DESCRIBE ONE SPECIALIST AREA OF WORK WITH YOUNG PEOPLE AND EVALUATE THE USE OF A VARIETY OF CREATIVE INTERVENTIONS IN YOUR WORKING PRACTICE

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"Give sorrow words, the grief that does not speak knits up the o'erwrought heart and bids it break"

(Shakespeare in Bowlby, The Making and Breaking of Affectional Bonds, 2005, p113)

Introduction

There are few things of which we are certain in this life; only that one day, we will die and that our lives will be touched by the deaths of others. The way in which we grieve for those we have lost is determined by a number of factors. The nature of death; was it anticipated or sudden? Was it violent such as murder or suicide? How close was the relationship? What is the age and developmental stage of the child or young person? How was the information given following the death? What support was available? How stable is the home environment? How are the carers dealing with their own grief? How are questions answered? (Harris-Hendriks, Black and Kaplan, 2000).

Traditionally, the feelings and beliefs of bereaved children and young people have been largely dismissed due to a belief that children do not understand, do not have the awareness or feelings of adults, and need to be protected from death. Many adults experience discomfort in talking of death - especially to children (Kubler-Ross, 1995). Research developments, allied with increasing experience in the area of palliative care and developing bereavement services have, in the past 20 years, led to greater awareness of the needs of bereaved children (Winter 2004). This has meant greater openness, recognition of the feelings and needs of the child or young person, development of approaches enabling children to engage in therapeutic bereavement work, and recognition of the importance of seeing each person – whether child or adult - as a unique being. Thus the approach used by the therapist is age appropriate and tailored to the individual.

In this essay, I will examine bereavement through the varying developmental stages of the child. I will look at the grief process and the effect of attachment patterns, suicide and murder on this process. I will give examples of client work and describe examples of creative approaches to enable work with young bereaved people.

Attitudes to death and dying vary from culture to culture. In Western cultures, death has become taboo replacing sex as the main forbidden subject (Aries, 1994). In Western Christian cultures, the dying person may be isolated and the death spoken of in hushed tones. The funeral, either burial or cremation, can be selective in those who

attend. Many other cultures involve the whole family, whether they involve burial, cremation or belief in reincarnation. The grieving may be more overt and verbal with support shown through the presence of others and the bringing of food. There may be regular or annual ceremonies to remember the dead.

> "……. The word mourning means "to remember" and stems from the same root as memory. In mourning we are held in the memory of what has been lost or abandoned until we have found a replacement for it. Mourning occurs whether we have ever experienced actual death or not. Mourning and depression are the other names of abandonment"
>
> (Franz in Verrier, [1997]. P. 39)
>
> "A failure to work through mourning results in a persecutory state of mind in which hostile feelings directed towards the lost loved one are turned back upon the self"
>
> Papadopolous Renos K. [2002], p. 105)

Grief is a process which enables us to adapt and adjust to a life without the person who has died. Parkes (1975) in Phases of Grief , Worden (1991) in Tasks of Mourning, and Kubler-Ross (1989) in Stages of Grief are all describing feelings and behaviours involved in the grieving process. These are not linear – people move around within the various stages and phases and this has to be remembered when working with children and young people who may lack the vocabulary to describe what they are experiencing.

Phases, Tasks and Stages are largely based on adult processes. A baby's grief, although difficult to discern, corresponds to stages observed in adults (Verrier, 1997). A child's memories will be limited, and mourning may be inhibited by adults removing evidence of the dead carer or not enabling the child to visit places they used to visit with the carer. Somehow, they are expected to just carry on as normal. To be denied a mourning process can result in serious depression, mental illness or complicated grief, (Bowlby, [1998], Murray Parkes, et al, [2003]). The person needs to move through the stages of searching, anger, guilt and depression as they move towards a new identity without the deceased (Mander, November 2005).

During the early months of life, an infant learns to discriminate a particular carer – usually the mother – showing a strong preference for her company. Throughout the

latter half of the first year and for the whole of the second and third year he is closely attached to the primary carer, content in her company, concerned about separation and distressed in her absence (Bowlby, 2005). Separation from the carer is one of protest and desperate efforts to find her again- loud crying, shaking the cot, looking towards sounds which could be her (Bowlby, 1998). Between three and five, there is no sense of the permanence of death and this limitation in understanding can make it difficult to help the child grieve. Nevertheless, support of the child and simple explanations appropriate to the developmental stage should still be attempted (Harris-Hendriks, Black and Kaplan, 2000; Murray Parkes et al, 2003).

After age five death may be attributed to an external intervention, such as 'a bogey-man' – someone who comes to take people away (Kubler-Ross, 1997) - but there is understanding that death is irreversible, the separation is permanent and dead and living are different (Harris-Hendriks, Black and Kaplan [2000]). Up to around age seven, therefore, children do not fully understand. They may be clinging anxious and find difficulty sleeping. There may be loss of confidence and fear of the loss of the other parent or carer which increases the sense of insecurity, as children know they cannot survive alone.

Adolescents may be more able to express feelings of loss and sadness in a similar way to adults. Hormonal and other influences tend to influence the desire for greater independence which can conflict at this time, with the tendency to become more dependent when bereaved. This can appear as indifference or lack of feeling (Harris-Hendriks, Black and Kaplan, 2000). Adolescents at the stage of separating from the parents may again become more involved with the family, especially if they are the eldest child or the same sex as the dead carer. Conversely, they may reject the family and develop new partnerships (Harris-Hendriks, Black and Kaplan, 2000).

In the first phase following loss, there is a period of protest during which time the child attempts to recover the lost person and is angry at being abandoned. Anger is an integral part of the grief reaction giving energy to the efforts to recover the lost person and to encourage him/her not to leave again. It is a necessary condition for healthy mourning (Bowlby, 2005) as it is only after every effort has been made to recover the dead person that the child comes to accept the death and reorients the self into the world from which the dead person is absent. The child will be unprepared for all the

events and situations at which the dead parent will no longer be present, and needs help anticipating the emotional experience of renewed loss.

This can be followed by a period of despair during which there may be swings between those feelings of anger and despair and pining. In young children, although there is still a longing for the lost mother, the hope of being reunited with her diminishes and the child may become withdrawn, depressed and detached. The second phase of alternating hope and despair can continue for some time while the child goes through a period of disorganisation until the third phase when some measure of detachment occurs. At this point, reorganisation occurs as the child accepts the permanent absence.

Children and young people may at this point demonstrate an aloofness or lack of response to affection and this may be the result of a defensive process within the child to defend against vulnerability against further loss (Verrier, 1997). In each of the phases a child may throw tantrums and demonstrate destructive behaviour (Bowlby, 2005) – important that the counsellor creates a safe, understanding and secure space.

Concrete thinking and egocentric view of the world mean children might feel guilty and responsible for the death. It may feel important to be good to avoid hurting others. As part of the bargaining stage, the belief may be that being good will return the deceased. Regression into thumb sucking, clinging or nocturnal eneuresis might occur. If the child has recently learned to walk, they may temporarily revert to crawling. Infections and illnesses are common in young children following the loss of a parent. Yet others may try to step into an adult place in order to care for the adults around them (www.crusebereavementcare.org.uk). There may be a tendency to idealise the dead person. Murray Parkes in Jacobs (1996) believes that this may be an unconscious attempt to deny angry feelings.

Gill is a young woman whose mother died when she was 10. She became the family carer with no support from her father who told her that they would all be separated and taken into care if she got it wrong. She regressed to bed-wetting and was punished. She felt she no longer fitted in with her peers as she had no mother, was too tired to do school work and would not go to school. No-one attended parents evenings, concerts etc. but she could not let people know how she felt.

Aged 14, she started drinking and was in trouble with the police. When we met, she was agoraphobic, experienced panic attacks, was depressed and drank. Her life was totally disorganised. Our work involved talking of her mother's illness and subsequent death, the circumstances preceding it, how she was told, and how she was supported. She acknowledged how she buried her grief in order to ensure that her siblings were not taken into care. We worked through the stages of grief and the feelings involved. Giving information about bereavement enabled her to recognise the normality of the childhood eneuresis and depression and how she presented her anger, despair and need for support through drinking and trouble with the police. Recognising her grief and how she became the carer with no-one looking after her enabled her to acknowledge strengths, and recognise how lost and scared she was as a child as she took control of the family

We acknowledged her unexpressed sadness and how her fear and loss of security were manifesting physically at the present time. We constructed a memory box which she decorated, containing the few photos she had and a letter she wrote to her mother to say how she missed her. She drew pictures of her memories and put in photos of herself. She bought a plant she felt her mother would like and together we planted it in the garden in a spot she felt her mother would like and where she could sit.

> "The young child's hunger for his mother's love and presence is as great as his hunger for food"
>
> Bowlby (1956) - Notes From Developmental Attachment Therapy Training (2006)

Children bereaved by suicide may assume responsibility and guilt for the suicide. These children experience more shame than other bereaved children, and may also equate the rejection of life with a personal rejection (Trickey, 2005). A high proportion of children bereaved by suicide were near the incident when it occurred (Trickey, 2005). This has implications for the child's memory of the deceased as the traumatisation 'trips up' the usual grieving process – each time the deceased comes to mind, it is the image of the event which takes over, thus making grieving very difficult.

Ali is a young refugee from an Eastern country. His father did not want him and told his mother that the child had died in an accident. His mother then committed suicide

and he was brought up by an aunt he believed to be his mother until he overheard neighbours talking. He experienced great guilt and depression. He felt stigmatised and responsible for her death until our work together enabled him to understand how little responsibility he as a baby carried for the actions of adults and how much his mother loved him. This realisation enabled him to feel acceptable in the world again and changed how he regarded himself.

Where one parent has murdered the other, the child loses both parents and this brings particular difficulties as people try to hide the truth from the children. Schore's work (1994) demonstrates how impairment of the right brain's coping system due to relational trauma in infancy has damaging consequences for the future adult. Where there is minimisation or over-reaction, children experience more physiological and emotional anxiety (Papadopolous, 2002). Children bereaved by suicide and murder face particular problems of high-profile reporting, gossip and stigma and this can lead to bullying at school or outside.

Attachment patterns influence grieving patterns and this is another factor in the child's response to loss. Securely attached children have hope of being helped as they have been loved (Cyrulnik, 2005). If the attachment system is organised to anticipate rejection and loss (anxious-ambivalent), or to suppress attachment-related feelings (anxious-avoidant), there is a greater likelihood of experiencing psychological and physical problems following bereavement (Fraley and Shaver in Cassidy and Shaver, 1999). This has implications for the relationship with the therapist, therapeutic approaches and possible duration of the therapy. Recent advances in neuropsychology and neurophysiology have increased our awareness of the reparative work which can be carried out as the therapist's right brain engages with the right brain of the child (Wilkinson, 2006).

Therapies

There is no one way of working appropriately with all children. Seeing each child as a unique individual and finding methods appropriate to the particular child or young person for the particular stage they have reached is a determinant for a more successful outcome (Geldard and Geldard, 1999). Painful memories are stored at different levels and associated with different senses (Kagan R. 2004). For this reason,

creative therapies (with the client's consent) can be very freeing tools. It is only fairly recently that the different arts have begun to be used as therapeutic approaches in their own right, rather than just adjuncts to predominantly talking therapy (Wetherick D. 2004).

> "Tell them and they hear, Show them and they see, Do it and they understand"
>
> (Ward B. and Associates, (1998) Good Grief)

The room in which I work is laid out with creative materials, poems, exercises, pictures in order that the young person has choice to enable them to work in a way appropriate to them and how they are feeling at that time. To have choice is of great importance at this time, as the young person often feels that life is out of control.

Art Therapy

> "It is the process of learning to feel, of uncovering the impact on life of experiences and events, of developing insights through image and creative art therapy rather than the end produce which is so healing
>
> (Rogers N, [2000]).

Art in crisis intervention can prevent denial, alienation or patterns of repression which can occur if a child becomes overwhelmed with feelings they can neither understand nor express (Heegard M., 1991). It involves working with image which has been allowed to become conscious – sometimes through guided fantasy. The image can be made visual in art form and the meaning of this then elucidated with the help of the facilitator (Silverstone, 1991). Art therapy using image is a "tangible manifestation of experience" (Hall, 2005).

Our left brained language system regards drawing as unimportant (Edwards, 2001). When we access image, the censoring aspect of the left-brain is removed.

> "…… what the person knows, but doesn't know at a verbal, conscious level therefore comes pouring out in the drawings ……. From this experience, you will develop your ability to perceive things freshly in their totality, to see the underlying patterns and possibilities for new combinations".
>
> (Edwards B., [2001])

Van der Kolk (CAPP lecture, March 2006) supports the use of creative therapies when working with clients who have lost verbal and expressive abilities due to childhood traumatisation.

> "Prone to action, and deficient in words, these patients can often express their internal states more articulately in physical movements or in pictures than in words".
>
> (Van der Kolk in Milia [2000])

It is important for the young person to be able to understand and negotiate what we are trying to achieve in the session. When working with creative visualisation in order to create image, there is a possibility of introducing material which could trigger difficult memories. I build in a safety outlet so that the young person can stop at any point. Our relationship therefore, needs to be one of trust in order that the young person can feel confident to take this step. I always leave time before the end of the session so that the young person can be grounded and safe to leave.

Photographs

My interest in photographs in therapy started when a young person with whom I was working brought me photographs of himself as a child with his brothers. Looking at the photographs, he commented on the unhappiness in his eyes. This reminded him of how he felt at that time and uncovered memories regarding his father's death. Photographs can reawaken emotional experiences, revive forgotten feelings and bring the past into the present (Berman, 1993).

Additionally, I always have available a variety of postcards. Clients can select one and explore what it means to them. Colour, shape, and scene may awaken memories and feelings and enable the person to reconnect with past experiences. Working this way can enable the person to get in touch with present, unexplained feelings and bring enlightenment. I feel that the strength of this intervention is that the young person is in control of what is worked with and what is explored. It is important to ensure the appropriateness of the work to the level of understanding and development of the child or young person.

Music

For many of the young people with whom I work, music is an important part of their lives. I have available relaxing music or they are free to bring their own. Music expresses what they feel and we can work with what the music says to them. Jon is a young man of 16 who brings a variety of music to the sessions with him. Jon's music selection enables him to identify how he is feeling and the events which led to that feeling. It is his first experience of being encouraged to examine how music speaks to him and expresses what he feels. This has enabled him to look at patterns in the music related to events and subsequent moods – anger at his dead mother, despair due to his fear of the future, moments of optimism. It has also enabled him to identify a way in which he can connect with himself and express the feelings which arise from that connection.

Poetry

A high proportion of young people with whom I work find expression through poetry. Some bring poems they have written in the past and ask me to read them so I can understand their history without them having to explain. Others, will process what has come up for them since the previous session by writing poetry. Still others will use poetry as a way of looking at their dreams.

> "Perhaps there is no other system of psychotherapy in which the client has so much control over the rate, depth and intensity of his or her personal therapeutic work"
>
> (Rasmussen and Tomm in Bolton et al, 2004, p. 106)
>
> "Poems …….. profoundly alter the man or woman who wrote them"
>
> (Abse in Bolton et al., 2004, p. 106)

The only equipment necessary are the words we use everyday, but poetry enhances the value and gives them more flexible use (Bolton and Latham in Bolton et al, 2004). Poetry written is often undertaken away from the counselling room, and does not disrupt therapeutic time. The client can also choose when the content of the poem will be shared – if at all.

I am not aware of any contraindications, other than fear of failure or ridicule. I feel that the client would not present poetry until it feels safe to do so - reinforcing client control.

Story

For Gersie(1997), the story is the "very substance of humanness". Story reminds us of our capacity to be distressed or happy by the sorrow or achievement of another. In creating our own narratives we make sense of our world, organise memory and perceptions (Lacher, Nichols and May, 2005). Children can be helped to identify with characters they have created in the stories – expressing wishes, hopes and fantasies, identifying distress, themes and emotions and through this, looking at alternative solutions (Geldard & Geldard, 1999).

I am not aware of any contraindications regarding use of story – especially when the young person is creating it, as they have control over the material. If I, as the therapist, choose the story without first checking it out, I could impose material which might retraumatise the young person.

Conclusion

In my practice, I believe the relationship is of great importance as it is only through this, that trust can grow enabling the child or young person to talk freely and openly about their experiences, fears, sorrows and anger relating to their bereavement; to express what has not been possible, in order to develop and ensure emotional health Working with the relationship also affords the opportunity for reparenting. The deceased person can be spoken about, guilt, anger, fear and shame can be expressed – concerns about remaining parents, relatives or relationships can be aired. If we do not enable this, these feelings will be turned in on the young person's self, thus risking complicated grief, future physical and mental illness, relationship issues, and possible fear of death. .

Depending on how childhood bereavement experiences are handled determines how we in turn might handle the experiences of others or handle our own future losses. Enabling young people to come to terms with their losses gives potential for fulfilled

lives with commitment to relationships and a legacy of understanding, which in passing to others, benefits society as a whole. Additionally, this is reflected in lower levels of mental ill-health and behavioural issues and decreased chances of offending which again benefits society. In my own family, a relative's unaddressed childhood loss of his brother resulted in anger, anxiety, depression, difficulties in relating to others both personally and professionally, and emotional shut-down. He is now divorced and has an uneasy relationship with his children. Losses are brushed off, offers of help rejected and he now rejects most people in his life. Had his loss been acknowledged at the time it occurred, I believe his life – and those touched by his – would have been greatly enriched.

In this essay, by attempting to describe the grief process and touching on related issues and creative interventions, I have tried to outline the process in a manner which highlights the importance to young people and society of addressing loss and bereavement and how detrimental it can be to fail to do so. Failing to help young people express their loss can have transgenerational impact, and with our increased knowledge of the effect of bereavement, I believe there is a duty to expand and develop young peoples' services in order to benefit both present and future generations.

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