EDITORIAL

In this issue, devoted to bereaved children and parents, we publish three papers by psychologists and social workers describing, in detail, interventions to help them. Dockrell and Dockrell reveal the way that a psychologist goes about trying to understand the reasons for a child's difficult behaviour, four years after his father's death which happened when the child was only 18 months old. Their combined approach of maternal counselling and family therapy was well designed as a result of careful attention to formulating and testing their hypotheses. Kitchener and Pennells lay out for us the structure and process of a group for bereaved children and Dyregrov, working in Norway, describes interventions to help parents bereaved by the death of a baby or child.

We need to be able to study such detailed work if we are to improve our skills as counsellors and therapists. We need, too, to listen to the bereaved whom we serve and we therefore welcome the honest account, on page 35, of a mother's feelings about the life-threatening and finally terminal illness and death of her adolescent son.

All the work we do with children owes its inception and inspiration to the work of the exceptional child psychiatrist, John Bowlby, who died last September, aged 83. A founder patron of Cruse, Bowlby's seminal and classic three-volume book detailing his theory on the nature of the child's attachment to his mother and the effects of the disruption of these attachment bonds by separation and death ('Attachment and Loss', Hogarth Press, London, 1969, '73, '80) has generated a body of research on both sides of the Atlantic which continues beyond his death. On page 29 we publish a tribute to him by Colin Murray Parkes, a colleague, collaborator and friend for three decades.

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A Family Copes with Death : A Case Study

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Introduction

Death seldom comes gently into our lives. More often it comes like a thief in the night stealing away our treasure, leaving us devastated, sick at heart, angry and vulnerable. We lose not only something we love, but someone who has loved us back; someone who has become a part of us. It takes time, understanding, a certain stamina and caring people to help us grow through these stressful periods. Most of us do. If this is true for adults who have been strengthened over the years and grown in understanding and independence, what does the child experience whose safety and security depends totally on the adults around him, and who is in the process of developing an appreciation of his self-worth?

The grief and desolation the baby and very young child experience at the death of a parent is well documented[1-3]. Without the cognitive ability to make sense of the loss or language to communicate feelings, children can only express themselves physically and emotionally. Furman points out that it is much easier for a child to understand the finality of death when it is not related to a loved one[3]. The dead frog in the animal corner of the nursery helps the child to begin to understand that death is a normal part of living. As Furman says, children need the opportunity to express their feelings and ask questions if they are to make sense of the phenomenon. The death of a pet is serious, painful and tearful, but it offers an opportunity to grow a little. Children who learn to cope with smaller stresses and losses develop strategies which they can use in other losses.

Physical and psychological dependence are key issues in childhood grief, but so are factors like the circumstances of the death, the physical and emotional well-being of the child, the stability of the family members, the relationship of the child to the deceased, and the models loved ones offer in coping with the death. Rutter[4] suggests that the serious detrimental effects of lack of support, discord, and multiple shifts of home are more likely factors in producing pathological grief than the bereavement itself. A supportive, stable, open family will help a child cope with grief.

When death comes to a family each member grieves the loss of a different relationship, and is so totally absorbed in his or her own grief that he may not see the grief and confusion of a child. Many parents, however, are all too aware of the child's confusion and may try to allay concern by religious allusions or metaphor which come easily to adults but may confuse or frighten the child. These fears show themselves in behaviour rather than words and, if adults can be helped to appreciate it for what it is, they in turn can help the child cope more effectively.

Children do not express their fears easily. By the time a child has reached the age of five years, there is a fear of loss of control and exposure of infantile dependency. Grief is often expressed in inappropriate behaviours. Boys especially have difficulty in expressing sadness. They may show aggressive behaviour or, on the other hand, compulsive care-giving. Either is more acceptable to the child, but neither allows him to come to terms with the difficulty.

Unexpected death is always more difficult to cope with. Death

is always unexpected and inappropriate for children. Where someone is suffering a terminal illness the child is often protected from the knowledge of the impending death until the last moment. Often, too, young people are not involved in the funeral or in the family grief and there is no opportunity to express their feelings.

Rutter's study shows that infants are less at risk than children bereaved in early childhood[5]. Some of these children may not show evidence of emotional disturbance until adolescence. Research suggests that if bereaved young people are not helped to come to terms with their loss early in their grief, the unresolved grief may affect their emotional stability in later years[6, 7]. The virulence of unresolved childhood grief is long-standing even to the next generation. Reilly[8] describes families of drug abusers intensely preoccupied with issues of attachment and separation. These parents of youthful drug abusers often suffered profound emotional losses within their own families of origin, having lost their own parents by death, divorce, rejection or neglect.

Families and loved ones are usually the best sources for resolving the grief of children and adolescents, but they are sometimes unable to cope and sometimes inappropriate. It is at such times that professionals and volunteers are most needed. With very young children it is often possible to work with the child by helping the mother in her own grief work or in family group sessions. Black's study of short-term intervention with bereaved families showed significant differences in the intervention group from the control groups in terms of healthier behaviour[9]. The surviving parent was also less dependent and sought less help elsewhere.

It is important to address grief in childhood and make it possible for young people to express their grief and make sense of their loss without a loss of dignity. The longer the grief lies hidden, the more complex the process of disentangling disturbed personal relationships. Our case study serves to illustrate this point. Martin, still battling with the repercussions of his father's death four years earlier, was presented to the psychologist as a behaviour problem by his mother.

Case Study

In the following sections we report the hypotheses entertained by the psychologist, the formulation of the problem and the therapy offered to Martin and his family.

Mrs. M is a well-dressed woman of 32 who appeared nervous but spoke confidently and articulately as she described Martin's problems. She calmly asked for help to discover what Martin thinks and why 'he hates me', and said that she felt she had tried everything to solve Martin's problems but 'none of it worked'.

Martin, aged 5 years 10 months, is two years older than his sister (P). His father died of a rare disease when Martin was 18 months old. A period of ten weeks elapsed between the diagnoses of cancer and Mr. M's death. At the time his mother was pregnant with P. Mrs. M has not successfully sustained a subsequent relationship since 'no one could replace him'. Mr. M was a successful professional in his late 30s when he died. Martin is said to look like his father, has the same initials and his father's 'stubborn streak'.

Martin was born ten months after the M's marriage and had always been a difficult child. Mrs. M resents this since it cheated her of time with her husband. In the past, Martin's unacceptable behaviour was sporadic: it had now become 'a continual part of our existence'. Martin is argumentative, which Mrs. M dislikes, and he resorts to physical aggression towards her—behaviour which she abhors and results in her crying in her room. Mrs. M does not like the idea of having a problem child and feels it threatens the image she portrays of a flawless woman.

Martin disobeys her, tells her he hates her and throws ornaments around in a rage. He is frightened at night, sleeps with his mother, wets the bed and saves all his money 'in case he needs it'. When upset he clings to his mother and continually needs to be reassured that she will not leave him. He is failing at his exclusive prep school despite being recognised as the brightest in the class, and his behaviour is unacceptable. In contrast, P is described as a charming, loving girl. Her misdemeanours are explained in terms of modelling her brother's bad behaviour. 'She is the ideal child.'

Mrs. M feels everything would be different and better if her husband were alive. She is angry that her husband died and not her son. She regards her marriage as the best thing that happened to her and cannot identify a single fault in her husband. He was the first person she could depend on and he 'looked after her'. Now she has no support. Her life now revolves around Martin's demands. She believes that Martin is unaware of the intensity of her feelings towards him.

Provisional hypotheses

The psychologist formulated a number of hypotheses which might explain Martin's behaviour and would guide the subsequent, more detailed assessment and intervention.

Hypothesis 1 centres around the possibility that Martin is experiencing a delayed excessive grief reaction. It is occurring at this stage because of the development of his cognitive skills with the ensuing realisation of the irreversibility of his father's death and the universality of death[10].

In contrast to what might be inferred from the initial referral, hypotheses 2-5 focus on Mrs. M's reaction to her current situation and the repercussions on Martin. Mrs. M's request for help with Martin might be an acceptable way of asking for help for herself without forcing a re-evaluation of her own mental state (Hypothesis 2). Alternatively, Martin could be seen to represent the bad part of Mr. M for Mrs. M (Hypothesis 3). This brings to the surface a range of unsolved grief reactions, especially anger, which are projected onto Martin, resulting in rejection and associated guilt. Martin's behaviour is a reflection of these negative and ambivalent feelings towards him[11].

Hypothesis 4 focuses on Mrs. M's dependent relationship with her husband and the effect of his unexpected death on her relationship with Martin. This has resulted in ill-defined boundaries between parent and child and the failure to set appropriate limits on Martin's behaviour. An inappropriate alliance has developed between mother and son. Martin's excessive anxiety and oppositional behaviour allows him to control the distance between himself and his mother.

Finally, hypothesis 5 reflects Mrs. M's apparent view of the world. She sees things in extremes. If something is bad, it has to be eradicated from her life. The request for help is an attempt to gain support for her feelings that Martin should be sent away. Thus, she has no reason to try to change her son's behaviour for the better since, if his behaviour improved, she would no longer have grounds for sending him away.

To investigate these hypotheses, assessments on two levels were indicated: firstly, Mrs. M's reaction to her husband's death and her subsequent adjustment (H2, H3), and secondly, assessment of the family situation to establish whether the pattern of family interaction served to exacerbate or maintain Martin's behaviour (H4, H5) possibly by secrets surrounding death (H1).

Assessment of Mrs. M

Mrs. M reports feeling very depressed. 'I go back to bed . . . try to sleep and often cry . . . it's like there's a black cloud hanging over my life.' In response to questions about her husband's death, she replied that she didn't have time to grieve. She still 'talks' to her husband, sleeps in the bed he made and has kept some of his clothes. A suit which epitomises him' hangs in her wardrobe. She tries to maintain things in the way he would have done. She cannot bear to think about the good times together and her eyes fill with tears as she talks. She is concerned about becoming terminally ill and has cervical smears and breast examinations every three to four months.

She wants to get married but the two relationships since her husband's death 'have failed'. Their failure is blamed on Martin's behaviour. Her own family are viewed as loveless, unsupportive and spongers. Mrs. M has always felt rejected by her mother and viewed as a failure by her father. She feels she was never good enough. She fears being like her mother. Her family failed to attend Mr. M's funeral. There has been no contact since. She says she will never forgive them. She rarely goes out because 'no one will look after Martin, he is so bad'. She sees herself as a changed person, with no self-confidence and at a loss what to do.

Family Assessment

The family session was designed: (1) to establish the boundaries in the family and who sets the rules; (2) to assess the resonance, i.e. the extent to which the family members were enmeshed or disengaged; (3) to examine the way in which Martin's symptoms were used by the family. The children were well dressed and polite. Mrs. M was reticent to say why they were there, preferring to place the responsibility with Martin to explain 'how he upset mummy'. The children chose to draw. Mrs. M gave knowing looks as Martin produced drawings of himself locked in a prison cell. Martin refused to accept his mother's instructions to sit and talk. The more she insisted the more active he became. She tried to remain calm but ended in tears. At this point Martin crawled onto his mother's knee, clung to her neck and hugged and kissed her. She responded in kind. Martin prevented any discussion of his father by increasing his activity level, thereby forcing his mother to reprimand him and repeat the circle of behaviour just described. During the session P watched, appearing to be a concerned outsider.

Psychologist's formulation

The initial hypotheses which were considered guided the assessment phase. It became clear that H3, which focused on Mrs. M's grief reaction, was central to the problems that the family were experiencing. However, the problem is compounded by Martin's own response to his father's death (H1). Thus, Martin's behaviour can be viewed as a result of dysfunctional relationships within the family characterised by an inappropriate alliance between mother and son and distancing of the daughter. The main predisposing factor is Mrs. M's chronic, delayed grief reaction characterised by idealisation, repression and avoidance. The situation is exacerbated by the family pattern of not talking about feelings and Mrs. M's fear of being rejecting like her own parents. Martin's problems support his mother's stuck grief by providing a contrasting denigrated figure and maintaining his mother's isolation by repelling boyfriends and preventing discussion of his deceased father.

Proposals for management

Since Mrs. M's grief reaction is seen as critical, individual session to help Mrs. M come to terms with her loss were planned. Having established these sessions, family therapy sessions were begun aimed at establishing appropriate boundaries in the family and providing a forum to explore the children's feelings about their father's death (cf. Barker[12]).

Treatment

Individual sessions

Mrs. M was seen for individual sessions before family therapy began. It was agreed that the sessions were to discuss her reactions to Mr. M's death and issues pertaining to her present functioning. Issues relating to Martin and the family were to be discussed in the family sessions.

Guided mourning procedures[13, 14] were used but there was flexibility to allow for discussion and interpretation when the loss was entangled with other losses[15]. The grief process was discussed with Mrs. M to provide her with a framework for our sessions. For the initial sessions Mrs. M was encouraged to talk about her husband and their relationship together. Mrs. M reacted emotionally and much of the two-hour sessions were spent in tears. Her feelings were legitimised. By the third session she was talking in a more composed fashion, though she still wept occasionally. To promote the acceptance of the loss, Mrs. M was asked to spend a set period each day when she was alone thinking about her life with her husband. Gradually the notion that it was safe to feel negative feelings about her husband was introduced. She was encouraged to express the anger she felt at her husband leaving her and the bitterness she felt about being left with a family that she felt unable to cope with. Parallels were drawn between the loss of her husband and the loss of her family. As this anger was expressed, new ways of handling being alone were explored, how to function as a single parent and how to accept being 'a less than perfect mother'. Between sessions she would practise these alternative solutions with the aim of reducing her dependence on her husband and showing herself that she could generate new patterns of behaviour. By session six, Mrs. M had stopped wearing her rings, in session eight she reported buying a new double bed for herself and by session 11 she had bought 'a totally impractical sports car'. The latter is particularly significant in view of earlier references to Mr. M's negative view of frivolous married women.

The main problem was keeping Mrs. M focused on herself and her husband rather than berating Martin. By the ninth session this was no longer an issue. During therapy Mrs. M was prepared for the sessions ending, and her fears about this were acknowledged.

Family sessions

The initial family sessions followed a set pattern. Mrs. M would begin the session by giving Martin the responsibility of choosing the topic to be discussed: 'tell . . . what you are worried about'. He would refuse, crawl on his mother's knee and the interaction described in the family assessment interview was repeated. Mrs. M was encouraged to take control . . . 'Is this what you want to happen? How can you help Martin to listen and contribute?'

During the initial sessions Mrs. M found it impossible to report her concerns or elicit Martin's worries, so various techniques were used to involve the children and clarify her role as parent. In session one a family tree was constructed. The children entered the family names on the blackboard as Mrs. M provided the information. This allowed Mrs. M to be seen as the parent figure and revealed to her the extent of, and misconceptions in, the children's knowledge. Clarifications could then be made, e.g. about their father's death and what his illness was. After each session a task was set. In this instance it

was to take a copy of the family tree and to go over the details again at home, answering all the children's questions. Similarly, in session three great concern surrounded Martin's worries, which he was unable to express. In this case Martin was to draw his worries and let his mother 'look after' them for him. The process was to be repeated at home. Symbolically his worries were acknowledged, but his mother took responsibility.

In each session Mrs. M needed support to follow through the requests she made of Martin. All of sessions two and four were devoted to getting Martin to sit down. By session five Mrs. M had taken responsibility for topics of discussion and therapist interventions were aimed at including both children. Session five focused on Martin's feelings (reported through his mother) 'that Martin had died at the age of two and "Magic M" (father's name) had survived'. Magic M was all good. The family initially colluded with this fantasy. Session six was concerned with management issues.

Effects of Interventions

Evaluation of the work with Mrs. M was in terms of relief of symptoms, ability to cope with life and ability to take risks in personal relationships. For the first time since her husband's death, Mrs. M had embarked on a relationship for fun. She felt happy with her life but admitted being frightened at the thought of 'the black cloud' returning. The situation with Martin was under control. She felt that the family sessions had shown her she could set limits and follow them through by herself: 'maybe that was the whole point of the therapy'. She acknowledged her husband's failings and was able to comment on how unsatisfactory their sexual relationship had been. She is still excessively concerned about becoming terminally ill.

The family sessions resulted in more appropriate boundaries being established. This was evident from behaviours exhibited in the final session and incidents reported from home. Further, Mrs. M was more confident in her role as parent and expression of feelings was accepted.

The family were seen six months later for follow-up. Martin and P listened attentively as Mrs. M reported that Martin had only had two temper tantrums, which she had found upsetting but had dealt with. Martin was now top of the class and behaving well. P was talking regularly about Mr. M's death. Mrs. M had taken both children on successful ho'idays.

They had brought with them an unseen film of the Ms' wedding. Mrs. M set up the projector with Martin's help. It was done cooperatively but with Mrs. M definitely in charge. P arranged the chairs. Mrs. M answered the children's questions. Mrs. M remarked that she was surprised she didn't cry.

Conclusion

Mrs. M had always argued that Martin was too young to be influenced by his father's death. In contrast, we believe—and the literature supports us—that Martin was influenced not only directly by his own grief but indirectly and profoundly by his mother's grief. Thus, two key interventions were required with this family. Mrs. M needed to acknowledge and 'work with' her own feelings of loss, and Martin needed his mother to take control of the family situation and acknowledge his own feelings of desolation and loss. It takes time, stamina and understanding for a widow to help her young family accept the loss of a father. The 'M' family case illustrates the difficulties with such a process and the role professionals can play in easing the way.

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OBITUARY

Dr. John Bowlby, CBE

Consultant Child Psychiatrist, Patron of Cruse

Born 1907, died 2 September 1990

All those who seek to understand bereavement owe a debt of gratitude to John Bowlby, the founding father of Attachment Theory and author of a major work (which bears comparison to Darwin's *Origin of Species*) *Attachment and Loss*. Bowlby was a great admirer of Darwin and followed him in drawing together evidence from a wide range of studies in order to formulate basic principles.

It was during his training psychoanalysis with Melanie Klein in 1955 that Bowlby first became interested in depressed patients whose illness had followed a bereavement. But he soon found himself in conflict with his analyst and set out to search for scientific evidence to support his own theories of separation and loss. In *Forty-four Juvenile Thieves: their Characters and Home Life* he reported the discovery of a high incidence of prolonged separation from their mothers in a series of children who had been referred to the London Child Guidance Clinic after committing thefts. He served as an army psychiatrist during the war and afterwards joined the staff of the Tavistock Clinic, where he was to remain for the rest of his life.

His next major publication was *Maternal Care and Mental Health* (later abridged as *Child Care and the Growth of Love*). Those arose out of an appointment as a consultant to the World Health Organisation, in the course of which he had the opportunity to study the effects of orphanhood and separation of children from their mothers in Europe and the U.S.A.

He exposed and explained the damaging effects which resulted from the admission of small children to hospitals, orphanages and other institutions which ignored their need for parental care and he spelled out in great detail exactly what he meant by this.

His work and that of James and Joyce Robertson, whose films of young children undergoing separation experiences was carried out in Bowlby's research unit, convinced all responsible authorities of the need for major reforms in the institutional care of children. Mother and baby units soon proved their value and one of the results was a major shift in favour of foster care and adoption, as opposed to orphanages, for children who had no parent available to them.

Of course Bowlby's ideas did not go unopposed. On the one hand he offended members of the Women's Movement who saw his insistence on the child's need for mothering as a threat to the liberation of women, and on the other hand he offended more orthodox psychoanalysts by criticising many of the tenets of Freud and Klein. These battles continue to rage, but in the long term it is these very movements which stand to gain most from his work; women because of the serious attention which is now being given to the need of mothers with children, and psychoanalysts because of the evidence which Bowlby has brought together to demonstrate the lasting influence of childhood experiences on mental disorders in later life. It is largely thanks to Bowlby that we now have the beginnings of a scientific basis for psychotherapy.

To adopt a more personal note, I joined John Bowlby's research unit in 1962 and had the pleasure of working closely with him for 13 years.

I was one of a group of researchers (others included Mary Ainsworth, Robert Hinde, and Mary Main) who between them