References

1. A much fuller version of this article may be found in: Walter T. War Grave Pilgrimage. In: Reader I, Walter T (eds). Pilgrimage in Popular Culture. London: Macmillan, 1993.
2. The Commonwealth War Graves Commission, which is at 2 Marlow Road, Maidenhead, Berkshire SL6 7DX (0628-34221), welcomes enquiries about particular graves.
3. Most of the World War II tours are offered by: Major and Mrs Holt's Battlefield Tours, 15 Market Street, Sandwich, Kent CT13 9DA (0304-612248); Galina International Battlefield Tours, 711 Beverley High Road, Hull HU6 7JN (0482-804409/806020); and Milestone Tours, 37A Outram Street, Sutton-in-Ashfield, Notts NG17 4BA (0623-517275).
4. Details from the Royal British Legion, Royal British Legion Village, Aylesford, Kent ME20 7NX (0622-716729/716182/717172).
5. Brittain V. Testament of Youth. London: Gollancz, 1933.
6. Society of St Barnabas. The Menin Gate Pilgrimage 1927. Printed Pilgrimage Souvenir.
7. Pain T. Say Goodbye to Granddad. *Guardian* 3-4 November 1990.
8. British Legion. A Souvenir of the Battlefields Pilgrimage 1928. Printed Pilgrimage Souvenir; pp45,134.
9. BBC. The Local Network, Radio 4. 18 September 1990.
10. Society of St Barnabas. The Menin Gate Pilgrimage 1927. Printed Pilgrimage Souvenir; p36.

Directive grief treatment in a group setting

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Over the past ten years we have developed a therapeutic method for people who have suffered a complicated trauma or loss so that they need professional help to work through their grief.

INDIVIDUAL ATTENTION

Our method, 'directive grief treatment in groups', consists of individual, short-term grief therapy in a group setting and is geared towards people who have suffered all kinds of bereavements. They may have lost loved ones through death or divorce, been struck by severe illness, or blinded or disabled in other ways. They may be suffering feelings of loss as the parents of a handicapped child or have been the victims of violent assault, traffic accidents or natural disasters.

The method was initiated in the Student Counselling Centre, Copenhagen, and later further developed in a setting where the treatment was offered free of charge to the general public (a research and training project financed jointly by the Copenhagen Municipality and a private foundation).[1] Since 1983 we have been running intensive training programmes on it for professionals. Our method has been found useful in many different settings, such as municipal welfare offices, general hospitals, counselling clinics of the Danish Cancer Society and the Danish Society for the Blind, student counselling centres and in institutions for treatment of psychotic children.

Obviously not everyone who experiences a loss needs treatment, though even those people who are able to grieve in a healthy way may lack a network with sufficient maturity and understanding to support them through the painful grief work. A self-help group can be very beneficial for these people. However, many self-help groups are burdened, or even disturbed, by members who are suffering from pathological grief who may, typically, have suffered very

EDITOR'S NOTE

Despite all the research and counselling that has been provided for bereaved people in recent years, there is still a great need for well-conceived group work to be developed. Groups can be large or small, open or closed, structured or unstructured, directive or un-directive, selected or unselected, led or leaderless (self-help), short, medium or 'marathon' in duration. Group leaders may be psychologists, social workers or lay people with a variety of theoretical orientations. If we are to choose between these bewildering alternatives we need accurate descriptions and evaluations of each approach. In this paper from Holland the authors describe their own method of providing short, focused, directive, open groups led by two therapists for people with a range of losses.

traumatic losses (suicide, or more than one bereavement within a short time), or have a background of unresolved losses, or have had a symbiotic or highly ambivalent attachment to the dead person. Even a well-functioning, self-help group in this situation may lose its healing power, but in our treatment group we can help these people by focusing exclusively on each client's losses or traumas.

Attachment, loss and grief

No-one who has suffered a major loss will ever be the same person again; it has been important for us to look for a deeper understanding of this. In our experience, the wound caused by a loss creates a dramatic turning point at which the mourner may follow a path either towards greater strength and personal freedom or towards a more cramped and neurotic life-style than before. It has become progressively clear to us that looking at the process of grief means focusing on some of the deepest layers of the personality (the process of individuation) to understand why some people emerge from grief with greater strength and wisdom, while others become strained, depressed, anxiety-ridden or develop psychosomatic symptoms. It is of great importance for professionals to be able to recognise symptoms of avoided and chronic grief and thus to be able to indentify those who are in danger of developing pathological grief.

Bereavement injures our feeling of affinity and attachment to others, and affects us vitally. It is therefore very understandable that people who have previously had difficulties in their attachment process also have problems living through the emotions of grief in a healing way. It is hard for them to say goodbye to one of their dear ones or to former life conditions and to welcome new contacts. They may also have problems in making efficient use of a network, which can have consequences for the way in which their grief work proceeds.

Bereavement and the role of weeping

Colin Murray Parkes[2,3] and John Bowlby[4] agree that part of the mourner's behaviour may be understood as an attempt to make contact with, or in some unconscious way to hold on to, the deceased. Weeping may thus be a way of summoning the deceased just as the baby cries to summon his mother.

In our work the great importance of weeping in the grief process has become more and more evident. Weeping may have various purposes. The calling weeping, which Bowlby described,[4] is an attempt to hold on to the person or thing that has been lost. It is a rather shallow weeping, with rapid breathing, and it does not bring the same relief as does the deep weeping, the sobbing, which occurs when the bereaved begin to let go of their attachment to the deceased. Thus human beings have what we in our book *Healing Pain* call both a 'calling' weeping and a 'letting-go' weeping.[1]

Human beings are born with an ability to reduce stress through weeping, but this is increasingly obstructed for most people as they grow up. Most children are taught to `control themselves' and some have, by the time they become adults, lost the ability to reduce stress through weeping. Others can be tearful, but without ever daring to give way to a releasing weep. Some of these people will weep often, but never achieve any true relief.

The weeping that heals in a profound way is the deep sobbing in which, like a baby, the tension of the body is released. If a person says that he has wept for hours, or that he still feels tense after weeping, we know that his tears are 'calling' weeping. 'Letting-go' weeping can, in our experience, only last 5-10 minutes, after which the mourner is exhausted, relaxed and feels some relief from the pain, at least for some time. Deep, relieving weeping does not appear until the mourner is, to some extent, ready to let go of what he has lost.

Why do so many people avoid deep weeping? Is it only because they learned as children that it is not the done thing to cry? Or is it also because they are afraid of getting into a state that reminds them of the time when, as infants, they were helpless and dependent on other people, a time when they fought to overcome feelings of chaos by attaching themselves to their mother? We know that human beings have a strong need to feel in control and to have meaning in their lives, and yet it is a fact that facing chaos and the uncontrollable in life can give us strength and courage. We learn to deal with the existential concern - death, existential isolation, meaninglessness and personal freedom.[5]

Undoing childhood deprivations through grief work

Particularly when a parent, spouse or child has been lost, it is our hypothesis that part of the grieving is for unmet emotional needs from childhood, needs that the person has been hoping, ever since, to have satisfied by those closest to him, one of whom has now died. Alice Miller[6,7] stressed that losses and traumas in childhood need not lead to neurotic development. If a child is given the opportunity with an understanding adult to express his grief and anger, then the wound left by the loss or trauma will be healed.

A therapist or therapy group that is prepared, through genuine understanding, to accommodate all the mourner's conflicting emotions of pain, anger, guilt, shame, perhaps jealousy and vengefulness, may give the mourner an experience that heals part of his childhood trauma. Grief may be the start to making contact with one's genuine emotions. The reason why the mourner dares to feel the pain is that the therapist or the group reflects and backs up what is healthy in the process.

When a person discovers that he can manage with less than the unconditional love for which he has always longed, he can value what he receives from a caring network. In that way, he can release a quantity of energy that he has, since childhood, bound up in longing or in suppressing his longing. In our experience, this new energy manifests itself in an optimism and a fearlessness of life, an ability both to be alone and to enjoy the company of others. Grief work in adult life has, in other words, the power to undo some of the efforts of childhood deprivations.

THE OPEN GRIEF GROUP METHOD

In developing our treatment, it was important to use a prototype model of grief work that would be useful in helping the members of the group to understand their own

grief process. The model would also be useful to therapists in determining which problems clients have with their grief process and in deciding on helpful interventions.

We found the American psychologist J W Worden's model a useful one.[8] He regarded grief work as consisting of four tasks. By using the term 'task' he emphasised the concept of grief work, which he sees as a process that requires an active effort from the mourner. The tasks are not phases, but intertwine with one another throughout any normal grief work. The four tasks are:

1. The loss has to be recognised on all levels;
2. The various emotions of grief have to be released;
3. New skills have to be developed;
4. The emotional energy has to be reinvested.

In our groups, between eight and ten clients meet once or twice a week, according to how far they have progressed in their process of grieving. Some need to attend only six to eight times, with others it is six to eight months before they can cope in a healthy way. We work with acute, delayed, avoided and chronic grief. Clients receive individual support so that each has the chance to find the forces that will heal a wound caused by a complicated loss or traumatic experience.

An open grief group session

We shall illustrate how the groups function by describing the behaviour of four typical clients during a single session. Liz was attending the open grief group for the second time. She had recently lost her eyesight and was evading grief by refusing to acknowledge the despair of her situation. John, an AIDS patient without a private network, had attended 12 times over a period of three months. Joan, who had been with the group for six weeks, was threatened by chronic grief; the suicide of her son had given rise to problems of such complexity that, two years after his death, he took up more space in her life than when he was alive. Lastly Susan, whose children had been murdered by her husband, leaving her in an acutely critical state with which her private network could not cope, was attending for the last time.

The members of the group introduced themselves to the blind member, Liz, and said why they each were there, so that she would know where in the room everyone was positioned. Liz said angrily that she wanted no special treatment, she hated being pitied, thereby becoming the first person to work with herself on that particular day. She told us that the last session, when she had mainly been an observer like anybody else attending for the first time, had left her shattered. She had been angry and frightened by all the weeping.

'I can't stand weeping,' she said.

'Why are you here again today if this is how you feel?'

'I wanted to give it a chance - and it was nice to have coffee with the group members afterwards.'

We had to tackle her handicap, which she seemed to be repressing.

'You don't want to use the word "blind". Why is that?'

'The word is without hope. I don't want to use it.'

'But Liz, you are blind.'

'I don't want to hear it.' (angrily).

'Liz, we feel sorry for you, but hard as it is, the fact is that you're blind.'

Liz stiffened and got angry, but she did not push away the hand that the client next to her placed on her arm. Several people in the group told her that they felt very sorry for her and that it must be really tough to lose one's eyesight. She did not object again. She had taken the first step towards recognition of her loss (first task) and the development of new skills, although her feelings of grief were not yet tangible to her.

Since the last session, John had been very ill. He said to Liz: 'When I first joined this group, I was as angry as you are now. I felt badly treated. I didn't want to face my own death. I wanted to be able to hope. Since then I have realised that hope, and facing one's own death, do not exclude each other. I expect to live on for quite some time, and of course I'm scared of dying. No-one survives my illness.'

He wept and told us that he had spoken with his father since the last meeting (third task). For the first time ever, he had demanded that his father should take him seriously. During the last session, John had read out to the group a letter he had written to his father, because he could think of no other way in which to establish a new and different sort of contact with him. He had felt embarrassed, tense and anxious at the prospect of talking to his father so he had read the letter to him, and his father had listened to John telling him of his fear of dying and had shaken hands with him. In this way, John had begun to acquire the network that he would need when he became too weak to manage himself. John's father had cried, John had cried with him, and right now he was crying with relief and joy because he had succeeded in getting through to his father. Spontaneously, the group began to applaud. Everyone knew what an enormous effort it had required.

Joan volunteered to be the next person to work with herself. She had missed a couple of meetings and told us that she had not felt like coming. She had been angry with the other members of the group and had felt that we were not prepared to understand why she was unable to turn away from her dead son, her only child. She was particularly angry with one of the therapists, who had suggested that, as she found it so difficult to be surrounded by people who had decided to say goodbye in order to turn towards a new life, perhaps she had better leave the group. In guilt and shame for her son's suicide, she had clung on to him continuously for two years (chronic grief). By never letting go of her feelings, she had avoided letting go of him. Evidently it was easier for her to bear her guilt than bear the separation.

In her anger with the group she now said, to her own surprise, that for the first time she was feeling angry with her son. We asked her to repeat this to a couple of the group members. While she was doing this, she began to cry (second task). Gently we supported this first step towards separation by reminding her that her son was dead and that she would never see him again. To our surprise, she turned out to have advanced further in her grief process than we had realised and she started to weep deeply. Covering her with a blanket, we let her cuddle one of the others, as she began, at last, to let go of her son. Her assignment for the next session was to write a letter to him about the separation she would have to accept before being able to turn towards other people (fourth task).

The last person to take time in the group was Susan. We insist that, if you have attached yourself

to people, you must also say goodbye properly (fourth task). This process always follows the same ritual: the person who is about to leave writes a letter to the group and the therapists, partly to assess the stage to which the grief work has progressed and partly to say farewell to us all. Susan read aloud the letter printed below and then said goodbye to each member of the group.

'Dear Nini and Marianne, and all you others in the group,

The time to say goodbye has come. In this quiet evening hour I am sitting with the picture of Martin and Jannie in front of me, and what is more natural than that the tears are welling up out of the corners of my eyes. Tears that tell of the enormous gap left by Martin and Jannie, tears at having to say goodbye to all of you who have meant so much to me.

It is more or less 18 months since I started, yes, started from the bottom. I could compare myself with a little, newborn child who is completely helpless. If only I had been adult enough to be able to manage for myself, but the spark was lost, the light had gone out - I had no zest for life; without your help I would be dead, perhaps not literally - my body would probably have gone on living - but my inner self would have been dead.

I remember so clearly the first time I sat down here on the blue cushions. I was stiff and apathetic, probably a bit afraid of what all this was. Could I use any of it for anything? A thought went through me. Who can help me? I shall never become a human being again; nobody can give them back to me, so there is no help to be had. As you can understand, I felt that just then I had nothing to live for.

Slowly, one session after another, all of you sitting here, and all those who have stopped coming in the course of time, have gradually pulled me up. It has been a long, hard and difficult process to have to go through, but when I sit here now and think back, there must, somewhere, have been some will to live left in me, for it is clear to me that, if I hadn't done anything myself, your help might have been wasted.

Many emotions have been touched, and I have written a number of letters. The letters to the children are probably the most important ones for me. I remember that when I read them out, I put the pictures of Martin and Jannie down in front of me. I really felt that they were right before me, a feeling that was both nice and nasty: nice, in the sense that I managed to say in words that they were both wanted children; and nasty, because, although they seemed to be there so close to me, they were not two little, living people who could be given a proper hug. Your understanding of the feelings which I had at that time towards Peter (I am thinking of when I missed him more than I hated him) has been quite an indescribable help to me. At that time everything was all just chaos to me, and at times I asked myself whether I was really quite sane. I tried to talk to the family about all these feelings, but I found no understanding there. They just flung at me, "Think of what he has done", and I got an even worse conscience about not just hating him. The support you gave me, when you said, "The one thing does not exclude the other, obviously you can't forget the good years you had together", was a fantastic help for me. I am glad that today I have got to the point of being able to say that I only hate him. I do not miss him at all. This step, I think, has been very important to me, for with it I have said goodbye to the past and hello to the future.

What this future holds I do not know, thank heaven, but though there may be more tragic events in my life, whatever may happen I believe that, with the experience I have had, I can understand better how to tackle the situation. Of course I hope that there are some good years in store for me, that the animal we all know here, that lives in us, will scratch at the wound less and less. The gap left by Martin and Jannie will always be there. They will always be a part of me, always fill part of my heart. I am not afraid of my own death, for I hope and believe that my two little children will be standing on the other side with arms outstretched to welcome me.

I have got to the bitter end, where this letter has to be wound up, and that means that I have to say goodbye to all of you. To all of you in the group. You have meant so much to me. You have been part of my life and will remain so, for I shall never forget you. I wish you the best. I shall miss you all, even though I know that it is the right thing for me to say goodbye to you today.
Goodbye.'

Final remarks

Susan's treatment gives us a good overview of the open grief group model. There were several reasons why Susan needed professional help to prevent her from ending up as a patient with symptoms of pathological grief, addicted to tranquillisers. Susan was an insecure and anti-aggressive woman who had suffered an emotionally deprived childhood. She had lived alone with her mother, and had regarded her mother's well-being as her responsibility. This meant that Susan not only had to go through an overwhelming grief process but also had, literally, to learn to grieve because she had never been allowed to express pain and anger.

Susan joined the group a few days after her children's funeral. She was in a state of shock. During the first couple of months she was given help to face the enormity of her loss (first task) and received both physical and psychological support to allow her to experience the healing pain. Time and again she would sit covered with a blanket on the lap of a group member or therapist, like a small, helpless, crying child (second task). It was a new skill for her to talk about the tragedy, share her feelings and use a network (third task). Her farewell letter showed that she could see glimpses of a future (fourth task).

On leaving the group, she was in touch with the healing forces in grief work. In fact she was a changed woman, a woman who had had intimate contact with the ultimate existential concerns - death, existential isolation, meaninglessness and personal freedom. Susan will, of course, have to continue living with a major scar in her soul, but her grief work became a turning point in her life.

References

1. Davidsen-Neilsen M, Leick N. Healing Pain, Attachment, Loss and Grief Therapy. London: Routledge, 1991. (Available from Cruse, £11.99 + £2.25 p&p)
2. Parkes CM. Bereavement, Studies of Grief in Adult Life. London: Tavistock Publications, 1972.
3. Parkes CM. Bereavement. *British Journal of Psychiatry* 1985; 146: 11-17.
4. Bowlby J. Attachment and Loss I-III. New York: Basic Books 1969, 1973 and 1980.
5. Yalom ID. Existential Psychotherapy. New York: Basic Books, 1980.
6. Miller A. The Drama of Being a Child and the Search for the True Self, For your Own Good: Hidden Cruelty in Child-Rearing and the Roots of Violence. London: Virago, 1987.
7. Miller A. Thou Shalt Not Be Aware: Society's Betrayal of the Child. London: Pluto Press, 1986.
8. Worden JW. Grief Counselling and Grief Therapy. Cambridge: Cambridge University Press, 1982.
9. Davidsen-Neilsen M, Leick N. Open Grief Groups: Individual Short-term Therapy Focusing on Complicated Loss. *Group Work* 1990; 2(3): 187-201.