

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.

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