CONCLUSIONS

HIV bereavement counselling may start as a discrete phase after death, but more frequently begins from the earliest contact with those close to a person with HIV before the patient dies. Using a family perspective helps this process. Comprehensive care can be offered through the stages of HIV from diagnosis to death by identifying, assessing and addressing the complex repercussions not only for the patients, and their close contacts but those who give the treatment and care[17]. By engaging the wider healthcare team, responsibility is shared[18], training in bereavement counselling skills is integrated into day-to-day practice, and stress on staff is reduced.

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Training in work with traumatised children: a placement at the Traumatic Stress Clinic, London, UK

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The clinic was founded in 1993 under the direction of Dr Dora Black who, in collaboration with colleagues, had accumulated experience of the long-term effects of horrifying events on children when they are not helped to grieve and to process the trauma.

THE WORK OF THE CLINIC

The functions of the clinic extend beyond offering direct help to children and families, through consultation, assessment and treatment, to various research projects, teaching, lecturing, and attending conferences here and abroad. The team now consists of Dr Dora Black, Consultant Child Psychiatrist and Director; Dr Jean Harris Hendriks, Consultant Child Psychiatrist; a family therapist; two clinical psychologists; a child psychotherapist; a research psychologist; and a team secretary. The clinic operates one-and-a-half days a week and all are part-time. Funding is complex and various, but the UK Department of Health has sponsored some staff, as well as the trauma training of Cruse counsellors.

Referrals to the clinic are widespread, from all over the UK. Social workers often accompany clients, to observe and to take part in the interview, as do lawyers acting on behalf of parents, relatives, or children where divided loyalties could emerge in the history-taking. In circumstances so highly charged, such decisions can sometimes feel persecutory to one side or the other.

Appropriate placements for children are often at the heart of the assessment, requiring a review of parenting skills, the preparation of meticulously detailed court reports,

EDITOR'S NOTE

A cohort of Cruse counsellors selected to receive training in trauma child counselling report on their experiences. They are participating in a seeding or cascade programme – training those who in their turn will be the trainers of larger groups, and so on. Such techniques are the best way to disseminate knowledge and skills widely, swiftly and economically, suggests Professor Parry Jones of Glasgow University' who advised the Macedonian Government on helping refugees from former Yugoslavia.

Evidence that children affected by disasters can be helped by such interventions includes findings recently presented by Goenjian et *al* from the Trauma Psychiatry Program at the University of California at Los Angeles, headed by Professor Pynoos. After the 1988 earthquake in Armenia they worked in schools with pre-adolescent survivors, using a matched, untreated control group for comparison. They found that the severity of post-traumatic symptoms increased significantly over the three years following the earthquake in the untreated young people, and decreased significantly in the treated group.

Other school-based programmes have been set up for children affected by civil conflict or war. For example, in Bosnia Professor Yule of the University of London, in partnership with UNICEF, and in Mozambique Dr Richman and colleagues working for Save the Children, devised programmes which target teachers as the main resource for troubled children. The aim is to teach them the appropriate skills for identifying children needing help and to train them in how best to give that help.

and the diagnostic assessment of parent, relative, or residential home as suitable caretakers for the future of a child. For these reports the staff pool their observations of interviews, which are one to two hours long. Always paramount is concern for the long-term welfare of the child.

TRAINING WITH THE TEAM

During our 10-week course, we followed the work of the clinic for one day each week (see timetable below). Providing families give their permission, which they usually do, observers can watch and listen to working session from behind a one-way screen.

It would be hard to be prepared for the impact of being temporarily part of a team working with such traumatised children and their parents. We were provided with relevant articles on our first day (see Reading list) which were significant as guidelines to our understanding but we could well have read these beforehand.

We were involved in sifting through background information and extracting relevant points from it; we took notes for the team, sometimes observing one sibling in the family group and developing a deeper insight into one aspect of this multi-layered trauma. All the parts would then be put together for joint assessment. Observing the depth of the ensuing deliberations brought home the seriousness of the decisions being made about the children's welfare.

In joining the team, we became part of a complicated three-act drama based on a traumatic incident in a child's life, the telling of the story of this terrible event and its psychological impact. The cast might include parents, siblings, carers, social workers or *guardians ad litem*, with the child/children in the central role. The trauma is told and seen from the child's perspective, with the team directing and producing the whole, against a backcloth coloured by the child in black and red – colours which predominate in the children's paintings. The plot follows strands of fact and feeling, sorting out the confusion of what is known but not understood, what is hidden and why, with the team determining an outcome in the best interests of the child. The actions of the team are based on the unfolding trauma, members of the 'cast' being included or excluded at different times, allowing for role change and role reversal which, for instance, might show the child parenting the parent, or a parent revealing the child in themselves.

The metaphor of the clinic as a stage can be extended to the trainees: it is as if we were the audience of a private viewing of a drama too horrific to be confronted openly, a position which perhaps mirrors the isolation and bewilderment felt by the child caught up in a private disaster which society can hardly bear to contemplate. The impact, therefore, was direct, affecting and penetrating, as a documentary can be, but because our point of reference was the traumatised child and our purpose was to learn through observation, we could relate theory to practice and watch its application through the interventions of the team.

The seminars gave us the chance to question and discuss our views and experiences in a more intimate way with the team, and to gain a fuller understanding of the professional perspective and expertise of individual members. In retrospect it would have been useful to have had some joint thinking space in these sessions to consider how we could apply this to our own bereavement work. But we were acutely aware of the generosity of the team in giving up their time in an extremely busy and emotionally demanding day.

The team welcomed us to their meetings, inviting us to comment from our own experiences in the counselling field. This reduced our feelings of strangeness and powerlessness about this specialist work, and our confusion in the face of the extremely disturbing and violent scenarios which the team regularly encountered. Such intense emotion can temporarily eclipse the capacity to think, and may reflect the paralysis of responsiveness in family members, particularly the children. As observers we were very aware of the importance of the daily staff debriefing session for the self-care of the team.

At the end of the course, we felt privileged to have had this experience, which proved to be disturbing, dynamic and educational.

TIMETABLE FOR TRAINING DAYS

9–10am	Team meeting for discussion of new referrals, reports on previous patients, consideration of policy, ethical and financial issues, and the allocation to staff of new cases.
10am–1pm	Interviews with existing patients, followed by assessment interviews of new referrals.
2–3pm	Seminar for the trainees with one of two of the team members focusing on an aspect of traumatic work with children, eg, talking to children, the legal system, debriefing work, cases needing intensive psychotherapy, family interventions.
3–5pm	Opportunity to view more family work (often multicultural)
5–6pm	Staff debriefing session

A case history: Dominique

One of the cases we observed was a referral resulting from a contact application by a father. Dominique had been looked after by her mother's sister (Florence) following the strangling of her mother by her father about two years before. Florence (mother's sister) was not married and had one three-year-old daughter of her own; she had become the legal guardian of Dominique, now aged five, and was hoping to adopt her.

The child's father was in a psychiatric hospital, and her aunt was reluctant for her to be in contact with him. 'I can't bear to disrupt her.' Florence felt that Dominique could not understand the shocking event, that she needed to grow up first, and that seeing her father could be like 'murdering her life'. Although Florence had told Dominique where her father was, she was uncertain whether Dominique really understood about psychiatric hospitals. So it transpired that Florence had come via her solicitor in order to enable Dominique to speak for herself.

The team affirmed Florence's courage in sharing the terrible event and its effects, acknowledged her primary importance for Dominique, who now saw Florence as her mummy. Since her mother's death, Florence had helped Dominique through some of her regressive responses, anxieties, fears, nightmares and poor appetite, rocking her like a baby through recurrent bouts of crying. Florence feared that a visit to her father could interfere with Dominique's progress. The father had killed previously, and was found by the Court to have diminished responsibility because he was mentally ill.

Dominique was quick to play with the toys in the consulting room. She put a doll in a crib and talked of the baby dying. Distracted, she moved away, starting to

sing a phrase from Pinocchio, and imagined that she was having a baby. Daddy pinched her, said Dominique, and she died and went to heaven; he went to prison. The therapist commented on the sadness of Dominique's mother's death, which led to Dominique drawing a bear hunt and talking about her father, saying that he had got sick in the head and had gone to a hospital for big giants, but that he would come out when he was good. The therapist confirmed for Dominique that her daddy was thinking about her and wanted to see her. Dominique told the therapist that her daddy had said he was sorry for her, and sorry for what he had done; in response the therapist asked Dominique if she cried, but she did not.

Asked if she wanted to see her father, Dominique replied that she wanted to go to Disneyworld, because if she went to see Daddy he would push her away and tell her to leave: he was not nice. (It was very hard for the child to talk about her father). Using baby talk she reverted to the reading books, liked the bear and wanted a donkey to sit beside her. Describing herself as big and fat, like the bear who had eaten too much, she said she could punch the therapist.

The therapist asked Dominique if she was going to see her father, but Dominique thought that this would not be safe. At this point the child put the doll/daddy figure in a bed and covered him, making a strangling gesture as she did so. Then she said 'you are going to jump in the water and you are going to be dead' (possibly there had been a fire on the bed where her mother died and water had been thrown on it). Florence had described a poignant incident at the grave side when Dominique had wanted to get her mother out, so the therapist tried to help the child to understand that death is permanent and irreversible.

There had been uncertainty about whether Dominique had witnessed the murder but her play seemed to indicate that she might have done, and that she was preoccupied with death and dying. The therapist had visited father in the prison hospital, and felt that it would help Dominique to see him, now that his behaviour was more normal, and for him to apologise to her for depriving her of her mother. The therapist accompanied her to the prison as the aunt did not want to see the father and the therapist would be better able to control the session. (Names and identifying details have been changed in this case history.)

OUR OBSERVATIONS AND REACTIONS

Being a trainee on this course transposed the experience of being a bereavement counsellor working one-to-one with a bereaved child to a wider setting. It may seem paradoxical but we found that observing the work of the clinic widened our vision and deepened our understanding of all bereaved children.

Children were seen at the Traumatic Stress clinic after:

- homicide in the family
- witnessing other homicide
- attempted homicide or severe injury to family member
- severe domestic violence
- child abduction
- Munchausen syndrome by proxy
- war or civil conflict
- man-made or natural disaster
- road traffic accidents
- parenting failures

The crisis intervention work uses the skills and techniques developed by the staff during their long-term experience in dealing with traumatised families. The child is presented with a safe and containing place to say the unsayable, and a context into which an event, involving the most primitive and violent emotions, can be placed and its meaning fixed. The context involves a delicate balance of reassurance, matter of factness, strength and sensitivity, signalling a familiarity with the special difficulties and circumstances which the child faces.

New skills and insights

The commonality of issues prompted a reappraisal of our past cases, not always comfortable, a reconsideration of methods and a reassessment of responsibilities. However, the overriding issue of confidentiality meant that we could not discuss this outside the clinic – a parallel with the child's need for a 'specialised' place to take his experience and the sense of isolation within that experience. Alongside was a developing confidence that we were acquiring new skills and insights, knowledge of debriefing techniques and appropriate responses to trauma, and the training to recognise the symptoms of post-traumatic stress disorder and when to refer on. We also increased our understanding of the legal framework relating to children's interests, important for their protection and representation.

At the same time, we became increasingly aware of the vicarious experience of working with trauma and the resulting fundamental need for quality supervision and self-care. We noted how important were the links with other professionals and agencies supporting a traumatised child and his family, in contrast to our commonly more-isolated model of client and counsellor work.

For us the course was an experience of crisis intervention at the sharp end, performed by a team whose confidence and competence resulted in allowing shocking dramatic memories to be reprocessed. As counsellors we have come to feel that post-traumatic stress disorder needs to be more widely understood through education and changing patterns of practice, so that the stresses of traumatised children and their caretakers can be met early in a crisis. We have been alerted to the question of boundaries in our work, and also to the potential transferability of skills. How and where do parallels exist between horrific bereavements by murder, the macro-crises of large scale disasters, and the loss experienced by children whose parents die through illness or accident? In considering these questions we hope that, for the sake of the children, we can seek new ways of working together with a greater immediacy.

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