THE REST OF THE STORY: PSYCHO-SOCIAL ISSUES

—by Michael Durfee

Elizabeth Kubler-Ross made death an official part of social science with her 1969 book, On Death and Dying (Kubler-Ross, 1969). We have learned something about unavoidable natural child death since the publication of that book. We have not learned how to address the helpless rage that comes with the violent death of a child, particularly at the hands of a caretaker.

This rage affects many people who knew and loved the child, including immediate and extended family members, friends, neighbors, teachers, pastors, and professionals who may have been involved with the family. Those who have seen, heard and touched the living child often experience particular pain on the child's death.

Law enforcement, fire, and emergency medical technicians are the first scene responders and must make almost impossible decisions about initiating life support for the child and human support for the family, services that may conflict with preserving a potential crime scene and making an arrest. Questions arise for which there is no training, such as "Should the family be allowed to hold the baby to say good-bye?" "Should I return for an interview tomorrow after the mother has stopped crying or is this a criminal suspect that I need to arrest now?" "Do I call a detective or a priest?"

Child protective services, law enforcement, and other agency line staff are often left to explain to family, friends, and themselves that they did what they could, that they are not responsible for the child's death. CPS staff may need to plan the funeral. Law enforcement officers may need to attend the autopsy to assist in the investigation. Public health nurses share the isolation of all professionals who make solo contacts with a child and family in their home away from the support of a clinic, office, or hospital. While they are trying to deal with their own grief, all of these professionals are a common target for a news media that is angry and looking for someone to blame for another child death.

We have not learned how to address the helpless rage that comes with the violent death of a child, particularly at the hands of a caretaker. Questions arise for which there is no training.

Predictable, systematic support for line staff who must deal with child fatalities is rare. Law enforcement may have counseling services for other problems, but not for the death of a child. Medical professionals, coroners, medical examiners, and court staff may direct personal support to comforting the immediate family, but do not direct support to their own line staff. CPS staff may be ignored or asked to reassure the agency that their paperwork is in order, working without direction to arrange funerals, explain the death to siblings, or find resources for the surviving family and for themselves. Staff who have to deal alone with the death of a child may quit, take anger home or to the next client, lose sleep, overeat, smoke, drink, or otherwise damage themselves.

We have limited literature on which to draw in creating programs and policies to assist professionals and surviving family members. Most studies on child fatalities focus on the deceased victim and the perpetrator. Graduate schools and agency training curricula generally ignore death, particularly the death of a child client, as a significant issue for their profession. We have to glean what we can from literature and experience with SIDS (National Institute of Mental Health, 1980), PTSD (Eth et al., 1985), and hospice programs, and from the general literature on children and death (Fitzgerald, 1994; Fitzgerald, 1992; Grollman, 1990). We must translate that knowledge to the experience of fatal child abuse and neglect.

Some agencies have developed support programs for professionals. The Los Angeles County Fire Department has a "critical incident debriefing" after the death of a child. Staff who were at the death scene are brought together with a senior fire department staff member and a mental health consultant to share experiences at the death scene and emotions that followed. Staff report relief and the agency reports less stress retirements. Other models include individual counseling, monthly open support groups and multiagency line support meetings. Meetings of multiagency child death review committees may also be therapeutic, particularly because they demonstrate that individuals do not have to be alone. However, most supervisors who wish to provide support for professionals and surviving family members, will have to innovate. APSAC is helping the author of this network of these professionals by publicizing his effort to do so (see box, p. 19).

The rest of this article outlines some of the considerations for supervisors who find themselves in this position.

When providing support to professionals:

- It is useful to have protocols and procedures in place before the problems occur.
- The management of the case should be assessed so the supervisor is informed and ready to deal with the line staff's doubts, questions, and possible failures.
- The staff member's relationship with the child should be assessed. How well did the worker know the child? How often had the child been seen? What sort of attachment, if any, had been formed? Touching and verbal and nonverbal communication are important experiences to assess.
- The worker should be assisted in making funeral arrangements. If the worker attends the funeral and visits the grave, he or she needs support, perhaps accompaniment, in these activities.
- Supervisors and peers should offer frank and immediate support, being willing to listen to help the line worker process the experience, no

continued on next page

The Rest of the Story: Psychosocial Issues

continued from page 47

matter how painful.

- Support should be ongoing, both from supervisors and peers and, when possible, from a good therapist.
- Expect that the worker can continue to function; assume competence. The worker may appreciate being temporarily relieved of work; on the other hand, being relieved of duties can send the wrong message and deprive the worker of a sense of continuing competence.

When working with surviving family members:

- Be aware of their actual experience at the time of the death; the circumstances of the death, their relationship to the victim, their relationship to the perpetrator, their involvement in the death.
- What is the developmental level of the surviving children; how was the abuse/neglect was explained to them?
- How was the individual and the family as a whole functioning before the death? Is there any evidence of psychopathology or adaptation before, during, or after the death?
- Is there support within the family? Are other supportive social systems in place, including extended family, friends, neighbors, clergy, agency professionals?
- Has the family participated in the funeral and other ceremonies? What other significant deaths or losses has this family endured? How much time has passed between the death and interventions designed to help?
- What has the impact of the investigation been? Has it supported or damaged family functioning?

When working with families and professionals:

- Ensure the immediate and ongoing basic safety of all individuals.
- Provide peer support groups when possible.
- Provide ongoing support of all kinds during the funeral and official mourning, during any court or investigative process, through at least a year to monitor the first anniversary response.

Qualities to seek in therapists or other support personnel working with children after the death of a sibling:

- basic knowledge of child abuse and neglect, domestic violence, substance abuse.
- knowledge of child development, family dynamics, PTSD, and dissociative phenomena
- a willingness to work with CPS, law enforcement, and the courts.
- experience with family violence intervention.
- experience with death, dying, mourning, and grief with emphasis on children.
- experience working with children of the age of the sibling.
- ongoing availability for at least a year.

Many, if not most, surviving siblings, other family members, friends, and professionals receive little or no formal intervention when a child dies. Our knowledge base for psychosocial intervention is limited. We need to share experiences and develop a literature to ensure that the survivors of fatalities receive the support they need.

References

Eth, S. and Pynoos, R.S. (1985) Interaction of trauma and grief. In Eth, S. and Pynoos, R.S. (Eds.), *Post-Traumatic Stress Disorder in Children*. Washington, DC: American Psychiatric Association Press. 171-182

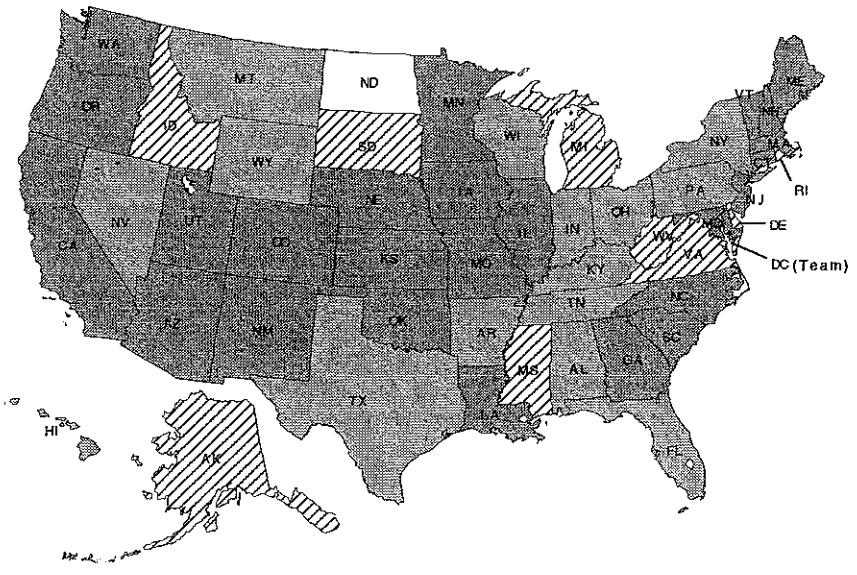
Fitzgerald, H. (1992). *The grieving child*. New York: Simon and Schuster.

Fitzgerald, H. (1994) *The mourning handbook*. New York: Simon and Schuster

Grollman, E. (1990). *Talking about death: A dialogue between parent and child*. Boston: Beacon

Kubler-Ross, E. (1969). On death and dying. New York: Macmillan.

National Institute of Mental Health. (1980). *Talking to children about death*. U.S. Department of Health and Human Services



Multiagency Child Death Review Teams: U.S.

State Team

Local Team Only

Formal Planning

No Team

Survey - Michael Durfee MD - November 28, 1994