

References

- FRYERS, T. (1987) Epidemiological issues in mental retardation. *Journal of Mental Deficiency Research*, **31**, 365–384.
- GILLBERG, C., PERSSON, E., GRUFMAN, E. & THEMENAR, U. (1986) Psychiatric disorders in mildly and severely mentally retarded urban children and adolescents: epidemiological aspects. *British Journal of Psychiatry*, **149**, 68–74.
- MID GLAMORGAN COUNTY COUNCIL POLICY RESEARCH AND EUROPEAN AFFAIRS UNIT (1993) *Census 1991. Mid Glamorgan in figures*. Mid Glamorgan County Council.
- ROYAL COLLEGE OF PSYCHIATRISTS (1992) *Psychiatric Services for Children and Adolescents with Mental Handicap*. Council Report CR 17. London: Royal College of Psychiatrists.
- WORLD HEALTH ORGANISATION (1992) *The ICD-10 Classification of Mental and Behavioural Disorders. Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organisation.
- Robert Colgate, Senior Registrar in Psychiatry, St David's Hospital, Carmarthen, Dyfed SA31 3HB (formerly Registrar in Psychiatry, Brynffynnon Child and Family Service, Pontypridd Mid Glamorgan CF27 4DD)

Grief counselling for bereaved families with children

A. Ubeysekara

The effects of losing a loved one through death on the physical and mental health of both adults and children are well documented in the literature. Children are likely to be referred to mental health professionals for various behaviour and emotional problems which may have a causative link with a bereavement within the family. In this paper I discuss the need for preventive work and, propose a role for child psychiatric services in preventive work for bereaved families with surviving children and adolescents. A ten-point plan is suggested as a guideline.

Most studies on the effects of bereavement on children have been of children who have lost a parent through death. In a 13-month follow-up study of 105 two to 17-year-old children bereaved of one parent, there was an increase in dysphoria, bed-wetting, temper tantrums, falling school performance, and loss of interest in activities, although this did not lead to an increase in psychiatric or general medical consultations (Van Eerdewegh *et al.*, 1982). The same study found that the mental health of the surviving parent was a contributory factor to the mental state of the child. In a later paper, Van Eerdewegh *et al.* (1985) pointed out the potential importance of availability of a support system and the quality of the relationships between the family members before and after the death. In a follow-up study of 20 families who lost a child from leukaemia, Binger *et al.* (1969) found that in half the families one or more previously well siblings showed behaviours suggesting difficulty

in coping. These included enuresis, headaches, poor school performance, school phobia and severe separation anxiety.

In my own practice in a National Health Service child and family service, a significant number of children and adolescents are seen who are referred for various emotional and behavioural difficulties, but on assessment it becomes clear that the presenting symptoms have a causative link with a bereavement within the family. Some of the common presenting symptoms are enuresis, encopresis, conduct problems, self-poisoning, somatic symptoms, uncontrolled psychosomatic illnesses, relationship difficulties and poor school performance. The children and the families who are referred are usually in one of three stages in relation to the bereavement, namely those facing an imminent loss, those experiencing acute grief, and those with unresolved grief up to several years following the loss. Most children respond well to help with grief work and, in the majority of families, helping the parents to work through their own grief leads to resolution of grief in the children as well (Ubeysekara, 1985).

Prevention

By the time these children are referred with behavioural and emotional problems, they are likely to have suffered significant social, emotional, educational, behavioural, and relationship difficulties following a bereavement

within the family which, in some cases, may extend over many years. These problems might be reduced if appropriate preventive work could be done, reducing the need for the scarce and expensive professional resources that would otherwise be required at a later time. Usually it is the extended family and friends or the local church who would provide the understanding and the support needed by the bereaved family to work through their grief. However, there is an increasing number of bereaved families who do not receive this support due to their own isolation, or due to the difficulties of the members of the support system in facing the bereaved ones. The primary care team – including the family doctor and the health visitor – may not have the time needed by the bereaved family and, in some cases, depending on the circumstances of the death, the family may find it difficult to work with the primary care team. This leaves a significant role for bereavement counselling services in helping bereaved families with surviving children and adolescents.

Bereavement counselling services

CRUSE (Bereavement Care, the national organisation for bereaved people) provides a valuable counselling service by trained volunteer counsellors, many of whom are themselves bereaved people. They are selected, trained and supervised by professionals. In addition to counselling individuals, CRUSE also offers groups for bereaved parents with children, but not all their branches organise these groups and there are still areas with no CRUSE branches. Compassionate Friends, the self-help organisation of bereaved parents, provide both individual and group support to parents who have lost a child through death. Their branches again are not widespread, and their clients do not generally include bereaved families with children unless the death was that of a child. Other voluntary organisations providing bereavement counselling include the Foundation for the Study of Infant Death, Bereavement Project of the Family Welfare Association, Miscarriage Association, Stillbirth, and Neonatal Death Society.

Multidisciplinary professional bereavement counselling services are being organised by hospitals, mental health centres, and other similar agencies in many parts of the world. The counselling in these services may begin before the death occurs, and will continue after it, but one does not hear of many such services which specifically aim to help bereaved families with surviving children and adolescents. The family therapy sessions offered to bereaved families with children in the study of Black & Urbanowicz (1984) proved useful, but it will not be feasible to

offer treatment by a very expensive and specialised service to all bereaved families with children.

A role for the child psychiatric service

Members of a child psychiatric service should be well aware of the importance of preventive work for bereaved families with surviving children, as they are bound to come into contact with and have to deal with problems related to a bereavement. Due to the absence of voluntary counselling services in some areas, and due to the criteria used by the services when available, it is likely that in many places there is no uniform service to offer bereavement counselling to families with surviving children and adolescents, irrespectively of whether the death was that of an adult or a child within the family. I propose a model in which the multidisciplinary team of a child psychiatric service could play a central role in encouraging and co-ordinating the various bereavement counselling services that could be made available to bereaved families with children living in the area. Their role would be to facilitate the setting up of new services, to support and supervise the counsellors, and participate in their selection and training, rather than offering direct counselling work with individual families. For a child psychiatric service embarking on this new venture of co-ordinating counselling services for bereaved families with surviving children and adolescents, the following ten-point plan is suggested as a guideline, based on my experience in helping to develop a community bereavement support scheme.

The ten-point plan

1. To survey the services available to bereaved families in the area.
2. To survey a population sample of bereaved families with children in the area to find out what counselling services would be most acceptable to them.
3. To identify the local agencies who are likely to come into contact with and would be in a position to help bereaved families with children. These would include general practitioners, health visitors, clergy, social services department, paediatricians, community medical officers, teachers, school psychologists, education welfare officers, funeral directors, and various voluntary bereavement counselling organisations.
4. To arrange a meeting of key persons and local representatives of these agencies to obtain their co-operation in planning a network of services which would reach

each bereaved family with surviving children in the area, through a central screening point.

5. To act as advisers to the professional and voluntary agencies and to help with the selection and training of the bereavement counsellors.
6. To provide on-going support and supervision of both the professional and voluntary counsellors.
7. To support other agencies and voluntary organisations in obtaining resources relevant to the bereavement counselling service.
8. To be available as a back-up service to help other workers and to be prepared to work with families developing psychiatric or other problems which are beyond the scope of the volunteer counsellor.
9. To continue to meet with other key workers regularly, in order to review and improve the counselling services offered in the area.
10. To evaluate and research into the various counselling techniques and services being offered.

Acknowledgements

My grateful thanks to Mr Neville Cox, Social Worker, for his support in my bereavement work, and to Mrs M. Edwards for her help with the manuscript.

References

- BINGER, C.M., ALBIN, A.R. & FEURSTEIN, R.C. (1969) Childhood leukaemia: emotional impact on patient and family. *New England Journal of Medicine*, **280**, 414–418.
- BLACK, D. & URBANOWICZ, M.A. (1984) Bereaved children: family intervention. In *Recent Research in Development Psychopathology* (ed. J.E. Stevenson). Oxford: Pergamon Press.
- UBEYSEKARA, A. (1985) Guided Mourning in the Child Psychiatric Clinic. Paper presented at the First International Symposium on Grief, Jerusalem, Israel, November 1985.
- VAN EERDEWEGH, M.M., BIERI, M.D., PARRILLA, R.H. & CLAYTON, P.J. (1982) The bereaved child. *British Journal of Psychiatry*, **140**, 23–29.
- , CLAYTON, P.J. & VAN EERDEWEGH, P. (1985) The bereaved child: variables influencing early psychopathology. *British Journal of Psychiatry*, **147**, 188–194.
- A. Ubeysekara, *Consultant Child and Adolescent Psychiatrist, Child and Family Centre, Merthyr Road, Pontypridd, Mid-Glamorgan CF37 4DD*