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

continued on p.11

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

continued overleaf

BEREAVEMENT BY SUICIDE

by

Dr. Susan Henley

BSc. PhD, ABPsS

The effect of a suicidal death upon surviving relatives

This is a summary of a literature search on behalf of Cruse's research sub-committee to help it decide the next major research project

There have been surprisingly few systematic investigations of the effects of a suicidal death upon surviving relatives. However, the evidence available—most of it from clinical case studies—is consistent with the view expressed by a number of writers [1, 2, 8, 11, 14, 17, 18, 19, 20] that bereavement following suicide is more devastating than that following other forms of death.

Effect of Suicide Upon a Spouse

Spouses bereaved by suicide encounter numerous difficulties over and above those normally associated with natural or accidental death [4].

A major source of problems is the widespread assumption that if an individual commits suicide someone must be 'to blame'. This attitude is manifested in negative social reactions—towards surviving relatives in general, and spouses in particular—which range from a failure to offer emotional support and practical assistance, through active avoidance, to downright hostility, accusations and ostracism [4, 6, 7, 14, 17, 22, 24, 25, 26, 27].

The most serious consequence of this lack of social support and actual or anticipated blame appears to be massive avoidance of communication regarding the suicide. Quite apart from the negative effects it may have upon surviving children (see below), this virtually prevents the working through of mourning by the spouse, not least because it limits opportunities for dealing with and eventually resolving, the intense and irrational guilts to which spouses bereaved by suicide seem particularly prone [4, 27].

Evidence of increased pathology [4, 13] among spouses bereaved by suicide becomes even less remarkable when, in addition to difficulties associated with the actual death, account is taken of the continuous, often prolonged stress to which many of them have been exposed as a result of the abnormal aspects of their partners' pre-death behaviour and psychological and physical functioning. (The husbands of one supposedly random sample of 12 suicide widows included a heroin addict, alcoholics, a polio cripple, a stroke victim, victims of work 'accidents' and a twice would-be suicide). Under such circumstances signs of disturbance are perhaps predictable.

Among recurrent patterns of disturbance observed in surviving spouses by Cain and Fast (1966) were:

(a) attempts to undo and repair the past, either by remarriage to a 'damaged object' (in several cases new spouses were either chronically ill, grossly physically handicapped, or handicapped in some other way) or, in the case of professional people, by means of elaborate, only marginally conceivable 'world rescue' plans, pursued with a near fanaticism often to the detriment of the person's other interests, responsibilities, and professional reputation.

(b) openly self destructive impulses and behaviours.

(c) projection on to a new partner of the complaints, grievances and accusations—real or imagined—of the person's previous partner against him.

(d) 'repetition compulsion', or what appeared to be an unconscious attraction to other suicidal persons.

Self destructive behaviours among spouses of suicides have also been reported by Wallace (1973).

However, Hindley [10] claimed to have found that, after a year some widows of suicides showed less disturbance than the normally bereaved. As Parkes has pointed out (personal communication, 1983), this could be interpreted as evidence that, while the effects of a suicide upon survivors may be disastrous in many cases, there are some philanthropic suicides which may be an overall blessing to the survivors.

Effects of a Parent Suicide upon Surviving Children

Consistent with what one might expect, high rates of psychological morbidity have been found among children bereaved of a parent by suicide [23].

In a study of 45 **disturbed** children, one of whose parents had committed suicide, Cain and Fast (1966) found the full gamut of symptom pictures. Many of the observed pathological reactions appeared to derive from three main

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Postbag, *continued*

of warmth and sympathy into what is for many bereaved people a desperately bleak day. This has been a particularly happy and rewarding enterprise and our Sunday afternoons have a genuine family feel about them, with a glowing Calor Gas fire, home-made scones, cakes, etc. It has also given the opportunity to those who feel that they no longer had a reason to do the traditional North East weekend bake to take it up again and share with others. Incidentally, it is 'Eddie', one of our widowers, who is our star cake maker—**not** such a North Eastern tradition!

Another valuable extension of the 'Drop In' is a weekly swimming session at a local leisure centre. This has now become known as the 'Plop In'. The idea was formed when 'Kathy', who has suffered from chronic depression since her husband died eight years ago, happened to say that the only thing she had ever been any good at was swimming. She was immediately appointed the 'expert' and a few weeks later the 'Plop In' was launched amidst shrieks of laughter, and considerable courage on the part of those of us worried about our shape, size and dignity! The result has been that Kathy, for the first time in many years, finds herself in a dominant role and there have been therapeutic benefits for all of us in terms of exercise, laughter and self acceptance.

We hope that this is just the beginning of a series of activities revolving around the 'Drop In' which will foster the growth of the 'rebuilding' skills which many bereaved people need so much.