Discussion

In interpreting the results of this study, the intention is to try to learn something about the characteristics of these counsellors, the training they have received and their response to it. The results suggest that they appear to have a reasonable grasp of bereavement processes, can probably largely separate normal from abnormal bereavement reactions, and they rate empathy as the single most important ingredient in counselling.

They regard counsellor qualities as more important than method, but there is some tendency to show uncertainty in knowing when to confront. This suggests that in future courses, issues surrounding avoidance and how to deal with it should be more fully discussed.

The usefulness of supplying information in the form of literature about bereavement processes which this sample commends may be of wider interest to counsellors and psychotherapists. It aligns them with the view of Yalom and his followers who commend giving information beforehand to educate participants in a particular therapy.

Recently McGrath and Lowson investigated economic arguments about psychotherapy in the United Kingdom's National Health Service[8]. One of the two main areas in which they considered cost arguments must be satisfied was in the general medical field. Cruse, although a voluntary organisation, is intimately connected not only with psychiatry but with general practice and if its counsellors adopt a psychotherapeutic stance, which those in this study appear to do, then one may consider bereavement counselling a suitable test for the future of psychotherapy in the National Health Service.

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The Anguish of Being in Need

by

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Photo: Courtesy of 'Social Work Today'

Those who offer help to the victims of disasters may be surprised and disappointed to find that their generosity is not immediately appreciated. In this paper Michael Stewart, who provided counselling to victims of the fire at the Bradford Football Club, explains why it is that people in need of counselling may find this difficult to accept.

Editor

Survivors and victims of disasters are distinguishable from the rest of us by the random way in which they happen to be in the wrong place at the wrong time. In this sense we are right to feel fortunate. It could have been us.

However, we are not only spared the pain of a thousand shocks by not being in that football stand, or on that ferry, in transit through King's Cross, or a resident of rural Berkshire. For them there has been a more insidious, more testing examination. How would we cope with an offer of psychological or emotional help, perhaps from a social worker or a counsellor? How do we rate our ability to cope and what state do we have to be in before we are able to acknowledge our need?

The great majority of people seen by professional and volunteer helpers following a disaster are unacquainted with the world of therapy and counselling. Often for the first time in their lives, they are reminded of their vulnerability. When disaster strikes, our human, everyday rhythms are disturbed. We face death, injury and the virtual destruction of our world as we know it. Our normal coping strategies appear to us as inadequate, even pathetic in the face of unthinkable fragmentation and loss.

Suddenly, humans have to adjust to a new reality. The world is vulnerable. We are vulnerable. Everything can change in an instant, in the twinkling of an eye. Buildings can be reduced to rubble, landscapes devastated, human tissue destroyed, whole communities transformed into apocalyptic images. In short, we are shown the frailty of life itself.

People react to these experiences with shock, disbelief, denial, anger and wonder. For most normal people it means having extremes of feelings unfamiliar in ordinary, everyday life. It can seem like madness.

Notwithstanding the horror of their experiences, survivors are reluctant to ask for help. They fear the stigma of having help in a society which believes in the ideal of independence. If you have a problem you deal with it yourself. It is all right to consult a solicitor if you are being divorced or a doctor if you have a broken leg. But it is not all right to feel "low" in yourself. The ethic is that one must soldier on. Feeling low is a sign of weakness, and weakness is for the weak. The fear of stigma is often felt more powerfully than the need for help. If we seek help our self-esteem will be diminished. Our ideal of being able to cope will be

threatened. And what will other people think of us?

How does this problem show itself? Jane is a mother of three and has a job. She escaped with her life from the Bradford stadium fire disaster. Two years later, her doctor persuaded her to see a counsellor. In spite of the all too obvious distress in her every word and gesture, she was at pains to point out that she had never asked for help in her life. Her family, friends and colleagues saw her as a "coper". She was the one that everyone came to when they needed a sympathetic ear. Her family needed her, so she could not "fall apart". However, her general practitioner knew she was heading for a psychiatric emergency.

The initial experience of receiving help was for this woman as bad as the problem itself. She could not allow herself to be vulnerable. She held on to her image as a coper until finally she let go. Jane had to learn how to be helped.

There were others, like Tom. He was a marathon runner. Two years after the Bradford fire, which he witnessed from the opposite side of the ground, he lived in dread of having a heart attack. He cried at the sight of his children at play. One day a friendly workmate told him to get some help. He did, but it had to be a secret. He was desperately worried about what people would think if they found out. His family still don't know.

People are wary of help, but especially of institutional help. It smacks of "the welfare". The welfare has a powerful potency about it. We shun it because it is associated with unpleasant things like child abuse, madness, death, poverty, juvenile delinquency and other reasons for being put away. Jane and Tom both feared they were on the edge of madness, but they would not approach any of the helping agencies. They were places which had about them an air of menacing authority and mysterious power.

People are also wary of helpers. Their fantasy, all too often correct, is that helpers operate on a higher level of experience and understanding than themselves. They "analyse" and use big words. Those in need sometimes worry that once they get into a counselling relationship they will never be able to get out of it. Because they know so little about the sorts of people counsellors actually are, they invest remarkable power in their image of them.

Those who help, both paid and voluntary, can approach this difficult problem in a practical and commonsense way. A barrier of sorts does exist between givers and receivers of help. Those who receive are genuinely afraid that their problem will be misunderstood, or that they will be patronised, or that there is some stigma attached (and let's face it, in many cases there is!). Those who give help are often frightened of failing; they may not be facing up to their own problems in life; in a minority of instances the right motivation for helping others may not be present at all. Whatever the reasons, the net result is that givers and receivers do not seem to be able to identify with each other.

The beginning of a solution is to recognise that we are all in the same boat, that all of us are vulnerable, that all of us need help at times in our lives. None of us are above human frailty. To the extent that we are all in the same boat, the helping relationship ought to reflect the quality and simplicity of our everyday relationships. Are we not all made of the same sensitive flesh and blood and do we not all hurt when we are wounded by the jealous pride and blind ambition of others? When it comes to entrusting ourselves into the safe keeping of a counsellor, do we not all have the deepest sensitivity about not being heard, about being put down, and most of all, about somehow ending up feeling diminished within by the experience of opening up?

Those we counsel are no different from ourselves. If we are able to act on this, the barrier dissolves on our side. It is simple. But it is not easy. You see, some people like barriers. Do you? Can you share your vulnerable self?

● *Michael Stewart has recently founded Stewart Associates, which he describes as "a group of professionals and lay survivors whose objective is to provide training and advice to those who counsel the bereaved, their managers and their organisations. They are uniquely experienced in the field of disaster after-care and combine in-depth professional knowledge with awareness of consumer needs. After Bradford, Zeebrugge and Hungerford they are now used by, a variety of groups and organisations at home and abroad". Address for contact is: 25 Harper Grove, Sutton-in-Craven, Skipton, North Yorkshire BD20 7JN, tel: 0535 35446.*

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GAY BEREAVEMENT PROJECT. One-Day Training Seminar. 17th September, 1988. Essex Hall, London. The seminar is designed to give bereavement counsellors, befrienders and others with experience or training in bereavement care, an insight into the special problems which lesbians and gay men meet on the death of a life-partner. Fee £10. Applications to Gay Bereavement Project, Unitarian Rooms, Hoop Lane, London NW11 8BS, marking envelope 'Seminar'.

PROFESSIONAL COURSE IN BEREAVEMENT COUNSELLING SKILLS. Ten Thursdays, 29th-September - 8th December, 1988, 5.30-9 p.m. The Hale Clinic, 7 Park Crescent, London, W.1. Directed by Dr Lyn Franchino. Lectures, videos and small group-work. Applications by 31st July to Nick Tyndall, Training Officer, Cruse House, 126 Sheen Road, Richmond, Surrey TW9 1UR, Tel. 01-940 4818.

UNDERSTANDING THE MANAGEMENT OF PERINATAL BEREAVEMENT. 9th November - 14th December, 1988. Tavistock Clinic, London, Wednesdays, 2-4.45 p.m. Organising tutors: Dr S. Bourne and Dr E. Lewis, Consultants to the Perinatal Bereavement Unit. Open to all professions coping with perinatal bereavement and its psychological sequelae. Fee: £55. Application forms available from The Training Administrator, The Tavistock Clinic, 120 Belsize Lane, London NW3 5BA.