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## Adaptation of a Grief and Communication Family Support Intervention for Parentally Bereaved Families in Sweden

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### ABSTRACT

This article aims to describe the adaptation of the evidence-based Family Bereavement Program to a Swedish context. Empirical support indicating that family communication is a protective factor for parentally bereaved children was used to motivate the focus of the intervention. Modules from the Family Bereavement Program manual were translated, culturally adapted, and modified to fit a family format. The manual for the Grief and Communication Family Support Intervention was pilot-tested with two families, which resulted in minor modifications being made to the manual. Therapists reported that they could follow the manual and adapt it to children's varying ages.



### Introduction

Parentally bereaved children are vulnerable to psychological and somatic problems which may occur directly following the parent's death or develop several years later (Ayers et al., 2014; Bergman, Axberg, & Hanson, 2017; Ellis, Dowrick, & Lloyd-Williams, 2013; Pfeffer, Karus, Siegel, & Jiang, 2000; Sandler et al., 1992; Worden, 1996; Worden & Silverman, 1996). The loss of a parent during childhood or adolescence is often a traumatic event and children in this situation typically need a lot of support. However, the remaining parent may be struggling with their own grief and changes in the family situation or family roles following the loss, which can affect their ability to communicate with their children or provide positive and supportive parenting (Weber, Alvariza, Kreicbergs, & Sveen, 2019).

Family communication is a known protective factor for the psychological health of parentally bereaved children (Kamm & Vandenberg, 2001). Furthermore, aspects of family communication such as sharing feelings, showing appreciation of one another, listening, and expression skills are found to be important aspects of positive and supportive parenting, which is a compensatory protective resource for parentally

bereaved children. This means that positive and supportive parenting can potentially reduce mental health problems for children independent of the impact of negative life events (Haine, Wolchik, Sandler, Millsap, & Ayers, 2006). Positive and supportive parenting creates an environment which supports children's needs, goals, and development, while compensating for negative life events which may threaten achievement of developmental milestones. Modeling of positive behavior may also promote the development of social skills, such as non-aggressive conflict resolution and problem-solving strategies, and other coping skills (Haine et al., 2006). Moreover, supportive parents have been shown to have an enhanced capacity for supporting their children (Blank & Werner-Lin, 2011; Haine et al., 2006; Lin, Sandler, Ayers, Wolchik, & Luecken, 2004).

Bereaved children and families may need professional support to cope with bereavement. In practice, there are many types of interventions for parentally bereaved children. These include support groups, group therapy, family therapy, and individual therapy, but most interventions have not been evaluated in research using a control group, follow-ups, or randomized controlled trials (Currier, Holland, & Neimeyer, 2007).

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There is currently no consensus regarding what should be included in these interventions or how the potential effects should be measured, but most interventions seem to include a strong psychoeducational component (Currier et al., 2007). Two separate systematic reviews of interventions with parentally bereaved children have concluded that relatively brief interventions may prevent psychological health problems in children and adolescents as long as they are conducted at an early stage and target children at higher risk of developing problems (Bergman et al., 2017; Currier et al., 2007). Bergman et al. (2017) suggest that support programs where the family has joint sessions rather than separate parent and child groups are important, as this gives the family an opportunity to talk about the loss and their emotions; for some, this will be the first time they talk about it as a family.

One intervention for parentally bereaved children that stands out due to the promising results of randomized controlled trials and long-term follow-up is the Family Bereavement Program (FBP), which uses both psychoeducational and cognitive behavioral techniques (Ayers et al., 2014; Sandler et al., 2003, 2018). In designing the FBP, Sandler and colleagues created an empirically supported theoretical framework, used this framework to derive implications for program objectives, and designed an intervention model to accomplish these objectives (Sandler, Gersten, Reynolds, Kallgren, & Ramirez, 1988). The original model for the FBP specified several factors which mediated the effects of parental death on child symptomatology, including parental demoralization, parental warmth, family cohesion, negative life events, stable positive events, family coping, discussion of grief-related issues, and satisfaction with social support (Sandler et al., 1992). Evaluation of the FBP using randomized controlled trials showed improved parenting skills, improved skills in coping with stress, improved mental health in parents and children, reductions in stressful events, and maintenance of family discussions on grief-related issues even at 6-year and 15-year follow-ups (Ayers et al., 2014; Sandler et al., 2003, 2018).

Despite the well-known consequences and risks for parentally bereaved children, and international efforts by organizations such as the National Alliance for Grieving Children in the US, The Irish Childhood Bereavement Network, and The Childhood Bereavement Network in the UK to establish standards of practice, there are no national standards of practice in Sweden regarding support and treatment for this group (Bergman & Hanson, 2014; Löwing,

2014). A Swedish report found that half of bereaved children felt that they had not received any support from their school or from the healthcare system, even though the child had felt that help and support were needed (Bergh Johannesson, Bondjers, Arnberg, Nilsson, Ängarne-Lindberg, and Rostila, 2014).

### **Adapting the grief and communication family support intervention**

The brief support intervention described here comprised three 90-min sessions where a parent and their child/children meet a family therapist together. This arrangement is in contrast to the original group-based format of the FBP where parent and child groups meet separately for 12 two-hour sessions (Ayers et al., 2014). The FBP covers many topics and skills, such as improving relationship quality, positive coping strategies, negative esteem and threat appraisals, adaptive control beliefs, adaptive emotional expression, positive parenting including communication skills, negative events, caregiver demoralization, and grief. Based on previous literature and discussion with the creator of the FBP, we chose to focus our intervention on grief and communication and have therefore adapted the grief or communication modules from the FBP to a family-based format. To achieve this goal, we combined the parent and child communication modules, which are meant to complement each other in a group format, so that they would work in a family format. Our intervention uses similar collaborative and active learning strategies as the FBP, such as modeling behavior, practicing new skills, and role-playing. Furthermore, emotional support is fostered by teaching parents and children effective skills for listening and expressing emotions, which are reviewed and practiced when negotiating and planning positive family activities (Sandler et al., 1988). Like the FBP, our Grief and Communication Family Support Intervention aims to reinforce open family communication, provide psychoeducation on grief, and promote healthy adaptation to bereavement.

The intervention was developed, after consultation with Irwin Sandler, the developer of the FBP, by a multi-disciplinary team including three family therapists, two psychology researchers, and two health care sciences researchers who were also registered nurses. This team had expertise in palliative care, bereavement care, and psychological interventions. The team met several times to discuss strategies for working with parentally bereaved families and to adapt and revise the communication focused modules included in the

treatment manual for the FBP. It was thought that a brief intervention consisting of three sessions, each 90 min long, conducted approximately 1 week apart, would be best suited to parentally bereaved families seeking support. This briefer format was considered to be more accessible for families with children and more feasible in the Swedish healthcare setting.

Inclusion and exclusion criteria were determined based on current literature and clinical experience. Families which had lost a parent at least 1 year ago due to illness and had children aged 3 years and older were eligible to be included. This timeline would give the family time to adjust to life without the deceased. The age limit of 3 years was established because most 3-year-old children are capable of expressing their thoughts and emotions and would be expected to be able to participate in the intervention even if in a somewhat limited capacity. To keep our sample as close to a realistic community setting as possible, there were no exclusion criteria for psychological or medical diagnosis or having sought support or therapy previously.

The therapists were instrumental in culturally adapting the FBP manual from an American context to a Swedish context by providing culturally relevant examples to include in the manual and adjusting the language to be less direct and more culturally appropriate. For example, “parents should” became “it could be helpful to try” and “families often struggle to talk about grief” became “sometimes it can be difficult to talk about grief.”

### The intervention modules

Like the FBP, which aims to promote resilience in parentally bereaved children by influencing multiple risk and protective factors (Ayers et al., 2014), the main goal of the Grief and Communication Family Support Intervention is to improve communication between family members, especially with regards to their grief and speaking about the deceased parent. This is accomplished through psychoeducation, with the therapist providing information for the family about common grief reactions and communication strategies which can increase open communication. Cognitive behavioral methods, such as skills training and role-playing, are used in conjunction with family therapy methods which focus on family relationships and emotional processing through family discussion. The intervention offers modules focused on grief and communication which can be modified based on the ages of participating children.

### Session one

The aims of session one are to establish a therapeutic alliance between the family and therapist, for the therapist to answer questions the family has about the intervention, and to clarify therapist and family member expectations. Session one focuses on providing the family with psychoeducation regarding grief and communication.

**Module 1: The family’s new circumstances.** The therapist should establish a therapeutic relationship/alliance and learn about the family’s situation, find out what the family would like to improve and what the family has been happy or unhappy with in their daily life, and learn more about their relationships and communication. This involves a semi-structured discussion, where each family member is encouraged to contribute their own experiences. It is also an opportunity for the therapist to observe family dynamics. Families discuss how their life and relationships were before the deceased parent became ill compared to how their life was during the parent’s illness and following the death including what types of psychological, somatic, or behavioral grief reactions they have experienced following the parent’s death.

**Module 2: Psychoeducation about grief.** The therapist provides the family with information about common grief reactions for preschool age children, school age children, adolescents, and adults using a brochure as a foundation. The brochure was developed by the research group and the family is encouraged to keep and review it at home. The therapist summarizes the important points of the brochure directly related to the family’s unique experiences. For example, if there are school aged children in the family, the therapist will focus on common grief reactions for school aged children and ask the family how that compares to their own experiences of grief.

**Module 3: Psychoeducation about what is “good” communication.** The therapist presents a clear overview of strategies which can contribute to good communication, such as using “I” messages and active listening. The family discusses these strategies and has the opportunity to ask questions.

**Module 4: Psychoeducation about what can make communication more or less difficult.** The parents and children are taught to identify barriers to good communication and to identify strategies which can ease communication in their family (e.g., not asking the parent for something or bringing up something important when the parent is on the phone or clearly busy with another task). The family is asked to generate examples from their own lives of what can make

communication more or less difficult. The therapist gives more examples or clarifies as necessary.

**Module 5: Summary of session one.** The therapist and family members summarize what was discussed and what the family members learned in the first session.

### *Session two*

The aim of session two is to increase parent and child understanding of feelings and to practice using “I” messages and active listening to share thoughts and feelings. The goal is for parents and children to begin understanding that everyone hides their feelings sometimes, start being able to identify and talk about feelings, and discuss how certain behaviors can be helpful in one situation, but unhelpful in another.

**Module 1: Reflections from session one.** The therapist summarizes the previous session and family members can ask questions or give feedback.

**Module 2: Hiding feelings.** The family is asked to generate examples of feelings which people may generally try to hide, using feelings cards (i.e., pictures of teddy bears expressing different emotions) provided by the therapist. Family members then discuss why hiding feelings may be problematic. This discussion is conducted at a more general hypothetical level to avoid forcing family members to admit they have done something “wrong.” Situations where hiding one’s feelings may be appropriate or beneficial are also discussed.

**Module 3: Sharing positive feelings.** Parents and children are asked to identify feelings, talk about feelings, and to identify some positive effects of sharing feelings with each other. The family brainstorms about why people do not share positive feelings with each other. The family is then asked to give examples of how they could share positive feelings with each other and how this could impact them. The therapist explains how sharing positive feelings can be beneficial in a family. The idea behind this module, as taken from the FBP, is that teaching the family to share positive feelings will eventually make it easier and more comfortable for them to share all types of feelings.

**Module 4: “I” messages and active listening.** Family members learn to clearly and concisely express their thoughts and feelings using “I” messages through psychoeducation and practice these skills in a number of exercises led by the therapist. Active listening skills are taught to parents and children and practiced in role-playing exercises.

**Module 5: Family time.** The therapist explains why spending time together as a family doing mutually enjoyable activities is important for bereaved families. The family then discusses their thoughts and feelings about spending time together and brainstorm fun activities that they can do together. The family is asked to choose one of these activities to do, or at least plan, before session three. The goal of family time is to start building strong family relationships through planned activities which generate positive interactions between family members. This is also an opportunity for the family to have fun again and take a break from their grief.

**Module 6: Summary of session two.** The therapist and family members summarize what was discussed and what the family members learned in the second session. The family members are asked to each bring a memento that reminds them of the deceased parent to share at the next session.

### *Session three*

The aim of session three is to teach parents to help their children solve problems effectively using open communication. Furthermore, the family will practice the skills included in the previous sessions during the memento exercise.

**Module 1: Reflections from session two.** The therapist summarizes what was talked about in the previous session and families can ask questions or give feedback regarding session two. Families are also asked to tell the therapist how family time worked for them during the previous week.

**Module 2: Problem solving.** The therapist introduces a method for problem solving which the parent and children then practice using a problem which one of the children has recently had as an example.

**Module 3: Memento.** If an individual has forgotten their memento at home, they are given time and materials to draw a picture of it. Each person is given a turn to share their memento with the other family members and the therapist. Parents are asked to summarize what their children said about their mementos, thus showing their children that they have listened. Family members practice combining all the strategies they have learned by sharing their thoughts and feelings and using “I” messages and active listening throughout the memento exercise.

**Module 4: Family discussion.** The family talks about their grief, including positive and negative changes which have occurred in the family since the parent’s death. The therapist should normalize these



changes and help the family see that they have the coping skills necessary to handle these changes. The family is asked to identify how their grief and/or communication may have changed during the intervention. The therapist should emphasize similarities and differences from the grief discussion in session one.

**Module 5: Conclusion and summary of the intervention.** Family members are asked to summarize what they have learned as well as what communication strategies they have found to be helpful or useful. The family discusses which strategies they would like to continue using. The therapist gives the family feedback regarding their progress and thanks them for participating.

### Initial testing of the adapted intervention manual

The manual was tested with two parentally bereaved families to ensure all the modules would fit into the allotted time and to gain a better understanding of which modules worked well. Follow-up phone calls with the participating parents were conducted by the first author, 2 weeks after the final session. The study was registered at [clinicaltrials.gov](https://clinicaltrials.gov) under the Unique Protocol ID: DRN 2016/1192/31/1 and was approved by the Regional Ethics Committee 2016/1192-31/1.

### Setting

The intervention manual was tested in private family therapy clinics with the surviving parent and children present for all three sessions. Two families were recruited through the research group's professional network, including participants from a previous interview study or clinical practice, and offered three sessions with a family therapist. Sessions were conducted approximately once a week during December 2017 and February 2018. Informed consent was obtained from the parents and informed assent was obtained from all children prior to participation.

### Intervention fidelity

Adherence to the intervention manual (Chan, O'Neill, McKenzie, Love, & Kissane, 2004) was evaluated by audio-recording each session with the family's permission and having the therapist complete an adherence checklist. The first author listened to the recorded sessions while completing an adherence checklist, which was then compared with the therapist's completed adherence checklist to assess agreement between the

therapist and first author. This process helped to determine if the therapist was able to follow the manual. Bereavement support competence (Chan et al., 2004) was ensured by using licensed family therapists with several years' experience of working with grieving families. These were the same therapists who were involved in writing and developing the manual.

### Participants

**Family 1.** Members were a father and two sons, ages 6 and 11 years. The children's mother died from cancer 18 months prior to the intervention. The father had previously participated in the research group's interview study, where he reported that his children avoided talking about their mother. The father was contacted by the research team to ask if he and his children would be interested in helping to test the adapted intervention manual. The father accepted and was put in contact with one of the three therapists. Approximately 1 week passed between each session.

**Family 2.** Members were a mother and her 7-year-old son. The father/husband had died 2 years previously. The mother spoke Swedish as her second language and sometimes struggled to understand the therapist. The therapist was able to adjust how she phrased her questions and responded to what the mother said to help clarify for the mother and prevent misunderstandings. The son was very shy but was engaged in the sessions and would answer the therapist's questions by nodding yes or shaking his head no.

### Case examples

The following case illustrates the components of the Grief and Communication Family Support Intervention, conducted in the initial test. The general structure of each session is described and followed by a description of how each family responded to the session.

### Session one

The therapist began the first session by thanking the family for their interest in participating and clarifying the procedures of the research study. The therapist explained that the goal of the three sessions was to help the family have an easier time communicating with each other. She started by informing them that they would meet three times to talk about the family's situation and grief and to try new communication strategies which the family might find useful. The

therapist began by asking the family about their current situation as well as similarities and differences between their current situation and the family's situation before the parent became ill. While the family shared, the therapist normalized their experiences of grief and loss and validated their feelings.

As this discussion became more focused on feelings of grief, the therapist shared the grief brochure with the family and talked about normal grief reactions among children and adults. The parents took the brochure home to review it with their children. The therapist then provided the family with psycho-educative information on communication and situations which could promote or hinder communication.

While the therapist met with Family 1, the children asked their father questions about their mother and the family began to create a narrative together. The children shared what they remembered and the father elaborated to fill in some details for the therapist. The children stated that their father had become stricter since their mother died. The father said that the children might be correct and explained that he had been feeling quite a lot of stress due to both the practical and the emotional changes associated with his wife's illness and death. He promised the children to discuss this change further and to try to be less strict and more emotionally available. In contrast to the children from Family 1, the son from Family 2 was very shy and didn't want to speak. The therapist responded to the son's shyness by asking him more direct questions which he could answer by shaking his head no or nodding yes. She also engaged him by having him draw a picture of his family before his father died and drawing a picture of his family after his father died and asking questions about the drawings.

While the children from Family 1 were verbally participating by asking questions and discussing which grief reactions they could relate to, the son from Family 2 was very calm and reflective during the discussion of common grief reactions aided by the grief brochure. With Family 2, the therapist was concerned by the son's lack of response and asked him who he normally talks to about his father and he didn't answer. The mother responded that her son never talks to her about his deceased father. The family then set a goal to learn how to talk to each other about the son's father. This was followed by a discussion of how the mother and son usually communicate about every day topics. The therapist suggested a few strategies which may improve their communication such as the mother sharing her own thoughts and feelings to help the son feel more comfortable sharing his.

The children from Family 1 were surprised to learn that their father had a hard time listening to them when he was busy with other household tasks or talking on the phone and agreed to work with their father to establish better rules for communication at home. This session was closer to two hours with each family rather than 90 min. The younger son from Family 1 was not able to sit still for so long and the therapist chose to give the family a break in the middle of the session.

### **Session two**

The session began with the therapist reviewing what the family had talked about during the first session and asking if they had any questions. The therapist then introduced the feelings cards which were used to assist the children in identifying feelings that people sometimes hide. The session continued with the therapist explaining "I" messages and demonstrating active listening. The session ended with the therapist explaining *Family Time* and discussing which activities the family liked to do together. The therapist explained that doing fun activities together was a good way to build strong family relationships and concluded the session by asking the family to bring mementos that reminded them of the deceased parent to the next session.

With some prompting from the therapist, the two children from Family 1 could share that they sometimes do not like to show that they are sad or upset. Their father explained that he does not like to show when he is worried and that sometimes his worry is expressed as anger or frustration. The therapist asked the children if they knew that their father worried about them, to which the children responded "no, he is an adult." This module seemed to help both the father and sons understand how feelings are sometimes hidden or masked as other feelings.

While conducting the module on hiding feelings with Family 2, the son was just as shy as he had been during the first session. The mother gave several examples of feelings she typically hides such as trying to hide her sadness and loneliness after her husband's death. The therapist validated that it was common for people to want to hide how sad they felt after someone dies possibly because they don't want to be a burden on others or make someone else upset. The therapist then used the feelings cards with both families to help them identify other feelings people may want to hide and talk about how they had been feeling. The son from Family 2 was very quiet during this

module and participated by choosing feeling cards for feeling shy and disappointed. The therapist and mother discussed reasons why people may want to hide their feelings and the son seemed to listen attentively.

In contrast, the children from Family 1 laughed and interacted with their father and the therapist while talking about feelings and acting out how they show feelings during the module *Sharing Positive Feelings*. The whole family was active and engaged and seemed to be having fun. The children from Family 1 and mother from Family 2 struggled with the module on “I”-messages but the father in Family 1 seemed to find it easy and useful. The module on active listening was easier for the children and parents, as the therapist explained what body language and eye contact were by acting out and role-playing what types of body language indicate if someone is listening or not.

The father from Family 1 expressed that spending time as a family doing fun activities was something he hoped they could prioritize more. He and his sons had an easy time discussing activities they would like to do together. Family 2 tried to identify some activities that both the mother and son enjoy. The son nodded yes or shook his head no to the various suggestions. The therapist used the son’s drawings from the first session to identify activities he used to do with his father that he could now do with his mother. Since the son was so quiet, the therapist gave him and his mother paper to write or draw what activities they would like to do together. The son became excited and started asking how to spell some of the activities he wanted to write down. They then compared their lists and saw that they both wanted to do the same activities.

This session fit within the planned 90 min. Although the younger son in Family 1 struggled to sit still, he did listen to the family discussions and commented on what his father and brother said. The older children were actively engaged throughout the session.

### **Session three**

The therapist asked the family what they had done since the last session and what they remembered from the previous session. She then introduced a strategy for problem solving. The memento sharing exercise provided each family member with an opportunity to share memories of the deceased parent. Everyone used active listening during this exercise. The therapist concluded the final session by asking the family about

their experiences of the intervention. The therapist reminded them that they could use whichever communication strategies they thought had worked best for them at home. She encouraged them to continue practicing the communication strategies and planning fun activities to do together. She then thanked the family for their participation.

The father from Family 1 said that since the previous session, the family had focused on spending time together doing fun activities like ice skating and baking cookies and stated that they had establishing family rules about when would be a good time to have important conversations and how to improve communication in the family. The mother and son from Family 2 had to cancel their plans for “Family Time” due to the mother’s work schedule.

The module on problem solving was omitted with Family 1 as neither child could come up with a problem or conflict that they wanted to share. During the problem-solving module with Family 2, the mother stated that one problem was that she can see her son has something to say to her but he isn’t brave enough to say it. The therapist asked her if she had ever asked her son why he was shy or uncomfortable speaking with people. She stated she had never asked. Her son sat next to her looking down while drinking a juice box. The therapist explained that sometimes children need an adult’s help to explain their thoughts or feelings and reminded the family about the strategies they had practiced in the previous sessions. The son explained some of the reasons he was afraid and the therapist encouraged him to tell his mother when he was scared and ask her for help. The mother further explained that her son does well in school academically and socially but at home he is very clingy and always wants to be close to her. The therapist explained that separation anxiety is common in children following a parent’s death and helped the mother to practice reassuring him without reinforcing his fear or dependence on her.

The younger son from Family 1 asked many questions about his mother and struggled to remember her accurately. His father answered his questions and provided more details and anecdotes about their mother, including how they had met and other aspects of their early relationship. This exercise resulted in a long discussion with Family 1 about the children’s memories and feelings. With Family 2, the son had his father’s old camera with him to share during the memento module. The mother had brought as her memento a photograph of her husband together with her son when he was only 10 days old.



She talked about how the photograph made her feel both happy and sad and that her husband had been her best friend upon whom she could always depend. The therapist thanked them both for sharing.

The therapist concluded the session by summarizing what the family had discussed in all three sessions and encouraged them to continue working on their communication. The father and children in Family 1 all said that the intervention provided as good opportunity to listen to one another and the father thought it had been very positive to have time together as a family just to talk. The mother in Family 2 excitedly stated that she thought her son was listening and sharing more.

### **Follow-up telephone call**

One follow-up telephone call was conducted with each participating parent by the first author 2 weeks after the final session. Parents were asked what they thought of the sessions and if they had any suggestions for improvement. Both parents stated that having an opportunity to speak and share with their children in a safe and structured environment had been meaningful to them. They also reported that their children spoke more openly with them and asked more questions about the deceased parent following the intervention. When asked, neither parent offered suggestions for improving the intervention.

### **Therapist adherence**

Examination of the completed adherence checklists and audio recordings of sessions indicated that the modules were not always completed exactly as planned and often took longer than expected, which signaled that modifications to the manual were needed.

### **Discussion**

The therapists reported that it was easy to follow the manual and felt that the participating families responded well to each session. The evidence provided from testing the adapted manual with two families showed that the therapists were able to follow the manual without any major deviation. During follow-up phone call with each parent, the parents stated that the intervention had been useful and meaningful as it seemed to improve communication and family relationships. On the other hand, the sessions frequently took longer than intended as the therapists

allowed family discussions to continue longer than anticipated, often at the expense of the skills training exercises.

As this intervention had never been tested and the research group felt the content of intervention manual was quite extensive, it was decided to do a test with only two families to allow the therapists to work with the manual and alter it before a larger pilot test was conducted. Having tested the intervention with only two families is a clear limitation but a positive trend for adherence, satisfaction, and subjective reports of improved communication and relationships in the families were found.

The advantages and disadvantages of each module were discussed and debated by the two therapists and the first author. Difficulties concerning the participating children's ages and developmental levels as well as issues related to family dynamics in the two test families were discussed. We also proposed changes to the intervention, which were implemented in a subsequent study. To make the first session fit into the allotted 90 min, the introduction to "I" messages was removed, as this content was discussed and practiced in session two. Additionally, another change to session one was that *Psychoeducation about what good communication is* was moved to appear immediately after *Psychoeducation about what can make communication more or less difficult*, because the latter addressed some barriers to communication, such as finding the right time to talk.

No changes were made to session two. The module on problem solving in session three seemed to put undue pressure on the children. Initially a step-by-step guide for problem solving involving a concrete skills training exercise, the module was condensed to provide a more general overview of problem-solving strategies and discussion with the family about what could be useful in their family. Focus was further shifted to a discussion of what types of problems would be appropriate for a child to solve on their own and when it would be appropriate or even necessary for a parent to help the child solve a problem.

During the revision process, it was decided that the exercises and role-play should be conducted more explicitly by the therapists rather than having a process-oriented discussion. Reasons for this included keeping younger children active and engaged, as well as allowing the family to practice the skills which were being taught.

One advantage of using a family context is that sessions may be easier to schedule than coordinating group sessions. However, a family context does not

provide families with the opportunity to exchange experiences with other bereaved families. As this intervention is brief and only comprised of three sessions, many families may need more support than what can be provided through this intervention alone. By starting with three sessions, therapists may be able to implement it in private practice, social service, hospital, hospice, or school settings and use it to assess how a family, or individual family members, are coping with their grief and recommend other supportive resources based on the family's unique needs.

This study describes the many factors considered during the development of the Grief and Communication Support Intervention. The empirical evidence showing the effectiveness of the Family Bereavement Program was important when determining the focus of this intervention (Sandler et al., 2018). The therapeutic approach and structure were also considered in an attempt to ensure the intervention would be possible to implement. Trialing the intervention with two families provided initial data suggested that that the Grief and Communication Support Intervention could be feasible as well as beneficial to families following the death of a parent. The knowledge we developed was used to improve and streamline the manual, which is being tested in an exploratory pilot study using pre-post assessments to evaluate fidelity and identify potential effects of the intervention on psychological health and family communication. If the intervention is found to be feasible and effective, the manual may be further revised and tested in a larger randomized controlled trial. Further testing may result in a feasible, effective, manual-based support intervention which improves psychological health and communication in parentally bereaved families.

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