

contributed to the development of that complex body of knowledge which is Attachment Theory. Bowlby drew on these and many other sources for the three volumes of *Attachment and Loss* (published in 1969, 1973, and 1980), a work which will remain a lasting influence on all who study the nature of love relationships.

Within the last year he wrote an epilogue to *Attachment Across the Life Cycle*, a tribute to his work to which many of the researchers who were influenced by him

have contributed (Eds. Parkes, Stevenson-Hinde, and Peter Marris). He also saw the publication of his own scholarly biography of his leading light, *Charles Darwin*. He remained, to the end of his life, an active, clear-thinking, and rigorous scientist whose fierce determination to find a rational basis for understanding and treating the problems of children and parents contrasted with the gentleness, patience and kindness, which endeared him to all who knew him. Bowlby seldom used the word

'love', considering it too laden with emotional connotations to be scientific. Yet, the fundamental message of his work is that in all caring relationships including that of therapist and patient, the essential ingredient is a form of attachment which provides security without sacrificing autonomy and this, in the end, is the basis of mature love.

Dr. Colln Murray Parkes, MD, FRCPsych
Senior Lecturer in Psychiatry

A Bereavement Group for Children

Susan Kitchener, CQSW
Social Worker, Northamptonshire
Social Services

Sr. Margaret Pennells, MA
Social Worker, Child and Family
Guidance Service, Northampton



Susan Kitchener



Sr Margaret Pennells

Introduction

In the space of one week several referrals to our Child and Family Guidance Service concerned children with behavioural and emotional problems related to recent family bereavements. This led our team to consider how best to approach these cases, and we decided to use group work methods.

Usually the most favoured treatment methods include individual counselling and family therapy^{1,2}. However, we chose group work because groups help to alleviate the feeling of isolation, increase self esteem and give reassurance of not being alone³. More importantly, group work gives peer group support.

Planning

Five children were referred to the group, comprising two sets of siblings whose mother had died within the previous six months and one child whose sibling died two years before. Four of the children were aged between eight and nine, and one was a six-year-old whom we considered mature enough to fit in with the group.

We decided it would be a closed group over a period of eight weeks. As well as the commitment to these weekly sessions, we requested three sessions with each family to be held at the beginning, middle and end of the sequence of sessions. Aware of our own need for supervision, we planned some sessions with a consultant psychiatrist.

Aims

The overall aims and objectives of our group were:

1. To help the survivor express the effect of the loss

2. To increase the reality of the loss
3. To provide the opportunity to voice fears and concerns and to create opportunity to acquire knowledge

4. To foster a sense of mutual identity and support

5. To encourage healthy withdrawal from the deceased

6. To aid readjustment after loss: to seek new relationships, adjust to a new position in family or adjust to a substitute family.

We planned each session to include games designed to facilitate sharing, confidence building, self-disclosure, trust, or relaxation, etc. Games would also help to channel energy which otherwise might be destructive to the group. Food and drink would be provided, with the children helping to give this out as a symbol of sharing and comfort. All sessions were to include some animation, e.g. art work, writing, movements and role-play.

We planned eight sessions as follows:

Session 1.

Aim: Joining Process.

1. Food and drink.

2. Introduction of workers and group members.

3. Explanation of group's purpose, the work it will involve, the safety and comfort we hope to provide, and the rules that help make it a safe place e.g. confidentiality, no fighting, respecting others and the building. Invited questions from members and rules they felt important.

4. Explanation of 'place-mats'. A poster was devised representing the eight sessions, the aim being for each child to complete each section by drawing what the group had represented to them on that occasion. When the sequence was finished the children would keep their 'place-mats' to symbolise their place in the process they had gone through.

5. Introductory games/ice-breakers⁴.

6. Introduction of 'Good News—Bad News', i.e. what good and bad things had happened during the week.

7. 'Place-mat'.

8. Introduction of next week's topic. Children were asked to bring a memento (link object) of their deceased.

Session 2.

Aim: Beginning to actualise the loss. Revive positive memories of the deceased.

1. Food and drink with 'Good News—Bad News'.

2. Introduction of memory revival by reading story to group⁵. Short discussion of feelings aroused by story.

3. Link object. Each member discussed what the object was, why they kept it, memories it aroused, etc.

4. Activity—drew pictures of happy times with deceased and shared them.

5. 'Place-mat'.

Session 3.

Aims: Identifying and expressing feelings about the death. Begin to focus on negative feelings. Mutual identity and group support.

1. Food and drink with 'Good News—Bad News'.

2. Recapped on last session's good memories then introduced other, more negative feelings.

3. Brain-stormed negative feelings and made list. Each member talked about the circumstances of the death of their relative, others encouraged to ask questions and make comments.

4. Activity. Each given sheet of three blank faces⁶ and asked to draw in the three negative feelings they felt the most.

5. 'Place-mat'.

Session 4.

Aim: Continuation of Session 3.

1. Food and drink with 'Good News—Bad News'.

2. The list of feelings drawn up in Session 3 had been transferred onto cards, one for each feeling, which were scattered around the floor. Children were asked to select the feelings they identified with the most, and from these they were to choose two to talk about to the group.

3. Activity: Emotions Game⁴. (Leaders asked children to act out chosen emotions.) Games to relieve tension.

4. 'Place-mats'.

Session 5.

Aim: Talk about the facts and fantasies. Increase the children's understanding of death.

1. Food and drink with 'Good News—Bad News'.

2. Brain-storm the meaning of words: Goodbye, unknown, death. Discussion of issues raised.

3. Activity—draw or paint what frightened them about death and discuss in group.
4. Games to relieve tension.
5. 'Place-mats'.

Session 6.

Continuation of Session 5.

1. Food and drink with 'Good News—Bad News'.
2. Draw worst nightmare and discuss in group.
3. Talk about fears and worries, worst things that could happen to them, what would they do, how would they cope. (Designed to uncover worries about their own mortality, being orphaned, own health, etc.).
4. Games to relieve tension.
5. 'Place-mats'.

Session 7.

Aim: Focus on the here and now problems resulting from their bereavement. (Activity based).

1. Food and drink with 'Good News—Bad News'.
2. Role-Plays designed to combat problems raised by the children concerning their peer relationships and redirection of aggressive feelings. Coping with nightmares.
3. 'Place-mats'.
4. Games.

Session 8.

Aim: The future. Goodbye and fun.

1. Re-cap on all sessions and work done. Feedback to children on their progress and hard work. Final section of 'place-mat' devoted to drawing their future, how they see themselves in one year.
2. Party with games.
3. Final goodbyes.

Evaluation

To help us with evaluation, we compiled a group report at the end of each session, plus individual reports on each child.

Individual reports allowed us an in-depth look at the way the children operated within the group and helped us to plan future work with them. We found these useful in compiling reports which informed the referrers of the outcome of the treatment. Equally, meeting to record immediately after each session helped us let off steam.

In addition to the reports, we devised a behavioural checklist which we sent to parents and schools at the beginning and end of the sequence. We asked them to rate behaviour according to the severity they perceived at the time. This enabled us to see whether the presenting behaviour had in-

creased, decreased or stopped altogether. We found that some behavioural problems (e.g. aggression) remained largely unchanged, but some emotional problems (e.g. nightmares and enuresis) had significantly decreased.

Of particular value were the meetings we held with each of the families. Our first session was to discuss with them the aims and objectives of the group, so they had some knowledge of the programme to equip them to deal with any issues the children brought back from the group. We talked about confidentiality and the parents' own needs for bereavement counselling.

The midway meeting was used as an evaluation point. It gave a chance for the families to feed back any problems they had encountered with attendance at the group. We also gave the children the opportunity to say whether they found any value or not in coming to the group and whether they wished to continue attending. One child chose not to return. At the time it seemed important to allow the children choice. However, after discussion and consultation we became uncertain whether it is appropriate to allow opting out and therefore to allow issues to go unchallenged.

Our final family session, which also included the referrers, was used to discuss the changes that had taken place in the individual and in the family as a whole.

In evaluating the experience ourselves, we felt that the overall content of the sessions largely fulfilled our original aims. However, we recognised that:

- (a) The task sometimes had to be abandoned in order to concentrate on the needs of the individual. This produced pressure on us in running such a structured, time-limited group.
- (b) It became increasingly obvious that eight sessions were too short a time sequence. However, we had at least begun a process which allowed

the children to look at their feelings and frustrations. Secondly, one hour was too short, and we felt that 1½-1½ hours would have been preferable.

In setting up our second group we took account of these particular points and extended the number of sessions from eight to 12. We also expanded the time to 1½ hours which we found less pressured and gave us the opportunity to try out new mediums.

We included the use of music, fantasy and relaxation, as well as providing a sealed question box and a visit to a local cemetery. These proved most helpful. The question box provided the opportunity for the children to write down things they were afraid to ask aloud, e.g. 'Where does your body go when you die?', 'What is God like?', 'How do they feel now?'. The visit to the cemetery gave the children the chance to look around and explore other graves in a more factual way, which relieved the tensions and fears normally associated with visiting the graves of their relatives.

Our next challenge is to run a further group for teenagers where our programme will need to be redesigned to meet their developmental stage.

In conclusion we feel that the main benefits of group work are those expressed by the children, i.e. the opportunity to share with others in a similar situation, the support this gave and the resulting reduction of isolation. As these had been our original aims we feel, overall, that the group approach is beneficial and worthwhile.

References

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REVIEW

AIDS—A GUIDE TO CLINICAL COUNSELLING

Riva Miller and Robert Bor.

London: Science Press, 1988.

The change in name and function which Cruse has recently undergone has meant that more Cruse counsellors will, from time to time, be counselling people who have been bereaved of someone who died from AIDS, or who are themselves HIV-positive and facing the prospect of their own death.

The circumstances which surround a death clearly have an influence on the subsequent grief process and this guide to counselling in the clinical setting is a valuable addition to the mass of literature relating to AIDS which is flooding onto the

market at present. The book provides a valuable overview of the clinical aspects of AIDS/HIV+ by a consultant haematologist working with haemophiliac patients. This helps to put the entire topic into a much broader framework than that usually presented, and the guidance for counselling benefits greatly from this.

There are sections defining the aims of a counselling session together with the theoretical framework for the counselling model offered, which is rooted very much in the techniques developed at the Milan Centre for Family Therapy. Thus emphasis is placed on the reciprocity of relationships and a 'system' approach to what is happening within the family unit. An outline is provided of the sort of issues which might

arise in a counselling interview, with a bias towards the pre-testing and post-testing phase of the illness. There is a wide variety of case illustrations, and a section on 'Bereavement: Working with Survivors' is to be found on pages 93-4 (not 97-8 as in the index). The approach of this section, and indeed of the entire book, is 'pithy' but helpful.

Those in Cruse and elsewhere who feel unsure of how to approach the counselling of people who have, or think they might have, AIDS or be HIV+, will find this book a valuable introduction. It deals with many of the issues of which they need to be aware.

Revd. Peter Speck
Chaplain, Royal Free Hospital, London.