VIEWPOINT

Bereavement
Journal of grief and responses to death

How was your lockdown? Reflections of a therapist during the Covid-19 pandemic

Julia Samuel

Vice President, BACP; Founder Patron, Child Bereavement UK

www.juliasamuel.co.uk

Keywords:
lockdown, therapy, grief, debrief

I am regularly asked 'how was your lockdown?' It is a good question. My brief answer is that I was busy. I did not make sourdough or learn to play an instrument; I worked. Harder than I have ever worked before.

In this article I would like to explore what that meant at a deeper level, both psychologically and practically; as a therapist, a woman and my multiple other roles. What were my challenges and what helped me keep my head above water? What have I learnt? I write this in the frame that 'the personal is the most universal,' the wise words of Carl Rogers, in the hope that you will identify aspects of yourself in my experience that may resonate with you, or not. Whatever your response is, it might give you insight for your own reflections – on your role in this broad field of bereavement care and research.

*

In my training, when asked that familiar question, 'why did I want to be a therapist?' I moved quickly from that common, and not inaccurate, understanding 'I want to help people, I like being needed' to recognising that I gave what I most wanted to receive. Additionally, I became aware that being in meaningful relationship was profoundly important to me. My curiosity was fired by what was going on below the surface, rather than what people showed. I came to see that being a therapist was by no means an altruistic endeavour but one that met my needs as well as having the satisfying aim of supporting my clients. The roots of this was certainly in my childhood and of course, being human; we are wired to relate and connect. For over 30 years in my supervision and therapy I regularly negotiate how those forces influence my practice. The reason I tell you this is that the pandemic turned the volume up on all those responses. In the crisis I had a greater drive to want to help, to meet the needs of others and form close relationships.

This initially showed itself by me offering to support a UK National Health Service (NHS) team of medical staff working in an intensive care unit. Two consultants liaised with me, and we decided on two lunchtime slots, of an hour, every week. I would be one side of the Zoom call and the team would be in the staffroom talking to me through a phone; taking it in turns to express the full gambit of emotion that you can imagine someone would feel in that situation. For confidentiality reasons I can only tell you my experience.

I gained a lot from being useful. Being part of the NHS, even in this tiny way, gave me a sense of belonging and purpose as we faced this crisis, which anchored me. Fortunately, I was able to draw on decades of experience supporting medical staff

in the NHS, which has left large reserves of respect and warmth for all health professionals. Those foundational responses stayed with me throughout the tumult of the work and centred me – and I think were felt by the team. We quickly developed the underlying key to a therapeutic relationship – trust – and formed a working alliance.

It was intense. My journal reminds me of some of my process: 'I always feel bad that somehow I can't offer enough, but I was glad they talked … so touched by the care they give patients.' Another one: 'I was proud today, excellent session … they were emotionally honest, and it felt an important part of keeping the team together … we discussed some useful coping strategies.' Or, 'a painful session, I was tense, worried that we all felt worse afterwards!' There were nights I woke with anxiety from difficult images and stories. Wonderful moments of black humour, raucous laughter, which sparked warmth and connection and a defence yes, but also a healthy protection in the face of the difficulties.

The pandemic had thrown us all into an alien and frightening landscape of grief. Grief is a messy, chaotic, unpredictable, subjective business. It often switches our autonomic nervous system to code red. Part of my professional practice is to find ways to keep myself centred when those I'm working with are suffering. I use habits like exercise to balance me: also theories as frameworks to turn to help me understand what is going on in the therapy. My pivotal theory is the dual process model (Stroebe & Schut, 1999). I like the dynamic oscillation between restoration orientation and loss orientation, the movement between the two. Allowing people to confront their pain and in restoration to avoid it. Often people describe grief as hitting them in waves. This theory allows for that, and allows for our natural survival mechanism, giving ourselves opportunities to have a break from the pain, to be distracted, have a plan, and most importantly have hope. It is hope that turns a life around. It discusses gender norms; men tend to be restoration oriented, and women tend to be loss oriented. I describe this theory to clients and told the ICU team about it; they too found it helpful to have a theory that helped them understand and accept themselves.

As I reflected then, and with more clarity now, the team was my client. There was a parallel process. I felt as powerless as them in the face of multiple difficult and traumatic deaths. (Of course, they saved many lives as well.) We were all in the helping profession, we wanted to make a difference and in our own way had to recognise the limits of what we could offer; accept that simply being present is of value – important. The curative power of listening, witnessing, being alongside someone, offering heartfelt care. Although working with many people was more of a psychological juggle, and it was therapeutic rather than therapy, I drew on similar knowledge, skills and practice that I would with a one-to-one client.

The emotional turmoil they lived was transferred through the screen to me, bodily. I felt surges of fear which I acknowledged: 'gosh that's frightening to even hear, it must have been…' and breathed into it, allow, but not act on. It was my job to hold steady, to listen, be an empathic presence who named the team's process; explore their individual difficulties, listen as they expressed their feelings, gain insight and through the collective sharing a normalisation of what they felt – they weren't failing by being distressed. Helping them recognise not to conflate their feeling with fact; they may feel they've failed if someone dies, but that does not make it so. Those responses are common in my one-to-one therapy too. Often the first step with a client is letting them know that however 'mad' or 'bad' they might feel, what they are feeling is normal in grief. Rather than self-attack, which can be a cruel default response in grief, encourage them to hold the messages from both their head and heart side by side. Hold the discomfort of feeling guilty while knowing they aren't actually guilty.

The team had to go straight from the session into the intensive care unit, so it was important to find a balance. As with all therapy it was a dance, of moving in and out – allowing and letting go. Using myself as a reference point as to what was going on. Trusting my instincts on how to respond, some worked, some didn't – I'd check what I missed and reconnect. Sometimes offering practical ideas; demonstrating breathing exercises, suggesting walks in nature. Using my voice and presence to contain strong feelings. It was turbulent, with missteps from me, but overall we did what we contracted to do: emotionally support the individuals in the team, which built resilience in the whole team, to manage themselves as they worked in the ICU.

Comparing this to my individual clients; I would explore at greater depth their internal process, perhaps use Gendlin's (1982) felt sense to help

them access their bodily wisdom. Working to align their mind–body connection, to find both the narrative they are telling themselves and what the emotional signals their body is transmitting to them mean. Creating a safe place where they come to trust that, as difficult as it is, pain is the agent of change. That paradoxically by allowing themselves to feel the pain of loss, voice it, express it, is what over time allows them to heal. It is what they do to block and anesthetise their pain; alcohol, food, sex, or busyness to name but a few, that over time leads to long-term negative consequences.

*

The demand in my private practice was immense. My experience was that my clients' pre-existing difficulties were intensified. If they had anxiety their fear ramped up. If they were grieving, having their usual social support and structures removed overnight meant many fell into despair. Some clients were dying which meant the very precious time they had left was not spent with their children or grandchildren, their last chance to be present at significant events was cancelled. Everything medical was supremely challenging.

Those new clients who were bereaved through Covid suffered traumatic grief; not being at the bedside, or the graveside, having no rituals or connected support. Their sense of frozen surreal grief, agonising as it was, is only now beginning to thaw. It will be a long road.

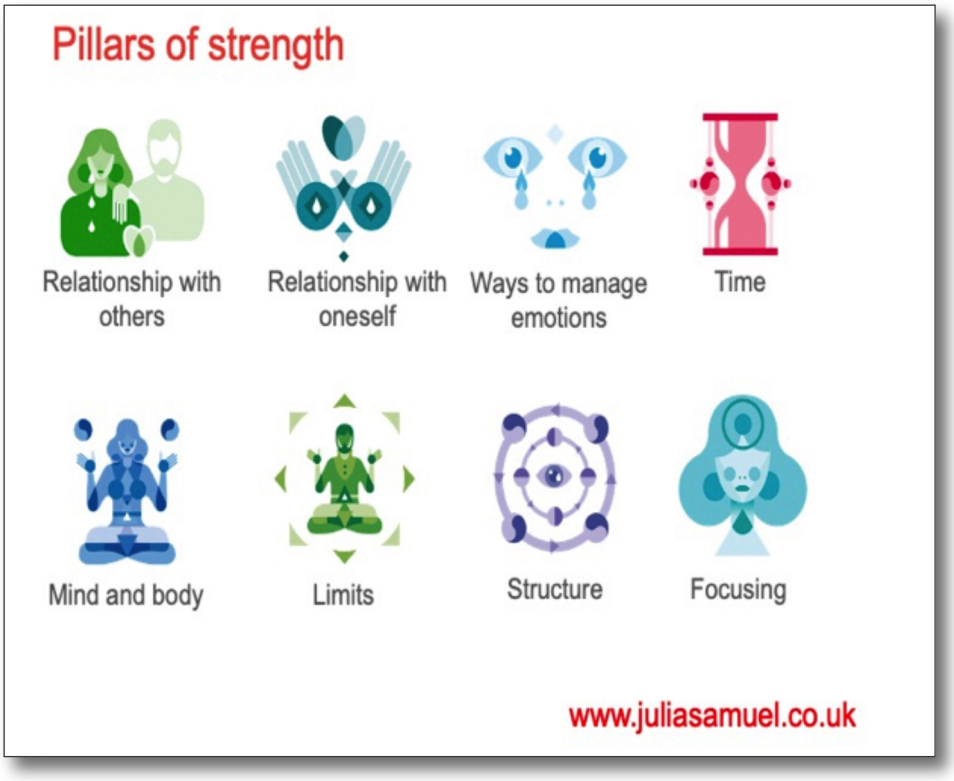
To sum it up, I saw more suffering in the last 18 months than I have seen in my three decades as a therapist. It was devastating. And their suffering was invisible, locked away in people's minds and homes. The mental health pandemic running beneath the health pandemic. I believe the greatest psychological pain was inflicted by the isolation. When people we love die, we need the love of others to help us survive. Their presence, their hugs and, yes, their dishes of lasagne. The path to recovery in grief needs to be paved with people and in the time of Covid it was a chilly emptiness. The fallout has not been reckoned with and I have no doubt it will inform the content of our therapy rooms for years ahead.

*

To finish on a personal note. I was unquestionably seduced by being needed; when I felt most overwhelmed by my own fear being busy and useful was my defence to cope with it. I see again (not exactly rocket science) that under duress I, and most of us, revert to default modes of coping, and in the future really clocking that early might enable me to make better informed choices.

I paid a price for being that busy. I didn't see my family as much as I would have liked. I wondered, did my clients get the best of me, with my family getting the dregs? I felt guilty and it echoed earlier guilt as a parent.

On the positive side I have good habits that enable me to stay sane and healthy. They are based on my 8 Pillars of Strength (see below) where I take lots of exercise, meditate, and am self-compassionate. My time boundaries held. I always stopped work at a reasonable hour. I ate with my family, watched a great deal of only happy television (much to my husband's irritation), and laughed and hugged – a lot. That physical holding was emotionally vital for me.



What have I learnt? To state the obvious, crises are a complex, extreme business. I found it demanding and rewarding in equal measure. I need to pay attention to how seduced I can be by my work. It has magnified my respect for the power of the human spirit. I am in awe of my clients, for both expressing their pain and their strength.

How we spend our days is how we spend our lives, time is precious. Use it mindfully.

I believe more profoundly that love is what matters most.

Fundamentally I am grateful for being in a profession that I truly love. To quote Freud, 'Love and work, work and love is all there is.'

References

Gendling E (1982) *Focusing*. Bantam Books.

Stroebe MS & Schut HAW (1999) The dual process model of coping with bereavement: rationale and description. *Death studies*, 23(3) 197–224.

Further reading/resources

Action for Happiness www.actionforhappiness.org

Beattie G (2004) Visible thoughts: the new psychology of body language. Routledge.

Ben-Shahar T (2011) *Happier: Learn the secrets to daily joy and lasting fulfillment*. McGraw Hill.

British Psychological Society (2008) 2008 *psychological debriefing* www.who.int/mental_health/mhgap/evidence/resource/other_complaints_q5.pdf?ua=1

Damasio A (1999) *The feeling of what happens: Body, emotion and the making of consciousness.* Heinemann.

Department of Health (2005) *When a patient dies*. https://bereavementupdate.blogspot.com/2005/12/department-of-health-uk-when-patient.html

Duhigg C (2012) *The power of habit.* Random House.

Gibbs (1998) Reflection model. www.ed.ac.uk/reflection/reflectors-toolkit/reflecting-on-experience/gibbs-reflective-cycle

Kabat-Zinn J 2012 *Mindfulness for Beginners: Reclaiming the Present Moment-and Your Life.* Sounds True.

Kabat-Zinn J (2001) *Full catastrophe living: How to cope with stress, pain and illness using mindfulness meditation.* Doubleday.

Mehrabian A (1972) *Nonverbal communication*. Aldine-Atherton.

Mind (2017) *Food and mood.* www.mind.org.uk/information-support/tips-for-everyday-living/food-and-mood/about-food-and-mood

Pennebaker JW (2004) *Writing to heal: A guided journal for recovering from trauma and emotional upheaval.* New Harbinger Press.

Pennebaker JW (1997) *Opening up: The healing power of expressing emotion.* Guilford Press.

Samuel J (2017) *Grief works: Stories of life, death and surviving.* Penguin.

Schut HAW, Stroebe MS, Boelen PA & Zijerveld AM (2006) Continuing relationships with the deceased: Disentangling bonds and grief. *Death Studies*, 30, 757–766.

Schore A (2003) *Regulation and the repair of the self*. Norton Books.

Tedeschi RG & Calhoun LG (2012) *Resilience: the science of mastering life's greatest challenges*. Cambridge University Press.