Psychotherapy and Supervision with a Bereaved Moslem Family: An Intervention that Almost Failed

Simon Shimshon Rubin and Haleh Zaheer Nassar

FAMILIES responding to loss are units that function and are embedded in particular cultural frameworks. The adequate clinician learns to work with different individuals and problems over time, and in this process he or she learns about the importance of a range of variables including sex roles, age, socioeconomic circumstance, and the like. In parallel fashion, the developing clinician also learns to work with different cultural and religious contexts as they affect and frame the client's experiences.

Cultures and peoples in conflict pose special difficulties for therapists. In Israel, the mosaic of subcultures and peoples offers an additional opportunity to consider the subtle interplay of humanity, transference, and countertransference as they underlie the work of therapists and supervisors. Given the atmosphere in the United States, one is able to learn about skills and limitations when working with peoples who are basically committed to coexistence and to finding a common meeting ground for divergent life-styles. In Israel, things are more complicated. The ongoing Arab-Israeli conflict has impacted very powerfully on the relationships between Jews and Arabs. Religious, political, linguistic, and cultural differences are typically reason enough for people to misunderstand and mistrust each other. In Israel today, these differences are embedded in a larger struggle for personal, cultural, local, and national existence that is far from resolution. Life for both Arab and Jew in Israel requires mutual interaction in a context wherein trust is hard won, never complete, and always fragile. Of all the helping professions, perhaps none is as sensitive to feelings of trust and mistrust as psychotherapy. Transference and countertransference are part of the terminology of our profession and reflect these feelings as anxiety and mutual sensitivity and defensiveness (Gorkin 1986).

The death of a child involves most people with the specific cultural and religious practices of their reference group. The authors' limited familiarity with Islamic practice circumscribed the ability to determine what was unique to the family and what was common to the subculture. As the authors' knowledge of the religious and cultural features increased, they proved valuable in adding an additional dimensions to the understanding of the

Simon Shimshon Rubin, Ph.D., and Haleh Zaheer Nassar are with the Department of Psychology, University of Haifa, Haifa 31905, Israel.

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It is perhaps a conceit of psychotherapists to assume that people are more human than otherwise, and that genuine caring and helping has a contribution to make even in the relationship of peoples in conflict. Such a stance can be interpreted as secular humanism, good Christianity, enlightened Islam, or ethical Judaism; or equally as naivété, wishful thinking, psychopathological denial, and the like. We leave that value judgment to the reader.

The following material represents a subset of the collaborative work of a supervisor of Jewish (and American) origin, an Arab Christian therapist in training, and a Moslem family in distress. The ultimate product of our collaboration was the improvement of the client family. To achieve this, however, it was necessary for the supervisor to understand both the therapist and the clients “well enough.” Similarly, the therapist had to consider whether to trust her supervisor “enough” as a professional and as a person. The clients had to weigh their needs and their fears, and to decide how much to trust the therapist as a professional and as a person. We shall return to this later.

ON LOSS AND THE FAMILY

The sudden and unexpected death of a child initiates a period of disequilibrium and crisis for all a family’s members. The period of greatest risk and opportunity for family members confronting loss is that of the first year following the death. During this period the interaction of parents and children, in every possible configuration, can exacerbate or mitigate each individual’s adaptive response to loss. The powerful impact of loss upon family members strains their capacity to cope and to assist each other in the critical period following the sudden death of a child (Rubin 1981, 1986).

Responding to the child’s death, each member of the family passes through an individual mourning period. As each has had a unique relationship with the deceased, so must each embark on a personal odyssey through the mourning process and face what he or she has lost. Despite numerous differences that are a function of maturation, personality, experience, and role, there does exist a basic parallel between the emotions and tasks of bereavement that parents and children confront.

The influence of parental response to the death of a child upon the reaction of surviving children underscores the pivotal role of parents in their children’s lives. As models for identification, as sources of support and attachment, as major determinants of the emotional and physical climate of a family, parents have a significant role to play. Their role weighs heavily upon them. The responsibility and authority that society and parents have vested in parents present grieving parents with a double burden. Acutely aware of their responsibility as parents to protect and develop their children, they experience the death of a child as a failure on their part to have completed the task of parenting. Thus, at the time when the family constellation is so sensitive and in need of their contribution to coping with the loss, the adult is typically racked by the combined force of the loss of the child, and a deep persistent sense of guilt and responsibility for having failed the deceased (Gardner 1971; Giladi 1989; Gourevitch 1973; Lindemann 1944; Rubin 1984b).

THE CASE. I

The following case presentation opens with one Moslem Arab family’s dysfunctional response to loss. The case was referred to Haleh Zaber Nassar (H) for evaluation and treatment because she is a native Arabic speaker. This was to prove a major asset in making contact with virtually all members of the family. Simon Shimshon Rubin (S) was to serve as her su-
 supervisor in a small weekly supervision group setting at the University consisting of H and two other students.

The Flanns (Everymans) were a working class family who made application to a local mental health center. The presenting complaints were that Reem, their 10-year-old daughter, was exhibiting symptoms following her brother's death 4 months earlier. Reem was having sleep difficulties, was often uncontrollable, and was looking for her deceased brother Nadir at construction sites in the neighborhood. Reem had witnessed her 10-year-old brother's death from a fall while the two had been playing together at a construction site.

In the initial set of interviews with the parents, H established that Reem had been told her brother was in "the hospital" although she had been present at the accident and had witnessed a different scene. Her father, Mr. Flann, was clinically depressed and harboring suicidal ideation arising out of strong guilt feelings related to the accident. To add to the confusion, Mrs. Flann was pregnant with a child conceived days after the death, whom she expected to take the place of the deceased.

To therapist and family, Mrs. Flann related that she was pregnant with a boy named Nadir who would restore the balance to the family. It was no wonder that the two additional surviving children (ages 7 and 13) also denied aspects of Nadir's death and objected to the display of the traditional memorial photo of the deceased.

From the outset, a number of cultural and religious indicators signaling dysfunction were present. It is traditional that the deceased be brought into the home before burial, but in Nadir's case this was not done. This contributed to the sense of parental "failure" vis-à-vis Nadir. The absence of the accepted opportunity to confront the dead body, the proof of the loss, may well have adversely affected the family's ability to accept the loss relatively early in the grief period. Similarly, while in the Israel-Islamic culture, it is not infrequent that a new sibling is given the name of the deceased, the haste and the extent to which the new child was endowed with Nadir's memory was unusual. A greater span of time between such a death and naming a new child with the name of the deceased is traditional in the culture. Lastly, construction of a monument to commemorate the deceased is generally done quickly. Mr. Flann had remained emotionally incapable of building the monument to Nadir. This failure also reflected and exacerbated his feelings of having failed his son and further added to his guilt.

All the clinical and cultural indicators pointed to a family in an acute disorganized state. Additional indicators of dysfunction resided in the father's inability to successfully earn a living, as well as the parents' inability to discipline the children, provide accurate information regarding the loss, or offer support to each other or the children. The traditional roles of family members had broken down. The parents were unable to achieve or model appropriate functioning, information sharing, or to clarify the difficulties caused by their response to the tragic events. Each parent and each child in the family was experiencing the anxiety and isolation inherent to the response to traumatic loss. Furthermore, the family support system was unable to mitigate their pain.

At the subjective level, the therapist was very taken with Reem and saw her as an appealing, friendly child who easily encouraged attachment. Mrs. Flann was perceived as an unappealing young woman who looked much older than her age, and who represented a social class quite removed from the therapist's own experience. Mr. Flann was terribly anxious and his anxiety served to increase the therapist's own anxiety level.

From all indications, the Flanns were a family in distress. It was clear that overall family dysfunction had characterized their response to Nadir's death. As father had recently entered outpatient therapy at a neighboring facility for depression, a treatment plan emphasizing work with
child and mother was decided upon. The initial treatment plan envisioned weekly sessions with child and mother to: (1) reduce their immediate level of distress, (2) provide support for Mrs. Flann while her husband was unable to do so, (3) support Mrs. Flann’s ability to accept Nadir’s death and thus help her family accept it as well, and (4) continue the assessment of the situation. In addition, contact with the facility and therapist treating the father was initiated to foster a more comprehensive approach to the intervention.

THE SUPERVISION. I

The first meaningful supervision intervention S made with H was to explore her fears and worries about Mr. Flann. A neophyte therapist, H was concerned that Mr. Flann would be overwhelmed by his anxiety and depression. She was terribly concerned as to what to do. By following H’s anxieties and asking her what she envisioned, it became clear that she feared Mr. Flann would have a psychotic break. S asked her what she thought would happen next, and again what she envisioned would happen thereafter. In response, H began to imagine not only the decompensatory process, but also the recovery process that would follow a psychotic break. H utilized the supervision to face the peak of her anxiety regarding Mr. Flann and to begin to experience her worst fears. This occurred within the supervision, but it had an additional contextual meaning. The anxiety accurately reflected the overwhelming response of this father to his loss.

With regard to the loss itself, the overwhelming nature of the grief response is one that we recognize as too massive to assimilate in a short period. Clinicians and researchers have described, from different vantage points, the vastness of the task of assimilating the knowledge of loss, and how difficult it invariably is (Bowby 1980; Freud 1917/1957; Parkes 1986; Rubin 1984a, 1985, 1990b, 1993; Stroebe and Stroebe 1987). How painful that knowledge was for Mr. Flann, was one of the insights that H learned from the nature of this father’s response to Nadir’s death.

THE CASE. II

Phase one of the treatment proper began appropriately. The first meetings with Reem showed her to be an active, intelligent, and well-developed child. At the outset she made spontaneous mention of her brother falling at the construction site and being taken by ambulance to the hospital. She did not, however, mention that he was dead. Instead Reem alluded to her concerns in a number of ways. Reem expressed her fears verbally. She told stories about animals eating each other, about a monster living near the house, and about dying as a result of cursing the “Quran” or being cursed by a neighbor. She was also busy part of the time in the sessions burying dolls with sand or throwing them on the floor. Clearly her mind was very much on what happened to her older brother.

During the third meeting Reem seemed restless and talked a lot about jumping and falling. Suddenly she got up on the table and jumped and fell to the floor before H could catch her. Then she held her hand with both hands and started to scream frightfully “I will not recover again, I will not recover again.”

Despite her youth, Reem was aware that something terrible had happened to Nadir. Her attempts to understand it were colored by her fantasies about why people died and by her fears and identification with what happened to Nadir. The lack of clear communication about the death in the house, the father’s depression, and mother’s pregnancy and helplessness were contributing to Reem’s anxiety and symptoms. Therapy for her alone could mitigate but not relieve her anxieties. The vivid reenactment of the accident was reminiscent of the intrusion of traumatic experiences seen regularly in victims of physical and psychic trauma.

About this time, H dreamt about Reem as if she were her daughter or little sister.
The child's appeal and distress combined in a dream where H was concerned about catching Reem and not letting her fall when she jumped off a building into danger. The therapy of the case had gotten off to a good start. H was very supportive of Reem while linking her jumping to Nadir's accident.

Reem's appeal and H's ability to forge a therapeutic alliance with the child stood in contrast to the relationship with the mother. Mrs. Flann was disorganized, depressed, and chronically dishevelled, making her a rather unattractive client. H conducted supportive parallel sessions with Mrs. Flann but these did not mitigate this bereaved woman's fatigue or depression. She complained of physical pains due to the pregnancy and reiterated her strong wish to give birth to a boy and give him his deceased brother's name.

MRS. FLANN: I told the children I was pregnant with a boy. Nadir would rejoin the family. I don't know what would happen if it were a girl, but it will be a boy. When Reem asks where Nadir is, I can't tell her he's dead so I say that he is in the hospital or in my tummy.

Mrs. Flann was afraid of disappointing her family by giving a birth to a girl who would not replace Nadir. Her state of distress mounted further as she informed the therapist that her husband had been admitted to a psychiatric hospital. Currently he was enrolled in their partial day-hospital program.

The fourth session with Reem and mother was not held. In their place, Mr. Flann arrived unexpectedly to tell the therapist his wife was ill. During the meeting, he stressed his wish to join his son Nadir wherever he was.

MR. FLANN: I think about Nadir all the time. I can't work, I see him all alone and he needs me. He calls to me to join him. There is no point of living. I cross the street and think about being with him. My letters to the municipality were ignored. I should have fenced off the construction site myself. There is nothing that psychiatry can do for me, my son is dead. I should have gotten to him more quickly. I used to hear him call to me to save him, now he calls to me to join him. I think about him all the time.

H experienced Mr. Flann's wish to be with his son, his anxiety, and his agitated depression as devastating. She listened to him and encouraged him to continue talking about these things with his own therapist. When the session was over, she was exhausted and overwhelmed. Within days, Mr. Flann would move from intensive outpatient therapy to the day-hospital unit at the mental health facility where he was enrolled. For the Flanns, the adaptive levels of functioning at both the individual and familial levels were continuing to deteriorate.

The second month of therapy saw the sessions become more irregular. Reem was brought in only once. Mrs. Flann came twice in a very anxious state and talked about her pregnancy. She refused to accept that she might have a girl. Attempts to encourage her to accept the possibility of a girl, and to assist her help the children accept Nadir's death were unsuccessful. At this point, she was not amenable to introspection, and support was not sufficient. Exploration of her difficulties did not increase Reem's attendance in therapy. Despite the effort expended here, neither change nor insight was forthcoming. The second phase of treatment, that of resistance and noncompliance, was developing.

THE SUPERVISION. II

It was about this time that H came in and was relatively silent about her case. S asked her how things were going and what she was feeling. H sat quietly for quite some time. S and the other supervisees waited as the tension built, and finally H began to speak. She began by speaking of her angry feelings about the second-class treatment of the Arab minorities in Israel. She felt in part that Nadir had died because he was Arab and no one had paid attention to the father's letters regarding the danger at the construction site. To hear H voice her feelings engendered mixed feelings in the supervisor. On the one hand, she had taken a risk to share
some very basic sentiments that were deeply felt, even if unspoken by this relatively private young woman. Of this S was glad. On the other hand, the gulf of mistrust between them yawned widely. Even if it were only a countertransferenceal projection, the form it took was an altogether too real reflection of the context of the realities of their lives together.

The supervisor mused quickly over the development of the case so far and decided to go with H’s anger and explore with her what else she was responding to. Despite a sensitivity to political issues and an appreciation of the reality sources of these difficulties, the supervisor’s sense here was that the Jewish–Arab dimension alone was not the main focus of the difficulties at this time. And he said so to H. She was asked: What and who else was she angry at? Hesitating for some time, H began to expand on the sources of her anger. She was angry at the clinic director, who had given her such a difficult case because she was the only Arabic speaker there. She was angry at her supervisor because he refused to allow her to close the case and move on. Unable to terminate the case because of the supervisory contract, she was stuck with the case and her feelings. Each time she waited anew for Reem, and each time she was disappointed. She was angry at the mother, angry at the father, and angry at the supervisor for not letting go.

While speaking, H’s face began to soften, and she became less angry and more sad. Asked if and how what she was feeling changed as she spoke, H confirmed a shift from anger to sadness. The sadness stemmed from the death of Nadir, from the limits of her beginning skills, and from her sense of helplessness in working with this family. The anger at the supervisor and at the political situation had served to protect her from being overwhelmed by the morass of feelings she experienced working with the case (Bibring 1953; Sullivan 1970). Earlier in the supervision of the case, H had felt both pushed and supported around the exploration of her concerns about the father. This time, H added that she had felt able, albeit not without difficulty, to share and explore her feelings in the supervision. This for her was a second meaningful experience of trust in the supervision.

From the supervisor’s vantage point as a supervisor of therapy (Rubin 1989a, 1989b), the course of events described in this supervisory session is typical of supervision that is working. The supervisee raises an issue that seems to threaten the supervision. The supervisor invites exploration, and the supervisee cooperates in the task (Mueller and Kell 1972). What is unusual here is the content of the therapist response, which raise issues of national identity and the underlying conflict between the participants by virtue of national origin and divergence. A basic human trust forged out of personal, academic, and supervisory contact allowed for this session to progress in a useful manner with benefit for understanding of the case. This did not require H to deny her experiences of being a victim of prejudice, but it was equally important to locate her experience of these feelings in the context of the therapy and its impasse.

Returning to the case, H’s response alerted us to the following: (1) the family’s feelings of depression and self-blame might also benefit from an exploration of their inner fantasies of who else might be responsible: the Jews, the municipality, the doctors, etc.; (2) the family’s experience of H might be a persecutory one in which H refused to accept the family’s dysfunctional decomposition and defensive avoidance; and (3) to look for anger as well as sadness in response to her interventions.

THE CASE. III

The next 6 weeks consisted entirely of missed sessions, with the therapist waiting for the family and telephoning to discover what had happened to mother and daughter. Each time the therapist received an explanation or apology, but the next session was missed as well. (It was...
like the "waiting" the family experienced waiting for Nadir.)

Clearly the case had reached a critical stage. The therapy work with Reem had proceeded well but was now interrupted. Instead of a corrective emotional and cognitive experience, Reem was exposed again to a relationship that was disrupted without explanation or warning. Reem was being exposed to an exacerbation of her difficulties because H had "disappeared" for her. How would she understand this when her parents were unable to attend to her? The potential to blame herself even more, while continuing her uninterpreted response (and partial reenactment) of the trauma, was a result of the truncation of Reem's therapy experience. How could the therapist bring the therapy forward or to a close when the family refused to come in?

Mrs. Flann herself was in need of help but not available for it. Her inability/resistance to coming in had paralyzed her treatment. She did not accept responsibility for her absences beyond making excuses (for having forgot, not feeling well, being busy, etc.) to the therapist. The case had to be brought back into a therapeutic contract or moved to a close. If the latter, what would be the fate of the replacement child (Cain and Cain 1964; Rubin 1990a)? How would the family fare if the maladaptive attempts to deny the loss were to continue? The last telephone contact in this 2-month hiatus period began as a final attempt to resuscitate the therapy. Mrs. Flann answered the phone in a tone of near panic. Her oldest child had been hit by a car and had damaged her shoulder. Mrs. Flann was scared and feeling totally unable to cope. Echoing her husband, she expressed a wish to die to obtain relief from her difficulties. Yet how was the therapist to help without the family coming in for therapy?

At this point, therapist and supervisor decided to explore a 2-session home visit regimen. Should the Flanns' inability to come to sessions reflect a coherent desire to avoid treatment, the case would be closed. Should, however, the inability to receive treatment reflect familial disorganization, it would be possible to intervene within the home.

With a broad mandate in how to behave, the therapist obtained the mother's agreement and a date for a home visit. The third phase of treatment, intervention within the home, was about to begin. The home visits signaled the beginning of a consistent and regular family treatment phase. Although we never knew who besides mother would be home, the sessions were dramatically productive. The meetings coincided with improvement in communication, the individuation of the expected infant, and the acceptance, in part, of Nadir's death.

The first session at the Flann home was uncomfortable for the therapist, unused to the bustle of a household during a therapy hour. This changed as mother and daughter took the therapist on a tour of the site of Nadir's death. Mrs. Flann explained in detail what had happened, as Reem listened intently. It was a very moving experience. When it was time for the therapist to leave, 3-year-old Reem accompanied her and explained how Nadir had gotten hurt and been taken away by ambulance. The tour had been cathartic for the Flanns, not because it was their first—it was not—but because it was done as part of an attempt to integrate the loss experience emotionally. Moving to the family's own location, surrounded by the familiar and by the home where Nadir had lived, served to ease the family's reentry into psychotherapy.

The two-session contract was extended to last until after the birth of the new baby. The regularity of the sessions served to increase family communication and made Nadir's death something that was discussed. Mr. Flann, improving in his own treatment, was present for some of the sessions and participated constructively. At this point, he was partly enrolled in the day-hospital program but was working part time as well. The acute suicidal phase of his depressive grief reaction had subsided and he was able to resume elements of his preloss functioning. The
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quality of his functioning continued to improve and undoubtedly contributed to the improvement in the family's ability to more adaptively assimilate Nadir's loss.

The next home visits were critical sessions for our identified patient. At home, sitting with her parents, Reem began by mentioning her anger at mother for not bringing her to the clinic. She spoke again of the construction site and the risk to people who went there. Nadir's loss and Reem's fantasies emerged through her play. She played at shooting a policeman and explained that he died and would be replaced by another man. As children are wont to do, she named all her family members save one. Returning to the living room to stare at her parents, she hesitantly continued that there was one more person—and his name had been Nadir—and he was gone.

The therapist responded to Reem's communication by acknowledging that Nadir had been with the family but was now gone. It had not been Reem's fault that he had died, but she and her parents had been sad and upset and even mad because of the loss. H said no more, and neither did Reem. The Flanns nodded silently and continued their "visit" with H.

Beginning here, Reem's symptoms diminished rapidly. Paralleling her improvement were changes in both parents. Mrs. Flann began to accept the distinctness of the new baby and ceased referring to it as a return of Nadir. The therapy focus shifted to helping the family realistically plan for the new child. By the time of the birth, 9 months after Nadir's death and 4½ months after treatment, the newborn girl was able to enter the family under a reduced cloud of expectations. She was no longer merely a female version of Nadir. Not only for Reem and her newborn sister, but for all family members, the intervention had been beneficial. Among the benefits were a diminution of Mrs. Flann's agitated depression, with a consequent return to appropriate dress and function.

The final phase of contact with the family followed the baby's birth. Mrs. Flann cried openly in her first postpartum session with the therapist. Holding the baby carefully, she explained that she had been slow to accept the new baby because it had been brought home to her at a deeper level that Nadir was gone. The acceptance of this fact was important to her—but also difficult to bear.

Over the course of the final four meetings, continued difficulties in accepting the new child and attending to the needs of the surviving siblings were present. It was clear, however, that both individual and familial functioning had rebounded. The greatest risk for the family had been averted and they were on the road to recovery.

The positive outcome of this case was associated with the therapists' willingness to take an activist outreach approach to therapy. Although traditional psychotherapy with a family focus would typically yield positive results in similar cases, there was a unique difference here. The Flann family was unable to meet the clinic requirements and appear for therapy. Both a theoretical and a personal sensitivity were needed to work with the case on terms that the family's disorganization dictated.

DISCUSSION

Loss and the Family

The breakdown in functioning that characterized the Flann family affected each member of the nuclear family. Although the presenting problem was the province of the 3-year-old, at the outset, each member of the family experienced an inability to acknowledge the reality of the loss in the manner that would allow uncomplicated mourning to proceed.

The parents' inability to effectively confront the loss and discuss it with the children was paramount in the emergence of an identified child patient. Collectively and individually, the members of the family were having difficulty in accepting the reality of the death. The myth that the son was in the hospital and the fantasy that he

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would return as the new infant were the expressions of the attempt at denial of the sad, painful, and anxiety-provoking fact that the son had died. Only when the parents were able to accept the loss in a realistic manner were the children able to do so as well.

Mr. Flann's guilt and remorse over his son's death took the form of blame for not having been sufficiently protective. In his mind, he had protested the lack of safety precautions at the neighborhood construction site, or had he reached the scene of the accident more quickly, he felt that he could have either prevented the accident or saved his son after the fact. Guilt is endemic to loss and has a complex multivariate etiology. Its sources are not easily dismissed or overcome (Klass 1988; Rubin 1984b; Smith 1971).

Children share with their parents a sense of troublesome guilt over a sibling's death. The confusion of fantasy with causation, of thought with action, of triumph with fear of punishment, and of rivalry with hate, serves to confuse children and their adolescent counterparts. These features also confuse the archaic child residing within every adult. Yet by virtue of their developmental status, children are closer to magical thinking than the adults in the family. Similarly, they have a greater degree of misunderstanding and confusion about the facts of death than their older siblings and parents (Furman 1974). They are at particular risk because they are rarely solicited, talked with or to about the facts of death. This is typically because of the discomfort that most adults have confronting the subject. In this case, the identified patient, Reem, was at particular risk because of her young age.

The initial maladaptive response of the Flann family to the sudden death of the 10-year-old stood in marked contrast to the postintervention outcome. Undoubtedly, the therapist's native fluency in Arabic provided the necessary language skills for communication with the family, whose first language was Arabic. Notwithstanding this, the therapy was in great danger of falling apart.

The shift to the home visits proved very important to the successful outcome. The decision to explore a home visit regimen was not taken lightly. Our reluctance to intrude into clients' home life space, particularly when they are ambivalent and distressed by the treatment, was balanced by the conflicting signals the Flann's communicated. We did not wish to overwhelm defenses nor to ride roughshod over clients' responsibility for their lives. Yet the level of crisis and disorganization prompted a probing of the limits of the intervention process. Once the home visits were accepted by the Flanns in principle, a clinical trial was necessary as well. The two most important features of this home intervention phase were the support of the mother (father receiving help elsewhere) and the facilitation of accurate communication within the family. Together with father's own improvement following his individual treatment, the home visits were important. Once the parents were afforded an external support system, they were able to reorganize their own responses and to confront together with their children the reality of the loss. A return to adequate functioning at the individual and family levels was accomplished, together with a beginning detachment from the deceased and a readiness to accept the new infant as a separate individual.

**Supervision**

There were three critical junctures in this supervision history. They were: (1) the exploration of H's fear of Mr. Flann's breakdown, (2) the exploration of H's anger at the Jewish establishment for their treatment of Arabs in general and for Nadir's death in particular, and (3) the support of H on a regimen of home visits until the therapeutic resolution. The lessons learned by the developing therapist
allowed her to grow in response to the therapeutic crises.

From the first crisis, H learned to meet her clients without an undue fear of the psychotic unknown. H did not continue to unconsciously equate breakdown with a final state of decompensation but saw it rather as a part of Mr. Flann’s struggle to assimilate Nadir’s loss. Thus, the “strange other” did not lose his humanity despite the anxiety he aroused (Havens 1987).

Second, the exploration of a segment of H’s tension surrounding the Arab–Jewish conflict was legitimized and followed to its location within the case. The perceived discrimination arising in response to Nadir’s death went beyond diffuse blame for those responsible for the conditions that played a part in the death. H’s further associations were toward those responsible for her remaining with the case. The therapist’s persecutory experience was of being “forced” to confront the painful situation of loss. This reflected in part the family experience and was useful for understanding the feelings of persecution that arose in response to the loss and to the therapy (Casement 1985).

Third, the home outreach was designed to either close the case coherently or move the therapy forward. The ability of the therapist and family to meet favorably helped provide a successful outcome. This outcome allowed H to more fully experience her sense of effectiveness and her learning. Although a child had died, through H’s work, room had been made for the new child to enter the family in her own right. Successful therapeutic work is one of the few rewards in our so demanding profession, and H had earned her sense of accomplishment.

To be helped to grow into the role of therapist is always a complicated task. In a case as difficult as this one, the young therapist who is assisted by a supervisor to a successful conclusion is changed by the process. The authors’ discussions of the learning process toward the end of the supervisory contract and later on underscored the value of our work together.

In dealing cross-culturally with loss, one should maintain a critically open mind. The interpersonal and psychological factors that we are familiar with determine much of the outcome to loss, but certainly not all (Bowlby 1980). Knowledge of the bereaved’s cultural reference framework can help diagnose difficulties and direct psychotherapeutic intervention. It can also help the therapist understand when injunction to grieve may run counter to tradition or in line with it. The cultural framework to this case was not the main determinant of response to loss, but as we learned more about it, we felt ourselves to be on surer ground in our conceptualization of the therapy and interventions. What we do want to highlight is that trust given between individuals is more than a precious and fragile commodity.

The Flanns, H, and S collaborated in a way that allowed for trust to develop. In a context where trust can be maintained, it has potential to allow for growth and healing (Bowlby 1977). We know that in the context of peoples in conflict, trust is hard to create and hard to maintain (Sager et al. 1970). In this therapy, sufficient trust allowed for healing and growth to occur. As a function of our bridge across cultural, linguistic, religious, and personal barriers, the Flanns were assisted to resume their lives while mourning Nadir in an adaptive manner. The bridging that occurred is of the essence in all psychotherapy.

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