BEREAVEMENT COUNSELLING: a th

by Robert Johnson, MRCGP, MRCPsych.

This hypothesis proposes that the bereaved often continue to seek obsolete and manifestly inappropriate parental-type support from the deceased. By 'educating' adults to accept that their parents' presence or approval is no longer absolutely essential for survival, the practitioner can help bereaved patients come to terms with their grief.

For each general practitioner, there are on average 120 widows (150 including widowers), in the United Kingdom.[1] The problem of bereavement is thus a large and growing one, since the proportion of those bereaved increases inexorably, reaching 100% among the oldest, usually bereft first of parents, then of spouse.

Though death has its own inevitability, many are ill-prepared for its concomitant effects. Not all bereavements lead to grief or morbidity. Lundin[2] notes that 'about two thirds of bereaved persons have a good outcome in the long term.' However, to assist those with a less satisfactory outcome, a therapeutic hypothesis is presented here.

The hypothesis states that many adults react as if loss of a parent (or parent-figure, commonly the spouse) is as much a threat to their survival now as it would have been were they still infants. Threats to survival whether realistic in childhood, or unrealistic in adult life, are invariably highly emotive, often unreasonable, and even irrational. Bereaved adults may benefit by having this obsolete emotional survival strategy brought gently out into the open.

Regrettably, it is not possible to escape from the current acrimonious controversy regarding the efficacy of psychotherapy in general. This has been well-documented in the literature, but space does not allow further discussion or justification of the arguments here.

The most fruitful way around the controversy is to coin the phrase 'emotional education', which implies that the patients or clients attend so as to learn more about their emotions than they knew before.

Emotional education

General. Emotional education covers counselling and psychotherapy (though hardly psychoanalysis), and all procedures by which one person imparts emotional knowledge or skills to another less well initiated. In the context of this hypothesis it implies re-educating patients who have suffered a bereavement, and who are showing symptoms of grief. Clearly, only those already 'educated' can (or at any rate should) presume to teach. On the other hand, an open mind and a willingness to learn can go a long way, especially in a stable and secure general practice consultation.

No method of consultation in general practice can hope to succeed if it is unduly time-consuming. The more orthodox psychotherapies, to judge by Bloch and Lambert, require in excess of 20 sessions, and certainly more than the 'princely total of 45 minutes'.[3] Even rechristening the process 'emotional education' does not miraculously increase the time available in which to practise it. But it does simplify the technique, and therefore allows more to be attempted, and, in favourable circumstances, to be achieved. All those patients included in this paper were seen during normal surgery consultations of 5-10 minutes, except patient D, who proved atypical.

The hypothesis. The method consists of 'educating' adults to accept that their parents' presence or approval is no longer absolutely essential to their survival. Such approval (or non-rejection) was essential in infancy, but is no longer. Many problems arise in grief reactions precisely because the bereaved individuals continue to believe they have lost a parent (or a parent-figure) without whom they cannot continue to survive. In reality, their need for parents ceased (or should have ceased) at the age of maturity, and with it their need to be emotionally dependent upon any sort of parent whatsoever.

What is required is to provide the patient with an opportunity to practise thinking in an area that has never been thought in before. The patient is naturally reluctant to do this, because it is painful and humiliating. In consequence, the whole topic is 'blocked off' or repressed. A self-imposed barrier is erected. The patient needs to be educated, gently, into dismantling this from the inside.

The problems. What is essential is that these painful emotions are approached in the gentlest possible manner. Fully informed consent is required for any surgical intervention, and this applies in significantly exaggerated form to all emotional interventions. Explicit informed permission is required before treading on painful areas. This permission will (and should be) witheld if the patient does not feel fully confident that the practitioner knows what he or she is about, or does not have the patient's best interests at heart. The motto is 'if they don't like it, don't do it' and equally important 'if you don't feel comfortable with it, don't do it either.' To argue with the patient is to lose.

These general guidelines are included since it is possible to make matters a great deal worse if neither party knows what is going on. The optimum would be to converse as between old friends. What is offered here is little more than a blue print to aim for.

Patients in this situation believe (falsely) that they cannot survive without the deceased. Quite how firmly this belief is embedded (or 'hidden') may well come as a surprise, certainly to the patient. There is a contradiction between the reality that they are adult (and their spouse or parent is dead), and the emotions which tell them that they cannot survive without the deceased. Manifestly, they are doing so. If they can gently be confronted with this contradiction, they may leap at it, and release themselves from grief reactions.

Some patients (indeed some readers of this paper) may be outraged by this hypothesis. Such people are fully entitled to their view and should always be allowed

---

Any approach which aims to help with the special problem of emotional dependence on a dead person deserves to be taken seriously. When, in addition this can be undertaken in five to ten minutes in the surgery of a busy GP one is inclined to become incredulous.

We publish this provocative paper in the hope that others will attempt their own evaluation of Dr. Johnson's claims. **EDITOR**

Reprinted with acknowledgement to The Medical Tribune Group, in whose journal, *Psychiatry in Practice*, this article first appeared, April/May issue 1986.

plenty of scope. The approach should be offered without any possible strings. If those to whom it is offered choose to take it up, all well and good; if not, it is wise to leave it strictly alone. Especial care is needed with the griefs and possible dependencies of the practitioner himself or herself. These latter can only be successfully dealt with in conjunction with a supervisor or 'educator' for the practitioners themselves. This is a useful adjunct at all times, and generally quite indispensible to begin with.

Survey results

Eight patients were included in my survey, all female, with ages ranging from 33 to 68. It was judged that more (or more details) would overload this short paper. The ratio of widowers to widows in the United Kingdom is 1:4.18 (1981).[1]

The tables show the presenting symptoms, and something of the initial and later responses to the suggestion that the bereaved were 'hanging on' to the 'presence' or approval of the deceased as a matter of emotional priority. They were also gently advised they could manage perfectly well without them, despite any appearances to the contrary.

Each individual expressed herself differently. It is difficult to compress their comments without some distortion. Nevertheless most had difficulty accepting that the deceased was indeed actually dead: to do so would be to acknowledge they were 'alone', thereby relinquishing any hope of continued dependency.

Similarly, expressions of anger, either at being 'abandoned' as in patient G, or at earlier marital abuse as in patients E and F, also indicate the ability on the part of the bereaved to distance themselves, and assert their emotional independence of their parent or parent-figure.

The outcome is obviously a subjective judgement on the writer's part: but the dramatic change for the better, even in the very body posture, was prompt and unmistakeable. Patient D declined to be budged from her position, or to accept any suggestions whatsoever that hostile feelings might exist on her part regarding her father. She initially presented when she found herself 'obliged' to care for two elderly relatives in circumstances which exactly echoed her dutiful nursing of her father at the age of 18. She may return at a later, calmer, date, or she may not. For the present, the hypothesis in her case is disproved, or at least unproven.

Table 1. Presenting symptoms.

Patient	Age	Relative who died	Time since bereavement	Presenting symptoms
A	33 years	Mother-in-law	3 months	Worries—especially about when deceased was in intensive care.
B	34 years	Husband	7 days	Stunned: I don't believe he's dead.
C	34 years	Father	5 months	Epigastric pains.
D	51 years	Father	33 years	Don't enjoy anything. Can't sleep.
E	61 years	Husband	4 years	Dizzy attacks, collapsed in waiting room after the end of surgery.
F	63 years	Husband	2 years	Worries. Everything going 'badly'.
G	67 years	Husband	18 months	I don't know. Crying all the time for no reason.
H	68 years	Husband	11 months	Stomach churning, doesn't want to go out socially.

Table 2. Reactions to the hypothesis.

Patient	Time to next consultation	Comments and response	Outcome to date
A	7 days	She's died and she's gone. (Later was much more confident.)	Excellent
B	7 days	Agrees she's angry with him and only grudgingly accepting he is dead.	Good—working
C	14 days	Can't believe he's dead. Haven't let him go yet. (Later accepted the origin of the pains).	Good
D	7 days	I don't like to blame Dad. It's all my fault. I'll never blame him. (No change later).	Totally unimproved
E	7 days	He was very selfish. I could never say 'no'. I had bottled it all up. (Later—he must have gone now).	Remarkable improvement
F	7 days	I want him back (but) he was so awkward. I've not let him go. (Later ambivalence cleared.)	Much more cheerful
G	42 days	Many a time been angry for his leaving me behind. (Later she began to smile cheerfully.)	Good
H	14 days	Hadn't accepted he's dead. Feels much better. Even talked to 3 other widows.	'Pounds better'

Discussion

Questions of proof are less straightforward in matters of emotional education than elsewhere.[4] The basic precept that adults can survive without parental assistance is unimpeachable. The hypothesis that left-over dependencies inflict emotional injuries which emotional independence can lift, is 'proven' or not, on each separate occasion. So many other circumstances impinge that it is unlikely to be proven to any absolute or guaranteed degree. Few things in medicine are.

Whether uninitiated practitioners can hope to achieve much by (or should be asked to attempt) emotional education in this sense is open to debate. The results obtained came only after years of training, experience and cautious observation. A much more extensive account has already been described.[5]

Provided the simple rules of courtesy and good professional conduct are scrupulously observed, together with the provisos set out above, then the writer firmly believes that the above hypothesis may indeed prove therapeutic in hands other than his. Indeed the prospect of a debate on this topic is to be warmly welcomed.

References

1 Annual Abstract of Statistics. Tables 2.5, 3.29, 3.30. 1981 figures. Central Statistical Office, vol. 121, HMSO, 1985.
2 Lundin T. Long-term outcome of bereavement. *Br J Psychiatry* 1984; **145**: 424-428.
3 Bloch S, Lambert MJ, What price psychotherapy? A rejoinder. *Br J Psychiatry* 1985; **146**: 96-98.
4 Johnson RA. Letters, *Guardian*, October 10, 1985: 13.
5 Johnson RA, *Healthier Emotions*, 1986, In press.

Forthcoming Courses & Conferences

UNDERSTANDING THE MANAGEMENT OF PERINATAL BEREAVEMENT

Once again this course of six weekly sessions will be run in 1987 at the Tavistock Clinic, for professional staff.

Details from The Training Administrator, Tavistock Centre, 120 Belsize Lane, London NW3 5BA.

CRUSE PROFESSIONAL COURSE 1987 will be held in London in the Autumn. It is an Introduction to Bereavement Counselling.

BEREAVEMENT: Helping the Survivors

June, 8-10, 1987 at London, Ontario. Contributors include Dr. Herman Feifel, Dr. William Worden, Dr. Robert Fulton, Dr. Alice Demi, Dr. Margaret Miles.

Enquiries to Dr. John Morgan, King's College, 266 Epworth Avenue, London, Ontario, Canada N6A 2M3.

Coinciding with this Conference at King's College is the second Conference of FIAV, the International Federation of Widow and Widower Organisations, to be attended by widows and widowers from many different countries.