

the support and care they received from their wives at home. For bereavement counsellors, hearing widowers' account of this gap left in their lives may be helpful in explaining why they value domestic assistance, beyond its sheer practical utility.

This observation supports the findings of Schut *et al*², who describe the effectiveness of differing counselling strategies offered to widows and widowers who were continuing to present with elevated levels of distress 11 months after the loss of their spouse. They suggest that for those who do not appear to respond to the perceived gendered counselling needs – that men require more problem-orientated, and women more emotional-orientated intervention – it may be appropriate to offer emotional counselling to men, and problem-focused counselling to women.


The analysis of my interviews revealed that the widows who coped well were the ones who were most likely to be involved in out-of-home activities – in other words those who had found self-identity within the public sphere. With the exception of one widow, whose manifestation of grief was similar to that of Queen Victoria as described by Parkes in the introduction, those widows who reported not coping well at the time of interview had coped well in the past, but were experiencing poor health.

The widowers who coped well were typically under the age of 80 years, and tended to have found emotional support from a cross-gender relationship or had moved into sheltered accommodation. The widowers who were not coping well were more likely to be older, frailer and less domestically competent when they lost their spouse.

CONCLUSION

The death of a spouse is likely, temporarily at least and occasionally permanently, to cause the individual's slide towards chaos. For the vast majority, although by no means all of the respondents, after the disorientation experienced with initial loss, when there seems to be no meaning to life, there was a gradual recovery of coherent existence. In line with well-documented evidence, the widows and widowers in this study said that, generally, they began to come to terms with life on their own after the second anniversary of the death of their spouse^{1, 16, 17}.

By and large, the adaptation process for the widowers was helped by making new, caring relationships. For the younger men these were typically with an exclusive, but non-resident, female partner: the older men more often formed closer ties with adult children and opted for sheltered accommodation where they maintained independence but had access to support. For the widows, successful adaptation included making a life outside the home, with friends and organisations as well as family.

These findings have implications for early bereavement counselling for both the bereaved person and their family, in particular adult children, in terms of understanding the origin of the gaps in these older people's lives and how they might guide the person in finding ways of filling them. 

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OBITUARY

Marion (Mollie) Mackenzie

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1907-2000



Mollie Mackenzie, chairman of the Department for Children and Parents at the Tavistock Clinic from 1968-1972, was a consultant child psychiatrist whose professional life encompassed many of the important developments in her speciality. She was a colleague and close friend of the greatest child psychiatrist of his time, John Bowlby, and became an enthusiastic exponent of attachment theory.

Mollie qualified as a doctor and then married in 1933 but continued to practise, which was unusual for women

doctors at that time. One of her junior paediatric hospital posts was with Dr Donald Winnicott and he inspired her with an interest in the mental life of children which was to remain with her for the whole of her life.

During WWII she worked as a single-handed general practitioner while she raised her son, taking a special interest in mother and baby clinics. After the war, she went back to work for Winnicott who had moved from paediatrics to child psychiatry. Mollie underwent a psychoanalytic training – her analyst, Eva Rosenfeld, had herself been analysed by both Sigmund Freud and Melanie Klein – and then joined the Institute of Psychoanalysis; no formal

higher qualifications were needed in those days to practise child psychiatry. In 1971 she was made a founder member of the Royal College of Psychiatrists and, soon after, a Fellow.

In 1950 she joined the children and parents' department of the Tavistock Clinic, becoming a consultant child psychiatrist in 1966, and succeeding John Bowlby as departmental chair. It was not easy taking over from such a charismatic and brilliant man, but she held together a difficult department, with its prima donnas, with her usual diplomacy, natural wisdom and toleration of different points of view.

Mollie was essentially a clinician who loved, above all, the face-to-face contact

with her young patients and their families. She also enjoyed teaching, ran seminars and discussion groups for doctors and health visitors, and published several papers on the emotional development of children and the dynamics of family life. Her seminal paper with Paul Argles – a case study of crisis intervention in a multi-problem family – was very influential to a younger generation of child psychiatrists, myself included, who were just beginning to explore the new therapeutic

techniques of family therapy.

Mollie was friends with many of the great figures who influenced the modern practice of child psychiatry, and she in turn influenced many of the present senior figures in her speciality. But she remained a modest person who enjoyed living right up to the end and took pleasure in her son's achievements and those of her friends. She is survived by her son, Malcolm.

Dora Black

Consultant Child and Adolescent Psychiatrist

After retirement Mollie moved to Suffolk and we met in 1977 because of my interest in starting a branch of Cruse Bereavement Care there. Already a member of Cruse Council, Mollie's knowledge, experience and enthusiasm were 'manna from heaven' and the Waveney Branch was launched in 1979, as the 46th Branch of Cruse.

During her nine-year involvement, Mollie's wisdom and guidance firmly established the branch (now Waveney and North Suffolk) as financially self-

sufficient, with its own library and annual lecture. She set up and ran the training courses for counsellors and helped with the formation of other local branches. Her expertise in all aspects of counselling proved invaluable to our volunteers and she was a wonderful chairman, always willing to listen while skillfully guiding the committee in the right direction. She is remembered with great affection by all who knew her. **BC**

Margaret Chad

President, Waveney and North Suffolk Cruse

COUNSELLING BEREAVED CHILDREN

Letting go the reins

Group therapy with bereaved teenagers

Simon Eedle

Project worker, Barnardo's Orchard Project, Newcastle-upon-Tyne, UK

When the idea of running a group for bereaved young people aged 12 to 15 was mooted, I felt enormous anxiety. How could I, and my co-facilitator, hold the turmoil of several bereaved young people? How could we remain in control? After some reflection my thoughts turned to activities that could be used to enable a group to explore feelings and experiences of bereavement and the exciting tingle of anticipation began. What anxiety remained was more than doubled by my co-facilitator's suggestion that we organise the group on Axline's principles of non-directive work: 'Group therapy is a non-directive therapeutic experience with the added element of contemporary evaluation of behaviour plus the reaction of personalities upon one another'.

Out of the window went my need to control and out went the programme of suitable activities. In came working at the children's pace, not leading or directing, giving permission for them to feel and be as they were at the time, enabling the existence of a group that would go where it wanted to go and would do what it needed to do.

Giving the young people the control was not an easy option. To take the risk we had to prepare the ground well, both for the young people and for ourselves. And we still had to prepare activities as options for the group should they want some input. As this was our first venture into bereavement groupwork together, my co-facilitator and I agreed that we could live with our occasionally reverting to being directive – a welcome safety net for me!

Our first task, having brought the group together, was to create a safe environment, a

AGE RANGE
12-15 years old

structured space that anchored the young people's work to the 'world of reality'. The first session's agenda gave permission to the group to express itself, to make choices and to decide the direction in which the group wanted, or needed to go. Together, we set boundaries such as the use of the building, time keeping, how the group would conduct itself and the need for agreement on confidentiality, recording and evaluation (this last we encouraged by providing pre-prepared charts on which we all stuck stars at the end of each session). We facilitators took responsibility for selecting group members and clarifying the roles of the adults, setting up the room, providing snacks, and for welcoming and accepting the young people as they were. We were also to set the times and dates of the sessions and arrange the transport, in consultation with parents and carers and the young people..

This session was crucial. It modelled the way in which we, as facilitators, were able to hold the group but not control it. So it was that the group decided how and when in that first session they would draw up the agreement and whether they would take up the ready-made options we had prepared, or choose to do something else. There was initial reluctance to accepting the control and much looking to us to take the reins. We resisted the temptation to take over, reflecting back to the group the difficulty they were experiencing and allowing them the space to find a way of coming to their own decisions. Their first choice was to play a game that we had prepared, designed to break the ice and enable everyone to learn each other's name. This highlighted the need for us to be prepared and, from the final feedback, it was clear that this was

a significant moment which helped promote the sense that we could hold and facilitate the group while they controlled its direction and content.

As the sessions went by the group readily accepted responsibility for the shape and content of each session. They chose a mix of activities, some prepared by us, others ideas of their own. These included watching videos, playing computer games and the creation of their own video which they made for the project to use as an introduction to future potential group members. Indeed, for much of the time we were made redundant, being asked to leave the room while the group got on with the tasks they had set themselves. This could have felt risky but the model we had encouraged of the group being in control and responsible for itself, created an atmosphere of trust that led to the group acting responsibly.

For the most part bereavement was not an apparent issue. However, from the follow-up evaluations it was clear that sharing time and behaving normally with other bereaved young people was a major benefit, a recognition that they were not alone. And this is the message being repeated time and again by workers in the bereavement field (as highlighted by several of the speakers at the recent 'Children and Bereavement, Who Cares?' conference (see p29 of this issue): bereaved young people need to share experiences with others in the same situation to help overcome their sense of isolation.

This brief look at one group is not a 'what to do', nor a 'how to do'; volumes have been written by others on these matters. It is, I hope, a message of encouragement to take the risk of offering bereaved young people the opportunity to come together and have real choices about how (and indeed whether) they use that safe time to further their bereavement work. **BC**

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