Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

William James College

Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE EIGHT ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Good Grief: Helping Children and Adolescents When a Friend Dies

Speaker

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It is a great privilege and honor for me to be invited to give the Eighth Erich Lindemann Memorial Lecture. As most you know, Dr. Lindemann's ideas about normal and pathological responses to bereavement, about crisis, about community psychiatry, about preventive work, carry important implications for the design and delivery of mental health services today. I think this is especially true for the services we design for children. It seems fitting to honor the professional work Dr. Lindemann did here in Boston by talking about a Boston-based program that is unique and is about to become a national program.

The idea of helping children and adolescents when a friend dies grew out of my experience as director of the Family Support Center at the Judge Baker Guidance Center. I was working with families who had lost a family member, and became quite intrigued and concerned about what I was hearing from some of them who told what it was like for kids when a classmate or playmate died. One day I said to our staff meeting, "I think we should start another program, and I think we should call it "Good Grief." To which I got a resounding "Yuch!"

I thought this was an auspicious beginning for the program! I asked, "Why yuch?" They said, "First of all, it's too frivolous. You'll never get away with calling it Good Grief. Second, Charles Schultz is going to sue you."

I decided to look into this and had quite a long correspondence with Charles Schultz. He said, "Charlie Brown may think he owns that phrase, but he really doesn't; and if it says what you want it to say, then go ahead and use it with our blessings." I would have liked his blessings to include things like drawing a logo for us. He said we were at the moment too narrow geographically for the Peanuts characters to help us, but to come back if we became national at any point. So he is about to hear from us again.

The second concern, that calling the program Good Grief was too frivolous, was also sobering. I asked, "What else could we call it?" The best idea the staff could come up with was, "When a Friend Dies." I said, "If you think I'm going to answer the phone, `Good morning, when a friend dies', you are wrong." We finally decided that we could live with the possibility that people might think it too frivolous an approach and try to share our belief that grief could indeed be good and growth-producing, health-promoting rather than overwhelming–really the core idea in preventive intervention. People quite frequently say to me, "How can you stand to do that type of work, working with death and dying all the time?" Somehow I think it is that hopeful side of the work that my satisfaction comes from: helping people to deal with issues of grief and loss as they

happen and anticipating what might be a good outcome for them. That's where I sense that it's not all gloom and doom.

Let me share with you some of the things that have happened during the past few months in the Boston area:

- A 17-year-old boy begged his teacher and classmates to leave the classroom and then shot himself in the head in front of those who remained.
- A third-grader with no known medical problems had a heart attack and died on the school playground during recess.
- A 5-year-old youngster fell from his window in the family's sixth floor apartment and died. One of his classmates saw him fall, and all his kindergarten classmates are asking the teacher when he is going to be coming back to school.
- An elementary school principal committed suicide one Monday evening.
- Two of the four high-school students going to a religious education class were killed when the 16-year-old driver lost control of the car. The driver survived to relive the accident.
- A 10-year-old was accidentally shot to death by a 15-year-old friend while they were playing soldier.
- Three siblings, all of whom attended the same elementary school, were burned to death in a house fire.
- A 12-year-old inadvertently stepped out of a neighborhood market into a fight and was shot in the head. He died a few days later without regaining consciousness.
- A seventh grader went home from school complaining of a headache and died that night of a cerebral hemorrhage.
- A 17-year-old high school student was killed in an automobile accident: she had been drinking that day, cut classes and missed the school-sponsored assembly by Students Against Drunk Driving.
- A science and math teacher who had also been the school's junior varsity coach for twenty years collapsed and died after suffering an apparent heart attack in the school gym.

Each of these deaths generated grief and mourning for the family of the victim, but also for groups of children or adolescents who had to deal with that loss too. Consider the following statistics: During 1982, fifty-two school-age children in the city of Boston died. Nineteen of those kids were between the ages of three and 12, and 33 of them were between 12 and 18. In order to understand the preventive implications of situations like this, think of the number of kids who are affected. Assume the younger pupils interact

with 25 classmates a day–and that's a very conservative estimate. That does not include any sports teams, youth groups or church groups. Say that high school students interact with 150 kids –that's an estimate of six classes of 25 each. Those 52 deaths, if we extrapolate that way, affected a minimum of 5,424 young people. That's the narrowest framing of that sort of material.

Communities have developed good mental health services to help bereaved family members. There are social workers, guidance counselors and other specialists in school systems to help individual kids when they have trouble, when they develop symptoms. There has been very little, however, in the way of services for groups of kids, particularly for groups before they begin to show symptoms. The services that have been provided have generally been provided by a community mental health center or by some professional who goes into a school on the basis of serving a particular geographic area. This means that it's been very difficult to build a body of knowledge, a service delivery model, a sense of expertise about what the needs of these groups of bereaved young people are.

When we started our program we thought we were going to focus on "helping groups of children when a classmate dies": helping schools become a base of support. We very quickly learned that the definition didn't cover the need. Children gather in many more places than schools: they gather in neighborhoods, in parks, in all kinds of places. And more than students die. There are teachers, principals, cooks, custodians, group leaders, camp directors, camp counselors, who would all figure in the situations we're talking about.

I will digress for a minute to talk about prevention. Preventive programs in their truest sense use a public health model, providing services to all members of an at-risk or vulnerable population. Interventions are oriented around critical life events. The traditional emphasis on treatment of troubled children in families is replaced by goals of health promotion and prevention of disease. The most effective prevention activities seem to be based in institutions that are part of a community's daily life: places like schools, churches and work sites rather than in the mental health clinic. Programs originating in a clinic, as ours does, have limitations; people say, "You've got to be crazy to get into this program," or, "What kind of troubles do I have to have before you serve me?" It's hard to convince them that they don't have to have any; that we are talking about situations that leave people vulnerable and at risk rather than about symptoms that they have.

Cowen identifies three requirements which a program must meet in order to qualify as primary prevention. First, it must be mass or group oriented, not targeted primarily to individuals. Second, it must be directed toward essentially well people, not the already affected, though targets can appropriately include those we know from

epidemiological studies to be at risk by virtue of life circumstances or recent experiences. Finally, primary prevention programs must be intentional; that is, rest on the knowledge base which suggests that a program's operations hold promise for strengthening psychological health or reducing maladjustment. Those are three useful criteria.

The death of a friend is a significant event in the lives of groups of children and adolescents. Most adults remember clearly the classmates or teachers who died when they were in school. I imagine if I asked you if there were any kids or any teachers who died while you were in elementary school, junior high school, high school or college, that most of you would have some recollection of some one who died during that period of time. Many remember equally clearly the fact that no one ever discussed those deaths with them. There is a great deal of evidence to support the notion of helping groups of bereaved children deal with the death of a friend. We know a number of things that underpin this work. We know that the death of someone who is an important part of their lives leaves young people vulnerable and at risk for physical, emotional and behavioral problems. An excellent report, synthesizing what is known about the outcomes of bereavement for adults and children, has just been issued by the Institute of Medicine's Committee for the Study of Health Consequences of the Stress of Bereavement, published by the Academy Press in Washington.

We also know that it is possible to "psychologically immunize" or "emotionally inoculate" young people by helping them to deal with intense or less-intense losses so that they will not be overwhelmed by later more personally meaningful deaths. This is the whole rationale for dealing with the death of the goldfish, death of a pet, death of a friend. I like to remind people about my very soft research about the life span of a Woolworth goldfish. Your luck may be better than mine, but mine is clear evidence that a Woolworth goldfish has a life span of one week.

The goldfish dies and what do we do with it? Mr. Rogers has a funeral for the goldfish, but most of us flush it down the toilet. That's death education lesson number one for many kids. I do a lot of work with pre-school teachers. They tell me that one of the most important pieces of information a pre-school teacher should have is where to find a good pet store. Why? I ask them. They come up and whisper to me afterwards, because they're too embarrassed to say it in

the group. They want one that is open long hours; they want one that has lots of kinds of gerbils. What happens is that the gerbil at school dies and they dash out that night; with any luck they find a matching gerbil and come back and put it in the cage. Then the next morning they don't have to deal with it with the kids. They're embarrassed because they know I'm not going to think that's a very great idea!

Such losses are opportunities to psychologically immunize or emotionally inoculate. Students who have been members of a school community that handled that well will be

able to cope with the deaths in the various communities they join as adults. We know from the work of such people as Dr. Lindemann that the pathological sequelae of unhealthy coping with bereavement can be prevented if community caretakers can help people mourn adequately.

There are four tasks for children when a friend dies. These are helpful to keep in mind in dealing with individual situations, but they are particularly important for people in organizations, like teachers and youth group leaders. To successfully grieve the death of a friend, groups of bereaved youngsters must accomplish the following four tasks:

First of all, understanding. That means knowing the person is no longer alive. I suggest that when we talk about death we talk in terms of the person's body having stopped working. This keeps you out of all those terrible mix-ups: that "he's gone to sleep," or "he looks like he's sleeping." If you can keep it biologically based–that his body has stopped working, that as far as we know we won't see him again, at least the way we knew him in our group–you leave room for a variety of beliefs about after-life. This seems to be a good foundation that one can build on without having to erase and start over. Obviously, to help with understanding we have to give appropriate, honest information; and people sometimes never get past that step very well. They cook up some remarkable stories to tell kids what happened.

The second task is grieving, which means experiencing and expressing the feelings that go with loss. For kids, this often means being mad, being sad and being bad. We're much more tolerant of kids being sad than of their either being mad or bad. We don't do so well with those kinds of expressions of grief, but they are very much a part of it. The specific content of the grief will depend on the child's relationship with the person who died and on a variety of other factors. It is reasonable to assume that by some kids the death of a friend may be greeted with absolutely intolerable relief! If he's the kid who spilled juice all over your painting in pre-school and did nothing but cause you trouble–always ran faster, always got the ball, or the good whatever else - there's going to be a mixed set of feelings about the fact that he's no longer on the scene, particularly if you don't understand that that is permanent. So people who work with groups of children need to be aware that there are large ranges of predictable and normal reactions that are not always very acceptable to adults.

The third task is commemorating, meaning formally or informally remembering, the life of the person who died. I constantly get asked about teen-age suicides when I go out to schools. Should we really memorialize these kids in any way? Won't that say to the other kids that the way to get attention is to kill yourself? I think the right way is to memorialize the life rather than the death, and to mark that the life was far too short, that the option chosen is one we don't agree with, and that it is very said that this life is

now gone. That small shift in remembering or commemorating to mark life instead of death makes a difference, I think, in how one can handle it.

Finally, the fourth task. I used to talk of only three; but I have now decided that there are four tasks for kids. The fourth one is called going on. After understanding and grieving the death and commemorating the life of their friend, groups of children need permission to resume their usual activities. Margaret Wise Brown addresses this in her books for children. In her 1958 classic, The Dead Bird, one of the earliest children's books on death, she writes: "Every day, until they forgot, the children went and sang to their little dead bird and put fresh flowers on his grave." It's not really forgetting, however, but it's having dealt with the death and then being able to go on with their living. There's a sense for many of these kids of needing permission, particularly at the high school level. Small kids will go ahead and do it, but for the older ones there is a difficult period when they're not sure if it's disrespectful to go back to living and doing things.

When children or adults die and their deaths affect groups of kids, these often turn to adults for help. Rarely do they go to parents, because as they get older, parents seem to know less and less about the groups that their children are a part of. Thus parents may or may not know their classmates or the school custodian or the camp counselor. Yet the adults who are turned to have rarely had any preparation for dealing with death and dying. Their own life experiences may or may not have been helpful to them in talking very comfortably about death and dying. In a survey of teachers in 1980, for example, it was reported that 92% of them said they had had no attention given during their undergraduate years to preparation in talking to students about death and dying.

I want to suggest to you that there are indeed ways that adults can be helpful. The first point is to recognize your own feelings. Unless people can deal with their own feelings about grief and loss it is extremely difficult for them to hear, let alone help, groups of bereaved kids.

The recent death of Miss Feldman's mother made it impossible for her to tolerate the unending discussion of death in the Special Needs class of nine to twelve-year-olds. Harvey's grandmother had died last month. Jerry's uncle was brutally murdered and his body dismembered in the near-by housing project where several youngsters in the class lived. Now Sheila was telling everyone that she had killed her mother. This was one of the distortions kids can make: Sheila had been told that junk food can kill you; she did not understand that her mother died from cancer, and not from the sip of soda Sheila gave her just before she died.

It was difficult for Miss Feldman to decide which aspects of her discomfort were caused by her own mother's recent death and which were the result of the difficult deaths these youngsters had experienced. It really didn't matter though, because although she

wanted to help the children she simply couldn't bear to hear them talk about death. She was willing, however, to have someone come in and work with this group of kids who wanted to spend all their class discussion time talking about these brutal and awful deaths that had happened in their lives.

It's perfectly all right to ask someone else to help you with a group of kids; but I say to teachers or counselors that they must not leave; they have to stay in the room when it's being dealt with, because it's their permission that the kids need in order to talk with anybody else.

Second, share the fact of the death with children and parents. An issue that arises over and over again is the use of the public address system in schools. They all say, "We can't help it. If we have fourteen classrooms, there's no way we can get around to everybody and talk about a death." So over this box should come, "We're terribly sorry to inform you that Billy died in an automobile accident yesterday, and shall we observe a moment of silence?" I am absolutely intolerant of that. I always tell them my feeling that they could take the first five minutes of the day and gather all the teachers somewhere and talk to them about what has happened and send them off to at least give the information to kids in some other way than over a box on the wall of a classroom.

Another thing that gets schools in trouble is that they don't notify parents. The result is that pupils come home and start talking about this death that has occurred in their lives, and is terribly important to them, and the parents don't know what is going on. Schools need to notify parents the same day they notify pupils, even if it's only with a memo to take back on the bus.

In informing parents and children about death we need to know at what cognitive and developmental stage the kids are. There are a lot of references that tell us about childrens' conceptions of death. I'm extremely fond of the little guys, because they are the most involved in trying to figure out what death and dying is about. Pre-schoolers see death as temporary and reversible; and no matter how gifted you are in talking to them about death, they will say, "Yes, I understand," and the next day will ask, "Where is he?" - like these kids who wanted to know when their classmate who fell out the apartment window was going to come back. They get it all mixed up. They'll smile sweetly and say, "Yes, I got it," and they don't at all. Their questions become quite amazing. "Is he living underground? Is it like living in a box?" It's very hard to given them an honest picture.

When the handicapped teacher's aide in their pre-school class died, one question came up over and over during the four-year-olds' discussion of her death. Think of how it might feel to have your teacher die while you're out on the playground. The feeling of the staff was, "Let's don't tell the kids. Let's just say she got sick and won't be back." After all, they already know she was in a wheelchair. The ambulance had come with its

flashing lights and its siren, but the teachers didn't want to talk to the kids about it except the head teacher, who said she would quit if she couldn't talk to them. She said she had never been dishonest with the kids before, and had no intention of starting now. That made a bit of a show-down for the trustees and staff. They finally agreed she could talk to the children.

As the discussion occurred, the kids did fine. They had no trouble. They had one persistent question, however. "What's going to happen to her wheelchair?" The teacher had the good sense to say, "What would you like to have done with that wheelchair?" The kids said, "We have to bury it with her. After all, how will she get around in the tunnels down there?" This is a very graphic example of living on under changed circumstances. For heaven's sake send her wheelchair along because she's going to need it to go tunnel by tunnel between the boxes.

Third, monitor particularly vulnerable children. There are all kinds of vulnerable children we have to pay attention to when we're dealing with the death of a friend. There are kids who have similar deaths or threatened deaths in their own families. There are kids who may know of illnesses that caused the death of other kids. One of the things I always advise people is to realize that very young kids can be suicidal. People don't like that. I read the 1982 Massachusetts public health vital statistic report yesterday. There is no possibility of categorizing the death of a child under ten as a suicide. This is absolutely bizarre, as people who work with kids know. We'd like to believe that young kids are not suicidal. They can be and they are. We're working in our program now with a four-year old who wants to drink poison to be with his friend who died. He's lonely; he'd like to be with him. He gets all mixed up about how permanent death is. We're also working with a nine-year old who has dreams of her brother saying to her, "Go ride your bike in the traffic so that you can come up to heaven and play with me up here." Clearly suicidal kids.

I went to a middle school–one of those I listed in that litany of horrors I began with –and the principal told me that all the kids were really doing fine. Afterwards the nurse came up to me and asked, "Can I talk to you for a minute?" She said that in the last week six kids had come to her making suicide gestures and attempted threats - one week after the death of a child with a cerebral hemorrhage who went home with a headache and died that night. Everyone was terrified: that kid had been healthy that day and went home and died. Indeed the kids were suicidal, but no one wanted to hear it because then what do you do?

Fourth: address kids' fears and fantasies. They have fears and fantasies about all kinds of things. Younger groups of kids, at least, are very clearly using magical thinking to explain their world. The world revolves around them: they are the most self-centered souls you could ever want to see. If anything happens it's because they thought it, they

said it, they didn't say it, they wanted it, they didn't want it, they stepped on a crack–you name it, they caused it in some way. The minute someone in their life space dies, they became convinced that it must have been their fault. They also use magical thinking to explain deaths that make no sense to them.

The son of one of our Good Grief volunteers was six or seven when his classmate died of a sudden virus. She had been alive on Monday and on Thursday she was dead. Jonathan kept asking his mother, "why did Susie die?" His mother claims to have answered that question twenty-seven times. She was counting every single time that he said it to her because she thought she was going to scream. It was so scary to think about it. If Susie could die, Jonathan could die equally well.

"Thank God." Then she said wisely: "Why did Susie die?" He said, "Because she ate her cookies before her sandwich."

Then his mother knew she was back at square one, that indeed he didn't understand it. What he was saying to her was, "Look, something as terrible as death must have been caused by something really awful." The most awful thing he could think of that could cause him to die was to eat his dessert before his dinner, or his cookies before his sandwich.

Fifth, discuss issues specific to the situation. These may range all the way from cultural and ethnic observances at a time of death to illnesses like cystic fibrosis; to violence: why people do crazy things, why adults get so angry and abuse kids and cause death. Without relevant information kids don't cope at all well. A brief example: Mrs. Weaver, a very special 38-year-old language teacher and advisor to the senior class at a private boarding school had a malignant inoperable brain tumor and appeared more and more confused. She collapsed on campus, she was acting remarkably bizarre, and nobody wanted to talk to the kids about it. The guidance counselor somehow shamed everybody into saying "You know we really ought to have Sandra Fox come and talk to us." So I got out there and obviously nobody wanted me to be there. As we talked - it was a very difficult discussion - some of the faculty began to cry. What they were finally able to talk about was that this woman was so very sick and dying; and the fact that it was her brain that had been injured by this illness was just devastating to these people at a school where education and learning were so highly valued. Until they grieved themselves they couldn't begin to think how to talk to the kids. They started grieving and then they were able to move on.

Sixth, support kids and adolescents as they grieve. Provide a place where boys can cry as well as girls. Make it possible to be mad, sad and bad. Realize that for young kids, grieving often comes out as mischievousness, boisterousness. It's almost as if "If I make a noise and crash around this room, you'll know I'm alive and not dead." Adolescents are shown in research to have symptoms of truancy and shoplifting associated with grieving.

Seventh, remember the child who died. The biggest problem adults get into with this is that they make the decisions about how friends of groups of kids should be remembered. The best example I know of is a high school where two pupils died over the Christmas vacation. The kids came back to school and the administration said they had decided to set up a scholarship fund in memory of the students. The kids said OK; it wasn't what they would have done, but who is going to say they didn't want to honor them? They decided, however, a little later in the year, that what they really wanted to do was to dedicate their Year Book to the two seniors who just died and to one who died last year whose death they are clearly still mourning. The faculty advisor to the Year Book said, "No, you absolutely may not dedicate your Year Book to the memory of those three students. Twenty years from now I don't want you looking at those Year Books and remembering those kids. You ought to remember happy things." The kids thought it was bizarre. So I am trying to figure out a strategy to help them and help the school to get some resolution. They are making it very difficult for these kids to do that final step of going on.

Last of all, what we need to do to help groups of bereaved kids is to establish or continue an on-going death education program. That can take many different forms. There are formal curricula, but it's hard to get a curriculum into most schools these days. They are too preoccupied with math, science, reading, etc. There are also very informal kinds of things. I think of a wonderful book of poems about schools and teachers, called The Geranium on the Windowsill Died but You Went Right on Talking. The poem goes like this:

It got very dark outside–but you just turned the lights on.
The wind started to blow–but you just closed the door.
The geranium on the windowsill died, but you went right on talking.

That's the antithesis of what we are aiming for. Use life experiences. Use the fact that the kids knew when Mrs. Gandhi died–there were pictures all over the papers. Use the fact that they have all seen the pictures of starving African children on TV. We don't have to look for curricula if only we would help people be comfortable enough to work with those issues as they come up.

Now a few words about the Good Grief Program, the source of the experiences I have been discussing. It is a collaborative program, co-sponsored by the Judge Baker Guidance Center and the Junior League of Boston. The model we follow uses both community volunteers and professional mental health people. It offers five kinds of services: crisis intervention, consultation, in-service training for teachers and others

who work with children; educational programming for community groups, especially parents; and finally, resource materials.

Crisis intervention means that I go talk with the children in the presence of their teacher or counselor in situations when a sudden tragic death has occurred and the adults are too overwhelmed to talk about it. Consultation, on the other hand, involves meeting with the school superintendent or a staff group and working with them so that they are able to go on and work with the group of kids. To give a recent example: the superintendent of a school where a kindergartner had been run over by the school bus had only one hour for consultation with me. He had had to rummage in the trash can that morning to find the Globe article telling about the Good Grief program and giving our phone number! In that hour we were able to cover multiple issues raised by the tragedy; all he needed was time to crystallize his thinking and he was ready to go.

Resource materials are provided without an additional charge in instances of consultation or crisis intervention, but in general we expect schools and community groups to meet the cost of services to the greatest extent possible. We believe it is essential that their budgets include funds for mental health services, both preventive and therapeutic, and we work with groups to achieve this goal. A waiver of part or all of the fee may be requested in hardship circumstances.

We would like to do the in-service training and the educational programming before a death occurs, so people can anticipate how they might work with kids. There is a tendency for us to be called in on an emergency basis after it has happened.

We have developed some excellent resource materials to fill in the gaps which we noticed when we began working in this field. Susan Linn, a professional puppeteer, made a video cassette for us, in which puppet characters mourn "The Death of a Friend." With the help of our Junior League Volunteers we have brought out an "Annotated Bibliography of Books and Films on Death and Dying for Children and Adolescents," and are about to complete a resource guide on cultural and ethnic issues and rituals which it may be important to recognize in dealing with families at time of a death. My own monograph describing the Good Grief Project is currently in press.

As the program goes into its third year, we have crystallized the model sufficiently so that it is ready to be replicated in other parts of the country. The Junior League of America has taken the first step by sponsoring a conference here in Boston which will train Junior Leaguers from other states who are interested in developing good grief programs in their communities.