COUNSELLING BEREAVED FAMILIES

by
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I think some of you may share the view that bereaved children are "at risk". We know from retrospective studies of adult patients that there are links between psychiatric disorders and the death of a parent in childhood.

Some time ago I was involved in a research project with bereaved families in which we attempted to evaluate the effects of early counselling. We wanted to know whether such interventions could minimise subsequent dysfunction.

In this article, counselling is taken to be a clarificatory and therapeutic task with the following aims:

1. To provide practical and emotional support.
2. To facilitate the mourning process.
3. To help parents understand children's feelings and find ways of helping them communicate about death and the dead person.
4. To provide outside help where required.

Underlying this work is an assumption that where a family is able to communicate openly about distress, pain and confusion, they may help each other to adapt to their loss.

Preparation for Counselling

Despite my own experience and training in marriage guidance, abortion counselling and psychiatric social work, I felt rather anxious about becoming a bereavement counsellor. Although I had worked previously with issues of loss, a deliberate commitment to working with a number of families in which a parent or sibling had died seemed somewhat daunting. In preparation for this painful task, I found it helpful to reconsider certain issues.

Firstly, to do "grief work" I suggest we need to take a very careful look at our own emotional and philosophical attitudes to death. Do we really understand our own motivation in choosing this field? Are we focussing more on our own needs or those of our clients? Are we sufficiently flexible to meet the needs of families from widely differing cultural, social and religious backgrounds? Above all, can we enable the family to help themselves rather than encourage their dependency on us? Can we empathise and counsel without becoming overwhelmed by the family's loss?

Unless you feel comfortable and positive about these questions, I think you may find it difficult to cope effectively with bereaved clients. At a personal level you may also run the risk of becoming confused and depressed by the work. For those of you who have suffered a personal loss within the last two years, I would strongly advise against doing bereavement work until you have had sufficient time to work on your own mourning.

Secondly, when working with families with young children, I found it helpful to remind myself of the normal stages of a child's development so as to have a clearer picture of what they might be experiencing and thinking, although clearly each child will respond to death in a idiosyncratic way. To help in our understanding, we need to find out the family's attitude to death prior to the loss, to bear in mind the child's age, whether he was prepared for the death, and how it was dealt with subsequently, as well as the kind of person he was. Children's perceptions of death will vary at different periods in their lives.

Thirdly, any intervention has to take into account the different phases of mourning, which, although possibly less protracted or obvious in children than in adults, nonetheless can be extremely intense. Numbness and shock is followed by protest and anger, then yearning and pining follows. In children this increases separation anxiety and they often respond with physical pain to psychological distress, as in the case of Billy.

> After his mother's sudden death, Billy, a five year old, clung tenaciously to his father. He constantly had headaches, tummyaches and toothache; he frequently fell asleep when it was time for him to go to school. This child could only express his distress through physical symptoms.

In the third phase of mourning, feelings of apathy and sadness predominate, whilst the fourth and final stage enables gradual reorganisation and adaption to the loss to take place.

How to Counsel

Although we all know that death is inevitable, until relatively recently there was an almost tacit agreement that it was a taboo subject, too painful to be discussed. Although common sense as well as our experience in various fields suggests that the death of a parent or sibling disturbs the patterns and equilibrium of family life, yet many of you may share some of my initial doubts about working with all the members of a family and focussing on the issue of death and its consequences. **Is it actually possible to help children express their grief, to tell us why they are so distressed, to help them come to terms with their pain and confusion? Or do we run the risk of heightening and compounding their anxieties? Is it feasible to communicate with children regardless of their age, and if so, do explanations help children cope with death? I suggest that we can do very productive work in this area and would like to consider specific ways of increasing our sensitivity and techniques.** My own counselling methods have been considerably augmented by a systems approach and a wide range of techniques, both derived from family therapy, although I also acknowledge a large debt to psycho-analytically oriented casework training. Clearly there will be as many ways of working as there are counsellors!

Observation

I see the family as the basic source of information if we are observant and percipient enough to pick up the clues. Careful observation of family interactions will tell us how that particular group is coping with a bereavement; but this means listening carefully to verbal exchanges, noting non-verbal cues, the amount of physical contact between members, assessing the contributions of each member, the interruptions, the general mood and capacity to care for and comfort each other. I always expect to see the whole family; for even the handling of a young baby demonstrates a parent's capacity to meet dependency needs at a traumatic time.

> Jasper's mother was overwhelmingly preoccupied with feelings of loss and despair after Donald, her eighteen month old son, was killed in an accident, and she was unable to care adequately for five month old Jasper. Sadly, no counselling was offered at the time. When the family was finally referred for help, Jasper was two, completely silent, extremely anxious and clung constantly to his mother.

This case highlights the importance of support and preventive

work at an early stage after bereavement. This parent taught me how extremely difficult it is to care for a dependent child, when feeling desolate and uncomforted oneself. In this kind of situation the counsellor has the additional task of ensuring that adequate help with the children is available, until their own parent is able to cope again.

Communication

Some parents have great difficulty in allowing or tolerating discussion of death because it reactivates their own sad feelings and they also often genuinely fear that talking about it upsets the children more. As counsellors, we should resist colluding with this, so that all members of a family have an opportunity to express their grief. After all, even very young children are very sensitive to atmospheres and will notice changes in family life; by three and four they are also developing a sense of sympathy.

> Timothy, a generally withdrawn and silent three year old, was usually resistent to cuddles or physical contact, but went up to his mother when she was crying over the death of Elvis Presley. He stroked her face and said "Elvis die, Elvis die."

Children need simple factual information about death, otherwise they tend to see it as a temporary departure, lacking finality.

> Rachel aged three, was convinced that her dog needed a walk, a week after he had died and she had helped her mother bury him.

Young children also often imagine causal links between simultaneous or similar events and we need to help clarify this 'magical thinking', during the course of our counselling interviews with the family.

> Clive, a four year old, thought that his rudeness to his granny had resulted in her death a week later; given a factual explanation, he was enormously relieved.

Techniques

Physically getting down to their level

Children communicate in many different ways, so I always try to provide coloured pencils, drawing paper and play material, such as flexible dolls, a toy ambulance, perhaps cars or a small dolls' house. Children may find participation in conversation too difficult or inhibiting, so I try to both observe their play and link it to the general discussion, trying to understand and help explain the child's feelings as expressed in their use of the materials.

> John, aged four, and Sally, aged seven, refused to speak at all during my visits, until I brought along a family of four dolls. They then fought over them, and finally both made the mother doll lie down; the children then became increasingly agitated and then threw away the two little dolls. At this point their father, who had been feeling very angry at being left to look after them after his wife's sudden death, had been talking of putting them into care. He had also insisted that the children could not possibly understand what he was talking about. I pointed out that the children in their play had clearly understood the situation although they could not express it in words; they were as angry and unhappy as he was at being abandoned, and feared that he, too, would leave them.

It is extremely important also to be aware of the language we use; I tend to take my cues about the kind of words and the general level of articulation from the family itself, ensuring that the children can also understand. I frequently stop and ask the children if they have understood what someone has said or what a certain word means, so that they feel less mystified and more involved. Euphemisms increase confusion, for if children are told, as frequently happens, that someone has "gone away", "gone on holiday" or "been put to sleep", this creates anxiety in the future when these expressions are used literally. It also makes it harder for the child to grasp a more realistic notion of death.

> One child, whose dog had died, was told the family pet had been put to sleep and, for a few days subsequently, at bedtimes, he had tantrums and was terrified that he, too, was "being put to sleep".

Children and parents often need an opportunity repeatedly to communicate about a traumatic experience, be it in words or play, before they can accept and digest it; children often talk or show you how the ambulance men came, or a parent might tell you time and time again of their unsatisfactory experience with a doctor.

Sometimes a counsellor feels quite stuck and unable to help the family mourn; I often ask to be shown a picture or ask if the family had any mementoes of the dead person, explaining that, as I did not know them, I would like to have an idea of what they looked like. Talking of past pleasant times also helps the children to recall the good moments before the loss.

Parents are sometimes distressed by their children's apparent unfeeling attitudes, while young people often feel guilty about enjoying themselves. Perhaps you can help them all to understand that to carry on at times with one's normal life is a healthy indication and does not necessarily imply that they are uncaring or insensitive. On the other hand, children can also be very protective of the surviving parent and behave as they feel is expected of them, which often means they have little chance to mourn openly or ask for comfort.

> Anthony was aged nine when his mother committed suicide. He was always very polite, reassuring and factually informative when I visited the family; he always wore a smile. On one occasion his father left the room and Anthony turned to me with the saddest possible expression and said, "No little boy should have to go through what I've been through". As soon as his father returned, Anthony adopted his usual cheerful look.

I had great difficulty on another occasion when this same father refused to acknowledge any sadness or difficulty in the family, although after his wife's death he had had to give up his job to stay at home with his son and four year old daughter. We also knew that the children were unhappy at school. Anthony ignored all the irrelevant subjects that his father tried to discuss and finally I asked the boy what book he was looking at. He replied, I'm only interested in talking about this", and showed me the cover which said, "History". I pointed out that of all of us, Anthony was the only one prepared to stick to the task of discussing the family's history and his mother's death—we then went on to do so more freely.

Adolescents

Older children also need help in expressing their concerns; adolescents will want to know how a father's death will affect their future. Will they suddenly be poor, should they stop studying and go out to work, and will they be expected to take on family responsibilities? By opening up subjects like this, the counsellor can do a lot to reduce anxiety and help the family make plans. But, as with the younger child, an adolescent, feeling resentment at being abandoned by the dead parent, may often displace this on to the surviving parent, who is left hurt and bewildered.

> Anne, a very forceful character of 16, was sensible and helpful after her father's death, even angry with people who would not talk about him in front of her in case she got upset. One day she forced her mother into an angry confrontation, accusing the latter of being weak and incompetent, which was patently not the case. She finally broke down, confessing that she herself felt very weak, and was worried that she would now have to look after her mother in her father's place.

Conclusion

Since death is an inevitability for us all, I think it inappropriate to

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regard clients who require bereavement counselling as patients. All of us have had experiences of death or loss and know that, for a period, we need to mourn and to recoup our strength. At this time of crisis, when we are at our most vulnerable, support and understanding, care and clarification can be vital. As counsellors we need to recognise the privilege, the pain and, above all, the temporary nature of our involvement with other families. I am sure that you are all well aware that unless a family is well prepared for our ending contact with them they may well feel our going as yet another loss. Hopefully we will have helped them to extend their range of problem-solving behaviours rather than encourage their dependency.

Ultimately, to be of most help to bereaved families, we as counsellors have to know ourselves, have a knowledge of family functioning and continually work to improve and extend our skills.

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WHEN MY MUM DIED

When my mum died, I felt that I didn't want to be here any more, and I thought "Why did my mum have to go?"

I felt lost and helpless. The more I thought of it, just being three of us, the more I thought it was a dream, and one day it would come to an end. But I think I am realising that she's gone and she's not coming back. But it's still hard to live with. Now my mum's gone, the house feels empty and boring, and most of the time I'm out.

Sometimes I feel like ending things for myself, but then that would put my dad in an even worse state than he's in now. And sometimes I think "Why couldn't I have gone in her place?", because she was good, kind, and was always willing to help people.

People tell me that I've got all my future in front of me. But my children will have no grandma on my side of the family, and my mum was looking forward to that.

The main thing is that you feel as though someone has taken the only thing you had, and nothing can replace it, not even all the money in the world. At night times you cry and cry, but not even that will bring her back.

Sharon, aged 14

REVIEWS

BRIEF THERAPY WITH SINGLE-PARENT FAMILIES

A. Morawetz & G. Walker. Brunner/Mazel, New York. 1985.

Over the last decade there has been a dramatic doubling in the numbers of families headed by a single parent. One in seven children in England and Wales is now in such a family. Added to the perennial problem of the death of one parent, we now have an explosion in divorce rates and in the number of unmarried women who choose to bring up their children single-handed. While this change in our society is noted, it is striking how little attention has been paid to the many problems these families face. The response of the helping professions has been uncoordinated and often despairing. Few reliable studies have appeared on the subject. For these reasons I warmly welcome this excellent book as a serious contribution towards developing strategies for dealing with single parents who find themselves unable, for various reasons, to cope with their children and their lives. At first sight it looks like a family therapy text-book, or for those who work professionally with families. It is, and the authors give a clear well-written account of how to work with a category of family which the professionals, often feeling de-skilled before the work starts, regard with apathy or even hostility. But it is also a handbook which will provide help and guidance for all, in both professional and voluntary spheres, who are concerned to maximise their skills in dealing with people in distress. It is based on the results of a three-year study of thirty families headed by a single parent, which was undertaken at the Ackerman Institute for Family Therapy in New York. The authors are both experienced social workers and specialists in family work.

The book is clearly laid out in three parts. The first deals not only with the theoretical approach to the work but also tackles the vital minutiae of engaging families. Challenging the current myths about the similarity of these families, the authors suggest that knowledge of the differing circumstances surrounding their creation is vital to understanding the way in which they handle loss. How can families formed by the birth of a child to a single woman; by the death, expected or unexpected, of a parent; by a divorce, whether mutually sought or bitterly fought; be considered as similar? And how can the emotional presence of a parent, whether dead or alive, be ignored? Based on this approach, the authors provide a well-reasoned summary of some of the common problems and developmental stages they have observed in these families. Such a framework gives the worker a most useful benchmark for organising material and formulating hypotheses; it also helps her to decide between the normal processes of grief and the problems which indicate that the family needs extra support.

One chapter is devoted to an excellent review of the evolution of the systems model of family operations, in which the differing elements in the development of the authors theoretical framework are clearly explained. This exposition is amplified in the case studies where theory comes vividly alive. The first part of the book ends with chapters on intake and the initial interview. Here are some of the best ideas in their arsenal. My experience is that what happens at the start of therapy generally is not monitored closely enough. The strategies the authors suggest to ensure that the worker does not unwittingly sabotage the therapeutic relationship at the beginning are eminently sensible. Practical suggestions abound. These include asking people to record symptomatic behaviour before the first meeting, this insuring accurate information with which to start treatment; also how to deal with a family member who attempts to trap the therapist into sharing confidential material. If the first interview is a microsm of the treatment, how the worker handles it is of crucial importance. Again the authors are sure guides, with suggestions about how to plan the session and ideas about the feelings, motives and behaviour of parents and children who have to seek help. The importance of checking who made the referral and why the family is seeking help when it does is also underlined.

Case studies form the second part of the book. I did not feel, as so often happens, that these are tacked on as padding, but that they illuminated the authors' approach and sensitively illustrated common themes in the families' lives. People are seen in terms of their strengths rather than their weaknesses, thus challenging the view of the single-parent family as a flawed version of the normal family. Morawetz and Walker deal with families who challenge their ability to remain neutral and to view family and context systemically; at times they side-step (and explain how they do so) and avoid traps set for the unwary helper who lands up sucked into alliances with family members or arguments with other agencies. There is recognition that for most families seeking professional help the dilemma is 'Solve our problem but don't change us'. Such ambivalence is realistically assessed and possible ways for applying therapeutic pressure towards change evaluated. Very little is said about how the authors define 'brief therapy'; we get the impression that often the therapy is demand orientated, with the families setting their own pace and contacting the Institute when they get into trouble.

For all those with an interest in bereavement the cases resulting from the loss of a parent are particularly thought-provoking. In neither of the cases included are things as single as they seem. In a large, poor family, each child in turn has a problem which keeps mother from worrying about father's gambling. A circular pattern of child in trouble, mother not coping and father coming back into the family to take control is shattered when he dies from a heart attack at 45 years. Mother fails to cope and becomes increasingly depressed by her problems and all the skills of the therapists are need to avoid her being sucked into becoming the homeostatic prop and protector of the family (which is what happens in so many social work situations). The end is unexpected, but it is one that is congruent to the family's needs, even though the therapists might have wished another. Such respect for the family is illustrated repeatedly. Therapists must accept the differing values and needs