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Alcohol and bereavement



Evelyn Ross

Evelyn Ross, ***BA, ALA. Dip Mgment***

Bereavement Counsellor, Health Promotion Agency, Liverpool, UK

The emotions which alcoholics and their families bring to mourning may be so powerful that they block, replace or supersede normal grieving. Counsellors may need to help the bereaved person to work through these blocks before grieving can occur, and they should be aware of scenarios that may have existed before death. Each alcoholic, each partner, is unique but there are behaviour patterns common to the illness of alcoholism, and to partners' reactions.

ALCOHOLISM

There are various ways of describing alcoholism. The one used here is from the voluntary fellowship Alcoholics Anonymous (AA) which suggests that alcoholism is a four-fold illness, attacking the addict on spiritual, emotional, mental and physical planes, striking at the core of being. This can mean that the partner of a drinking alcoholic lives with, and attempts to cope with or to overcome, an almost impossible situation.

Patterns of mutual behaviour

Alcoholism can create an almost mirror-image co-dependency. This pattern of behaviour can result from the efforts of the alcoholic's partner to effect change in the drinker's life-style, often without understanding what is actually happening in that life-style, and why. There may be a strong element of control, a need to organise the life of someone who is so obviously not in control. This can be destructive for both parties, causing pain and struggle and inhibiting recovery in each.

Even with, or in love, it seems doubtful that any one person can change another, especially someone in the grip of addiction. The partner, however, will often feel a duty or a responsibility to effect change. Gradually the partner's own life-style takes on traits of the alcoholic's, ie criticism, judgmental behaviour, blame, and devious schemes to 'do good' because, after all, the partner wants to help. The effect of this on drinkers may be unwittingly destructive, causing them to 'vanish' – geographically, mentally into their own heads, or physically into drink.

Other patterns of mutual behaviour may include a complete stand-off: each person aims for control, power and understanding, each blames the other, each asks 'why?' Often neither partner can step back and let go, even when the situation seems beyond control. In fact, the greater the loss of control, the greater the need to be in control.

There may be elements of mutual punishment. The drinking alcoholic may alternate between periods of sobriety and relapse, and the partner between a desire to help and the need to punish. The constant moving of the goalposts can lead to a stop-start relationship, with the alcoholic becoming the pursued and the partner, the pursuer and the enemy.

Feelings of guilt, anger, pain, helplessness and frustration may build up, and resentments increase, with exhaustion and despair. In the struggle to find a solution, the partner's identity may be blurred, or lost in confusion and inadequacy.

Practical difficulties

Not only are there emotional problems to deal with, but material, financial and physical factors caused by the alcoholic's drinking may be present and may be carried into bereavement. These may include:

- Abuse by the drinking alcoholic – physical, sexual, emotional
- Poverty, destitution, homelessness, debt, legal problems
- The alcoholic's criminality – theft, violence, drunk driving
- Prostitution with the risks of violence and AIDS.

The manner of the alcoholic's death may have been traumatic, violent or unpleasant, involving, for example, cirrhosis, paralysis, brain damage, cancer, murder, suicide or accident.

Problems carried into grieving

It may be seen from the preceding outline that the bereaved person is likely to need not only to grieve, but

EDITOR'S NOTE

Newly bereaved people may increase their intake of alcohol as a form of self-medication to cope with sleeplessness, heightened anxiety, tension and the pain of grief. Over a third of the young widowers and widows in one study were drinking more alcohol one year after bereavement than before the death[1]. For others, as Ross points out here, the death of an alcoholic spouse may have disrupted a complex symbiotic relationship and the author helps us to distinguish between the two, offers guidance about the special problems in counselling where alcohol is involved, and gives advice about some sources of further help. If the individual has become addicted and is motivated to change, he or she may also need encouragement to seek medical help to end their dependence by entering a detoxification programme or taking antabuse.

1. Parkes CM. Bereavement: Studies of grief in adult life. London, UK: Tavistock, 1972.

to heal and recover. They may be feeling anger, resentment and frustration. Problems with denial and blame, both of self and partner, may be accompanied by strong attempts still to control the situation mentally, and a need to re-write the whole script with a different ending. Questions like 'why?' and 'why not?' loom large.

There may be a refusal to believe the illness was more powerful than either themselves or their partners. The inability to stop the partner's drinking may have brought on a lack of self-esteem, self-questioning, and feelings of inadequacy and rejection. Incorrect and unreasonable expectations of the bereaved person, from people not involved in the alcoholic's drinking, can lead to the partner experiencing guilt and resentment.

The grieving process may be further hampered by revelations of the alcoholic's previous behaviour, ie visits from police or court appearances, and by continuing problems with debt or homelessness.

WHAT SHOULD BE THE COUNSELLOR'S APPROACH?

Counsellors will find it helpful to understand the concept of addiction as an illness (and addicts as sick people, rather than evil ones), and the powerlessness of both the drinking alcoholic and the partner over recovery and relapse. The struggle both to grieve and recover can be agonising.

The counsellor should be aware of the physical and emotional problems the bereaved person may experience, as he or she withdraws from co-dependency. These can include depression, panic attacks, agoraphobia, chronic anxiety, guilt and shame. It can be the case that these clients have been attracted to others with addiction problems because they, too, have hidden, unrecognised addictions of their own. These may surface in the grieving process, once the distraction of trying to cope with an addictive partner is removed. These and other issues, such as self-blame and fault-finding, need to be recognised, acknowledged and worked through.

Self-help groups and the 12-step programme

If there is great anger and bitterness, attendance at some 12-step self-help programme, such as those run by Al-Anon or Emotions Anonymous (EA) can help. Here the bereaved will hopefully be able to identify with others, and come to experience fewer feelings of isolation and denial, of being somehow responsible. It may even be helpful to go to an open AA meeting, depending on the bereaved person's willingness to look at the illness.

Any 12-step programme contains a powerful, spiritual message (although they are not religious groups, nor do they preach any religion) and there may be a spiritual dimension to the partner's suffering. Exploring any belief system is obviously a delicate, sensitive business and may be blocked by the client, especially if there has been a loss of faith, and anger at the injustice of it all has taken over.

Many people seem to need to have control over every aspect of their lives, and this may sometimes lead to frustration, anger and resentments when things go wrong. One of the purposes of the 12-step programme is to guide them through the very painful process of letting go of what is beyond their control, leading them to cope with the problems they can solve, and helping them to accept things as they are (not as they might, ought, or should be) and be healed.

The release from blame brought about by attending a self-help group and the discussions with the counsellor afterwards should eventually allow the grieving process to flow. There should be a shift of attention away from the alcoholic on centre stage and a gradual centring of attention on to the bereaved person.

Addictive behaviour in the client

There are added complications for a counsellor working with a bereaved person whose own drinking is a problem.

Because denial and secrecy are aspects of addiction, it may be difficult to differentiate between a person using alcohol as a pain-killer during bereavement, a person whose bereavement drinking may cross the line into alcoholism, and a person with an ongoing alcohol problem. In all three, drinking masks and postpones grieving and recovery, encouraging imaginary fears, extreme self-pity and depression. The shifting of goalposts mentioned earlier may now start between counsellor and client, with the counsellor encouraging coping skills, while the client responds on one level, but lives on another. Counsellors may find themselves becoming completely absorbed in and deflected by the drinking problem.

Where the bereaved client has a history of serious drinking, the counsellor may need to disentangle the alcohol and grieving threads in their sessions. It may not always be clear what need the client is bringing to the counselling, bearing in mind that many issues will be fogged by alcohol. The reaction, response and commitment to counselling will vary according to where the client is in the drink situation (ie in relapse, in recovery or drinking).

Counselling the bereaved alcoholic

Counselling problems with a client who is misusing alcohol may start with missed appointments. Does the counsellor assume help is not needed, or simply that the client is unable to cope either with the problems or their solutions? The counsellor, in these cases, may have to accept a 'stop-start' situation, with the client welcoming support sometimes and rejecting it at others.

Where possible the counsellor should monitor the drinking levels, being aware of sensible drinking habits, unit measurement, the dangers of solitary drinking and possible physical damage, and pointing out the need for the client to be at least 24 hours without a drink before a session. It can be very difficult for the client to be honest about the amount being drunk, but on this may depend the progress in the sessions.

The client's denial of the situation often leads to comments like: 'I don't have a problem' and 'I can do this (recover) on my own'. Sadly, neither is likely to be the reality. Denial may also result in resistance to self-help groups and other alcohol service agencies. What the counsellor can do here is have available as much information as possible on other sources of help, and be ready to offer them when the time is right for the client. Offers of attendance at meetings with the client are sometimes welcome, especially on the first few occasions. People can only recover when they are ready to do so, and the counsellor should be sensitive to this.

Social activity and support, and family involvement (where relevant) should be encouraged. The bereaved is often seen as 'letting the family down', and is forced into isolation. The counsellor should also encourage the support and involvement of health-care professionals, self-help

groups and general practitioners. Severe depression may require short-term medication of some kind.

For clients already in a 12-step programme (ideally with a sponsor), or receiving counselling from an alcohol services agency, the support they are already receiving may well go a long way to alleviating the alcohol problem in the grief situation.

Ending the therapy

During the last sessions, clients should be encouraged to set their own boundaries, accept that no-one is all-powerful, and that many things in life go beyond our control. Sometimes meditation or assertiveness courses help. By this time the bereaved person may be ready to go into some social group. Al-Anon, for instance, has a nationwide programme which encourages personal and telephone self-help.

Whatever the approach, recovery and healing can be a long, slow, exceedingly painful process. It is a journey during which many bereaved people find themselves and their lives completely changed.

Details of local groups of Alcoholics Anonymous or Emotions Anonymous can be obtained from a local Samaritans branch.For information about local Al-Anon groups (for families, friends and relatives of alcoholics) telephone 0171-403-0888

FORTHCOMING CONFERENCES

Death and Spirituality. 12–15 May 1996. Ontario, Canada. 14th King's College Conference on Death and Bereavement. Co-ordinator: Dr John D Morgan, King's College, 266 Epworth Avenue, London Ontario, Canada N6A 2M3. ☎ 519 432 7946.

Gone Forever Project: Helping Children and Young People to Understand and Cope with Bereavement and Loss. 13 July 1996. Sheffield, UK. Apply to: Conference and Short Course Centre, Sheffield Hallam University, Collegiate Crescent campus, Sheffield S10 2BP. ☎ 0114 253 2511.

Fourth International Conference on Children and Death. 5–8 April 1998. The Netherlands. Contact: Dr Z Zylicz, The Pallium Foundation, PO Box 90, 7010 AB Gaanderen, The Netherlands. ☎ 31 26 3645792

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Death and people with learning disabilities:

Interventions to support clients and carers (part 1)

Fiona Cathcart, *MA, MSc, CPsychol, AFBPsS*

Principal Clinical Psychologist, Department of Clinical Psychology, Gogarburn Hospital, Edinburgh, UK

The needs of people with learning disabilities who are bereaved have been acknowledged in the last decade. There is more understanding of ways to meet these needs. Carers need training and support when working with people who are dying or bereaved. This paper reviews the relevant literature, offers guidelines for practice and highlights areas for further development.

EVIDENCE OF GRIEVING

There is an extensive literature on dying and bereavement[1,2,3,4,5,6] but there has been little research into the needs of people with learning disabilities. Oswin[7,8] challenges the view that people with learning disabilities do not understand death and therefore could not grieve. She argues[9] that participating in the social response to death is both a right and a support in itself. People with learning disabilities will be bereaved and face death themselves and they may need assistance to interpret what is happening to them.

Emerson[10] found that some behavioural problems in people with learning disabilities had been precipitated by a bereavement. She reported that those caring for the person had minimised the significance of death or misunderstood the reactions to it. Disturbed behaviour such as aggression may be the only means of expression for some people with profound handicaps[11].

An early paper by Ray[12] describes two families in which the fathers died. Both mothers thought that their children would not understand and did not expect them to grieve. It became clear that the children's difficulties with understanding was not protective but added to their distress.

John, with Down's syndrome, was nine years old when his father died suddenly. Later his mother tried to discuss the loss with him but John became distressed and tried to injure himself. When a male visitor arrived John became excited, 'but when he looked at the man and realised it wasn't his daddy he just crumpled to the floor and started wailing'. On another occasion, on returning from a school trip, he ignored his mother waiting nearby and gazed around the car park saying 'Daddy'.

Bill was 16 years old when his father became ill. He saw his father's health deteriorating and visited him in hospital. Bill was staying in respite care when his father died and was unable to return

EDITOR'S NOTE

Adults who have learning disabilities (formerly described as adults with mental handicap) are a neglected group in relation to many services. In the days when they were hidden from public view in institutions, it was unlikely that volunteer bereavement counsellors would have been asked to help them. With care in the community a reality, not only are learning-disabled adults more likely to be living near us, their losses may be more difficult for them to bear when there are fewer people to share them. Fiona Cathcart has pioneered studies of how best to help these 'children in adults' bodies' to cope with the death of a loved one and points out that our knowledge of how children grieve, and their needs, can help us. We have already published an article by Cathcart[1] on this subject, and are delighted to reprint this comprehensive review article which enables us to share her wealth of experience in this field. Practitioners working with people with learning disabilities will find much to help them.

1. Cathcart F. Bereavement and mental handicap. *Bereavement Care* 1991; 1(1): 9-11.