BEREAVED CHILDREN - FAMILY INTERVENTION

A Research Report



The publication of Dora Black's research is an important milestone. This is the first scientific evaluation of family counselling after bereavement and it confirms the efficacy of this method of counselling.

When a parent dies the surviving parent is often afraid to talk to his or her children about what has happened for fear (a) that the child will get upset, (b) that the parent will get upset, and (c) that this will make a bad situation worse for both of them. We can now see that when a parent is counselled to talk and share feelings about bereavement with a child, the child does get upset and so does the parent—but this makes the situation **better,** not worse.

Evidence of this kind has great educational value as well as opening the door to improved methods of counselling for bereaved parents. We look forward to hearing more about these counselling techniques in future editions of "Bereavement Care".

Colin Murray Parkes

A 10 year old spastic girl said to her father, as her mother lay dying from a stroke, "I am an awful trouble to mummy—do you think that is why she is so ill?" She was merely expressing what many children believe but do not say—that the world begins and ends with them and they must be the cause of all the bad things that happen in their world. Whether it is this omnipotent thinking, or the difficulty in conceptualising death, or the enormous changes they have to adapt to as a result of the death of a parent, or all three, bereaved children fare badly at least in the short term.

Various studies (see Black (1978) for summary and Raphael B. (1982), Kaffman & Elizur (1979), Elizur & Kaffman (1982) and Van Eerdewegh, et al (1982)) have shown that the short term distress is high. Something approaching 50% of children under 17 are markedly hindered in their everyday functioning because of symptoms of anxiety, depression, learning difficulties and behaviour problems in the year following the death of a parent. In one long-term study (Kaffman & Elizur (1982)) this proportion did not markedly diminish more than three years after the death of their father. There is some evidence, too, that children bereaved of a parent are more vulnerable during childhood and in adulthood to other losses which may precipitate a depressive illness (see Black 1978 for review). The repeated experience in clinical work of the effects of loss on children, combined with my work in a Parent Circle for the Watford branch of Cruse, led me to postulate that there might be a way of preventing or mitigating some of this distress. With the financial support of the Mental Health Research Fund and sponsorship from Cruse I embarked in 1977 on a controlled study of the efficacy of a family-based intervention in bereavement in children. I am here reporting on the preliminary results of a two year follow up.

Study

The families were identified with the aid of the records clerks of four hospitals and twelve general practices. Every week they were contacted and the names of all patients dying the previous week between the ages of 25 and 60, together with the names of their general practitioners were obtained. Each G.P. was then phoned, the presence of children under 17 ascertained and permission obtained to include them in the study. The families were randomly allocated to treatment and control groups. The latter were not contacted at all until one year after the death. The treatment families received a letter from one of our therapists on Cruse notepaper about two months after bereavement offering to visit the family, to help with any problems that may have arisen since the bereavement. Twenty-two familes, approximately half the group allocated to treatment, accepted the offer and completed 3-6 family therapy sessions.

The treatment sessions were conducted by social workers experienced in family therapy in a child psychiatric setting who had undergone further training in bereavement counselling. Their aims were to open up communication in the family about the dead parent, particularly between the surviving parent and the children and to enable the parent to facilitate mourning in his or her children. The therapists used techniques familiar to family therapists to enhance emotion and increase participation and use was made as appropriate of drawing materials

by

Dr. Dora Black

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and toys. During the treatment the therapist helped the family to anticipate the smaller grief reaction her departure would provoke and to mourn appropriately.

Both the treatment and control families were seen at one year post bereavement and again at two years by a different interviewer who administered a structured questionnaire to the parent which covered a detailed enquiry into the functioning of each member of the family including their physical and emotional health and their functioning at work or at school. In addition questionnaires were sent to the school (Rutter Teachers Questionnaire) and given to the parents to complete (Rutters Parent Questionnaire). All the treatment families except one agreed to follow up and there was no attrition. 75% of the control families agreed to the first year follow up (24 families). Six of them containing 10 children refused second year follow up. We therefore have a unique sample of 83 children (38 treatment and 45 control) on whom we have an immense amount of information.

Results

In spite of not being able, initially, to match our treatment and control groups we were pleased to see how similar they were. The children in the control groups were slightly younger and there were more surviving mothers, but the differences were not significant. There were also no significant differences between the two groups on the working hours of the surviving parent (most of them were working more than 20 hours a week) or on financial changes since bereavement. Only four treatment and three control parents were better off than before the bereavement and approximately 50% were worse off.

Table 1 summarises the major differences between treatment and control groups at first year follow up. On the other measures we used there were no significant differences but nearly all results showed a trend in favour of the treatment group. Our conclusion at the first follow up was that treatment had not done any obvious harm and that the treatment group appeared to have had a slightly better outcome. Furthermore, looking at the total group, both treatment and controls, a favourable outcome had been associated with the child crying about and talking

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Postbag

From:

BARBARA WARD,

Chairman Hillingdon Cruse

With reference to the letter of Jane Insley replied to by Dr. Parkes on the subject of Social Groups v. individual counselling in the Spring 1983 edition of **"Bereavement Care"**, our Branch runs a weekly "Call-In" Centre where individual counselling and a supportive Social Group are held in adjacent rooms. In this way the newly bereaved, having benefited from individual counselling in the early stages, can then move into the Social Group when ready. They are then free to move between the two as the needs arise.

We also find we have fewer requests for home visits, which are always offered.

Our new Group WIMM (Widowed in Mid-Marriage) also aims to provide a similar service. WIMM'S philosophy very much echoes Derek Nuttall's description of "The Good Group" on page 2 of the same issue of "Bereavement Care".

It would be appreciated if Dr. Parkes would advise us if the Research in England and Australia quoted by him offered alternatives to personal counselling to the widows and widowers who have been studied.

Colin Murray Parkes writes: The English bereavement project was carried out at St. Christopher's Hospice where both the counselled and uncounselled bereaved people had the opportunity to attend a monthly social evening. The Australian project offered no such help to either group.

From:

Revd. D. GODWIN,

Hospital Chaplain, Royal East Sussex Hospital

I read with interest the short article "Mental Handicap—a new exploration of grief"; (Spring issue 1983). I have as part of my responsibility as Hospital Chaplain two homes for mentally handicapped people. From time to time I am asked to conduct the funerals of these people. Although staff and relatives (if there are any) usually attend, very rarely do any of the person's fellow residents attend. I suppose that it is thought that a funeral service is hardly suitable and that they will disrupt the service anyway. Yet these people have been, in many cases, the dead person's family for many years, and it is sad that they cannot be together on this occasion.

It is also, I suspect, thought that mentally handicapped people cannot cope with death. Yet in my limited experience, I would suggest that we who are 'normal' have much to learn from the uncluttered straightforward approach of a mentally handicapped person. The film "Being There" with Peter Sellers is well worth seeing on this point.

The mother of a girl in one of our units died in hospital. The girl was never taken to see her mother and when she finally died was not told until some time afterwards. Admittedly this was all done at the request of the girl's father. Judging from the calm reaction to the news of her mother's death, I could not help feeling that she would have coped quite adequately if she had been involved in what was going on.

From:

WYN ROSS,

Newcastle Cruse Committee member

Reading about Oxford Cruse branch's activities in **Bereavement Care** inspired the Barnardo/Cruse Project in Newcastle to look into the possibility of setting up a 'Drop In' Centre for the bereaved.

Soon after we began our search for suitable premises, we were fortunate enough to be provided with the use of a room (once a week) attached to one of the oldest churches in the city, right in the middle of the main shopping area.

Our aim was to provide a street level resource where anyone who has suffered a bereavement, regardless of age, sex and creed could feel welcome. While the emphasis was to be on individual counselling by project workers and trained volunteers we also hoped to make available practical advice along with appropriate D.H.S.S. leaflets.

We decided to keep the publicity at a fairly minimal level initially as we felt that the opening up of such a sensitive area of need required a tentative, low-key approach. So, after modest advertising we opened the doors with very few preconceptions about what would happen!

That was in the middle of last October. Since then the weekly 'Drop In' has developed from a small but steady trickle into a thriving mini community. A considerable proportion of those who came initially for individual counselling have gradually linked up with others and a number of small informal groups have formed themselves within the Centre where the emphasis is on self help and mutual support. We have also tried whenever possible or appropriate to introduce those who come to other community resources e.g. Age Concern, W.E.A., Singles Group.

Gratifying though it has been to see friendships forming and a nucleus of regular attenders, we are anxious to avoid the pit-fall of the 'Drop In' becoming too much of a club. One of our primary aims after all is the welcoming and comforting of bereaved individuals many of whom have reached 'rock bottom' (a frequently heard term) and who have had to muster all their courage to come. Often they are far from ready to 'socialise' and it is important that they do not feel exclusion or pressure from a 'clubby' atmosphere. One of the helpers' tasks therefore is unobtrusively to encourage existing groups to remain small and 'loose'.

To provide for the 'club needs' of those who are ready the 'Drop In' has produced several spin-offs in response to expressed wishes.

The first of these was the Sunday tea club, where the aim was to insert a patch

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about the dead parent, particularly amongst the older children. Over 5s who cried more had fewer and less serious behaviour and emotional problems. ($p = .002$) Treatment was associated with increased crying scores and a decrease in behaviour problems. The other association with good outcome for children in the total group was the well-being of the surviving parent and on measures of parental mood at follow up (a composite score of present grief, worry, depression and suicidal thoughts) the treatment families did better than controls. This also applied to the physical health of the parents. On the whole the surviving mothers did worse on our measures than the fathers, and since there were more mothers in the control group, we corrected for this in our analysis.

When we came to examine the second year follow up results, most of our significant findings had disappeared, although I want to emphasise that we are still analysing this data and these findings are provisional. Table 2: Treated children at second year follow up had fewer behaviour changes since bereavement and are talking more about the dead parents. Their parents are in better physical health, but there is one finding that goes contrary to expectation. The younger children's health is worse in the treatment than the controls although not significantly so. However that is the only unexpected finding. Although there are few significant results, the vast majority of findings again tend in the desired direction. The majority of bereaved children are doing well by the second year follow up and by that time there are few differences between the treatment and control groups. Whereas at the first year post-bereavement about half our sample had troubling and troublesome behaviour changes this had reduced to about 20% by two years. Treatment appears to have shortened the duration of behaviour problems—at the first year follow up 21% of the treatment group had behaviour changes compared with 41% of the controls ($p = .05$). Treatment may have been more effective for the parents than for the children. The parents certainly felt this to be so and the benefits for the parents persisted longer than for the children.

There are many possible reasons for the attenuation of our differences. One possibility is that the controls who refused second follow up were different, perhaps worse than the acceptors. We do have some knowledge about them from first year follow up data and the refusals certainly had worse behaviour problems and worse child health. Their parents were also rated worse in physical health and depression at first follow up. Interestingly none of the children were reported as crying about the dead parent at first follow up amongst these refusers. It is likely therefore that this group would have done worse than the acceptors; since they represented a quarter of the control group, their absence has distorted the findings of second year follow up.

Other possible reasons for the improvement in outcome is that intervening variables modified results differentially. For example the treatment group had far more deaths in the family than the controls after the initial bereavement. One important reason for the attenuation of differences over time may have been that the nature and duration of our intervention was not optimal and I think that this was an important factor. Our design was an arbitrary one.

For many of our families six visits were not enough. Their needs went far deeper than this rather superficial intervention could supply. It may be that it would be more economical or effective to work only with the parent or to use some other method of intervention. What we can say is that we were able, using a brief intervention, to shorten the period of distress in children bereaved of a parent and that our techniques which were aimed at promoting grief in children, far from harming them, appears to have been the factor which was associated with good outcome, at least in the short term. The intervention was appreciated particularly by the parents as their wholehearted co-operation shows.

Perhaps most significantly, by the first year follow up 25% of the control group had found their way to other forms of psychological help whereas none of the treatment group had felt the need of anything other than our intervention. I think we now have modest evidence that an intervention designed to promote grief in children and enhance communication in families can help prevent short term distress following bereavement and appears to be free from harmful effects.

TABLE 1 **First year: Summary of significant differences between treatment and control groups**

Treated children at 1st year follow up:—

1. Had fewer and more transient behaviour problems.
2. Had fewer post-bereavement sleep problems.
3. Had better health.
4. Cried more about the dead parent.
5. More often talked about the dead parent.
6. Were less restless.
7. Had fewer learning problems.

Treated parents at 1st year follow up:—

1. Mood was less depressed.
2. Had better physical health.
3. Sought less help from other professionals.

TABLE 2 **Second year: Summary of significant differences**

Treated children at 2nd year follow up:—

1. Had fewer behaviour changes since bereavement.
2. Talked more about the dead parent.

Treated parents at 2nd year follow up:—

1. Had less depressed mood.
2. Had better physical health.

REFERENCES

1. **Black, D. (1978)** Annotation. The Bereaved Child. J. *Child Psychol. Psychiat.*, 19, 287-292.
2. **Black, D. and Urbanowicz, M.A. (In press)** Bereaved children and family interventions. *Aspects of Current Child Psychiatry Research.* *ed* Stevenson J., Pergamon, Oxford.
3. **Elizur, E. & Kaffman, M. (1982)** Children's bereavement reaction. II J. Amer Acad. *Child Psychiatry*, 21, 5: 474-480.
4. **Kaffman, M. & Elizur, E. (1979)** Children's bereavement reactions following death of the father. *Int. J. Fam. Ther.* 1:3, 203-229.
5. **Raphael, B. (1982)** The young child and the death of a parent in *The Place of Attachment in Human Behaviour ed* Parkes, C. M., and Stevenson-Hinde, J., Tavistock, London.
6. **Van Eerdewegh, M. M., Bieri, M. D., Parrilla, R. H., and Clayton, P. J. (1982)** The bereaved child. *Brit. J. .Psychiat.*, 140, 23-29.

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