a loss while honoring and perhaps even holding on to the meanings, memories, investments, and identities connected to the deceased” (p. 53).

Marwit and Klass (1996) challenged the predominant 20th century Western theories of grief that conceptualize grief therapy as helping the griever toward the eventual withdrawal of emotional ties to the deceased. Indeed, an alternative view of successful grief resolution has been emerging recently (Klass et al., 1996; Marwit & Klass, 1996; McCabe, 1997; Shapiro, 1996). Cited in Marwit and Klass (1996), M. Stroebe, M. Gergen, K. Gergen, and W. Stroebe (1992, 1993) claimed that the prevailing orientation to grief is specific to this culture at this time, noting that in other cultures, attachments to the deceased and guidance by the recently deceased and the long-deceased ancestors have been valued. They stated that “images” of the deceased serve positive functions by providing guidance as role models in decision making. Silverman and Klass (1996), in exploring the parameters of healthy grief, stated “we should not impose any requirements for what healthy grief looks like. We need to allow individuals room to make their own meaning and their own peace” (p. 353).

McCabe (1997) proposed a similar theory of grief to that of Klass et al. (1996). McCabe suggested that the American Psychiatric Association’s (1994)

Diagnostic and Statistical Manual of Mental Disorder-IV assessment of pathological grief fails to represent persons' actual experiences and is formed by philosophical and sociocultural assumptions that have not been critically examined. Shifting from a positivist to a constructivist knowledge paradigm and making use of material from a variety of domains, McCabe (1997) suggested that grief be identified as a possibly "ongoing and recursive experience that is affected by the self-other relationship, the existential given of death and time, one's ongoing experience and maturity, and the traumatic, individual, and sociocultural context of the death" (p. iv).

"By any standard, the field of grief counseling is in revolution," Neimeyer (1999) claimed (p. 65). He stated that in response to growing dissatisfaction with traditional models of mourning, a "new wave" of grief theory is emerging that embodies the "expression of a changed zeitgeist about the nature of bereavement as a profound transition in our lives" (p. 66). In his alternative model of mourning, a constructivist approach similar to that of McCabe (1997), Neimeyer (1999) contended that "meaning reconstruction in response to a loss is the central process in grieving" (p. 67).

Contrasting the traditional models of grief that uphold the idea that all or most bereaved persons respond similarly to loss at an emotional level, Neimeyer (1999) stated that the "meaning-reconstruction view emphasizes the subtle nuances of difference in each griever's reaction, so that no two people can be presumed to experience the same grief in response to the 'same' loss" (p. 68).

Thus, in the reconstructive grief process, each person is viewed as a constructor of a different phenomenological world and as occupying a different position in relation to broader discourses of culture, gender, and spirituality, and each caregiver approaches the bereaved individual from a position of “not knowing” rather than from a position of presumed understanding (p. 68).

Riches and Gordon (2000) expanded on Neimeyer’s (1999) constructivist ideas and concepts. They developed a chart comparing principal differences and similarities between the conventional, new, and systems models of grief on the following constructs: 1) nature of grief, 2) relationship, 3) deceased, 4) grieving, 5) ‘presence’ of the deceased, 6) model of the world, 7) complicated grief, and 8) research model (p. 44). According to Riches and Gordon (2000), conventional models stress individual counseling with emphasis on the emotional distress of the individual and on helping them face the reality of the death and detach themselves from the lost relationship. ‘New’ models call for reducing emotional distress through maintaining a continuing, if changed, relationship with the deceased, possibly a more natural and effective way of coping with bereavement. Systems models emphasize the influence of family and other relationships on how the death is perceived, whether grief can be openly expressed, whether roles other than that of bereaved parent or sibling are called forth, and whether family members are able to reminisce about the deceased together (Riches & Gordon, 2000).

Bertman (1999) expressed concern about trivializing or minimizing the uniqueness of personal or communal grief by reducing it to mere explanation or method. She proposed that anxiety, emptiness, and meaninglessness can be allayed, even retroactively, by enabling those in pain to 1) connect with their wholeness; 2) make peace with, discover, and respect the coherence of their life's story; 3) seek reconciliation with alienated family and/or friends; 4) give and receive love, forgiveness, appreciation, and expressions of affection; 5) say good-byes; 6) complete relationships with others; and 7) assure continuity, relationship, and meaning beyond death (p. 14).

Bertman (1999) conceived that human grief exists both in time and timelessness and that a healing trajectory includes periodic revisits of grief, both planned and unexpected. Similar to Klass et al. (1996), Bertman (1999) concurred that grief is not "resolved" in the medical sense of the word; rather, it becomes a repositioning and revival of the loved one in an inner space and time, accessible forever, whenever one needs, wants, or is forced to feel the connection (p. 15). She described the healing power of grief as a paradox. "At the moment of connection, the emptiness and void are gone, or at least temporarily held at bay" (p. 15).

Characterizing the ability to understand grief only and entirely as it is filtered and interpreted through subjective experience, Bertman (1999) stated that "initially [grief] captures us, but we can capture it back and reshape it; and the expressive arts and therapies function beautifully as vehicles to help us

reshape grief” (p. 15). Moreover, the potential for healing in the midst of suffering exists because grief is about creating and transforming bonds of attachment, not severing them irrevocably (p. 15).

Family Bereavement Therapy

We need our families but we don’t always behave well in them. We love and hate them, yearn for them deep in our bones and feel so disgusted with them that we want to spit...families are sad and happy, complicated and simple, and full of victories and failures...it’s impossible to capture the diversity or complexity of families (Pipher, 1996, p. 4).

A review of the literature on family grief therapy revealed that the majority of research focused on the marital dyad (Kamm, 1999; Schildhaus, 1997), sibling grief, parent grief (Anderson, 1998), child grief (Breer, 1997; Dominguez, 1999; Tozeland, 1999), child bereavement group (Graham, 1999; Housley, 1997; Vargas-Irwin, 1999), and adolescent grief groups. Bernstein, Duncan, Gavin, Lindahl, and Ozonoff (1989) observed that the “specific topic of death of a child has generally received little attention” (p. 227). Even in their study, Bernstein et al. focused separately on the parental, marital, and sibling subsystems in examining the impact of the loss of a child while acknowledging that these systems are “intimately interwoven and do not operate independently” (p. 228). Moos (1995) stated that “models of grief and bereavement have focused primarily on individuals with little attention paid to the role of family processes and models of family grief” (p. 337). In her model of grief, Moos (1995) described

grief as occurring on multiple levels: an individual level, a family level, and a societal level. The family is seen as a system, a key aspect of which is that individuals are defined by their interactions with others (Moos, 1995).

Moos (1995) provided a list of family symptoms that include changes in communication patterns, changes in structure of the family, and changes in extrafamilial relationships. Goldberg (1975) and Worden (1991) suggested family tasks of mourning: 1) communicating acknowledgement of the death, which happens on intrapersonal and interpersonal levels; 2) allowing mourning to occur, also at intrapersonal and interpersonal levels; 3) relinquishing the memory of the deceased whereby both the family and individuals focus on adapting and adjusting to the new roles and absence of the deceased member; 4) realignment of intrafamilial roles involving the interrelationship of members; and 5) realignment of extrafamilial roles, involving developing relationships that can fulfill the roles that the deceased previously performed (Moos, 1995).

In working with bereaved families, Moos (1995) believed it necessary to look at the individual's psychological filtering of events and relationships, because the interpretation that each family member brings to the family interaction patterns directly affects the family grief reactions and the coping strategies used to reinstate order in the family system (Moos, 1995). The way an individual interprets the death event is dependent upon the circumstances and individual perceptions that are colored by individualized ideals of cultural constraints, family history, and nuclear family functioning (Moos, 1995; Walsh &

McGoldrick, 1991). Cultural expectations and reactions to death are integral in how families and individuals within those families deal with the death of one or more of their members (Moos, 1995). Family history is comprised of all the intergenerational rules and expectations, such as gender roles, religious beliefs, and rituals regarding death, including family patterns of coping (Moos, 1995; Walsh & McGoldrick, 1991). Nuclear family functioning entails the patterns of interactions and functioning that the family experienced prior to the death; hence, the more flexible the family regarding roles, boundaries, or differentiation, the more successful and adaptable they are likely to be in integrating the changes death brings (Moos, 1995; Walsh & McGoldrick, 1991).

Other aspects Moos (1995) considered when working with bereaved families are family interaction patterns, family grief patterns, and family coping strategies. Family interaction patterns undergo a significant transition following the death of a family member (Detmer & Lamberti, 1991; Moos, 1995; Walsh & McGoldrick, 1991); open communication about coping and grieving styles and reassignment of roles for everyday functioning can help normalize and ease that transition (Moos, 1995; Walsh & McGoldrick, 1991).

The difference between a family perspective of grief and an individual one is the interactional component of family grief (Moos, 1995). Each family member has individual grief; however, in addition, families often react as a unit. "The pressure on the members to conform to the family's traditional way of dealing with pain and loss issues is often very powerful" (p. 357), much like people in

crowds (Moos, 1995). With one member of the family gone, the structure is permanently changed, which results in a confusing period Moos labeled as family grief.

Family coping strategies focus on active or passive attempts to move on with life (Moos, 1995). Walsh and McGoldrick (1991) expressed that “death poses shared adaptational challenges, requiring both immediate and long-term family reorganization and changes in a family’s definitions of its identity and purpose” (p. 7). Two family adaptational tasks include 1) shared acknowledgment of the reality of death and shared experience of loss; and 2) reorganization of the family system and reinvestment in other relationships and life pursuits (Walsh & McGoldrick, 1991). They stated that “adaptation does not mean resolution, in the sense of some complete ‘once and for all’ coming to terms with the loss. Rather it involves finding ways to put the loss in perspective and move on with life” (p. 8).

In their article on family grief assessment and treatment, Lamberti and Detmer (1993) stated that grief literature has basically focused on individual reactions rather than relationships. Even though reactions of individuals to the death of a family member triggers change throughout the family system, individuals’ health and functioning have been measured, but the family system’s has not. According to Lamberti and Detmer, assessing whether the family is behaving in ways that will ultimately promote recovery and aid in regaining function, or in ways that will hamper or prevent recovery and thus contribute to dysfunction in the family system, is most important.

To assess a bereaved family's functioning, Lamberti and Detmer (1993) suggested integrating Minuchin's (1974) model of family structure along with Bowen's (1982) family systems theory. Minuchin's model of family structure provides a logical conceptualization of how grief affects family subsystems and boundaries. Bowen's family systems theory allows the counselor to examine the grieving family from the perspective of how each individual family member affects and is affected by mourning within the family system. Minuchin's (1974) theory stresses structure, while Bowen's (1982) theory places more emphasis on process. Both are critical in working with grieving families (Lamberti & Detmer, 1993).

Lamberti and Detmer's (1993) model has many similarities to Moos' (1995) model. Both look at the role of flexibility or rigidity within the family system and subsystem, at multi-generational family history for clues to traditions in mourning losses, at rituals or lack thereof, and at expectations regarding grieving. In rigid or closed family systems, freedom of expression is not allowed, whereas in open or flexible family systems individuals are more differentiated and are able to use both cognitive and emotional functioning to integrate the loss (Lamberti & Detmer, 1993). According to Lamberti and Detmer (1993) differentiation will be temporarily at a lower functional level following a severe loss. While moving toward togetherness may relieve anxiety for a grieving family, such movement may be accompanied by high expectations to share the same feelings and grief behavior (Lamberti & Detmer, 1993; Moos, 1995). Generally,

however, families with high levels of differentiation during noncrisis periods will become uncomfortable with the extreme togetherness and will return over time to their previous level of differentiation (Lamberti & Detmer, 1993).

In the treatment of bereaved families, Lamberti and Detmer (1993) stressed that the counselor use assessment as an ongoing process throughout the course of therapy, so interventions can be adapted to a particular family. Relevant to counseling families who lose a child, the counselor should monitor the ongoing transformation of the family system's hierarchical structure and specific roles to insure no one child is designated responsible for taking over all tasks and/or identity of the deceased sibling (Lamberti & Detmer, 1993).

McCown and Davies' (1995) study of grief in children after the death of a sibling identified aggressive and attention seeking behaviors that may be masking depression and expressing a desire to solicit a reaction from the parents and thus reassure themselves of their place in the family. Heiney (1991) stated in her study that siblings experience a prohibition against mourning from parental, personal, and societal influences that encourage strength and silence rather than reminiscence and expression of feelings. She contended that siblings try to protect parents, and thus

siblings may deny the event or experience sadness, anger, guilt, and fear...the child may complain of bodily discomfort or act out by refusing to obey rules. On a more serious level, the sibling may become depressed, misbehave excessively, or withdraw and be indifferent. (p. 122)

With regard to how the family system is processing grief, Lamberti and Detmer (1993) noted that “in cases where no mourning patterns/rituals exist or a desire is expressed to move away from existing patterns, the counselor should work with the family to develop appropriate rituals” (p. 64) that will serve to foster openness within the family. The goal for family bereavement treatment, according to Lamberti and Detmer (1993), is “grief resolution, and individual and family functioning that equals or exceeds the precrisis level” (p. 66).

Gilbert (1996), in her article on loss and differential grief in families, contended that

attempting to understand the process of grief as it affects and is affected by family dynamics is difficult. In research, intervention, and common thought, grief is conceptualized most often as an individual response to loss with little attention paid to family processes. Yet loss and grief are embedded in social and relational contexts. (p. 270-271)

Gilbert (1996), like Moos (1995) and Lamberti and Detmer (1993), explored the issue of individual grief and family grief; however, Gilbert asserted that individuals grieve within a variety of contexts, one of which is the family; the family itself does not grieve.

Unlike Moos (1995) and Lamberti and Detmer (1993), Gilbert (1996) addressed couple factors, gender differences, and developmental stages of various family members in grief. She stated that acceptance of differences inherent in grief styles and the ability to take a positive view of these differences

served to strengthen couples' marriages. According both to her and to Walsh and McGoldrick (1991), men are more likely than women to avoid expressing emotions related to loss and to experience less intense grief that is resolved more quickly. Morgan (2000) also noted, regarding gender, that men are socialized much less than women to share the burdens of life. While men tend to confide only in their spouses, women tend to confide not only in their spouses but also in relatives and friends. Golden (1996) asserted that due to the brain structure of the corpus callosum, men have difficulty producing tears and are less conscious of their own emotional states.

Gilbert (1996) also reported that age and developmental stage affect the ways in which family members grieve. Children, in particular, experience recurrent cycles of grief as they move through various developmental stages. Although he stated that each child's responses are different, Wolfelt (1996) provided developmental stages, typical grief responses for each developmental stage, and ways for parents and caregivers to acknowledge and address these responses. Webb (1993) and Wolfelt (1996) differentiated between child and adult grief: 1) a child's world is primarily a world of play, 2) a child mourns in "doses" – or on an intermittent basis, 3) cognitive development affects a child's capacity to integrate the finality, inevitability, and irreversibility of death, 4) children are more at the mercy of those around them for help or hindrance, and 5) children, particularly teens, do not want to be different from their peers. While Gilbert (1996) adapted Jordan (1990) and Walsh and McGoldrick's (1991) tasks

of grief resolution, the consensus of the literature is that the family's ability to engage in open and honest communication is the single most important factor in successful grief resolution (Bowen, 1991; Gilbert, 1996; Lamberti & Detmer, 1993; Moos, 1995; Nadeau, 1998; Rando, 1984; Rosen, 1990; Walsh & McGoldrick, 1991; Wolfelt, 1996; Worden, 1996).

Wolfelt (1996) referred to "the illusion of the dyad in grief counseling" (p. 202). The therapeutic environment includes not only the counselor and the child but also the child's family and other influences such as peers, school, media, and society in general. Therefore, regardless of the family make-up, bereaved children cannot be considered as separate from the social contexts in which they live (p. 203-204). An advocate for family-oriented bereavement counseling, Wolfelt (1996) described beginning therapy with an initial family session early on in the process, then moving family in and out of sessions depending on the unique needs that evolve over time. He even advocated the appropriateness, at times, of bringing together the relevant "family:" the teacher, clergy person, grandparent, neighbor, or other significant person (Wolfelt, 1996; Worden, 1996).

Shapiro's (1996) social developmental grief model ascertained that death and grief initiate a developmental crisis and require rebuilding of family identity both in managing disrupted family roles or function and in managing newly intensified shared emotions. She contended that:

the first priority for a grieving family is reestablishing the stable family conditions that support the family's day-to-day functioning...[R]esonating

both consciously and unconsciously to emotional cues from one another, family members responsively adapt to each other's attempts to control overwhelming emotions, reestablish stable patterns of daily living and relating[,] and reconstruct a sense of self. (p. 14)

Unlike Lamberti and Detmer (1993) who conceptualized the successful therapeutic outcome as "grief resolution," Shapiro (1996), similar to Klass et al. (1996), described both children and adults as undergoing a life-long process of relational revision with both the living and the deceased family members. In the view of these latter authors, the implications of loss do not diminish but, rather, unfold and, at times, expand with the passage of time (p. 321-322).

Shapiro (1996) stated that "writers on bereavement are increasingly recognizing that mental health models prescribing detachment contradict the needs of most grieving families, whatever their cultural background" (p. 325). Therefore, the transformed relationship with the deceased becomes an important resource supporting the family's ongoing development, rather than being a sign of psychopathology (Klass et al., 1996; Shapiro, 1996). "A reworking of the relationship with the deceased is a necessary part of the transitional period in the creation of new social roles and a new sense of the shared family self" (Shapiro, 1996, p. 325).

Finally, in working with families, Shapiro (1996) stated that in promoting an arduous and creative family developmental process, counselors need to help families become aware of referent tensions at the interface of historical, cultural,

familial, and individual experience so as to resolve them in a way that best suits their own history and current life circumstances. Humphrey & Zimpfer (1996) urged counselors to be collaborators in a process rather than act as experts. Only the individual client or family knows the depth and meaning of their grief experience. Counselors cannot and must not put all grievers into presupposed categories, treating them all the same based on a presumed category of their loss (p. 70).

Nadeau (1998) stated that in developing her role as a grief counselor she became aware of how little is known about family grief. She conducted a qualitative study on family meaning-making with 10 multigenerational, grieving families who lost an adult member aged 39 to 91. The participants' ages ranged from 18 to 74 with at least two family members interviewed per family. Following the study, she observed that:

when the study was designed, nothing in the literature dealt directly with the intersection of family processes, meanings, and grief. Such is still the case. A recent extensive search of the relevant literature did not turn up any study or theoretical work dedicated primarily to how family members interactively make sense of the loss of a family member. What was found were studies and theoretical works that in some way corroborate or further illuminate certain dimensions of family meaning-making or point to better methods for the study of such phenomena. (p. 248)

Nadeau (1998) acknowledged that whereas most studies have focused on individual grief, her study was unique in examining family grief. She contended that the families in her study provided a window into how the meaning-making process occurs.

When someone dies, family members struggle to make sense of the death by talking among themselves. The meanings they make have a great deal to do with how they will grieve. Bereaved families make meaning in couples, dyads, and family groups. Their meaning-making is inhibited or stimulated by such family characteristics as family rules, family structure, family rituals, and the nature of the death. Bereaved families make a myriad of meanings by using multiple strategies: They tell stories, they dream, they make comparisons, they make something of coincidences, they characterize the deceased, they use common daily discourse, and they talk about what the death does not mean. The meanings that families make may be positive or negative and range from the most substantive to the most abstract, from those closely associated to the current death to those about life in general. The meanings that bereaved families make greatly affect the way they grieve (p. 247).

Riches and Dawson (2000) conducted an exploratory qualitative study with bereaved parents and siblings in which, for six years, they engaged in extended one and a half to three or more hours taped interviews with over 50 bereaved parents and siblings. Their interest was in studying the impact of a

child's death on marital relations. Ages of the child at death ranged from unborn to 30 years. The time between the child's death and the interviews varied from 11 months to 23 years, though most fell within two to six years. Most siblings interviewed were bereaved during childhood or adolescence with a few bereaved during adulthood and much later adulthood. Riches and Dawson sought to gain details of the child's life, death, and events in the family since the death as well as perceptions of support, professional help if sought, self-help groups if attended, perceptions of their partner and surviving children's grief, and perceptions of the affect of the death on their marriage and their family's relationships.

Neither Nadeau (1998) nor Riches and Dawson (2000) worked with the entire family unit, nor did they obtain information from young children about a child's perceptions of loss within the family. Although these studies were "family grief" studies, the findings do not offer families with preschool and school-aged children who are struggling with the loss of a family member a model for healing or for relational revision with both the deceased and the living family members.

Expressive Arts Therapy with Families

A literature review on expressive arts therapy with families revealed that very little has been written on this topic. The roots of expressive arts therapy with families most likely began with the work of art therapists Landgarten (1981, 1987) and Kwiatkowska (1967, 1978). Kwiatkowska (1978) developed the mode of

therapy known today as Family Art Therapy and was the first to have family members actually produce art together in a therapeutic setting.

Landgarten and Kwiatkowska experienced support for their groundbreaking work with families from institutions regarded as early proponents of family therapy, the Thaliens Family Child Department of Psychiatry in Sinai Hospital, Los Angeles, and the National Institute of Mental Health (Landgarten, 1991). Landgarten (1981, 1987) further developed art therapy with families by studying Kwiatkowska's (1978) work as well as the renowned work in family systems psychotherapy of Nathan Ackerman, Murray Bowen, Carl Whitaker, Salvador Minuchin, Virginia Satir, and Jay Haley. Thus, originally, techniques of each arts therapy discipline were used with specific family treatment theories (Landgarten, 1991).

In the 1970s, some arts counselors began to use an integrative model but only in terms of integrating theories of family therapy. A single theory of family therapy was considered to be too limited; however, an amalgamation of different family therapy theories provided the flexibility that was needed for arts therapists to work with the diverse needs of their clients (Landgarten, 1991). Therefore, Landgarten (1987) stressed the importance of understanding that art therapy with families be understood as a psychotherapeutic technique that compliments all existing family therapy theories.

The use of arts therapies with family treatment has been expanding throughout the 1980s and 1990s (Landgarten, 1991). One of the reasons for this

expansion, Landgarten (1991) stated, is the idea that arts therapists can use their skills with any type of family problem. In fact, the most resistant families are often the best candidates for the arts therapies (Landgarten, 1991).

One of the most important aspects of family art therapy, according to Kwiatkowska (1969), is that it is a modality distinguished from all other types of therapies due to the fact that the entire family simultaneously becomes engaged in a form of non-verbal, expressive behavior. In addition, Landgarten (1987) stated that the collaborative effort can prove to be enjoyable which “offers the family a means to discover some of its strengths and acts as a catalyst for positive change” (p. 7).

Linesch (1999) maintained that “art therapy is an effective and powerful action method that can facilitate expanded self-expression, increased awareness, and experimentation with changes in behavior” (p. 241). Used with families, Linesch stated that art making facilitates the pictorial or graphic communication of all family members. She noted that, during the art making process, each member is able to pursue an alternative form of self-expression, even as the graphic depiction of the family system emerges. The resulting depictions, Linesch observed, are “often richly symbolic and laden with multiple levels of meaning that offer the family opportunity to shift patterns of speaking to each other, of listening to each other, and of interacting with each other “ (p. 228).

Wilson explored family perceptions in family art therapy in a 1989 study. He hypothesized that changes in family members' perceptions of their

interactional styles and areas of dysfunction as measured by the Family Environment Scale (F.E.S.) would be significantly greater for those families who received family art therapy than for families who received traditional family therapy. Families were videotaped performing a specific thematic art therapy task designed to bypass family members' traditional verbal defenses. The family was then confronted with concrete examples of their various styles of interaction during a follow-up session utilizing videotape feedback. The study was a pre-test, post-test control group quasi-experimental design. All data were secured from the F.E.S. that was administered pre and post treatment to 10 families in traditional family therapy and to 10 families in family art therapy with videotape feedback. The results indicated that the family art therapy treatment group experienced significantly greater absolute change than the control group on six of the 10 subscales of the F.E.S. (Wilson, 1989).

Expressive arts therapies for families is a relatively recent concept. In addition to traditional family art therapy techniques, Gil (1994) included many expressive techniques that family therapists can use to treat families, such as movement, role-play, psychodrama, family sculpting, puppetry, play therapy, mutual story-telling, and others. She stated that "play techniques can engage parents and children in enhanced communication, understanding, and emotional relatedness" (p. 42).

Expressive Arts Therapy with Bereaved Families

A review of the literature revealed that relatively little has been written on the use of expressive arts therapy with bereaved families. The focus, instead, has been on the use of art therapy with bereaved children (Davis, 1989; Knox, 1999; McIntyre, 1988; Serazin, 1996; Wilkinson, 1996), the use of art therapy with bereaved widows (Schimmel & Kornreich, 1993), the use of art and/or creative therapy with bereaved adolescents (Lang, 1992; Loy, 1999; Miller, 1991), the use of creative expression in healing loss with an individual (Sinito, 1993), the use of art therapy with a single case grieving sibling (Heiney, 1991), and bereavement groups with elementary school students (Adams, 1996).

Zambelli, Clark, Barile, and deJong (1988) described a program for children and parents that incorporated the use of creative arts as an interdisciplinary, or expressive arts, approach to clinical intervention for childhood bereavement. The children, each of whom had lost a parent within the past year, were placed in a creative arts group that utilized art, drama, movement therapies, and education. In conjunction with the children's group, a companion parent support group focused on didactic and open-ended discussions of loss and single parenting. These groups met for one hour weekly for eight weeks. In addition, the researchers required each family to participate in an intake interview and an ending evaluation. Families could request special consultation meetings as needed during the eight-week period. A master's level registered art therapist conducted the creative arts group, and a master's level social worker facilitated the parent group.

The evaluation of the program was based on the parents' and children's evaluations and the counselors' observations. At the end of treatment, the parents described their children as being more secure, more expressive, and better able to deal with referent anger about the death. The children reported enthusiasm about the creative arts activities and about meeting other children. Some children had difficulty articulating their feelings about grief. The parents found that meeting other parents and discussing single parenting issues was more helpful than time spent dealing with the pain of their loss. More than half of the parents and children felt it beneficial to attend two eight-week sessions rather than one. Implications and conclusions from observations of the program indicated that when a child did not have a parent in the companion group, the intervention was not as effective. Zambelli et al. (1988) found that utilizing the creative arts therapy and parental support groups as an approach heightened the likelihood of an overall family system adaptation to the parental death. In addition, "initial observations suggest that the grieving child must be considered in the context of his or her family system and that the value of therapy is redoubled when offered as part of an interdisciplinary intervention" (p. 49).

Zambelli et al.'s (1988) study indicates that a child may benefit more when considered in the context of his or her family system, while at the same time using interdisciplinary creative arts activities as interventions. Their study did not include standardized measurements in a pre-test, post-test control group quasi-experimental design to determine the significance of the changes being reported

by parents and children, which points to the need for further research that includes these design components.

A similar study was developed, implemented, and evaluated by Graves (1991) as an intervention program focusing on bereavement intervention with children. Graves implemented eight-week activity groups for children, aged five through ten, and a companion parent support group designed to educate parents in managing their children's grief reactions. Following participation in the program, Graves noted that parents and children perceived more similar levels and types of communication shared about the death. In addition, children displayed fewer behavioral manifestations of grief, particularly depression, sleep disturbances, irritability, denial, and feelings of guilt about the death (Graves, 1991). Neither the assessment instruments used to measure these behavioral changes nor the significance levels of results were indicated.

The results of Graves' (1991) study are promising with regard to the use of activity groups as interventions with children and the use of parents' groups in managing the grief reactions of their children. However, the focus of Graves' study remained on the child rather than on the family; neither the parents' grief nor the family's grief was addressed. Clearly, more research is needed in understanding how the family can best be helped with a loss of this magnitude.

Loy (1999) conducted a study of the effectiveness of a camp intervention for bereaved adolescents who were bereaved as the result of the death of a family member or friend. Six components representing camp theory were linked

to bereavement literature and programming. Sixty-one adolescent children, ages 10 to 17, were recruited to participate. An experimental, treatment-control, post-measure-only design was employed to examine grief recovery using the Texas Revised Inventory Depression Scale. In addition, a survey of all participants and their guardians provided quantitative and qualitative data regarding camp effectiveness.

The results revealed difficulties involved in measuring grief, though, reportedly, the camp experience was overwhelmingly positive. Survey results indicated that several aspects of camp were beneficial, including counselor competence, fun, nature of the camp, and the opportunity to share thoughts, feelings, and emotions. Additionally, participants reported increases in their thoughts about being normal, in their knowledge and understanding of death and loss, and in the intensity of and ability to share their feelings. Both participants and their guardians reported seeing changes such as becoming more open, more willing to talk about the deceased, and more able to share their feelings and emotions. Participants further indicated improvement in attitude and self esteem, in behavior at home and in school, and in the ability to understand others. Following the camp experience, participants and guardians reported a sense of family progress and increases in both family communication, and closeness among family members (Loy, 1999).

To summarize, McIntyre (1987), in a study using art therapy with bereaved children, maintained that art therapy for bereaved children is critical to healthy

child development. Art therapy, according to McIntyre, provides a counterbalance to loss, is a healthy release for the strong emotions, brings clarity to grief issues, and leads to verbalization and sharing. Zambelli, Clark, and DeJong-Hodgson (1994), in writing about childhood grief from an object relations perspective, expressed the belief that an art therapy group facilitates the creation of a holding environment where the pain associated with the death of the object is made bearable and the “potential for creative living can be regenerated” (p. 19). Zambelli et al.(1994) noted that the “art therapy process appeared to promote emotional growth and development as well as increase acceptance of [the children’s] loss” (p. 22).

Nevertheless, because of design limitation in studies to date, the effectiveness of expressive arts therapy with bereaved families has not yet been demonstrated clearly. Zambelli et al. (1988) and Graves (1991) conducted studies using activities that focused on the children’s, but not the family unit’s, grief process. McIntyre’s (1987), Heiney’s (1991), and Loy’s (1999) studies also focused on children and not on the family system. Consequently, their findings are encouraging but not conclusive.

Walsh and McGoldrick (1991) emphasized that death poses major adaptational challenges for the family as a system as well as for each individual family member. During grieving, families often show evidence of emotional cut-offs, factions, and other emotional disruptions in family relationships. Counselors need to know what, if any, interventions work most effectively to reduce these

common disruptions (Bowen, 1976; Parks & Weiss, 1983). When designing their studies, researchers need to include the entire remaining family in which a family member has died if they are to discover the most effective interventions. A pretest/posttest quasi-experimental research design that uses standardized instruments sensitive to the anticipated changes one might hope to find during treatment is an important component in determining results of treatment. A qualitative research component would also provide important phenomenological information and would strengthen the findings that could shape future research possibilities for helping bereaved families.

In addition, expressive arts therapy with grieving families not only may prevent future problems with displaced grief and complicated grief reactions but also may assist the emotional healing process and integration of healthier family functioning within a shorter period of time. As a result, children most likely would experience fewer social and behavior problems in their learning environments. Overall anxiety and depression levels associated with bereavement may also be experienced at more manageable levels given the opportunity to participate in expressive arts therapy as a family unit.

Current Trends in Treatment of Bereaved Families

In addition to the studies cited in the literature, current nationwide trends in the treatment of bereaved families consist of grief recovery centers, such as The Warm Place in Fort Worth, Texas, and The Journey of Hope Grief Support Center in Plano, Texas. I (Webb-Ferebee) conducted interviews with Peggy

Bohme (personal communication, May 10, 1999), founder and director of The Warm Place; Mark Hundley (personal communication, August 2, 1999), founder of Journey of Hope Grief Support Center, and Jane Le Vieux (personal communication, July 30, 1999), a certified thanatologist.

Bohme explained that The Dougy Center, The National Center for Grieving Children and Families, of Portland, Oregon, was the first grief center of its kind established in the country. She stated that Beverly Chappell with the help of Elizabeth Kübler-Ross organized The Dougy Center in 1982. According to Bohme, The Warm Place, modeled after The Dougy Center, is now also a nationally recognized center and provides consultation services for grief support centers throughout the United States. Hundley stated that the Journey of Hope Grief Support Center was modeled after the Dougy Center and The Warm Place.

Both Bohme and Hundley described how their centers' approach to grief support is focused on providing support groups for grieving children between the ages of 5 and 19, with non-obligatory groups for parents or guardians concurrently meeting in a separate location. Children are divided into developmental age groups that meet twice a month. Families do not meet as individual family units to facilitate healing within and as a family unit. Parents/guardians determine when to terminate services and give two week's notice to the center when they terminate. The focus of these grief centers is primarily on assisting the children's grief process rather than on facilitating the family unit's healing from their loss. This study focuses on providing not only

developmental children's groups and a variety of parent group formats, but primarily on fostering healing within the individual family unit.

All three interviewees reported that the average time families begin to seek services is between three and 24 months. While some families may be ready earlier than three months, these experts agreed that most families wait at least six to nine weeks following the death before entering into the programs offered by grief support centers. In addition, Bohme, Hundley, and Le Vieux emphatically supported the need for research in investigating interventions for the entire family unit. Each expressed high hopes that this study might provide potentially important information for professionals and laypersons that serve grieving families.

Summary of Related Literature

In summary of the review of literature, expressive arts therapy is shown to have ancient roots in holistic health and healing of the individual and of relationships. When talk became the dominant psychotherapeutic modality in the late 19th and early 20th century Western world, expressive arts as a therapeutic modality was largely lost. Since the 1940s the re-introduction of expressive arts therapy has been gaining momentum and now holds tremendous promise for research in many areas. One such area is as a method of prevention and intervention for bereaved families. Along with the traditional models of grief, Klass et al. (1996), in their new model, have conceptualized grief as a life-long process with no final resolution or completion and one in which a transformative

relationship continues throughout the developmental stages of an individual's life. This model shows cause to reevaluate the grieving process of the family in which a member has died.

Current work in the field of bereaved family therapy, though sparse, has yielded a body of information that points toward the effectiveness of working with families. Counselors do well to recognize that grief occurs on multiple levels and that the family treated as a system may be a key aspect of healing. The role of the counselor as a collaborator with the family and not as the expert fits well with the role of an expressive arts therapist. Both affirm the belief that only the individual family knows the depth and meaning of their grief experience, just as only the creator of an expressive art piece can determine the meaning of the piece. It is the nature of the inner conditions of creativity that creativity cannot be forced but must be permitted to emerge (Rogers, 1961).

Although research to date has illustrated how the combination of art forms as therapeutic tools can serve as a significant means of assisting individuals to become more self-aware, insightful, and integrated (Gladding, 1998), no existing treatment models have applied expressive arts therapy with grieving families. Piaget's (1962) research supports the idea that traditional talk therapy would not be developmentally appropriate for young children. He asserted that children are not developmentally able to engage fully in abstract reasoning or thinking until approximately age 11 (Landreth, 1991).

Landreth (1991) also supported a more expressive approach for children when he contended that children's feelings are often inaccessible at a verbal level, as children lack the cognitive capacity to express feelings in a verbal exchange. Rubin (1999), in her foreward to Malchiodi's recent publication, Medical Art Therapy with Children, observed that "children have always used art and play spontaneously, to cope with stresses over which they have no control" (p. 9). She asserted that many a preschooler returns from a visit to the doctor and then plays the role of nurse or doctor, taking care of a doll or a playmate. Clearly, the experience of being able to take charge, even in the small sphere of a piece of drawing paper, is vital when a child is not able to control either the medical condition or the interventions of others (p. 9-10). Malchiodi (1999) stated that:

children use art for self-expression, conflict resolution, and emotional reparation. Art is believed to be a visual language for children and a developmentally appropriate form of communication, especially for young children who may not have the cognitive abilities to express themselves with words. (p. 16)

Whereas traditional talk therapy approaches are not developmentally appropriate or effective with family units consisting of young children, expressive arts therapy is developmentally appropriate and effective with all family members, which does allow for the treatment of the entire family unit.

Current approaches of grief support centers divide family members into developmental groups and focus on assisting the children's grief process. While developmental groups allow for use of age-appropriate treatment methods, the needs of the family unit are not adequately addressed.

Information relevant to the scope of grief and loss therapy with the family unit is provided by this study. Specifically, this study contributes to the knowledge of the extent to which expressive therapies can facilitate the healing process for grieving families and each of their members. Out of this knowledge, hopefully, will come a preferred model of grief treatment that can be used nationwide.

CHAPTER II

METHODS AND PROCEDURES

The purpose of this study was to determine the effectiveness of expressive arts therapy with bereaved families as a method of prevention and intervention for families who have lost a child. Specifically, this study was designed to determine the effectiveness of expressive arts therapy in: 1) positively impacting family functioning in the areas of cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral religious emphasis, organization, and control; 2) decreasing social problems and total behavior problems of children in areas of school maladjustment, clinical maladjustment, personal adjustment, and overall emotional symptoms as reported by self, parents, and teachers; 3) decreasing anxiety levels of family members as reported by self, parents, and teachers; and d) decreasing depression levels of family members as reported by self, parents, and teachers. This chapter addresses definition of terms, hypotheses, instrumentation, selection of subjects, collection of data, the Camp Sol – Healing the Family Heart model of expressive arts therapy procedures, the treatment facilitator, and statistical analysis.

Definition of Terms

The following terms have special meaning for this study and are defined

as follows:

Expressive arts therapy in this study denotes the experience of the arts used in combination as therapeutic tools (Rogers, 1993). The combination of art forms used in this study included drawing, painting, sculpting, music, movement, storytelling, guided imagination, writing, phototherapy, collage, sandplay, and drama (Carey, 1991; Feder & Feder, 1981; Fleshman & Fryrear, 1981; Landy, 1993; Rogers, 1993; Segal, 1984).

Bereaved family is defined in this study as a group of interconnected individuals made up of at least one parent or guardian and one or more of his/her/their living children between the ages of 3 years and 18 years who have lost one or more of his/her/their children to death within the past 2 to 36 months.

Grief represents thoughts and feelings that are experienced within oneself—the internal meaning one gives to the experience of loss (Wolfelt, 1992).

Mourning is a shared social response to loss, a cultural response to grief. Implied in this definition is that grief, like other reactions, takes no one single form but, rather, is socially and culturally influenced (Rando, 1984; Wolfelt, 1992). For example, in Western culture, men traditionally mourn differently than women (Golden, 1996; Martin & Doka, 2000). Furthermore, developmentally, bereaved children mourn more through behaviors than through words (Webb, 1993; Wolfelt, 1992).

Loss, from a family systems perspective, can be viewed as a transactional

process involving the deceased and the survivors in a shared life cycle that acknowledges both the finality of death and the continuity of life. Coming to terms with this process is the most difficult task a family must confront in life (Walsh & McGoldrick, 1991).

Family functioning is defined in this study as the help and support that family members give to each other, the extent family members are encouraged within the family to express feelings and to act openly, and the amount of expressed conflict and anger within the family (Billings & Moos, 1982; McGee, Williams, & Silva, 1984).

Hypotheses

To carry out the purposes of this study the following hypotheses were formulated:

Family Functioning Hypotheses

1. The experimental group families' posttest mean scores on the "Family Incongruence" scale on the Family Environment Scale (FES) will be significantly lower than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

2. The experimental group families' posttest mean scores on the "Cohesion" subscale of the FES will be significantly higher than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

3. The experimental group families' posttest mean scores on the "Expressiveness" subscale of the FES will be significantly higher than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

4. The experimental group families' posttest mean scores on the "Conflict" subscale of the FES will be significantly lower than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

5. The experimental group families' posttest mean scores on the "Independence" subscale of the FES will be significantly higher than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

6. The experimental group families' posttest mean scores on the "Achievement Orientation" subscale of the FES will be significantly higher than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

7. The experimental group families' posttest mean scores on the "Intellectual-Cultural Orientation" subscale of the FES will be significantly higher than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

8. The experimental group families' posttest mean scores on the "Active-Recreational Orientation" subscale of the FES will be significantly higher than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

9. The experimental group families' posttest mean scores on the "Moral-Religious Emphasis" subscale of the FES will be significantly higher than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

10. The experimental group families' posttest mean scores on the "Organization" subscale of the FES will be significantly higher than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

11. The experimental group families' posttest mean scores on the "Control" subscale of the FES will be significantly lower than (1) their pretest mean scores, and (2) the control group families' posttest mean scores.

Child Behavior Hypotheses

12. The experimental group children's posttest mean scores on the Behavior Symptoms Index (BSI) as indicated on the Behavior Assessment System for Children-Teacher Report Scale (BASC-TRS) will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(a) The experimental group children's posttest mean scores on the Externalizing Behavior Problems composite as indicated on the BASC-TRS will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(b) The experimental group children's posttest mean scores on the Internalizing Behavior Problems composite as indicated on the BASC-TRS will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(c) The experimental group children's posttest mean scores on the School Problems composite as indicated on the BASC-TRS will be

significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(d) The experimental group children's posttest mean scores on the Adaptive Skills composite as indicated on the BASC-TRS will be significantly higher than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

13. The experimental group children's posttest mean scores on the Behavior Symptoms Index (BSI) as indicated on the Behavior Assessment System for Children-Parent Report Scale (BASC-PRS) will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(a) The experimental group children's posttest mean scores on the Externalizing Behavior Problems composite as indicated on the BASC-PRS will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(b) The experimental group children's posttest mean scores on the Internalizing Behavior Problems composite as indicated on the BASC-PRS will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(c) The experimental group children's posttest mean scores on the Adaptive Skills composite as indicated on the BASC-PRS will be

significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

14. The experimental group children's posttest mean scores on the Emotional Symptoms Index (ESI) as indicated on the Behavior Assessment System for Children -Self Report of Personality (BASC-SRP), ages 8 to 18, will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(a) The experimental group children's posttest mean scores on the School Maladjustment composite as indicated on the (BASC-SRP), ages 8 to 18, will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(b) The experimental group children's posttest mean scores on the Clinical Maladjustment composite as indicated on the (BASC-SRP), ages 8 to 18, will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

(c) The experimental group children's posttest mean scores on the Personal Adjustment composite as indicated on the (BASC-SRP), ages 8 to 18, will be significantly higher than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

Anxiety Hypotheses

15. The experimental group parents' posttest mean scores on the Beck Anxiety Inventory (BAI) will be significantly lower than (1) their pretest mean scores, and (2) the control group parents' posttest mean scores.

16. The experimental group children's posttest mean scores on the "Anxiety" subscale as indicated on the BASC-PRS, will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

17. The experimental group children's posttest mean scores on the "Anxiety" subscale as indicated on the BASC-TRS, will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

18. The experimental group children's posttest mean scores on the "Anxiety" subscale as indicated on the BASC-SRP, will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

Depression Hypotheses

19. The experimental group parents' posttest mean scores on the Beck Depression Inventory (BDI-II) will be significantly lower than (1) their pretest mean scores, and (2) the control group parents' posttest mean scores.

20. The experimental group children's posttest mean scores on the "Depression" subscale as indicated on the BASC-PRS, will be significantly lower

than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

21. The experimental group children's posttest mean scores on the "Depression" subscale as indicated on the BASC-TRS, will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

22. The experimental group children's posttest mean scores on the "Depression" subscale as indicated on the BASC-SRP, will be significantly lower than (1) their pretest mean scores, and (2) the control group children's posttest mean scores.

Limitations

This study has the following limitations:

1) Because this study involved only families who have lost a child to death due to chronic illness, the results of this study cannot be generalized to those families who have lost other family members or have lost children under circumstances other than death due to chronic illness.

2) Because this study involved an insufficient number of participants to allow for formation of a control group, the results of this study cannot be conclusively attributed to the treatment.

3) Because this study involved only families who volunteered for the treatment, results cannot be generalized to families who do not or would not volunteer for such a treatment.

4) Because this study involved only families who attended the camp weekend at no cost to them, the results of this study cannot be generalized to families who would pay to attend the camp weekend.

5) Because this study involved only participants who received services for their children and families from Children's Medical Center of Dallas (CMC), the results of this study cannot be generalized to families who have received services for their children and families from any other medical center. In addition, because this study involved participants from CMC who did not attend the hospital bereavement group that is offered once a month for all parents who have lost a child to death, the results of this study cannot be generalized to families who are receiving other services concurrent with a treatment comparable to the one used in this study.

6) Because this study involved participants who the researcher recruited and whose child's/sibling's date of death was within 2 to 36 months of the onset of this study, the results of this study cannot be generalized to families who are offered services immediately following death.

7) Because this study involved the Behavior Assessment System for Children-Self Report of Personality (BASC-SRP) instrument, that is designed for use only with children ages 8 to 18, the results of this study cannot be generalized to children under the age of eight who have lost a sibling to death due to chronic illness or any other cause.

8) Because this study involved only two counselors who were professionally trained in expressive arts therapy, and 10 counselors who received a four hour expressive arts training module prior to the time of treatment, the results of this study cannot be generalized to families whose expressive arts therapy was not facilitated by professionally trained expressive arts therapy counselors.

Instrumentation

Family Environment Scale

The Family Environment Scale (FES) is comprised of 10 subscales that measure the social-environmental characteristics of all types of families. The FES can be used to describe and compare family social environments, contrast parent and child perceptions, identify family strengths and problems, and examine actual and preferred family milieus. Thus, the FES helps clinicians formulate clinical case descriptions, identify important issues in family treatment, and learn about the dynamics of family systems.

Three forms are available for use: 1) the Real Form (Form R), which measures people's perceptions of their conjugal or nuclear family environments; 2) the Ideal Form (Form I), which measures people's conceptions of ideal family environments; and 3) the Expectations Form (Form E), which measures people's expectations about family settings. For the purposes of this study Form R, the Real Form, was administered (Moos & Moos, 1986).

The 10 FES subscales assess three underlying sets of dimensions: Relationship dimensions, Personal Growth dimensions, and System Maintenance dimensions. The Relationship dimensions, composed of Cohesion, Expressiveness, and Conflict subscales, measures the help and support that family members give to each other, the extent members are encouraged within the family to express feelings and to act openly, and the amount of openly expressed conflict and anger within the family (Moos & Moos, 1986).

The Personal Growth dimensions are comprised of Independence, Achievement Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation, and Moral-Religious Emphasis subscales. These dimensions consider the extent to which family members make their own decisions, assert themselves, and are self-sufficient; the extent to which activities such as school or work fall into a competitive or achievement-oriented framework; the degree of interest in political, social, intellectual, and cultural activities; and the relative importance of ethical and religious issues and values (Moos & Moos, 1986).

The System Maintenance dimensions include Organization and Control subscales. These subscales assess the importance of clear organization and structure in planning family activities and responsibilities and to what degree certain rules and procedures are used to run family life (Moos & Moos, 1986).

Families are grouped according to their most salient aspects, considering first personal growth, then relationship, and then system maintenance characteristics. Then, families are classified as being representative of one of

seven family types: Independence-oriented, Achievement-oriented, Moral-religious-oriented, Intellectual-cultural-oriented, Support-oriented, Conflict-oriented, and Disorganized. Billings and Moos (1982a) were able to classify 90.2 percent (N=241) of 267 family profiles into one of the seven types.

In addition to the subscale scores and typology of family environment classification, an overall Family Incongruence Score is derived that measures the degree of disagreement between family members. The Family Incongruence Score is derived by comparing the 10 FES subscale scores of each combination of two family members, finding the absolute difference on each subscale and summing the differences. The average of these incongruence scores yields a Family Incongruence Score.

The FES, used with ages 8 and older, consists of 90 sentence items describing family functioning that require a response of true or false. Using a template, X's are marked and summed at the bottom of each column. An average can then be calculated for all the members of each family for each subscale. Subscale and Family Incongruence scores can be converted to standard scores. Normative data has been collected on 1,625 families (1,125 normal and 500 distressed) with scores for both normal and distressed groups (Moos & Moos, 1986).

Test manual authors reported that internal consistency for the Cohesion subscale was $r=.78$ (Moos & Moos, 1986). Test-retest reliability, over periods of 2, 4, and 12 months, was $r=.86$, $r=.72$, and $r=.63$, respectively. Expressive

subscale internal consistency was $r=.69$ with test-retest reliabilities of $r=.73$ (2 months), $r=.70$ (4 months), and $r=.69$ (12 months). The Conflict subscale had an internal consistency of $r=.75$ and test-retest reliabilities of $r=.85$ (2 months), $r=.66$ (4 months), and $r=.76$ (12 months). Independence subscale internal consistency was $r=.61$ with test-retest reliabilities of $r=.68$ (2 months), $r=.54$ (4 months), and $r=.52$ (12 months). The Achievement Orientation subscale had an internal consistency of $r=.78$ with test-retest reliabilities of $r=.74$ (2 months), $r=.66$ (4 months), and $r=.69$ (12 months). The Intellectual-Cultural Orientation subscale internal consistency was $r=.78$. Test-retest reliability was $r=.82$ (2 months), $r=.86$ (4 months), and $r=.79$ (12 months). The Active-Recreational Orientation subscale internal consistency was $r=.67$ with test-retest reliabilities of $r=.77$ (2 months), $r=.83$ (4 months), and $r=.72$ (12 months). The Moral-Religious Emphasis subscale internal consistency was $r=.78$. Test-retest reliability was $r=.80$ (2 months), $r=.91$ (4 months), and $r=.89$ (12 months). The Organization subscale internal consistency was $r=.76$ with test-retest reliabilities of $r=.76$ (2 months), $r=.73$ (4 months), and $r=.81$ (12 months). The Control subscale internal consistency was $r=.67$. Test-retest reliability was $r=.77$ (2 months), $r=.78$ (4 months), and $r=.79$ (12 months) (Moos & Moos, 1986).

Construct validity for the FES was supported by the results of several studies (Moos & Moos, 1986). Cohesion subscale scores were found to be positively related to the Procidano-Heller indices of perceived support from family members and friends. Those reporting higher Cohesion scores also reported

receiving from family members more behaviors indicating social support. Cohesion subscale scores also were found to be positively related, and Conflict scores negatively related, to scores on the Family Routines Inventory measuring situations of two or more family members' behaviors that occur regularly (Jensen, James, Boyce, & Harnett, 1983). Cohesion, Expressiveness, and Conflict were found to be related to the Spanier Dyadic Adjustment Scale (Abbott & Brody, 1985).

The Children's Family Environment Scale (CFES) is a 30 item pictorial adaptation of the FES for children ages 5 to 11 (Pino et al., 1983). Each of the dimensions and subscales of the FES remain. Test-retest reliability over four weeks was $r=.80$. Content validity was measured by assessing the common meaning assigned to each set of pictures by a group of children. All the scales were correctly identified at the $p<.01$ level.

Behavior Assessment System for Children (BASC)

The Behavior Assessment System for Children (BASC) is a multidimensional instrument that assesses the child's, parent's, and teacher's view of the child's adaptive functioning and level of behavioral problems. Three versions of the BASC were used for this study: BASC-Self-Report of Personality (BASC-SRP), BASC-Parent Rating Scales (BASC-PRS), and BASC-Teacher Rating Scales (BASC-TRS) (Reynolds & Kamphaus, 1992).

BASC-Self-Report of Personality (BASC-SRP)

The BASC-SRP evaluates the personality and self-perceptions of children. Two forms are used: one for children ages 8-11 (BASC-SRP-C) consisting of 12 scales, and one for adolescents ages 12 - 18 (BASC-SRP-A) consisting of 14 scales. The BASC-SRP-C contains 152 statements, and the BASC-SRP-A contains 186 statements, each requiring a response of True or False. Four composite scores comprise the BASC-SRP-A and the BASC-SRP-C: School Maladjustment, Clinical Maladjustment, Personal Adjustment, and the Emotional Symptoms Index. These composite scores provide good indications of global problems of personality and behavior (Reynolds & Kamphaus, 1992).

The Clinical Maladjustment composite is made up of the Anxiety, Atypicality, Locus of Control, Social Stress, and, at the adolescent level, Somatization scales. This composite reflects the clinical internalizing problems a child may be experiencing. The School Maladjustment composite consists of the Attitude to School, Attitude to Teachers, and, at the adolescent level, Sensation Seeking scales. This composite is a broad measure of adaptation to school. The scales included in the Clinical Maladjustment composite and the School Maladjustment composite make up the Clinical Scales of the BASC-SRP (Reynolds & Kamphaus, 1992).

The Personal Adjustment composite includes the Relations with Parents, Interpersonal Relations, Self-Esteem, and Self-Reliance scales. The scales included in the Personal Adjustment composite comprise the Adaptive Scales of the BASC-SRP. The Emotional Symptoms Index (ESI) is the most

comprehensive indicator of serious emotional disturbance, particularly internalized disorders. It is comprised of the Social Stress and Anxiety scales from the Clinical Scales, the Interpersonal Relations and Self-Esteem scales from the Adaptive Scales, and the Depression and Sense of Inadequacy scales that are not associated with a composite (Reynolds & Kamphaus, 1992).

BASC-Teacher Report Scale (BASC-TRS)

The BASC-TRS measures adaptive and problem behaviors in the school environment. Three forms are used: one for preschool ages 4 to 5, one for child ages 6 to 11, and one for adolescent ages 12 to 18. Each form contains descriptor phrases (109 for preschool, 148 for child, and 138 for adolescent) that the respondent rates on a four-point scale: never, sometimes, often, and almost always. Five composite scores constitute the BASC-TRS: Externalizing Problems, Internalizing Problems, School Problems, Adaptive Skills, and the Behavioral Symptoms Index (BSI) (Reynolds & Kamphaus, 1992).

The Externalizing Problems composite contains the Aggression, Hyperactivity, and Conduct Problems scales. This composite reflects disruptive behavior problems such as aggression, hyperactivity, and delinquency. The Internalizing Problems composite is made up of the Anxiety, Depression, and Somatization scales. This composite contains scales that measure depression, anxiety, and similar difficulties that are not marked by disruptive behavior. The School Problems composite scales include the Attention Problems and Learning Problems scales. This composite reflects academic difficulties including problems

of motivation, attention, and learning and cognition. These three composites together comprise the Clinical Scales of the BASC-TRS (Reynolds & Kamphaus, 1992).

The Adaptive Skills composite includes the Adaptability, Leadership, Social Skills, and Study Skills scales. This composite summarizes prosocial, organizational, study, and other adaptive skills. It comprises the Adaptive Scales of the BASC-TRS.

The Behavioral Symptoms Index (BSI) is a broad composite score comprised of a combination of central scales from Externalizing Problems, Internalizing Problems, and School Problems composites. The BSI assesses the child's overall level of problem behaviors (Reynolds & Kamphaus, 1992).

BASC-Parent Report Scale (BASC-PRS)

The BASC-PRS measures adaptive and problem behaviors in the community and home environments. Three forms are used: one for preschool ages 4 to 5, one for children ages 6 to 11, and one for adolescent ages 12 to 18. Each form contains descriptor phrases (131 for preschool, 138 for child, and 126 for adolescent) that the respondent rates on a four-point scale: never, sometimes, often, and almost always. Four composite scores constitute the BASC-PRS: Externalizing Problems, Internalizing Problems, Adaptive Skills, and the Behavioral Symptoms Index (BSI) (Reynolds & Kamphaus, 1992).

The Externalizing Problems composite contains the Aggression, Hyperactivity, and Conduct Problems scales. This composite reflects disruptive

behavior problems such as aggression, hyperactivity, and delinquency. The Internalizing Problems composite is made up of the Anxiety, Depression, and Somatization scales. This composite contains scales that measure depression, anxiety, and similar difficulties that are not marked by disruptive behavior. The Externalizing Problems composite and the Internalizing Problems composite together comprise the Clinical Scales of the BASC-PRS (Reynolds & Kamphaus, 1992).

The Adaptive Skills composite includes the Adaptability, Leadership, and Social Skills scales. This composite summarizes prosocial, organizational, and other adaptive skills. The Adaptive Skills composite comprises the Adaptive Scales of the BASC-PRS.

The Behavioral Symptoms Index (BSI) is comprised of a combination of central scales from the Externalizing Problems composite and the Internalizing Problems composite. The BSI assesses the child's overall level of problem behaviors (Reynolds & Kamphaus, 1992).

BASC Reliability and Validity

Test Manual authors (Reynolds & Kamphaus, 1992) reported that general norms for the BASC are based on a large national sample that is representative of the general population of U.S. children with regard to age, gender, ethnicity, and clinical or special education classification. Normative scores provided for each scale include a T score and a percentile. Classifications are given for the Adaptive Scales and the Clinical Scales. Adaptive Scales are classified as Very

High (T=70 and above), High (T=60 to 69), Average (T=41 to 59), At-Risk (T=31 to 40), and Clinically Significant (T=30 and below). Clinical Scales are classified as Clinically Significant (T=70 and above), At-Risk (T=60 to 69), Average (T=41-59), Low (T=31 to 40), and Very Low (T=30 and below), with the exception of the Anxiety Scale on the BASC-SRP for which the Clinically Significant range begins at T=65 rather than T=70 (Reynolds & Kamphaus, 1992).

Three indexes are provided to measure validity: the F Index, the L Index, and the V Index. The F Index is included on all the rating forms and measures the child's, teacher's, or parent's tendency to be excessively negative regarding behaviors or self-perceptions and emotions. The L Index detects an adolescent's attempt to deny problems, either intentionally or inadvertently, reflecting below-average insight into one's own behavior and feelings. To check the validity of the BASC-SRP scores in general, the V Index is used. Two or more of the nonsensical statements marked true may invalidate the BASC-SRP. The V Index may indicate poor reading comprehension, failure to follow directions, or poor contact with reality (Reynolds & Kamphaus, 1992).

Overall, reliability of the BASC-TRS was high (Reynolds & Kamphaus, 1992). Internal consistencies averaged above .80 for the scales of all three age levels. All composite reliabilities except two equaled or exceeded .90, and the reliability of the Behavioral Symptoms Index (BSI) ranged from .95 to .97. Test-retest correlations were reportedly high with median values of .89, .91, and .82 for the scales at the three age levels. Interrater correlations were relatively high,

indicating that different teachers tended to interpret the items similarly. Five other instruments have been correlated with the BASC-TRS. Those BASC-TRS scales and composites measuring externalizing and school problem behaviors correlated highly with the Teacher Report Form (Achenbach, 1991), the Revised Behavior Problem Checklist (Quay & Peterson, 1983), and Burks' Behavior Rating Scales (Burks, 1977) (Reynolds & Kamphaus, 1992).

Reliability of the BASC-PRS was high to moderate (Reynolds & Kamphaus, 1992). Internal-consistency was in the middle .80s to low .90s for the scales of all three age levels. The Behavioral Symptoms Index (BSI) reliabilities ranged from .88 to .94. Scale reliabilities averaged in the mid to upper .70s and were fairly consistent across age levels. Test-retest correlations had a median value of .85 (preschool), .88 (child), and .70 (adolescent) for scales at the three age levels. Retest correlations for the composites were in the upper .80s (preschool), .90s (child), and .70s (adolescent). Interparent reliability was fairly high on the adolescent level scales (.67) but somewhat lower on the preschool (.46) and child (.57) levels scales. The BASC-PRS correlated highly with the Child Behavior Checklist (Achenbach, 1991) and with externalizing scales of the Conners' Parent Rating Scales (Conners, 1989).

The BASC-SRP reliability also was high (Reynolds & Kamphaus, 1992). Internal consistencies averaged .80 for each gender at both age levels. Composite score reliabilities were also very high, ranging from the mid-.80s to the mid-.90s. Retest correlations for the scales at each level had a median value

of .76. The composite retest correlation, with one exception, was in the low to middle .80s. The Minnesota Multiphasic Personality Inventory (Hathaway & McKinley, 1942, 1943 [renewed 1970]), Achenbach's Youth Self-Report (Achenbach, 1985), and the Behavior Rating Profile (Brown & Hammill, 1983) showed a number of high correlations with the BASC-SRP scales.

Beck Anxiety Inventory (BAI)

The Beck Anxiety Inventory (BAI), developed by Beck, Epstein, Brown, and Steer (1988), is a 21-item scale that measures the severity of anxiety in adults and adolescents. The 21 descriptive statements of anxiety symptoms are rated on a 4-point scale with: "Not at all" (0 points); "Mildly, it did not bother me much" (1); "Moderately; it was very unpleasant, but I could stand it" (2); and "Severely; I could barely stand it" (3). The BAI total score is the sum of the ratings for the 21 symptoms. The maximum score is 63 points. Total scores from 0-7 points are considered to reflect a minimal level of anxiety, scores of 8-15 indicate mild anxiety, scores of 16-25 reflect moderate anxiety, and scores of 26-63 indicate severe anxiety.

Test manual authors reported that BAI total scores for women with anxiety disorders may be an average of 4 points higher than for men with anxiety disorders. In addition, BAI total scores are inversely related to age; younger people report more anxiety than do older people (Beck & Steer, 1987).

Beck et al. (1988) studied a subsample of 160 outpatients for their reliability and validity analyses. The sample had the following diagnostic

composition: 40 primary major depression, 11 dysthymic or atypical depression, 45 panic with agoraphobia, 18 agoraphobia with panic attacks, 12 social or simple phobia, 18 generalized anxiety, and 16 as miscellaneous nonanxiety or nondepression disorders, such as academic problems and adjustment disorders. Beck et al. (1988) reported that the BAI had high internal consistency reliability (Cronbach coefficient alpha = .92). They completed a test-retest reliability study on a subsample of 83 outpatients. The correlation between intake and one-week BAI scores was .75 ($p < .001$).

Investigation of concurrent validity demonstrated that the BAI is significantly and substantially related to other accepted measures of both self-reported and clinically rated anxiety. Correlations include .51 ($p < .001$) with the Hamilton Anxiety Rating Scale – Revised (Hamilton, 1959) as reconstructed by Riskind, Beck, Brown, and Steer (1987); .51 ($p < .001$) with the anxiety subscale of the Cognition Check List (CCL-A) (Beck, Brown, Steer, Eidelson, & Riskind, 1987); and .51 ($p < .001$) with the Trait subscale, and .47 ($p < .001$) with the State subscales of the State-Trait Anxiety Inventory (Form Y) (STAI) (Spielberger, 1983).

Beck et al. (1988) used a principal-factor analysis with a promax rotation that yielded two highly correlated dimensions. The first factor represented predominantly somatic aspects of anxiety, and the second factor represented both subjective and panic-related aspects of anxiety. They also found four clusters. The first subscale or cluster included seven symptoms reflecting the

neurophysiological symptoms of anxiety: “numbness,” “wobbliness,” “dizzy,” “unsteady,” “hands trembling,” “shaky,” and “faint.” The second subscale represented subjective aspects of anxiety: “unable to relax,” “fear of the worst happening,” “terrified,” “nervous,” “fear of losing control,” and “scared.” Symptoms of “heart pounding,” “feelings of choking,” “difficulty breathing,” and “fear of dying” represented the third subscale and were considered to be typical of those experienced by patients during panic attacks. The fourth subscale symptoms included “feeling hot,” “indigestion,” “face flushed,” and “sweating,” suggesting primarily autonomic aspects of anxiety. All correlations between the clusters were significant beyond the .001 level (Beck & Steer, 1987).

Beck Depression Inventory (BDI)

The Beck Depression Inventory-Second Edition (BDI-II) is a revised version of the BDI (Beck, Ward, Mendelson, Mock, and Erbaugh, 1961), a widely accepted instrument for assessing the severity of depression in diagnosed patients and for detecting possible depression in normal populations aged 13 years and older (Beck, Steer, & Brown, 1987). The BDI-II was developed for the purpose of assessing depressive symptoms consistent with the DSM-IV (1994).

The instrument consists of 21 groups of statements. The examinee chooses one statement from each group that best describes the way he or she has been feeling during the past two weeks. The ratings are summed for the 21 items, with a maximum total score of 63. Scores are interpreted according to guidelines derived through the use of receiver operating characteristic curves: 0

to 13 is minimal, 14 to 29 is mild, 20 to 28 is moderate, and 29 to 63 is severe (Gleitman, 1986).

Psychometric characteristics of the BDI-II were investigated using various psychiatric outpatient samples and a college-student sample. The internal consistency coefficient alpha was .92 for the outpatients and .93 for the college students. Estimated test-retest stability, with an approximately one week interval between administrations, resulted in a significant correlation of .93 ($p < .001$).

Construct validity of the BDI-II was estimated through several analyses. All correlations were significant beyond the .001 level. Examples include a study using outpatients from Kentucky where the correlation between the BDI-IA and BDI-II was .93 ($p < .001$), and a study using outpatients from Philadelphia where the correlation between the take-home BDI-IA forms and the BDI-II forms was .84 ($p < .001$). The BDI-II factorial validity was provided by the intercorrelations among the 21 BDI-II items. Kaiser's measure of sampling adequacy (Dziuban & Shirkey, 1974) was .95. Underlying cognitive-affective and somatic dimensions were highly correlated for both outpatients and students. No significant correlation existed for race/ethnicity; however, significance with respect to gender was found. The mean BDI-II total score for female students was significantly greater than for male students.

Selection of Participants

Participants included families referred from the Child Life Department at Children's Medical Center of Dallas (CMC), a division of The University of Texas

Southwestern Medical Center in Dallas, Texas. Referred families had received services during the diagnosis, treatment, and death of one of their children. At CMC, the ill child and family members may have occasionally received play therapy and/or filial therapy. In addition, families received general emotional support from Child Life Specialists, Social Workers, and/or Hospital Chaplains. When appropriate at CMC, referrals were made to a hospice program at St. Paul's hospital. The goal of the Child Life program at CMC is to develop a trusting personal relationship with each ill child and their family members and to provide therapeutic and educational activities based on individual, developmental, and medical needs. At the ill child's death, however, services for remaining family members end abruptly. The Director of Child Life and the Child Life Specialists at CMC have begun recently to advocate that CMC add a full continuum of care by implementing a bereavement team to develop a program for families at CMC.

Beginning in March, 1999, the hospital social workers and hospital chaplains implemented a bereavement follow-up program for families at CMC. At the time of death, each family has been offered a memory box into which they may choose to place any of the following memorabilia of the deceased child: a Polaroid photograph, an ID band, a lock of hair, fingerprints and/or footprints, and personal belongings. Further services have been offered to parents. These include resources and referrals, including where to go for help; books and references for family members; and contact information for specific counselors.

Follow-up services also have included an invitation to attend a bereavement group facilitated by a hospital social worker that meets once a month at the hospital; condolence letters that have been mailed at intervals of two weeks, two months, six months, and eleven months after the child's death; and mailed invitations to the Annual Memorial Service held at Children's Medical Center. No follow-up services have, as yet, been developed for siblings of the deceased child or for the family unit as a whole.

In anticipation of this study, I met with the Director of Child Life and two Child Life Specialists (CLS) at CMC. Together we developed an invitational letter and flyer (Appendix A) announcing the offering of "Camp Sol - Healing the Family Heart", a pilot program consisting of a weekend offering a variety of activities for families, both adults and children, and three follow-up activity sessions. We utilized the term "pilot program" in lieu of "research study" in an effort to attract families who might initially feel intimidated by the idea of participating in a "research study."

Criteria developed for participation in the study included: (a) a family with at least one parent or guardian and one or more of his/her/their living children between the ages of 3 years and 18 years who have lost one or more of his/her/their children to death within the past 2 to 36 months; (b) all family members able to verbally communicate in the English language well enough to participate in the activities; (c) all family members 5+ years of age able to complete pre-tests and post-tests; (d) all family members willing and able to

attend the weekend grief camp, “Camp Sol - Healing the Family Heart”, at Camp John Marc, and no fewer than two follow-up sessions of expressive arts therapy; (e) all family members willing to sign the consent to participate form; and (f) the family not currently receiving expressive arts therapy or any other bereavement counseling, except the monthly bereavement parent support group at CMC.

I did not discriminate on the basis of gender, race, religion, or ethnic background of participants. I did discriminate on the basis of age, reflecting the inability of a very young child below the age of three to participate in several of the activities in a way that would allow parents and/or siblings to experience meaning from the activities. I obtained demographic information for adults and children through a demographic form (adapted from Bratton & Webb-Ferebee form for The Child & Family Resource Clinic at The University of North Texas) the participating parents completed (Appendix C).

The CLS identified 50 families as potential participants who met the first three criteria for participation in the study. They mailed each family a registration packet comprised of an invitational letter, a flyer, and registration forms to be completed and returned by the deadline date (Appendix A). Potential participants responded to two options on the registration forms: (1) My family would like to register for “Camp Sol – Healing the Family Heart,” and (2) My family is unable to register for “Camp Sol – Healing the Family Heart;” however, we want to register for and attend the three free family activity sessions beginning the week of May 1, 2000.”

The CLS and I set the camp limit to the first 15 families whose completed registration packets we would receive by the deadline date. We determined the number of families accepted by the amount of the grant we had received to operate Camp Sol. If more than 15 families had registered, those families in addition to families who chose the second option on the registration form would have comprised the control group.

We received eleven registration packets. Several of the families who responded made telephone contact to express fears and concerns to the CLS and to me about “dragging up the pain,” the fathers and adolescents being the most reluctant to attend camp. Despite several lengthy consultations with me and/or the CLS, one week prior to camp one family withdrew. Camp commenced on March 24, 2000, and that afternoon two more families withdrew due to conflict within the families about attending a grief camp, leaving eight families (27 participants) who remained for the duration of the camp and who completed the study.

No families expressed interest in option two on the registration form; however, several families telephoned the CLS and stated that they were unable to attend camp and were interested in receiving future information about camp. Despite many attempts by the CLS to solicit these and other qualifying families to participate in the control group, only three families agreed. One family later declined, while two completed only pretests and would not complete or return posttests. Consequently, this study proceeded without a control group.

Prior to the onset of the study, each family signed up to attend a group orientation on either March 13 or March 19, 2000 at my office. At the orientation, despite the fact that childcare was provided, it became obvious almost immediately that the group format would involve too much distraction to make the orientation viable or effective. Therefore, I directed each family into a separate room and explained the purpose and the requirements for participating in the pilot program. I also explained that the structure of the pilot program was a research study; the family could opt not to participate in the pilot/research and, instead, to participate in a future camp that probably would not involve research. All families chose to participate.

I oriented the families to expressive arts therapy and provided them with materials (beads, markers, stickers, feathers, elastic, and tags) to create their camp nametags before leaving the orientation. I also provided information about how confidentiality would be maintained, and I encouraged them to ask any questions before signing the consent form (Appendix B) and completing pretest instruments. I also gave participants the opportunity to receive a summary of the results of this study (Appendix B). All families chose to receive the results.

The location we selected for “Camp Sol - Healing the Family Heart” was Camp John Marc, a facility in the north end of the Texas Hill Country about 85 miles southwest of Dallas. Additionally, participants met for three follow-up sessions. I honored the parents’ requests by facilitating two of these sessions in participants’ homes, then I secured Scottish Rite Hospital’s Shriver’s Park for the

third follow-up event.

The only cost to families for this study included their registration fee of five dollars per family and their transportation to and from the camp and the follow-up sessions. Assistance was made available for families who requested help with transportation; no help was requested. A \$5,000 grant from the Chip Moody Foundation provided the lodging, meals, and camp materials, and participants attended the follow-up sessions at no charge. I (Webb-Ferebee) arranged for childcare to be provided during orientation, camp, and the final session.

The experimental group families were comprised of 7 mothers, 2 grandmothers, 1 grandfather, and 9 children. The parents ranged in ages from 26 to 66 years of age, and the children ranged in age from 3 to 15 years of age. The experimental group families were approximately 64% European American, 16% African American, 16% Hispanic-Latin American, and 4% Bi-racial. Of the experimental group parents 30% did not complete high school, 7% earned a GED, 4% completed trade school, 26% completed high school, 11% completed some college, 19% completed college, and 4% completed a master's degree. The marital status of the experimental group families was 75% married and 25% divorced. Annual family income ranged from less than \$10,000 to over \$90,000.

The University of North Texas Office of Sponsored Projects and Grant Accounting Institutional Review Board approved the Application for Approval of Investigation Involving the Use of Human Subjects to conduct this study. In addition, The University of Texas Southwestern Medical Center of Dallas

Institutional Review Board approved the Application for Review of New Research Involving Human Subjects that described this study.

Collection of Data

All families who participated in the study completed pretest and posttest instruments. They completed consent forms, adult and child demographic sheets, and pretest instruments at the orientation for families. Pretest instruments included 1) Family Environment Scale (FES), 2) Behavior Assessment for Children (BASC), 3) Beck Anxiety Inventory (BAI), and 4) Beck Depression Inventory (BDI). Also at the orientation, parents supplied the child and teacher/childcare provider contact information for the BASC-TRS that consisted of the child's name and birth date, the school's address, and the teacher/childcare provider's name for the administration of the BASC-TRS. In the event an older child had more than one teacher, the child was asked to choose the teacher to receive the instrument. In this case, in the hope that the teacher would consult with colleagues, the letter to the teacher/childcare provider specified that when the child had more than one teacher, a consensus of all teachers would be preferred.

The week following the orientation, I mailed a packet to the teacher/childcare provider of each child that consisted of 1) a letter explaining the child's participation in the research study and instructions for completing the BASC-Teacher Report Scale (BASC-TRS) (Appendix B); 2) the BASC-TRS instrument with identifying information already completed by the parent; 3) a

business card with my name and phone number, in the event the teacher/childcare provider had any questions; and 4) a self-addressed, postage paid envelope for mailing upon completion. Several teachers did request copies of signed consent forms authorizing them to release information about the child they were assessing.

Eight weeks after the camp weekend, at the conclusion of the third follow-up event, parents received a posttest packet from me that included 1) posttest instruments identical to the pretest instruments, 2) final evaluations, and 3) a self-addressed, stamped envelope. I requested the parents to return to me in the postage paid envelopes the posttest instruments, final evaluations, and journals. The children completed their posttest instruments and final evaluations at the conclusion of the third follow-up event. Counselors were available to assist the children, if needed.

The week following the final follow-up event, I mailed teachers/childcare providers packets containing 1) a letter explaining the conclusion of the research study and instructions for completing the posttest instrument, 2) a posttest instrument identical to the pretest instrument, 3) a business card in the event the teacher/childcare provider had any questions, and 4) a self-addressed, stamped envelope. All teacher/childcare providers completed and returned the posttest in the self-addressed, stamped envelopes.

On both occasions I was available to answer any questions family members may have had regarding the battery of instruments. The assessments

required approximately 30 minutes to complete, and the final evaluations required approximately 30 minutes or more to complete.

The information provided on the instruments and final evaluations was kept confidential. I maintained participants' confidentiality by using a code number for each participant on information obtained from the instruments and evaluations. Only the CLS and I have a copy of the participants' names that were, at the request of the families, placed on the Camp Sol mailing list for future mailings and activities, but not in any way identified as study participants.

Procedures For Implementing Expressive Arts Therapy

For "Camp Sol - Healing The Family Heart" Weekend

Based on my anticipated enrollment of 15 families, I invited 20 students from the University of North Texas (UNT) counseling program to assist in the study as volunteer counselors: some who had recently completed the master's program, some who were completing a master's field practicum, and some who were doctoral students. Other counseling program students also expressed an interest in volunteering if I needed them. Once I received the families' registration forms and knew the ages of the child participants, I determined I would need only 13 counselors during the camp weekend for the facilitation of expressive arts activities for multi-family groups, developmental age groups, parent gender groups, and individual family groups. I chose the 13 counselors I considered to have the best clinical skills and to have specializations in counseling related to grief, family, child, expressive arts, and/or group counseling. In particular, I

wanted a play therapist assigned to each family, as well as play therapists for the children's groups. I also wanted counselors with group expertise and who were skilled with adults. Of the 13 counselors who participated, 10 had trained in play therapy.

I facilitated a four-hour training session module for the counselors that focused on grief theory, on confidentiality issues, and on expressive arts activities planned for the weekend camp. Counselors received camp information, activity and staffing schedules, and co-leader assignments for group work (Appendix D). I facilitated the follow-up sessions for the families.

Expressive arts activities for this study utilized a combination of didactic and experiential components designed to foster emotional healing, resolve inner conflict, and awaken individual and family creativity. The counseling staff worked to create an environment in which participants would feel safe enough to express and explore thoughts and feelings surrounding the loss of their family member.

I requested counselors to remind the participants that while they were encouraged to participate, they were not required at any time to talk about their art creations with anyone. In addition, I asked them to clarify their roles to family members in the following ways: first, to let the participants know that art is recognized as a very personal experience and that the person creating the art is the only one who can assign meaning to a piece of work; and second, that the counselor is there to help family members gain understanding of their own expressions, never to determine for them what their expressions mean (Davis,

1989; Fryrear & Corbit, 1992).

For each of the activity sessions, I requested counselors to stay continually aware of and be sensitive to the emotional needs of the group members in selecting appropriate activities and art media for expression. I also requested that instructions given by the counselor during the sessions be adapted to the developmental cognitive level of the youngest participants of the group. During the processing of each activity, I asked the counselors to give feedback to participants that could facilitate heightened awareness of feelings, thoughts, and/or behaviors as related to their deceased loved one, to themselves, to others, and/or to their world.

Expressive Arts Activities—Camp Sol

Friday evening

The weekend camp began on Friday evening, March 24, 2000. Upon arrival to camp (see Appendix E, Figures 1 - 6) at approximately 6:30 p.m., camp staff assigned the families to their cabins. At registration, each family created a family flag out of brightly colored felt, sponge letters, a wooden flagpole and stand, and a variety of craft materials. Each family placed their flag on a table in the dining hall (see Appendix E, Figure 7 - 8). The flags were centerpieces as well as markers for families, especially young children, to find their eating space. I provided snacks for everyone prior to the opening group session.

The opening group session began with the families and the counselors gathering in a large circle in the dining hall. There, I welcomed the families and

introduced the counselors and staff. The families were invited to play, “Family Bingo,” an ice-breaker game (Appendix E) designed to help the families get acquainted with each other and to help begin the process of building a safe environment for the weekend activities. I gave each family a sheet of paper with 25 squares. Each square contained a characteristic that could pertain to a family such as, “likes to go camping,” “has a computer at home,” “has a dog and cat at home,” and “owns a blue car or van. I instructed the families to find other families who fit the criteria in each square and to have them sign the square(s). The family with the most signatures by the 15-minute time limit received a prize.

After “Family Bingo” I led singing with my guitar. Everyone participated in the singing and movement song “If You’re Happy and You Know It” with added verses and movements for sad, lonely, angry, and guilty feelings (Appendix E). I then taught the song “Circle of Friends” by Jim Newton (Appendix E). “Circle of Friends” was sung at different times throughout the weekend. I chose the first song, a familiar tune, with added movement, for all ages, as a possible outlet for tension, excitement, and anxiety. I also chose the first song to help communicate that Camp Sol could be a place where people can feel safe openly expressing feelings that are usually not expressed openly and in ways that children can also feel comfortable expressing themselves. The second song, “Circle of Friends,” I chose to hopefully encourage families to reach out, to get to know each other, and to support each other.

Prior to introducing the first multi-family group expressive arts activity, I

provided journals and pens to family members. I asked them to record their thoughts, feelings, and experiences for the duration of the study. In addition, I encouraged them to decorate their journals and to use any art media they wished in expressing themselves in their journals. I wanted participants to have a private and intimate venue for expressing personal reactions and experiences during the study as well as possibly raising self-awareness and stimulating growth. I told the family members that I would collect their journals and other creative products of the weekend, that I would arrange for their journals to be typed and their art products photographed, then would return their originals to them.

In addition, as an ongoing expressive arts activity for the weekend, I placed a 4' X 6' paper maché heart (see Appendix E, Figure 84) and a tray of markers on a table in the dining hall. I told participants that the heart and markers were there for them (1) to express ways they had learned to take care of themselves that they would like to share with others, (2) to place their own names and the name of their family member who died, and (3) to convey messages they may wish to send to their deceased child. Having the heart available on an ongoing basis allowed for the possible outer expression of mourning and possible support for and from others.

I introduced the multi-family expressive arts activity, "family mural puzzle" (see Appendix E, Figures 9 -16), by asking each family to choose a puzzle piece that had been cut out of large white poster board. I then asked them to create, using a variety of art media (Appendix D), a visual image of "who their family is

and why they are at Camp Sol.” During the activity counselors began forming relationships with families by assisting wherever they saw a need for their help and especially with young children so parents could focus on their own expression.

Upon completion, I enlisted the families to find the other family(ies) that had the puzzle piece(s) that fit onto their piece. Once all the pieces were finished and put together, they made a long mural. I requested the families to tell about their puzzle piece, to describe their family, to describe themselves, and to state their reason(s) for attending camp. I especially invited the children to participate by telling about their family’s puzzle piece they helped create. The counselors mounted the mural on the dining hall windows where it stayed for the remainder of camp.

The “family mural puzzle” activity was approximately one and one half hours in length. I wanted to provide an enjoyable vehicle for the whole family unit to participate in exploring and disclosing their family identity with others and to be able to talk openly about themselves and their loss. In addition, I hoped this activity would set the tone for the entire weekend by fostering a sense of a larger group identity as well as each family having their own individual family identity. Every family piece was one part of the whole, the whole representing all of the families whose common loss brought them together for Camp Sol.

Following the processing of the mural puzzle pieces, the camp staff lit a bonfire at the lake for everyone who opted to attend. Most families attended at

least a portion of the bonfire at which camp staff entertained them with songs and storytelling. Camp staff also invited everyone to roast marshmallows and make s'mores. After the bonfire, I held a staffing meeting with the counselors to process their experiences throughout the evening and to discuss plans for Saturday. The terms "counselor" and "facilitator" are used interchangeably for the remainder of this section describing the camp weekend expressive arts activities.

Saturday Morning

Following a family style breakfast at 8:00 a.m., I called for the families to break out into family groups for a session from 9:00 – 11:00 a.m. Two or more facilitators were assigned to each family, depending on the size, ages, and special needs of each family. The facilitators took their families to a secluded area on the campgrounds. There, facilitators provided each family with a large block of low-fire white modeling clay, a cardboard tray, a small container of water, a supply of paper towels, and a variety of tools designed for sculpting clay, and then gave directions for a two-part "Clay Animal Sculpture Activity."

For the first part of the activity, facilitators asked the family members to get acquainted with their clay by closing their eyes and exploring it with their hands. Using a slow gentle process, they guided family members to squeeze, pinch, poke, pound, and roll the clay. Once acquainted with their clay, facilitators told family members to "think of an animal you identify with or that you are most like or that best symbolizes you. Make that animal out of your portion of clay. Your animal doesn't have to be real; it can be a creation or a compilation of several

animals” (Bratton & Webb-Ferebee, 2000; Oaklander, 1988).

When the clay sculptures were finished, facilitators asked family members to tell each other about their animals and to tell why they chose that particular animal. I encouraged facilitators to tailor their questions to fit the needs of the family. I also gave them some questions from which to choose to help family members clarify their descriptions of their sculptures: “What are the strengths and shortcomings of your animal? How does your animal get along with other animals? What kinds of things does your animal like to do? What does it wish it could do? What does it wish it didn’t have to do? What does your animal need?” (Bratton & Webb-Ferebee, 2000).

For the second part of the activity, facilitators asked the family to take a walk on the camp grounds and pick out a few objects of nature that would help them as a family to create the perfect home for their animals. When they returned, the facilitators asked them to construct a home for their animals and to place their animals where they would be most comfortable in their new home. Questions I had suggested that facilitators consider using to help the family clarify their experience included: “Why did you pick that spot for yourself? What do you like best about it? If you could change something, what would it be? Does your home need anything else? Is there anything you would miss if you lived here?” (Bratton & Webb-Ferebee, 2000).

The clay animal sculpture activity (see Appendix E, Figures 17 - 28) provided each individual family with an opportunity to discover and learn about

themselves and each other in a non-threatening way through an expressive, sensory, non-verbal process. Facilitators observed how family members related to one another with the hope of gently assisting them in becoming more aware of expressed needs that were projected onto the sculptures, a way of promoting a greater level of intimacy among family members.

Following the clay animal sculpture activity, families had an hour of free time. Families signed up for a variety of unstructured camp activities scheduled for that time, including ropes course, fishing, sports, arts and crafts, cooking, resting, or taking walks. After a family-style lunch, families reconvened for the afternoon break out session scheduled from 1:00 to 4:00 p.m.

Saturday Afternoon

For the afternoon break out session mothers went to the arts and crafts room, fathers went outside behind the dining hall, and children went with their developmental age groups. Each group had two or more facilitators, depending on size and need.

Mothers' "Altar-Making" activity, 1:00 – 3:00 p.m. Facilitators provided the mothers with a variety of baskets, fabrics, netting, ribbons, tissue paper, construction paper, markers, paints, beads, feathers, silk flowers, candles, and candleholders, etc., and asked them to create an altar to their child who died (see Appendix E, Figures 29 - 35). Mothers were invited to include two handwritten notes, one to themselves from their child, and one from themselves to their child to place in the basket. Music was played in the background during the

construction of the altars. When the altars were finished the facilitators asked the mothers to form a circle, to light their candles, and to tell about their altars and what it was like creating their altars. I encouraged the facilitators to openly acknowledge how very personal this experience may have been for the mothers and to emphasize that there was no pressure to share beyond their individual comfort levels.

Fathers' "Altar-Making" activity, 1:00 – 3:00 p.m. Facilitators provided fathers with an assortment of wood pieces, hammers, nails, saws, sandpaper, paint and brushes, candles in glass containers, a variety of art media, and asked them to create an altar to their child who died. Once they completed their altars, the facilitators asked the fathers to bring themselves and their altars into a circle, to light their candles, and to tell each other about their altars and what it was like building the altars. I encouraged the facilitators to openly acknowledge how very personal this experience may have been for the fathers and to emphasize that there was no pressure to share beyond their individual comfort levels.

Parent groups, 3:30 – 4:00 p.m. I requested all parents to bring their altars and to meet in groups of six with spouses together. Each group of six met with a single facilitator. Facilitators asked the parents to briefly tell each other about their altars and their experiences in making their altars.

The gender group "Altar-Making" activity allowed parents to share significant gender-related experiences, to hopefully experience the common bond of being a mother or father who has lost a child, and to have an opportunity to

grieve with other mothers or fathers. The six-member parent groups served several purposes. These included having a chance to hear what it was like to be in the mothers' group or fathers' group, to gain insight into the similarities and differences inherent in each group, and to increase mutual awareness and appreciation of each other's individual journeys.

Children's group ages 3-5. Three facilitators served as counselors for the four children in this group. I provided the facilitators with a list of various developmentally appropriate activities (Appendix E) for their selection, depending on the needs of the children. Initially, the facilitators decided to begin with approximately 15 minutes of unstructured free play, in which the children were able to choose from a variety of activities such as running, playing with balls, drawing with sidewalk chalk, or playing in the sand.

From the unstructured free play, the facilitators moved into a brief structured circle activity (Appendix E), for approximately 10-15 minutes. They asked the children to state the name of their sibling who died, to draw a picture of their sibling, and then to show the group their picture and to tell the group about their sibling. The facilitators chose the circle activity to provide an opportunity for the children to experience other children the same age who also have lost a sibling and to provide an opportunity for commemoration in the grieving process.

The next activity, approximately 15 minutes in length, was creative movement to music (adapted from Oaklander, 1988) using large colorful silky fabric squares, approximately 4' x 6'. The children chose the color of fabric they

liked best. The facilitators introduced the activity by telling the children that when they heard the music, they were to dance with the fabric. When the music stopped, the children were to freeze, notice how they felt, and start moving when the music started again. The facilitators used this activity to help the children get in touch with what their muscles do when they are asked to move in specific ways to express emotions and to help them discover ways of expressing outwardly rather than inwardly.

After the movement activity, the facilitators chose to do a structured 20 minute activity, "Body Drawings" (see Appendix E, figure 40). Facilitators asked the children to lie down on long, wide pieces of white butcher paper, large enough for the children to be comfortably traced, and then facilitators traced the children's bodies with black markers. The children then expressed themselves by painting their body drawing with poster paints "to look like them." Facilitators chose the body drawing activity to help the children attain greater body awareness and to help them become conscious of how they use color to depict themselves in their bodies.

The 3-5 year old group ended with a final period of unstructured free play. Throughout the entire group time, facilitators used a combination of directive, didactic, non-directive, and limit-setting responses seeking to create an atmosphere of safety that would foster the children's free expression of thoughts and feelings. In keeping with the developmental needs of 3-5 year olds, the facilitators alternated between short periods of structured and unstructured

activities and of highly active and moderately still activities, allowing time for expression of both verbal and nonverbal experiences.

Children's group ages 6-8. One counselor facilitated this group of three children. The facilitator chose activities based on the developmental level and on the observed needs of these particular children. This group worked outside in a space with access both to a large open concrete area and to a large grassy area with trees. The group formed a circle, put all of their art supplies close by, and talked about what they wanted during group time.

They began group time with the "Magic Power Shield Activity" (Appendix E), a structured activity of approximately 30 minutes in length. The facilitator gave each child a shield made of poster board and wood. She asked the children to think about colors, shapes, or objects that represented power and strength to them. The children talked about fearful experiences and ways to keep safe. They decorated their shields with a variety of art media, portraying images and symbols of safety for themselves (see Appendix E, Figure 36). They told each other how they could use their shield to help them feel safe. The facilitator chose the "Magic Power Shield Activity" to help the children explore their sense of feeling safe or unsafe (adapted from The Dougy Center).

For the next activity, "Body Drawings" (Appendix E), approximately 25 minutes in length, the facilitator traced the children's bodies on large pieces of butcher paper. She then encouraged them to color their body drawing by showing where in their body they felt different feelings and by drawing what these

feelings looked like to them. The facilitator chose this activity to help guide the children into greater body awareness and to help them connect to their own felt sense of experiencing within their bodies.

In between the body drawings and the next structured activity, the children participated in unstructured free play for approximately 20 minutes. They sang songs, marched around, blew bubbles, made wishes on the bubbles, and popped and/or chased the bubbles. Free time served as an opportunity to release anxiety, frustration, and/or aggression that may have arisen during the structured activities.

The next structured activity was “Feeling Masks” (Appendix E) and was approximately 20 to 25 minutes in length. The facilitator invited the children to brainstorm all the feelings they ever remembered feeling. She talked about how we sometimes hide our feelings and do not allow other people to see our feelings on the outside. She then asked the children to give examples of how they hide their feelings.

The facilitator handed plain white paper plates to the children and asked them to paint the inside of the plate with feelings they sometimes feel on the inside, and on the outside of the plate to paint what feelings they show on the outside (see Appendix E, Figure 37). They discussed with the group the differences between the group member’s inner experiences and their outer expressions of feelings. The activity provided them an opportunity to express their feelings nonverbally and to increase their awareness of how they choose to

express themselves (adapted from The Dougy Center).

The final structured activity for this group was “Summer Solstice” (Appendix E) and was approximately 25 minutes in length. The facilitator gave each child a yellow circle made of construction paper. She asked the children to create on their circle either a letter to their sibling who died or a memory of their sibling who died (see Appendix E, Figure 38). When finished, they punched a hole at the top of their circle and put a ribbon through the hole to make the circle ready to hang on a tree. As they hanged their circle on a tree, each child shared a memory of their sibling who died. The “Summer Solstice Activity” provided the children with an opportunity for commemoration in the grieving process (adapted from The Dougy Center). The facilitator concluded the group time with another period of unstructured free playtime, approximately 20 minutes in length.

Throughout the group time, the facilitator used a combination of directive, didactic, non-directive, and limit-setting responses seeking to create an atmosphere of safety that would foster the children’s free and open expression of thoughts and feelings. In keeping with the developmental needs of 6-8 year olds, the facilitator designed moderate length periods alternating between structured and unstructured activities and between highly active and moderately still activities, allowing time for expression of both verbal and nonverbal experiences.

Children’s group ages 10-15. Based on the pre-registration of families, facilitators originally planned two separate groups, one for pre-adolescents and one for adolescents. The facilitators of the two groups and I discussed the

possibility of combining the groups because only one adolescent attended camp. We decided to ask the children for their preference, which was to combine the groups. This group met in a tree house. As they were hiking to the tree house with their facilitators, the group members and facilitators began forming relationships by asking general questions of each other such as age, grade in school, cabin number at camp, etc.

Upon arrival at the tree house, the group began their first structured activity, “Wave Goodbye” (Appendix E) approximately 40 minutes in length. The facilitators introduced the activity by talking about hands and by having the group touch their own hands, pull their fingers, rub the front and back of their hands, and shake them. The group talked about what hands can do and demonstrated by waving, applauding, hugging, shaking hands, etc. The facilitators provided art materials so the group members could trace their hands, cut them out, and decorate them (see Appendix E, Figure 39). Facilitators asked the children to write a goodbye message on each finger of the cut out hand. They then encouraged the children to use their decorated hands to say goodbye to their sibling who died. The facilitators chose the “Wave Goodbye Activity” to provide an opportunity for the children to experience saying goodbye in the grieving process (Adapted from The Dougy Center).

For the duration of group, facilitators alternated 25 minutes of unstructured free time with same length or longer structured activities. The children chose to play basketball and make jewelry during their unstructured free

times.

For the next structured activity, “Summer Solstice,” the facilitators asked the children to cut a circle out of yellow construction paper and to decorate it with memories of their sibling who died, or with a special recollection of their sibling who died. When completed, they punched a hole at the top of the circle and put a ribbon through the hole to make the circle ready to hang on a tree. As the children hanged their circles on a tree, they shared a memory about their sibling who died. The “Summer Solstice Activity” provided the children with an opportunity for commemoration in the grieving process (adapted from The Dougy Center).

The facilitators began the group’s final activity, “feeling masks,” by inviting the children to brainstorm all of the feelings they ever remembered feeling. The group talked about how people sometimes cover up their feelings and do not allow other people see their feelings on the outside. The facilitators asked the children to give examples of how they cover up their feelings. They handed paper plates to the children. They asked the children to write on the inside of the plate one feeling they sometimes feel and then to write on the outside of the plate to write the feelings show on the outside. They discussed with the group the differences between the group member’s inner experiences and their outer expressions of feelings. The activity provided them an opportunity to express their feelings nonverbally and to increase their awareness of how they choose to express themselves (adapted from The Dougy Center).

Throughout the group time, the facilitators used a combination of directive, didactic, non-directive, and limit-setting responses seeking to create an atmosphere of safety that would foster the children's free and open expression of thoughts and feelings. In keeping with the developmental needs of 10 to 15 year olds, the facilitator alternated between longer periods of structured activities and moderate periods of unstructured activity, allowing time for the expression of both verbal and nonverbal experiences.

Saturday Evening

During family free time from 4:00 to 6:00 p.m., families signed up for any of a variety of unstructured camp activities. These activities included rock climbing, fishing, sports, arts and crafts, cooking, resting, or taking walks. I gave each family a "Nature Scavenger Hunt" activity to bring back after dinner.

I scheduled a staff meeting during family free time for counselors to process the afternoon activities and to plan a skit for the talent show. Camp staff served a family-style dinner at 6:00 p.m. The talent show began at 7:00 p.m. Just prior to the show, families presented their objects for the nature scavenger hunt, and all children won prizes. These prizes included candy and stuffed animals. The talent show began with the counseling staff skit. After the counselor's skit, many children performed their own skits, some in spontaneously-formed small groups, others alone. When the talent show ended, the camp staff built a campfire in the fireplace indoors and entertained by telling stories and singing songs. For a late night snack, participants roasted marshmallows and made

s'mores.

Sunday Morning

Camp staff served a family-style breakfast at 8:00 a.m. I facilitated a parent group session from 9:00 to 10:30 a.m. During the large group session, parents addressed personal issues and any concerns they had regarding the camp experience and the study. They gave feedback on what they wanted for themselves and for their families for the follow-up meetings. While the parents were meeting, the children played outside, participating in large group activities such as running games and circle games. In addition, the children decorated flowerpots for planting flowers during the remembrance service.

The parents joined their children at 10:30 a.m. The families decorated containers full of unique rocks and minerals for a "family ritual with rocks" activity (Appendix E), and decorated a 5" X 7" picture frame (see Appendix E, Figures 43 - 47). One at a time, families posed for a photograph with the paper maché heart the families had been decorating all weekend (see Appendix E, Figures 41-42). I later placed the photographs in the picture frames each family had decorated and gave them to the families at the final follow-up session. In addition, counselors took an individual Polaroid photograph of each participant on the campgrounds that I saved for a phototherapy family collage activity scheduled for completion during the final follow-up session.

While families were working on their projects, the camp staff moved the parents' altars/memorials to the chapel and prepared for the "Remembrance &

Celebration Service.” The families carried their decorated flowerpots as they walked to the chapel. They set their memorials in a semicircle and lit the candles. Reverend Melissa Graham served as the Chaplain for the service. The service, approximately one hour in length, focused on the elements of grief--anger, sadness, hope, and relief--and included music, readings, and group participation (Appendix E).

As a closure for the service and for the camp, the families and counselors gathered as a community, formed a circle, held hands, and sang “Circle of Friends” together, the song they learned the first night of camp. A counselor then led a rhythmical activity, “Rain” (Appendix E). “Rain” is a nonverbal activity that begins with one person rubbing hands together and moving one by one to finger snaps, hands slapping thighs, and feet stomping on the ground and going back through the movements and sounds again in reverse order. The activity ends with arms above one’s head forming a sun (see Appendix E, Figure 48). This activity personified a rainstorm (anger, hurt, tears) building to its peak and then subsiding into stillness as the sun (memories of good times that peek through and warm up the sad times) begins to shine through and create a rainbow (hope, protection).

Following the Remembrance and Celebration Service, parents expressed the desire to take group photographs of children together, mothers together, fathers together, families together, and counselors together (see Appendix E, Figures 49 - 53). I took photographs of the clay sculptures, memorials, and

artwork (Appendix E, Figures 1 - 47). I kept the photographs, and the participants took their artwork home with them.

The counseling staff met for lunch at 1:00 p.m. Following lunch, I facilitated a debriefing session for approximately 1½ hours. The counselors formed a circle and processed their personal experiences. In addition, they offered feedback regarding the overall effectiveness and flow of the camp.

Expressive Arts Therapy—Follow-up Sessions

I scheduled three follow-up sessions held over a six-week period with approximately one week in between the sessions. I served as the facilitator for these sessions; however, I enlisted the help of several of the camp counselors to assist with the final multi-family session.

Follow-up Session One

One of the fathers held the first follow-up session for fathers at his home. The session began with the fathers telling, one at a time, how their lives had been progressing since the camp experience. I introduced a collage activity to the fathers with the following theme: “What has helped each of you get through the experience, thus far, of the diagnosis, the treatment, and the loss of your child from a chronic illness.” They each chose a large sheet of colored construction paper, a pair of scissors, a glue stick, and several magazines. Then they created their collages (see Appendix E, Figures 54 - 58) and processed them with one another. While this session was originally scheduled for two and a half hours, the fathers continued processing for approximately four hours and,

once the session concluded, a few fathers resumed their discussion at a nearby coffee shop.

One of the mothers held the first follow-up session for mothers at her home. I followed the same protocol as with the fathers. The mothers began by telling, one at a time, how their lives had been progressing since the camp experience. I introduced, and they participated in, the same collage activity as in the fathers' group (see Appendix E, Figures 59 - 67). Like the fathers, the mothers continued processing for approximately four hours and probably would have continued had I not facilitated closure.

Follow-up Session Two

One of the couples held the second follow-up session for parents at their home. The session opened with parents telling, one at a time, how their lives were progressing. I divided them into gender groups and gave each group two large pieces of poster board and some colored markers. I asked each group to choose a writer and a speaker for the group. Then I requested each group to generate three lists: (1) a list of what they felt they needed from their spouse, (2) a list of what they thought their spouse needed from them, and (3) a list of what they thought their surviving children needed from them.

Following a short break, the two groups reconvened and processed their lists with each other. I invited each parent to choose one item from their spouse's list that they would be willing to provide their spouse and to share that item with their spouse and with the group. Each parent then chose one item from the

children's list to provide for their surviving child(ren) and shared that item with the group. While this session was originally scheduled for two and a half hours, the couples continued processing for approximately four hours and probably would have continued had I not facilitated closure.

Follow-up Session Three

I facilitated the final follow-up session, a family picnic, on May 21, 2000, from 2:00 to 5:00 p.m. at Shiver's Park on the Scottish Rite Hospital grounds. The families and counselors brought their picnic lunches, and I brought a brightly decorated cake (see Appendix E, Figure 68) for celebrating the final gathering of families for this study. Following lunch, families participated in several activities: "Parent-Child Face-Painting," "Three-legged Races," and a "Family Phototherapy Collage."

Counselors set the face-painting supplies out on the tables and placed sets of two chairs facing each other around the tables. I invited the children to paint their parents' faces and the parents to paint their children's faces, so that each child painted on each of their parent's faces and each parent painted on each of their children's faces (see Appendix E, Figures 69 - 70). I designed this activity to allow each child and their parent a special, fun way of giving and receiving nurturing touching and to provide an opportunity for them to experience looking intently into each other's faces.

A three-legged race followed the face-painting activity. I gave instructions for each family to pair up one parent and one child per gunnysack to run the race

together, competing with other families. We held several races so every child would have the opportunity to race with one of their parents. All children received prizes. Aerobic activity combined with physical closeness and low-stress competition provided families with opportunities for emotional and physical release and for an increased sense of family identity and cooperation.

For the “family phototherapy collage” activity, I gave the families the Polaroid photographs that were taken on the last day of camp, a large piece of colored poster board, supplies, and a variety of art media. I asked the families to place their photos on their poster board in whatever way they liked best. I told the families they could decorate their family photo collage using any of the supplies and art media that were available. Once the families finished, I requested family members to cut a piece of yarn and to glue one end of the yarn to their own picture and the other end to another person’s picture in their family with whom they would like to feel closer and spend more time. Counselors assisted families with younger children, if help was needed.

When completed, I asked the families to gather around each collage and listen while each family told about their collage and what they noticed about themselves as a result of participating in this activity. I encouraged the families to honor the yarn connections on their collages by finding ways to enhance those relationships represented by the yarn placement.

The families spent the remainder of the picnic time reminiscing and saying goodbye. I gave the families their framed family photograph taken in front of the

paper maché heart the last day of camp along with extra prints of camp activities and creative products. Counselors assisted children in completing the posttest instruments and final evaluations of their experiences with “Camp Sol – Healing the Family Heart” (Appendix D). Parents took their posttest instruments and final evaluations with them and mailed them to me, along with their family journals, in a self-addressed, stamped envelope. In addition, counselors completed and returned their journals to me.

Facilitator

I, the investigator of this study, was the primary facilitator for the Camp Sol – Healing the Family Heart expressive arts activities. I am a Licensed Professional Counselor in the state of Texas, a Registered Play Therapist-Supervisor, a Nationally Certified Counselor, and a doctoral candidate in counselor education at The University of North Texas. As part of my doctoral studies, I completed courses in art therapy at The University of Houston-Clear Lake. In working with children and families, I completed various courses in play therapy, filial therapy, family therapy, and group therapy. In addition, I received training in grief and loss. I am presently a clinician for the Timberlawn Mental Health System, and I maintain a private practice in Las Colinas.

Prior to pursuing studies in counseling, I taught music for numerous years to people at all levels. As a professional singer/songwriter, I have written, performed, produced, and published my compositions. I studied dance on and off for several years, and I play several musical instruments. I have performed major

roles in musical theater and have directed and produced musicals with middle and secondary school students.

Statistical Analyses

I keyed pretest and posttest data from the families into the computer and analyzed the data using WebStat Version 2.0 (West & Ogden, 2000). I then computed a paired comparison or dependent t-test to test the significance of the difference between the pretest and posttest means for each hypothesis. I established a significance level of .10 as the criterion for either retaining or rejecting the null hypothesis. I chose this level to balance the relative risk of Type I and Type II error in this exploratory, pilot study.

I examined the responses from the participants' final evaluations and from the personal reactions and experiences noted in participants' journals. I also examined personal reactions and experiences noted in the counselors' journals. In addition, I examined my own observations. I noted possible themes and patterns that emerged as a result of my investigation of both qualitative and quantitative data.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents quantitative and qualitative results of the data analysis of this study. In addition, a thorough discussion of findings, observations, implications, and recommendations is offered.

Quantitative Results

The results of this study are presented in the order in which the hypotheses were tested. I (Webb-Ferebee) performed t-tests for all hypotheses, and I established a level of significance of .10 as the criterion for either retaining or rejecting the hypotheses. Because no control group was available for this study, control group results are not included.

Family Functioning Hypotheses

Research Hypothesis 1

The experimental group families' posttest mean scores on the Family Environment Scale's (FES) "Family Incongruence" scale will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 1 presents the combined pretest and posttest means of the FES "Family Incongruence" score for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance.

Table 1

T-test of Pretest and Posttest FES “Family Incongruence” scores

<u>FES FI</u>	Mean	<i>N</i>	SD	<i>t</i>	df	Significance
Pretest	15.45	8	6.48			
Posttest	15.51	8	3.88	.026	7	.51

Note. FI=Family Incongruence. An increase in the mean score indicates an increase in the degree of disagreement between family members.

Table 1 shows that the significance for *t* was .51, indicating no significant increase in the experimental group families’ mean total scores for the FES “Family Incongruence” score. On the basis of this data, hypothesis 1 was not retained.

Research Hypothesis 2

The experimental group families’ posttest mean scores on the “Cohesion” subscale of the FES will be significantly higher than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 2 presents the combined pretest and posttest means of the FES “Cohesion” subscale for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance.

Table 2 shows that the significance for *t* was .09, indicating a significant increase in the experimental group families’ mean total scores for the FES “Cohesion” subscale. On the basis of this data, hypothesis 2 was retained.

Table 2

T-test of Pretest and Posttest FES “Cohesion” Subscale scores

<u>FES</u> C	Mean	N	SD	t	df	Significance
Pretest	6.41	8	1.92			
Posttest	6.94	8	2.18	1.486	7	.09

Note. C=Cohesion. An increase in the mean score indicates an increase in the degree of commitment, help, and support family members provide for one another.

Research Hypothesis 3

The experimental group families’ posttest mean scores on the “Expressiveness” subscale of the FES will be significantly higher than their pretest mean scores.

Table 3

T-test of Pretest and Posttest FES “Expressiveness” Subscale scores

<u>FES</u> EX	Mean	N	SD	t	df	Significance
Pretest	5.62	8	1.43			
Posttest	6.19	8	1.41	1.383	7	.10

Note. EX=Expressiveness. An increase in the mean score indicates an increase in the extent to which family members are encouraged to act openly and to express their feelings directly.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 3 presents the combined pretest and posttest means of the FES

“Expressiveness” subscale for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance.

Table 3 shows that the significance for t was .10, indicating a significant increase in the experimental group families’ mean total scores for the FES “Expressiveness” subscale. On the basis of this data, hypothesis 3 was retained.

Research Hypothesis 4

The experimental group families’ posttest mean scores on the “Conflict” subscale of the FES will be significantly lower than their pretest mean scores.

Table 4

T-test of Pretest and Posttest FES “Conflict” Subscale scores

<u>FES</u> Con	Mean	<i>N</i>	SD	t	df	Significance
Pretest	3.34	8	1.78			
Posttest	3.27	8	1.92	.264	7	.39

Note. CON= Conflict. A decrease in the mean score indicates a decrease in the amount of openly expressed anger, aggression, and conflict among family members.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 4 presents the combined pretest and posttest means of the FES “Conflict” subscale for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance.

Table 4 shows that the significance for t was .39, indicating no significant decrease in the experimental group families’ mean total scores for the FES

“Conflict” subscale. On the basis of this data, hypothesis 4 was not retained.

Research Hypothesis 5

The experimental group families’ posttest mean scores on the “Independence” subscale of the FES will be significantly higher than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 5 presents the combined pretest and posttest means of the FES “Independence” subscale for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance.

Table 5

T-test of Pretest and Posttest FES “Independence” Subscale scores

<u>FES</u> Ind	Mean	N	SD	t	df	Significance
Pretest	6.74	8	.890			
Posttest	6.31	8	1.501	1.434	7	.90

Note. Ind=Independence. A decrease in the mean score indicates an decrease in the extent to which family members are assertive, are self-sufficient, and make their own decisions.

Table 5 shows that the significance for t was .90, indicating no significant increase in the experimental group families’ mean total scores for the FES “Independence” subscale. On the basis of this data, hypothesis 5 was not retained.

Research Hypothesis 6

The experimental group families' posttest mean scores on the "Achievement Orientation" subscale of the FES will be significantly higher than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 6 presents the combined pretest and posttest means of the FES "Achievement Orientation" subscale for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance.

Table 6

T-test of Pretest and Posttest FES "Achievement Orientation" Subscale scores

<u>FES</u> AO	Mean	N	SD	t	df	Significance
Pretest	5.96	8	1.08			
Posttest	5.78	8	1.31	.697	7	.74

Note. AO=Achievement Orientation. A decrease in the mean score indicates a decrease in the extent to which activities are cast into an achievement-oriented or competitive framework.

Table 6 shows that the significance for t was .74, indicating no significant increase in the experimental group families' mean total scores for the FES "Achievement Orientation" subscale. On the basis of this data, hypothesis 6 was not retained.

Research Hypothesis 7

The experimental group families' posttest mean scores on the "Intellectual-Cultural Orientation" subscale of the FES will be significantly higher than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 7 presents the combined pretest and posttest means of the FES "Intellectual-Cultural Orientation" subscale for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance.

Table 7

T-test of Pretest and Posttest FES "Intellectual-Cultural Orientation" Subscale scores

<u>FES</u> ICO	Mean	N	SD	t	df	Significance
Pretest	5.01	8	1.34			
Posttest	4.85	8	1.95	.372	7	.64

Note. ICO=Intellectual-Cultural Orientation. A decrease in the mean score indicates a decrease in the degree of interest in political, social, intellectual, and cultural activities.

Table 7 shows that the significance for t was .64, indicating no significant increase in the experimental group families' mean total scores for the FES "Intellectual-Cultural Orientation" subscale. On the basis of this data, hypothesis 7 was not retained.

Research Hypothesis 8

The experimental group families' posttest mean scores on the "Active-Recreational Orientation" subscale of the FES will be significantly higher than their pretest mean scores.

Table 8

T-test of Pretest and Posttest FES "Active-Recreational Orientation" Subscale scores

<u>FES</u> ARO	Mean	N	SD	t	df	Significance
Pretest	4.26	8	1.43			
Posttest	5.01	8	2.01	2.136	7	.03

Note. ARO=Active-Recreational Orientation. An increase in the mean score indicates an increase in the extent of participation in social and recreational activities

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 8 presents the combined pretest and posttest means of the FES "Active-Recreational Orientation" subscale for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance..

Table 8 shows that the significance for t was .03, indicating a significant increase in the experimental group families' mean total scores for the FES "Active-Recreational Orientation." On the basis of this data, hypothesis 8 was retained.

Research Hypothesis 9

The experimental group families' posttest mean scores on the "Moral-Religious Emphasis" subscale of the FES will be significantly higher than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 9 presents the combined pretest and posttest means of the FES "Moral-Religious Emphasis" subscale for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance.

Table 9

T-test of Pretest and Posttest FES "Moral-Religious Emphasis" Subscale scores

<u>FES</u> MRE	Mean	N	SD	t	df	Significance
Pretest	7.30	8	1.90			
Posttest	6.95	8	2.01	2.246	7	.97

Note. MRE=Moral-Religious Emphasis. A decrease in the mean score indicates a decrease in the degree of emphasis on ethical and religious issues and values.

Table 9 shows that the significance for t was .97, indicating no significant increase in the experimental group families' mean total scores for the FES "Moral-Religious Emphasis" subscale. On the basis of this data, hypothesis 9 was not retained.

Research Hypothesis 10

The experimental group families' posttest mean scores on the "Organization" subscale of the FES will be significantly higher than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 10 presents the combined pretest and posttest means of the FES “Organization” subscale for the experimental group families, standard deviations, t-value, degrees of freedom, and level of significance.

Table 10

T-test of Pretest and Posttest FES “Organization” Subscale scores

<u>FES</u> Org	Mean	N	SD	t	df	Significance
Pretest	5.97	8	2.11			
Posttest	6.06	8	2.49	.189	7	.42

Note. Org=Organization. An increase in the mean score indicates an increase in the degree of importance of clear organization and structure in planning family activities and responsibilities.

Table 10 shows that the significance for t was .42, indicating no significant increase in the experimental group families’ mean total scores for the FES “Organization” subscale. On the basis of this data, hypothesis 10 was not retained.

Research Hypothesis 11

The experimental group families’ posttest mean scores on the “Control” subscale of the FES will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 11 presents the combined pretest and posttest means of the FES “Control” subscale for the experimental group families, standard deviations, t-

value, degrees of freedom, and level of significance.

Table 11

T-test of Pretest and Posttest FES “Control” Subscale scores

<u>FES</u> Ctl	Mean	N	SD	t	df	Significance
Pretest	5.23	8	1.03			
Posttest	4.77	8	1.03	1.201	7	.13

Note. Ctl=Control. A decrease in the mean score indicates a decrease in the extent to which set rules and procedures are used to run family life.

Table 11 shows that the significance for t was .13, indicating no significant decrease in the experimental group families' mean total scores for the FES “Control” subscale. On the basis of this data, hypothesis 11 was not retained.

Child Behavior Hypotheses

Research Hypothesis 12

The experimental group children's posttest mean scores on the Behavior Symptoms Index (BSI) composite as indicated on the Behavior Assessment System for Children-Teacher Report Scale (BASC-TRS) will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 12 presents the combined pretest and posttest means of the BASC-TRS BSI composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 12

T-test of Pretest and Posttest BASC-TRS “BSI” Composite scores

<u>BASC-TRS BSI</u>	Mean	N	SD	t	df	Significance
Pretest	48.56	9	4.56			
Posttest	48.22	9	3.99	.174	8	.43

Note. A decrease in the mean score indicates a decrease in the overall level of problem behavior.

Table 12 shows that the significance for t was .43, indicating no significant decrease in the experimental group childrens’ mean total scores for the BASC-TRS BSI composite. On the basis of this data, hypothesis 12 was not retained.

Hypothesis 12.a

The experimental group children’s posttest mean scores on the “Externalizing Behavior Problems” composite as indicated on the BASC-TRS will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 13 presents the combined pretest and posttest means of the BASC-TRS “Externalizing Behavior Problems” composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 13

T-test of Pretest and Posttest BASC-TRS “Externalizing Behavior Problems”

Composite scores

<u>BASC-TRS</u> <u>Ext Beh</u>	Mean	<i>N</i>	SD	<i>t</i>	df	Significance
Pretest	46.22	9	2.77			
Posttest	46.89	9	5.07	.469	8	.67

Note. An increase in the mean score indicates an increase in disruptive behavior problems such as aggression, hyperactivity, and delinquency.

Table 13 shows that the significance for *t* was .67, indicating no significant decrease in the experimental group childrens’ mean total scores for the BASC-TRS “Externalizing Behavior Problems” composite. On the basis of this data, hypothesis 12.a was not retained.

Research Hypothesis 12.b

The experimental group children’s posttest mean scores on the “Internalizing Behavior Problems” composite as indicated on the BASC-TRS will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 14 presents the combined pretest and posttest means of the BASC-TRS “Internalizing Behavior Problems” composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 14

T-test of Pretest and Posttest BASC-TRS “Internalizing Behavior Problems”

Composite scores

<u>BASC-TRS</u> <u>Int Beh</u>	Mean	<i>N</i>	SD	<i>t</i>	df	Significance
Pretest	51.44	9	9.50			
Posttest	52.44	9	7.50	.376	8	.64

Note. An increase in the mean score indicates an increase in depression, anxiety, and similar difficulties that are not marked by acting-out behavior.

Table 14 shows that the significance for *t* was .64, indicating no significant decrease in the experimental group childrens’ mean total scores for the BASC-TRS “Internalizing Behavior Problems” composite. On the basis of this data, hypothesis 12.b was not retained.

Research Hypothesis 12.c

The experimental group children’s posttest mean scores on the “School Problems” composite as indicated on the BASC-TRS will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 15 presents the combined pretest and posttest means of the BASC-TRS “School Problems” composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 15

T-test of Pretest and Posttest BASC-TRS “School Problems” Composite scores

<u>BASC-TRS</u> Sch Prob	Mean	N	SD	t	df	Significance
Pretest	52.17	6	8.13			
Posttest	50.17	6	10.07	1.225	5	.13

Note. A decrease in the mean score indicates a decrease in academic difficulties including problems of motivation, attention, and learning and cognition.

Table 15 shows that the significance for t was .13, indicating no significant decrease in the experimental group childrens’ mean total scores for the BASC-TRS “School Problems” composite. On the basis of this data, hypothesis 12.c was not retained.

Research Hypothesis 12.d

The experimental group children’s posttest mean scores on the “Adaptive Skills” composite as indicated on the BASC-TRS will be significantly higher than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 16 presents the combined pretest and posttest means of the BASC-TRS “Adaptive Skills” composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 16

T-test of Pretest and Posttest BASC-TRS “Adaptive Skills” Composite scores

<u>BASC-TRS Adap Skills</u>	Mean	N	SD	t	df	Significance
Pretest	49.89	9	10.03			
Posttest	50.44	9	8.19	.229	8	.41

Note. An increase in the mean score indicates an increase in prosocial, organizational, study, and other adaptive skills.

Table 16 shows that the significance for t was .41, indicating no significant increase in the experimental group childrens’ mean total scores for the BASC-TRS “Adaptive Skills” composite. On the basis of this data, hypothesis 12.d was not retained.

Research Hypothesis 13

The experimental group children’s posttest mean scores on the Behavior Symptoms Index (BSI) composite as indicated on the Behavior Assessment System for Children-Parent Report Scale (BASC-PRS) will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 17 presents the combined pretest and posttest means of the BASC-PRS BSI composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 17

T-test of Pretest and Posttest BASC-PRS “BSI” Composite scores

<u>BASC-PRS BSI</u>	Mean	N	SD	t	df	Significance
Pretest	52.39	18	10.16			
Posttest	47.33	18	8.57	3.173	17	.002

Note. A decrease in the mean score indicates a decrease in the overall level of problem behavior.

Table 17 shows that the significance for t was .002, indicating a significant decrease in the experimental group childrens’ mean total scores for the BASC-PRS BSI composite. On the basis of this data, hypothesis 13 was retained.

Research Hypothesis 13.a

The experimental group children’s posttest mean scores on the “Externalizing Behavior Problems” composite as indicated on the BASC-PRS will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 18 presents the combined pretest and posttest means of the BASC-PRS “Externalizing Behavior Problems” composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 18

T-test of Pretest and Posttest BASC-PRS “Externalizing Behavior Problems”

Composite scores

<u>BASC-PRS</u> Ext Beh	Mean	N	SD	t	df	Significance
Pretest	54.11	18	9.68			
Posttest	48.89	18	7.33	4.148	17	.0003

Note. A decrease in the mean score indicates a decrease in disruptive behavior problems such as aggression, hyperactivity, and delinquency.

Table 18 shows that the significance for t was .0003, indicating a significant decrease in the experimental group childrens' mean total scores for the BASC-PRS "Externalizing Behavior Problems" composite. On the basis of this data, hypothesis 13.a was retained.

Research Hypothesis 13.b

The experimental group children's posttest mean scores on the "Internalizing Behavior Problems" composite as indicated on the BASC-PRS will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 19 presents the combined pretest and posttest means of the

Table 19

T-test of Pretest and Posttest BASC-PRS "Internalizing Behavior Problems"

Composite scores

<u>BASC-PRS</u> Int Beh	Mean	N	SD	t	df	Significance
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Pretest	46.61	18	8.04			
Posttest	43.16	18	7.49	2.151	17	.02

Note. A decrease in the mean score indicates a decrease in depression, anxiety, and similar difficulties that are not marked by acting-out behavior.

BASC-PRS “Internalizing Behavior Problems” composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 11 shows that the significance for t was .02, indicating a significant decrease in the experimental group childrens’ mean total scores for the BASC-PRS “Internalizing Behavior Problems” composite. On the basis of this data, hypothesis 13.b was retained.

Research Hypothesis 13.c

The experimental group children will attain a significantly higher mean score on the “Adaptive Skills” composite score as indicated on the BASC-PRS at post-testing than will the control group children.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 20 presents the combined pretest and posttest means of the BASC-PRS “Adaptive Skills” composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 20

T-test of Pretest and Posttest BASC-PRS “Adaptive Skills” Composite scores

<u>BASC-PRS</u> Adap Skills	Mean	N	SD	t	df	Significance
Pretest	44.44	18	12.44			
Posttest	47.78	18	11.99	2.062	17	.02

Note. An increase in the mean score indicates an increase in prosocial, organizational, study, and other adaptive skills.

Table 11 shows that the significance for t was .02, indicating a significant increase in the experimental group childrens’ mean total scores for the BASC-PRS “Adaptive Skills” composite. On the basis of this data, hypothesis 13.c was retained.

Research Hypothesis 14

The experimental group children’s posttest mean scores on the “Emotional Symptoms Index” (ESI) composite as indicated on the Behavior Assessment System for Children-Self Report of Personality (BASC-SRP), ages 8 to 18, will be significantly lower than their pretest mean scores.

Table 21

T-test of Pretest and Posttest BASC-SRP “Emotional Symptoms Index”

Composite scores

<u>BASC-SRP</u> ESI	Mean	N	SD	t	df	Significance
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Pretest	53.67	3	11.15			
Posttest	50.00	3	10.00	.862	2	.23

Note. A decrease in the mean score indicates a decrease in the cumulative effects of a large number of emotional difficulties, no single one of which may be considered serious.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 21 presents the combined pretest and posttest means of the BASC-SRP “Emotional Symptoms Index” composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 21 shows that the significance for t was .23, indicating no significant decrease in the experimental group childrens’ mean total scores for the BASC-SRP “Emotional Symptoms Index” composite. On the basis of this data, hypothesis 14 was not retained.

Research Hypothesis 14.a

The experimental group children’s posttest mean scores on the “School Maladjustment” composite as indicated on the BASC-SRP, ages 8 to 18, will be significantly lower than their pretest mean scores.

Table 22

T-test of Pretest and Posttest BASC-SRP “School Maladjustment” Composite scores

<u>BASC-SRP</u> Sch Mal	Mean	N	SD	t	df	Significance
Pretest	47.67	3	4.93			
Posttest	45.67	3	5.03	.555	2	.31

Note. A decrease in the mean score indicates an increase in adaptation to school.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 22 presents the combined pretest and posttest means of the BASC-SRP “School Maladjustment” composite for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 22 shows that the significance for t was .31, indicating no significant decrease in the experimental group children’s mean total scores for the BASC-SRP “School Maladjustment” composite. On the basis of this data, hypothesis 14.a was not retained.

Research Hypothesis 14.b

The experimental group children’s posttest mean scores on the “Clinical Maladjustment” composite as indicated on the BASC-SRP, ages 8 to 18, will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 23 presents the combined pretest and posttest means of the BASC-SRP “Clinical Maladjustment” composite for the experimental group

children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 23 shows that the significance for t was .36, indicating no significant decrease in the experimental group childrens' mean total scores for the BASC-SRP "Clinical Maladjustment" composite. On the basis of this data, hypothesis 14.b was not retained.

Table 23

T-test of Pretest and Posttest BASC-SRP "Clinical Maladjustment" Composite scores

<u>BASC-SRP</u> Clin Mal	Mean	<i>N</i>	SD	t	df	Significance
Pretest	50.00	3	13.23			
Posttest	48.67	3	11.59	.394	2	.36

Note. A decrease in the mean score indicates a decrease in a broad index of distress that reflects clinical, internalizing problems.

Research Hypothesis 14.c

The experimental group children's posttest mean scores on the "Personal Adjustment" composite as indicated on the BASC-SRP, ages 8 to 18, will be significantly higher than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 24 presents the combined pretest and posttest means of the BASC-SRP "Personal Adjustment" composite for the experimental group

children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 24 shows that the significance for t was .13, indicating no significant decrease in the experimental group childrens' mean total scores for the BASC-SRP "Personal Adjustment" composite. On the basis of this data, hypothesis 14.c was not retained.

Table 24

T-test of Pretest and Posttest BASC-SRP "Personal Adjustment" Composite scores

<u>BASC-SRP</u> Per Adj	Mean	<i>N</i>	SD	t	df	Significance
Pretest	48.00	3	8.66			
Posttest	53.33	3	4.04	1.533	2	.13

Note. An increase in the mean score indicates an increase in positive levels adjustment.

Anxiety Hypotheses

Research Hypothesis 15

The experimental group parents' posttest mean scores on the Beck Anxiety Inventory (BAI) will be significantly lower than their pretest mean scores.

Table 25

T-test of Pretest and Posttest BAI scores

<u>BAI</u> Scores	Mean	<i>N</i>	SD	t	df	Significance
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Pretest	8.07	14	10.19			
Posttest	5.86	14	6.44	.897	13	.19

Note. A decrease in the mean score indicates a decrease in anxiety symptoms.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 25 presents the combined pretest and posttest means of the BAI for the experimental group parents, standard deviations, t-value, degrees of freedom, and level of significance.

Table 25 shows that the significance for t was .19, indicating no significant decrease in the experimental group parents' mean total scores for the BAI. On the basis of this data, hypothesis 15 was not retained.

Research Hypothesis 16

The experimental group children's posttest mean scores on the "Anxiety" subscale as indicated on the BASC-PRS, will be significantly lower than their pretest mean scores.

Table 26

T-test of Pretest and Posttest BASC-PRS "Anxiety" subscale scores

<u>BASC-PRS</u> Anxiety	Mean	<i>N</i>	SD	t	df	Significance
Pretest	47.78	18	9.37			
Posttest	41.11	18	8.32	3.314	17	.002

Note. A decrease in the mean score indicates a decrease in the tendency to be nervous, fearful, or worried about real or imagined problems.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 26 presents the combined pretest and posttest means of the BASC-PRS “Anxiety” subscale scores for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 26 shows that the significance for t was .0021, indicating a significant decrease in the experimental group children’s mean total scores for the BASC-PRS “Anxiety” subscale. On the basis of this data, hypothesis 16 was retained.

Research Hypothesis 17

The experimental group children’s posttest mean scores on the “Anxiety” subscale as indicated on the BASC-TRS, will be significantly lower than their pretest mean scores.

Table 27

T-test of Pretest and Posttest BASC-TRS “Anxiety” subscale scores

BASC-TRS Anxiety	Mean	N	SD	t	df	Significance
Pretest	49.67	9	7.83			
Posttest	51.11	9	5.82	.668	8	.73

Note. An increase in the mean score indicates an increase in the tendency to be nervous, fearful, or worried about real or imagined problems.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 27 presents the combined pretest and posttest means of the

BASC-TRS “Anxiety” subscale scores for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 27 shows that the significance for t was .73, indicating no significant decrease in the experimental group children’s mean total scores for the BASC-TRS “Anxiety” subscale. On the basis of this data, hypothesis 17 was not retained.

Research Hypothesis 18

The experimental group children’s posttest mean scores on the “Anxiety” subscale as indicated on the BASC-SRP, will be significantly lower than their pretest mean scores.

Table 28

T-test of Pretest and Posttest BASC-SRP “Anxiety” subscale scores

<u>BASC-SRP</u> Anxiety	Mean	<i>N</i>	SD	t	df	Significance
Pretest	52.00	3	16.37			
Posttest	48.67	3	9.29	.769	2	.26

Note. A decrease in the mean score indicates a decrease in feelings of nervousness, worry, and fear; the tendency to be overwhelmed by problems.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 28 presents the combined pretest and posttest means of the BASC-SRP “Anxiety” subscale scores for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 28 shows that the significance for t was .26, indicating no significant decrease in the experimental group children's mean total scores for the BASC-TRS "Anxiety" subscale. On the basis of this data, hypothesis 18 was not retained.

Depression Hypotheses

Research Hypothesis 19

The experimental group parents' posttest mean scores on the Beck Depression Inventory (BDI-II) will be significantly lower than their pretest mean scores.

Table 29

T-test of Pretest and Posttest BDI-II scores

<u>BDI-II</u> Scores	Mean	<i>N</i>	SD	t	df	Significance
Pretest	14.14	14	11.57			
Posttest	10.43	14	9.00	1.887	13	.04

Note. A decrease in the mean score indicates a decrease in overall depressive symptoms.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 29 presents the combined pretest and posttest means of the BDI-II scores for the experimental group parents, standard deviations, t-value, degrees of freedom, and level of significance.

Table 29 shows that the significance for t was .04, indicating a significant decrease in the experimental group parents' mean total scores for the BDI-II. On the basis of this data, hypothesis 19 was retained.

Research Hypothesis 20

The children's posttest mean scores on the "Depression" subscale as indicated on the BASC-PRS, will be significantly lower than their pretest mean scores.

Table 30

T-test of Pretest and Posttest BASC-PRS "Depression" subscale scores

<u>BASC-PRS</u> Depression	Mean	<i>N</i>	SD	t	df	Significance
Pretest	47.72	18	8.44			
Posttest	45.67	18	9.73	1.474	17	.07

Note. A decrease in the mean score indicates a decrease in feelings of unhappiness, sadness, and stress.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 30 presents the combined pretest and posttest means of the BASC-PRS "Depression" subscale scores for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 30 shows that the significance for t was .07, indicating a significant decrease in the experimental group children's mean total scores for the BASC-

PRS “Depression” subscale. On the basis of this data, hypothesis 20 was retained.

Research Hypothesis 21

The experimental group children’s posttest mean scores on the “Depression” subscale as indicated on the BASC-TRS, will be significantly lower than their pretest mean scores.

Table 31

T-test of Pretest and Posttest BASC-TRS “Depression” subscale scores

<u>BASC-TRS</u> Depression	Mean	N	SD	t	df	Significance
Pretest	49.33	9	8.83			
Posttest	49.33	9	5.55	.000	8	.50

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 31 presents the combined pretest and posttest means of the BASC-TRS “Depression” subscale scores for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 30 shows that the significance for t was .50, indicating no significant decrease in the experimental group children’s mean total scores for the BASC-TRS “Depression” subscale. On the basis of this data, hypothesis 21 was not retained.

Research Hypothesis 22

The experimental group children’s posttest mean scores on the “Depression” subscale as indicated on the BASC-SRP, will be significantly lower than their pretest mean scores.

A one-tailed t-test for dependent samples was used to compute the test statistic. Table 32 presents the combined pretest and posttest means of the BASC-SRP “Depression” subscale scores for the experimental group children, standard deviations, t-value, degrees of freedom, and level of significance.

Table 32

T-test of Pretest and Posttest BASC-SRP “Depression” subscale scores

<u>BASC-SRP</u> Depression	Mean	N	SD	t	df	Significance
Pretest	53.00	3	2.00			
Posttest	49.67	3	4.73	2.000	2	.09

Note. A decrease in the mean score indicates a decrease in feelings of unhappiness, sadness, and dejection.

Table 32 shows that the significance for t was .09, indicating a significant decrease in the experimental group children’s mean total scores for the BASC-SRP “Depression” subscale. On the basis of this data, hypothesis 22 was retained.

Discussion

This section is organized in two major subsections. The first major subsection addresses participant changes between the beginning and ending of

this study. This subsection is further divided into three minor subsections that address changes in the family as a whole, in parents, and in children. For the purpose of discussion in the first major subsection, a previously reported significance level between .1 and .2, though not statistically significant, will be considered a positive trend. The second major subsection addresses the expressive arts activities that comprised the focal aspect of the treatment in this study.

An element that may have important implications for this study, and that I find important to include before the discussion of hypotheses results, is my initial experience of the experimental group families. I met the families at the camp/study orientation. I sensed that many of the parents were somewhat cautious, if not passively hostile, about participating in the study, especially about responding to the pretest measures. While the Camp Sol invitational letter (Appendix B) referred to the study as “a type of pilot study” and mentioned the orientation, it did not refer to pre and post assessments. The intention of the letter was to attract participants by emphasizing the potential benefits of the camp and follow-up sessions, however, several parents expressed that they would have preferred to have known about the instruments prior to orientation and to have seen the child(ren)’s assessments to ensure the questions were acceptable to them.

One mother stated that she did not bring her son to the orientation because “he was afraid he would have to answer questions and he refused to fill

out any questions that were of a personal nature.” After I expressed to her the importance of his participation, his mother retrieved him, at which time the family completed orientation procedures. During camp, another parent stated, “I was afraid you were planting dangerous ideas in my son’s head with those questionnaires. We almost didn’t come to camp because of that.”

Certainly a more comprehensive information session about the assessments at the orientation could have helped alleviate these parents’ fears, thus effecting their initial responses on the instruments, and may have increased their willingness to be more open and trusting of me and of the counseling staff at the outset of the study. I now proceed with discussion of the hypotheses results.

Of the 32 separate parts listed as hypotheses in this exploratory pilot study, 11 were retained and 21 were rejected, with 4 of the rejected hypotheses exhibiting positive trends. Considering the unique circumstances of the population in this study, one of the 17 hypotheses that indicated no significant change or positive trend, could be inversely hypothesized and results interpreted as significant at the .02 level of significance. Because no no-treatment control group participated in this study, no changes can be definitively attributed to any aspect of the treatment. In addition, no alternative control group that isolated the independent variable of expressive arts therapy—such as a weekend of traditional family therapy addressing family bereavement—was used. Consequently, even if changes could be attributed to the treatment, they could not be attributed to the expressive arts factor exclusive of other potentially

therapeutic aspects of the treatment. With these caveats in mind, I discuss in the next section the extent to which participants' changes are consonant with expected effect of expressive arts therapy.

Participant Changes

Family

Family Environment

Between the beginning and ending of this study the experimental group families demonstrated increases in Cohesion, Expressiveness, and Active-Recreational Orientation. Furthermore, the families showed a positive trend towards healthier family functioning as regards the factor of Control. Other results that merit further discussion due to the unique qualities of this population include Moral-Religious Emphasis and Intellectual-Cultural Orientation. No change occurred on Conflict, Independence, Achievement Orientation, Organization, or Family Incongruence. In these five areas, the families were either higher than the norm, or very close to the norm on both pre and post tests.

Table 33 shows a comparison of the experimental group families' subscale means and standard deviations to those of the normal and distressed

Table 33

FES Comparison between Subscale Means and Standard Deviations of the Experimental Group Families, Normal Families, and Distressed Families

<u>FES</u> Comparison	Experimental N=8 Pre		Experimental N=8 Post		Normal N=1125		Distressed N=500	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Cohesion	6.41	1.92	6.94	2.18	6.61	1.36	5.03	1.98

Expressiveness	5.62	1.43	6.19	1.41	5.45	1.55	4.60	1.76
Conflict	3.34	1.78	3.27	1.92	3.31	1.85	4.28	1.93
Independence	6.74	.890	6.31	1.50	6.61	1.19	5.89	1.24
Achievement	5.96	1.08	5.78	1.31	5.47	1.61	5.29	1.55
Orientation								
*Intellectual-Cultural	5.01	1.34	4.85	1.95	5.63	1.72	4.55	1.84
Orientation								
Active-Recreational	4.26	1.43	5.01	2.01	5.35	1.87	4.29	1.82
Orientation								
*Moral-Religious	7.30	1.90	6.95	2.01	4.72	1.98	4.45	1.87
Emphasis								
Organization	5.97	2.11	6.06	2.49	5.41	1.83	5.06	1.91
<u>Control</u>	5.23	1.03	4.77	1.03	4.34	1.81	4.84	1.87
Family	15.45	6.48	15.51	3.88	15.34	5.20	17.16	5.67
Incongruence								

Note: Bold=attained significance, Underlined=positive trend, Asterisk=alternative interpretation.

families in the Moos and Moos (1986) FES manual (p. 6). Table 34 illustrates an interpretation of the experimental group families' pre and post subscale results on the FES. The reader is referred to these Tables throughout the remaining discussion in the Family Environment section.

In formulating my hypotheses regarding the FES, I made assumptions. Because the normal family means were lower than the distressed family means on the variable of Conflict, Control, and Family Incongruence, I assumed that any decrease in the experimental families' scores would reflect movement toward healthier functioning. Because the normal family means were higher than the distressed family means on all other variables, I assumed that any increase in the experimental families' scores would reflect movement toward healthier family

functioning. These assumptions did not allow for the complexity that emerged with the actual results.

Table 34

Interpretation of Experimental Group Families' FES Subscale Results Compared to Normal Family Means

Subscale Range	Pre			Post		
	Low	Mod	High	Low	Mod	High
Family Incongruence	X			X		
Cohesion		X				X
Expressiveness		X				X
Conflict	X			X		
Independence			X			X
Achievement Orientation			X		X	
*Intellectual-Cultural Orientation		X		X		
Active-Recreational Orientation	X			X		
*Moral-Religious Emphasis			X			X
Organization		X			X	
<u>Control</u>		X		X		

Note: Bold= significance, Underlined=positive trend, *=alternative interpretation

To better understand how to interpret the FES (Moos & Moos, 1986), I contacted Dr. Rudolph Moos (personal communication, May 14, 2001). Over the course of our email communication, I gained the confirmation I was seeking regarding questions about the stated hypotheses and results. According to Dr. Moos, the initial stated hypotheses were reasonable. However, he more specifically indicated:

I think it is important to distinguish between change per se (which is simply an empirical question based on the actual results) and whether that change is 'positive' (which is an interpretation, and may depend in part on the actual FES subscale scores). (R. Moos, personal communication, May 14, 2001)

The following discussion addresses the reported increases and positive trend in family environment, the comparison of these increases to the norm, implications of these increases for healthy functioning, and, assuming such a change reflects enhanced family health, the role of expressive arts activities and/or other factor(s) to which the increases could be attributed. In addition, areas of family environment in which the unique characteristics of bereaved families necessitate a variation in the interpretation of results is discussed.

Family Cohesion—the degree of commitment, help, and support that family members provide for each other—increased considerably among experimental group families from the beginning to the end of this study. The families' Cohesion levels were somewhat below the normal family mean before the study and well above that mean after, indicating movement in the direction of increasingly healthy family functioning. Expressive arts activities could conceivably foster such a change. Moos and Moos (1986) indicated that a family's Cohesion would be expected to be higher immediately following the death of a child. Only two of the experimental group families experienced the death of their child 3 to 4 months prior to the study; however, Moos and Moos did not give a time frame for what constitutes "immediately following the death of a

child.” Thus the possibility exists that the experimental group families’ Cohesion may have increased as a result of their participation in expressive arts activities throughout the study.

Family members also, from the beginning to the end of the study, increased the extent to which they felt encouraged to act openly and to express their feelings directly. It is noteworthy that the participating families were already higher than the normal family mean on Expressiveness at the beginning of the study. An increase in Expressiveness that coincided with an increase in Conflict and/or Family Incongruence could indicate decreased functioning that would warrant further clinical attention. However, such was not the case in this study, indicating that the increased Expressiveness reflected healthier family functioning. As the name suggests, expressive arts activities could be expected to directly affect an increase in family Expressiveness.

The extent of family members’ participation in social and recreational activities increased from the beginning to the end of the study. However, even with the notable increase reported by the experimental families, they were still below the normal family mean on Active-Recreational Orientation. One of the normal behavioral responses to grief is to withdraw to some degree from social and recreational activities. Therefore, increased levels of social and recreational activities could be a sign of increased family health, while at the same time, the lower level in comparison to normal families could reflect the bereaved families’ ongoing grief. Even taking into account the lower level compared to normal

families, the increase that occurred in Active-Recreational Orientation could be a result of the active participatory nature of expressive arts therapy.

Family Control, the extent to which set rules and procedures are used to run family life, indicated a positive trend from the beginning to the end of the study. These results indicated that, given a larger sample, the change in Control might very well have attained significance. Although Control decreased for the experimental families on the posttest, their Control continued at a higher level than the normal families' Control. Emerging from an experience of chronic illness and death of a child, in which family members felt helpless and powerless, higher level of control might be expected. Experiencing the creative process often promotes a sense of inner freedom; therefore, it is possible the expressive arts activities contributed to this decrease.

Overall, the experimental families' functioning at the end of the study was, for the most part, within range of normal families' functioning. The most notable exceptions include Moral-Religious Emphasis and Intellectual-Cultural Orientation. Interpreting these areas from a perspective that considers the unique characteristics of bereaved families yields results that may more accurately reflect the experimental families' movement toward healthier family functioning.

The Moral-Religious Emphasis subscale pre and post results indicated a significant decrease rather than the hypothesized increase. Interestingly, Table 35 shows what happened when I submitted the decrease to a one-tailed t-test.

Table 35

Alternative T-test of Pretest and Posttest FES “Moral-Religious Emphasis”

Subscale Scores

<u>FES MRE</u>	Mean	N	SD	t	df	Significance
Pretest	7.30	8	1.89			
Posttest	6.95	8	2.01	2.246	7	.02

This decrease reflected my observation during the study, which I expressed to Dr. Moos via email:

My experience of the families was that, in the beginning, there was a somewhat rigid quality to their moral-religious emphasis and expression. Over the course of the study, I found the families beginning to expand their thinking and to question and explore their beliefs. (Webb-Ferebee, personal communication, 2001)

Dr. Moos (personal communication, May 14, 2001) confirmed, “In general, when families experience the severe illness and death of a child, their scores on Moral-Religious Emphasis tend to increase during the process, and, therefore, one might expect a decline and a return to ‘normal’ afterwards.”

Even though the experimental families reported a decrease in Moral-Religious Emphasis at the end of the study, they were noticeably higher on this

aspect of family functioning, both, prior to and after the study. A typical response in grief could be reliance on religion as a support—even as a defense-mechanism. Grief work, especially through expressive arts activities, may have reduced the need for that support/defense.

Table 36

Use of Religious Symbols in Families' Artwork

Religious Symbols in Artwork	Number of Families	Number of Children	Number of Mothers	Number of Fathers
Family puzzle pieces	4	1	0	0
Paper Maché Heart	3	0	1	0
Clay sculptures	1	0	1	0
Children's Art	-	3	-	-
Altars	-	-	3	3
Dad's/ Mom's collage	-	-	8	3
Couple's brainstorming	-	-	0	0
Phototherapy collage	1	0	0	0

Indeed, a closer examination revealed an apparently decreasing use of religious references in the artistic expressions and verbal processing by parents and a few children throughout the study. Table 36 presents a chronological listing of art activities throughout the study along with the incidence of religious symbols in that artwork. Appendix E presents a compilation of the self-reported use of religious symbolism in collages, clay sculptures, children's art, altars, and the paper maché heart. Interestingly, in creating the final phototherapy collage, only one family used a religious symbol.

Thus, it appears the original hypothesis that Moral-Religious Emphasis would increase was based on an erroneous assumption that more would necessarily be better. Rather, among the families in this study, the decrease from

very high to high reflected a movement toward normalcy and, most likely, toward more healthy functioning.

Experimental families in this study were lower in Intellectual-Cultural Orientation than were normal families. Because of focusing on the process and sequelae of a child's illness and death, a family's lack of attention to intellectual and cultural phenomena would be expected. Further, the decrease in the post score could be related to a renewed focus on the family's loss during the study that would, again, reduce the desire to attend to extra-familial political, social, intellectual, and cultural interests and activities.

Family Overall Functioning

Regarding overall family functioning, I made several qualitative observations that may not have been reflected in the quantitative findings or might have influenced the quantitative findings in ways assessable only qualitatively. For example, within the eight families participating, I noticed a wide range of functioning levels. I observed one family in particular as very low functioning and as totally unaware of how they impacted others. Over the course of the study, I observed the child of this family progress from extreme hyperactive behavior and a high emotional state of anxiety, to relatively greater emotional stability and self-control.

I observed in my work with the parents of this family that each displayed incongruent affect, repeatedly giggling when referring to their child's death or events surrounding their child's death; the mother displayed this incongruence

even more than the father did. I am of the opinion that my work with this couple served to facilitate their mourning and, even more importantly, to facilitate their awareness of their incongruency and their deep discouragement and frustration at not feeling heard, accepted, or appreciated by each other.

During the family clay sculpture activity, the very young surviving child of this family created exactly what his father created—a turtle—and set his sculpture where it was touching his father's sculpture. The mother created a bear. The parents identified the characteristics of themselves that were like their sculptures. The mother was of a heavy stature, aggressive, intrusive, and continually attempted to talk for the father. The father protected himself from the mother with his turtle shell. He was cautious about venturing out of his shell and expressing his thoughts or feelings about their child who died or about their surviving child. The father reportedly wept for his dead child for the first time during our work together. Later the facilitators of the father's altar-making activity reported that in processing with the other fathers, this father wept profusely.

Note: When I went to photograph this family's sculpture, it was not in the location where the work was completed as I requested. Therefore, unfortunately, this sculpture was the only sculpture not included in Appendix E.

According to Moos and Moos (1986), the family environment has a powerful influence on a family's successful adaptation to change, both in normal developmental transitions and in family crises, such as chronic illness of a child. The previously mentioned family's Family Incongruence mean score increased

substantially while most other families' decreased in varying degrees. This increase quite possibly reflected the clay sculpture work this family did together, which, by raising their levels of awareness, could easily have created a higher level of disagreement between them in their struggle to communicate their needs to one another, particularly with the father giving himself permission to express his feelings and his needs.

Moos and Moos (1986) stated that, "in general, well-organized families characterized by moderate or high cohesion and expressiveness and low conflict are able to adapt successfully to varied changes and demands" (p.39). They also indicated that families who participated in a home care program for chronically ill children showed greater family commitment and support and stronger religious values than families of comparative children who died in the hospital (p. 36). The previously mentioned family's chronically ill child did not receive home care. The child spent most of his life in the hospital, where he also died. In fact, the family faced a difficult decision to discontinue life-support for their child after the doctors informed them that he was dying and that no more treatment options existed. The scores on the Moral-Religious Emphasis subscale for this family were low, whereas scores for the remainder of families were high.

Table 37

FES Typology of Family Environments

Typology of Family Environments	Families	
	pre	post

Personal Growth – Oriented Families		
Independence-oriented	1	2
Achievement-oriented		
Moral-religious oriented (S-structured, U-unstructured)	4-S 2-U	4-S 1-U
Intellectual-cultural oriented		
Relationship – Oriented Families		
Support-oriented		
Conflict-oriented	1	1
System Maintenance – Oriented Families		
Disorganized families		

The experimental group families exemplified three different family typologies (Moos & Moos, 1986) illustrated in Table 37. The pretest identified four families as Structured Moral-religious oriented, indicating that these families preferred a higher mixture of Intellectual-Cultural orientation and Organization than the Unstructured Moral-religious oriented families. Two families exemplified Unstructured Moral-religious oriented families. These results substantiate observations described earlier that the families exhibited a high level of Moral-Religious Emphasis. This finding could also, however, be specific to the social region in which this study was conducted, commonly referred to as the “Southern Bible Belt Region.”

On both pre and post measures one family identified as Independence-oriented, while another family identified as Conflict-oriented. The Conflict-

Oriented family was earlier described as showing increased levels of conflict and an increased score on Family Incongruence at posttesting. This finding serves as a quantitative confirmation of how I observed them qualitatively.

Summary of Family Effects

Families experienced several increases and a positive trend in some of the aspects of family environment. Due to the unique characteristics of this population, the results of one of the aspects could be interpreted as a movement towards healthier family functioning.

In addition, the counseling staff validated the effects in their observations of increased openness and willingness of many participants to engage in the creative process. Family members also confirmed these findings in their journals and evaluations, some of them stating that, after the study, their families felt closer. I observed the parents exploring their spiritual beliefs somewhat more openly than prior to the study. Keeping in mind the limitations of this study, it appears that expressive arts therapy shows promise for affecting change in some aspects of total family functioning.

Parents

Anxiety

Between the beginning and ending of this study, parents reported no reduction of anxiety symptoms. The outcome, however, did indicate a positive trend. A larger sample might have yielded a statistically significant decrease in overall anxiety symptoms. The most common anxiety symptoms reported by the

experimental group families included indigestion or discomfort in abdomen, unable to relax, fear of the worst happening, hands trembling, nervous, heart pounding or racing, feeling hot, fear of losing control, and shaky.

Table 38

BAI Pre and Post Score Ranges on Pre and Post Measures

BAI Ranges	Pre				Post			
	Min.	Mild	Mod.	Sev.	Min.	Mild	Mod.	Sev.
Mothers	3	3	2	1	4	4	1	
Fathers	5	2			7			

Table 38 illustrates the score ranges of the mothers and the fathers and portrays the differences between them. These BAI score ranges correspond to findings that in families who have experienced the loss of a child, mothers tend to experience a more intense level of grief or distress than fathers (Martin & Doka, 2000). Strategies for dealing with the loss also differ. Mothers are more likely to seek outside support and ventilate feelings, while fathers are less likely to express affect. Fathers see themselves as providers, protectors, and problem solvers, making it difficult for them to accept and receive help. Also, men tend to be more private, intellectual, and introspective in their grief and will often choose activity as a way of adapting (Martin & Doka, 2000).

Depression

Between the beginning and ending of this study, parents reported a substantial reduction in depressive symptoms. Unlike their anxiety symptoms, the parents reported a much higher level of depressive symptoms at the beginning of

the study. No particular set of symptoms was shared by the experimental group parents. Instead, I noticed a difference between the intensity of depressive symptoms, with mothers' responses tending to be more intense

Table 39

BDI-II Score Ranges on Pre and Post Measures

BDI-II Range	Pre				Post			
	Min.	Mild	Mod.	Sev.	Min.	Mild	Mod.	Sev.
Mothers	3	1	2	3	4	2	3	
Fathers	5	1	1		6		1	

than fathers'. Table 39 illustrates the score ranges of the mothers and the fathers and denotes the differences between genders. Again, Martin and Doka's (2000) findings appear to be reflected in the sample of participants in this study.

Summary of Parent Effects

The parents apparently did experience some benefit from participating in the treatment of this study. The findings of this study did correspond with recent research describing gender differences during grief and mourning.

Keeping in mind the limitations of this study, it appears that expressive arts therapy shows promise for affecting change in decreasing parent symptoms of depression and shows a positive trend towards affecting parent symptoms of anxiety. Further research is indicated.

Children

Child Overall Behavior

Between the beginning and ending of this study, parents reported a pronounced reduction, but teacher/childcare providers reported no reduction, in overall behavior problems. Results indicate that parents observed a significant reduction in the total behavior problems of their child(ren).

Like the parents, the camp staff reported a reduction in overall behavior problems of the children. Specifically, from the beginning and ending of this study, the camp staff noticed that many of the children demonstrated improved levels of self-control, decreased levels of hyperactivity, and increased ability to focus.

Specific Aspects of Child Behavior

Externalizing. Between the beginning and ending of this study, parents reported a pronounced reduction, but teacher/childcare providers reported no reduction, in disruptive behavior problems. These problems included acting hostile verbally and/or physically in threatening ways towards others; participating in antisocial/rule-breaking behavior; and being overly active, rushing through activities, and acting without thinking (Reynolds & Kamphaus, 1992).

Like the parents, the camp staff reported a noteworthy reduction in externalizing behavior during camp. Overall, they observed that halfway through the camp, the children were noticeably less aggressive, less whiney, more confident, and much more relaxed than they previously had been. One counselor commented about a child, "The day before, he was hyperactive, all over the place, he had to have one-on-one attention at all times. Even though he still

needs one-on-one attention, there was a change in the child during the clay activity. He calmed himself and did lots of reflection. From then on he was different. He was able to maintain eye contact and was just different. He stayed more calm for the remainder of the camp.”

Internalizing. Between the beginning and ending of this study, parents reported a marked reduction, but teachers reported no reduction in Internalizing problems. These problems possibly included feeling nervous, fearful, or worried about real or imagined things; feeling unhappy, sad, or stressed possibly resulting in thinking about suicide; and being overly sensitive to and complaining about relatively minor physical problems and discomforts (Reynolds & Kamphaus, 1992). One of the counselors wrote in her journal, “One [father] very solemnly and seriously thanked me for my work with [his child] the day before. He reported that since that activity, she has been less withdrawn, more involved, and has been talking more...he saw important changes in her.”

Like the parents, the camp staff reported a notable decrease in internalizing behavior during camp. Overall, they observed a decrease in nervousness, sadness, and fearfulness. Camp staff stated that after the children participated in the expressive arts activities, they noticed the children seemed more peaceful and less sad. They also noticed the older children taking more risks in talking about their deceased siblings and in supporting one another.

School. Between the beginning and ending of this study teachers reported no reduction in school behavior problems. Results did, however, show a positive

trend indicating that, given a larger sample size, a statistically significant reduction might have occurred. School problems included the tendency of the children to be easily distracted, to be unable to concentrate more than momentarily, to be unmotivated, and to have difficulty understanding and completing schoolwork (Reynolds & Kamphaus, 1992).

Even though teachers did not see a reduction in school problems, camp staff did notice a reduction in the children's distractibility, inability to concentrate, and difficulty in understanding and completing tasks.

Adaptive Skills. Between the beginning and ending of this study, parents reported a substantial increase, but teacher/childcare providers reported no increase, in the child's ability to adapt readily to changes in the environment and to develop interpersonal skills useful in home, school, and community settings that could result in stronger academic performance, effective organizational skills, and solid study habits (Reynolds & Kamphaus, 1992).

Like the parents, the camp staff reported an increase in adaptive skills during the camp. Overall, they observed development of better interpersonal skills, of more flexibility when changes occurred, and of willingness to interact with and to help others.

Emotional Symptoms. Between the beginning and ending of this study, children reported no reduction in internal feeling of emotional upset (Reynolds & Kamphaus, 1992). No reduction does not indicate serious emotional disturbance but rather that the children's emotional view of themselves did not change.

Three children in the experimental group families were in the 8 to 18 age range required for participating in the BASC-SRP. One child's scores, on both pre and post measures, indicated he may have been in denial or responding in a socially desirable manner rather than truthfully. The child's parents expressed concerns to me that he covered up his emotions and that he had not mourned his sibling's death. The child did weep at the camp remembrance service for the first time since his sibling died. On the first night of camp, this same child spontaneously used stuffed animals, which were sitting around the meeting rooms, to "talk through" when communicating with others. I observed him experiencing acceptance from camp counselors, parents, and peers, for behaving in ways that helped him feel safe; this acceptance could have aided in setting the emotional tone that later allowed him to be able to openly express sadness at the remembrance service.

Another child's scores indicated that she was possibly at risk for emotional problems. The camp staff and I observed her, with a few exceptions, as withdrawn and sullen, as distancing herself from her family, and as exhibiting negativism. Shortly after the study ended, this child was diagnosed with leukemia and died a few months later. The butterfly this child created in the clay sculpture activity, along with her withdrawal and distancing behavior during camp, took on another level of meaning when I received news of her diagnosis and death.

The counselors and I observed the third child as making the most noticeable changes between the beginning and ending of this study. At the

beginning he appeared insecure, somewhat withdrawn, and afraid of taking risks. By the close of camp he demonstrated more confidence, openness, and eagerness to connect to other participants, particularly the children, but also with adults. The counselors who worked with his age group noticed that he served as a role model for the other children. During the expressive arts activities he actively participated and reportedly disclosed his thoughts and feelings about his sibling who died, after which other children, who had been reluctant or hesitant also disclosed. In this child's evaluation of Camp Sol he answered the question, "How have you changed since you got back from camp," by stating, "I am more brave of almost everything".

School Maladjustment. Between the beginning and ending of this study, the three children participating in the BASC-SRP reported no reduction of school problems. Generally, they did not feel greater satisfaction with schooling, nor did they perceive their teachers to be fairer, more caring, or less demanding (Reynolds & Kamphaus, 1992).

All three children reported themselves within the average range on both pre and post measures. The counselors' observations did not coincide with the children's responses. One child connected in a very meaningful way with her counselor while constructing her clay sculpture. This connection is described in detail in the Process Observations section of this dissertation. Her parents, other counselors and parents, made comments throughout the study regarding the development of the therapeutic relationship between this counselor and child.

The other two children were noticed to be demonstrably more expressive both verbally and physically as the study progressed. I would see them hanging on counselors or parents in ways that preteens tend to behave when they feel accepted and part of a group. I would also see them scoop up young children in their arms and swing them and hug them.

Clinical Maladjustment. Between the beginning and ending of this study, the three children participating in the BASC-SRP reported no reduction in internalizing problems. The children did not experience a reduction in any combination of the following: feelings of nervousness, worry, and fear; tendency towards feeling overwhelmed by problems; mood swings and thoughts and behaviors that may be considered “odd”; feeling controlled by external events or other people; stress and tension in relationships and excluded in social activities; over-sensitivity to minor physical problems and discomforts; unhappiness, sadness, and dejection; or feeling unsuccessful and inadequate (Reynolds & Kamphaus, 1992).

The child who was more withdrawn, and who was later diagnosed with leukemia, reported feeling fearful and worried, feeling controlled by external events and by her family, and feeling general malaise. Another child’s reports tended to minimize or hide unpleasant thoughts and feelings

Personal Adjustment. Between the beginning and ending of this study, the three children participating in the BASC-SRP reported no increase in positive levels of adjustment. Their reports did, however, indicate a positive trend. A

larger sample might have shown a considerable increase in any combination of the following: feelings of self-esteem, self-respect, and self-acceptance; perception of having good social relationships; positive regard for parents and feeling esteemed by them; confidence in ability to solve problems; and belief in one's personal dependability and decisiveness (Reynolds & Kamphaus, 1992).

The counseling staff observed more improvement in two of the children. Counselors noticed these same improvements in the third child; however, she relating contained a different quality or sense that could have been related to her impending diagnosis and death. Overall, the counseling staff and parents reported increases in feelings of self-esteem, self-respect, and self-acceptance. The parents of the boys commented about how the two of them found, in each other, a very special friend. Both counselors and parents noticed in the children, a higher level of confidence in their ability to solve problems; and in their beliefs in their own personal dependability and decisiveness.

Anxiety. Between the beginning and ending of this study, parents reported a substantial reduction, but teachers and children reported no reduction, in anxiety symptoms. These symptoms included worries, fears, phobias, nervousness, generalized oversensitivity, and self-deprecation (Reynolds & Kamphaus, 1992).

On the BASC-SRP, scores below a certain level may reflect an inflated sense of well-being. Such was the case with one of the older children's pre and

post scores on the anxiety subscale, which fits in with his self-report on emotional symptoms and clinical maladjustment.

Like the parents, the camp staff reported a definite progressive reduction in many of the children's overall anxiety symptoms, primarily during the camp weekend, but also during the final follow-up session. The counselors observed in many of the children, less physical agitation, improved ability to focus, more eye contact, less crying, and a greater stabilized mood.

Depression. Between the beginning and ending of this study, parents and children reported a pronounced reduction, but teachers reported no reduction, in depressive symptoms. These symptoms included dysphoric mood, suicidal ideation, withdrawal from others, and self-reproach (Reynolds & Kamphaus, 1992). Childrens' reported reduction denotes a decrease in loneliness and sadness, and an increase in the ability to enjoy life (Reynolds & Kamphaus, 1992).

Like the parents and children, the camp staff reported considerable reduction in depressive symptoms. Overall, they observed children talking about their deceased siblings and acknowledging the specialness of meeting new friends, who also lost a sibling. One child stated, "it was so nice to meet another boy like me who lost a brother. The other camp I go to only has kids who have lost a parent." I observed these two boys growing closer and heard them making plans to get together after camp.

Critical Items on BASC. Critical item responses for the BASC are included to highlight specific behaviors that may suggest danger to the well-being of the child or others. Various critical items may represent thoughts, feelings, or behaviors that may need more attention such as those possibly related to suicidal ideation. Other critical items contain thoughts or behaviors that may be out of control or that may indicate extreme feelings of isolation and despair. Some items, such as physical complaints, may signal the need for a referral to other professionals (Reynolds & Kamphaus, 1992). Table 40 displays the critical item responses reported by parents and teacher/childcare providers, and Table 41 displays the critical item responses reported by children ages 8 to 18.

Table 40

BASC-TRS and BASC-PRS Critical Item Responses

Critical Item Responses <u>BASC-TRS</u> and <u>BASC-PRS</u>	Pre #Families			Post #Families		
	T	M	F	T	M	F
Stutters	1	2		1	2	
Uses medication often or almost always	2	1	1	2	2	1
Sleeps with parent		7	4		6	4
Toileting accidents	1	1	1	1	2	2
Wets bed		2	2		2	1
Eye problems	1	2	1	1	2	1
Hearing problems	1	1	1		2	1

Child stated, "I want to kill myself"			1
Child stated, "I want to die or I wish I were dead"			1
Child threatens to hurt others	1	3	1 3
Child tries to hurt self sometimes	1		
Uses foul language		1	1
Throws tantrums sometimes	1		2
Child stated "Sometimes I want to hurt myself"	1		
Child stated, "I just don't care anymore"	1		
Child stated, "I give up easily"	1		

Note: T=teacher/childcare provider; M=mother; F=father

Each of these critical item responses could be related to grief, as children commonly report and/or exhibit these and other behaviors, feelings, and expressions when they are mourning (Rando, 1984; Wolfelt, 1996; Worden, 1996). Some of the items noted on the pretest did not appear on the posttest;

Table 41

BASC-SRP Critical Item Responses

Critical Item Responses BASC-SRP	Pre	Post
I can't seem to control what happens to me	1	1
No one understands me		1
I cannot control my thoughts		1
I cannot stop myself from doing bad things		1
Sometimes I want to hurt myself	1	
I give up easily	1	

however, some items that were not indicated on the pretest did appear on the posttest. A number of explanations could account for this phenomenon. I observed that the participating families displayed caution and protectiveness; these qualities may have contributed to their not making full disclosure on the pretest. Another possible explanation could be the changing level of awareness of the families during the study as they gained self-awareness and gathered information about children's grief behaviors. Other causes could be responsible for these responses at this time in these childrens' lives. Most families have ongoing issues unrelated to, but concurrent with, the illness and death of a loved one.

Summary of Child Effects

Children apparently did experience many benefits from participating in the treatment of this study. Even with the unusual and odd combination of children in a group, comprised of two boys age 10, and one girl age 15, changes were reported. Throughout this section a marked discrepancy appears between the parent and teacher/childcare providers' responses. This discrepancy may be attributed to the possibility that parents, in getting some of their needs met during the study, reported perceptions of their child(ren) that may actually have reflected their own improvement. In other words, as they themselves improved, their perception of their child(ren) improved rather than the children themselves having improved.

It also is possible that the children improved in ways observable only under the relatively personal conditions of family life but not under the relatively more impersonal conditions of the school setting. An even stronger probability exists that the treatment impacted the parents' perceptions of themselves and their children, while the teacher/childcare providers' perceptions of themselves and the children were not impacted.

However, like the parents and children, camp staff also reported a marked change in the behavior of the children. The adult-child ratio in the camp setting ranged from 1:1 to 1:3. Therefore, the counselors were in more personal relationship with the children than were the teacher/childcare providers, possibly enabling counselors, like parents, to observe the children more closely and note changes more easily.

Keeping in mind the limitations of this study, it appears that expressive arts therapy shows promise for affecting change in decreasing children's behavior problems. These findings are very encouraging and warrant further investigation.

Summary of Participant Changes

Families, children, and parents showed apparent improvement in at least one-third of the areas assessed in this study. If observations by the teacher/childcare providers, which consistently showed no effect, were removed, over one-half of the effects hypothesized in this study showed change.

These findings indicate that the use of expressive arts therapy in a treatment format similar to that described in this study shows promise in affecting constructive change. Thus, the use of expressive arts therapy with bereaved families is deserving of future research.

Process Observations

In this section, I will discuss each expressive arts activity and the follow-up sessions, integrating discussion of the journal entries and evaluations of families and counselors. I will also include my own observations and the observations I gleaned from the counseling staff at various intervals during and following the study.

Camp Sol-Healing the Family Heart

Nametags and Family Flags

My office was, I quickly discovered, not conducive for an orientation to even a medium sized group with highly active small children who were attempting to fill out paperwork and make nametags. After the families completed the pretests they made their nametags for camp. At first the parents were reluctant to engage in this activity; however, once they did, they playfully selected beads, feathers, stickers, and markers to create their nametags. A couple of dads were very meticulous and took extra care and time in constructing intricate patterns for their nametags. I noticed that the children became very engaged in making their nametags, often squealing with delight as they sifted through beads and selected stickers. The very young children did need some help with this activity, which did

interrupt the parents' process at times, despite the help of an assistant. The families appeared to have fun being together while creating their own special nametags that would be waiting for them at camp when they arrived. One parent expressed in her journal, "We had already made our name tags last Saturday. That was fun."

Figures 1-6 (Appendix E) show the campgrounds of Camp John Marc. During the summer months, Camp John Marc holds one-week camps for children with chronic illnesses, such as cancer, diabetes, and cardiology; and during the Fall, weekend camps are held for specific diagnoses, such as brain tumors. For children who do not survive their illness, the child's name, birth and death dates are carved into a brick and set in a brick pathway located on the campgrounds. Of the experimental group families, seven of the eight children who died attended Camp John Marc at least one time. One mother described what it was like for her to come to Camp John Marc,

I was so happy to be here where [deceased child] spent her last 'fun times'...It is probably the main reason that I am here—to see where [deceased child] was. Now the whole family was here—I feel connected to [deceased child] here. I feel her presence. I think '[deceased child] probably walked here and saw that same view or sat around the bonfire like we are'...The facilities are beautiful. I had a wonderful weekend. Being here with other families who share the same loss has been a warm experience. We feel like we already are a big family from the 6th floor at

the hospital. We understand each other and we know what we all have been through.

Another mother also described how she felt about coming to camp, “It was exciting to see [deceased child’s] brick with her name on it. I was also happy to know that I shared the very same room that [deceased child] had lived in when she went to camp.

Once the families settled in their cabins at camp, they checked in and began the first family activity. Each family chose a wooden flagpole with its base, a felt flag, the foam letters of their last name and various art media to decorate their family flag. Figures 7-8 (Appendix E) are examples of family flags created that evening at Camp Sol. The staff and I observed the families as they made their flags: the relationships between the parents and children, who took leadership roles, who made decisions, what degree each family member participated, frustration levels of parents, perfectionistic needs of parents and/or children, etc. Most parents made an effort to include the children in choosing the items for their family flag. Right away, the staff and I noticed that most of the families came to camp to be together and to have fun as a family. One parent, however, stated in his journal, “I came up to camp mad. Mad at the fact that we have to be here. My motivation for coming was for [surviving child]—he’s so lonely and I’m at loss as how to temper his feelings....”

Once completed, the families took their flags to the dining room and selected the table where they would be eating during camp. The staff and I

noticed the families looking proud and feeling excited about their flags, especially the children who seemed to relish in creating a symbol of family identity. Wolfelt (1992) stated that one of the reconciliation needs of childhood mourning is developing a new sense of self-identity. Families in mourning also must develop a new family identity (Shapiro,1996).

Introductions, Family Bingo, and Singing

At the initial gathering, the families and counseling staff sat in a circle at the end of the large dining hall. The room was too acoustically live, and it was hard to hear. I proceeded with introducing myself, and the staff introduced themselves. At this point the parents seemed anxious and unsure about camp, and the children seemed hyper-excited. The child life specialists later acknowledged they also felt very anxious about the camp being a good experience for the families. They stated that they wanted to make sure that the families had fun, a motive the intensity of which was unknown to me until many months after the study ended. I will further explore this important factor later in this section.

I introduced the Family Bingo Game (Appendix E) as an ice-breaker activity. All the families actively searched for other families who could sign their Bingo sheets. The atmosphere became very energized, which was good in some ways, but was very loud and difficult to manage in such a large room. A smaller, more contained room would have better served the introductions and this activity. A prize was awarded to the family who collected the most signatures within a set

amount of time. One counselor observed the bingo activity as “a great way for families to meet and share glimpses of their lives. They seemed to enjoy this activity a lot.”

Next, the entire group participated in singing the songs, “If You’re happy and you know it” and “Circle of Friends” (Appendix E). I observed the younger children as very demonstrative and physically active during the singing. They helped lead the movements to the first song. The children sang loudly and with great enthusiasm. I also observed the children as feeling very important and special as they moved into the center of the circle to help me lead the songs. One of the counselors observed, “excellent—for the kids...it involved visual, auditory, and kinesthetic processes...they had lots of energy and it worked well...the adults seemed happy/proud during the songs.”

Following singing, the counselors handed out journals and pens to every family member. Using art materials on the dining room tables, the families decorated their journals. I was not sure how the children would react to the journals. They seemed very excited about it, especially about having their very own journal, and immediately began journaling by writing and drawing pictures. The parents reacted in various ways. No one refused to journal and approximately half of them returned journals to me at the end of the study. The journals contained anywhere from one entry to many entries. One mother made the statement, “I hate journaling,” and proceeded to consistently write the most

emotionally moving entries of any parent in the study. The most salient contents of the journals will appear throughout the discussion section of this dissertation.

I also introduced another ongoing expressive activity for the weekend. I showed the families the large paper maché heart and the tray of markers. I invited them to commemorate their deceased loved one by using words or drawings and to express ways they had learned to take care of themselves. The heart represented the theme “Healing the Family Heart.” The staff and I observed the parents and the children writing and drawing on the heart all weekend. The giant heart shown in Figure 84 (Appendix E) surprisingly turned out to be one of the most important yet least structured activities at camp. Family members left messages to their deceased child. They used the heart to say goodbye. Some of the children wrote their own names on it and told their sibling that they loved them and missed them. The last day of camp I photographed each family next to the heart. Figures 41-42 (Appendix E) show two examples of the family photographs.

Family Puzzle Piece Activity and Bonfire

I introduced the major therapeutic expressive activity for the evening, “Family Puzzle Piece Mural.” Once each family selected a puzzle piece, they established a working place for themselves and they engaged deeply in the process of creating a way to tell about who they were and why they were at camp. The families selected items for their puzzle piece from a wide variety of art media (Appendix D). The staff and I observed how intensely the families worked

to create their puzzle pieces. While the families appeared to be having fun, they also seemed very passionate about making sure they included the aspects that best represented themselves and their child who died. When the puzzle pieces were finished, I asked the families to search for the other families whose pieces fit with their piece. The staff and I noticed how the families looked as if they were enjoying themselves and how they became better acquainted as they worked together to fit all of the mural pieces together.

Once the pieces were in place each family told about their puzzle piece, who they were and why they were at camp. The children eagerly shared their own perspectives of their family and why they were at camp; they were very active during the entire process. Even though the dining hall was not the optimal place for this level of sharing, most of the children seemed to sense the depth of feelings being expressed. One counselor remarked, "I realize that you wanted all of the family there, however, the little ones [age two and under] did not seem to get much out of being present while all shared and they disrupted their parents and others who were very involved in the process...the little I experienced of the activity seemed quite powerful for some families."

The family members did express their sadness and did reach out to each other during this sharing process. I observed an overwhelming sense of caring and understanding being exchanged between most families. However, one counselor noticed, "Some people showing their grief struck me while others tried hard to hide it and deny it, saying 'we're here only to support others who've gone

through this.” The children seemed to be looking at one another curiously, perhaps realizing that the other children there also had a brother or sister who died. The children later shared their curiosity with the counselors. Figures 9-16 (Appendix E) are examples of the “Family Puzzle Pieces.”

A counselor later commented, “I was very touched by their stories. It seemed that even though the focus was not on the grief of losing a family member, it seemed clear that their feelings associated with their loss were coming out.” Another counselor expressed,

The mural was very powerful...novel...the families were able to build reality as they knew it and a lot of them had not gotten to do that, especially for kids...the kids took the lead, helping parents see how they wanted things to be...what their relationships were like with the deceased child...the kids understood more than the parents...kids were more empathetic and very curious about what other kids did.

Following the puzzle piece activity, the Camp John Marc (CJM) staff held a campfire by the lake. Most families attended, however some with very young children went to bed. The CJM staff told stories and helped everyone roast marshmallows and make s’mores. The staff and I noticed that many of the family members sat quietly by the campfire, in a more reflective psychological state.

One of the counselors remarked,

The activities...story-telling...s’mores were fun...could do more singing... but more importantly, [the families] spent some silent reflective time just

looking into the fire and watching the sparks/embers/smoke, etc.” I experienced the campfire as a peaceful ending to first day of camp. Another counselor stated, “I think the campfire at the end of the night was great. It was a nice relaxing way to end the evening.”

One mother remarked, “We had fun putting our part of the puzzle together, it was related to [deceased child], how we felt and how she felt.” At the conclusion of the evening, a father wrote in his journal,

It was good to see families that shared the experiences we did...we are all trying to move on with life, but we all know it'll never stop hurting. To my surprise the interaction of building our puzzle piece was a good experience—I felt the anger lift from me and really faded quickly. Not only did our family get involved with the puzzle, but I saw the whole group bond with their own creations—it was a nice feeling to see our friends again—we all have so much in common....

Another parent shared, “Strangely, I enjoyed working together on the puzzle piece—our tribute to [deceased child] and our family”. An older child wrote in his journal, “I liked camp because...of the bonfire...it was funny...of the puzzle pieces, they were interesting.” A young child wrote in her journal,

This is the best day I ever had and I had songs. This is the best camp. I hope we can do it again soon and everyone liked our picture of my family and it looked like it was cute with the halo on [deceased child]. She was

the cutest one on the picture [child drew a picture of the family puzzle piece].

Friday Staff Meeting

I held a late night staff meeting during which the counselors processed the evening's events. Overall everyone reported feeling pleased and excited about being at camp. One counselor stated, "One thing I would have liked for the evening was more activities where the participants could get to know the counselors a little better. At times I felt like I was intruding during the puzzle pieces".

The staff and I determined that, for the remainder of camp, changes needed to be made with regard to the number of counselors per developmental age group. The entire staff noticed that the young children were exhibiting hyperactive, out-of-control behavior, that the children would run off without telling their parents, that the children were needing attention, and that the parents did not seem aware of the extent of their children's needs. The staff decided that three of the 3 to 5 year olds needed one-on-one supervision, even when involved in individual family groups, so as to allow the parents to engage in the creative process of the activity.

Family Clay Animal Sculptures

The first break out session on Saturday was the "Family Clay Animal Sculpture" activity, Figures 17-28 (Appendix E). Each family accompanied their counselor to a secluded area on the campgrounds. There the counselor gave

each person a block of clay and a variety of modeling tools. When the counselor finished introducing the activity, each person began sculpting an animal out of the clay. Then the family gathered materials to make one environment for all of their clay animals and placed their animals in the finished environment while telling each other about what they needed and wanted for their animal in the environment.

For families with young children, more than one counselor facilitated the clay activity. The decision to have a counselor for the younger children seemed very important and effective in allowing parents to focus on their own creative process. One counselor expressed, “It was very beneficial to have an extra [counselor] to work with the youngest [children]. This really let the family focus on their activity and not worry about taking care of the little ones.” The child’s counselor helped the child by assisting with the child’s sculpture, by bringing the child into the family process, and by taking the child for walks while the parents worked on their sculptures.

For a couple of the counselors, challenging situations presented themselves during the clay sculpture activity. One of the families who expressed negative feelings about the clay activity stated that they felt the counselor was too pushy and intrusive by asking too many questions they did not want to answer. The counselor, however, portrayed the experience very differently. The counselor stated,

I left this session somewhat confused and disoriented. I was feeling as though I may have done something wrong. But the more I thought about this session, I soon realized that [the parent's] anger, although directed at me, was not about me... I sought supervision afterwards...I felt almost that [one parent] was 'stuck/obsessed' with their child's death and [the other parent] wanted to move on.

The second family expressed anger about perceiving the counselor as attempting to get the parent to cry. In both cases my observation was that for the families' part, strong personalities existed in both families and, for the counselors' part, greater sensitivity to the emotional frame of mind of these family members most likely could have prevented these situations from occurring. The counselor of the second family acknowledged that he was following his own agenda and was not as aware of the parents' emotional state as he needed to be.

One of the parents who was indignant and who angrily stated how useless the activity was, protected his clay sculpture and would not allow anyone to touch it or carry it but himself. This parent's sculpture of a beached whale shown in Figures 17 and 19 (Appendix E) was phenomenal, not because it was perfect, but because it contained an emotional quality beyond verbal expression that embodied his daughter's life and death and his undying love for her. He passionately labored to mold his sculpture into what he needed to express through the sculpture.

I believe that this parent's behavior speaks to the power of this kind of experiential work. Even though he lashed out in anger, his expression and his behavior indicated to me that his sculpture held immense meaning for him. While the counselor did recognize the power of this experience, I believe the results could have been very different if the counselor had also recognized the limitations of the family's ability to move beyond where they were in their own process.

The experiences with the remaining families were generally positive. One mother described her experience with the clay sculpture activity:

We first worked with clay, we really got our minds to work, by just getting the feel of it. At the same time see how we feel and work as a family—and how we felt about what [deceased child] would feel, and how the animals that we choose fitted in to our lifes [sic], how we compared them to [deceased child]—or ourselves...in some way each thing could relate to us in some way.

I wanted the counselor's role to be that of facilitator, facilitating the family by taking the family's awareness to whatever level felt safe for the entire family. I facilitated a family, described earlier, where the parents recognized themselves in their sculptures and realized how these characteristics were impacting their lives. They reportedly gained awareness about each other and about their child that they did not have prior to this experience.

I will now briefly discuss each family's sculpture based on observations and comments of the counseling staff and my own observations. Any interpretation is based on family members' reported understanding of their creation. Clay sculpture #1 shown in Figures 17-20 (Appendix E) was that of a raccoon, Pokemon, and whale. The raccoon was chosen "because of its independence and ability to not be dependent on others." The raccoon's weakness was that it might not survive if it needs to go into the city for food. The Pokemon strengths were "being smart and powerful" and weaknesses were "not being able to do what it wants—having to do what others want him to do." "Pokeman needs friends." The whale was described as the deceased child's favorite animal. The whale's strengths were its "ability to be a leader and to be free...gets along only with animals of its own kind." The whale's weakness is that "it is a predator." In the perfect environment the raccoon would stay in the box because "everything the raccoon needs is in the box," the whale would "stay out on the tray where it's free," and the Pokeman would stay outside the box between the whale and the raccoon. To make life perfect, all the whale needed was a mermaid; the Pokeman needed friends; and the raccoon was in its perfect world in the box and, therefore, did not need anything more.

In Clay Sculpture #2 shown in Figures 21-23 (Appendix E) each person started out with an animal that turned into another animal. One parent chose a bull at first, then turned it into an antelope, stating it was

Fast, free, and a survivalist...The antelope can't protect himself from everything and he does not threaten other animals, they won't kill each other...The antelope likes to have fun and wishes always to be free...The one thing the antelope wishes it didn't have to do is die one day...He needs protection...a safe place and refuge”

The other parent started out making a dog, then decided to turn it into a dog/turtle combination. She stated,

The family dog is an important family member and she sometimes feels like a turtle pulling into its shell to survive...The strength of the animal is its shell; however, it's not always protective...Perceives herself as no threat to other animals, that they won't kill each other...Likes to chase its tail, relax and have fun and would like to do that more and not have to worry about anything...also wishes it didn't have to die some day...she needs freedom.

One parent made a seal for the deceased child and the other parent made a headstone. They stated,

Everyone loves seals, everyone loved [the deceased child] and she was so easy to love...the seal likes to make people smile and wishes it could be with [her parents]...Wishes it didn't have to be dead...It needs water and food.

In their perfect environment, “these animals are most comfortable when close together for companionship...It would feel safe, comfortable and

enjoyable...would like to have their deceased child back with them.” Through their animals, these parents expressed how much they missed their child and how they wished they could have her back.

In Clay Sculpture #3 shown in Figure 24 (Appendix E), one parent made a Manatee, while the other parent made a dolphin. One child made an owl and a squirrel and placed the squirrel high in a tree to eat some nuts. She also made a cheetah to represent the deceased child. The youngest child, two years old, made clay objects to place in the environment; however, she did not make a specific animal. The manatee “needed to be at the beach in Florida...Manatees like to just float around, but boats can hit them so they are quite vulnerable.” The dolphin is “free, nice, a helper, a protector, and is smart.” The owl is “cute, especially as a baby, good at getting food because they can see at night.” One parent stated that the deceased child loved cheetahs and that she looked like one, but that she was too sweet to be a cheetah. The other parent stated that the deceased child was driven—pressured herself to achieve—and never complained. In the environment the cheetah, deceased child, was placed above the owl, surviving sister, to look over her. The manatee and dolphin, the parents, were facing the other animals on land, as if looking out of the water to keep an eye on the other animals. The owl complained about where she was placed and moved herself. The squirrel stayed removed—high in the tree. The two year old quietly stabbed the cheetah before her counselor redirected her. Through their animals and their behavior towards the deceased child’s animal, the children

could have been expressing how they felt about the deceased child still holding the center place in the family.

In Clay Sculpture #4 shown in Figure 25 (Appendix E) one parent created a bear in a cave and the other parent created a bird. The child created an alien Loch Ness monster. The bear is “strong, a protector, he hunts, gets food, and takes care of things, he’s very strong. He wants to get rid of the monster with the laser, he’s independent, and wishes he could fly. The perfect home would be safe, you wouldn’t have to worry about predators.” The monster has “different powers, he’s in the middle of the water where he can hide, doesn’t get along with anyone, he doesn’t get caught.” The perfect place for him would be “a lot of trees so people would think it was a forest and see the lake, so he wouldn’t have to hide.” He wishes he “could get along with the bear and that the bear wouldn’t be so mean, and that the bird wouldn’t poop in it’s lake all of the time. There’s not enough fish because the bear eats them and so do the birds.” The bird “takes care of others, has more friends, and stays up in the tree.”

In her journal, the mother commented, “I didn’t quite understand the significance of the clay animals. It was nice to sit together and work on the project. [Surviving child] worked better than usual—I mean he really was focused and seemed to think about what he was doing (not just “throw” something together).” The father also commented in his journal, “[Surviving child] surprised me with his clay Figure. He really put some thought into it—reality and fantasy.”

The child relayed his entire day, “I liked ropes. It was fun. I went the zipline. It was fun. The animals we made were fun. It was a tiring day.”

In Clay Sculpture #5 shown in Figure 26 (Appendix E), one parent created a bear and another parent created an eagle. The child formed a fish. The bear “could take care of itself and live alone with her cub.” The eagle would “be able to fly and have a sense of peace.” The child chose not to be engaged in the process. In her journal, the mother described how the clay activity impacted her,

The individual activity with family was good. Working with the clay and just doing things with [surviving child] and [other parent] is really enjoyable.

The hardest part was making my thing for [deceased child]. It brought up feelings I thought I forgot about or put behind me. It helped me with dealing with the things I need to deal with. I miss [deceased child] so much.

In Clay Sculpture #6 shown in Figure 27 (Appendix E), the family required four facilitators due to the ages and special needs of the children. One parent constructed two animals, a rhino and a wiener dog that evolved into a lizard because the legs fell off, at which time he stated, “Kind of like our family, sometimes it’s quite a zoo.” When asked what his animal likes to do, the parent stated, “Oh, I don’t know, I hadn’t really thought about it.” The other parent attempted to create an animal but kept allowing the children to distract her by asking for assistance. Once all the sculptures were completed, one parent stated she did not know what her animals was—it was “one of a kind...close to the

ground, liked to go for walks, likes to be outside, and to play.” A younger child stated that her animal, a dog, was “mean, that it likes to be happy sometimes, likes to walk and to write.” Another child created a bird and expressed that she “likes to play with her animal’s toys and that she is crying because others make fun of him.”

The oldest child with gentle attentive support from a counselor, fashioned a purple butterfly and shared that her butterfly “likes to be happy...that the dots protect him from the sun.” The counselor gave this description of the process:

Most people in the family tore into the clay--especially the little ones...[the child] didn’t like the wet feel of it. She didn’t want to touch it or make an animal. I began talking to her...first I asked her to think of an animal she liked most and we talked about it. Since she still didn’t want to make it, I began for her, getting detailed instructions the whole way. She instructed me on how she wanted the body, what size and how it should look. Next we worked on the wings. I created one, then the other to her specifications...I asked her what else she needed...she indicated antennae by ‘drawing’ them in the air...She became increasingly frustrated that I wasn’t doing it the way she wanted. She finally stated ‘here’ and took the clay from me. She was cautious to barely touch it. She rolled it on the table surface touching the clay with only her finger pads. Then she rolled it into antennae. She twisted off more clay for the second antennae, but this time she didn’t hesitate to dig into it...She attached the wings to the body

and added extra clay between the two [for stability]. She smoothed the added clay and made the butterfly pieces blend into a whole butterfly. She attached the antennae, then took a sculpting instrument and carved the wings into the exact shape she wanted. She next fashioned two eyes and a smile and affixed them to her creature. Finally she created the dots and placed them on each wing. She told me that they protected her from the sun. Later, however, before she moved her butterfly into the family environment, she took off the six dots. She seemed to not be able to make them look how she wanted them. When it was time to place the butterfly in the family environment, she was quite concerned about moving it and it not coming apart...We carefully made room for [the child's] butterfly. She stated that purple was her favorite color, so her butterfly is purple”.

A swan, rock, balls, eggs, color, and sticks were also added. The environment was described as a “big house...all beautiful...they think they like it.” One counselor described this family’s process:

Mom is very helpful to the children, asking them questions to facilitate the activity. She allows them freedom and responds with encouraging statements. Many voices were part of the process. The exercise was fluid, free flowing and had a life of its own...the family, although busy and seemingly disjointed appeared to work together, taking turns coming in and going out of the process.

In Clay Sculpture #7 shown in Figure 28 (Appendix E), the mother made a cat while the father made a fish with antlers—a deerfish, expressing that hunting was an activity that the parent and the deceased child enjoyed together. The child made a small giraffe for himself and a big giraffe for his deceased sibling. The cat “gets away from things, is moody, alone, and doesn’t care about what people think...she ends up comforting everyone else...needs to be left alone, love, encouragement, and affection”. The deerfish is a “getaway...wants to get away and not be bothered...needs water to live, not get shot—survival.” Symbols of the deceased child were scattered throughout the families’ environment, “butterflies, stars, and skipping rock.” The mother responded to the question, “If you could change anything what would it be,” by stating that the only change would be that the deceased child “would have all of us inside together, not so scattered because he was such a loving child...always wanted to help everyone...always a smile.” The young child chopped off the cat’s head, and the mother repaired it. The child’s counselor commented that “the child heard the mother’s comments about the deceased child and that the child was hyperactive and difficult to manage during the entire process.” The child may have demonstrated how he saw himself in relation to his deceased brother by creating the large giraffe as his brother and placing it in the center, and himself as a small giraffe over to the side. In addition, he possibly showed his mother how he felt about her portrayal of his deceased sibling as being so loving and helpful, and always smiling, by chopping off the cat’s head.

Overall, based on the comments and observations of the staff, several variables could have contributed to the problems that were encountered with the clay sculpture activity. First, the therapeutic relationship between counselor and family needed more time to be developed prior to the activity. Second, the activity may have been too powerful to place so early in the camp schedule and might have served the needs of the family better at a later time in the weekend after the family experienced other kinds of expressive activities that were less intimidating. A third variable was the need for more extensive experiential training for the counselors with this and other expressive activities.

Mothers' and Fathers' Altar-making Activity

For the afternoon session, I divided the parents into groups of mothers and fathers. I provided the mothers with a variety of baskets and craft materials, and I provided the fathers with a variety of wood pieces and tools for building. I directed the groups to create an altar to their deceased child. One of the mothers reacted to using the term "altar". She stated, "I have a problem with that word, altar, when it is a memorial I'm creating for my daughter. 'Memorial' would be a better term to use." Other mothers appeared surprised by the reaction, however one or two others followed the first mother's lead. I expressed to them that whatever they chose to call it was okay with me.

Both groups immediately became engaged in the process of creating their altars. Examples are shown in Figures 29-35 (Appendix E). The counselors for the mother's group noted how the mothers gathered themselves around a couple

of tables and told stories about their deceased children, laughing and weeping together as they made their altars. The counselors remarked how they sensed that the mothers were becoming very close to one another. One mother stated in her journal, "I enjoyed meeting with the women, making our baskets, sharing ideas".

One counselor commented about the lack of relationship between the two counselors who facilitated this group and the prior relationship between the other counselor and the group, as a limitation in facilitating the group process. She stated:

[There] seemed to be some unspoken alignment between the moms and [the other counselor]... [I] really appreciated [the other counselor] being there for the families because they had the prior connection, but not a good idea to pair a [stranger] (the bad guy) with her, especially in the eyes of the moms... It was almost a 'me against them' type of interaction with [the other counselor] being on the 'them' side.

In further discussion with this counselor, she disclosed how alone and inadequate she felt after the experience of co-facilitating the mother's memorial making activity.

Once the altars were finished, the counselors requested that the mothers bring their altars outside and sit in a circle. They lit the candles on their altars and processed their experiences. Later, however, a few mothers expressed irritation, to the counselor they already knew, about being asked to sit outside in a circle,

stating that they would have rather stayed in the room than to go outside to process. One of the mothers, attempting to speak for the group, stated that the mothers had already done all of their processing while they made their memorials and that the counselors, had they listened, would have learned more than they needed to know. Thus, the processing/closure component was unnecessary according to this mother. She further stated in her journal,

If the counselors this weekend had just sat around and listened and occasionally asked questions, they would have gotten so much information from these families. Sitting around in a circle expecting us to answer questions pretty much closes us up. We'll only tell you so much of the safe upper surface. But with each other, we feel safer and we will go down to the hurting layers.

Another mother concurred in her journal:

Put us families together and you will hear us talk about our 'special child', our feelings and emotions without limits. They are always there and all we want is to share our stories.

During processing, one of the counselors invited the mothers to read the personal notes they wrote to their deceased child and to themselves from their deceased child. The invitation was optional and no mothers chose to read their notes. A few of the mothers later expressed the feeling that the counselor was intrusive by inviting them to share very personal experiences. Even though the counselor was aware that the mothers appeared constricted, I think this is

another example of when a heightened awareness of the group's needs and the ability to accommodate those needs while continuing to facilitate a meaningful closure to the activity could have resulted in a more positive outcome. The counselor did reflect later, "I felt very bad that I had asked about their cards, a question I prematurely thought might help them work through some of their grief."

I also observed that the other counselor aligned with the mothers in the group. At the hospital her role was different than the role of a counselor in the counseling relationship. In the mother's group, rather than use her relationship with the mothers to attempt to facilitate a meaningful experience and closure to the activity, she chose to sit back and to not share her reported personal awareness of her own discomfort or the discomfort she noticed of others in the group. In addition, the few mothers who felt uncomfortable did not take responsibility for themselves by voicing their preference for staying inside.

Most of the mothers, however, reported that the altar-making activity was deeply meaningful for them. One mother described in her journal her experience with altar-making:

Making the altar was soothing. I didn't feel any pressure to do it a certain way. I decided to use the confetti and it was fun finding little pieces that reminded me of [deceased child]. It's also so enjoyable to be able to talk freely about him. We're at 11 months and many people don't mention him anymore—this felt good! The discussion afterward felt awkward. It would have been more comfortable sitting around the table I think—continuing to

talk casually. I like hearing about everyone's kids. It was hard to think about writing the cards, but once I got started it also felt good and yet emotional. I wouldn't want to share them with anyone, though. They were extremely personal to me.

The counselors for the father's group reported that the fathers worked very hard and very intensely while creating their altars. The counselors observed that during the creative process there was mostly silence. Of significance to the facilitators was how several fathers made altars that resembled headstones for a grave. One facilitator reflected, "seeing those crosses with each child's name on it encouraged [sic] tears to well in my eyes." Another father appeared to have difficulty completing his altar/memorial. He spent an extra 15 minutes working even though the other fathers were finished. The counselors perceived him as wanting his effort to produce perfection. A facilitator described the altar, "The shape was interesting. It was two layers thick and a completely closed-in box with no opening." At the end of camp, he was the only father who did not take his altar home. Several counselors wondered about whether the father was extremely self-critical and whether he had unusually high expectations of himself.

According to the facilitators, when the fathers gathered together to process their experience, they talked about their own child's illness and what it was like struggling through the process with the hospitals and with chemotherapy. Common themes the counselors noticed were anger and guilt. "Many of the fathers expressed deep emotion and wept." A facilitator noticed how

a father “expressed his guilt about how he had put [his deceased child] through more pain with the treatment and still his child died. His voice cracked at the mention of guilt...he was visibly moved.” This father later reflected in his journal, “I wasn’t really into the building of my ‘altar.’ The most powerful part was when we met and talked about our children—all the experiences—all the pain—all the anger and guilt.”

A few fathers, however, according to the counselors, “had their story down...like they were standing at the podium...there was no real emotion expressed by these men, although each of them voiced anger.” Another father wept as he expressed his pain about losing [his daughter]. He mentioned that “he had not cried like that since [she] died.” Both counselors noted that one father began crying instantly as he began speaking to the group. He then continued crying openly in the brief couple’s group where he expressed more sadness, guilt, and some anger. A facilitator observed, “I think it was quite beneficial for [the father]. Someone who saw [the father] after the activity said [the father] looked him in the eye for the first time.”

A counselor mentioned that, during the brief couple’s group following the mothers’ and fathers’ groups, “one of the fathers expressed that he thought it was better sharing intimate feelings, as he had shared earlier, with men. However, one of the mothers voiced that she was interested in feelings her husband had about making his altar.”

One of the issues that emerged during the altar-making activity for the fathers was that they felt they did not have enough time to process once the building part was completed. They stated that they were “just getting into their emotions” when I asked them to stop because of scheduling constraints. I had already added on 30 to 45 minutes of extra time to accommodate their needs. I felt concerned that it was time for the open family activities and that the children were eager to be reunited with their parents. One father remarked in his journal,

‘Dads’ by nature are uncomfortable and insecure about sharing their feelings and crying in front of other men. Our ‘dads’ session was cut off way too soon—we were just getting started and then had to stop...there has to be flexibility to stray away from the original path and be allowed to carry on—the way dads tend to do. It’s already hard enough to get us all together in one room to talk; now that you have us all together—don’t drive us away with strict time slots.

Another activity was scheduled for later in the afternoon; however, I was sensing that the parents were emotionally exhausted. I consulted with other staff members and decided to postpone the phototherapy activity. When I announced the schedule change, the families seemed appreciative and acknowledged that they were very tired.

Children’s Activities

While the parents were making memorials, the children participated in developmental age group activities. Ample opportunity existed for children to

express themselves fully, without fear of being too much of any feeling or behavior, pleasant or unpleasant. Counselors working with the children were able to acknowledge the childrens' wishes and their feelings, to provide unconditional positive regard, and provide total acceptance.

Children Ages 3 to 5. The children's group ages 3 to 5 alternated between free playtime and loosely structured expressive activities. The children talked about why they were at camp, named their sibling who died, and drew a picture of their sibling. The counselors observed the children to be open and eager to have fun. The children especially enjoyed dancing with silk fabrics in the breeze. One counselor commented that the children experienced some difficulty connecting to their feelings when the music stopped and they held their pose. The body tracing and painting of their self portraits, the counselors later stated, were out of control and chaotic. Expecting young children to identify feelings or to be in control while painting outside was developmentally unrealistic. Rather, counselors could direct the children to show specific feelings while dancing with fabrics for a more appropriate use of this activity. The counselors suggested that using markers rather than paints would keep the activity more easily contained, and would be easier, more effective, and more successful for the children.

Children Ages 6 to 8. The children's group ages 6 to 8 determined for themselves how they wanted to spend their time together. The counselor stated that the children "worked at an individual pace and engaged deeply in the creative process of making art." Even though they participated in several

activities such as making body drawings, the hanging circles of commemoration, feelings masks, and power shields, the group chose to spend most of their time creating their power shields. Each of these activities is shown in Figures 40, 38, 37, and 36 (Appendix E) in the order listed above. The facilitator noted, “One child put an ‘H’ on her shield that represented her hurt and used the words ‘my hurt self’...Themes of a tornado and feeling safe were [also] present.” Another child’s themes were “closeness to family members with gladness of being alive and close to God.” The counselor observed the third child as hard on himself and perfectionistic. He reported feeling “scared of the dark.” Later, his parent stated that when she moved her son’s power shield off of his dresser, he became very distressed and angry with her. She expressed how surprised she felt that he was so attached to his power shield.

Children Ages 9 to 15. The children’s group ages 9 to 15 was an unusual group. Group members included two boys, age 10 and one girl, age 15. The counselors allowed the children to chose whether to combine their age groups. Afterwards, however, both counselors expressed that having the two boys together and the girl with her own counselor would have been a better choice. One counselor stated, “Although I think this was highly beneficial for [the girl], I think [one of the boys] was hindered by her. The counselors emphasized how important it was for them to be very flexible with this age group, to allow the children some freedom of choice in activities and free time.

According to the counselors, during the “waving goodbye” activity shown in Figure 39 (Appendix E), much of the children’s conversation focused on how tired the children were of hearing their parents talk about their sibling who died. The counselors noted that the girl tended to withdraw and not to participate. One boy was very open which seemed to encourage the other boy to share special memories of his sibling as well. One child shared that “right before his brother’s death he and his brother were looking at artwork and that he was trying to paint the picture they both liked.” One of the counselors reflected, “I noticed that as [the child] shared it was almost like he gave permission for [the other child] to share. One of the boys commented in his journal, “I did make some new friends and I was glad to know someone else who had actually lost a brother...I’d like older kids to attend and make it a yearly thing and invite new families.”

The counselors also observed that while they were engaged in creating the feeling masks shown in Figure 37 (Appendix E), the children shared about their siblings’ funerals, whether or not they cried, and what it was like for them. One counselor noticed,

What struck me was the way [the child] slowly moved closer and closer to [the counselor] and actually shared with us his special memory of his brother. It seemed that [the child] needed time to establish a trusting relationship before disclosing his true feelings and he seemed to have been able to feel safer and safer to express himself as the session progressed.

Another observation of one of the counselors was,

“It seemed that each child was at a different stage of grief but it was neat to have them together to give them the opportunity to hear stories and experiences of others. They each shared similarities and differences but it seemed that they were able to bond and were gentle to each other as they shared.

Nature Scavenger Hunt and Talent Show

According to everyone’s reports and observations, the children enjoyed the Nature Scavenger Hunt (Appendix E). One family actually found all items on the list out in nature on the campgrounds. They seemed very proud of themselves and thrilled about displaying their scavenger hunt items. All children received prizes and expressed a great deal of excitement.

The talent show started out with a counselor skit that the parents apparently found highly entertaining. They seemed to especially enjoy seeing the counselors acting silly. The children decided to participate in various ways. The older children included the younger children in their skits, and the very young children serenaded everyone with unlimited stanzas of “Jingle Bells” and “If You’re Happy and You Know It.” The younger children appeared to relish being the center of attention; very different from when their sibling was sick and required constant care from family. Getting them to stop singing in order to allow for other skits was the most challenging part of the evening for me.

Parent Meeting and Decoration of Special Items

Sunday morning, a child life specialist/counselor who knew most of the parents disclosed to me that parents were expressing frustration and anger to her about camp. I decided to readjust the schedule by calling a parent group meeting. I wanted to provide an open forum for the parents to express their feelings and concerns. While the parents met, the children played group games outside and decorated some of the special items.

I opened the parent meeting by acknowledging my awareness of some confusion, irritation, and frustration regarding the study, and my desire to hear and understand their concerns. One parent expressed how angry he felt about being part of the study. Other parents expressed similar sentiments, sort of joining in with the angry parent, stating that they did not feel that they received enough specific information about what the camp or study would entail.

At times during the meeting I felt there was one parent in particular whose anger served as a catalyst and stirred up fears and insecurities in the other parents who may not have otherwise felt concerned. Some parents even seemed surprised by the intensity of this parent's anger. The dynamic, however, did seem to serve the purpose of uniting the families by targeting me with their anger. Many parents vehemently and passionately expressed feelings about building trust and then being cut-off. A parent pointedly asked me, "Are you going to just drop us when you're done with us like the hospital dropped us and hospice dropped us?" A few families expressed no interest in coming to any follow-up sessions as individual families and stated that such sessions were not what they

needed, nor would they attend even though they agreed to do so when they signed the consent forms.

At first I felt defensive, but then I realized that my defensiveness was not what was needed. Once I began to acknowledge their feelings and their desire for me to help create an ongoing support group for families—an opportunity for them to continue their newly gained connections and not to drop them, I felt a shift. The shift may have just been within myself, but I felt it as bigger than myself. Then, we began a dialogue that created the structure for the remainder of the study.

The parents were very clear about what they felt they needed and wanted in terms of follow-up sessions for the study and beyond. Regarding the study's follow-up sessions the parents expressed the desire for the fathers to meet again and for the mothers to meet again. They also wanted to meet as a parent group, and they wanted to have a meeting for all families. For ongoing support, the parents suggested they meet at least once every two to three months.

By the close of the parent meeting, they began talking about how neat it was to be the first group of Camp Sol families and how special it was to be the original study group. The parents appeared to be feeling much better about the camp and the study and much more eager to express what they felt they needed. I expressed to them that they were my teachers about what bereaved families need and want, and that I needed their hard-earned expertise and help to create effective and beneficial services for bereaved families. I adjourned the meeting.

The parents joined their children to participate as families decorating their rock jars, flowerpots, and picture frames shown in Figures 43-47 (Appendix E). The parents seemed more relaxed and light-hearted as they worked with their families on the decorations. One counselor observed,

Eventually the parents came in and I gave each family a picture frame and briefly explained the project to them. Several families pushed tables together and shared supplies and conversation while they decorated the frames...Before the families arrived at the art building, I read some of the messages on [the large paper maché heart]. When they arrived, several [parents] made a beeline for it and decorated very personal messages now. Previously they were very general like 'I miss you, [deceased child's name].' Now, they seemed so much deeper. I could instantly tell that whatever happened in the meeting they just came from, they are now in a much better place than they were a couple of hours ago. The whole atmosphere felt different, lighter. They didn't seem to be as weighed down by their problems and losses. I was quite curious as to what had just transpired in the saddle room.

One of the mothers commented in her journal,
I am glad we were able to air some of the problems we were having at camp. My main problem which almost kept us from attending, was the questionnaire [surviving child] had to fill out...I just don't like the fact that he might feel they are suggesting he feel certain ways...such as 'I want to

hurt myself' etc... the fact that we were able to have that 'gripe' session right in the middle of camp was wonderful. Instead of having bad feelings in the way of this wonderful camp experience we were able to talk about how we were feeling and clear the air.

Another mother reflected in her journal about the parent meeting,

I saw hurt people, angry people, bitter people, people that was like just in between. I could relate to most of the people, wanting more group—family get togethers, that was nice. Some people felt pressured by the counselors, I didn't feel any of that.

Remembrance Service

A chaplain from VNA Hospice planned and officiated the service (Appendix D). The staff placed the parents' altars around in the open-air chapel and lit the candles. The parents stayed close to their altars. The youngest children were difficult to manage during the service; thus, some of the parents were not able to focus fully on the commemorative experience. The service included readings for adults and for children, lighting a large rainbow candle that signified the families' common loss, and special music, "Ladybug" that I played and sang. The chaplain closed the service by inviting all participants to sing the song we learned the first night of camp, "Circle of Friends". Then, one of the counselors led the rhythmic body activity, "Rain" shown in Figure 48 (Appendix E).

Even with the disruptions of the younger children, the service was emotionally moving for most participants. One counselor disclosed to me, “during the service it suddenly hit me, why these families were here, and I couldn’t handle it. I had to run out into the woods and weep...I had not cried in years.” Another counselor expressed, “This was really good! I liked that the counselors kind of stepped back a little and let the families have their time. Although I was in the background, it helped give me closure for the weekend.” Another counselor expressed,

This closure was good for the families. They listened intently to all the things stated and sung... family members were protective of that which they created, especially the memorials [altars]. They seemed to like the rain activity and the hug was a nice closure activity.

The parents expressed the desire to take group photographs of the children, the mothers, the fathers, the families, and the counselors shown in Figures 49-53 (Appendix E). Their desire to take these group photos, especially of the counselors, indicated to me that the overall camp experience was indeed meaningful for these families.

Final Staff Meeting and Counselor Feedback

At the closing staff meeting, the counselors wanted to know about what transpired at the parent meeting. Many counselors expressed how protective they felt of me, wondering what the parents were saying to me. One counselor wrote, “I was really mad about the meeting that they had with the parents. Not

knowing what was being said was tough. I wanted to protect Kelly. I Figured [the angry parent] was putting her through the ringer.” The counselors expressed how angry they felt that the parents seemed to be so unappreciative.

I explained to the counselors that I did not fully understand exactly what happened or what the dynamics meant but that I felt the meeting was absolutely necessary for the study to be able to continue. I also told them that I felt very connected to the families after the meeting whereas before I sensed some irritation and distress from a few parents, and that now I felt there was a chance that maybe I could build a trusting relationship with them. I talked about the shift I felt in the room when I stopped feeling defensive and was able to hear the parents’ expressions of fear and pain.

The counselors processed what the camp experience was like for them. One counselor expressed,

Overall, I enjoyed the experience. I was very glad that there was processing time for the counselors. I don’t think I would have been able to get through the weekend otherwise. At times I wish there had been more processing time. It was very helpful for me. I thought the camp went very well, but I also saw areas that I wish might have been a little different...I noticed that the counselors were at all different levels of experience and training...I was uncertain of exactly what my ‘official role’ was and wasn’t sure the parents knew either. Finally, I wish there had been more time...I would have enjoyed a 3-4 day weekend. I think this would have helped

greatly...I would do this again in a second!...I thought the camp was well organized and thought out [,] which helped things run much smoother.

The counselors expressed how deeply they were touched by the entire experience. They expounded on how successful the camp was, even with the problems and issues. I reminded them and myself that this study was about learning, not about already knowing; therefore, problems and challenges were bound to emerge.

The chaplain for Camp Sol wrote about the importance of Camp Sol for the grieving family:

Grieving the death of a child challenges a family's ultimate, most trusted beliefs about the goodness of life. Because these anchoring beliefs are at the center of a person's self-esteem, because they drive a person's search for happiness, because they provide much needed security in a fast-paced world, the threat to these beliefs affects an individual at every level of being: physical, emotional, social, spiritual. This threat, coupled with our society's confusion about grief care, leaves many families desperately alone and miserable after the death of a child. Therefore, events such as Camp Sol are an oasis of understanding, support and sound grief education. Camp Sol encourages families to mourn and teaches them about mourning differences between genders, ages, and family cultures. Grief and mourning are greatly misunderstood in our country and unsupported bereaved persons are at risk for a variety of

physical, mental, and emotional disorders. Our society needs programs such as Camp Sol that promote healthy mourning. I was honored to share in this great experience.

The chaplain also described what she liked about the camp's structure:

1) Family focus: I feel that the most efficient way to care for grieving families is to utilize a family systems approach—to encourage them to relate as a family in grief care rather than as isolated 'patients;' 2)

Utilization of expressive arts: The experience of mourning the death of a child is one of such exquisite pain that words often fall short of communicating and soothing. Therefore, the use of art and music helps mourners express that which may be inaccessible to the spoken or even the written word. In addition, these media can reach into deep, spiritual places of comfort where words have often either neglected or wounded outright; and 3) Brief duration: The work of mourning is exhausting. The demands upon mourners and caregivers are intense and could not be sustained for more than an extended weekend, I do not believe.

Follow-Up Sessions

Fathers' collages and Mothers' collages, Follow-up Session One

The families expressed the desire to meet in each other's homes for the follow-up sessions, which added another dimension to my knowledge and understanding of the host families. At the first follow-up meeting the fathers

seemed moderately uneasy until they reconnected. Then, I noticed they began to enjoy themselves. The host father wrote,

When we first got back together I felt we reconnected quickly. It was good to see how everyone was doing and I was very interested in hearing everyone's story. Sitting as a group and sharing experiences was what I liked best.

Once re-acquainted, the fathers' interactions became more focused on their bereaved children. They told each other about what it was like for them at the moment of their child's death. Additionally, they stressed the importance and significance of being able to tell their stories and to hear the stories of other fathers. I felt deeply moved by their stories about their deceased children and about their surviving children. I sensed that they were so intensely engaged in their process that they were almost unaware that I was sitting amongst them facilitating the process.

I noticed however that one father seemed somewhat disconnected from the group. He even sat in a chair that was not completely in or out of the circle that the other fathers had formed. I made several attempts to draw him into the group process, even though he often responded inappropriately and remained fairly inconspicuous. While the other fathers were accepting of him and seemed to care about him, they appeared slightly uncomfortable as though they were not sure how to include him.

I wondered how the fathers would respond when I asked them to create a collage about what had helped them get through the experience of diagnosis, treatment, and death of their child. They went to work immediately. At first there was conversation banter back and forth amongst them, then as they moved deeper into the creative process the room became quiet. One father's collage had a big plate of food on it shown in Figure 54 (Appendix E). He openly stated that he used food to help him get through the experience and that he felt stuck. Indeed, he relayed that he had gained approximately 100 lbs. since receiving the diagnosis of cancer for his child. I thought he exhibited a tremendous amount of insight and courage to share his struggle in using food to "stuff" his emotions.

Most of the fathers included a symbolic representation of their marriages, and a few of them included religious symbols shown in Figures 55-58 (Appendix E). The father who seemed somewhat disconnected from the process placed no images on his collage and wrote these words, "Live life celibrat deth [sic]" shown in Figure 56 (Appendix E). He also inscribed the same phrase on the paper maché heart. The difference in his emotional developmental level combined with his educational level as compared to the other fathers was challenging for me as the facilitator. I wondered if perhaps he would be better served in a more homogeneous group.

The mothers were very glad to see each other as evidenced by their hugs and exclamations of excitement as they greeted one another. Similar to the fathers, the mothers also required some reconnecting time, though not as much

time as the fathers. One mother remarked in her journal, “It was great to walk into [host’s home] and see everyone again...We had to break the ice a little in the beginning but soon I felt right at home.”

The mothers spent time talking about their marriages, their surviving children, and their child who died. For the collage, most of them sat on the floor and made themselves very comfortable. In the beginning of the activity I felt high energy and heard a fair amount of laughter and conversation. Then, as the mothers moved deeper into the creative process, I noticed a shift to a quieter atmosphere.

The mothers’ collages contained many of the same themes as the fathers’ collages, such as religious symbols and symbols of their marriages and children; however, the mothers tended to use many more images than did the fathers. They also incorporated images with darker, heavier emotional content, which indicated to me their willingness to express and explore deeper levels of fear and pain. One mother included an image of a face with big eyes and a frightened, panicked expression next to a black tornado accompanied by the words and/or phrases, “there is nothing normal here”, “help”, “worst”, “what will you do” around the tornado image shown in Figure 66 (Appendix E).

Another mother cut a large black circle out of construction paper and placed red colored words, “It’s enough to make you scream,” in the center of the circle shown in Figure 61 (Appendix E). One collage included large printed words, “Going Crazy,” and a junk drawer that appeared to signify chaos shown in

Figure 59 (Appendix E). Another collage displayed, “It’s Not Your Imagination” in large words shown in Figure 60 (Appendix E). Finally, one collage contained an image of a woman attempting to walk while loaded down with excessive, heavy baggage and the single word, “help,” next to the image shown in Figure 64 (Appendix E). Other themes common to the mothers’ collages not found in the fathers’ collages were those of anxiety, sleep difficulties, depression, anger, self-care, friendship, feeling like they have to put on a false face to people who do not understand, and quality of relationships with surviving children.

I observed the spouse of the father who appeared somewhat disconnected in the fathers’ group acknowledge to the other mothers that she felt she monopolized the time talking about her deceased child. The mothers conveyed to her that she could talk as long as she needed to talk, showing her that they accepted her where she was in her grief. I noticed that with the expression of acceptance from the other mothers, she was able to conclude her comments. I think that the feelings of acceptance may have created an emotional shift in the mother. Afterwards she exhibited a greater ability to empathize with others and appeared more self-accepting. Her collage, shown in Figure 65 (Appendix E), contained mainly words, with the only image being a hand drawn heart around her child’s name and date of his death. On her collage she quoted verbatim the lyrics from the movie “Titanic’s” popular song, “My Heart Will Go On.” an indication of her understanding about her child’s death.

Both group sessions were originally planned to last approximately two and a half hours. However, it soon became apparent that the parents needed more time. Because of this need I decided to extend the processing time, and then facilitated closure at four hours. Undoubtedly the parents would have continued processing if they had been given more time and, in fact, some of the fathers did continue at another location.

Couples Brainstorming, Follow-up Session Two

The parents greeted each other with open affection and with what appeared to be genuine regard for each other. After a period of general conversation, each parent checked in by telling the group how they were doing. The parents seemed to be feeling very close and comfortable with one another. I divided them into gender groups and asked them to brainstorm three main ideas: 1) what they needed from their significant others, 2) what they thought their significant others needed from them, and 3) what they thought their children needed from them. Each group designated a recorder and a spokesperson. The recorder wrote down all of the group's ideas on a large piece of poster board. I heard animated discussion and loud laughter coming from both groups during the brainstorming. When the groups rejoined, each designated spokesperson presented their group's findings. I noticed they were having fun; however, I noticed they were also extremely curious about what the other group wrote on their poster board.

From their list, the fathers related that they needed affection and support, that they needed more agreement with their spouses on parenting the children, that they needed time alone, that they needed to be noticed whenever they felt sad or depressed, and that they needed for their spouse to be consistent and to follow through when telling the children, “no.” The fathers conveyed their beliefs that their spouses needed more quiet time, more help with maintaining the house and caring for the children, for fathers to spend more time at home and less time at work, and for fathers to give more of themselves to people who are in need of help. The fathers determined that their children needed for their parents to provide limits and guidance, that they needed more of their parents’ time, that they needed for their parents to get along, that they needed for their parents to realize that the surviving children are not their deceased child, and that they needed their parents to be good role models.

From their list, the mothers related that they needed more talking, more listening, more understanding, more help around the house, more couple time, more planning, and more time alone. The mothers conveyed their beliefs that their spouses needed more talking, more listening, more couple time, and more time alone. The mothers determined that their children needed more attention, more consistency, more balance, and less one-on-one time with mother.

The parents selected one item from each other’s list to give to their spouse. Each of them then selected an item to give to their child. I observed that some of the parents experienced difficulty choosing an item and instead asked

their spouse to chose the item they wanted to receive, thus changing the intended dynamic of accepting accountability for the choice. Overall, the fathers responses seemed more reflective and demonstrated more self-awareness than did the mothers. Accordingly, on the activity evaluation (Table 39), the fathers rated this session very high, while the mothers rated it fairly low. In the final evaluations, however, both mothers and fathers reported this session as very helpful.

One of the fathers expressed his experience of the couples group, The exercise was good—the best one yet. It made me reflect on [spouse] and [surviving child] in a different way. I felt more involved this time and maybe it's because we are feeling close as a group now...I enjoyed talking with everyone and that always seems to 'lift my spirits'.

A mother also reflected on her experience,

It felt good to get back together again...I loved the discussions—I enjoy so much talking to the moms but it was great to have the dads there and listening to their experiences and opinions...It's really nice to really be able to open up and talk, to say the things I really feel...It's so hard because most people don't want to hear these things—our reality. I can't begin to express how important this is—for me anyway...I didn't care much for the exercise—it felt a bit silly...I always leave these group meetings feeling good—clear-headed. Like I understand myself better.

Another mother wrote in her journal, “The parents’ session and women’s’ session were very good—we were focused on one activity and we found some help. Families should have this kind of session in the future—along with a long weekend at Camp John Marc.”

Family Picnic/Phototherapy Collage, Follow-up Session Three

For the final follow-up session, the families brought their picnic lunches, ate cake provided by me and decorated especially for this occasion, shown in Figure 68 (Appendix E), and participated in an afternoon of expressive activities. I watched the families arrive and seek each other out to eat together and to catch up on how their lives were progressing. The parents and the children appeared relaxed and comfortable, much like a family reunion. After lunch, the families ran three-legged sack races with one parent and child sharing a sack. I observed the families as very energetic and happily engaged in the sack race, especially the children. Every child in each family ran a race with one of their parents. All of the children received prizes.

For the second activity each child painted an image on their parents’ faces and each parent painted an image on each of their children’s faces. Watching the face-painting was emotionally moving for me. I noticed the children holding very still as their parents painted on their faces, and the children seemed to especially enjoy being able to paint their parents’ faces. The face-painting activity needed more brushes than was provided. Rather than complaining and not participating, the families used their own creativity to find ways to construct some brushes from

the craft materials. Figures 69-70 (Appendix E) are two exceptional examples of fathers and sons engaged in the face-painting activity.

The main expressive arts activity for the afternoon was the family phototherapy collage. Using the photos taken at camp and a variety of art media, each family created a photo collage of their family, shown in Figures 71-77 (Appendix E). The main difficulty during this activity was the distraction of the park and playground for younger children. Somehow, though, the families managed to get the collages completed, and then the entire group walked around to each collage and listened as each family told about their collage.

Even though I originally planned this activity to take place during the camp, in many ways this activity fit particularly well as the closure activity for this study. The puzzle piece activity, a family collage, marked the beginning of each family's journey through the study, and the phototherapy activity, a different kind of family collage, marked the end of the family's journey through the study. Upon examining the differences in the two collages, I noticed at least one very striking difference: The child who died was portrayed differently when included in this second collage. For some, the deceased child was no longer in the center, bigger than life, compared to the rest of the family. One mother stated, "I finally got it...the light bulb went off...my son didn't want his sister in the center...the spotlight any longer. He wanted to be there, so I let him lead and determine where he wanted his picture and where he thought the others could go." Figure 9

(Appendix E) shows this family's beginning collage, and Figure 83 shows their ending collage.

Another family portrayed themselves with a drawing of the deceased child in the middle, but more recessed in the background using different art media than they used with the rest of the family. These family members' photos were noticeably in contact with and connected to each other using bright yellow construction paper and art media on bright pink poster board as background, shown in Figure 82 (Appendix E). This family's first collage portrayed the deceased child in the center of the family standing in a line with no one touching, shown in Figure 13 (Appendix E).

Finally, I observed a family who in their first collage focused totally on the deceased child with photos of him on the collage and comments to him, shown in Figure 16 (Appendix E). For the second collage the surviving child's photo was placed prominently in the center of the second collage accented with a big bow. Instead of using photos of the deceased child, the family chose have the deceased child's presence there by using colors and an image of a dog that the child loved, shown in Figure 80 (Appendix E).

In their journals a few parents included comments about the final follow-up session. One parent remarked, "It was good to see everyone." One other parent expressed:

It was wonderful being able to get together with the other families to see how they were doing...To catch up on what's been happening since the

last get together... ..[good part of pilot program] The arts and crafts sessions that broke the ice between families, fathers, mothers, siblings and enabled them to feel comfortable talking to each other....[what's needed at Camp sessions] A session on what literature is available for grieving parents for themselves, children who are grieving...grieving families need guidelines so they do not waste time on the not so good stuff.

Summary of Process Observations

The practice of art therapy embraces the idea that the graphic arts provide opportunities for individuals to express themselves in ways that are creative, nonlinear, and less rigidified by defense mechanisms and that reveal many levels of potential meanings (Linesch, 1999, p.225).

Linesch's (1999) quote illustrates the power of expressive arts therapy as reflected in the process observations of this study. From the beginning to the end of the study, several prominent themes emerged for me. The most dominant theme that emerged was the dynamic of verbal resistance to the activity accompanied by involvement and emotional expressiveness in carrying out the activity; most vividly exemplified by the description of the father's construction of the beached whale, and the family's reaction to the counselor, to the activity, and later, to me. These seemingly contradictory behaviors and comments displayed by parents began at the orientation and culminated at the parent meeting on Sunday morning when the parents aired their concerns and banded together as a

group. Many experiences of ambiguity of feelings, a natural part of grieving, occurred throughout the process of this study.

Another important theme that emerged was that of rectifying and resolving the deceased child's and the surviving child(ren)'s place in the family. In the beginning of the study, I noticed that the deceased child occupied a central place in the artistic and verbal expressions of the family. As the study progressed, however, the surviving children began to move into a more centralized position in the family. One mother who struggled with the changing relationships stated in her journal, "Driving home I thought a lot about what Kelly talked to me about—ways to keep that connection with [deceased child]. That's something I think about a lot." I observed and the counselors observed the families and family members using expressive arts activities as a vehicle for exploring and working on this theme throughout the study.

The role of religion emerged as a dominant theme at the beginning of the study. While still important at the end of the study, the symbolic and verbal expression exuded a different quality and appeared with somewhat less frequency by the end of the study.

The formation of a new family identity also emerged as an important theme in this study. The families utilized the expressive arts to begin the process of restructuring their family identity. Creating family flags and collages, the remembrance service, and participating in picnic games and face-painting provided opportunities for families to explore their new identities.

Finally, the need for parents to spend more time together as mothers, as fathers, and as couples became apparent as the study progressed. The use of expressive arts activities reportedly assisted parents in discovering more about themselves as individuals, fathers, mothers, parents, and couples in their journey through grief and mourning.

According to the family members' reports on creative process, comments, and journals the families, children, and parents overall experienced of expressive arts activities in this camp setting to be helpful, worthwhile, and beneficial to them. In addition, the counselors' observations concurred with the families' reporting of a seemingly beneficial and meaningful experience. These reports and observations are heartening and indicate that further research in the use of expressive arts therapy with bereaved families is warranted.

Family Evaluations

The children and the parents received final evaluations for the study. The children completed their evaluations with the assistance of counselors at the final follow-up session. The parents took their evaluations and posttest instruments home, completed them, and mailed them, along with the family's journals, to me. I received all of the evaluations and posttest instruments and approximately half of the journals. A few participants who were not as educated as other participants and who experienced substantial difficulty with responding to the writing portions of the evaluations, relayed their feedback to me over the telephone. In addition, I also received all of the teachers/childcare providers' instruments.

Summary of Child Evaluations

Table 42 shows a summary of the most frequent and descriptive responses found in the child evaluations. These responses revealed that, overall, the children enjoyed participating in the expressive arts activities, that they made new friends, that some of them felt closer to their families, and that doing the expressive activities made them feel better.

Many of the children indicated that they would change nothing about Camp Sol. All of the children reported that they would like to return to Camp Sol.

Summary of Parent Evaluations

Table 43 shows a summary of the most frequent and descriptive responses found in the parent evaluations. The parents' evaluations showed mindful and thoughtful consideration.

Some of the most prominent themes expressed included the importance of connecting with other families who shared a common loss, of feeling the freedom to talk openly about their deceased children, and of seeing and participating in activities at the camp where their children played during the last weeks of their lives.

Table 42

Child Overall Evaluation Responses

Child Evaluation Questions	Overall Responses
What did you like best about Camp Sol?	*making my own things... *the flag... *the scavenger hunt... *all the other people... * met a friend... *ropescourse... *everything

What did you not like about Camp Sol?	*I liked everything... *nothing... *Memorial service... *singing... *crafts
What would you change about Camp Sol if you could be in charge?	*change nothing ... *the rules – the time you have to eat... *singing.. *a heated pool
How has your family changed since you went to Camp Sol?	*all had fun together... *everything's the same... *Spend less time together... *We are more acquainted with each other... *Nothing except for me cause I'm six
How have you changed since you got back from Camp Sol?	*feel the same... *have more friends... *I am more brave of almost everything... *doing the activities made me feel better
Would you come to Camp Sol again if you could?	<u> 7 </u> yes <u> 0 </u> no
Would you want your family to come with you to Camp Sol if you came back?	<u> 6 </u> yes <u> 1 </u> no comments: I wish I could come by myself... I would like to bring my uncles

Many parents felt that there were no least valuable aspects to the study, while a select few continued to express dismay about feeling pushed to disclose their emotions. All of the parents expressed how important this camp was to them and how important it was for the camp to continue for them and for other families.

Another predominant theme that emerged was that of normalcy—a sense of relief that other families shared similar feelings and emotions. One parent stated, “Family camp was wonderful—it was there that I felt normal. The parents expressed a desire to continue their relationships in a ongoing support group.

Table 43

Parent Overall Evaluation Responses

Parent Evaluation Questions	Overall Responses
What has been the most valuable aspect of this entire experience for you personally?	*Given me a sense of peace... *feel whole again... *connection with other families... *sharing stories with other families ... *sharing feelings as a family and individually ...*ability to talk about our children without anyone changing the subject ... *to go to Camp John Marc where [deceased child] went to camp... *liked group meetings at camp and after camp... *all was valuable... *work I did at camp— discussion and activities... *father’s activity/ *mother’s activity... *came for the children
What has been the most valuable aspect of this entire experience for your family?	*brought me and my child a lot closer... *there are others struggling like us... *enjoyed recreating together ...*talking with others who have had the same feelings, experiences ...*getting to visit camp to see where my child stayed...
What has been the least valuable aspect of this entire experience for you personally?	*Having to leave such a wonderful place... *All of it was valuable – was no least valuable... *brought up a lot of feeling... *being put “on the spot” to share emotions... *feeling forced to hurry because of time restraints...
Parent Evaluation Questions	Overall Responses
What has been the least valuable aspect of this entire experience for your family?	*filling out forms without explanations for the children... *activities at the last picnic – difficult to keep everybody focused on the project... *doing arts and crafts, but my child liked them...
What do you notice different about yourself as a result of this entire experience?	*I’ve gotten a little over-protective of my child... *confirmation that helping others helps me... *try to keep a perspective of our family as a unit— more time doing activities together, even just talking as a family about deceased child...*that we are not alone, that what we’re feeling is okay – normal...*I am a stronger person... *I learned a different way of dealing with

	my child's death.
Discuss any differences you have observed in your child(ren) between the time you arrived at Camp and now	*my surviving child is tired of my deceased child still being the center of attention... *having a friend who also lost a brother ... *seems to be more open with his grief and anger... *talks about sibling a lot more
What do you notice different about your family as a result of this entire experience since the weekend camp experience?	* an underlying feeling of lightness... *as a family group we are okay with going together for counseling ... *left camp full of hope and enthusiasm ... *closer as a family ... *realize each other has sadness and hurts—that we are there for each other... *seem less stressed, more considerate towards each other... *feel a sense of relief that other families have shared similar feelings and emotions... *my family is calmer
Please list recommended activities and resources that you feel would be beneficial to include for families coming to Camp Sol in the future?	*more time to spend with everybody ... *resources to turn to... * I liked creating the memorials and some of the family art activities... *I think it was pretty well-organized... *parent's could call each other from time to time.

Table 44

Support Services For Families

Support During Treatment	Majority of responses
Amount of support that you felt was or would have been most beneficial for your family, and important for other families dealing with chronic illness and death of a child.	<u>13</u> I feel strongly that having a counselor/play therapist assigned to families, especially for those families facing life-threatening circumstances is vital to any hospital program that serves children and their families
Comments:	We felt out in the cold afterward... Didn't know where to turn for help...now feel or see that different levels of support are needed...do feel strongly that counseling should be

	consistent through diagnosis and the entire illness of the child...cancer affects the entire family and all needs of the family should be addressed...we could have used a counselor and play therapist... I needed much more support
Beliefs regarding the way services were or could have been most beneficial for your family, and for other families dealing with chronic illness and death of a child.	<u>14</u> I believe a counselor/play therapist should be available for the whole family: <u>11</u> from the moment of diagnosis of a chronic or life-threatening illness <u>13</u> to provide bereavement/aftercare for families that includes: <u>13</u> a combination of parent groups, sibling groups, and family groups
The diversity of what should be offered in the groups should include:	<u>10</u> groups with activities and talking, groups only with talking, groups receiving written resources on family grief and talking, and filial group

In Table 44 more than half of the parents expressed strong opinions.

These responses included the kind of support services they needed prior to, during, and after the death of their child.

Table 45

Hospital Program Services

Ideal Hospital Program	Comprehensive Responses
If you could design the perfect hospital support program and aftercare for families facing a diagnosis of chronic illness, complicated medical	1) should have a counselor assigned to each family to follow through from first diagnosis to death or life, as the case may be. Also, could be available after the death of a child to help the family. 2) *Meet counselor immediately after diagnosis *Explain program and services available. *Have family evaluated for services *Counselor

illness, complicated medical procedures and treatment, process of dying/hospice care and death, what would it look like?	<p>checks with family during hospital admits. *Support group meetings in the hospital. * Meeting other families, sharing experiences, problems, and solutions. *Support families with other children – offering filial classes and one-on-one counseling. *Have regular play therapy for ill child. *Hospice-weekly visits, counseling, referral to funeral home. *Family should be able to connect with a group like Camp Sol families.</p> <p>3)*During the child’s treatment: Play therapy for sick child and siblings; Social groups of families with sick kids; Camp for family including sick child, with play therapy; Religious church support. *After Child’s Death: Training on how to cope and how to help siblings heal. Meet with other families and find out how they are coping; Get some counseling</p>
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In Table 45, I chose several parents’ detailed descriptions of their future vision of an ideal hospital program for families who could use these services. All parents stated that the services they experienced through Camp Sol were immensely significant, and some parents even expressed an intense desire to do whatever they could to make sure these services continued.

Table 46 shows responses to some key aspects of families’ journeys once Diagnosis was received. These responses provided me with a deeper

Table 46

Key Aspects for Parents

From the time of diagnosis to now, what has been:	Responses of parents
The most difficult period of time for you	when she died...when I found out I was pregnant... last few days in ICU ...

	treatment – second guessing myself... My child gone – very empty...1+ yrs past loss— Now the hurt is deeper, more raw, I feel like everyone else expects me to move on – less outside support for me now... Diagnosis, relapse, death ... Realizing my child was going to die... Learning to live with loss...afraid to make a decision it could hurt her...
The scariest moments for you	watching my baby slowly slip away... initial diagnosis...relapse...ICU...death...worrying if my other child will become ill... hope was gone – why?...lived in fear of the inevitable ...Death—we wanted some reassurance that she was going to be okay. It came when she smiled and looked at the rosary hanging on our mirror... I told my child to hold my hand and give me some of the hurt... decisions about life support
From the time of diagnosis to now, what has been:	Responses of parents - continued
The most challenging moments for you	Explaining my child's death to sibling...back and forth from home to hospital... hard time getting support to ease my child's final months...going on hospice care—no more hope...single and having to do everything for my ill child and my healthy child
The time you received the most support and from whom	My mother gave me more support than my own husband... in ICU... when my child died—our families, friends, and neighbors ...Spouse, my strongest supporter day in and out!...parents...adult siblings...child life specialist... hospice...church.. Last on my list is the hospital as far as support.
The time you needed more support	when he died...weeks after my child died, we needed to know what to expect of ourselves, our children, our families, friends, and neighbors... being told about diagnosis and relapse ...beginning of treatment... Three months after my child died—because that's when people expect you to be over it...One year after he died.
The most important moments for	Getting to hold my child one more time...

you	explaining child's death to sibling...seeing doctor, nurses, child life people at my child's memorial service... remembering my time with my child...the moment I was told my child had cancer – life changed forever that moment... when my child held me in her arms and told me she loved me a couple of days before she died—It was a long and quiet hug
The most helpful for you	Filial program I used for my surviving child...that it was okay to be scared... being with parents like us, who've lost kids to cancer... visiting Lourdes, France for healing and prayer... child life, hospice, my family, all the doctors and nurses who helped make my dying child as comfortable as possible.

understanding of these families, but also served as an expressive activity valuable in and of itself. Some parents responded that they had never given thought to some of these aspects and that spending time writing the responses gave them an opportunity to gain personal insight as well as attaining some sense of clarity and closure.

Table 47

Expressive Arts Activity Means

Expressive Arts Activities	Families' Means	Childrens' Means	Mothers' Means	Fathers' Means
Nametags	3.25	4.50	2.89	2.29
Family Flags	3.92	4.56	3.67	3.43
Large Heart Decorating	4.12	4.22	4.22	3.00
Family Bingo "get acquainted" game	3.60	4.38	3.00	3.00
Family Puzzle Piece Mural	3.30	3.78	3.33	2.86
Singing	3.56	4.56	3.33	2.71
Family Clay Sculptures	3.00	4.44	2.11	2.43
Altar-making	-	-	4.00	3.29
Children's activities	-	5.00	-	-
Nature Scavenger Hunt	3.17	4.86	2.44	2.43

Talent Show	3.72	4.56	3.56	2.86
Parent Group Meeting	-	-	4.78	4.29
Decorating Frames	3.96	4.67	4.11	2.86
Decorating Rock Jars	3.72	4.33	3.89	2.57
Decorating Flower Pots/planting	3.76	4.44	3.67	3.00
Remembrance Service	4.04	3.88	4.33	3.86
Mother/Father groups/collage "What helped you make it"	-	-	4.22	3.60
Parent Group "Brainstorming Needs – significant other/self/children	-	-	3.22	4.00
Family Photo Portrait	3.84	4.89	3.44	3.00
Family Picnic	4.22	5.00	4.00	3.50
Journaling	3.13	4.00	2.78	2.43
Total mean	3.64	4.50	3.55	3.07

Note: 1=less meaningful; 5=most meaningful

Table 47 lists the expressive arts activities and shows a comparison of the means for families, children, mothers, and fathers. The few parents who openly complained about the clay sculpture, in particular, may have negatively influenced other parents' attitudes. Overall, these parents did not demonstrate understanding that most of the activities were designed to include the child(ren) in a fun and meaningful way. In addition, as I mentioned before, the clay sculpture activity may have been either too scary for the parents, as clay is the least controlled of all art materials, or might have worked better scheduled at a later time in the camp itinerary.

Based on the total mean of each group, the children attained the highest mean, followed by the families, then the mothers, and finally the fathers. These results validate the importance of using expressive arts activities when working with the family unit and/or multi-family units. Interestingly, each groups' overall mean rated in the above average to high range indicating that the families

experienced the expressive arts activities as meaningful. In addition, these results point to the need to include more opportunities for parents to verbally process their feelings and experiences.

Table 48 illustrates a comparison of rankings for families, children, mothers, and fathers. Preferences are easier to identify utilizing these rankings again, pointing to the importance of providing children with activities that encourage free expression of the full gamut of emotions; and to the importance of initially providing parents with opportunities for verbal processing, along with a creative outlet for emotional expression and total family participation. Parents, as illustrated, did not exhibit an understanding of the purpose of the expressive activities being designed so that their children could participate with them in the healing process. Parents do need to have a better understanding about the purpose of the activities.

Table 48

Ranking of Expressive Arts Activities

Ranking of Expressive Arts Activities	Families	Children	Mothers	Fathers
Nametags	12	6	13	13
Family Flags	5	5	7	6
Large Heart Decorating	2	10	3	8
Family Bingo “get acquainted” game	9	8	12	8
Family Puzzle Piece Mural	11	13	10	9
Singing	10	5	10	10
Family Clay Sculptures	15	7	16	16
Altar-making	-	-	5	5
Children’s Activities	-	1	-	-
Nature Scavenger Hunt	13	3	15	12
Talent Show	8	5	8	9

Parent Group Meeting	-	-	1	1
Decorating Frames	4	7	4	11
Decorating Rock Jars	8	9	6	11
Decorating Flower Pots/Planting	7	7	7	8
Remembrance Service	3	12	2	3
Mother/Father/groups collage “What helped you make it”	-	-	3	4
Parent Group Brainstorming Needs - significant other/self/children”	-	-	11	2
Family Photo Portrait	6	2	9	8
Family Picnic	1	1	5	5
Journaling	15	17	14	12

Final Closing Thoughts From Journals

Parent #1: Thinking back on camp—it was a wonderful experience for us. I feel more connected with [deceased child]—his spirit. Right now we are almost at the one-year mark and I feel people around us are uncomfortable mentioning [him] even though we try to bring his name up often. This weekend—being able to talk freely about him—was like medicine for my soul—really! This camp couldn't have happened at a better time for me.

Parent #2: I just hope this camp will carry on, because it means a lot to me and my family and families to come. I pray that this will be successful and will help a lot of families...You need to try and help single parent families because it's really hard on them to go through something like this alone.

Parent #3: This is actually very therapeutic...It was wonderful for our family...We all had a wonderful time.

Parent #4: Having a camp for [families] who have lost a child to cancer is a great idea. I just don't understand why there wasn't one started sooner. I understand that this is a pilot program/study to see if there is a need for

something like this. THERE IS A NEED FOR SOMETHING LIKE THIS!...I very much want a “Camp Sol” and will do what ever I can to help get it started

Parent #5: Being at [Camp Sol] has given me a sense of peace I thought I would never have.

Counselor #1: I wish there had been more time. I know this wasn't possible but I would have enjoyed a 3-4 day weekend. I think this would have helped greatly, besides I liked being there! The place was GREAT! I WOULD DO THIS AGAIN IN A SECOND!

Counselor #2: It was a very special weekend with lasting memories and impressions.

Counselor #3: Relationships were built [at Camp Sol] we could have never [made happen otherwise]...[Camp Sol was] a place where they could go and be safe from people's expectations, feeling like they have to take care of people...an opportunity to hang out...A time families could get away as a family...here they could be a family, eat together as a family, have fun as a family, have a sense of being a family when their whole idea of 'family' has really changed.

Child #1: Entry 1—drawing of family puzzle piece, Entry 2—drawing of a ghost, Entry 3—drawing of a toothbrush with a happy face, Entry 4—drawing of a tooth with a happy face, Entry 5—drawing of a little girl crying many tears with a heart on her dress, Entry 6—Papa is a sleepy head, Mama is too. They are both

sleepy heads. [Deceased child] is the best sister in the world. She is kind. She is gentle.

Child #2: Entry 1— First drawing is of a car with a woman and a boy in it. The sun is shining. Second drawing is a pyramid shaped house with a door and doorknob. Entry 2—First drawing looks like a stone road. Second drawing looks like a sunflower with a door in the center.

Child #3: Entry 1—I drew a collage and made a flag for our table. We put a fire on and made a smore. Entry 2—Missing [deceased child]. I missed [deceased sister] less when [surviving brother] was born. Drawing of a girl.

Recommendations for Future Expressive Arts Therapeutic Interventions for Bereaved Families

The expressive arts processes, observations, journals, and final evaluations reflect the rich diversity in developmental levels among both children and adults, in individual and family functioning levels, in and between mourning styles, in and within artistic expression, and in relaying thoughts and experiences of all participants in the study. For the consideration of future experiences with Camp Sol-Healing the Family Heart and others who may wish to provide similar services for bereaved families, I offer the following recommendations for consideration and implementation.

1. Counselors who facilitate the actual expressive arts therapy activities with bereaved families should have at least a master's level degree and/or be licensed in mental health; should demonstrate empathic, non-invasive counseling

skills; should have adequate knowledge of grief theory, play therapy, family systems theory, group therapy, and developmental grief and mourning processes; and most importantly, should complete at least eight hours of experiential training with designated trainers, focusing on personal grief issues while engaging in the activities they will be facilitating. Weiner (1999) emphasized that “only direct experience with these methods will convey fully their value and impact in therapy” (p. xvi). The counselors must experience the activities themselves: the power, the resistance, and the encounter with self—bringing something new into being. Rollo May (1975) stated, “The essential point is not the presence or absence of voluntary effort, but the degree of absorption, the degree of intensity; there must be a specific quality of engagement” (p. 40).

2. Volunteers assisting the counselors should demonstrate empathic, non-invasive communication skills; should have adequate knowledge of developmental grief and mourning processes; and should complete at least eight hours of experiential training in the activities with which they will be assisting.

3. As a component of training, counselors, volunteers, and camp personnel should understand that:

Expressive arts therapy is grounded not in particular techniques or media but in the capacity of the arts to respond to human suffering. The fundamental concept of aesthetic responsibility implies an ability to use appropriate media for therapeutic purposes. The expressive arts therapist must therefore be prepared to work with sound, image, movement,

enactment and text as they are required in the encounter and lived situation of the client. (Levine & Levine, 1999, p. 11)

4. Camp personnel should not be allowed to assist with the expressive arts activities unless they specifically meet the volunteer requirements listed above.

5. The clinical director should provide counselors, volunteer assistants, and participating camp personnel with clear role definitions and policies regarding the importance of maintaining appropriate relationships with family members and with staff members. These policies would include to whom one reports, expresses complaints and/or concerns when a personal issue arises.

6. The clinical director should provide structured and unstructured opportunities for emotional support of counseling, volunteer, and participating camp staff. In addition, supervision should be available for counselors during staff meetings and on an individual basis, if needed.

7. The clinical director should provide and facilitate activities that promote and foster the development of therapeutic relationships between counselors and family members during the opening session of camp.

8. The clinical director should provide families with opportunities for additional emotional support when needed.

9. The clinical director should provide guidelines and recommendations for a continuum of order in which expressive arts activities are implemented, beginning with activities containing opportunities for lighter content, for minimal

contact, and for less intense emotional impact, and moving towards activities containing opportunities for deeper content, maximum contact, and powerful emotional healing experiences.

10. To maximize the benefits of family therapeutic work, the clinical director should structure activities, either prior to camp or in the beginning phase of camp, that allows parents to meet needs of connecting with other adults—as parents, as mothers, as fathers, as couples, as grandmothers, and as grandfathers—before engaging in individual family expressive arts activities. Allowing parents to connect in a variety of ways before participating in family group work ensures a higher possibility that the parents will be emotionally available to engage with their children and find meaning in their work together as a family.

11. The clinical director should work closely with the executive director of the camp to provide a balanced schedule of structured therapeutic activities, such as expressive arts activities and talk therapy groups, and unstructured therapeutic activities, such as ropes course, fishing, hiking, and bonfire. A longer weekend for the camp should be considered. Additionally, the clinical director should include ongoing individual play therapy for the younger children.

12. The clinical director should work closely with the chaplain in planning the memorial service for families. Parents and older children should have time for thoughtful reflection prior to the younger children arriving at the service. Children should have an active role in the memorial service once they do arrive.

13. Clinical, executive, and camp directors should coordinate efforts and promote positive professional relationships.

14. The clinical director, the executive director, and at least two parent volunteers should implement an ongoing support group of families who attended camp. The parent volunteers would be primarily responsible for coordinating the support group's participation in social gatherings, workshops, and family activities.

15. The clinical director should solicit annual evaluations from family members, counselors, and volunteer assistants, and should utilize the observations and suggestions gained from the evaluations in planning future events.

16. The clinical director should provide parents with information about normal developmental grief and mourning behaviors of children and adults as well as abnormal feelings and behaviors that may indicate that the family should seek additional professional help. The clinical director also should provide resources and referrals for families seeking additional information and/or help

17. The clinical director should provide parents an opportunity to develop filial relationship skills with their children that could reduce levels of fear and anxiety the children may be experiencing as a result of losing a loved one.

18. The clinical director should work to develop and implement a mentoring program for survivors at hospitals that would allow surviving parents to provide

support to parents with children who are newly diagnosed with chronic illnesses such as cancer.

19. The clinical director should work to develop and implement a counseling program at hospitals for families with children who are newly diagnosed with chronic illnesses such as cancer. This program would include play therapy services for the ill child and siblings, filial therapy for parents, family therapy, counseling for parents, grief education for parents, and referring the parents to a mentoring program such as the one mentioned in #18.

Implications for Future Research

Bereaved families in this study participated in expressive arts therapy during a residential camp weekend and three follow-up sessions over the course of eight weeks. From the beginning to the end of the study, participants showed improvement regarding total family functioning, social problems and total behavior problems of children, anxiety levels of family members, and depression levels of family members. The parents' reports of significant reduction in their children's overall social and behavior problems, their children's anxiety levels, and their own depression levels were particularly promising.

Immense possibilities for further research in combining the fields of bereavement and expressive arts therapy are evident from the comprehensive investigative results of this study. Parents and children alike reported important benefits from expressive arts activities, which appeared to facilitate the expression of the full range of emotions. The opportunity to hold both ends of the

emotional spectrum at the same time is valuable in itself, as Levine (1982) described:

In grief one cannot push away hell in order to attain heaven any more than one can grasp heaven in one's teeth by embracing hell. It is not either/or – it is both/and. Which brings to mind a photograph of the silent Indian teacher Hari Dass standing with his chalk board on which is written, “We must do all” (p.96).

Levine (1982) also thoughtfully observed,

Grief comes from trying to protect anything from being what it is. From trying to stop change. Even for those whose priority is to trust, there may be experienced the great pain of loss as the tendrils of their connection with a loved one are cut, leaving them bereft of their heart's contact with themselves. Each experiences his [sic] humanness to the degree he can open to his joy and sorrow. (p. 97)

Camp Sol-Healing the Family Heart gave families a chance to experience themselves on many levels and in many ways in their grief journey: as a family, as individuals within a family, as parents, as fathers, as mothers, and as part of the greater whole of families who have lost a child to death.

Based on the results of this study, the following recommendations are offered:

1. Repeat the study by incorporating recommendation for improvement and by including no-treatment and alternative treatment control groups that

isolate the effects of expressive arts therapy. Further study comparing families who receive services from community grief programs and families who receive services from Camp Sol-Healing the Family Heart.

2. Conduct long-term follow-up for the study described in #1.

3. Compare the process and effects on families who receive bereavement support from conventional community services versus families who receive services such as those described in this study.

4. Extend research to include other bereaved populations, such as grandparents who have lost a grandchild; parents who have lost their only child; adult children who have lost a parent or a sibling; and families who have lost a family member due to sudden death, including SIDS, suicide, murder, or accident.

Conclusion

This study has demonstrated that bereaved families need and want opportunities for healing in an environment where the entire family participates together and where parents participate together as mothers, fathers, and couples. Expressive arts therapy is ancient and ageless. In the opinion of Grainger (1999), expressive arts therapy is used "not so one can abandon that [painful] experience but in order to change it by revisiting it from 'somewhere else'" (p. 14). He stated, "healing is seen not as something produced but as something that emerges...from this point of view, the healing function of the arts therapies is to create contexts for existential change" (p.130).

As a result of this study, the child life specialists and I held a meeting of parents who participated in this study, counselors who participated in this study, doctors, nurses, child life specialists, and community grief support representatives who expressed interest in planning a second Camp Sol-Healing the Family Heart experience. This group now forms the Board of Directors and the Advisory Board of Camp Sol, which incorporated as a 501(c) (3) tax-exempt organization in December 2000. Camp Sol, Incorporated's mission statement is "Healing the family heart through a supportive, warm environment where grieving families share experiences and participate in a variety of fun and nurturing activities specifically designed for families, adults, and children."

In March 2001, 27 families were registered for the second camp; however, 19 families actually attended. From the eight families that participated in the pilot study described herein, seven registered to attend the second camp. Of these, one family did not attend because they relocated to another state a week before camp, and four others did not attend due to major conflicts, but stated that they wanted to return next year. The family that did not register was the family I mentioned earlier who, a few months after the first camp, lost another child, this time to leukemia. Thus, three pilot study families returned to camp, and 16 new families attended.

I felt challenged by the increase in participants; however, the clinical director and the programming committee implemented many improvements, and camp ran much more smoothly this time. I feel I learned more and I have much

more to learn. Although I am struggling with some new problems, I feel confident Camp Sol-Healing the Family Heart will continue to thrive. I conclude with profound reflections of Stephen Levine (1982):

There is no security in this world of change. There is no unchanging ground on which to place our seemingly solid feet. Nothing remains the same. There is only the constant flow of changing events, of shadows flickering on the wall. And it is in the holding to such temporal things that suffering originates... There is a story of a Zen monk mourning beside the grave of his recently dead teacher. One of the other monks comes up to him and says, "You are supposed to be a monk, why are you crying?" The grieving monk turns and says sternly, "I am crying because I am sad" (p.96).

APPENDIX A
CONSENT FORMS

CONSENT FORM

Dear Family Member:

I am conducting a research study about various helpful activities for families who have experienced the death of a child. These activities are for understanding death loss and they appeal to children and adults alike. The activities are designed to help you reduce or avoid grief related problems. There will be four questionnaires to complete before and after the study, taking approximately 30 minutes of your time. You will also be asked to have your child(ren)'s teacher(s) complete one questionnaire before and after the study.

A total of 30 families will participate. Fifteen families will attend a weekend camp where they will take part in activities with other families, with their own family, and in separate parent and age-appropriate children's groups. Each family will attend three follow-up sessions, approximately two hours every other week, engaging in assorted activities. Fifteen other families will have the option to take part in three individual family sessions beginning the first week in May.

Benefits you may experience as a result of participating include: 1) can provide a safe place to explore feelings, especially for children, 2) can help ease children's feelings of confusion, sadness, and anger, 3) can assist the family in adapting to changes in their lives, 4) can help solve problems and prevent future problems children often face, and 5) activities are for the entire family. Each session will be audio/videotaped. There is no charge for these sessions.

In order to gather information that is truly representative of your family, it is most important that all family members voluntarily agree to participate in the study. For that reason I ask that each of you read and sign the Consent Form. You will be provided with a copy of the signed consent form for your records. Also, I offer each of you the opportunity to discuss any questions or concerns you might have about participation in this study with me prior to the first session.

Though it is unlikely that these activities will be difficult experiences, it is possible that you may feel uncomfortable at times. You will be asked to give some of your time, and to be willing to explore some new ideas and feelings related to your loss and your family. There may be times that you could express sadness, anger, or frustration; and these sessions may increase your awareness of your emotion. Hopefully, these sessions will help you deal with these emotions more effectively. In the unlikely event that during an activity or during the course of the study you find it difficult to continue, you are free to stop. A referral for other services will be provided upon request. Your participation is completely voluntary.

To ensure confidentiality, your questionnaires, products of your activities, and audio/videotapes will be coded with a number rather than your last name. To further ensure your confidentiality, only your first names will be used in the sessions. After the entire study is completed, your expressive arts products will be erased of any family identifying marks, and the audio/videotapes will be erased and incinerated unless you give your consent to allow them to be used for teaching purposes. This will be discussed with you at the end of your participation in the study.

Thank you for participating. If, for any reason, you need to contact me, please reach me at:

Kelly Webb Ferebee
Child and Family Resource Center
University of North Texas
Phone: 940-565-2066 or 214-814-2054

YOUR CONSENT:

I have read the preceding information, and I agree to participate in this study. I am aware that this project has been reviewed and approved by the University of North Texas Committee for the Protection of Human Subjects (940.565.3940) and that it will be conducted by Kelly Webb Ferebee. I understand that the activity sessions will be audio/videotaped. The information on the tapes will be used only for the purpose of gathering information for this study. Should Kelly Webb Ferebee wish to use the tapes for teaching or training purposes, further written consent will be obtained from me for that purpose. To ensure my confidentiality, I understand that any identifying marks will be removed from products of these activities and that the audio/videotapes will be erased and disposed of at the end of the study.

I am aware that my participation in this study is voluntary and that I may terminate my participation at any time during this study.

Signature

Date

Signature

Date

CHILD/CHILDREN'S ASSENT

I understand that no one will tell what I have said or show what I have done without me saying it is okay with me. When I write my name or make my mark on this paper, it means all of this is okay with me.

Child's Name or Mark

Signature of Witness

Signature of Investigator

Date

REQUEST TO RECEIVE RESULTS OF STUDY

I, _____, as a participant in the family activity sessions, request to receive a summary of the results of this study conducted by Kelly Webb Ferebee. I understand that I will receive these results no later than one year following the family sessions.

Name

Address Zip

Camp Sol Counselor Compliance Agreement

I, _____, a counselor for Camp Sol 2000, received a copy of the Multiple Project Assurance of Compliance with DHHS Regulations for Protection of Human Research Subjects on March 10, 2000, during the counselor training and orientation meeting, and agree to comply with the statements therein. I acknowledge that this document will be kept with other records of the research, which may be subject to review by the IRB at UT Southwestern.

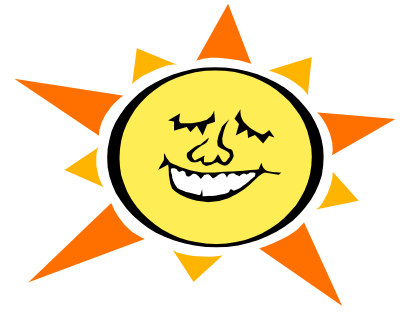
Counselor Signature

Date

Kelly Webb Ferebee, Research Coordinator

Date

APPENDIX B
MARKETING MATERIALS



Camp Sol - Healing the family heart. . .

♥ a FREE weekend getaway for your family ♥



For Families who have Lost a Child

What: A weekend of fun, free-time, outdoor activities, reflection, small group time, and a variety of activities designed for families, adults, & children, and continuing after the weekend with three special activity sessions just for your family - scheduled with your family's needs in mind. *The family may not be receiving other bereavement counseling, except for Children's Medical Center's monthly parent group. Babysitting will be provided for children under 4 years of age.*

When & Where: Friday evening - Sunday noon, March 24-26, 2000 at Camp John Marc (see letter for details). The deadline for receiving your registration forms is February 26. Orientations will be scheduled for Saturday or Sunday, March 18 or 19.

Benefits

- ♥ Can provide a safe place to explore feelings, especially for children
- ♥ Can help ease feelings of confusion, sadness, and anger
- ♥ Can assist the family in adapting to changes in their lives
- ♥ Can help solve problems and prevent future problems children often face
- ♥ Activities are for the entire family
- ♥ Surrounded by nature in a gorgeous camp facility

For more information contact Child Life Specialists: Lesley Lingnell, 214.456.8115 or Lori Dunn, 214.456.8116

Dear

I'm writing to tell you about a special opportunity. While you were at Children's, we were able to offer many services to support your family during the illness and death of your child. I believe, however, that the support a family needs does not end with the death of their child. Families face many changes after their loss. Without continued support, problems may arise later on, especially for siblings.

Few families know what to expect or what to do when their child dies, and are at a loss as to how to help themselves or their children. Yet, there are many childhood normal reactions to grief such as poor grades, aggressive behaviors, fears, sleeplessness, mood swings, headaches, withdrawal, anxiety, crying, stomach and/or other physical ailments, fatigue, and regressive behavior. Even overly good or perfectionistic behavior, often missed by parents and teachers, can indicate difficulty in grieving a sibling's death.

In an attempt to help you reduce or prevent grief related problems we have designed a program "*Camp Sol - Healing the Family Heart*," that begins with a weekend getaway for your family, March 24-26, 2000, at Camp John Marc (a gorgeous camp facility just southwest of Dallas). The second part takes place following the weekend getaway, but in the Dallas area. Each family will attend three individual family activity sessions, scheduled at your convenience, over a period of several weeks.

Camp Sol will include fun, free time, outdoor activities, reflection, small group time, and a variety of separate activities designed for families, adults, and children. Child life specialists, nurses, counselors, and camp staff will assist with activities. Childcare will be provided for children under 4 years of age. The camp activities and follow-up activity sessions will be directed by Kelly Webb-Ferebee, a Licensed Professional Counselor.

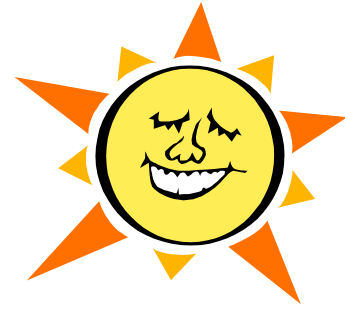
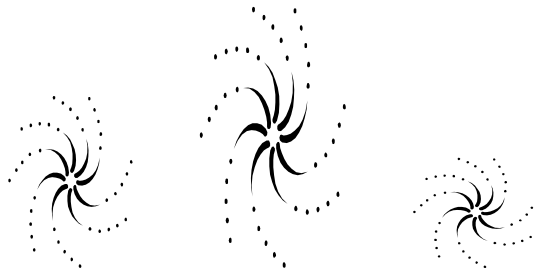
The Chip Moody Foundation is generously supporting "*Camp Sol - Healing the Family Heart*," which means that the only cost for your family is a \$5 registration fee and transportation. (If transportation is a challenge for your family, we may be able to assist with that—just let us know). Due to housing limitations, only 15 families will be able to attend "*Camp Sol - Healing the Family Heart*". Families who are unable to attend are encouraged to register for three free individual family activity sessions scheduled to begin on May 1. Orientation meetings for all families will be held Saturday - Sunday, March 18 -19.

Your participation in this program, a type of pilot study, will help us develop services that meet the ongoing needs of our families. Enclosed are a flyer and a registration form for you to complete and return in the enclosed envelope. The registration deadline is February 26, after which time we will contact you to schedule your family's orientation. We hope you and your family want to be a part of "*Camp Sol - Healing the Family Heart*" for both the weekend and sessions, or for the sessions only. If you have any questions, please call us.

Sincerely,

Lori Dunn, MS, CCLS
Child Life Specialist
214.456.8116

Lesley Lingnell, MS, MEd., CCLS, RPT
Child Life Specialist
214.456.8115



Camp Sol - Healing the Family Heart

Registration Form

*Deadline for registration ♥ February 26, 2000
Mail in enclosed, self-addressed, stamped envelope*

Please ✓ indicate one choice below:

_____ My family would like to register for “Camp Sol - Healing the Family Heart”. Registration includes the weekend getaway on March 24 -26, 2000 and 3 activity sessions scheduled for my family at our convenience. (***Note: Families attending the weekend getaway agree to attend the orientation, the weekend getaway and to complete all three activity sessions. All family members agree to attend.***)

_____ \$5.00 registration fee enclosed

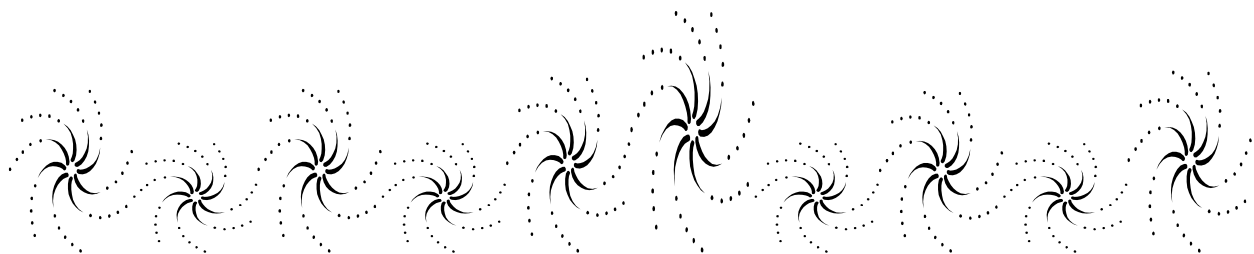
_____ We request assistance with transportation to Camp John Marc

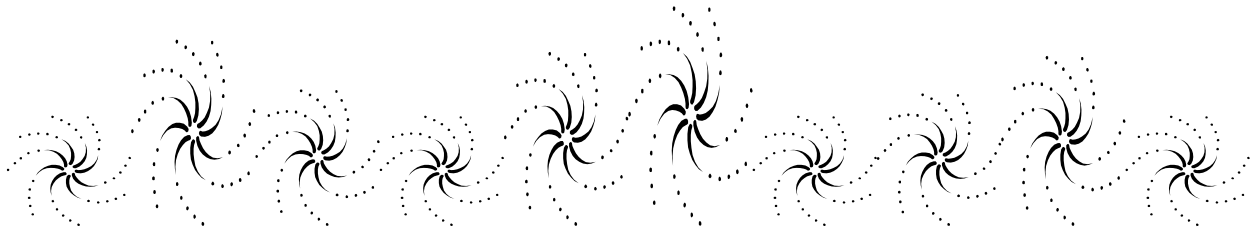
OR

_____ My family is unable to register for “Camp Sol - Healing the Family Heart;” however, we want to register for and attend the 3 free family activity sessions beginning the week of May 1, 2000 that will be scheduled for my family at our convenience. (***Note: We agree to attend the orientation and three activity sessions. All family members agree to attend.***)



The weekend getaway staff will contact you on or shortly after February 27 to confirm your registration and to schedule an orientation time for your family.





Parent(s)/Guardian(s) attending:

_____ Last First Last First

Child(ren) attending:

_____ Last First Age Last First Age

_____ Last First Age Last First Age

Mailing Address:

_____ Street/Box Apt. City Zip

Telephone: _____ (Home) _____ (Work) _____ (CellPhone)

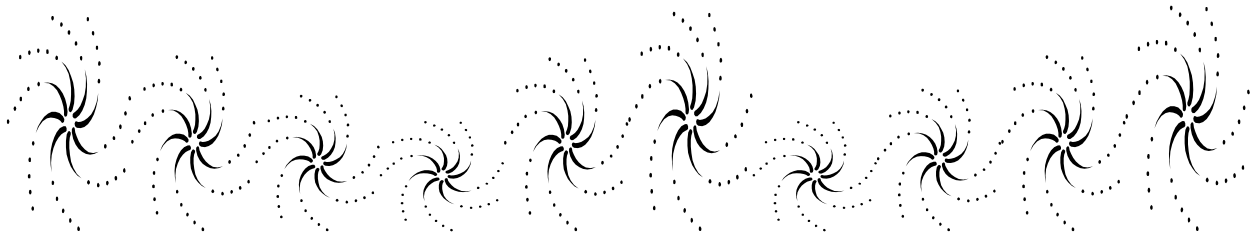


_____ **I will need Childcare:** If yes, list names and ages of child(ren) under 4 years old needing childcare. _____

name age

name age name age

Special needs: (Please list any special needs your family may have such as dietary needs, translator needs, or other needs. Camp John Marc is totally wheelchair accessible.)



If you have any questions or need further information, please contact Lori Dunn at 214.456.8116 or Lesley Lingnell at 214.456.8115.

Kelly Webb Ferebee, M.Ed., L.P.C., N.C.C.
7527 Summitview Dr.
Irving, Texas 75063
972.754.1584
e-mail: dferebee@swbell.net

Dear Teacher, Childcare Provider, or Counselor,

I am a doctoral candidate in the Department of Counseling, Development, and Higher Education at the University of North Texas. I am writing to ask your help in completing a Behavior Assessment for Children (BASC) for the child listed on the enclosed two-sided form. This child and his or her family are participating in a research study and have signed a consent form granting permission for you to participate by completing the BASC. The results of this study will benefit other families and children.

This assessment will take approximately 10 minutes to complete. Please answer all of the questions based on your knowledge of this child prior to March 24, 2000, leaving no questions blank. If there is more than one teacher for this child, you may choose to consult with other teachers for a more complete picture of the child.

Once you have completed this pre-assessment, please place it in the enclosed self-addressed, stamped envelope and mail it to me. In six weeks, you will receive the post-assessment, (the same form) to be completed based on your knowledge of the child at that time.

Thank you very much for your cooperation. I know how busy I was as a teacher and I appreciate you taking time out to help with this study. I am enclosing my business card in the event you have any questions. Please do not hesitate to call if you need assistance.

Sincerely,

Kelly Webb Ferebee, M.Ed., L.P.C., N.C.C.
Doctoral Candidate
Department of Counseling, Development, and Higher Education
University of North Texas

Kelly Webb Ferebee, M.Ed., L.P.C., N.C.C.
7527 Summitview Dr.
Irving, Texas 75063
972.754.1584
972.717.3530
e-mail: livingsimple@hotmail.com

Dear Teacher, Childcare Provider, or Counselor,

I am now gathering the final data for my study with bereaved families. Once again I am requesting your help in completing a Behavior Assessment for Children (BASC) for the child listed on the enclosed two-sided form. I appreciate the BASC you completed earlier this spring based on this same child's behavior prior to March 24, 2000.

Please answer all of the questions based on your knowledge of this child now, leaving no questions blank. If there is more than one teacher for this child, you may choose to consult with other teachers for a more complete picture of the child. Once you have completed the post-assessment, please place it in the enclosed self-addressed, stamped envelope and mail it to me.

Thank you very much for your help, especially at this busy time of year. I am enclosing my business card in the event you have any questions. Please do not hesitate to call if you need assistance.

Sincerely,

Kelly Webb Ferebee, M.Ed., L.P.C., N.C.C.
Doctoral Candidate
Department of Counseling, Development, and Higher Education
University of North Texas

Kelly Webb Ferebee
7527 Summitview Drive
Irving, Texas 75063
972.444.8306
972.717.3530
e-mail: livingsimple@hotmail.com

May 16, 2000

Ms. Bea Stone
Scottish Rite Hospital

Dear Ms. Stone,

This letter is to confirm our conversation regarding my reserving Shivers Park at Scottish Rite Hospital this Sunday, May 21, 2000 from 1:00 – 4:00 p.m. for a family bereavement picnic. You offered to provide 2 trashcans, 32 chairs, and 4 tables draped for arts and crafts. I will be responsible for clean-up.

I am so appreciative of this opportunity. I know this will be a very special experience for the families participating in my research study.

Thank you,

Kelly Webb Ferebee

APPENDIX C
DEMOGRAPHIC DATA

ADULT DATA FORM

(Adapted from Bratton & Webb-Ferebee form at the Child & Family Resource Clinic,
Univeristy of North Texas)

Please answer all information as completely as possible. Information given is strictly confidential. Feel free to ask for assistance, if needed.

Name: _____
Last First MI
Home Phone: _____ **Work Phone:** _____ **Gender:** M ___ F ___

Date of Birth: _____ **Ethnicity:** Africa American ___ Asian ___ Bi-racial ___
Caucasian ___ Hispanic/Latin ___ Native American ___ Other (explain) _____

Home Address: _____
Street Apt. City State Zip

Gross Household Annual Income:

___ Less than \$10,000	___ 18,001 - 22,000	___ 29,001 - 50,000
___ 10,000 - 14,000	___ 22,001 - 26,000	___ 50,001 - 90,000
___ 14,001 - 18,000	___ 26,001 - 29,000	___ 90,001 - up

Educational Level:

___ 8th Grade or Below	___ Trade School	___ Master's Degree
___ High School	___ Some College	___ Ph.D. Degree
___ GED (Date _____)	___ College Graduate	

Marital Status (indicate all that apply and duration of each, ex. 1965-1985):

Never married _____ Married _____ Remarried _____ Divorced _____
Separated _____ Widowed _____ Number of Marriages _____

Present Family

Name	Age	Gender	Relationship to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Deceased Child's Name _____ **Gender:** M ___ F ___ **Age at Death:** _____

Date of Birth: _____ **Date of Death:** _____ **School grade at death:** _____

* **HEALTH** *

Date of LAST complete physical _____ **Physical Disability:** yes__ no__
(if yes, explain) _____ **Chronic Illness:** yes__ no__ (if yes,
explain) _____

List medication you are currently taking:

<i>Medication</i>	<i>Dosage</i>
_____	_____
_____	_____

Other treatment you have received: None__ Individual counseling__ (dates: _____)
Family counseling__ (dates: _____) Group counseling__ (dates: _____) Couples
Counseling__ (dates: _____) Hospice__ (dates: _____) Hospitalization__
(dates: _____) Other (explain) _____

*** FAMILY HISTORY/EXPERIENCES ***

Emotional Concerns: Emotional problems__ Suicidal thoughts__ Suicide attempts__
Loss of energy or fatigue__ Lost weight__ Gained weight__ Appetite change__
Heard voices when no one was around__ Other (explain) _____

Anxiety Symptoms (indicate all that apply): Obsessive worrying__ Keyed up, on edge__
Phobias__ Irritable__ Physical symptoms (below)__ Other _____

Health/Physical Problems (indicate all that apply): Headache(kind) _____ Nervous
stomach__ Diarrhea__ Bone/joint/muscle__ PMS__ Dizziness__ Shortness of breath
without exertion__ Heart Palpitations__ Chest pain__ Surgeries__ Major illness__
Major accident__ Disability__ Chronic illness__ Hospitalization__ Developmental
delay(s)__ Sleep problem__ Bedwetting__ Serious overeating or undereating__
Neurological problems/exam__ Other _____

Dissociative Symptoms (Indicate all that apply): Walked in sleep__ Trance-like episodes where
you lost track of time__ Large parts of childhood after age 5 you can not remember__
Memories suddenly flashback__ Periods of missing time__ Things of yours that are
missing__ Things appear, but you do not know where they came from__

Trauma/Stressor (Indicate all that apply): Child separated from parent (how long and
when) _____ Death of a significant person__ Death of a pet__
Incarcerated family member__ Sexual Assault__ Victim of trauma (unusual, terrifying
experience)__ Medical__ Natural Disaster__ Other _____

Interpersonal Problems (Indicate all that apply): Frequent arguments__ Taken advantage of__
Temper outbursts__ Slapping, hitting, shoving, etc., other people__ Loner__
Other _____

Family Atmosphere (circle the number that best describes how you view your current family, if applicable):

Very lenient 1 2 3 4 5 Very strict

Very non-religious 1 2 3 4 5 Very religious

Chaotic 1 2 3 4 5 Highly structured

Few expectations 1 2 3 4 5 High expectations

Inconsistent 1 2 3 4 5 Consistent

Family Support System (such as church, friends, relatives, school)

Hardly any support 1 2 3 4 5 Considerable support

CHILD DATA FORM

(Adapted from Bratton & Webb-Ferebee form at the Child & Family Resource Clinic,
Univeristy of North Texas)

Please answer all information as completely as possible. Information given is strictly confidential. Feel free to ask for assistance, if needed.

Child's Name: _____ **Date of Birth:** _____ **Gender:** M__ F__
Last First

Parents' Names: Mother _____ Father _____

Grade Level (now): _____ **Ethnicity:** African American__ Asian__ Bi-racial__
Caucasian__ Hispanic/Latin__ Native American__ Other (explain) _____

*** CHILD'S HEALTH ***

Date of LAST complete physical _____ **Physical Disability:** yes__ no__ (if yes, explain) _____ **Chronic Illness:** yes__ no__ (if yes, explain) _____

Medication your child is currently taking?

Medication	Dosage
_____	_____
_____	_____

Other Treatment your child has received: None__ Individual counseling__ (dates: _____)
Family counseling__ (dates: _____) Hospice__ (dates: _____) Play Therapy__
(dates: _____) Hospitalization__ (dates: _____) Other (explain) _____

School Problems: (indicate all that apply): Academic problems__ Severely teased__ Discipline problems__ Unpopular__ Other (explain) _____

Emotional Concerns: (indicate all that apply): Emotional problems__ Suicidal thoughts__
Suicide attempts__ Loss of energy__ Lost weight__ Gained weight__ Appetite change__
Heard voices when no one was around__ Other (explain) _____

Behavior Problems : (indicate all that apply): Misbehaved a lot__ Trouble with the law__
Involved with the juvenile system__ Ran away__ Impulsive__ Alcohol and/or drug use__
Hyperactive__ Attention problems__ Accident-prone__ Frequent arguments__ Taken advantage of__
Temper outbursts__ Slapping, hitting, shoving__ Loner__
Other _____

Physical Problems: (indicate all that apply): Major illness__ Major accident__ Disability__
Chronic illness__ Hospitalization__ Developmental delay(s)__ Sleep problem__
Bedwetting__ Serious overeating or undereating__ Neurological problems/exam__
Other _____

*** CURRENT CONCERNS ***

- Adjustment to life changes (changing schools, parent's divorcing, moving, etc.)
- Bed wetting and related problems/soiling
- Abuse (physical, emotional, sexual)
- Disturbing memories (past abuse, neglect or other traumatic experience)
- Drug or alcohol use (both legal and illegal drugs)
- Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
- Feeling anxious (nervous, fearful, worried, panicky, obsessive-compulsive, lacking trust, withdrawn)
- Feeling angry or irritable
- Feeling guilty or shameful
- Feeling sadness depression or suicidal urges related to grief
- Gang related concerns (explain _____)
- Health concerns (physical complaints and/or medical problems)
- Illegal behaviors (runaway, stealing, repeated run-ins with the law, etc.)
- Learning/Academic difficulties
- Parent-Child relationship
- Child's disruptive behavior (aggression, acting out, attention deficit, hyperactivity, annoying).
- Child's inappropriate behavior
- Non-family relationship (roommates, classmates, teachers, playmates, friends)
- Sleep problem (nightmares, night-terror, sleeping too much or too little, etc.)
- Speech problem (not talking, stuttering, etc.)
- Unusual experiences (loss of periods of time, sensing unreal things, etc.)
- Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
- Other (explain _____)

Family Atmosphere (circle the number that best describes **how you think your child** views the atmosphere in your home):

- Very lenient 1 2 3 4 5 Very strict
 Very non-religious 1 2 3 4 5 Very religious
 Flexible 1 2 3 4 5 Highly structured
 Few expectations 1 2 3 4 5 High expectations
 Inconsistent 1 2 3 4 5 Consistent

Family Support System (such as church, friends, relatives, school)

- Hardly any support 1 2 3 4 5 Considerable support

APPENDIX D
CAMP SOL MATERIALS

CAMP SOL 2000
ARTS MEDIA LIST

Craft Glue
Glue sticks
Glue guns
Scissors
Multi-Colored tissue paper
Variety of markers
Glitter glue
Foam letters
Multi-Colored craft sticks
Sequins (all different kinds)
Multi-colored construction paper
White drawing paper
Water-color paper
Colored posterboard (red, black, yellow, orange, blue, green, gold, silver)
White posterboard (20 sheets)
Bottles of bubbles
4' X 6' silky fabric pieces
Wood (2 x 4 cut into 4" lengths) and wooden dowels for family flags and family banners
Wood glue
Stuffed animals – all sizes – need several very large stuffed animals for the Saddle Room
Multi-colored felt
Broken ceramic tile pieces
Baskets or special containers for Mom's altars
Low-fire white modeling clay from Trinity Ceramics
Clay modeling tools
Paper towels
Flowerpots and flowers to plant
Crayon-type face paints
Assortment of stickers – for kids and for parents (stars, flowers, dinosaurs, bugs, hearts-all sizes, teddybears, Victorian, etc)
2 large toolboxes
Variety of wood pieces for Dad's altars
Paints and brushes for Dad's memorials (red, blue, green, yellow, black, white, brown; brushes of different sizes and shapes)
Tools for Dad's memorials (sandpaper, hand held screw drivers, hammers, saws, safety glasses, boxes of nails – finishing nails 5/8" & 1 1/2 " & 3", and penny nails 2" & 3", measuring tapes, 2 metal or plastic squares, 2 metal or plastic rulers)

Candles and holders for altars
Acrylic paints – tubes of red, yellow, green, blue, brown, black, orange, purple, white
Water-color paints
Variety of paint brushes – several each of different shapes and sizes
Children’s paint brushes
Poster paints (red, yellow, blue, green, orange, black, white, brown)
Wide assortment of beads for nametags and expressive activities – (sparkle, animal shape, teddybear shape, heart shape, lots of different kinds – need hundreds of beads)
Assortment of feathers, colored and natural (several bags of each)
Assortment of yarn skeins (primary and pastel colors)
Assortment of special papers (decorative papers)
Aluminum foil
Assortment of fabrics for mom’s memorials – lacey, netting, soft, children’s themes
Poloroid film for phototherapy
Assortment of ribbons – all kinds and sizes
Assortment of lace
Assortment of pipecleaners – all colors and types
Pom poms – all sizes and colors
Eyes – all shapes, sizes, and colors
Assortment of buttons
Sewing needles and white thread
Miniatures for sandtray
Sandtrays and sandtray sand
Sand toys – (several buckets, shovels, funnels, sieves)
Assortment of rocks and minerals (quartz, amethyst, pyrite, turquoise, obsidian, agate, moonstone, jasper, tiger’s eye, aventurine, amazonite, lapis lazuli, hematite, desert rose)
Prizes for Nature Scavenger hunt – candy & toys
Juice and sodas for snacks
Crackers/popcorn/fruit/nature bars/chips/nuts for snacks
Musical instruments for children (rhythm sticks, sand blocks, shakers, tambourines, slide whistles, kazoos, gourds, talking drums with mallets, rainstick)
Poloroid cameras (6)
Boom boxes
Variety of music CD’s
Guitars
Box of images for collage

Camp Sol - Healing the Family Heart

♥ March 24 - 26, 2000 ♥

To All Group Facilitators,

Thank you for agreeing to assist me as a volunteer counselor for my dissertation research study. I hope your experience will be rewarding and meaningful. Facilitators are divided into two categories, those who work with children and those who work with adults. All of you will be working as co-facilitators with the multi-family groups and individual family groups.

♥ Training ♥

You are invited to my home, 7527 Summitview Drive, in Irving, on Friday, March 10, from 5p.m. - 8p.m. for training on the expressive activities for the camp. If we need to go later, that will be fine, but if you need to leave at 8 p.m. that will be okay too. A casual dinner will be served. Some of you have asked to bring a dish - feel free to bring whatever you'd like to share.

♥ List of Facilitators ♥

Children

Steve Armstrong
Dr. Sue Bratton, Dissertation Committee
Dr. Mary Costas, Follow-up sessions therapist
Lori Dunn, Camp Sol Director
Marcia Ertola (not confirmed)
Jenny Jenkins
Leslie Jones
Lesley Lingnell
Kevin Moffit
Maggie Orona
Tammy Rhine
Kelly Webb Ferebee, Clinical Director & Follow-up session's therapist

Adults

Paul Abney
Mark Hundley
Vannessa Hundley
Chris Simpson
Dr. Pam Tess
Katie Walker

♥ Types of Groups ♥

Multi-family groups	Children's developmental age groups (depending on final enrollment)
Parent single-gender groups	Ages 3-5 Ages 12-14
	Ages 6-8 Ages 15-18
Parent mixed-gender groups	Ages 9-11
Individual family groups	

♥ General Information ♥

Name of Research Project: Expressive Arts Therapy with Bereaved Families

Purpose: This study will determine the effectiveness of expressive arts therapy as a method of prevention and intervention for bereaved families who have lost a child to death.

Brief Summary of Project: A total of thirty families will participate. Fifteen families will attend a weekend camp where they will take part in activities with other families, with their own family, and in separate parent and age-appropriate children's groups. These activities are designed for children and adults to help them understand their loss and to help reduce or prevent grief related problems. Each family will attend three follow-up sessions, approximately two hours every other week, engaging in assorted activities. Fifteen other families will have the option to take part in three individual family sessions following an initial six week waiting period. All families will attend an orientation where the purpose and the requirements of participating in the study will be explained. There will be four questionnaires to complete prior to and after the study. Statistical measures and personal observation will determine the outcome.

Camp Weekend Structure:

The camp site is Camp John Marc (map enclosed), which is about 1³/₄ hrs. southeast of Dallas. Your room and board is provided for you by private funding (\$60 per person). Travel expenses will not be reimbursed, unless they are a major problem. If they are, please let me know and I will see what I can arrange. You will receive cabin assignments when you arrive.

♥♥ **Friday Evening - Therapists meet for staffing 5:30 p.m. - Saddle Room** (*Dinner will not be provided -there will be snacks available*)

♥♥ **Friday Evening - Opening session for families and staff**

7:00 - 7:30 p.m. The families, counselors, and staff will gather for a brief introduction and ice-breaker activity - family bingo. A camp song that can be sung at the close of each session will be taught - children will be able to play on a variety of instruments.

A big heart made of sturdy material will be placed on the wall for family members to write on and decorate at any time during the camp experience. Before the closing ceremony on Sunday, each family will have their picture taken next to the heart. The pictures will be developed and framed for the families to receive at their first follow-up session. The heart will be displayed in the hospital following the camp experience.

7:30 - 8:30 p.m. Multi-family group activity - small mural in form of puzzle pieces where each family's piece will fit with another family's piece. On their puzzle piece family members will create a visual image of who their family is, why they are here, and something about each family member. Children will explain the visual images for their family.

8:30 - 9:30 p.m. Campfire, songs, and toasting marshmallows down by the lake.

♥♥ Saturday

8:00 a.m. Breakfast (8:30 - 9:00 staffing for therapists in Saddle Room)

9:00 - 11:00 a.m. Individual family activity - Clay animal sculptures activity

11:00 - 12:00 noon. Family Free Time

12:00 noon. Lunch/Free time

1:00 - 3:30 p.m. Two activities with break in between for developmental age groups. One activity for single gender parent group, break and then re-gather into mixed-gender groups and process same activity.

3:30 - 4:30 p.m. Family Free Time/Therapists plan and practice their skit

4:30 - 6:00 p.m. Individual Family Group - Phototherapy Collage activity

6:00 p.m. Dinner/free time

7:00 - 8:30 p.m. Family & Counseling Staff Talent/Skit Show

8:30 - 9:30 p.m. Campfire, songs, making s'mores down by the lake.

♥♥ Sunday

8:00 a.m. Breakfast (8:30 staffing for therapists in Saddle Room)

9:00 - 10:30 a.m. Individual Family Activity - 1) Decorate 5”X7” frame for family photo. 2) Decorate candle jar for Remembrance and Celebration Service. 3) Decorate container for feeling rocks; choose the rocks and identify specific feelings for each rock. The families take the candle and feeling jar of their special rocks home to use once a week as a way of letting each other know how they are feeling. Family photos taken by the “Big Heart” with Kelly’s 35mm camera, will be developed, placed in each family’s frame, and given to the families at the first follow-up session.

10:30 - 11:30 a.m. - Multi-Family Activity - Remembrance & Celebration Service. Poems, songs, flower in a basket, candle lighting ceremony, plant a tree. Closure, bouncing ball activity. Everyone says “Goodbye.”

12:00 - 1:30 p.m. - Lunch provided by Kelly/Debriefing of counseling staff.

♥ Please bring a Polaroid camera if you have one for the phototherapy activities (film will be provided). Also, if you play guitar or another instrument suitable for campfire singing, please bring it and join in. You will need bedding (sleeping bags are fine), pillows, towels, flashlight, and personal hygiene items.

Ideas for Developmental age group activities:

Adolescents - Photo scavenger hunt, writing poems in the tree house, body tracing

Preschool children - bubbles, treasure boxes, large movement, body tracing

Elementary age children - memory frame, rosebush drawings, bouncing ball, shields of armor, boat in storm drawing, body tracing.

Free time activities include possibilities for:

Ropes course, hiking, sports such as basketball, arts and crafts, cooking in groups, napping, fishing, reading, etc.

Any questions? Feel free to call Kelly 972.444.8306 or 972.754.1584.

thanks a million!!!

May 21, 2000

Dearest Camp Sol 2000 Families,

There are no adequate words to express my heartfelt appreciation for allowing me to learn from you and offer to others the wisdom you have so generously shared. Camp Sol, in spite of some of its' faltering first steps, was a first; a first in what we hope to create as an ongoing opportunity for families. You were courageous enough to take those first steps with us. For that, I am deeply grateful!

I ask you to take a few days to reflect over our experiences together and then fill out the final questionnaires. Keep writing in your journals until the day you mail everything to me. It is very important that each person express his or her individual experience without talking with each other while you are filling out the forms. Once I receive everyone's forms, I will be able to synthesize all of your experiences into what I hope will be a model for us and for others who are eager to help families traveling similar paths.

If you do not remember how to fill out the forms, please call me and I will be more than happy to help you. Once they are completed, please take your journals and place everything in the postage-paid self-addressed envelope and mail them to me.

I will return your journals and art pieces unless you specify that you do not want them. I will be back in touch, once I see what kind of ongoing support works best for you.

Take care, be well, and know that you are in my heart and my mind.

Fondly,

CAMP SOL 2000 & FOLLOW-UP MEETINGS PERSONAL EXPERIENCE AND SUGGESTIONS

Please fill this out without discussing these questions with anyone. I am looking for your unique and authentic experience. Your experience and suggestions are crucial to helping develop a model for a hospital program that meets families' needs. If you need help, please contact me and I will be happy to assist you. My new e-mail is livingsimple@hotmail.com

NAME _____

Date _____

- 1. What has been the most valuable aspect of this entire experience:
*for you personally?***

for your family?

- 2. What has been the least valuable aspect of this entire experience:
*for you personally?***

for your family?

- 3. What do you notice different about yourself as a result of this entire experience? (i.e. awareness's you may have gained about yourself, etc.)**

4. **Discuss any differences you have observed in your child(ren) between the time you arrived at Camp and now.**

5. **What do you notice different about your family as a result of this entire experience since the weekend camp experience**

6. **Please rate your personal experience of these activities on a scale of (1) least meaningful to (5) most meaningful? Circle the number that best represents your experience.**

	Least meaningful			Most meaningful	
making nametags	1	2	3	4	5
making family flags	1	2	3	4	5
decorating the large heart	1	2	3	4	5
family "get acquainted" bingo game	1	2	3	4	5
family clay animal sculptures	1	2	3	4	5
family puzzle pieces/mural	1	2	3	4	5
singing together	1	2	3	4	5
parent group meeting	1	2	3	4	5
Dad's/Mom's making memorials	1	2	3	4	5
talent show	1	2	3	4	5
journaling	1	2	3	4	5
nature scavenger hunt	1	2	3	4	5
memorial service	1	2	3	4	5
decorating frames	1	2	3	4	5
decorating rock jars	1	2	3	4	5
decorating flower pots for flowers	1	2	3	4	5
Moms'/Dads' group/collage					
"what's helped you make it"	1	2	3	4	5
Parents' group brainstorming needs					
(significant other, self, children)	1	2	3	4	5
family photo portrait	1	2	3	4	5
family picnic	1	2	3	4	5
other: _____	1	2	3	4	5

7. **Please list recommended activities and resources that you feel would be beneficial to include for families coming to Camp Sol in the future?**

8. **What is your vision for continuing support for Camp Sol Families 2000? Check the choices that you would like to see.**

<input type="checkbox"/> once a month	<input type="checkbox"/> camp early Spring	# days? _____
<input type="checkbox"/> once every 3 months	<input type="checkbox"/> camp early Fall	# days? _____
<input type="checkbox"/> once a year	<input type="checkbox"/> other ideas?	_____

Comments:

Would you be willing to occasionally host families in your home for a continuing support meeting? yes no

9. **Check those items that express the amount of support that you feel was or would have been most beneficial for your family, and that would be important for other families dealing with chronic illness and death of a child.**

I did not feel my family needed support and would not have used the services of a counselor/play therapist for the whole family.

I feel my family received exactly what we needed during diagnosis, treatment, our child's dying process, and aftercare.

I feel each of my family members, including our chronically ill child, needed the support of a counselor/play therapist on a consistent basis.

I feel strongly that having a counselor/play therapist assigned to families, especially for those families facing life-threatening circumstances, is vital to any hospital program that serves children and their families.

Comments:

10. Check items that express what you believe regarding the way services the hospital offered were or could have been most beneficial for you and your family and could be for other families dealing with chronic illness and death of a child.

_____ I believe a counselor/playtherapist should be available for the whole family:

- _____ from the moment of diagnosis of a chronic or life-threatening illness
- _____ throughout medical treatment and procedures
- _____ during your child's dying process/hospice
- _____ to provide bereavement/aftercare only for parents
- _____ to provide bereavement/aftercare only for siblings
- _____ to provide bereavement/aftercare only for each family unit
- _____ to provide bereavement/aftercare for families that includes:
 - ___ a variety of parent groups (dads/moms, granddads/grandmoms, couples/all parents),
 - ___ sibling groups (age appropriate)
 - ___ family groups (variety of multi-family and individual family)
 - ___ a combination of all of the above

_____ I believe the diversity of what should be offered in the groups should include:

- ___ groups with activities and talking
- ___ groups with only talking
- ___ groups receiving written information on family grief and talking
- ___ filial group—enhancing the parent/child relationship
- ___ incorporate all of the above

_____ I believe that the community grief support programs (all of which focus on helping children through grief) offer all the support that a family needs.

11. If you could design the perfect hospital support program and aftercare for families facing a diagnosis of chronic illness, complicated medical procedures and treatment, process of dying/hospice care and death. what would it look like?

12. **From the time of diagnosis to now, what has been**
the most difficult period of time for you—

the scariest moments for you—

the most challenging moments for you—

the time you received the most support and from whom—

the time you needed more support—

the most important moments for you—

the most helpful for you—

**CAMP SOL 2000
CHILD'S EXPERIENCE**

Name _____

Date _____

1. What did you like best about Camp Sol?

2. Circle the number that tells how much you liked that activity.

Activity	Did not like	Liked okay	Liked a lot		
making nametags	1	2	3	4	5
making family flags	1	2	3	4	5
decorating the large heart	1	2	3	4	5
family "get acquainted" bingo game	1	2	3	4	5
family clay animal sculptures	1	2	3	4	5
family puzzle pieces/mural	1	2	3	4	5
singing together	1	2	3	4	5
activities with other children (shields, body drawings, faces, etc)	1	2	3	4	5
talent show	1	2	3	4	5
journaling	1	2	3	4	5
nature scavenger hunt	1	2	3	4	5
memorial service	1	2	3	4	5
decorating frames	1	2	3	4	5
decorating rock jars	1	2	3	4	5
decorating flower pots for flowers	1	2	3	4	5
family photo portrait	1	2	3	4	5
family picnic	1	2	3	4	5
other: _____	1	2	3	4	5

Comments about any of the activities (*adults helping very young children please write down any significant comments said as you read the list to them*):

3. **What did you not like about Camp Sol?**
4. **What would you change about Camp Sol if you could be in charge?**
5. **How has your family changed since you went to Camp Sol?**
(i.e. spend more time together, spend less time together, my parents like me more, my parents like me less, etc.)
6. **How have you changed since you got back from Camp Sol?**
(i.e. I feel better, I feel the same, I feel worse, I feel closer to my parents, I feel I can't talk to my parents, I have more friends/less friends, I feel more lonely/ less lonely etc.)
7. **Would you come to Camp Sol again if you could?**
_____yes _____no comments:
8. **Would you want your family to come with you to Camp Sol if you came back?**
_____yes _____no comments:

APPENDIX E
CAMP SOL ACTIVITIES

Camp Sol 2000 Pictorial Representation



Figure 1: Camp John Marc, Dining Hall and Saddle Room



Figure 2: Camp John Marc, Library and Administration Building



Figure 3: Camp John Marc, Bandid Box, Counselor Cabin



Figure 4: Camp John Marc, Arts and Crafts Building



Figure 5: Camp John Marc, The Barn, Children's Activities and Sports



Figure 6: Camp John Marc, Bonfire Pit, Fishing Pier, and Lake



Figure 7: Example of a Family's Flag, Altars, Puzzle Piece, Rock Jar, Flower pot, and Clay Sculpture



Figure 8: Example of a Family Flag



Figure 9: Family Puzzle Piece

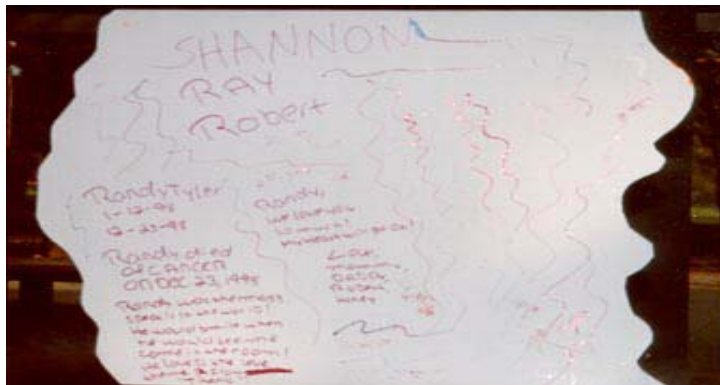


Figure 10: Family Puzzle Piece



Figure 11: Family Puzzle Piece



Figure 12: Family Puzzle Piece



Figure 13: Family Puzzle Piece



Figure 14: Family Puzzle Piece

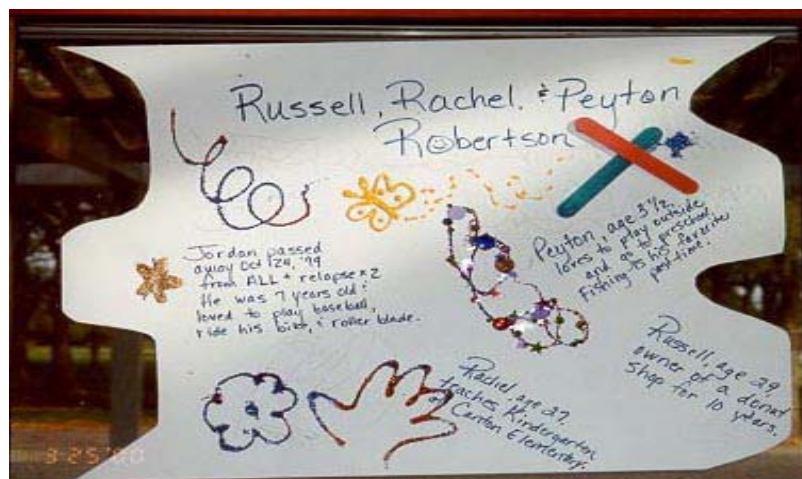


Figure 15: Family Puzzle Piece



Figure 16: Family Puzzle Piece



Figure 17: Family Clay Sculpture



Figure 18: Family Clay Sculpture



Figure 19: Family Clay Sculpture



Figure 20: Family Clay Sculpture



Figure 21: Family Clay Sculpture



Figure 22: Family Clay Sculpture



Figure 23: Family Clay Sculpture



Figure 24: Family Clay Sculpture



Figure 25: Family Clay Sculpture



Figure 26: Family Clay Sculpture



Figure 27: Family Clay Sculpture



Figure 28: Family Clay Sculpture



Figure 29: Father's Wood Altar, Mother's Basket Altar, and Flowerpots



Figure 30: Father's Wood Altar, Mother's Basket Altar, and Flowerpot



Figure 31: Father's Wood Altar, Mother's Basket Altar in background, and Flowerpot



Figure 32: Parents' Basket Altars

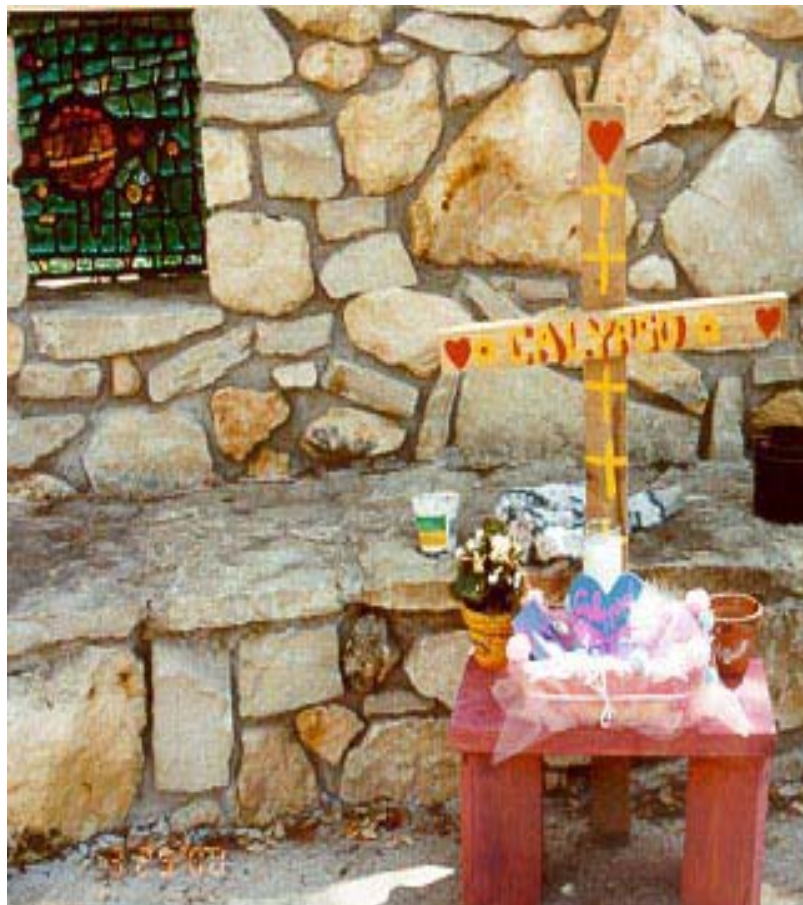


Figure 33: Father's Wood Altar, Mother's Basket Altar, and Flowerpot



Figure 34: Mother's Basket Altar



Figure 35: Father's Wood Altar, Mother's Basket Altar



Figure 36: Children's Shields



Figure 37: Children's Feelings Masks



Figure 38: Children's Summer Solstice Activity



Figure 39: Children's Drawings of Sibling Who Died, Waving Hands Activity



Figure 40: Children's Body Portraits



Figure 41: Family Photo with Large Paper Maché Heart. Photos were placed in the 5"X7" frame the family decorated and given to the family at the picnic.



Figure 42: Family Photo with Large Paper Maché Heart. Photos were placed in the 5"X7" frame decorated by the family and given to the family at the picnic.



Figure 43: Families Decorating Photo Frames, Rock Jars, and Flowerpots



Figure 44: Families Decorating Photo Frames, Rock Jars, and Flowerpots

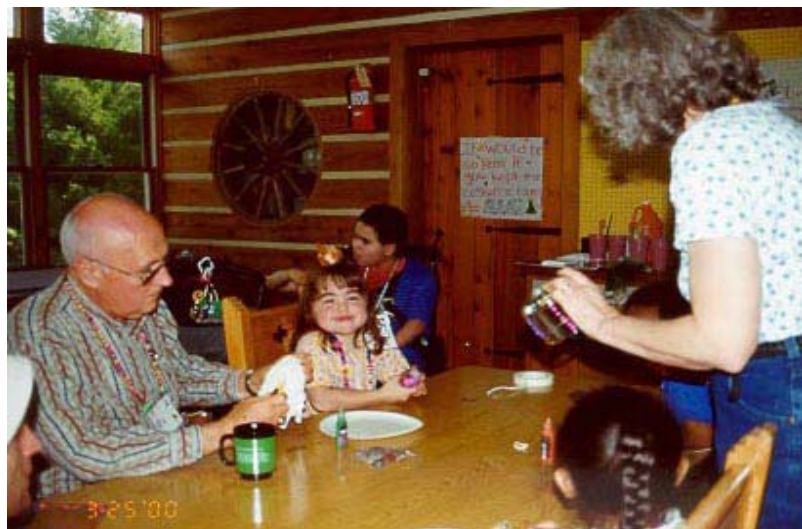


Figure 45: Families Decorating Photo Frames, Rock Jars, and Flowerpots



Figure 46: Families Decorating Photo Frames, Rock Jars, and Flowerpots



Figure 47: Examples of Decorated Photo Frames and Rock Jars



Figure 48: Rain, Remembrance Service Closure Activity



Figure 49: Group Photo of Camp Sol 2000 Children



Figure 50: Group Photo of Camp Sol 2000 Mothers



Figure 51: Group Photo of Camp Sol 2000 Fathers



Figure 52: Group Photo of Camp Sol 2000 Families



Figure 53: Group Photo of Camp Sol 2000 Counseling Staff

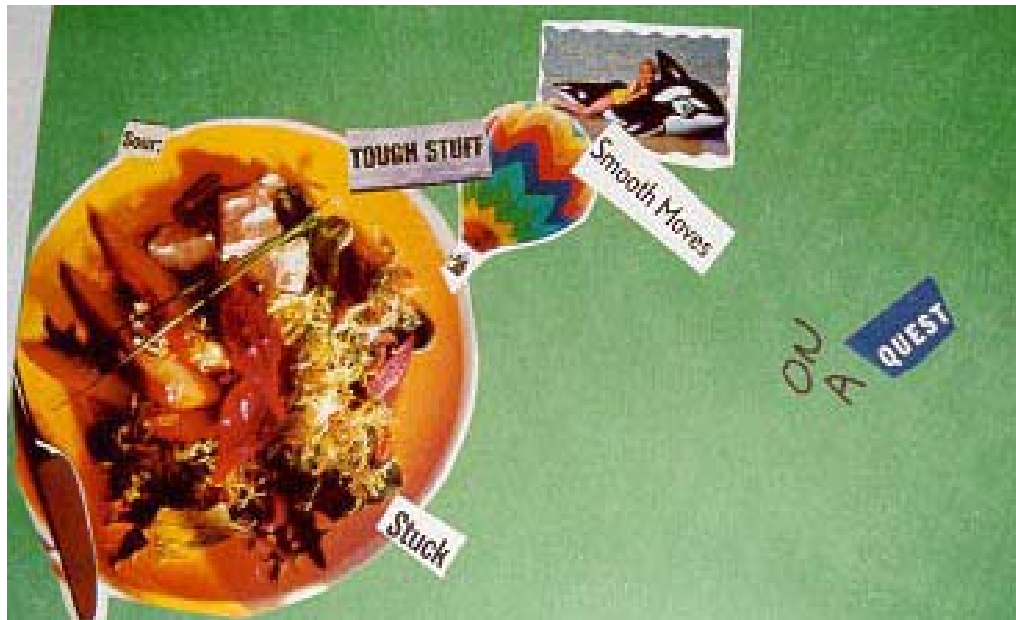


Figure 54: Father's Collage Activity, Follow-up Session #1

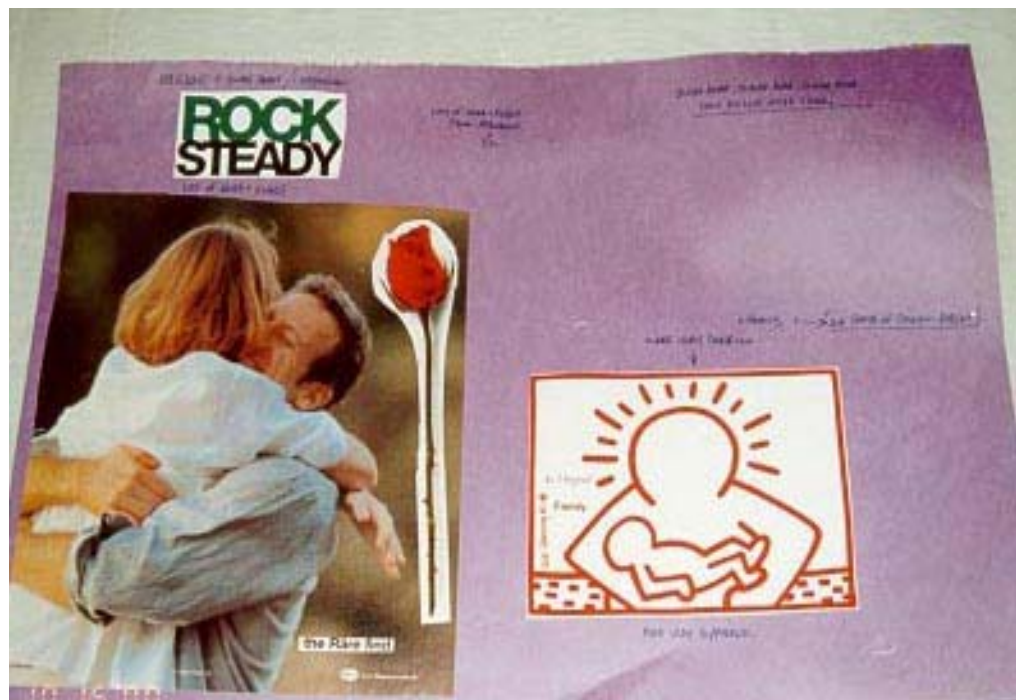


Figure 55: Father's Collage Activity, Follow-up Session #1

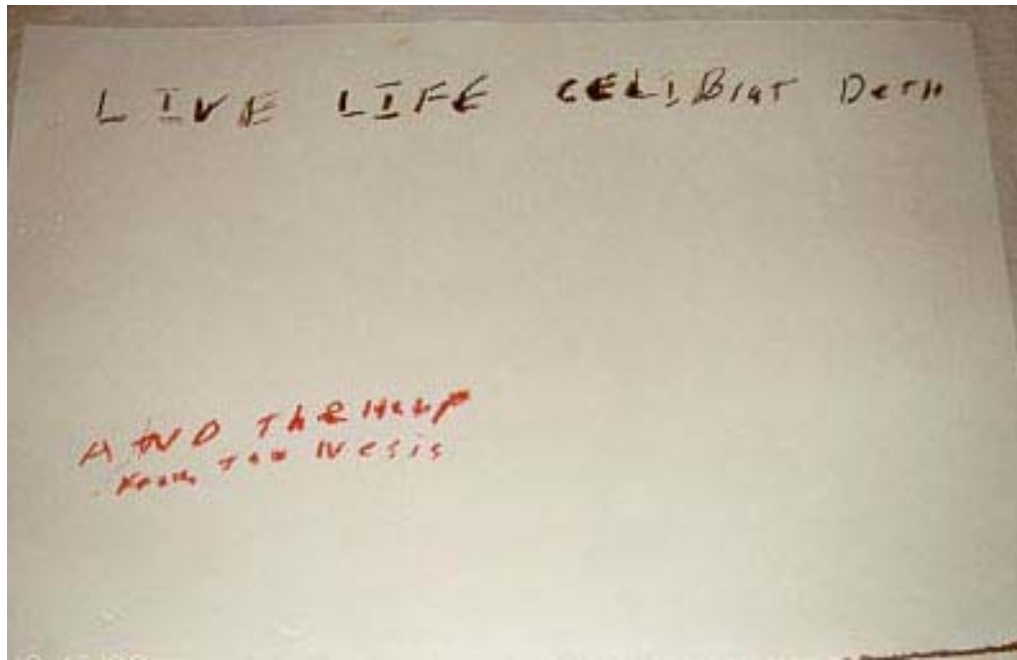


Figure 56: Father's Collage Activity, Follow-up Session #1



Figure 57: Father's Collage Activity, Follow-up Session #1



Figure 58: Father's Collage Activity, Follow-up Session #1

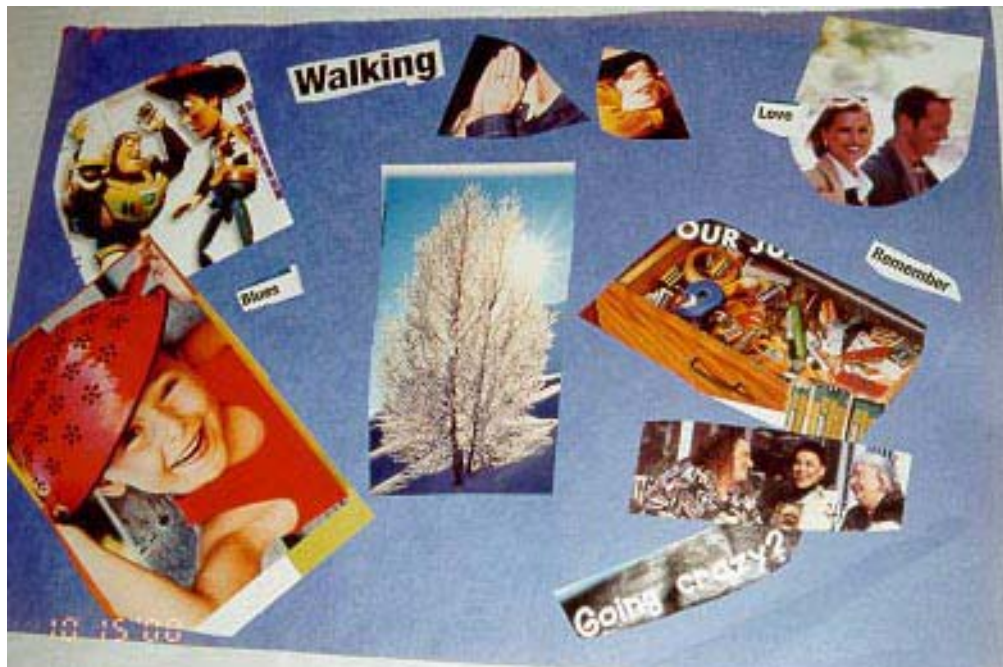


Figure 59: Mother's Collage Activity, Follow-up Session #1

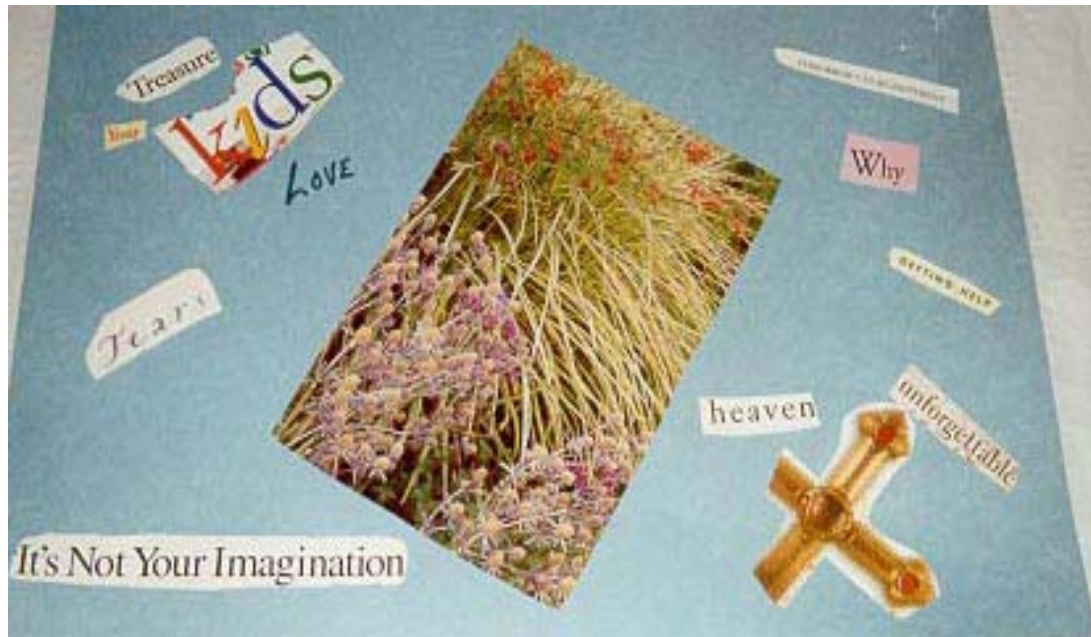


Figure 60: Mother's Collage Activity, Follow-up Session #1



Figure 61: Mother's Collage Activity, Follow-up Session #1



Figure 62: Mother's Collage Activity, Follow-up Session #1



Figure 63: Mother's Collage Activity, Follow-up Session #1

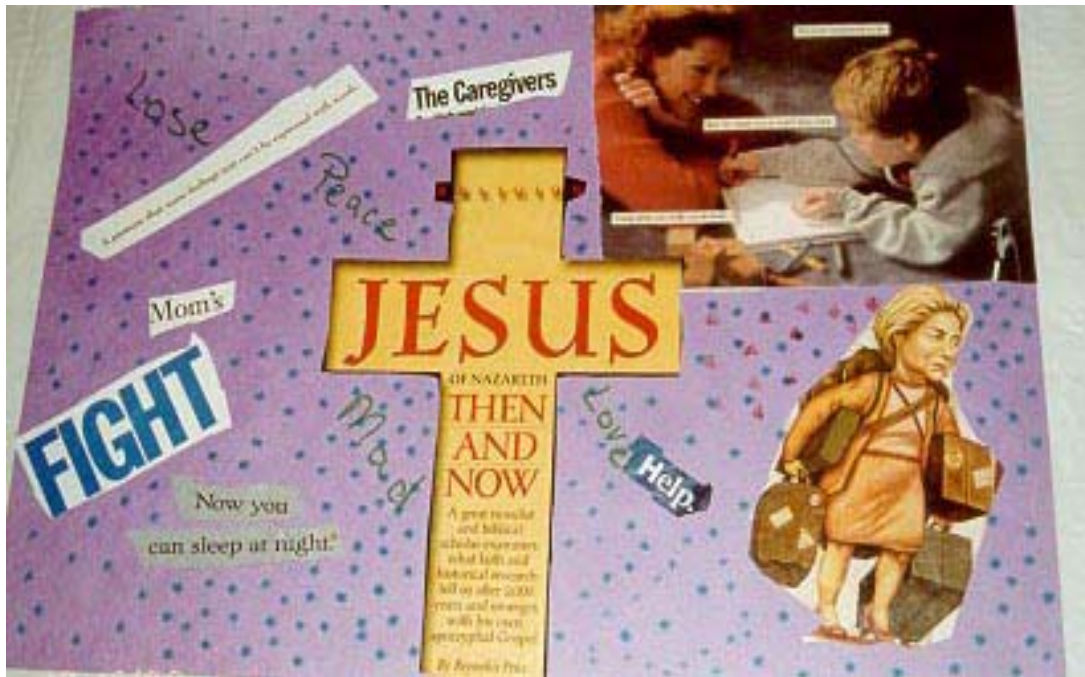


Figure 64: Mother's Collage Activity, Follow-up Session #1



Figure 65: Mother's Collage Activity, Follow-up Session #1



Figure 66: Mother's Collage Activity, Follow-up Session #1



Figure 67: Mother's Collage Activity, Follow-up Session #1



Figure 68: Cake for the Family Picnic, Follow-up Session #3



Figure 69: Parent-Child Face Painting, Follow-up Session #3



Figure 70: Parent-Child Face Painting, Follow-up Session #3



Figure 71: Families Making Family Portraits, Follow-up Session #3



Figure 72: Families Making Family Portraits, Follow-up Session #3



Figure 73: Families Making Family Portraits, Follow-up Session #3



Figure 74: Families Making Family Portraits, Follow-up Session #3



Figure 75: Families Making Family Portraits, Follow-up Session #3



Figure 76: Families Making Family Portraits, Follow-up Session #3



Figure 77: Families Making Family Portraits, Follow-up Session #3



Figure 78: Family Portrait, Follow-up Session #3



Figure 79: Family Portrait, Follow-up Session #3



Figure 80: Family Portrait, Follow-up Session #3



Figure 81: Family Portrait, Follow-up Session #3



Figure 82: Family Portrait, Follow-up Session #3



Figure 83: Family Portrait, Follow-up Session #3



Figure 84: Camp Sol 2000 Heart

CAMP SOL ACTIVITIES

Healing the Family Heart

Decorate Nametags (Individual family activity)– Using a variety of beads, stickers, and feathers, family members decorate their nametags for the Camp Weekend. Kelly will bring them to camp (*Webb-Ferebee).

Family Flag (Individual family activity) – family creates their own family flag with name and symbols at registration, prior to first session. These flags will be placed on the dining room tables as centerpieces marking each family’s eating space (*Program FAST).

Family Bingo (multi-family activity)– families will receive a sheet of squares with directions to get as many signatures as possible in 15 minutes. The family who gets the most squares filled will get a prize (a giant bottle of bubbles) (*Bratton, Costas, Dunn, Webb-Ferebee, Hollon, Hundley, Jones, & Lingnell).

SONG “If You’re Happy and You Know It” (O’Toole)

If you’re happy and you know it
 Clap your hands (children clap)
If you’re happy and you know it
 Clap your hands (clap)
If you’re happy and you know it
 Then your hands will surely show it
If you’re happy and you know it
 Clap your hands. (Clap)
If you’re lonely and you know it
 Give yourself a hug (hug self)
If you’re angry and you know it
 Stomp your feet (stomp feet)
If you’re sad and you know it
 Shed a tear (boo-hoo)
If you’re feeling guilty and you know it,
 Make amends, (shake hands)
If you’re friends are feeling sad
 Tell them you care (say, “I care”)

Paper Maché Heart instructions (ongoing activity) -“things you’ve gained, ways you’ve learned to take care of yourself that you can give to others”, family names, name of child who died

Camp Song (multi-family activity)— Staff & families will learn a short song to be sung at the close of camp. Children will be invited to play musical instruments along with this opening song..

Multi-Family Puzzle Mural (individual and multi-family activity) – Each family receives a large poster board puzzle piece upon which they will create a visual image of who their family is, why they are here and something about each family member. Children will tell about the images for their family. Family members will find how their pieces fit together to make a mural on the wall. Close with song and group hug

Campfire, songs, and s'mores (multi-family activity - optional) – down by the lake.
Saturday, March 25

Clay Animal Sculptures (Individual family activity) – Give each family member a block of clay on a paper plate, have available water, paper towels, pre-moistened towelettes and clay tools such as garlic press, potato masher, wire cutter, pencil, etc. Have the family members get acquainted with their clay by closing their eyes and exploring it with their hands. In a slow, gentle process, instruct them to squeeze, pinch, poke, pound and roll the clay. Music can help facilitate this exploration process.

Begin the activity by telling family members: “Think of an animal you identify with or that you are most like or best symbolizes you. Make that animal out of your lump of clay—your animal doesn’t have to be real—it can be a creation or compilation of several animals.” After they have finished, have them tell each other about their animals and why they chose that particular animal. Helpful questions: “What are the strengths and shortcomings of your animal? How does your animal get along with the other animals? What kinds of things does your animal like to do? What does it wish it could do? What does it wish it didn’t have to do? What does your animal need?”

Tell them to create the perfect place for all their animals to live together, out of the materials you give them (twigs, moss, sand, rocks, shells, string, foil, cellophane, paint, paper, craft sticks, tape, glue, boxes, etc.) As the home develops, encourage group members to talk about what the perfect home would be like. When through, ask members if they were that animal, where would they feel most comfortable in their new home, and then ask them to place their animal in that location. Next, ask them to be their animal and tell what it would be like to live in this ideal place. Other questions: “Why did you pick that spot for yourself? What do you like best about it? If you could change something, what would it be? Does your home need anything else? Is there anything you would miss if you lived here?” Tailor your questions to fit the needs of the family (*Bratton & Webb-Ferebee).

Moms/Dad's Altar-making Supply a wide variety of art media, baskets, wood, other materials, and tools for groups to construct altars to their deceased. Provide each parent with a candle and holder. Moms write notes to their child and from their child to themselves. Process. Do in gender groups/ then process as couples.

Developmental Age Group Activities (choose two activities or more with breaks in between; parents divided into gender groups first hour, break, then mixed gender groups second hour):

Age 3-5

STORYINGTELLING (*O'Toole)

Time: 30 minute activity

Goal: To allow children to tell stories about their loss.

Description: Children are invited to tell stories of the loss they have had. Ask the storyteller to share whether the loss they had was positive, negative, or both.

BUBBLES (*The Dougy Center)

Time: 20 minute activity.

Goal: to use bubbles to represent thoughts and feelings that are meaningful to the children.

Description: Blow bubbles for children, or allow them to blow their own. Take time to watch the bubbles fall and pop. The following can be done with bubbles:

- 1) Blow bubbles and relate them to feelings (e.g. big, small, fragile, etc.)
- 2) Bubbles can send a message to their sibling who died (e.g. "This bubble is to tell my sister/brother _____.")
- 3) Children can watch bubbles fall and describe them through a story (e.g. "There are two bubbles stuck so close together they don't want to let go, and then they're gone." "there is a tiny bubble stuck to your sleeve that doesn't want to go away.")
- 4) Children can name the feelings they want to blow away and then do so, or they can stamp on the bubble to smash a feeling they want to get rid of.

FEELINGS & COLORS (*The Dougy Center)

Time: 30 minute activity

Materials: paper, crayons, markers, black letters for tracing

Goal: To learn names within the group in a fun way. To acknowledge that different feelings make people think of different colors and that we all have lots of different feelings at the same time.

Description:

- 1) Identify and discuss 6-8 feelings. (e.g. happiness, sadness, anger, jealousy, guilt, silliness, pride, love, etc.
- 2) Ask for experiences that indicate these feelings along with a color for each feeling (e.g. happy=yellow, sad=brown). Facilitators explain that different children will use different colors to represent the same feelings (e.g. red may mean angry to one child and love to another).
- 3) Each child colors the letter of his/her name using different colors to represent the many feelings the child has.
- 4) Invite each child to share his or her drawings.

READING with ACTIVITIES FROM When Someone Very Special Dies: Children Can Learn To Cope With Grief

Time: 30 minute activity

Goal: To acknowledge how we all are changing and growing

*BODY TRACING (*Benzwie)*

Time: 20 minute activity

Materials needed: large pieces of butcher paper, markers/crayons

Goal: To gain body awareness and color feelings where they are in your body.

Description:

- 1) The facilitator traces the child's body onto a sheet of butcher paper. Music can be used during this activity. (*For older children ask them to close their eyes and tune in to their feelings.)
- 2) The child uses markers to draw how the inside of his/her body is feeling with designs, pictures, words, or just scribbling.
- 3) Cut out the outline and hang it up.
- 4) Ask who is this person—filling in "I am. . .I feel. . .I can. . .I want. . ."

*MOVEMENT (*adapted from Oaklander)*

Time: 15-20 minute activity

Materials needed: enough pieces of cloth for each child

Goal: To get in touch with what their muscles do when they are asked to move in specific ways to express emotions. To discover ways of expressing outwardly rather than inwardly.

Description:

- 1) Pile large pieces of cloth of different colors in the middle of our circle.
- 2) Ask each child to choose a cloth
- 3) (Optional) can play music for them to dance with

KINETIC FAMILY DRAWING (*Burns)

Time: 15 minute activity

Materials needed: paper and pencils

Goal: To process who is in their family now and how they experience their family.

Description: Draw everyone in your family doing something. Use real people instead of stick figures.

Age 6-8

RAIN (multi-family activity) (*Moffit) & Rainbow Protection Picture (O'Toole)

Talk with families about the importance of sunshine and rain to make things grow. Need both. Like the sunshine. Don't always like the rain. Need both. Talk about the stormy times of grief—rainy times (anger, hurt, tears) and the sunny (memories of good times that peek through and warm up the sad times). Rainbows symbolize hope. It takes both sunshine and rain (clouds) to make a rainbow. Hope protects us and keeps us knowing that a rainbow can happen. Have each child draw a picture of themselves or write their name on a piece of paper and then draw a Rainbow over the top. (*O'Toole)

GOOD GRIEF COOKBOOK (O'Toole)

Children write a recipe for helping themselves or someone else during periods of grief. Compile the "recipes" into a booklet called "Good Grief Cookbook". These may be done in poetic form. Children may draw pictures illustrating "good grief" that illustrates their recipe.

GROWING THROUGH GRIEF—A STORY IN PICTURES (*O'Toole)

Children make a book of drawings and design a cover.

- a) This is me before the loss
- b) This is a picture of what happened
- c) This is how I felt then.
- d) This is how I feel now.
- e) This is what helped me (or will help me)
- f) This is how I'll feel someday—or—This is how I'll remember my loss.

"I HATE YOU" EXPRESSIONS (*O'Toole)

Assist children, in creative ways, to express anger: through the writing of "I hate _____" letters or poems that can be discussed, torn up, etc. Punch pillows or use punching bags. Let them imagine themselves as "terrible two"-yr. olds wanting their own way. Let them stomp their feet and yell "I don't want to!" and "No! No! No!" until they feel tired and experience a release of energy. Discuss non-hurtful ways to express

strong negative feelings. Discuss how feelings that are released can be transformed. Following the tantrum, have everyone have a laughing contest to see who can laugh the longest and hardest. Follow these activities by drawing pictures of whatever feelings they are having or had during these activities. Then hold an “I learned _____” round room discussion.

RAINBOW CONNECTION (*O’Toole”

Idea that three things that are needed for plants to grow are sunshine, soil and rain. Give examples in nature of how the cycles of life include change. (Leaves fall from trees giving nitrogen to the soil, new trees grow from tree stumps, moss growing on a dead tree, etc.) Discuss how people can grow from rain (tears). Who/what provides the sunshine when there has been a loss? Write poems or draw pictures that show how grief can bridge from the past to the future and eventually bring out more color in peoples’ lives.

HANGING UP MEMORIES (*O’Toole)

Drape rope or string across areas of room. On 3X5 cards children write a memory they want to celebrate, or draw a picture that symbolizes growth. Using paper clips, attach the memories to the string. Use the decorate the room for the party.

DANCE OF LIFE (*O’Toole)

Working in small groups or in pairs children choose music and choreograph a dance of life that shows the ups and downs, losses, changes and growth.

JOURNALING (O’Toole)

Teens begin writing a journal to chronicle their thoughts, feelings, and what they have learned. Encourage them to include quotes, newspaper clippings, poems, etc. to elaborate on the experience. Develop an acceptable plan regarding how these will be kept private and confidential and whether the instructor will review them.

LIFE IS HELLO...LIFE IS GOODBYE COLLAGE (O’Toole)

Teens bring items or use magazines to clip images that can become part of a collage entitled “Life is Hello...Life is Goodbye...The pain and Gain of Change.” Items should identify some type of loss or growth from change, or some attitude of our culture, or their own about loss, change and grief.

Songs and loss they represent:

Cycle of Life

Every Must Change – Judy Collins

Turn, Turn, Turn, Seeger

Forever Like the Rose Seals and Croft

Loss through death
Fire and Rain James Taylor
Seasons in the Sun Billy Jacks
Lullaby Chuck Mangione

*Other activities adapted from Dougy Center.

SUMMER SOLSTICE

Materials: Yellow construction paper, ribbon and hole punch
Description of Activity: Have the participants cut yellow paper into a circle 6-8 in. wide, then punch a hole at the top and loop a ribbon through it. Then have them draw a picture on the surface and inside write messages to the person inside. Hang these circles on a tree. Have each person share about the person who died while hanging circles on the tree.

FEELING MASK

Materials: paper plates, paints or markers
Description of Activity: Discuss how what we feel inside is different from what we express openly on the outside. On one side of the plate, have participants draw their feelings on the inside, and on the other, what feelings they express outwardly. Then discuss the differences.

WAVE GOODBYE

Materials: construction paper, crayons, magazines, glitter, ribbon, buttons, butcher paper, scissors and glue
Description of Activity: Talk about hands with the participants, and have them touch their hands, pull on their fingers etc. Then talk about what hands can do and have them demonstrate. Have each person trace his or her hand on a piece of construction paper, then cut it out and decorate it. On each finger, the participants can write a goodbye message. After everyone is finished, the group arranges their hands on the sheet of butcher paper to symbolize saying goodbye to their loved one. Then hang the sheet of paper and talk about the feelings associated with saying goodbye through this activity.

MAGIC POWER SHIELD

Materials: Poster board, colored markers, crayons, pencils, paint, glue scissors, construction paper, beads feathers, fabric and yarn
Description of Activity: Have the group brainstorm objects, colors, shapes, etc. that hold power for them, then design shields from the poster board and cut it out, along with a strip for the handle. Have them draw, paint, or glue the powerful objects on the shield and decorate. Tape the handle to the back, and then explain how their shield is used to keep them safe.

Family Bingo

Has been to Disneyland in the past year	Own a strange pet	Has always lived in Texas	Who has two different brands of toothpaste at home	Who likes to go camping
Who owns the video "Beauty and the Beast"	Who ate at McDonald's last week	Who collects/collected Beanie Babies	Who enjoys reading together	Who has a garden
Who owns a blue car or van	Who has attended a baseball game recently	Who visit grandparents every week	Has a Nintendo at home	Has a computer at home
Has gone to a hockey game recently	Has a cell phone	Trades Pokemon cards	Goes to the library every week	Has a birthday this month
Has 9 or more letters in their last name	Can speak a different language	Has a dog and a cat at home	Has lived in a state other than Texas	Can play a musical instrument

CIRCLE OF FRIENDS

Jim Newton
©1996

CHORUS: CIRCLE OF FRIENDS
ALL HOLDING HANDS
SHARING OUR LIVES
ALL PART OF THE PLAN
GIVING THE GIFT
THAT NEVER WILL END
WE EACH TAKE OUR PLACE
IN THE CIRCLE OF FRIENDS

THE ROAD WE TRAVEL ON IS ROUGH AND ROCKY
WEARY, WE STRUGGLE ON UNTIL
WE MEET GOOD FRIENDS WHO CARE AND HELP US TO MAKE IT
THROUGH
AND WE ALWAYS WILL

CHORUS

TIME WILL SLIP AWAY BEFORE WE KNOW IT
AND SOON THE DAY IS ALL BUT GONE
BUT FRIENDS REMEMBER THE LOVE AND THE LAUGHTER
AND WE CARRY ON...

CHORUS

(TWICE AND SECOND HALF CHORUS TAG)

Nature Scavenger Hunt

Something big
Something small
Something round
Something flat
Something soft
Something hard
Something long
Something short
Something orange
Something red
Something blue
Something green
Something yellow
Something black
Something brown
Something shaped like a heart
Something shaped like a square
Something dead
Something alive
3 things that you heard

BONUS:

Bone
Feather
Fur

FAMILY RITUAL WITH ROCKS

The family gathers around a table and takes out their special rock jar. Family members talk about the rocks; how some are polished, shiny and smooth and others are rough and unpolished. They talk about how the process a rock goes through to become polished and gemlike represents the path we take through life – the rough rocks with sharp edges and cracks are put in a tumbler with water and course grit. The rocks tumble against each other and are sanded down by the grit, polished and rounded to become like gems. Just like these rocks, we as humans tumble through life with knocks, pain, tears, disappointments, losses, deaths and hardships. It is hard and it hurts, but in the process we too can become more gemlike.

The polished rocks you have chosen represent the healing that has taken place within you. The rough rocks represent the part of you that still hurts and may always hurt; but that is okay.

Family members choose a rock to hold that signifies how they are feeling. They tell each other, one by one with no one interrupting:

1. Why they chose the rock and the feeling their rock represents to them
2. What they appreciate about each person in the family to that person (ex. daughter says “Mom, I appreciate that you never come into my room without knocking”)
3. What they have learned from each person to that person (ex. son says: “Dad, I’ve learned that it’s okay to cry and that I don’t have to be strong all the time”)
4. Something they remember doing with each person that was special (ex. parent says: “Tom, I remember when we went fishing last year and we”) and/or they could tell something they remember doing with the child who died.

After the last person has spoken, there is a family hug. If there is someone who is hurting, the family could do a sandwich hug by having the person who is hurting get in the center of the family and everyone squeeze. This ritual could be done once a week following a meal or just before bedtime. (If you don’t have time for all four items, do #1 and one or two of the other three).

(Adapted from The Dougy Center)

RITUAL OF REMEMBRANCE AND CELEBRATION
CAMP SOL – SPRING, 2000

Participants assemble in dining hall. Altars, candles, and decorated flowerpots and flowers are already at chapel. Families process to chapel and sit in family units. Staff on hand to help support little ones during service.

DEFINING SACRED SPACE

Upon arrival at the chapel, group stands in a circle and chaplain opens: “In the beginning, humanity’s sacred places were not buildings – temples, churches, synagogues, mosques, shaman’s huts. They were places like this – places near water and trees – elevated places that revealed a beautiful view”.

We come this morning to remind ourselves that this place is sacred because it reminds us of something greater than ourselves. It is said that sacred space is any place where your heart touches the great heart of the universe. And for those who mourn, it is especially comforting to be connected to that great heart – for there, the loved ones we’re remembering this morning live and move and have their being”.

As the music “Kum Ba Yah” plays, I would like each family to sit in a circle. This is to be your own personal time of prayer, so there is no need to rush”.

As the music plays memorials, memory baskets, candles, and flowers/pots are placed within the family circle.

HONORING ANGER

Chaplain: “I read this morning from a book called “Psalms of Lament,” written by a mother whose son was murdered. In the introduction, she writes that the only way she was able to retain her sanity was to write prayers of anger and sadness, expressing before God the fullness of her grief and agony. The experience of grief takes us through many emotions, and anger is often not honored – especially anger at God. But I say to you today that it is acceptable to be angry – even angry at God (Reading from Psalm of Lament #15)”.

HONORING SADNESS

Chaplain: “We honor our sadness today with a candle-lighting ceremony. Death is very often seen as a light being extinguished—we talk about a life being “snuffed out”. So today, we are going to light candles to remind ourselves of what we have lost: the company of our children, a future of opportunities for them, the privilege of teaching them and watching them grow. But we also light these candles to remind ourselves of that which we will never lose—our love for them and our memories of them. Please light your candles and place it on or near the memorial in your circle. Share memories about your child who died. Hold hands and say a prayer or share your wishes. In doing so, you bless this time of

memories and sadness. Chaplain lights the large rainbow candle in the center of the chapel and recites the poem, "We Remember Them".

We Remember Them

In the rising of the sun and in its going down,
we remember them;

In the blowing of the wind and in the chill of winter;
we remember them;

In the warmth of the sun and the peace of summer,
we remember them;

In the rustling of the leaves and the beauty of autumn,
we remember them;

In the beginning of the year and when it ends,
we remember them;

When we are weary and in need of strength,
we remember them;

When we are lost and sick at heart,
we remember them;

When we have joys we yearn to share,
we remember them;

So long as we live, they too shall live,
for they are now a part of us,

as we remember them.

Solo, "Ladybug" sung with guitar accompaniment

HONORING HOPE

Chaplain: "You may plant the flowers in your decorated flower pots as a sign of hope for new growth".

HONORING RELIEF

Chaplain: "We close today with a reading from the "Velveteen Rabbit", a beloved children's book. (reading from the end of the story, beginning with the visit from the fairy)".

CLOSING CIRCLE – HONORING COMMUNITY

Chaplain: "And now will you stand and join hands in a circle. We close with a song about friends because we hope that you have made some friends this weekend. In a world which so seldom understands the depth of your grief, you have a circle of friends here at Camp Sol who are willing to be sojourners with you – friends who have either experienced the death of a child or who are willing to learn from you what your grief is like and to support you without judging your expressions of mourning.

The song says, "Circle of friends, all holding hands
Sharing our lives – a part of the plan
Giving the gift that never will end
We each take our place in the circle of friends".

Close with song.

**Remembrance Service Readings*
Psalms of Lament

O God, why have you abandoned me?
I sit and wait for you and you do not come.
I watch everyone who passes, but it is not you.
I sit by myself on the side of life and cry to you,
 but you do not come.
I stand and look from the window,
 but you are nowhere in sight.
I need you, O God, but you have left me all alone.
I try to talk myself into believing that you're on the way,
 perhaps tomorrow, or the next day...
 but you do not appear.
How can I walk in this pain all alone?
How can I stand knee-deep in suffering without you?
Where are you, O God of my life?
Where are you when I'm in such danger?
Will you let me slip away simply because
 you didn't get here on time?
O God of mercy, do not abandon me.
Show your face at my window and wipe the tears from my life.
Please come to me.
Please take care of me.

I will shout your name from the rooftops!
I will dance your praise among the stars.
I will tell the world that you would never abandon me.
Velveteen Rabbit

"I am the nursery magic Fairy," she said. "I take care of all the playthings that the children have loved. When they are old and worn out and the children don't need them any more, then I come and take them away with me and turn them into Real."

"Wasn't I Real before?" asked the little Rabbit. "You were Real to the Boy," the Fairy said, because he loved you. Now you shall be Real to every one." And she held the little Rabbit close in her arms and flew with him into the wood. It was light now, for the moon had risen. All the forest was beautiful, and the fronds of the bracken shone like frosted silver. In the open glade between the tree-trunks the wild rabbits danced with their shadows on the velvet grass, but when they saw the Fairy they all stopped dancing and stood round in a ring to stare at her.

"I've brought you a new playfellow," the Fairy said. "You must be very kind to him and teach him all he needs to know in Rabbit-land, for he is going to live with you for ever and ever!"

And she kissed the little Rabbit again and put him down on the grass. "Run and play, little Rabbit!" she said.

But the little Rabbit sat quite still for a moment and never moved. For when he saw all the wild rabbits dancing around him he suddenly remembered about his hind legs, and he didn't want them to see that he was made all in one piece. He did not know that when the Fairy kissed him that last time she had changed him altogether. And he might have sat there a long time, too shy to move, if just then something hadn't tickled his nose, and before he thought what he was doing he lifted his hind toe to scratch it.

And he found that he actually had hind legs! Instead of dingy velveteen he had brown fur, soft and shiny, his ears twitched by themselves, and his whiskers were so long that they brushed the grass. He gave one leap and the joy of using those hind legs was so great that he went springing about the turf on them, jumping sideways and whirling round as the others did, and he grew so excited that when at last he did stop to look for the Fairy she had gone.

He was a Real Rabbit at last, at home with the other rabbits.

REFERENCES

- Achenbach, T. (1991). Child behavior checklist computer scored profile, parent and teacher forms. Burlington, VT: University of Vermont.
- Achenbach, T., & Edelbrock, C. (1981). Behavioral problems and competencies reported by parents of normal and disturbed children aged four through sixteen. Monographs of the Society for Research in Child Development. 46 (1, Serial no. 18).
- Achenbach, T., & Edelbrock, C. (1983). Manual for the child behavior checklist and revised child behavior profile. Burlington, VT: University Associates in Psychiatry.
- Achenbach, T. (1985). Youth Self-Report. Burlington, VT: Author.
- Adams, K. (1996). Bereavement counseling groups with elementary school students [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9607 156
- Allan, J. (1988). Inscapes of the child's world: Jungian counseling in schools and clinics. Dallas, TX: Spring.
- Anderson, D. (1998). Recovery from loss through grief support groups at Riverside Community Hospital [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9826046

Aries, P. (1974). Western attitudes toward death: From middle ages to present. Baltimore: John Hopkins University.

Bailey, S. (2000). From mourning to mourning. In J. Morgan (Ed.). Meeting the needs of our clients creatively: The impact of art and culture on caregiving (pp. 123-132). Amityville, NY: Baywood Publishing

Barnard, P., Morland, I., & Nagy, J. (1999). Children, bereavement and trauma: Nurturing resilience. Philadelphia, PA: Jessica Kingsley.

Barton, M., & Bischoff, R. (1998). Rocks and rituals in producing therapeutic change. Journal of Family Psychotherapy, 9 (3), 31-41.

Bayles, D., & Orland, T. (1993). Art & fear: Observations on the perils (and rewards) of artmaking. Santa Barbara: Capra Press.

Beck, A. T., Brown, G., Steer, R.A., Eidelson, J.I., & Riskind, J.H. (1987). Differentiating anxiety and depression: A test of the cognitive content specificity hypothesis. Journal of Abnormal Psychology, 96, 179-183.

Beck, A. T., Steer, R.A., & Brown, G. (1987). Beck depression Inventory manual. San Antonio, TX: Harcourt Brace.

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. Journal of Consulting and Clinical Psychology, 56, 893-897.

Beck, A.T., Ward, C., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. Archives of General Psychiatry, 4, 561-571.

Beck, T., & Steer, A. (1990). Beck anxiety Inventory manual. San Antonio, TX: Harcourt Brace.

Becker, E. (1973). Denial of death. New York: Free Press.

Bernstein, P., Duncan, S.W., Gavin, L., Lindahl, & Ozonoff, S. (1989). Resistance to psychotherapy after a child dies: The effects of the death on parents and siblings. Psychotherapy, 26, 227-232.

Bertman, S. (Ed.) (1999). Grief and the healing arts: Creativity as therapy. Amityville, NY: Baywood Publishing Company.

Billings, A.G., & Moos, R..H. (1982). Social support and functioning among community and clinical groups. Journal of Behavioral Medicine, 5, 295-311.

Bliss, S. (1991). The art process in therapy: A phenomenological study. Unpublished doctoral dissertation, University of North Texas, Denton.

Bowen, M. (1991). Family reaction to death. In F. Walsh & M. McGoldrick (Eds.). Living beyond loss: Death in the family, (pp. 79-92). New York: W.W. Norton.

Bowlby, J. (1980). Attachment and loss: Vol. 3. Loss. New York: Basic.

Brown, L.L., & Hammill, D.D. (1983). Behavior Rating Profile. Austin, TX: PRO-ED.

Burks, H.F. (1977). Burks' Behavior Rating Scales. Los Angeles: Western Psychological Services.

Burns, R., & Kaufman, S. H. (1972). Actions, styles and symbols in kinetic family drawings. New York: Brunner/Mazel.

Bratton, S., & Webb-Ferebee, K, (1999). The use of structured expressive art activities in group activity therapy with preadolescents. In D. Sweeney & L. Homeyer (Eds.). Group play therapy: How to do it, how it works, whom it's best for (pp. 192-214). San Francisco, CA: Josey-Bass.

Breer, M. (1997). Testing a multi-level model of family adaptability and functioning after the death of a parent [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9822413

Carey, L. (1991). Family sandplay therapy. Arts in Psychotherapy, 18, 231-239.

Cattanach, A. (Ed.) (1999). Process in the arts therapies. Philadelphia, PA: Jessica Kingsley.

Clement-Millican, V. (1996/1997). The development and exploration of an Adlerian family art therapy assessment tool with families of adolescents. (Doctoral dissertation. The University of North Texas, 1996). Dissertation Abstracts International, 57/07, 2875.

Coles, R. (1990). The spiritual life of children. Boston, MA: Houghton Mifflin.

Conners, C.K. (1989). Conners' Parent Rating Scales. North Tonawanda, NY: Multi-Health Systems.

Cousins, N. (1979). Anatomy of an illness. New York: W.W. Norton.

Croll, L. (1999). A family-focused approach for the treatment of grief and loss: Group and family therapy [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: MQ32087

Davies, B. (1999). Shadows in the sun: The experiences of sibling bereavement in childhood. Philadelphia, PA: Taylor & Francis.

Davis, C. (1989). The use of art therapy and group process with grieving children. Issues in Comprehensive Pediatric Nursing, 12, 269-280.

Decker-Voigt, H.H. (1975). Musik als Lebenshilfe. (Music as a healing agent). Lilienthal, Germany: ERES.

Decuir, A. (1991). Trends in music and family therapy. The Arts in Psychotherapy, 18, 195-199.

Detmer, C.M., & Lamberti, J.W. (1991). Family grief. Death Studies, 15, 363-374.

Dileo, J. H. (1983). Interpreting children's drawings. New York: Brunner/Mazel.

Doka, K. (Ed.) (1995). Children mourning: Mourning children. Philadelphia, PA: Taylor & Francis.

Doka, K., & Davidson, J. (Eds.) (1998). Living with grief: Who we are: How we grieve. Philadelphia, PA: Taylor & Francis.

Dominquez, M. (1999). The treatment of complicated mourning in children [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9935424

- Engel, G. (1964). Grief and grieving. American Journal of Nursing, 64, 93-98.
- Fanos, J. (1996). Sibling loss. Mahwah, NJ: Lawrence Erlbaum Associates.
- Feder, B., & Feder, E. (1981). The expressive arts therapies. Englewood, Cliffs, NJ: Prentice-Hall.
- Finkbeiner, A. (1996). After the death of a child: Living with loss through the years. New York: Free Press.
- Fisiloglu, H., & Lorenzetti, A. (1994). The relation of family cohesion to marital adjustment. Contemporary Family Therapy, 6, 539-552.
- Fleshman, B., & Fryrear, J. (1981). The arts in therapy. Chicago: Nelson-Hall.
- Freud, S. (1957). Mourning and melancholia. In Standard Edition of the complete psychological works of Sigmund Freud (Vol 13), London: Hogarth Press.
- Fryrear, J., & Corbit, I. (1992). Photo art therapy: A Jungian perspective. Springfield, IL: Charles Thomas.
- Fryrear, J., Corbit, I., & Taylor, S. (1992). Instant images: A guide to using photography in therapy. Dubuque, IA: Kendall Hunt.
- Fryrear, J., & Stephens, B. (1988). Group psychotherapy using masks and video to facilitate intrapersonal communication. The Arts in Psychotherapy, 15, 227-234.

Furth, G. M. (1988). The secret world of drawings: Healing through art. Boston: Sigo.

Gabriels, R. L. (1999). Treating children who have asthma: a creative approach. In C. Malchiodi (Ed.), Medical art therapy with children (pp. 95-112). Philadelphia, PA: Jessica Kingsley.

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

Gilbert, K. (1996). "We've had the same loss, why don't we have the same grief?": Loss and differential grief in families. Death Studies, 20, 269-283.

Gillis, J.S. (1980). Child anxiety scale. Champaign, IL: Institute for Personality and Ability Testing.

Gillis, J.S., & Cattell, R.B. (1979). Comparison of second-order personality structure at 6-8 years with later patterns. Multivariate Experimental Clinical Research, 4, 93-99.

Gladding, S. (1998). Counseling as an art: The creative arts in counseling. Alexandria, VA: American Counseling Association.

Goldberg, S.G. (1973). Family tasks and reactions in the crisis of death. Social Casework, 54, 398-405.

Golden, T. (1996). Swallowed by a snake: The gift of the masculine side of healing. Kensington, MD: Golden Healing.

Goodman, L. (1981). Death and the creative life. New York: Springer.

Gowensmith, W. (2000). The effects of postfuneral rituals on adjustment to bereavement [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9947937

Graham, H. (1999). Help or hindrance: An examination of the effectiveness of children's grief support groups [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9935946

Grainger, R. (1999). Researching the arts therapies: A dramatherapist's perspective. Philadelphia, PA: Jessica Kingsley.

Graves, A. (1992). Development, implementation, and evaluation of a children's bereavement group with a parent support group [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9200297.

Greenspoon, D. (1986). Multiple-family group art therapy. Art Therapy, 7, 53-60.

Hamilton, M. (1959). The assessment of anxiety states by rating. British Journal of Medical Psychology, 32, 50-55.

Hankin, D. (1997). Families and illness: Coping with the death of a child from cancer. (Doctoral Dissertation, The California School of Professional Psychology at Alameda, 1997). Dissertation Abstracts International, 58/05 2676.

Hathaway, S.R., & McKinley, J.C. (1942, 1943 [renewed 1970]). Minnesota Multiphasic Personality Inventory. Minneapolis: University of Minnesota Press.

Havelka, J. (1999). Culture, creativity and death. In S. Bertman (Ed), Grief and the healing arts: Creativity as therapy (pp. 217-224). Amityville, NY: Baywood Publishing Company.

Heiney, S. (1991). Sibling grief: A case report. Archives of Psychiatric Nursing, V (3), 121-127.

Housely, P (1997). Effectiveness of grief support groups for children [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9722309.

Hughes, M. (1995). Bereavement and support: Healing in a group environment. Washington, DC: Taylor & Francis.

Humphrey, G., & Zimpfer, D. (1996). Counseling for grief and bereavement. Thousand Oaks, CA: Sage.

Jensen, E.W., James, S.A., Boyce, W.T., & Harnett, S.A. (1983). The family routines inventory development and validations. Journal of Social Science and Medicine, 17, 201-211.

Johnson, S. (1987). After a child dies: Counseling bereaved families. New York: Springer.

Jordan, J. (1990). Loss and family development: Clinical implications. Paper presented at the 98th annual convention of the American Psychological Association, Boston.

Jozefowski, J. (1999). The phoenix phenomenon: Rising from the ashes of grief. Northvale, NJ: Jason Aronson.

Kaduson, H., & Schaefer, C. (Eds.). (1997). 101 favorite play therapy techniques. Northvale, NJ: Jason Aronson.

Kamm, S. (1999). Psychological adjustment, relationship satisfaction, and communication in bereaved parents [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9936943

Kastenbaum, R. (1993). Reconstructing death in postmodern society. Omega, 27:1, 75-89.

Kissane, D.W., Bloch, S., McKenzie, M., McDowall, A., & Nitzan, R. (1998). Family grief therapy: A preliminary account of a new model to promote healthy family functioning during palliative care and bereavement. Psycho-Oncology, 7, 14-25.

Klass, D., Silverman, P., & Nickman, S. (Eds.) (1996). Continuing bonds: New understandings of grief. Washington, DC: Taylor & Francis.

Knill, P. (1994). Multiplicity as a tradition: Theories for interdisciplinary arts therapies. An overview. The Arts in Psychotherapy, 21(5), 319-328.

Knoff, H., & Prout, H.T. (1985). Kinetic drawing system for family and school: A handbook. Los Angeles, CA: Western Psychological Service.

Knox, S. (1999). A healing journey: The use of art therapy with bereaved children [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 1394026

Kramer, E. (1993). Art as therapy with children. Chicago, IL: Magnolia Street.

Kübler-Ross, E. (1969). On death and dying. NY: MacMillan.

Kübler-Ross, E. (1983). On Children and Death. New York: Macmillan.

Kübler-Ross, E. (1995). Death is of vital importance: On life, death, and life after death. Barrytown, NY: Station Hill.

Kutscher, A. (Ed.) (1969). Death and bereavement. Springfield, Ill: C.C.

Thomas

Kwiatkowska, H.Y. (1967). Family art therapy. Family Process, 6, 36-55.

Kwiatkowska, H.Y. (1978). Family therapy and evaluation through art.

Springfield, IL: Charles C. Thomas.

Lamberti, J., & Detmer, C.M. (1993). Model of family grief assessment and treatment. Death Studies, 17, 55-67.

Lamers, E. (2000). Children, death, and fairytales. In J. Morgan (Ed.), Meeting the needs of our clients creatively: The impact of art and culture on caregiving (pp. 195-211). Amityville, NY: Baywood Publishing.

Landgarten, H.B. (1981). Clinical art therapy. New York: Brunner/Mazel.

Landgarten, H.B. (1987). Family art psychotherapy: A clinical guide and casebook. New York: Brunner/Mazel.

Landgarten, H.B. (1991). Family creative arts therapies: Past and present. The Arts in Psychotherapy, 18, 191-193.

Landreth, G. (1991). Play therapy: The art of the relationship. Muncie, IN: Accelerated Development.

Landy, R. (1993). The child, the dreamer, the artist and the fool: In search of understanding the meaning of expressive therapy. Arts in Psychotherapy, 20, 359-370.

Lang, L. (1992). Expressions of grief: Art therapy used as an intervention in the treatment of bereaved adolescents [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 1347863.

Lantz, J. & Alford, K. (1995). Art in existential psychotherapy with couples and families. Contemporary Family Therapy, 17, 331-343.

Levine, S. (1982). Who dies? An investigation of conscious living and conscious dying. New York: Anchor Books.

Levine, S., & Levine, E. (Eds.) (1999). Foundations of expressive arts therapy: Theoretical and clinical perspectives. Philadelphia, PA: Jessica Kingsley.

Liao, L. (1989). Polyasthetik und Eigengesetzlichkeit der Künste. (Polyaesthesia and the inner laws in the arts). Polyaesthesets Journal, 4 (2). Salzburg: Mozarteum.

Liebmann, M. (1987). Art therapy for groups: A handbook of themes, games, and exercises. Cambridge, MA: Brookline.

Liebmann, M. (Ed.). (1996). Arts approaches to conflict. Bristol, PA: Jessica Kingsley.

Lindemann, E. (1943). Symptomatology and management of acute grief. American Journal of Psychiatry, 101, 141-148.

Linesch, D. (1999). Art making in family therapy. In D. J. Weiner (Ed), Beyond talk therapy: Using movement and expressive techniques in clinical practice (pp.225-243). Washington, D.C.: American Psychological Association.

Lochner, C., & Stevenson, R. (1988). Music as a bridge to wholeness. Death studies, 12, 173-180.

Loy, M. (1999). A study of the effectiveness of a camp intervention for bereaved adolescents [CD-ROM]. ProQuest File: Dissertation Abstracts Item: 9923242

Malchiodi, C. (Ed.) (1999). Medical art therapy with children. Philadelphia, PA: Jessica Kingsley.

Martin, T., & Doka, D. (2000). Men don't cry...women do: Transcending gender stereotypes of grief. Philadelphia, PA: Taylor & Francis.

Marwit, S., & Klass, D. (1996) Grief and the role of the inner representation of the deceased. In D. Klass, P. Silverman, & S. Nickman (Eds.), Continuing bonds: New understanding of grief (pp. 297-309). Washington, DC: Taylor & Francis.

May, R. (1975). The courage to create. New York: Bantam.

Meyer, G. (1999). An exploratory study of the theory and technique of five expressive art therapy modalities [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9918493

McCabe, M. (1997). The paradox of loss: Toward a theory of grief [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9733101.

McCown, D., & Davies, B. (1995). Patterns of grief in young children following the death of a sibling. Death Studies, 29, 41-53.

McGee, R., Williams, S., & Silva, P. (1984). Background characteristics of aggressive hyperactive girls and aggressive hyperactive boys. The Journal of the American Academy of Child Psychiatry, 23, 280-284.

McGoldrick, M., & Walsh, F. (1991). A time to mourn: Death and the family life cycle. In F. Walsh & M. McGoldrick (Eds.), Living beyond loss: Death in the family (pp. 30-49). New York: W.W. Norton.

McIntyre, B. (1987). The use of art therapy with bereaved children [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 8809607

McNiff, S. (1981). The arts and psychotherapy. Springfield, IL: Charles C. Thomas.

McNiff, S. (1992). Art as medicine. Boston: Shambhala.

McNiff, S. (1998). Art-based research. Philadelphia, PA: Jessica Kingsley.

Miller, J. (1992). Healing loss through the exercise of creativity [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9033582

Minuchin, S. (1992). Families and family therapy. Cambridge, MA: Harvard University.

Mitchell, R.R., & Friedman, H.S. (1994). Sandplay: Past, present and future. London: Routledge.

Moos, N. (1995). An integrative model of grief. Death Studies, 19, 337-364.

Moos, R.H. (1974). Family environment scale. Palo Alto, CA: Consulting Psychologists.

Moos, R.H. & Moos, B.S. (1986). Family environment scale manual (2nd ed). Palo Alto, CA: Consulting Psychologists.

Morgan, J.D. (Ed.) (2000). Meeting the needs of our clients creatively: The impact of art and culture on caregiving. Amityville, NY: Baywood Publishing Company.

Nachmanonitch, S. (1990). Freeplay: The power of improvisation in life and the arts. New York: G.P. Putnam's Sons.

Nadeau, J. (1998). Families making sense of death. Thousand Oaks, CA: Sage.

Neimeyer, R. (1999). Narrative strategies in grief therapy. Journal of Constructivist Psychology, 12, 65-85.

Oaklander, V. (1988). Windows to our children. Highland, NY: Center for Gestalt Development.

Oliver, K. (1991). The lives of mothers following the death of a child: Toward an understanding of maternal bereavement [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9110200

Oster, G.D., & Gould, P. (1987). Using drawings in evaluation and therapy. New York: Brunner/Mazel.

Osterweis, M., Solomon.F., & Green, M. (Eds.). (1984). Bereavement: Reactions, consequences, and care. Washington, DC: National Academy Press.

- Papp, P. (1984). The links between clinical and artistic creativity. Networker, 5, 20-28.
- Parkes, C.M. (1972). Bereavement: Studies of grief in adult life. NY: International University Press.
- Parkes, C.M., & Weiss, R.S. (1983). Recovery from bereavement. New York: Basic.
- Paul, N.L. & Grosser, G.H. (1965). Operational mourning and its role in conjoint family therapy. Community Mental Health Journal, 1, 339-345.
- Payne, H. (1993). Directory of arts therapies research. In H. Payne (Ed.), Handbook of inquiry in the arts therapies: One river, many currents (pp. 231-250). London: Jessica Kingsley.
- Payne, H. (1993). Introduction to inquiry in the arts therapies. In H. Payne (Ed.), Handbook of inquiry in the arts therapies: One river, many currents (pp. 1-6). London: Jessica Kingsley.
- Peters, J. (1987). Music therapy: An introduction. Springfield, IL: Charles C. Thomas.
- Piaget, J. (1962). Play, dreams, and imitation in childhood. New York: Rutledge.
- Pine, V.R. (1969). Comparative funeral practices. Practical Anthropology, 16, 49-62.
- Pipher, M. (1996). The shelter of each other: Rebuilding our families. New York: Putnam.

Plach, T., (1980). The creative use of music in group therapy. Springfield, IL: Charles C. Thomas.

Plummer, D. (1999). Using interactive imagework with children: Walking on the magic mountain. Philadelphia, PA: Jessica Kingsley.

Quail, J., & Peavy, V. (1994). Phenomenologic research study of a client's experience in art therapy. Arts in Psychotherapy, 20, 45-57.

Quay, H.C., & Peterson, D.R. (1983). Revised Behavior Problem Checklist. Coral Gables, FL: University of Miami, Department of Psychology.

Rando, T. (1984). Grief, dying, and death: Clinical interventions for caregivers. Champaign, IL: Research Press.

Rando, T. (1988). Grieving: How to go on living when someone you love dies. Lexington, MA: Lexington Books.

Reynolds, C., & Kamphaus, R. (1992). Behavior assessment system for children manual. Circle Pines, MN: American Guidance Service.

Riches, G., & Dawson, P. (2000). An intimate loneliness: Supporting bereaved parents and siblings. Philadelphia, PA: Open University Press.

Riley, S. (1993). Illustrating the family story: Art therapy, a lens for viewing the family's reality. Arts in Psychotherapy, 20, 253-264.

Riley, S. (1994). Integrative approaches to family art therapy. Chicago, IL: Magnolia Street.

Robbins, A. (1994). A multi-modal approach to creative art therapy. Bristol, PA: Jessica Kingsley.

Rockwood, M. (1999) Art as a way of healing [CD-ROM]. Abstract from:
ProQuest File: Dissertation Abstracts Item: 9946038

Rogers, C. (1961). On becoming a person: A counselor's view of psychotherapy. Boston: Houghton Mifflin.

Rogers, N. (1993). The creative connection: Expressive arts as healing. Palo Alto, CA: Science & Behavior Books.

Rosen, E. (1990). Families facing death: Family dynamics of terminal illness. Lexington, MA: Lexington Books.

Rosenblatt, P. (1996). Grief that does not end. In D. Klass, P. Silverman, & S. Nickman (Eds.), Continuing bonds: New understanding of grief (pp. 45-58). Washington, DC: Taylor & Francis.

Rubin, J. (1984). Child art therapy. New York: Van Nostrand Reinhold.

Rubin, J. (1984). The art of art therapy. New York: Brunner/Mazel.

Sanders, C.M. (1999). Grief: The mourning after: Dealing with adult bereavement (2nd Ed.). NY: J. Wiley.

Schildhaus, W. (1997). Marital adaptation and growth after the death of a child [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9713150

Schimmel, B., & Kornreich, T. (1993). The use of art and verbal process with recently widowed individuals. American Journal of Art Therapy, 31, 91-97.

Schneiderman, G., Winden, P., Tallett, S., & Feldman, W. (1996). Update on bereavement risk. Journal of American Academy of Child and Adolescent Psychiatry, 35(2), 132-133.

Sedney, M., Baker, J., & Gross, E. (1994). "The story" of a death: Therapeutic considerations with bereaved families. Journal of Marital and Family Therapy, 3, 287-296.

Segal, R. (1984). Helping children express grief through symbolic communication. Social casework, 12, 590-599.

Serazin, L. (1996). Gallery of grief: Utilizing art therapy to reduce future risk in bereaved children [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 1379083

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

Shapiro, E. (1996). Family bereavement and cultural diversity: A social developmental perspective. Family Process, 35, 313-332.

Sherebrin, H. (1999). The role of the visual image in psychodynamics of grief resolution: Viewed through Jewish law and tradition). In S. Bertman (Ed), Grief and the healing arts: Creativity as therapy (pp. 237-252). Amityville, NY: Baywood Publishing Company.

Sherr, C., & Hicks, H. (1973). Family drawings as a diagnostic and therapeutic technique. Family Process, 12, 439-460.

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

Silverman, P., & Klass, D. (1996). Introduction: What's the problem? In D. Klass, P. Silverman, & S. Nickman (Eds.), Continuing bonds: New understandings of grief (pp. 3-27). Washington, DC: Taylor & Francis.

Silverman, P., & Nickman, P. (1996). Concluding thoughts. In D. Klass, P. Silverman, & S. Nickman (Eds.), Continuing bonds: New understandings of grief (pp. 349-355). Washington, DC: Taylor & Francis.

Sinito, G. (1993). Healing a loss through creative expression: A personal journey [CD-ROM]. Abstract from ProQuest File: Dissertation Abstracts Item: 1347859

Smith, S. (1999). The forgotten mourners: Guidelines for working with bereaved children (2nd Ed.). Philadelphia, PA: Jessical Kingsley.

Soden, L. (1998). Insight imagery: Towards personal wellness through spontaneous art-making and empathic co-reflection [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: NQ35326

Spielberger, C.D. (1983). Manual for the State Trait Anxiety Inventory (Form F). Palo Alto, CA: Consulting Psychologists Press.

Stroebe, M., Gergen, M., Gergen, K., & Stroebe, W. (1996). Broken hearts or broken bonds? In D. Klass, P. Silverman, & S. Nickman (Eds.), Continuing bonds: New understanding of grief (pp. 31-44). Washington, DC: Taylor & Francis.

Tozeland, J. (1999). Working through grief and loss with children and their families: Group and individual approaches [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: MQ32269

Vaisanen, L. (1997). Family grief and recovery process when a baby dies: A qualitative study of a family grief and healing processes after fetal or baby loss [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: Not available from Uml

Van der Kolk, B.A. (1996). Traumatic stress: The effects of overwhelming experience on mind, body and society. New York: Guilford Press.

Vargas-Irwin, M. (1999) Evaluation of a bereavement group for children [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: 9920197

Villeneuve, C., & LaRoche, C. (1993). The child's participation in family therapy: A review and a model. Contemporary Family Therapy, 15, 105-119.

Wadeson, H. (1976). The fluid family in multi-family art therapy. American Journal of Art Therapy, 15, 115-118.

Wadeson, H., Durkin, J., & Perach, D. (1989). Advances in art therapy. New York: John Wiley & Sons.

Waller, D. (1993). Group interactive art therapy. New York: Routledge.

Walsh, F., & McGoldrick, M. (Eds.). (1991). Living beyond loss: Death in the family. New York: W.W. Norton.

Walsh, F., & McGoldrick, M. (1991). Loss and the family: A systemic perspective. In F. Walsh & M. McGoldrick (Eds.). Living beyond loss: Death in the family, (pp. 1-29). New York: W.W. Norton.

Ward, C. (1999). Shaping connections: Hands-on art therapy. In A. Cattanach (Ed.). Process in the arts therapies, (pp. 103-131). Philadelphia, PA: Jessica Kingsley Publishers.

Waser, G. (1991). The role of the communicative unconscious in creative therapy, with particular reference to transitional relationships. CREATE, Journal of the Creative & Expressive Arts Therapies Exchange, 1. Toronto: Palmerston Press.

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

Weiner, D.J. (Ed.). (1999). Beyond talk therapy: Using movement and expressive techniques in clinical practice. Washington, D.C.: American Psychological Association.

West, W. & Ogden, T. (January 26, 2000, most recent update). WebStat Version 2.0 [on-line]. Available:

<http://www.stat.sc.edu/webstat/version2.0/data/Work.html>

Whyte, D. (1990). Where many rivers meet. Langley, WA: Many Rivers Press.

Wilkinson, J. (1996). Therapeutic art-making with bereaved children to facilitate death education and grief expression [CD-ROM]. Abstract from:

ProQuest File: Dissertation Abstracts Item: 1378718

Wilson, D. (1989). An exploration of family reactions to video feedback in family art therapy [CD-ROM]. Abstract from: ProQuest File: Dissertation

Abstracts Item: 8816876

Windsor, G. (1999). Sensing experiences: Voices of the bereaved [CD-ROM]. Abstract from: ProQuest File: Dissertation Abstracts Item: MQ34468

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

Wolfelt, A. (1996). Healing the bereaved child: Grief gardening, growth through grief and other touchstones for caregivers. Fort Collins, CO: Companion Press.

Woltmann, A. (1960). Spontaneous puppetry by children as a projective method. In A. Robin, & U. Haworth (Eds.), Projective techniques with children, (pp. 305-312). New York: Grune & Stratton.

Worden, J. (1991). Grief counseling and grief therapy: A handbook for the mental health practitioner. New York: Springer.

Worden, J. (1996). Children and grief: When a parent dies. New York: Guilford.

Zambelli, G., Clark, E., Barile, L., & deJong, A. (1988). An interdisciplinary approach to clinical intervention for childhood bereavement. Death Studies, 12, 41-50.

Zambelli, G., Clark, E., & deJong-Hodgson, A. (1994). The constructive use of ghost imagery in childhood grief. The Arts in Psychotherapy, 21, 17-24.