Europeans do not care to wear their emotions on their sleeves – witness not only the Royal Family last week, but also many who, often silently, supported them. But nobody wants impersonal funerals. We all prefer funerals that tell something of the life of the one who has died. Such funerals thereby tell people that it's okay to talk about the dead, that it's okay to be honest about the dead if it's done with love. Such funerals can begin a process of talking that for the mourners may never end, and never should end. Only thus does memory become history. Only thus can individuals, families and whole societies live with their past, and gain strength to face the future. BC

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This text comprises a talk given to the Bereavement Research Forum at the Barbican, London, on 11th Sept 1997 and part of a longer talk given to the Cruse Bereavement Care Annual Conference in Swanwick, Derbyshire, on 17th September of the same year.

LETTER TO THE EDITOR

Dear Editors

I am carrying out research on how bereavement counsellors encounter and work with religious and spiritual issues in therapy. As part of this project, I am interviewing bereavement counsellors who are accredited, or are eligible for accreditation, by the BAC, UKCP or BPS. I would be very grateful to hear from any UK counsellors who would be willing to take part in this project, which would involve a single interview of approximately one hour.

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Domestic killing

The perpetrator's need to grieve

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With a contribution by Rufus McGinty
Mental Health Service user

Many patients in Broadmoor have killed members of their families and, though not all are psychotic, most have killed while they have been suffering from the acute symptoms of mental illness. Does this exclude them from the grieving process and therefore the need to grieve? I believe not. It is my opinion, backed up by my experience, that mental illness actively magnifies feelings of grief, and that therefore loss may be more deeply felt.

People are admitted to our hospital from all walks of life, men and women, via the Courts, regional secure units and other health care settings, including prisons.

The main precipating factors for those who kill family members while mentally ill are depression, self-loathing, poor sense of self-worth, paranoia, hallucinations – both auditory (voices which compel them to act) and visual ('seeing things', for example the devil incarnate), alcohol and drug abuse, anger, hate and jealousy. The percentage of my clients which fall into each category changes, but the vast majority (98%) suffer from the enduring mental illness, schizophrenia; the remaining 2% suffer from personality disorder, with depression.

For those patients with schizophrenia, it is during the acute phase of their illness that their perception of reality alters and the offence occurs. When they are in remission they can become aware of the terrible event which has taken place and in some cases, including one client of mine, may attempt or succeed in taking their own lives. In the case of those patients with personality disorder, most act on instinct, with self-preservation high on the agenda; they also have low impulse control due to being brought up in a family in which they never learned that control.

SPECIAL PROBLEMS AFFECTING MENTALLY-ILL PRISIONERS

Mentally-ill patients have to contend with not only the loss of a family member, and their feelings of responsibility and guilt

EDITOR'S NOTE

It is not uncommon for bereaved people to blame themselves for the death of a person they have lost. Usually such feelings are unjustified. But what if they are not?

In this paper Ken Dolman and one of his unfortunate patients, who naturally prefers to write under a pseudonym, report on one of the worst griefs imaginable, the grief of people who, as a consequence of mental illness, have killed a member of their own family.

Mental illnesses take many forms and, although only a very small minority of mentally ill people place others at risk, that minority gives rise to a great deal of public fear and hostility. We are right to expect that they will be kept securely locked away for as long as they remain a risk to society, but this does not absolve us from the obligation to ensure that they will also receive the care which they need. This must include not only proper treatment of the mental illness, but also counselling to enable them to come to terms with the many losses which they and their families have suffered.

The serious implications of domestic murder for children and other members of the family have been described in previous issues of *Bereavement Care*[1-5]

1. Black D, Harris-Hendriks J, Kaplan T. Father kills mother: post-traumatic stress disorder in the children. 1993; 12 (No 1): 9-11.
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5. Parkes CM. Psychiatric problems following bereavement by murder or manslaughter. 1993; 12 (No 1): 2-6

about that, but also loss of the mental health which allows most people to come to terms, in time, with the death of a loved one. Added to this, the patients in this situation would not have the opportunity to attend the funeral because they are in custody, and thus they miss out on the 'goodbye' process. Missing important rites can even bring about a delusional process, as it did with one of my clients who was prevented from believing that the family member he had killed was in fact dead.

A double burden of losses

Fraser[1] argues that there is yet another reason why this particular group of patients might be expected to experience complicated grief reactions. The functions of attachments which develop between humans, and why the lack of such a close attachment to another person may be associated with a subjective feeling of insecurity and danger, have been discussed by Bowlby[2]. Loss emerges as a key concept in the understanding of bereavement. When we consider that those who are found guilty of murder or manslaughter will usually be remanded in custody, and that the eventual outcome is likely to be either a prison sentence or admission to a hospital with secure facilities, it is obvious that there will be many losses other than those associated with the bereavement. The access of offenders to family and friends will be severely limited. Their usual occupations and pastimes will be unavailable to them and, of course, their freedom itself is lost. There is likely to be a grief reaction to these losses, so that prisoners who have killed a family member are subjected to a double burden of losses, increasing the probability of abnormal grief.

A PATIENT'S EXPERIENCE OF GRIEF

To illustrate the grieving process of these patients within an institution, there follows an intimate account of his own grieving by one of my ex-clients. Rufus (not his real name) is 35 years of age, his mental disorder is categorised as schizophrenia, and his index offences were unlawful wounding and the manslaughter of his mother.

The public's perception of a killer

'*Cold killer, emotionless, definitely heartless, destroyer of people's lives* – these are stereotypes of a murderer, and how we want to hold on to them, to focus our pain, fear and hatred as we reel from the utterly catastrophic effect he has had upon our lives. I say 'he', and in most cases it is not a 'she', but when it is perhaps even more confusion is thrown upon those affected by her actions. 'How could a mother do such a thing? What sort of woman is she?'

In 1995 there were approximately 600 reported killings in England and Wales and, of these, 484 of the victims knew their attackers and 400 were in the same family! Perhaps some of you reading this have been taken half-way to hell by having a loved one torn away in such vicious circumstances. How confusing, then, to find that the killer is your son, husband, aunt or brother. The loss is often doubled: you not only lose the victim, but the perpetrator of the crime as well. Your family is decimated. No one seems to understand. 'These sort of things just don't happen to people like us.' It's incomprehensible.

'Many would say that those convicted of killing someone else should rot in hell. Believe me, they often do.'

You are obviously not alone, but it's not the sort of news to jolly along a social gathering. The subject is so rarely breached in public to save embarrassment and the consequent shunning, so just how do people come to terms with their tragedy, with the mental torture? How many people have to deal with it on their own?

The television, on the whole, is not much help. Nightly films featuring murder as light entertainment tend to be parodies of good *versus* evil, and don't explore the characters behind the crime in any real depth. Shakespeare, on the other hand, certainly did. In plays such as *Hamlet* and *Macbeth* he manages to convey the emotional confusion of those characters and show not only the full extent of their actions, but also their inner worlds of darkness, guilt, and confusion. But Shakespeare leaves so many people cold.

There are often documentaries on the television featuring prisons and their inmates, but to me they don't convey very well the inner world of prisoners or patients in Special Hospitals. There is a practical difficulty in communication because these are closed institutions and the alienating circumstances that brought us into prison preclude, or make difficult, an understanding of who we are. One of the many insights I have gained since being locked away for manslaughter, is the need for understanding of others as part of the healing process. Nothing will ever be the same again, but people can learn to live as positively as possible alongside a murder in the family or community.

Shame, guilt and suffering

The vast majority of the people I have met who have committed murder, mostly diagnosed as being mentally disordered, feel intense shame and guilt over what they did. For many it is a force which crushes the life out of them, as if they were being steadily strangled. At least for the group labelled 'mentally unwell' there are psychiatric drugs, or various therapies and support. For those sent to prison for life sentences, the environment of punishment, hostility and 'hate thy neighbour' makes it just as hard to come to terms with their actions as those suffering from psychiatric disorders.

Many would say that those convicted of killing someone else should rot in hell. Believe me they often do. I choose not to, but it is with the help of others that I have reached this point. In my ascent from hell, not only did I have to deal with the death of my mother but, the most horrible twist of all, that I had killed her. How on earth do you ever explain it to yourself, let alone anyone else? One moment of complete madness and you've done this terrible, wicked thing, it is completely irreversible and the horror just goes on and on and on. It is you that punishes, nay persecutes, yourself more than anyone else, some even to death.

The recovery process

As part of my recovery, I worked for a year with Ken to address the loss issues surrounding my mother's death. The work we achieved had a very positive effect on me, releasing so much grief and enabling me to start living again. I now accept the loss, accept how much I did in fact love her, and have moved on. The denial of my right to grieve (it seemed ridiculous, how could I be so perverse as to grieve for the person I hated so much that I killed her?) left me in an unhealthy state for a long time. Along with the horror and guilt it aggravated mental illness in me.

It may seem quite outrageous to some for the so-called 'killer' to be expressing these opinions, that murderers grieve for their victims, especially when they are loved ones. It is for the survivors, if they can bear it, to understand that these fatal actions are but part of us, sometimes a very small part, not the whole. Murder tends to hang like a black cloud over those it has touched; people need to grieve, and that includes the perpetrators.'

COUNSELLING PATIENTS IN A SPECIAL HOSPITAL

I have been counselling patients in Special Hospitals for five years and worked in a mental health care setting for 23 years. It is my experience that my clients do have 'normal' grief reactions if a relative dies while they are in custody. Their guilt can be prolonged and could be helped by counsellors who have a basic knowledge of mental illness.

The grieving process of mentally-ill offenders imprisoned for domestic manslaughter is more difficult, not only because they usually have the added complications of mental illness but also, as my client clearly identifies, because there are prejudices and intense feelings expressed about them. There is no doubt that these people need to grieve, and I have found that counselling helps both with the pain and with coming to terms with the circumstances which led up to the tragic moment. However, a counsellor who has insufficient knowledge or experience of mental illness and personality disorders could have an adverse effect.

Forgiveness plays no part in my approach to the client. I make a point of saying that I cannot condone what he or she has done, and as yet have not had a client ask me for forgiveness. However, in some cases the forgiveness of the remaining relatives is important to the recovery. It is sometimes possible to convince families that these offenders have been unintentionally cruel to those they love. If a meeting is planned, this must be very delicately and sensitively handled, as other members of the offender's family may naturally be unwilling or afraid, and family dynamics must be carefully considered.

RECOMMENDATIONS

It is my experience that the guilt and pain that the majority of my clients feel is not acknowledged by the majority of staff, not even the medical staff. On most occasions the grieving process is not identified as needing treatment. Therefore a patient could, in theory, be admitted to hospital for several years and eventually leave without this major issue being addressed, possibly leading to relapse, and even violence again. This major vacuum in the therapeutic organisation of these hospitals creates another 'loss' for the patients, impeding their recovery. A better-coordinated, quality service is needed so that patients do have access to skilled bereavement counselling and grief therapy. BC

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New for 1998 in *Bereavement Care*
Peta Hemmings and her colleagues will be contributing a regular section on ways of working with bereaved children based on their work at the Barnardo's Orchard Project in Newcastle.

Explaining death to children



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To give children ready-made explanations about death is to diminish their bereavement experience. From the age of four, children have an ability to comprehend the facts of death, but information alone is not enough; they also need an opportunity to explore the feelings generated by a death in order to believe the facts and come to a personal explanation of their meaning.

Enabling children to discover for themselves the significance of their experience after a death is particularly important because the resolution of bereavement is not a finite process, but one which continues throughout the rest of life[1,2]. Bereaved children will need to return to bereavement-related issues many times and review their meaning against the backdrop of their changing world. This commonly occurs most intensely at times of developmental change and during other times of transition.

A good explanation cannot be delivered in a one-off session: it is a two-stage process, dealing first with facts and then with feelings. The optimum outcome is that the child is able to construct an appreciation of the loss which is compatible with the developmental stage.

EXPLAINING THE FACTS

The first stage of the process involves assessing what the child understands already, what he can tolerate to know at present and what level of knowledge is permissible within the family: this last point is particularly important in the case of a stigmatised death. The manner in which these facts of death are explained to a child depends upon these and a number of other factors: age, developmental maturity, previous experiences of loss, the nature of the relationship with the dead person, the type of death, cultural norms and the belief system of the family.

Children's understanding of death

Children discover death quite naturally through play, experience and observation. Research studies have demonstrated that most children develop an interest and an understanding in death-related subjects from three to four years old and that this appreciation develops progressively, reaching maturity when the child is nine or 10 years old[3,4,5]. Although most 10-year-olds will be able to understand what death means (see Table on p32), it is unwise to assume that all children of this age will do so, or that only children of this age can do so. Kane's research[6] has shown conclusively that children from as young as four years who have been bereaved have the capacity for a mature understanding of death. This finding has important implications, not least of which is that age alone is no longer a reason for excluding a child from the family's collective experience. The problem it raises is how to explain death to children who, because they are so young, have a limited vocabulary.

Unhelpful explanations

The way in which many adults respond to the questions of very young children is

EDITOR'S NOTE

A two-year-old boy, told by his mother that the park café would be closed that day 'because Princess Diana had died', ran into the park the next day and finding the café open said, 'Princess Diana must be alive again!' Peta Hemmings illustrates for us some of the cognitive and emotional processes in young children who have to cope with death, and teaches us how important it is that we respect and draw out each child's unique way of understanding and coming to terms with bereavement, using play materials, myths and symbolism to help allay fears and lay ghosts.